MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 16TH NOVEMBER 2023 - DAY 71

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1 THE INQUIRY RESUMED ON THURSDAY, 16TH NOVEMBER 2023, AS
2 FOLLOWS:
3
4 CHAIRPERSON: Good morning, thank you. Yes,
5 Mr. McEvoy. 10:00
6 MR. MCEVOY: Good morning, Chair, good morning, Panel.
7 There is a Restriction Order application, Chair, in the
8 first instance. If the application could be dealt with
9 in the normal way.
10 CHAIRPERSON: Okay, well we're getting very used to 10:00
11 this. We'll cut the room to Room B so the application
12 can be made. Only persons present who have signed a
13 confidentiality agreement or Inquiry staff, yes.
14
15 RESTRICTED SESSION 10:01
16
17 OPEN SESSION
18
19 MR. MCEVOY: Chair, Panel, the witness this morning is
20 Mr. John McCart and the statement reference number is 10:02
21 178.
22 CHAIRPERSON: There's no problem about using his name
23 of course.
24 MR. MCEVOY: No.
25 10:03
26 MR. JOHN MCCART, SWORN, QUESTIONED BY MR. MCEVOY:
27
28 CHAIRPERSON: Good morning Mr. McCart, can I welcome
29 you to the Inquiry and thank you very much for coming

1 along to help us, and I will hand you over to
2 Mr. McEvoy.
3 MR. MCEVOY: Good morning, Mr. McCart, my name is Mark
4 McEvoy, we met briefly this morning. In a moment I am
5 going to read in a statement dated 30th October which 10:03
6 you have provided to the Inquiry. For your reference
7 and to your right-hand side, I think under that little
8 green folder that you have there, there's a page which
9 contains a list of names and corresponding ciphers. It
10 may be that during the course of my reading of your 10:03
11 statement, and also of course then your answers to any
12 questions later, you may need to refer to names and
13 therefore if you do, if you would please just check
14 that list and use the ciphers?
15 CHAIRPERSON: Can I ask you to stop for a second. I'm 10:04
16 not getting a transcript feed. I've got up to there is
17 a Restriction Order application. Can you give me a
18 second, I am sorry, I am going to close it and reopen
19 it.
20 CHAIRPERSON: We're all good, sorry. 10:04
21 MR. MCEVOY: Mr. McCart, I was explaining about the
22 importance of the ciphers and if you could if possible
23 use the ciphers numbers. If you don't, please don't
24 worry, arrangements are in place if a name does slip
25 out, it has happened. All I would ask you to do is 10:05
26 make an effort to apply if you can.
27
28 As you have seen, we have a stenographer, the
29 stenographer is keeping a transcript for the record of

1 the Inquiry. We want to make sure we capture
2 everything that is said and when I do come to ask you
3 questions if you would do your best to answer slowly so
4 that everything is caught, thank you.
5 10:05
6 So I am going to commence then with the statement of
7 30th October, Mr. McCart:
8
9 "My connection with Muckamore is that I was
10 professional social worker from 1980 until I retired in 10:05
11 2012. I initially was employed by the North and West
12 Belfast Social Services which later became the Belfast
13 Social Care Trust. I have worked for 32 years in
14 learning disability. The relevant time period I can
15 speak about is between 1984 and 2012. 10:06
16
17 From 1974 to 1977 I undertook a degree in social
18 science at Queens University, Belfast. I then did a
19 Masters in Social Work from 1979 to 1980 at the
20 University of Ulster. Most of my work was focussed on 10:06
21 the provision of disability services for people living
22 in the community in North and West Belfast.
23
24 From 1984 I worked in mental handicap, as it was
25 referred to at that time, which became the Community 10:06
26 For Learning Disability in North and West Belfast. I
27 started as a team leader and ended up as Programme
28 Manager and Associate Director of Social Work in
29 Learning Disability.

1
2 Prior to the late 1990s Muckamore was in the Northern
3 Trust area but run by the South and East Belfast Trust.
4 There was a reorganisation in the late 1990s and
5 Muckamore was then transferred to the North and West 10:07
6 Belfast Trust. When it was under the control of the
7 North and West Belfast Trust this was a big ticket
8 project for that Trust as it was it's main hospital,
9 and Richard Black, the Chief Executive of the North and
10 West Belfast Trust was interested in the place. He 10:07
11 actually had his office in Muckamore and that is where
12 he was located on a daily basis.
13
14 Muckamore was then transferred to the Belfast Trust, it
15 may have been in the early 2000s, but I do not recall 10:07
16 exactly when this was.
17
18 The Belfast Trust had the responsibility for several
19 large hospitals such as the Royal Victoria Hospital,
20 the City Hospital and Knockbracken Hospital. Muckamore 10:07
21 was a small outlying hospital and did not get the
22 attention that it deserved.
23
24 I worked in North and West Belfast for the majority of
25 my career. Families within that area were already 10:08
26 socially deprived and if they had a child with learning
27 disabilities this added to their situation. When
28 families admitted their children to Muckamore it was
29 because they had no alternative. Once a child became

1 too difficult to manage at school the education
2 authority would issue a letter to the family saying
3 that the child could no longer be educated. The family
4 had the option of sending their child to a day care
5 facility or to Muckamore. 10:08
6
7 Learning disability services were never a priority in
8 health and social care. It was always poorly
9 resourced. There was little consideration given to
10 learning disability services. They were passive 10:08
11 receivers and never seen as an area that should be
12 provided with funding. This resulted with people being
13 stuck in unsuitable places for their needs and
14 requirements, some of the patients in Muckamore being a
15 good example. On some occasions people were put into 10:09
16 Muckamore because there was nowhere else for them to
17 go.
18
19 I cannot recall any specific examples but I do stand
20 over this statement: If proper investment and 10:09
21 resources had been applied to provide alternative
22 assisted living then a lot of people would have avoided
23 going into Muckamore.
24
25 My central belief is that people with learning 10:09
26 disabilities should be treated equally to those who do
27 not have learning disabilities. Muckamore should be
28 used as a place to examine and treat patients but it
29 never should have been used as a permanent place for a

1 person to live.
2
3 I was the Associate Director of Social Work in the
4 Belfast Trust from in and around 2002 until I retired
5 in 2012. This post was a band 8B, 8C. In my post I 10:09
6 was responsible for social work teams in learning and
7 adult protection and I managed day services which
8 included Muckamore. I recall there was a team of four
9 to five social workers in Muckamore. There was a team
10 leader who I mainly engaged with, I do not want to 10:10
11 disclose her name. The team leader reported to another
12 person, again I do not want to disclose her name, who
13 ultimately reported to me.
14
15 The social work team at Muckamore managed the transfer 10:10
16 of patients into and out of the hospital. I have no
17 family connection to Muckamore and none of my relatives
18 worked in Muckamore.
19
20 I was based in the Everton Complex, Ardoyne, Belfast 10:10
21 and also at Fairview Building which was opposite The
22 Mater Hospital in Belfast. I was never based in
23 Muckamore, however I did have a lot of interaction with
24 the social workers in Muckamore. I attended Muckamore
25 anything from one to four times per week. I met with 10:11
26 the social worker team leader who was located in the
27 administration building in Muckamore and we discussed
28 particular cases and issues of concerns in her team. I
29 also spent some time on various wards where it was

1 necessary for me to meet a patient which the team
2 leader wanted to discuss. Given the passage of time, I
3 cannot recall any specific cases, however, or what
4 specific wards that I attended. I never witnessed any
5 abuse when I attended Muckamore. 10:11
6
7 I reported to the Director of Learning Disability which
8 was H477, pre-2002, then Miriam Summerville from 2002
9 to 2010 and then H730 from 2010 to 2012. I felt
10 supported in my role, particularly Miriam Summerville 10:11
11 had very high standards and knew learning disability
12 inside out. She would not have tolerated abuse. She
13 ran a tight ship and she was keen to link Muckamore
14 with the community. She had integrity in what she was
15 doing. During this time H359 was the Associate 10:12
16 Director of Learning Disability. She also knew what
17 she was doing. When Miriam retired, H730 took her
18 post.
19
20 It is my view that H730 had no knowledge of or interest 10:12
21 in learning disability and only obtained the post
22 because he was due a position at director level and the
23 post at Muckamore had become available. Perhaps I am
24 biased, however, as I felt I should have been given the
25 position as Director of Learning Disability and I felt 10:12
26 I was overlooked for the post.
27
28 In and around 2011, H507 took the post of Associate
29 Director of Learning Disability in Muckamore. She came

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1 from a mental health background and also knew nothing
2 about learning disability. Therefore, the two most
3 senior people in the hospital had no experience of
4 working with people with learning disabilities.
5 10:13
6 I recall my first impression of Muckamore was that it
7 was a big institution. The Muckamore building was
8 built in an out-of-sight location. It was located in
9 Antrim and run by Antrim people. Personally I felt a
10 bit like an outsider as I was not from Antrim. From a 10:13
11 social work perspective it felt like there was a divide
12 between the community staff and the hospital staff.
13
14 The community social workers advised me that it was
15 sometimes hard to keep track of patients once they were 10:13
16 admitted to Muckamore. When I took the post of
17 Associate Director in 2002 I organised speed meeting
18 sessions at Muckamore to introduce the community social
19 workers to the social workers in Muckamore in an
20 attempt to help relations. I have no love for big 10:13
21 institutions, however I appreciated that it was a
22 necessary requirement for the treatment of some
23 patients. I prefer to treat people in the community if
24 possible. I did not like the wards. Some doors were
25 locked and that was how the place was run. I cannot 10:14
26 recall any specific patients but I do recall patients
27 going into Muckamore receiving good treatment and being
28 discharged.
29 From 2006 onwards I was responsible for the

1 resettlement programme for Belfast-based patients at
2 Muckamore. My role was to try and resettle
3 Belfast-based patients out of Muckamore as soon as
4 possible. I did not deal with the day-to-day matters
5 however. I did not contribute to individual patient 10:14
6 plans, that was the team leader's role, but I did have
7 oversight and was a member of the senior management
8 team at Muckamore. I attended monthly
9 multidisciplinary team meetings where individual
10 patients were discussed. 10:14
11
12 I recall that Miriam Summerville chaired these meetings
13 when she was the director. The meetings were attended
14 by consultant psychiatrists, senior nurses, social
15 workers and other healthcare professionals involved 10:15
16 with individual patients. A care manager was appointed
17 for a patient and the care manager was responsible for
18 co-ordinating all of the patient's requirements so that
19 they could be resettled.
20 10:15
21 There was a dowry system in place at this time whereby
22 a patient would be allocated a budget for their
23 resettlement. The first option explored whether the
24 patient could return home to their parents. If that
25 was not viable then accommodation was sourced from the 10:15
26 statutory, private or independent sector. Resettlement
27 is a difficult role as it is very patient specific and
28 the funding is not always adequate for the patient's
29 requirements. The Eastern Health Board, via the

1 Department of Health, would identify a pot of money
2 available to the Belfast Trust which could be spent on
3 resettlement. However, if there was a delay in a
4 patient being resettled, for whatever reason, there is
5 no guarantee that this money would be available for 10:16
6 that patient in the future. This caused difficulty for
7 resettlement as it was very stop-start.
8
9 A lot of families were happy with Muckamore and did not
10 want their relatives to be resettled out of Muckamore. 10:16
11 Some of the members of the Society of Parents and
12 Friends of Muckamore were opposed to resettlement out
13 of Muckamore. They could see resources available in
14 Muckamore which were not available when patients were
15 discharged into society. This added to the difficulty 10:16
16 in having patients resettled.
17
18 Most of the patients that we resettled out of
19 Muckamore, in my view, were a success. I cannot
20 remember any specific examples however. I resettled 10:16
21 patients into Rigby Close off Cavehill Road, Belfast
22 and Trench Park off Finaghy Road North in Belfast.
23
24 I also conducted vulnerable adult investigations in
25 Muckamore if a patient had an unexplained injury. I 10:17
26 cannot recall any specific cases, however. If I was
27 made aware of possible safeguarding instances at
28 Muckamore my role was to decide whether I needed to
29 make a report to the PSNI. In Muckamore every physical

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1 intervention had to be reported on an incident form.
2 These would come across my desk to review. I would
3 read and discuss each issue. If the incident was
4 serious there would be a case conference where we would
5 discuss whether the staff member needed to be 10:17
6 disciplined. I cannot recall any specific examples,
7 but typically this would have been if a patient had
8 received an injury and we had to decide whether the
9 injury was caused as a result of inadequate supervision
10 or some other reasons such as a problem with equipment, 10:18
11 it have been caused by a patient on patient incident.
12
13 I also assisted with investigations around staff poor
14 practice and I recall sitting on a Muckamore
15 Disciplinary Board a few times as a non-medical panel 10:18
16 member, however none of these related to abuse. I
17 cannot remember any specific examples.
18
19 I would refer the Inquiry to the Equal Lives Report in
20 2005. This was part of the Bamford Review of Learning 10:18
21 Disabilities in Northern Ireland. The report was
22 prepared by Siobhan Bogues who had a good vision for
23 people with learning disabilities. There has never
24 been a proper implementation of the Equal Lives Report.
25 The implementation was stop-start and subject to 10:18
26 financial constraints. It looked at hospitals like
27 Muckamore. I would also refer the Inquiry to the
28 Winterbourne Report which was based in a community
29 facility in England. This report came out in the

1 2000s.

2

3 Politicians have been saying that they did not know
4 what was happening in Muckamore, but this is nonsense.
5 I personally know a number of politicians' family 10:19
6 members were in Muckamore but I do not want to provide
7 names. Abuse can and does happen everywhere. The
8 events which have been recorded in evidence to the
9 Inquiry by patients and families is not something which
10 only happens in Muckamore, it happens in the community 10:19
11 as well. The response is always to discipline the
12 staff and sack them. In addition what needs to be done
13 is to give staff training and set proper standards from
14 the outset.

15 10:19

16 I am involved in an organisation called Vocal, which is
17 an association which provides independent advocacy
18 services. During my involvement with Vocal I met a
19 former patient of Muckamore called P19 who spent most
20 of his life in Muckamore. His brother, P20, also spent 10:20
21 most of his life in Muckamore. In and around 2015 or
22 2016, P20 was resettled after 40 years in Muckamore.
23 He had no speech, a poor swallow and needed a
24 particular diet. He was due to go to a nursing home
25 [named]. He was resettled into this nursing home in 10:20
26 [named] and lasted one month before he choked to death
27 in the nursing home. An 18 year old care assistant
28 left a yoghurt and unpeeled orange in the room. P20
29 ate both and choked to death. He had survived 40 years

1 in Muckamore. I assisted P19 to take a civil case
2 against the nursing home. I am giving the Inquiry this
3 example as I make the point that abuse and neglect
4 happens everywhere, not just in Muckamore.
5 10:21
6 I am angry and upset about what the Inquiry is
7 uncovering as to events which occurred to patients in
8 Muckamore, but there are also wider examples of what
9 has happened in the community for people with learning
10 disabilities." 10:21
11
12 So, Mr. McCart, having heard me read that out are you
13 content to adopt it then as your evidence to the
14 Inquiry?
15 A. Yes, I am. 10:21
16 1 Q. Coming back then to the beginning of your statement and
17 the substance of your memories of the earlier period
18 which relate to the Inquiry's terms of reference, so
19 really the opening decade I suppose of this Century.
20 You tell us in paragraph 4 that when the hospital 10:21
21 transferred from the North and West Belfast Trust to
22 the Belfast Trust?
23 A. Yes.
24 2 Q. It became essentially I suppose a smaller fish in a
25 larger pond? 10:22
26 A. Yes.
27 3 Q. I know you mention Mr. Black having his office at
28 Muckamore but after that did you see senior management
29 from the Belfast Trust having a presence at Muckamore,

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1 walking the wards in the same way that Mr. Black did?
2 A. No, I don't really think so for the reasons that I
3 think I have alluded to in my statement, the fact that
4 they were also responsible for the Royal Hospital, the
5 City Hospital, Knockbracken Mental Health Hospital, so 10:22
6 it was a much, as I say in the statement, it was a much
7 smaller issue. Certainly they did, certainly the Chief
8 Executive would have visited Muckamore, there is no
9 doubt about that. But the amount of time that senior
10 management I think were able to give to Muckamore was 10:22
11 understandably reduced.
12 4 Q. Yes. At that time were you aware of a concern among
13 your sort of community of social workers about that,
14 about that decrease in management attendance or senior
15 management attendance at Muckamore? 10:23
16 A. Yeah. Well, you know, that's not to be critical of the
17 senior management and the Chief Executive of the newly
18 formed Belfast Trust, but I think the reality of it was
19 that it was such a big organisation that to be able to
20 get a focus on learning disability services was very 10:23
21 difficult. I think I have alluded to in my statement
22 that I felt, and I think it was a common feeling in
23 learning disability services, that learning disability
24 was always a bit of a Cinderella services, if I could
25 use that term. For example, it was commonly within the 10:23
26 Directorate of Mental Health and Learning Disability
27 and learning disability always came after mental health
28 for example. And mental health, as people probably
29 know, comes a long way down the pecking order within

1 health and social care. So learning disability came,
2 in my view, even after mental health. So when the
3 Belfast Trust was formed it had a huge focus on -- it
4 employed, when I was there about 25,000 people were
5 employed within that Trust and I suppose it was natural 10:24
6 that the focus on Muckamore was not great at the top
7 table.
8 5 Q. Thinking back to that period of time, I think it was
9 around the middle of that decade, the first decade of
10 this century when the amalgamation of Trusts took 10:24
11 place. Have you a view about looking back on it, I
12 suppose, obviously from mount hindsight I guess, but
13 have you a view about how things might have been done
14 differently when the Trusts were amalgamated so as to
15 make adequate provision for mental health and more 10:24
16 particularly learning disability?
17 A. I think it was, I think it was difficult. One of the
18 things that has always been difficult, I suppose, was
19 the geographical location of Muckamore. Added to that
20 sense of it being apart from the Belfast Trust. It sat 10:25
21 physically, what was it, 12 or 15 miles up the road,
22 whereas everything else was in Belfast and people had
23 to make a journey up to it. It was a curious anomaly
24 that the learning disability hospital which served the
25 Belfast Trust, not only served the Belfast Trust, it 10:25
26 served the Northern Trust as well and there were a few
27 patients from the Southern Trust and Western Trust and
28 indeed a few from the Republic as well, but it was a
29 curious anomaly that it was physically in Antrim. I

1 think that was a problem and I think when -- I suppose
2 there might have been an argument that it might have
3 been better served under the reorganisation to go to
4 the Northern Trust rather than being with the Belfast
5 Trust. 10:26
6 6 Q. And had it gone to the Northern Trust, I mean Trusts
7 were being amalgamated across Northern Ireland of
8 course as the Inquiry has heard, but had it gone again
9 to the Northern Trust, it still would have been in
10 quite a big Trust set up? 10:26
11 A. Oh, it would, it certainly would. I suppose that
12 brings us back to the fact that, whatever way things
13 were organised, there was too much focus for the health
14 and social care of people with learning disabilities
15 within a hospital. 10:26
16 7 Q. Yes?
17 A. And I suppose the real sort of strategic issue was that
18 there should have been a greater range of community
19 services. Whatever way hospitals were organised, it
20 was always going to be an issue. 10:26
21 8 Q. I mean you are very clear in your statement about your
22 philosophy that learning disability is best dealt with
23 in the community as far as possible?
24 A. Yes.
25 9 Q. And clear about indeed Muckamore as a place to examine 10:27
26 and treat patients?
27 A. Yes, assessment and treatment, yes.
28 10 Q. We heard evidence earlier in the week from another
29 social worker who recollected that in the earlier part

1 of the Century, in the first part of the 2000s, she
2 recollected there being a general drive that when a
3 patient came into the hospital that the process of
4 looking towards their discharge, whatever that might
5 look like, began almost right away within 7 to 14 days, 10:27
6 can you speak to that?
7 A. That certainly is what the policy and procedures were
8 and that is what should have been happening. As I said
9 earlier, Muckamore should have been -- the model was by
10 that stage that patients should have been going there 10:28
11 for assessment, treatment and discharge rather than,
12 you know, patients had no other address for example, to
13 receive post, to vote, to receive their benefits other
14 than the hospital, which was clearly probably, you
15 know, a contradiction of their basic human rights. But 10:28
16 one of the issues was that the patients got what was
17 used in sort of shorthand term, patients got stuck in
18 Muckamore because their discharge was delayed. If we
19 come on to talk about the resettlement programme, there
20 was a category of patients at one stage within 10:28
21 Muckamore who were delayed discharge.
22 11 Q. Yes?
23 A. And those patients were, the numbers of days they were
24 delayed discharge were counted and some of them got
25 into thousands of days because they had been 10:29
26 technically ready for discharge if and when a suitable
27 community facility was available for them.
28 12 Q. We will come on to talk about that specific issue in a
29 few moments. Could I ask as well if you could try and

1 slow down. There is plenty of information that you are
2 giving and it is important obviously that we get a
3 clear note of it?
4 A. Sorry.
5 13 Q. It's very natural, very natural. I have to remind 10:29
6 myself as well to slow down. In the next paragraph,
7 which is paragraph 8 of your statement, which I wanted
8 to ask you about, you talk about your position as
9 Associate Director of Social Work in the Trust from
10 2002 until your retirement then in 2012. You talk 10:29
11 about the responsibility that you have for social work
12 teams in learning and adult protection and your
13 responsibilities vis-a-vis the management of day
14 services, including Muckamore. In this paragraph you
15 recall a team of four to five social workers in 10:30
16 Muckamore. If we can get perhaps touch on this issue
17 first of all, maybe get it out of the way if we can.
18 You make reference to two members of staff whose names
19 in the body of your statement you were reluctant to
20 disclose? 10:30
21 A. Yes.
22 14 Q. I'm not going to ask you if you are able to, to give
23 those names out loud. But if you are, are you able to
24 give the names even on a piece of paper if that can be
25 provided to you? 10:30
26 A. Yes, yes, I'm happy with that, yes. My handwriting is
27 quite difficult to read, hopefully you can read that.
28 15 Q. That's all right. You wouldn't be alone in that
29 regard.

1 CHAIRPERSON: Are you asking for those names not to be
2 read out loud.
3 A. Sorry?
4 CHAIRPERSON: Are you asking that those names are not
5 read out loud? 10:30
6 A. Sorry, I'll just write that down.
7 16 Q. MR. MCEVOY: So those persons have ciphers by which
8 they are known and their ciphers then for the Inquiry's
9 record are H446 and H94?
10 CHAIRPERSON: Sorry H446? 10:31
11 MR. MCEVOY: H446 and H94.
12 CHAIRPERSON: Thank you. If you could keep your voice
13 up as well, Mr. McEvoy.
14 17 Q. MR. MCEVOY: Yes. I will move my microphone. Was
15 there a particular reason why you were reluctant to 10:31
16 give those names?
17 A. I suppose I haven't had an opportunity to speak to
18 those people in advance and I was reluctant to name
19 them before I spoke to them in advance.
20 18 Q. Okay. Now, in terms of your role based at the Everton 10:32
21 Complex, that's where you spent -- that was your
22 office, effectively your office base?
23 A. Yes.
24 19 Q. In paragraph 9 then you describe the level and degree
25 of interaction you had at Muckamore? 10:32
26 A. Yes.
27 20 Q. You were there one to four times per week?
28 A. Yes.
29 21 Q. You met with the social worker team leader who was

1 located in the admin building at Muckamore, discussed
2 particular cases and issues of concern. So just that
3 phrase, issue of concern, if I can alight on that for a
4 moment. What kind of issues of concern would you have
5 discussed? 10:32
6 A. Well that would have been a variety of things. One of
7 the issues would have been when the resettlement
8 programme was ongoing, we would have been checking on
9 the progress of an individual's resettlement plan. We
10 also may have been checking on any new admissions to 10:33
11 Muckamore, what were the circumstances behind those
12 admissions and if there were any particular issues, for
13 example, if they were vulnerable adults, concerns about
14 a patient, might have been checking on the progress of
15 any investigations or any case conferences which were 10:33
16 arranged.
17 22 Q. Earlier this week in other evidence from social workers
18 we heard how, certainly in the earlier years of the
19 Inquiry's terms of reference, social workers were able
20 to go onto the wards reasonably freely to see patients 10:33
21 and that then changed later where that sort of freedom
22 to see patients on wards was a practice and it became
23 discouraged. Can you speak to that at all?
24 A. Again, I left the service in 2012 so I can't speak of
25 anything after 2012. I wasn't aware during my time 10:34
26 that there was, that it was an issue for social workers
27 getting access to wards. I would say that during my
28 period there, the social work team there was a well
29 established, well regarded and fairly well resourced

1 and experienced team. The team leader had been, was
2 there for a number of years, was very competent. The
3 social workers, there was little or very little
4 turnover within the social work team which you
5 typically got within a social work team in the 10:34
6 community. The social work team was good and
7 established. They had particular wards that they were
8 allocated to cover. They probably felt they could have
9 done with more bodies, but the social work team, they
10 had their office first of all in the admin block, then 10:34
11 they moved across to a stand alone office. But my
12 impression, I think the general impression of the
13 social work team that they were well regarded, well
14 integrated into the general staff in Muckamore and I
15 was never aware that they had an issue accessing the 10:35
16 wards.
17 23 Q. Thank you. Okay, and then in terms of in paragraph 10
18 you talk about the reporting relationships you had with
19 more senior members of staff. You are very
20 complimentary of Miriam Summerville in particular and 10:35
21 you describe her as having high standards. If I can
22 recall correctly, she came from a speech and language
23 background; is that right?
24 A. Yes, she did. But I think significantly she had worked
25 in senior positions in learning disability in England, 10:35
26 I think in Birmingham, and I thought she brought a
27 different perspective to the work. I think learning --
28 I think, depending on what part of England you were in,
29 in some places learning disability services were in

1 advance of what they were in Northern Ireland.
2 Certainly they had moved forward on their programme of
3 moving away from large hospital institutions and I
4 thought she brought that perspective to Northern
5 Ireland, which I thought was helpful. 10:36
6 24 Q. When you talk about high standards, can you give us an
7 example?
8 A. Well, for example, I think she brought in, there was a
9 document we worked on between the community and the
10 hospital called "The Big Plan" which was a sort of a 10:36
11 vision for learning disability services in the Belfast
12 Trust, including Muckamore. And it was, there was a
13 lot of emphasis in that on getting the views of people
14 with learning disability themselves and their
15 relatives. And I thought that work was quite, you 10:36
16 know, up-to-date and in some respects ahead of its
17 time, it was an example, I think, of good practice in
18 Northern Ireland.
19 25 Q. Can you tell us when that was, roughly what year?
20 A. The Big Plan, it might have been about 2009, 2010, I'm 10:37
21 sorry, I'm not good on dates.
22 26 Q. That's fine. So that title, The Big Plan, was that a
23 sort of kind of an in-house nickname for something
24 else?
25 A. No, no, it was called The Big Plan deliberately so as 10:37
26 people could understand it.
27 27 Q. Yes, it was clear?
28 A. Yeah, yeah. I think, for example, there was a fairly
29 standard written version of it, but then there was an

1 easy read version, sorry, an accessible version of it
2 which people with learning disabilities could
3 understand. So it was deliberately called The Big Plan
4 so it was easy to understand.
5 28 Q. The audience was intended to be -- 10:38
6 A. Yes, people with learning disabilities.
7 29 Q. And to include families --
8 A. And patients, yes.
9 30 Q. So, after Mrs. Summerville then retired, H730 took the
10 post. You observed that he did not have any knowledge 10:38
11 or interest in learning disability. Do you know what
12 his background was?
13 A. I think this references back to where we talked about
14 earlier to the restructuring when North and West
15 Belfast went into the Belfast Trust. At that stage 10:38
16 there was a major restructuring at director and
17 co-directors, as they were called, level. And I don't
18 think the two things happened exactly at that time
19 because there was a time, there was a while when Miriam
20 Summerville, was still the co-director, I'm trying to 10:39
21 remember, but then after that Miriam moved on. My
22 feeling was at that time because there was, because it
23 was a bigger organisation there were people at senior
24 level who were slotted into positions that I don't
25 think they particularly had experience in. I think 10:39
26 that individual came from a family and childcare
27 background. He certainly had no experience of learning
28 disability.
29 31 Q. Okay. So you're clear he had no experience and

1 therefore -- and how did his lack of, I suppose so the
2 Inquiry better understands, how did his lack of
3 interest that you describe sort of manifest itself?
4 A. Well I suppose it would be unfair to say he wasn't
5 interested. He was interested but I think he lacked, 10:39
6 he certainly lacked in any vision for learning
7 disability. He certainly lacked in the vision that,
8 for example, Miriam Summerville would have had. He
9 certainly, I think, didn't have an extensive knowledge
10 or any knowledge of the Equal Lives document and I 10:40
11 think that the vision and the drive went out of the
12 services when that happened.
13 32 Q. Okay. Now, in this paragraph you also say, in perfect
14 fairness to you and in candor you say:
15 10:40
16 "Perhaps I'm biased however as I felt that I should
17 have been given the post of Director of Learning
18 Disability and I felt I was overlooked for the post."
19
20 A. Yes. 10:40
21 33 Q. Do you want to say anything more about that?
22 A. No.
23 34 Q. Okay. You also observe then:
24
25 "In or around 2011 H507 took the post of Associate 10:40
26 Director of Learning Disability in Muckamore. She came
27 from a mental health background and also knew nothing
28 about learning disability."
29

1 And you say then that:
2
3 "The two most senior people in the hospital had no
4 experience of working with people with learning
5 disabilities." 10:41
6
7 It is clear what you are hinting at there, but can you
8 give us your view of where all this was leading?
9 A. I suppose that again goes back in some way to the
10 reorganisation and the fact that it was a large Trust. 10:41
11 I think there was a feeling somewhere that Muckamore
12 was too closed, that the staff who had been working
13 there, had been working there for a number of years and
14 perhaps people who had -- I suppose the counter
15 argument to my argument would have been that Muckamore 10:41
16 needed fresh pairs of eyes on it and it needed other
17 people who weren't institutionalised into it to look
18 into it. But I suppose my feeling is, from where I was
19 sitting, was that the people lacked in the experience
20 and again, I say, the vision and the drive. 10:41
21 35 Q. Yes. You go on then in your statement at paragraph 11
22 to describe Muckamore as a big institution, out of
23 sight and you say then: "Located in Antrim and run by
24 Antrim people." Was that during the entirety of your
25 experience of it? 10:42
26 A. Well I suppose there was always a bit of a feeling
27 between the community, you know, when it was in North
28 and West Belfast, between the people who worked in
29 community learning disability services and the people

1 who worked in Muckamore, there was always a bit of a
2 strive to try and keep --there was always a feeling
3 that there was a division between the services, that
4 the services in Belfast were services in Belfast and
5 the services in Muckamore were the services in 10:42
6 Muckamore. It was difficult at times to ensure that
7 there was the same vision, the same principles that
8 were all, for want of better words, singing off the
9 same hymn sheet.
10 36 Q. CHAIRPERSON: Can I just ask in relation to that, what 10:43
11 do you mean by run by? Do you mean it was staffed by
12 or do you mean it was managed by?
13 A. I think staffed by would be a better way of explaining
14 it, yeah.
15 37 Q. MR. MCEVOY: I suppose on one view it could be said 10:43
16 that it would be natural that in terms of the staff
17 running the day-to-day business I guess of the
18 hospital, it might be natural, might be seen as natural
19 for staff, people from the local area to come and work
20 there? 10:43
21 A. Yes.
22 38 Q. But is there another view?
23 A. Well, one of the things was that there was some staff,
24 I can give a couple of good examples of staff who
25 worked in Muckamore and then transferred out to work in 10:44
26 the community. But there wasn't an awful lot of
27 interaction between community staff and Muckamore
28 staff. One of the problems was, you know, in English
29 terms people might think that it's only 12 or 15 miles

1 up the road, but there was always a reluctance I think
2 from people who had worked in Belfast to go and work in
3 Antrim and people who had worked in Antrim to go and
4 work in Belfast. I, and other people, thought it would
5 have been healthy to have more interaction between 10:44
6 community staff and hospital staff. And there were,
7 you know, very good examples of people who moved out of
8 Muckamore and worked and worked very well in the
9 community. But that was a difficult thing. Also, you
10 know, different allowances within the hospital and, you 10:44
11 know, people had shift patterns and overtime payments
12 for shift patterns which might have been available in
13 the hospital, which weren't available in the community.
14 So those practical issues stopped the interaction I
15 think of staff between the community and the hospital 10:45
16 which I think would have been a healthy thing.
17 39 Q. DR. MAXWELL: Can I just ask you also about grades,
18 because sometimes grades in the community are lower
19 than in hospital?
20 A. Yes, that's right. 10:45
21 40 Q. DR. MAXWELL: Is that the situation as well?
22 A. Yes.
23 41 Q. DR. MAXWELL: So it was a financial incentive to work
24 in the hospital rather than in the community?
25 A. Yes, that's certainly correct, yes. 10:45
26 42 Q. MR. MCEVOY: Was there any, I know you have described a
27 sort of a disconnect, was there any, picking up on Dr.
28 Maxwell's point, any resentment in any direction about
29 that distinction?

1 A. Well, you know, I suppose there may have been. One of
2 the examples that I give, when the Belfast Trust came
3 in, we organised a thing called speed meeting, which
4 was like a day where we tried to get the community, it
5 was actually in Muckamore, we tried to have two tables 10:46
6 of people where staff rotated around, where community
7 staff met hospital staff and hospital staff met
8 community staff, so we tried to encourage more
9 integration of community and hospital staff.
10 43 Q. I mean given that there was this divide, perceived or 10:46
11 otherwise, do you think there might have been
12 implications for the patients?
13 A. Yeah, I think that's always the problem with large
14 institutions, you know. I think there is a line where
15 I say that, you know, institutions like Muckamore were 10:46
16 built out of sight. It's been suggested to me, for
17 example, that the term, it is in some ways a derogatory
18 term, but it is still unfortunately in common parlance,
19 the term around the bend, where somebody has gone
20 around the bend actually comes from the fact that 10:47
21 institutions like Muckamore and for example, Purdysburn
22 which is now Knockbracken were built out of towns and
23 around the bend and out of sight. Whether the term
24 around the bend comes from that or not, I'm not sure,
25 but I think the feeling is that generally society wants 10:47
26 to have people that they are not particularly
27 comfortable with out of sight and around the bend.
28 44 Q. Picking up on a theme we touched on a few minutes ago
29 which was around access to the wards, at the end of

1 this paragraph you say that you did not like the wards,
2 some doors were locked and that was how the place was
3 run. I asked you about the recollection we had from
4 other witnesses we had this week who recall having more
5 access. What are you getting at when you tell us that 10:48
6 the doors were locked, do you mean that metaphorically
7 or actually?
8 A. Well some doors were locked. You know, some doors
9 within community facilities were locked. Doors should
10 only be locked for particular reasons. I think the 10:48
11 deprivation of liberty is a term that came in fairly
12 late, probably 2019, where restrictive practices, a
13 locked door would be seen as a restrictive practice.
14 There are sometimes good reasons why doors have to be
15 locked. I don't think anyone likes to be in an 10:48
16 environment in which doors are locked. For example,
17 the doors of this room are not locked now, if they were
18 locked it probably would make me feel uncomfortable.
19 It's an unfortunate circumstance that on occasions
20 there were wards in Muckamore that doors were locked. 10:49
21 Hopefully -- or sorry, that should have been done for
22 particular and very specific professional reasons, but
23 was something that always made one feel uncomfortable
24 when one was up there. You know, if you see staff, you
25 know, if you saw staff with a jangling keys and having 10:49
26 keys around their waist, to me that was always an
27 indicator of poor practice.
28 45 Q. DR. MAXWELL: But just to clarify, it wasn't sort of
29 random across all wards?

1 A. No.
2 46 Q. DR. MAXWELL: There were some wards that were
3 designated as locked wards?
4 A. No, absolutely not.
5 47 Q. DR. MAXWELL: It wasn't at the discretion of individual 10:49
6 staff, these wards had been designated and always
7 locked?
8 A. Some, I wouldn't know the details of that but certainly
9 I was aware that to access some wards, the doors were
10 locked. 10:50
11 48 Q. DR. MAXWELL: But that was presumably a corporate
12 policy?
13 A. Yes.
14 49 Q. DR. MAXWELL: We can argue about whether it should have
15 been, but it was a corporate policy and not an 10:50
16 individual member of staff?
17 A. Yes, that's correct, yes.
18 50 Q. MR. MCEVOY: Okay, so turning then to the resettlement
19 theme, can you give us a picture of what your
20 responsibility was for resettlement programme for 10:50
21 patients in Muckamore?
22 A. Yeah, so again I'm very bad on dates and I apologise,
23 but, I think it was around possibly 2006 that after
24 Equal Lives, there was a resettlement programme which
25 was directed from the Department of Health down through 10:50
26 what then was the Eastern Board. Each patient in
27 Muckamore became, belonged to a particular Trust. So,
28 for example, the Trust that had the most patients in
29 Muckamore would have been the Belfast Trust, then the

1 South Eastern Trust.
2 51 Q. These are the Owning Trusts that we have heard about,
3 this concept of the Owning Trust?
4 A. Yes, so each group of patients then, I don't know,
5 there might have been 60 or 70 patients who belonged to 10:51
6 the Belfast Trust. Individual patients were then
7 assessed about whether they were still having active
8 treatment or whether they were ready for discharge and
9 then a subcategory was delayed discharge. So a
10 programme then across the hospital and across the Board 10:51
11 and the Trust areas, plans were drawn up for the
12 resettlement of patients. Now, because of the numbers
13 involved there was only -- has a dowry system been
14 mentioned?
15 52 Q. Yes you discussed that in your statement? 10:52
16 A. So for example, let's talk about the Belfast Trust, so
17 for a particular year, the Belfast Trust, and again I
18 am not sure about figures, the Belfast Trust might have
19 been given 15 or 20 dowries and that was money that was
20 available for an individual patient to be resettled. 10:52
21 And then so, the care managers then became involved,
22 the social workers became involved, the
23 multidisciplinary teams for the individual patient in
24 the hospital to draw up a programme, draw up an
25 individual programme for the resettlement of that 10:52
26 patient.
27 53 Q. So that we're clear then, you think this was about
28 2006, I'm not holding you to the date, I know you've
29 been clear that you're unclear about them. But am I

1 right, are we right in understanding that delayed
2 discharge was already a live issue in 2006?
3 A. Yes, yes. Yeah, it's some time ago but if the evidence
4 given to the Inquiry by Professor McConkey, I think he
5 covered some of the strategic issues about the funding 10:53
6 of the resettlement programme. The funding of the
7 resettlement programme was also complicated, well
8 complicated by the fact that not all of the resources
9 should have or could have come from within the health
10 and social care budget. For example, some of the 10:53
11 resources, for example, the housing resources where a
12 person is moving into supported living, some of the
13 financial resources should have come from and did come
14 from the Housing Executive budget. So one of the
15 issues about resettlement where a person was moving 10:53
16 into supported living, so you might look for a provider
17 for the social care.
18 54 Q. The Housing Executive, just for the assistance of the
19 Inquiry, the Housing Executive is an arms length body
20 of a different department, not the Department of 10:54
21 Health?
22 A. That's exactly it, that's exactly it. So one of the
23 things was to, they worked through, typically worked
24 through housing associations who provided housing. So
25 for example, if a third sector provider, for example, 10:54
26 Positive Futures, who were and still are one of the
27 biggest providers of Learning Disability Service in the
28 supported living sector in Northern Ireland, if they
29 were identified as someone who could provide a package

1 of support for an individual patient who was coming
2 from Muckamore, they would work up the cost of, you
3 know, the staffing cost, how they could support that
4 person. Now, some of that would have been in a housing
5 cost and they also had to identify a location where the 10:54
6 person should live. So that would typically, Positive
7 Futures always worked through housing associations. So
8 a housing association might be identified but one of
9 the questions with that was the capital cost, if there
10 wasn't a house, there might have been a house 10:55
11 available, but if there wasn't a house available the
12 capital cost to build the house was coming from the
13 housing budget and also the proportion of the support
14 costs would be housing support costs and that would
15 come from the supported people budget within the 10:55
16 housing finance. So one of the issues was that to make
17 sure --
18 55 Q. That was coming from another agency i.e. the Executive
19 which in turn reported to a different department?
20 A. Yes, yes. So one of the issues there was to 10:56
21 co-ordinate the streams of funding.
22 56 Q. Yes, so just on that point, just so that we are clear,
23 the dowry was composed of elements from which sources
24 then?
25 A. Well it was mostly for an individual composed of money 10:56
26 from the health and social care budget.
27 57 Q. Yes?
28 A. But could have also been composed of an input from the
29 housing budget.

1 58 Q. Okay. And presumably then tailored to that
2 individual's requirements; is that right?
3 A. Yes, that's exactly right.
4 59 Q. CHAIRPERSON: Sorry, do you know do those come from
5 different government departments? 10:56
6 A. Yes.
7 CHAIRPERSON: Right.
8 A. So for example, Health and Social Care Department, the
9 Health and Social Care Department funded Muckamore,
10 funded community services as well. Housing Executive 10:56
11 was a separate --
12 CHAIRPERSON: Yes.
13 A. Was the Department of environment or some other
14 department.
15 60 Q. CHAIRPERSON: Was that, just so I understand it, I may 10:57
16 be the only person in the room who doesn't, but are you
17 saying there is therefore tension as to who is going to
18 have to pay?
19 A. Yes, there is tensions and there is also issues with,
20 you know, one year, so you might have known what budget 10:57
21 was available from the health and social care budget,
22 but you also maybe had to access a source of funding
23 from the housing and if that wasn't available you had
24 difficulties putting the package together.
25 61 Q. CHAIRPERSON: So the resettlement wouldn't happen? 10:57
26 A. Well it was difficult, yes.
27 62 Q. PROFESSOR MURPHY: Sorry, can I just clarify, when you
28 say that for a particular year you might get funding
29 for 20 --

1 A. Yes.
2 63 Q. PROFESSOR MURPHY: -- people to be discharged, was that
3 funding amount, say X thousand pounds, the limit of
4 what you would get, regardless of the kind of patients
5 that you were resettling because obviously some 10:58
6 patients cost a lot more than others?
7 A. That's certainly right and I am trying to remember,
8 because it is a number of years back, certainly there
9 were, I think there was a flexibility, I think there
10 was an overall budget but I think, you're quite 10:58
11 correct, that within that there was a flexibility.
12 There was an understanding that some -- I think there
13 was a basic dowry funding level and I can't recall,
14 that we were supposed to put a package of support
15 together for a patient. And I think when you went 10:58
16 beyond that, you either had to balance up if you had so
17 many resettlements at the basic cost and perhaps there
18 were some cheaper, it sounds terrible, but there were
19 some less expensive packages and then there were some
20 more expensive packages and you had to try and balance 10:58
21 the finances.
22 64 Q. PROFESSOR MURPHY: Yes, thank you.
23 A. But it was difficult because my recollection, it was
24 year on year funding so it was difficult to do a lot of
25 forward planning. Sorry, am I speaking too quickly? 10:59
26 65 Q. MR. MCEVOY: Well the Panel will soon tell us. In
27 terms then of the care manager appointed to look after
28 the co-ordination of the requirements, was there a
29 particular discipline that that person would have come

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1 from?
2 A. Care management was a system, not only within learning
3 disability, I think it came first within older peoples
4 services where care managers were typically accessing
5 private nursing homes for older people and then it was 10:59
6 rolled out into mental health, learning disability,
7 physical health and disability and the posts were open
8 to a range of individuals. A lot of them did come from
9 social work. A few came from nursing and a few came
10 from OT. But certainly the main care managers I worked 11:00
11 with typically came from social work.
12 66 Q. Would it have been, if you were looking after the needs
13 or the requirements for a patient at Muckamore would it
14 have been specified -- this is possibly too detailed a
15 question and if you can't, I understand why, answer. 11:00
16 But if it was around looking after and co-ordinating
17 the needs of a patient at Muckamore, would the job spec
18 and personnel spec have detailed a particular
19 professional background?
20 A. Yeah, again it would have been open to different 11:00
21 backgrounds. For the care management and learning
22 disability, the most significant care managers I
23 remember had a strong background within learning
24 disability.
25 67 Q. Yes, okay. Chair, I am mindful of the time, it is five 11:01
26 past, I'm in your hands?
27 CHAIRPERSON: How long do you think you've got to go?
28 MR. MCEVOY: Possibly another 40 minutes.
29 CHAIRPERSON: Oh, really, okay. Yes, let's take a

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1 break now and we'll take 15 minutes and then of course
2 you've got the restricted part of the evidence to deal
3 with as well, okay, thank you very much.
4
5 THE HEARING ADJOURNED FOR A SHORT PERIOD. 11:01
6
7 THE HEARING RESUMED AS FOLLOWS:
8
9 CHAIRPERSON: Thank you. Yes.
10 MR. MCEVOY: Thank you, Chair, so, Mr. McCart, taking 11:20
11 up again on the topic or the theme of resettlement.
12 Had you a means or a method for reporting concerns or
13 inadequacies in relation to funding and resettlement?
14 A. Yeah, there would have been -- I suppose that happened
15 at two levels. There was a co-ordination meeting 11:21
16 between the hospital, typically chaired by Miriam
17 Summerville as the Director of the hospital, and all of
18 the Trusts involved, that would have been the five
19 Trusts in the Eastern Board and a representative from
20 the Northern Trust. That tended to meet monthly when 11:21
21 they went through all of the resettlement plans, Trust
22 by Trust, and you reported on what progress or lack of
23 progress you had made. Secondly, there was, I'm not
24 sure of the job title, but there was somebody within
25 the Eastern Board who co-ordinated, I think it was 11:21
26 called like a learning disability steering group or it
27 was an attempt to look at the implementation of Equal
28 Lives. It would have been chaired by whoever had the
29 senior role within the Eastern Board. I can't think of

1 the names of the individuals. And, for example,
2 Professor Roy McConkey would have sat as an advisor on
3 that and then representatives from the Trusts and from
4 Muckamore Hospital would have sat there and it was an
5 attempt to look more strategically at the problems, for 11:22
6 example, the problems like the co-ordination of the
7 funding between the Health Service and Housing
8 Executive. So you would have been reporting individual
9 problems at the monthly resettlement steering group,
10 and then the more strategic issues I was bringing to 11:22
11 the meeting at the Eastern Board.
12 68 Q. Thank you. You tell us that you recall a lot of
13 families being happy with Muckamore and indeed were
14 resistant to resettlement of their relatives?
15 A. Yes, yeah. 11:23
16 69 Q. And you identify some members of the Society of Parents
17 and Friends being opposed?
18 A. Yes.
19 70 Q. To the idea and the concept?
20 A. Yeah. 11:23
21 71 Q. Why do you think that was?
22 A. Okay, I don't want that to sound as if it's being
23 critical of families. Typically families, you know, a
24 family may have placed their son or their daughter in
25 Muckamore when they were very young after perhaps years 11:23
26 of struggling or attempting to support them within
27 their own family with very little community support.
28 If we are going back to the 60s or 70s or even 80s when
29 a lot of patients were first admitted to Muckamore,

1 there would have been very few community supports. For
2 example, I think I alluded to schooling for people with
3 learning disabilities. Certainly within my time I
4 constantly came across families who got the dreaded
5 letter from the education authorities to tell them 11:24
6 their son or daughter couldn't be educated and
7 therefore could not get a place within the schooling
8 system. Actually until the mid 70s, health and social
9 care ran sort of quasi schools for people with learning
10 disabilities or mental handicap as it was referred to 11:24
11 at that time because they had no access to education.
12 I am giving that as an example of lack of supports for
13 families. So against that background, families were
14 often in some ways pleased when a member of their
15 family got into Muckamore and when they saw what they 11:25
16 judged to be good care within Muckamore. And if a
17 person had lived there and seemed to be happy over
18 decades, for somebody they didn't know to suddenly turn
19 around and say well actually no, this is not right,
20 your son or daughter would be happier and better 11:25
21 supported living out in the community, that's quite a
22 thing. Families had moved on and some of them were
23 quite elderly at this stage and it was quite a thing
24 for them suddenly to be faced with. Typically they may
25 have been up and in very good contact with their 11:25
26 families and had established a pattern maybe of going
27 up to see them on a Sunday, taking them home for Sunday
28 lunch. And then for somebody they didn't know to
29 suddenly arrive and say actually the best plan is for

1 resettlement to a place they didn't know anything
2 about, I wouldn't criticise people for being, you know,
3 very concerned about that. One of the things when we
4 got a list of patients for resettlement, there was a
5 column for what was the next of kin's attitude and in 11:26
6 some of them it would have been next of kin opposed to
7 resettlement. If that was the case, that was something
8 then you had to work with. You had to try and explain
9 to the family what resettlement was about and try and
10 bring them to see, typically you brought them to see 11:26
11 community facilities to try and explain to them. But
12 certainly, the grouping of families who were opposed to
13 resettlement -- and there was an issue, I've talked
14 about politicians later in my statement. There was an
15 issue that families would, some families would then 11:26
16 lobby politicians and in some cases they would lobby
17 the Health Minister. At one stage the view was that,
18 and the view coming from I think Ministerial level was
19 that no patient whose family were opposed to
20 resettlement out of Muckamore, the resettlement was not 11:27
21 to go ahead, which was an issue for us.
22 72 Q. Can you recall roughly when that was?
23 A. That would have been in the mid 2000s when the
24 resettlement programme was at its height.
25 73 Q. CHAIRPERSON: Sorry, I am so sorry, how was that 11:27
26 political interference being communicated to you? How
27 was that coming through to you?
28 A. Yes, well it was probably communicated on an individual
29 basis first of all. But it was always ambivalent, it

1 was always, you know, what I think you had on a number
2 of occasions, you had the public statement by the
3 ministers and politicians that they were behind the
4 resettlement programme and that was the way policy was
5 going, that was the general policy and it was the right 11:28
6 policy. While they were making that as a policy
7 statement, then on an individual parents were coming to
8 them and saying I'm not happy and I would say don't
9 worry about that, your son or daughter shouldn't be
10 resettled without your say-so. And that was being 11:28
11 communicated down. We've been to see --
12 74 Q. CHAIRPERSON: It would often be the parents, would it,
13 or the relatives who would be communicating that
14 through to the Trust?
15 A. The parents would then come back and say I have spoken 11:28
16 to X, Y and Z and they said don't worry about it, there
17 won't be any resettlement against your wishes.
18 75 Q. PROFESSOR MURPHY: Presumably sometimes it was families
19 saying I am being pressurised for my son or daughter to
20 go and live in place X and I don't feel that's 11:28
21 appropriate?
22 A. Yep, yes.
23 76 Q. PROFESSOR MURPHY: Either because it was a very long
24 way from their home or they felt there wasn't
25 sufficient support to be provided? 11:29
26 A. Yes.
27 77 Q. PROFESSOR MURPHY: So was it mainly things like that or
28 was it people I never want my son or daughter to be
29 resettled?

1 A. I think it was a combination of things. There were,
2 you know, some families were very happy with the care
3 and treatment they saw their sons or daughters getting
4 in Muckamore. Alongside that, some families did want
5 their sons or daughter resettled into the community. 11:29
6 So, a mix of views. And certainly, I'm not saying that
7 every resettlement package was an ideal package and
8 indeed there were a lack of available resources within
9 the community. There was huge pressure, for example,
10 huge pressure, for example, on community placements and 11:30
11 support packages for people who were living in the
12 community. So, you know they were also needing
13 resources. So quite often you're correct that the
14 packages or the support plans being offered to an
15 individual were probably far from ideal, but the best 11:30
16 that could be manufactured under the circumstances.
17 78 Q. PROFESSOR MURPHY: We've heard from some families that
18 they weren't able to get day care?
19 A. Yes.
20 79 Q. PROFESSOR MURPHY: Was there a particular problem with 11:30
21 provision of day care?
22 A. Yes, you know, I managed the day care within the
23 Belfast Trust. Day care, typically in the 80s and 90s
24 and into the 2000s revolved around fairly large day
25 centres. And to some extent those large day centres 11:31
26 are there and they are alongside more community
27 involvement for people with learning disability, more
28 job opportunities. But, there was a pressure on day
29 care places, people coming out of special schools into

1 day care, there was a pressure on day care places
2 anyway. There was also a query about whether people
3 who went into, for example, private nursing homes which
4 were being resourced on a 24 hour, seven days a week
5 basis to provide nursing, there was an argument that 11:31
6 people who were in nursing homes shouldn't have access
7 to day care. Now within the Belfast Trust we tried not
8 to stick to that policy, but that was certainly an
9 issue. For example, people in Muckamore who were in
10 wards typically could go out to day care three or five 11:32
11 sessions per week and then if the plan was for them to
12 move in a nursing home, they didn't always have access
13 to a similar service, yes, that's correct.
14 PROFESSOR MURPHY: Thank you.
15 80 Q. MR. MCEVOY: Just before we leave that topic and I know 11:32
16 you do mention politicians in your statement as you
17 say, but at what level was the political lobbying, I
18 know you have mentioned a Minister?
19 A. Yes.
20 81 Q. That's the Minister For Health? 11:32
21 A. Yes.
22 82 Q. Was that a devolved Minister For Health as opposed to a
23 direct rule one?
24 A. My recollection is that it was one or two devolved
25 Ministers of Health, yes. 11:32
26 83 Q. Was there lobbying then from other political figures or
27 lobbying of other political figures?
28 A. Well there would have been times when an individual
29 politician would have lobbied on behalf of a patient in

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1 the hospital.
2 84 Q. At what level?
3 A. Typically at MLA level, yes.
4 85 Q. The Chair asked you a few moments ago about how the
5 message was conveyed to you about don't resettle X or Y 11:33
6 patient, the relative has been -- how was that messaged
7 cascaded? I know you said, or was it indeed, I know
8 you said that the family would tell you directly?
9 A. Yes.
10 86 Q. But how else, if at all, would the message have been 11:33
11 conveyed to you?
12 A. I can't be certain but I think phone calls would have
13 been made and on some occasions letters would have
14 arrived from politicians.
15 87 Q. Okay. Now, can we just look at what you say about 11:33
16 safeguarding incidents then and your awareness and
17 involvement in any of those. You tell us that you
18 conducted vulnerable adult investigations if a patient
19 had an unexplained injury. You don't recall any
20 specific cases. You do say that if you were made aware 11:34
21 of possible safeguarding instances, your role was to
22 decide whether you needed to make a report to police.
23 A. Yes.
24 88 Q. I suppose stepping back just from that step, how would
25 you have been made aware of a potential safeguarding 11:34
26 incident?
27 A. I suppose, first of all, the principle was that the
28 same standards of protection and of investigation of
29 vulnerable adult situations should have been the same

1 within the hospital as it was within the community.
2 During my social work career that was something that
3 evolved and no doubt has continued to evolve. For
4 example, when I trained in social work, sexual abuse,
5 you know, people's sexual abuse was not a topic, for 11:35
6 example, when I trained in the early 1980s and then it
7 became more prominent. So, child protection evolved I
8 think slightly before adult protection and then adult
9 protection evolved, I think, really on the same model
10 as child protection. And the principle was that it 11:35
11 should apply both the same way in the hospital as in
12 the community. So where a social worker would have
13 been involved, if there had been an issue for example,
14 in a family or within a community day centre or
15 community residential facility of potential abuse or an 11:35
16 unexplained injury, that would be investigated by a
17 social worker and other members of a multidisciplinary
18 team. The principle was that something similar should
19 have applied in Muckamore. Typically it would be
20 picked up on the wards first and it should have been 11:36
21 referred to the Muckamore social work team. Things
22 could get a bit difficult and confused because, as I
23 alluded to earlier, patients in Muckamore nominally
24 belonged to an Owning Trust. So, for example, if a
25 patient from South and East Belfast Trust, Lisburn for 11:36
26 example, there was a responsibility for the owning
27 Trust and then there was a responsibility in Muckamore.
28 So things could get confused or difficult between who
29 was -- you know, the differing responsibilities of the

1 hospital staff and the owning Trust staff to
2 investigate that matter. And how and when those
3 matters were referred to the police, that certainly
4 changed during my time and it's probably changed since.
5 At one stage, and again I'm not good on times, years, 11:37
6 but at one stage not everything was reported to the
7 police which in later years would have been reported to
8 the police, you know.
9 89 Q. Okay. And that confusion you describe between the
10 owning Trust, the role of the owning Trusts and the 11:37
11 role of Muckamore in relation to safeguarding, can you
12 tell us a bit more about that?
13 A. Yeah, confusion is probably a fair enough word, or
14 boundaries would be important too. The Muckamore staff
15 should have picked up issues first of all and that 11:37
16 should have been reported across to the social work
17 team and the social work team then would do the
18 investigation and they probably should have been
19 notifying the owning Trust social workers so as -- I
20 think it was important that it was an outside of 11:38
21 Muckamore perspective on it. Then there was the issue
22 of who was liaising with the family, was that going to
23 be done by the Muckamore staff or by the owning Trust.
24 90 Q. And, how did you decide, what was the threshold for
25 reporting? I know you said things changed with regard 11:38
26 to reporting to PSNI?
27 A. I suppose, and again I can't give specifics, but there
28 would have been guidelines, there would have been
29 guidelines in place for what was reported and what

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1 wasn't reported.
2 91 Q. Would you have been trained in the use of those
3 guidelines or familiarity with them?
4 A. Yeah, yeah, yeah and, yes, I would have been and the
5 staff, the social work team in Muckamore would have 11:39
6 included in and should have and were included in any
7 training which was going on about vulnerable adults
8 protection.
9 92 Q. Did the police participate in that training?
10 A. With some training, yes, they should have been. One of 11:39
11 the roles, I think it may be later in my statement, one
12 of the roles in the late, probably in the late 2000s,
13 the Trust appointed what was Associate Directors of
14 Social Work across all programs. I was the Director of
15 Social Work, Associate Director of Social Work in the 11:39
16 learning disability. That was across all disciplines
17 and it looked at the governance of social work. At
18 those forums they would have discussed things like
19 vulnerable adults and then how it applied within the
20 various disciplines, including learning disability. 11:40
21 93 Q. In terms of the incident reports, what was the
22 governance around those?
23 A. Yeah, yeah. There certainly were governance, it was at
24 a number of levels. For example, I recall that Miriam
25 Summerville chaired a learning disability governance 11:40
26 meeting which typically met every couple of months and
27 we would have looked at various issues across it. For
28 example, somewhere in my statement I refer to the
29 Winterbourne Report which was about a similar issue in

1 England. I recall that we did a workshop on the
2 Winterbourne Report and what were the implications for
3 us within our services. Those are the sort of issues
4 that we would have looked at at our governance
5 meetings. Then there were what were called untoward 11:41
6 incident forms where somebody, well, an untoward
7 incident form which may have included an injury. The
8 incident was discussed, the cause of it was discussed
9 and then they were collated and patterns were then
10 discussed at the governance meeting. 11:41
11 94 Q. CHAIRPERSON: Sorry, could I just -- when you say you
12 did a workshop following the Winterbourne View Report?
13 A. Yes.
14 95 Q. CHAIRPERSON: Who would have attended that workshop and
15 what was the outcome of it? 11:41
16 A. It would have been the group who attended the
17 governance meetings. That would have been the heads of
18 the multi -- it would have been psychiatry, psychology,
19 nursing, social work, care management, occupational
20 therapist. 11:42
21 96 Q. CHAIRPERSON: Did you go to it?
22 A. Yes, yes.
23 97 Q. CHAIRPERSON: And what form did it take?
24 A. It took the form of examining the report, as I recall,
25 and looking at what the failures were, what the 11:42
26 recommendations were in that report and then applying
27 that to our services and seeing what lessons we could
28 learn and what changes we needed to apply in our
29 practice from that.

1 98 Q. CHAIRPERSON: And as far as you can remember did things
2 alter at Muckamore, were practices changed at Muckamore
3 in any way as a result of the review of that report?
4 A. Well, I would hope so, I would hope so. I can't
5 remember specifics but I would hope. You know, there 11:42
6 was little point in having a workshop if you didn't
7 learn from it and there was no point in looking at the
8 learning if you didn't put it into practice as well.
9 99 Q. DR. MAXWELL: Was there a written action plan following
10 the workshop? 11:43
11 A. I don't know.
12 100 Q. DR. MAXWELL: Because some workshops are about just
13 sharing information?
14 A. That's right.
15 101 Q. DR. MAXWELL: Where you say this is the report and this 11:43
16 is what it says and everybody goes oh?
17 A. Certainly the governance meetings were minuted and
18 recorded and there were action plans from each
19 governance meeting and they were reviewed at the next
20 meeting. 11:43
21 102 Q. DR. MAXWELL: But you don't recall a specific action
22 plan as a response to the Winterbourne View?
23 A. No I don't recall that, sorry.
24 103 Q. MR. MCEVOY: Was it a one off, was there further
25 meetings down the line to discuss whether it had been 11:43
26 taken into account or implemented?
27 A. The governance meetings, they were consistently held
28 and alongside the governance meetings there were
29 monthly senior management meetings which I attended

1 which were typically held in Muckamore and they would
2 look at things like untoward incidents, they would look
3 at staffing levels, they would look at budgets, they
4 would look at the discharge programme.
5 104 Q. Can you recall how you decided when a case conference 11:44
6 was necessary, what was the threshold for that
7 decision?
8 A. Yeah, I think it would have been, for example, if we
9 take somebody you discovered with a bruise or an
10 injury. I suppose the first thing was, you know, the 11:44
11 description of that injury and what is the explanation
12 given on the untoward form. And if that was --
13 somebody could, I could get up from this chair and trip
14 over the leg of the table and fall and injure myself.
15 That is probably an untoward incident so you would go 11:44
16 through so what was the seating arrangement, what was
17 the table arrangement and what could you physically
18 learn from that. If there was a suggestion that the
19 injury may have occurred because it wasn't an accident,
20 you know, if for example the person was supposed to be 11:45
21 under the supervision and support of a member of staff
22 and that seemed to be the cause of the antecedence of
23 the injury, well that might have led you to think that
24 this is something that needs to go to a case
25 discussion. You know, depending on what had come to 11:45
26 light or what might come to light at the meeting, it
27 might be a matter that needed reported to the police.
28 105 Q. And do you recall such necessity as having arisen?
29 A. Certainly there were issues which were reported to the

1 police, yes. There was, and at different times the
2 benchmark for that was increased.
3 106 Q. Yes?
4 A. That did cause some difficulty, at times people thought
5 that things were being reported to the police which 11:46
6 should haven't been reported to the police. But once
7 you had a policy that meant that you reported all
8 issues to the police, that was a big change in policy
9 and a problem for some people.
10 107 Q. When you say some people, without naming names, what 11:46
11 level or what role of person had that reservation?
12 A. Well I suppose, you know, staff may have felt their,
13 you're reporting me to the police, you're putting me
14 under investigation. Sometimes families may have felt,
15 look, why are you reporting this matter to the police. 11:46
16 108 Q. That was a factor or that was an issue that was
17 expressed?
18 A. Well yeah, yeah, it would have been.
19 109 Q. CHAIRPERSON: And can you put a time frame on that,
20 when was that, when was that change? 11:46
21 A. Probably in the mid 2000s, probably in the mid 2000s.
22 110 Q. CHAIRPERSON: You mean between 2000 and 2010?
23 A. Yes.
24 111 Q. MR. MCEVOY: You retired in 2012?
25 A. 2012, yes. 11:47
26 112 Q. In terms of your recollections about assisting with
27 investigations in the staff poor practice, you recall
28 sitting on disciplinary boards in Muckamore a few
29 times?

1 A. Yes.
2 113 Q. As far as you recollect, none of those related to
3 abuse?
4 A. Yeah.
5 114 Q. What kinds of things were you looking at? 11:47
6 A. Yes, for example, if somebody -- I recall if somebody
7 was assigned to provide individual support, sometimes,
8 I think there was a thing calling specialing which
9 typically meant that the person had to be within,
10 basically within touching distance of the patient. And 11:47
11 on a few occasions the person had received an injury or
12 an incident happened which seemed to indicate that the
13 member of staff who was allocated to be in support of
14 that person wasn't carrying out the duty as it were.
15 Typically if it was a serious matter that would come to 11:48
16 a disciplinary hearing and that was discussed there.
17 CHAIRPERSON: Can you remember to keep your voice up
18 again.
19 A. Sorry.
20 MR. MCEVOY: Bring your Chair forward if you can, if 11:48
21 it's comfortable for you.
22 A. Okay.
23 115 Q. MR. McEVOY: Now, in your statement you spoke about,
24 you know, you give your opinion on the Equal Lives
25 Report and indeed you've mentioned it earlier on in 11:48
26 your evidence this morning. Have you a particular
27 knowledge of that report and it's, more importantly I
28 suppose its compilation, how it was put together?
29 A. Yeah.

1 116 Q. Can you tell us about it?
2 A. I think the Equal Lives Report was a subreport from
3 probably a report called People First, sometimes called
4 the Bamford Review after the name of its author. The
5 Equal Lives subreport, one of the main authors of it 11:49
6 was a woman called Siobhan Bogues, sadly now deceased.
7 I had some input into the production of that report,
8 yes.
9 117 Q. And you very plainly say in your statement that there
10 has never been a proper implementation of the Equal 11:49
11 Lives Report. "The implementation was stop-start and
12 subject to financial restraints." And it looked at
13 hospitals like Muckamore. You're quite categorical
14 there that it's never been properly implemented. Can
15 you give us the headlines on why you take that view? 11:49
16 A. Well, if you take an example, for example, in some
17 parts of England -- the overall, one of the key things
18 in it if you relate it to Muckamore was that there
19 wasn't a need for big institutions like Muckamore.
20 There wasn't a need for people with learning 11:50
21 disabilities to live their lives in hospital. They
22 should only be admitted to hospital, like you or I,
23 where they need treatment, assessment or treatment. If
24 they need specialist -- the role of hospitals like
25 Muckamore was to provide specialist assessment and 11:50
26 treatment for people with learning disability. So that
27 was, even before Equal Lives, that was policy or that
28 was the thinking. That had moved forward in some
29 places a lot quicker than it moved forward or it has

1 moved forward in Northern Ireland. For example, you
2 know, the large, I think it's called Lennoxville
3 [Lennox Castle], the large long stay hospital in
4 Scotland, I know people who were involved with, indeed
5 I do advocacy work with people who were involved with 11:51
6 the closure of Lennoxville. I think there were, just
7 something has come into my mind, I will just mention it
8 now, there is an official history of Muckamore, a book
9 written, I don't know if the Inquiry has come across
10 that. 11:51
11 CHAIRPERSON: Yes.
12 A. You have, good. That sort of paints the picture of how
13 institutions like Muckamore came about. I think there
14 were five of them possibly in Northern Ireland at one
15 stage. I think Northern Ireland has been behind in a 11:51
16 lot of its social care, the development of its social
17 care, and has relied and still relies on too much
18 institutional care. Typically that was not only in
19 learning disability, but also in mental health as well
20 and possibly in physical health and disability and 11:51
21 services for older people. Why has that come about?
22 Well, for a variety of reasons. Is Northern Ireland a
23 fairly conservative society that has been slow to adapt
24 and change its health and social care? There is a lot
25 of thinking that that is the case. The Northern 11:52
26 Ireland, the Bengoa Report, has that been implemented
27 for healthcare and I suppose my feeling is that within
28 social care that has been a problem, that services,
29 community learning disability services have been slow

1 to develop. One of the issues is that if you're
2 running large institutions like Muckamore, the
3 resources in learning disability are centered, the
4 financial resources are centered within the hospital
5 and therefore it makes it very difficult at the same 11:52
6 time to resource community resources.
7
8 One of the issues, for example, in the mid 2000s again
9 when there was considerable investment in
10 infrastructure in Muckamore, people like me and others 11:53
11 in the community were looking at the investment that
12 was going into the infrastructure in Muckamore and
13 saying hold on a minute here, we really should really
14 be investing in community resources. When there is a
15 finite amount of resources, if they were being put into 11:53
16 the redevelopment of the hospital, they also needed to
17 resource community resources at the same time.
18 118 Q. And did that happen?
19 A. No, not really, and still hasn't happened. Again I'd
20 refer back to, for example, the testimony of Professor 11:53
21 McConkey when I think he was very critical of the lack
22 of proper resourcing and consistent resources in the
23 community to allow that to happen.
24 119 Q. One of the odd patterns one could observe is that there
25 was, as you say, investment into new parts of the 11:53
26 hospital and new facilities in the hospital at a stage
27 and then a swing away from providing facilities et
28 cetera at the hospital to a push to resettlement. Can
29 you give us an idea of when you think that point, that

1 kind of pivot point was reached in your own
2 professional experience?
3 A. I don't know if it ever was a pivot point because I
4 think, you know, up until I retired in 2012 that
5 probably still was the case. 11:54
6 120 Q. Which was the case, that into the hospital as opposed
7 to resettlement?
8 A. Yeah. Probably the people who were involved in running
9 the hospital felt they hadn't got enough resources but
10 certainly within the community, we felt that we were 11:54
11 scarce on resources and we felt, rightly or wrongly,
12 that one of the issues why we were scarce in resources
13 was the resources were going into the hospital. As to
14 a pivot point, I suppose it was always like that.
15 121 Q. And just looking back on something you said a bit 11:55
16 earlier in your statement in terms of resettlement, you
17 gave examples, you say that resettlement was successful
18 in your experience and you name some facilities?
19 A. Yes.
20 122 Q. In Belfast, in the greater Belfast area? 11:55
21 A. Yes.
22 123 Q. You were of the view that most of the resettlements
23 that you were involved in did work out, even against
24 little to no resources?
25 A. Yeah, there are many good examples of resettlement. 11:55
26 There are many good examples of people leading full and
27 equal lives within the community. There are many good
28 examples of people moving from wards in Muckamore to
29 having a key to their own front door. There are many

1 good examples of people with learning disabilities
2 living in streets where, and I don't mean this in a bad
3 way, where you wouldn't know they are living, there are
4 no plaques to say this is a hostel or a home for people
5 with learning disability, they are living in ordinary 11:56
6 houses.
7 124 Q. And --
8 A. The two examples I give are examples that they are in
9 the statutory sector, the Trust provided. But there
10 are many good examples where a number of organisations 11:56
11 in the voluntary sector or the private sector provided
12 those services. For example, an organisation like
13 Positive Futures, which is now a large provider of
14 supported living and serving people with learning
15 disability. They have many good examples across 11:56
16 Northern Ireland and indeed in the rest of Ireland of
17 that and there are a number of other organisations
18 which are providing excellent support to people with
19 learning disability in the community.
20 125 Q. Towards the end of your statement you say, you make the 11:56
21 observation that abuse can and does happen everywhere,
22 you also observe then it's obviously not something
23 that's confined to Muckamore, it happens in the
24 community as well. You say that the response is always
25 to discipline the staff and sack them. Then you say: 11:57
26
27 "In addition what needs to be done is to give staff
28 training and set proper standards."
29

1 On that second point are you saying that what is
2 currently in place in terms of training and standard
3 setting is not adequate?
4 A. Well, first of all I can only comment up to 2012. I
5 have been involved a little bit in the learning 11:57
6 disability field since then. I go on to talk about
7 Vocal, so I have some knowledge of learning disability
8 after that. I think it's important that the person who
9 is at a director level for example sets a high
10 standard. And, for example, they need to set a culture 11:57
11 where, you know, abuse will not be tolerated, if there
12 is any abuse that will be dealt with, that will be
13 found out, that will be, there are proper procedures to
14 deal with that. I think where there is a slack culture
15 there is more likely to be abuse because people very 11:58
16 quickly figure out, yeah, I can get away with the odd
17 slap or the odd push. Whereas if proper standards are
18 set, proper training is given, people will know not
19 only should I not do this, but if I did do it I'm going
20 to get caught. 11:58
21 126 Q. Yeah. In the final substantive paragraph of your
22 statement you, as you say you touch on your involvement
23 now in your retirement with Vocal and you point to your
24 experience in relation to P19, P20. The death to which
25 you refer took place outside of Muckamore and you draw 11:58
26 the contrast then between how that patient had 40 years
27 in Muckamore?
28 A. Yeah.
29 127 Q. And then after a month of resettlement lost their life.

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1 I suppose can we be sure, though, that, you know, the
2 seeds of that tragedy weren't sewn in terms of
3 resettlement, if you see what I'm saying?
4 A. Well, indeed it was a very tragic case and sadly the
5 gentleman lost his life and his brother, who indeed I 11:59
6 was speaking to last night on the telephone because I
7 still continue to do some advocacy work with him, so I
8 have fairly detailed knowledge of what happened. That
9 matter was both a criminal case and a finding was found
10 against the company who ran that and then the 11:59
11 gentleman's brother took a civil case. A very detailed
12 resettlement plan was in place, including a speech and
13 language assessment, including a dietary assessment.
14 It's uncontestable that that was not followed. Now,
15 that's not to say that -- I can't judge, I'm not 12:00
16 passing a judgment on the quality of that service, I
17 think that service is still around. Unfortunately
18 wrong things do happen within all services but I'm just
19 giving that as one example of how, and that's not to
20 say that the service or support for that individual 12:00
21 within Muckamore might have been perfect, I think there
22 are examples of how it was far from perfect, but I'm
23 saying that it's an example of how services -- it's too
24 simplistic to take a view that bad things happened in
25 Muckamore, yes, they did, and bad things could not have 12:01
26 happened if people were not in Muckamore. Bad things
27 could happen and do happen elsewhere if the proper
28 services are not in place.
29 MR. McEVOY: All right. At this stage, Chair, then I

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1 am happy to deal with that restricted section.
2 CHAIRPERSON: Shall we see if there are Panel questions
3 on this part first. There aren't any Panel questions.
4 Before we close the feed, please leave the feed open.
5 I just want to say we are going to go into restricted 12:01
6 session now. I don't think it will take very long
7 because it is just to deal with one paragraph. I will
8 also say this, accredited journalists are entitled to
9 be in this room provided of course, as I'm sure they
10 will, they observe the Restriction Order. But we will 12:01
11 now close the feed to Room B in a moment. I do have
12 some short closing remarks to make about this week
13 which will be in unrestricted session after we've just
14 dealt with the next passage of evidence so can we just
15 close the feed to Room B now. 12:02
16
17 RESTRICTED SESSION
18
19 OPEN SESSION
20 12:08
21 CHAIRPERSON: That is the last witness I think we've
22 got for today.
23 MR. MCEVOY: Yes, Chair.
24 CHAIRPERSON: This was the first week, of course, of
25 what I'm referring to as the staff experience. We've 12:08
26 heard evidence from six witnesses. It has been, for us
27 certainly, a useful and instructive week. It's also
28 allowed us to demonstrate our ability to hear evidence
29 in different formats. We've had two witnesses granted

1 anonymity. We've had one via Zoom link. We've had
2 witnesses screened and not screened. So I want to say
3 once again that we will do whatever we can to
4 facilitate staff giving evidence in just the same way
5 as we did with the patient experience witnesses. 12:08
6 Whatever the evidence being given this should be a safe
7 and receptive place to be heard. Work in the meantime
8 has been ongoing to identify members of staff that we
9 want to speak to.
10 12:09
11 And I should also mention that an analysis of the last
12 section of patient experience evidence which we heard
13 in the period ending on the 12th October is being
14 undertaken and a fresh set of patient document
15 requests, or PDRs as we call them, will, we hope, issue 12:09
16 before Christmas.
17
18 The next sitting day is scheduled to be Monday the 4th
19 December and we will publish the schedule for that week
20 as soon as we can and we also intend to sit in the week 12:09
21 of the 11th before breaking for Christmas. So that's
22 the plan for the rest of this year.
23
24 Okay, can I thank everybody for their attendance and we
25 will see you back hopefully on the 4th of December. 12:09
26
27 The INQUIRY ADJOURNED TO MONDAY, 4th DECEMBER 2023
28
29