MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Date: 15 November 2023

I, **Briege Donaghy**, make the following statement for the purpose of the Muckamore Abbey Hospital ("**MAH**") Inquiry ("**the Inquiry**").

The statement is made on behalf of the Regulation and Quality Improvement Authority ("**RQIA**") in response to a request for evidence by the Inquiry Panel.

This is my second statement to the Inquiry. In exhibiting any documents I will use my initials "BD" and "2" to represent that this is my second statement. Therefore, my first document will be "Document BD2/1".

Introduction

1. During Module 5(a) of the Inquiry, RQIA provided evidence relating to RQIA's history, statutory remit, objectives, inspection procedures and methodology, procedures for ensuring improvement and the role and responsibilities of RQIA relevant to MAH.

2. My first statement to the Inquiry is dated 24 February 2023 and I provided oral evidence to the Inquiry on 3 May 2023.

3. By letter of 28 September 2023, the Panel requested that RQIA provides additional clarification and information to assist the Inquiry following my live evidence to the Inquiry on 3 May.

4. I have been supported in providing this statement by previous and current employees of RQIA, including RQIA's current Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

Inspections of MAH prior to the Inception of RQIA

5. In my first statement to the Inquiry, I explained that prior to the establishment of RQIA in April 2005, each of the then four Health and Social Care Boards in Northern Ireland operated a Registration and Inspection Unit. The units employed a team of Inspectors whose primary responsibilities were to inspect independent sector providers of residential care homes, nursing homes and children's homes. The Registration and

Inspection Units reported directly to the Health and Social Care Boards. The four Registration and Inspection Units were subsumed into RQIA following its establishment in 2005 to form the nucleus of the newly established RQIA.

6. The four Registration and Inspection Units were each an arm's length body of the four respective Health and Social Care Boards at that time. Those who worked for the Registration and Inspection Units were already, therefore, considered to be independent of the Health and Social Care Boards. There was no corporate connection between the Registration and Inspection Units and Health and Social Care ("**HSC**") Trusts i.e. the service delivery bodies

7. The Inspectors transferred across into RQIA in 2005 although, to RQIA's knowledge, the Regulation and Inspection Units did not inspect hospitals or other services provided by HSC Trusts (of which there were 18 at that time). It was only upon the transfer of functions from the Mental Health Commission ("**MHC**") in 2009 that RQIA first inspected HSC Trust hospitals of any kind, which was the programme of inspection of mental health and learning disability ("**MHLD**") settings described in my first statement to the Inquiry. However, RQIA's 'Reviews' programme (which is detailed at paragraphs 112 to 113 of my first statement to the Inquiry) did continue throughout this time and included reviews that related to MHLD hospitals provided by HSC Trusts.

8. It is not known to RQIA whether the Department of Health ("**the Department**") or the Health and Social Care Boards would have inspected MAH prior to 2005.

9. It was only following the Clostridium difficile (C. difficile) outbreak in 2008 and a subsequent request from the Department for RQIA to begin inspections of hospitals specifically in relation to hygiene that RQIA's HSC Trust hospital inspection programme, outside of MHLD settings, commenced.

10. The MHC did not inspect MAH in the way that RQIA inspects MAH. The MHC (pursuant to Article 86(b) of the Mental Health (Northern Ireland) Order 1986 ("**the 1986 Order**")) would visit and interview in private patients who were liable to be detained in hospital under the 1986 Order. This function was fulfilled by the MHC by way of visits to MAH to speak with patients about their experience in the service. RQIA has provided to the Inquiry a copy of any reports of MHC visits that RQIA retained following the transfer of functions from the MHC.

Inspector Independence

11. All RQIA employees are required to sign a "declaration of interest" form (**Document BD2/1)** upon commencing employment and this process is repeated annually. During my evidence to the Inquiry on 3 May 2023, the Chair expressed concern about the independence of RQIA employees who, prior to their employment with RQIA, have previously held roles in HSC Trusts or services that they then go on to inspect. Our current "declaration of interest" process would not cover this situation as the process requires employees to declare only *current* roles and interests.

12. As a result of this concern being raised during the Inquiry, RQIA is reflecting on its processes in this regard as part of its wider programme of learning from the Inquiry. Current practice is that for a period of time upon leaving a HSC Trust or service, an Inspector is not 'aligned' to (that is, takes lead responsibility for) that HSC Trust or service. In a small jurisdiction such as Northern Ireland and with a small team of MHLD Inspectors at RQIA, we do not consider that a blanket policy could be implemented which stated, for example, that Inspectors who have previously worked for a particular HSC Trust will never inspect services operated by that HSC Trust. RQIA will continue to mitigate risk in the following ways:

    (a) Peer review process of inspection outcomes;

    (b) Review of outcomes and decisions by both a Senior Inspector and Director or Assistant Director of the MHLD directorate; and

    (c) Where possible and necessary, ensuring that inspections are undertaken in groups rather than by individual Inspectors.

Transfer of functions from the Mental Health Commission

13. In 2009, when RQIA assumed the functions previously held by the MHC, there were very few people from the MHC who began employment with RQIA. There was no 'TUPE' transfer of employees and no full time employees of the MHC began employment with RQIA. There were a small number of MHC sessional staff who had held part time roles at MHC and who subsequently began employment with RQIA. They interviewed for these roles as there was no transfer of staff from one organisation to the other.

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("OPCAT") OPCAT/ UK's National Preventive Mechanism ("NPM")

14. In my first statement to the Inquiry (at paragraphs 31 to 33) I explained that RQIA is a member of the UK's NPM, which is a group of 21 statutory bodies that independently monitor places of detention in the United Kingdom.

15. The criteria for NPM members is set out in Article 19 of OPCAT; the key criteria for NPM members is the power to enter places of detention without notice (Article 20). On 31 March 2009, in a written ministerial statement to Parliament[1], the UK government designated 18 bodies that already had these powers to form its NPM. By designating these multiple, existing bodies to form the NPM, the UK government acknowledged that their existing powers were compatible with those required under OPCAT.

16. Membership of the NPM is beneficial to RQIA as it provides access to a collaborative group of members across the UK to share best practice and new guidance. The NPM hold conferences for members annually, which RQIA attends. The NPM is a collaborative group and does not have powers of enforcement nor does it independently evaluate its members.

17. The NPM publishes annual reports, which I have not produced as exhibits to this statement because they are freely available on the NPM's website. I am not aware of any independent evaluation of RQIA's effectiveness by the NPM. RQIA provides information annually to the NPM, which is collated by the NPM and, together with information provided by other members, forms the NPM's annual reports. I am not aware of there being any independent oversight of the RQIA by the NPM.

18. It may be of interest to the Inquiry that, in 2019, the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("**the Subcommittee**") carried out its first visit to the UK, between 9 and 18 September 2019. The Subcommittee conducted joint visits to places of deprivation of liberty with the NPM, in order to observe the work of the mechanism in practice. The visits were led by the representatives of the NPM, with the members of the Subcommittee acting as observers. The Subcommittee also conducted visits to places of deprivation of liberty on its own. The Subcommittee set out its observations, findings and recommendations relevant to the prevention of torture and ill-treatment of persons

[1] https://hansard.parliament.uk/Lords/2009-03-31/debates/ec6b50c8-1f57-47d7-8e36-dcf0eda56742/WrittenStatements#contribution-09033129000139

deprived of their liberty under the jurisdiction of the UK in its report *'Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the State party'* (**Document BD2/2**).

19. While the Subcommittee's visit focused on detention in the criminal justice system, the overarching conclusions of the Subcommittee in relation to the operation of the UK NPM may be of interest to the Inquiry. The Subcommittee's report provides background and structure of the UK's NPM (pages 4 and 5) and the 'legislative basis' of the UK's NPM (pages 5 to 7). The report explains that *'while each of the 21 bodies has a legal basis of its own, the NPM as a collective entity does not have a separate legal basis in the UK'* and *'this lack of a formal legislative text establishing the NPM has long been a matter of concern to the Subcommittee. The Subcommittee's unequivocal view is that the situation of the mechanism in UK remains precarious as it is not underpinned by a clear legislative basis'.* The report adds *'the Subcommittee urges the United Kingdom to provide its NPM with a formal legislative basis*'.

20. The UK Government responded to the United Nation's report (**Document BD2/3**). The UK report notes that *'the UK undertook a consultation on 'strengthening the independent* scrutiny *bodies through legislation' in 2020 which proposed options for reform to strengthen the scrutiny bodies. This included proposals to place the NPM and a number of prison scrutiny bodies on a statutory footing'.*

RQIA'S monitoring of the use of PRN Medication at MAH

21. RQIA appoints Second Opinion Appointed Doctors (also known as 'Part IV Medical Practitioners') to provide a second opinion in relation a patient's treatment plan in defined circumstances. Those treatment plans may cover the use of PRN medications, which are intended for use to help manage a patient's distress when required.

22. Part IV Medical Practitioners are medical practitioners at Consultant Psychiatrist level who have specialist experience in the diagnosis or treatment of mental disorder. When RQIA is considering whether to appoint a Part IV Medical Practitioner to that role, RQIA has regard to the practitioner's relevant experience, training, professional standing, qualifications and indemnity. RQIA remunerates these practitioners for providing second opinions.

23. Under Article 64 of the MHO 1986, the administration of psychotropic medicine for three months or more after its first administration during any continuing period of

liability for detention requires either consent or, in absence of consent, requires a second opinion.

24. Consent, given by a detained patient, must be validated by the Responsible Medical Officer (Part II Medical Practitioner) or by a Part IV Medical Practitioner.

25. If valid consent is not given or cannot be given, a second opinion must be obtained from a Part IV Medical Practitioner. Part IV Medical Practitioners are appointed by RQIA and requests for the provision of a second opinion must be made to RQIA by the Trust.

26. The process for a psychotropic medication second opinion is as follows: HSC Trusts must advise RQIA of their second opinion requirements each month for the following month. RQIA receives approximately 40-50 medication second opinion requests per month across all services. RQIA then assigns the requests to the Part IV Medical Practitioners. The Part IV Medical Practitioners arrange to carry out the second opinions directly with the HSC Trusts.

27. If the Part IV Medical Practitioner is satisfied that the treatment recommended is clinically defensible, that consideration has been given to the views and rights of the patient and that the treatment is safe, effective and compassionate, the Part IV Medical Practitioner should complete and sign the required 'Prescribed Form 23' (which includes the patient's treatment plan). This form should provide details of the treatments prescribed, including medication, dosage, frequency, rationale for administration and reasons why the Part IV Medical Practitioner has agreed to the treatment plan. A copy of the Prescribed Form 23 is sent to RQIA to be logged in RQIA's IConnect document management system.

28. The HSC Trusts request a further second opinion from RQIA when the authority to detain a patient is being renewed under Article 13 of the 1986 Order.

29. A review of RQIA's IConnect document management system (for MAH records from January 2019 to present day), has identified 121 Prescribed Form 23s relating to MAH patients. A review of RQIA's historic 'M_Drive' has identified record logs identifying 217 Prescribed Form 23s[2].

30. Medications are also considered by RQIA in the context of inspections. Some inspection teams include members of RQIA's Pharmacy team and they report on their

[2] A sample undertaken by RQIA showed the majority of these treatment plans included PRN medication.

findings. **Document BD2/4** is the current template record of inspection used by Pharmacy colleagues when attending acute MHLD wards.

31. During most inspections, even when Pharmacy colleagues are not present, the Inspectors consider the use of medications including PRN medication and the systems and procedures that are in place at a service relating to such medication. When undertaking an inspection, Inspectors are guided by a Record of Inspection document (**Document BD2/5).** PRN medications are considered as part of two sections; (1) medicines management; and (2) restrictive practices.

32. Inspectors review a sample of patients' medication prescription sheets, care plans and minutes of MDT meetings. They consider communication and information sharing with the patient and their families (where appropriate). When reviewing sample care plans, Inspectors will consider, for example, the times of administration of the medication and whether this is in keeping with any behaviour supports. Inspectors review samples of records to check for evidence that medication is being administered as prescribed and is recorded. The Inspectors will consider whether other methods of de-escalation are implemented as part of the care plan prior to PRN medication being given and will also consider whether staff are recording the effectiveness of the use of such medication. Often, there will be first, second and third line PRN medications prescribed and effective prescribing should also advise of the duration between doses. The team will consider whether administration has taken account of the above. Notable findings are included in the record of inspection.

RQIA's Monitoring of Detentions

33. Article 86(1) of the 1986 Order outlines that it is the general duty of RQIA to keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by the 1986 Order.

34. In exercising its functions under Article 86(1), the duties imposed upon RQIA by Article 86(2) specifically in relation to detention are:

    (a) to make inquiry into any case where it appears that there may be improper detention in hospital3;

[3] Article 86(2)(a) of the 1986 Order

(b) as often as RQIA thinks appropriate, to visit and interview in private patients who are liable to be detained in hospital under the 1986 Order[4];

(c) to bring to the attention of the Department, the Secretary of State, or the HSC Trust the facts of any case in which in the opinion of RQIA it is desirable for the Department, the Secretary of State or the HSC Trust to exercise any of their functions to secure the welfare of any patient5, including by terminating their improper detention in hospital[6]

35. In exercising its functions under Article 86(1), RQIA may:

(a) where it thinks fit, refer to the Review Tribunal the case of any patient who is liable to be detained in hospital or subject to guardianship under the 1986 Order[7];

(b) at any reasonable time visit, interview and medically examine in private any patient in a hospital[8]; and

(c) require the production of and inspect any records relating to the detention or treatment of any person who is or has been a patient in a hospital[9].

36. The two principal ways in which RQIA considers detentions in practice is (1) by receipt and review of 'prescribed forms' relating to detention of patients; and (2) as part of the inspection process.

37. RQIA published the document "***Guidance for the completion of Prescribed Forms (Forms 1–12) under the Mental Health (NI) Order 1986***", which is enclosed at **Document BD2/6**. The purpose of this document is to provide guidance and clarity for those completing prescribed forms about the information that must be recorded and the manner in which the forms should be completed. **Document BD2/7** is a list of all the 'prescribed forms' under the 1986 Order. This exhibit also details the relevant Article of the 1986 Order associated with each prescribed form.

38. HSC Trusts are required to submit all 'prescribed forms' to RQIA. The forms are reviewed differently by RQIA depending upon the type of the form. The initial stage for

[4] Article 86(2)(b) of the 1986 Order

[5] Article 86(2)(c) of the 1986 Order

[6] Article 86(2)(c)(iii) of the 1986 Order

[7] Article 86(3)(a) of the 1986 Order

[8] Article 86(3)(b) of the 1986 Order

[9] Article 86(3)(c) of the 1986 Order

all forms is receipt to a dedicated team of administrative staff who are trained to review the forms. RQIA's iConnect system is also designed to support with monitoring of these forms. The procedure checks for errors including, for example, ensuring that the doctor completing the form has the necessary Part II status to do so. The procedure also detects situations when dates on the prescribed forms may not align to the dates of previous forms. It also identifies whether an earlier form for a particular patient is missing, thus making the later form potentially invalid.

39. Where identified issues cannot be resolved simply between an RQIA administrator and the HSC Trust, the issue is escalated to an Inspector, Senior Inspector or Assistant Director at RQIA. RQIA may also seek advice and guidance from one of its Consultant Psychiatrists.

40. A Prescribed Form 10 must be completed by a HSC Trust when a patient is detained for treatment. The HSC Trust must then provide a copy of this form to RQIA. The extent of scrutiny of forms by RQIA has been considered at various times over the years. Following a review and audit of Prescribed Form 10s in or around 2018/2019, current practice by RQIA is that all Form 10s are reviewed for both accuracy and consideration of the lawfulness of detentions. All Prescribed Form 10s are scrutinised by a Band 7 MHLD Inspector, who can seek input from a psychiatric consultant if the Inspector considers that their input or advice would be beneficial. The template audit form that is completed by Inspectors when reviewing a Prescribed Form 10 can be found at **Exhibit BD2/8**.

41. RQIA also considers detentions during its inspections of services. As part of the inspection process, RQIA Inspectors will, where possible, speak with patients who are detained. Inspectors also review a sample of care and treatment records relating to detention which includes consideration of whether the patients' rights are being considered, rights have been explained and that staff have confirmed that patients have understood their rights. RQIA will consider whether restrictions are appropriate and proportionate and that safeguarding arrangements are in place. The records viewed during inspections are not retained by RQIA but significant findings are included in the record of inspection under the 'restrictive practices' section of the document.

42. In March 2023, the Inquiry heard evidence from Alex Ruck Keene KC in relation to the changing landscape of legislation relating to deprivation of liberty. He outlined the provisions under the 1986 Order and the Mental Capacity Act (Northern Ireland) 2016 and associated case law.

43. Until such time as the Mental Capacity Act (NI) 2016 comes fully into force, deprivation of liberty provisions in the Mental Capacity Act (NI) 2016 and the 1986 Order remain in force concurrently, although if a person can be detained under the 1986 Order, then the 1986 Order framework must be applied. Where a patient does not meet the grounds for detention under the MHO 1986 but is subject to restrictions on their liberty then the Mental Capacity Act (NI) 2016 would apply. During its review of sample records during inspection, RQIA seeks to establish which is the appropriate legislation to be used in a patient's case and, where necessary, considers whether the HSC Trust and clinicians have considered and recorded whether the criteria for detention under the 1986 Order applies.

44. It is necessary for RQIA Inspectors to be familiar with deprivation of liberty requirements under both the Mental Capacity Act (NI) 2016 and the 1986 Order. . RQIA has provided information and training to its Inspectors in relation to deprivation of liberty (for example, provision of an *aide memoir* for inspectors when visiting a service (**Document BD2/9**) but RQIA has not undertaken its own formal review of the evolving law in this area.

45. RQIA has been in discussions with the Department in relation to its role under the Mental Capacity Act (NI) 2016. Section 43 (5) of the Mental Capacity Act (NI) 2016 requires deprivation of liberty authorisation extension reports to be provided to RQIA.

46. Section 80 (7) of the MCA requires applications to the Review Tribunal for appointment of a nominated person to be forwarded to RQIA as soon as practicable, where the applicant is an appropriate healthcare professional or the managing authority of a hospital or care home.

47. RQIA receives approximately 250 to 300 authorisation extension reports under the Mental Capacity Act (NI) 2016 each month. RQIA has requested additional funding from the Department in order to consider those forms. This has been refused by the Department to date on the basis that the Department considers that the Mental Capacity Act (NI) 2016, while requiring service providers to notify RQIA in relation deprivation of liberty, creates no positive obligation upon RQIA to review or monitor those detentions.

48. It remains RQIA's interpretation that the reporting requirements upon service providers under the Mental Capacity Act (NI) 2016 establishes a flow of information to RQIA to enable RQIA to act, utilising the powers in its primary legislation, where necessary. While the Mental Capacity Act (NI) 2016 itself does not specify the actions that RQIA

should take upon receipt of the information received, RQIA considers that this is because RQIA's role and powers are already stated in primary legislation; and in its designation as part of the NPM under OPCAT.

49. In the context of the partial implementation of the Mental Capacity Act (NI) 2016, and in response to and preparation for the Inquiry, RQIA is re-examining the way in which it carries out its core duty and associated functions in respect of persons suffering or appearing to suffer from mental disorder. RQIA plans to set out the scope of, and intend to undertake, such a review, including RQIA's approach to inquiry into detentions.

50. RQIA's work in this regard is also reflecting upon a recent Judicial Review application, in response to which RQIA agreed that it has a regulatory role in relation to *community* mental health services provided by the HSC Trusts. RQIA had previously stated, in response to a concern raised with it that it did not regulate community mental health services, which it has now accepted was as a misdirection in law. RQIA accepts that it does have a regulatory role for community mental health services provided by HSC Trusts. Given the move towards community MHLD provision, and away from hospitals such as MAH, it is increasingly important for RQIA, and other organisations within the HSC system, to have clarity as to how the law applies in community settings, given that the delivery of care as it is evolving today was not envisaged when the 1986 Order was drafted.

Development of Inspection Methodology 2009 to 2011

51. In giving my evidence to the Inquiry, I was asked about the development of an inspection methodology following RQIA's assumption of responsibility of the functions previously undertaken by MHC. In particular, the Inquiry sought information concerning those responsible for the methodology development, who was consulted in establishing that methodology and what sources, including academic resources, were considered in proposing a new methodology.

52. As I have previously observed in my evidence, when RQIA began inspecting of MHLD facilities in 2009, it did not inherit an established inspection methodology. RQIA had developed a new inspection methodology for regulated services and was still in the process of rolling out its inspection methodology for regulated services in the period 2009 to 2011.The underlying expectation when the functions of the MHC transferred to RQIA in 2009 was that the inspection methodology for MHLD hospitals would align with the methodology of inspection for regulated services. This included a focus on

both self-assessment and a risk-based approach. The proposed methodology in respect of regulated services was itself approved by the Authority in 2006. In developing that methodology, RQIA undertook public consultation in the early part of 2006.

53. In 2006, the Authority approved a methodology in respect of regulated services underpinned by i) focusing on improving care and outcomes for service users, ii) promoting the providers' responsibility for the quality of services, iii) targeting resources where they are most needed and weighted to risk and iv) the provision of timely, user-friendly reports. As appears from the 2006 consultation document, aspects of that methodology were informed by the minimum standards set by the Department and following consideration of approaches to inspection in other jurisdictions.

54. Throughout 2009, RQIA's MHLD team delivered presentations at a variety of events to stakeholders explaining its role and its intended approach to regulation and inspection of MHLD community-based facilities and hospitals. In August 2009, RQIA, with a view to developing a coherent inspection methodology, appointed a specialist human rights advisor, Virginia McVea. The development of that methodology was focused largely upon human rights compliant standards and indicators, identified through a number of sources and informed by the approaches to inspection of other regulatory bodies in other parts of the United Kingdom and Ireland. The standards were designed to measure patient and client experience and were also influenced by the standards developed by the Northern Ireland Practice and Education Council in conjunction with the Royal College of Nursing.

55. In July 2009, RQIA piloted a scheme entitled 'Open Surgeries Pilot' with detained service users and with engagement from the Trusts. MAH was not included in the pilot. A quarterly Advocates Forum was also established in November 2009, in which RQIA's MHLD Team met with user and carer advocates. This assisted in the planning and implementation of the pilot scheme, which subsequently became known as Patient Experience Reviews. This work was supported by the Department and by the Patient and Client Council. The feedback from the Open Surgeries Pilot formed the basis of the planned programme of inspections to be piloted in June 2010.

56. Although I am unable to provide an exhaustive list of those events and sources which influenced the development of the inspection methodology, papers held by RQIA show that it undertook consultation and participated in a number of events from 2008 onwards. RQIA sought input from sessional experts, including Dr McGinnity, Consultant Psychiatrist and a meeting with the Chair of the Mental Health Review

Tribunal. Extensive work was undertaken and those experts had extensive influence in developing both the methodology and the indicators.

57. Around that time, RQIA, in seeking to develop Human Rights indicators for use during the inspection process, arranged a symposium of internationally recognised experts in human rights legislation and mental health and learning disability care. Attendees included the former UN Special Rapporteur, Paul Hunt, Professor Peter Bartlett, the leading author in the field of mental health and human rights and Professor Phil Fennell, a leading adviser to Northern Ireland agencies on mental health and learning disability legislation. The event facilitated the consideration of the MHLD Human Rights based indicators which had been proposed.

Revision of Inspection Methodology 2014-2015

58. In my first statement to the Inquiry (paragraphs 47 to 50), I provided details of the revision of inspection methodology in 2014 to 2015. I do not believe, on the basis of documents available to me and upon making enquiry with colleagues that the revision to methodology in 2015 was motivated by an individual concern or that it was prompted by an identifiable event or incident. I have previously indicated that the methodologies employed by RQIA evolved and developed over time, both in respect of regulated services from 2005 and in respect of MHLD facilities from 2009. These methodologies have been subject to on-going assessment and review and have been informed by prevailing healthcare themes, policies and strategic plans.

59. As noted in my first statement, in or around 2015, RQIA focused its programmes of inspection, review and monitoring of MHLD in-patient facilities around the theme of person-centred care and sought to address three specific domains, assessing whether care was i) safe, ii) effective and iii) compassionate. In the period 2015-2016, the MHLD team within RQIA focused its programmes of inspection on those important themes. The approach was intended to align RQIA's work with the strategic vision of the Department as set out in Quality 2020, formally launched in November 2011. In view of the emphasis on quality by DHSSPS, RQIA sought to place greater emphasis on evaluating care outcomes for individual patients and clients and attempted to reflect this emphasis in its inspection methodologies.

60. Prior to implementation of the pilot methodology in 2015, person-centred care had become a dominant theme in international healthcare and strategic planning. Person-centred care was also a key component of the recently launched Regional Mental Health Care Pathway as well as the Service Framework for Learning Disability.

61. The overarching inspection theme of person-centred care was clearly referenced in 5.3.3 of the Quality Standards for Health and Social Care 2006 which required the relevant organisation to promote a person-centred approach and actively involve service users and carers in the development, implementation, audit and review of care plans and care pathways.

62. In my first statement to the Inquiry at paragraph 48, I referred to a 2015-2016 pilot of the new inspection methodology. I am able to confirm that the Cranfield (Female) Ward of MAH was included in this pilot, as one of 12 MHLD units/wards. The pilot included a ward/unit from each of the main types of inpatient MHLD provision which RQIA inspected across the five HSC Trusts In the period 2015-2016.

The use of Self-Assessment Questionnaires in Inspection Methodology

63. During my evidence to the Inquiry, the Inquiry sought clarification concerning the rationale behind cessation of the use of self-assessment information by the service provider prior to inspection by RQIA. Commentary and feedback which was submitted prior to the implementation of the pilot methodology recommended that RQIA take this step. Although return of self-assessment forms was, in theory, an effective means by which a facility could evaluate its performance against the requisite level of service, assessment of the forms by Inspectors questioned the effectiveness of the method. In reality, Inspectors' assessments of facilities often returned rather different results to those contained within the self-assessment forms. The methodology adopted in 2015 sought information from a variety of sources prior to the inspection, which would be analysed by Inspectors and used to inform the inspection process. The methodology encouraged the service provider to devise its own improvement plan upon receipt of the inspection report.

Inspections and Patient Experience Reviews

64. Following the development and piloting of a rights-based approach to inspection in 2009-10, RQIA began to inspect MAH facilities from October 2010. These inspections were announced inspections until June 2012.

65. In 2009, RQIA developed and piloted a process of 'Open Surgeries'. The purpose of these was to enable RQIA to engage with service users who had been detained under the 1986 Order. These later became known as 'Patent Experience Reviews' or 'Patient Experience Interviews'. From June 2010, patients detained under the Order were invited to meet with representatives of RQIA to talk about their experience of detention,

care and treatment. These visits were announced, and occurred on a separate date from inspections.

66. From a review of RQIA's records of inspection of MAH and Patient Experience Reviews/Interviews, it appears that such visits did not occur in the period after transfer of functions from the MHC in April 2009 until the development of the inspection methodology and first inspections in 2010.

67. In 2013, the invitation to speak with RQIA Inspectors was extended to all patients and not just those who were detained under the 1986 Order.

68. The Patient Experience Reviews/Patient Experience Interviews were, initially, conducted separately to the inspections but from around 2015, these formed part of the inspection process.

69. The table at **Document BD2/10** provides a summary of RQIA inspections and Patient Experience Reviews throughout the relevant period. Not all inspections were broad 'care' inspections; some were focussed on specific areas, for example, infection prevention/hygiene, medicines management, finance, or 'follow up' inspections further to a previous inspection.

Assessment of Culture

70. RQIA considers the culture of a service in a number of ways. One way is via a questionnaire that enables staff, service users or relatives to respond and raise concerns over levels of care provided and the setting generally. Inspectors also seek to understand what surveys have been completed by the service providers themselves.

71. The questionnaire used by RQIA is at (**Document BD2/11**).

72. The questionnaire includes reference to culture, whether that be a culture of learning, empowerment, reporting concerns, kindness, dignity and respect. These completed questionnaires can be provided to Inspectors during the inspection visit or sent to RQIA after the inspection. Staff are provided with a QR code to allow them to access the questionnaire electronically.

73. In assessing culture during inspections, Inspectors are pointed towards two documents to support them in identifying a 'closed culture' (closed culture is defined by the Care Quality Commission as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. Those documents are:

(a) The Care Quality Commission document ***'Identifying and responding to closed cultures'*** (**Document BD2/12**) ; and

(b) The University of Hull document ***'Early Indicators of Concern Residential and Nursing Homes for Older People'*** (**Document BD2/13**).

74. Culture is also assessed in terms of learning, innovation and continuous improvement. The setting being inspected is required to demonstrate/provide evidence of this. Presently, RQIA does not expressly conclude on its findings in relation to culture within its inspection reports; albeit the topic of culture permeates many other aspects of its written conclusions. RQIA is reflecting upon how it can better articulate findings in relation to culture within its inspection reports.

75. When undertaking an inspection, Inspectors complete the template Record of Inspection (**Exhibit BD2/5**). The records of inspection are set out in themes, including:

(a) Environment;

(b) Incidents and Adult Safeguarding;

(c) Staffing;

(d) Physical Health;

(e) Restrictive Practice;

(f) Patient Experience;

(g) Governance;

(h) Patient Flow;

(i) Medicines Management; and

(j) Mental Health.

76. The 'Governance' theme (page 54 of **Document BD2/5**) contains a section dedicated to culture and outlines how an Inspector should consider culture during inspection. An extract from the relevant section of the record of inspection template is below:

(a) *Do staff feel supported, respected and valued by the organisation and its leaders?*

(b) *Is the culture centred on the needs and experiences of patients using the service?*

(c) *Do staff express positivity/feel proud to work in the organisation?*

(d) *Are there good performance management systems in place and is there evidence of actions taken to address behaviours when appropriate?*

(e) *Is there openness, transparency and honesty at all levels – governance information is shared appropriately?*

(f) *Can staff raise concerns with the right people at the right time without fear of retribution?*

(g) *Is there good staff development and learning opportunities – ward based learning, training, appraisals and career development?*

(h) *Is staff safety and wellbeing in focus?*

(i) *Does the staff team work well together, are conflicts detected early and addressed appropriately?*

(j) *There is an inclusive culture that ensures equality and respect among staff– (any evidence of discrimination/staff conflict is promptly addressed and actions to manage same and in evidence).*

(k) *Is there a supportive staff culture - one of learning and not blame when something goes wrong?*

(l) *Are there any indicators of a closed staff culture i.e:*

i. significant management changes over a short period;
ii. high use of non-permanent staff;
iii. poor response to complaints;
iv. limited/no evidence of staff supervision arrangements;
v. patients more likely to be at risk of harm/dependent upon staff.

Assessment of care given by nursing staff

77. Inspections involve triangulation of evidence. This includes direct observation of care, review of records and discussion with staff, and with patients and relatives where possible. Inspectors consider the processes that feed into the quality of nursing care provision, for example, the provision of induction, ongoing and regular nursing supervision, staff development processes, training records and current membership of nursing professional bodies. Inspectors also consider availability of specialist

multidisciplinary team input at times where patient records would suggest that it should be in place.

78. RQIA does not assess individual nurses against the standards set by the Nursing Midwifery Counsel but RQIA is mindful of those standards. As part of its assessment of a service, RQIA observes the interaction between staff and their interaction with patients and families and considers whether there appears to be compassionate care given to patients. RQIA reviews samples of patient records to assess whether these reflect good practice and RQIA also seeks feedback from patients and their families about the care provided to them.

79. Inspectors are not routinely trained in all communication techniques. In seeking feedback from patients, the MHLD Inspectorate Team use their professional judgement for interactions and engagements with patients, including those patients with a learning disability. When undertaking an inspection, the Inspector liaises with the Ward Manager and nursing staff to understand the communication needs and preferences of patients within their care to determine whether a particular patient could engage with them. Should that patient be non-verbal then the Inspector would discuss with staff as to how that patient communicates, whether it be using PECS (Picture Exchange Communication System) Makaton signing or otherwise. If any patient wishes to communicate with the Inspector then they are accommodated to do so.

80. While nursing care feeds into RQIA's assessment of a service, this is not considered in isolation. RQIA's role is to inspect the service rather than being a regulator of nursing staff or doctors; RQIA considers nursing care as part of the holistic, multi-disciplinary care provided. Patients in MAH often have complex needs and any care delivery should be assessed against the Multi-Disciplinary Team Care Plan. RQIA Inspectors consider whether the care planning involves psychiatry, psychology, behavioural specialists, social workers, and occupational therapists, for example, with input from the patient themselves where possible. Nurses support the delivery of care against prescribed best practice determined by the multidisciplinary team. The care plans and patient records reviewed by RQIA are considered against best practice guidance (for example, the Department's *'Regional Policy on the use of Restrictive Practices in HSC Settings and regional operational procedure for the use of Seclusion'*).

Serious Concerns Meetings

81. At paragraphs 60 to 62 of my first statement to the Inquiry, I explained that if RQIA's concerns about a service warrant escalation beyond ward/site level, RQIA can convene a Serious Concerns Meeting or an 'Intention to Serve' meeting with the service provider. In seeking to identify when such meetings took place between RQIA and the Belfast HSC Trust in relation to MAH, RQIA has reviewed records including:

    (a) Evidence of "escalation meetings" held within its iConnect data management system and earlier electronic files held on the RQIA M-drive;

    (b) Inspection reports;

    (c) Minutes of RQIA's internal "Serious Concerns and Complaints" group meetings;

    (d) Email correspondence between members of the MHLD team and the Belfast HSC Trust; and

    (e) Archived hard copy documents held by RQIA relating to MAH.

82. This review indicates that there were 14 occasions between November 2011 and May 2021 where the RQIA met with BHSCT, constituting a ‘serious concerns meeting’ or further escalation meetings, such as an "Intention to Serve' meeting.

83. In 2011, there were three such meetings; two relating to Moylena Ward and one relating to Finglass Ward. These followed from concerns identified during inspections.

84. In 2013, there was one such meeting; relating to Ennis Ward. This followed on from concerns identified during an inspection.

85. In 2015, there were two such meetings; relating to Killead and Moylena Wards. Both followed concerns identified during inspections.

86. In 2016, there were two such meetings; relating to Erne and Donegore Wards. Both followed concerns identified during inspections.

87. In 2018 there was one meeting relating to Cranfield Ward. This followed on from a whistleblowing report.

88. In 2019, there were four such meetings. By this stage, RQIA were inspecting using a 'whole-hospital' approach rather than by individual ward. Two of these meetings in March and August 2019 were ‘Intention to Serve Improvement Notice’ meetings. In

October and November that year, there were two meetings convened to review progress relating to the Improvement Notices previously issued.

89. In April 2020 a teleconference meeting (due to Covid-19 risks) was convened to review progress relating to the Improvement Notices previously issued.

Health and Social Care Board "(HSCB") / Strategic Planning and Performance Group ("SPPG")

90. RQIA would normally notify the SPPG (and the HSCB before it), along with other key stakeholders, when an Improvement Notice is issued. In some cases, RQIA might inform the HSCB *in advance* of serving an Improvement Notice, for example, if it is anticipated that the decision will have an impact that goes wider than the service in question and has the potential to impact upon commissioning requirements (such as the need to redirect placements outside of the service in question).

91. RQIA was contemplating issuing Improvement Notices in relation to MAH in July 2022 following inspection (the Inspection Report is enclosed at **Document BD2/14)** , Given the ongoing MAH Inquiry and the public interest that was likely to arise from the issuing of Improvement Notices, RQIA informed the SPPG and the Department that it was in the process of deciding whether to issue Improvement Notices, subject to the outcome of an "Intention to Serve an Improvement Notice" meeting that was to be held with the Belfast HSC Trust. The purpose of communicating with the Department and the SPPG at that stage was to inform those organisations of the current situation. It was not to seek their input into, opinion on, or approval of RQIA's proposed course of action.

92. RQIA later met with the Belfast HSC Trust's Chief Executive and senior leadership team at an 'Intention to Serve' meeting to discuss RQIA's intention to issue two Improvement Notices relating to staffing/workforce and adult safeguarding. During this meeting, the Belfast HSC Trust's Executive Management Team presented a comprehensive action plan describing their commitment and plans to address the concerns arising from the inspection. As a result of the assurances provided and the comprehensive action plan, RQIA decided not to issue the Improvement Notices. This information is recorded in the Inspection Report at **Document BD2/14** which provides comprehensive information on RQIA's findings and decision making process

Northern Ireland Medical and Dental Training Agency ("NIMDTA")

93. During oral evidence to the Inquiry, NIMDTA gave evidence that it could be prompted by RQIA to undertake a visit to a facility at which students are undergoing training. RQIA is not aware of any such discussions taking place with NIMDTA in relation to MAH.

94. RQIA and NIMDTA entered into a Memorandum of Understanding in December 2021 which characterised the working relationship between the two organisations. It was agreed that NIMDTA will be advised of any RQIA inspection or review reports that have relevance to the work of NIMDTA and that each organisation will inform the other of any issues that raise significant concerns about clinical governance that fall into their respective responsibilities. NIMDTA are now listed on RQIA's formal list of stakeholders, which means that they are notified in the event of enforcement action being taken by RQIA.

Training of Inspectors

95. My first statement to the Inquiry (at paragraphs 67 to 76) outlined training given to MHLD Inspectors at RQIA. It may however be helpful for me to set out the current programme of training for Inspectors who are newly recruited into the MHLD team.

96. There are currently seven Inspectors within the MHLD Inspectorate Team. All MHLD Inspectors employed by RQIA are from a nursing, social work or allied health professional background and all are required to have professional qualifications and maintain professional registration with their relevant regulator; for example, nurses must be registered with the Nursing and Midwifery Council and Social workers with the NI Social Care Council.

97. Upon taking up the role, a new inspector undergoes a mandatory corporate induction followed by a six-week induction period.

98. An example template Induction Timetable for weeks one to six is exhibited at **BD2/15**. At the time of writing, MHLD currently have a new inspector part way through her induction. Although the induction follows a six week timetable it does allow for flexibility depending upon the work being undertaken within the MHLD team during that time.

99. As explained in my previous statement, during the induction period, each inductee spends time shadowing experienced inspectors on areas outside of inspections. In addition to this, the new inspectors work alongside different members of the MHLD

team and inspectors from other teams within RQIA. This allows the inspectors to gain exposure to and understanding of the role of Inspector across RQIA. As set out in my first statement, much of the training for new inspectors is centred on shadowing, mentoring and 'on the job' learning, which provides the inspectors with the practical experience required for the role.

100. RQIA also provides access to ongoing learning. Over the past year there have been a series of Development Days for MHLD Inspectors. The agendas for these three days are at **BD2/16**. The Development Days covered all aspects of the MHLD inspector role including:

(a) pre-inspections (the pre-inspection assessment tool is at **BD2/17**);

(b) inspection planning;

(c) record of inspection (including inspection themes – **BD2/5**);

(d) report writing;

(e) importance of patient, staff and family engagement;

(f) escalation procedures;

(g) serious adverse incident review and procedure;

(h) quality assurance; and

(i) risk management and safety.

101. These development days provide an opportunity for Inspectors to re-familiarise themselves with the inspection process and the inspection methodology and standards to be adhered to. They also provide the team with an opportunity for open discussion and to develop how the team would shape inspections going forward.

102. A product of the development days was an updated Record of Inspection template (**Document BD2/18**), which now incorporates *aide memoires* for the Inspectors to refer to during their inspections. There are aide memoires for each of the inspection themes and each is centred on the patient, their well-being, safety and their experience of the care delivered.

Ongoing oversight of healthcare assistants, nurses and doctors

103. At paragraphs 92 to 107 of my first statement to the Inquiry, I provided details of the various groups attended by RQIA in which there is ongoing oversight of staff who have been under investigation in relation to MAH.

104. Oversight of Healthcare Assistants and Nurses falls under the remit of the MAH Operational Working Groups. There is a MAH Operational Working Group at four of the five Trusts, and staff members currently working in the particular HSC Trust are discussed at those meetings (more detail is provided at paragraphs 98-106 of my first statement to the Inquiry).

105. The oversight of doctors falls under the remit of the MAH Medical Staff Operational Working Groups. The Belfast HSC Trust and the Southern HSC Trust each operate a MAH Medical Staff Operational Working Group as it is within these HSC Trusts that the individuals concerned are employed. These groups operate in a similar way and with similar objectives to the MAH Operational Working Group but instead relate to doctors who are implicated in MAH investigations rather than nursing staff (paragraph 107 of my first statement to the Inquiry).

Protected Disclosures/ Whistleblowing

106. As I set out in my first statement to the Inquiry (paragraph 110), RQIA is a "Prescribed Person"[1] for the purposes of the Public Interest Disclosure (Northern Ireland) Order 1998. RQIA can therefore receive protected disclosures in respect of matters relating to the quality, safety, and availability of health and social care services provided by statutory, independent, community and voluntary providers in Northern Ireland.

107. A protected disclosure arises where a worker makes a disclosure to their employer or to a prescribed body (such as the RQIA) about a wrongdoing in their workplace. This is often referred to as "whistleblowing". Only certain kinds of disclosures qualify for protection and these include those circumstances which amount to a:

(a) Criminal offence;

(b) Breach of legal obligation;

(c) Miscarriage of justice;

[1] Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2012 (legislation.gov.uk)

(d) Danger to the health and safety of any individual; or

(e) Deliberate covering up of information relating to any of the above five matters.

108. In order to locate the details of protected disclosures in relation to MAH, RQIA has undertaken extensive searches and interrogations of its system, including :

(a) carrying out electronic searches of all concerns logged on its document management system 'iConnect' from when RQIA began recording concerns on this system in 2016 to the end of the relevant period in 2021.

(b) For disclosures that existed prior to 2016, reviewing electronic files held on its internal 'M_drive' and also undertaking searches of hard copy documents that had been scanned and catalogued. Searches were carried out using the terms "concern"; "whistle"; "alleg"; and "complaint" to identify files that could have been relevant to whistleblowing.

109. To date, RQIA's searches have identified a total of twelve instances that may amount to protected disclosures reported to the RQIA between 2009 and the end of 2021.

110. The reports identified relate to a number of MAH wards. Four reports relate to the Cranfield wards. There were also reports in relation to the Ennis, Sixmile, Greenan, and Erne wards respectively.

111. These searches have not identified any reports for the period up to 2012.

112. The searches have identified four reports for the period from 2012 to 2015. These disclosures were in relation to:

(a) Inappropriate behaviour of staff – waking and dressing patients at 6am, confidential patient information being shared with other patients and staff on staff bullying;

(b) Physical abuse of patients- – patient being dragged by her ankles and another patient leaving a bathroom with a bloody nose; and

(c) Negligence of staff – patient's meals being delivered late, staff not replenishing stale water, poor recording of incidents by staff, and questions as to whether staff had properly investigated whether patients engaging in sexual activity were able to give informed consent.

113. The searches identified one report for the period from 2016 to 2018. This disclosure reported senior management ignoring concerns of staff in relation to (1) wards being

short staffed to the point it was "critically dangerous"; (2) staff being "highly stressed" "crying" and "anxious" and (3) emergency procedures not being followed properly due to lack of staff.

114. The searches identified seven reports for the period from 2019 – 2021. These disclosures were in relation to:

(a) Improper handling of patients – staff member incorrectly restraining a dysregulated patient;

(b) Negligence of staff – patients being left in urine soaked beds[10], faeces and urine being left in baths patients were washing in, failure to follow speech and language therapy (SALT) assessments and staff sleeping on shift;

(c) Concerns over senior management – lack of experience of senior management, failure of senior management to communicate with ward staff and senior management dismissing staff concerns; and

(d) Abuse of patients – staff shouting at patients and threatening them pulling a patient's mask down following a struggle, 'bantering' with patients with learning difficulties. .

The Department's Early Alert system

115. At paragraph 111 of my first statement to the Inquiry, I explained that one way in which RQIA receives intelligence is via the Department's Early Alert's System. In May 2010, the Department first advised on the operation of an Early Alert System. The Department's document *'Policy Circular HSC (SQSD) 10/2010 Early Alert System'* (**Document BD2/19**) provided guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations. The attached Circular explains in further detail:

(a) The background to and establishment of the Early Alert system;

(b) The purpose of the Early Alert system;

(c) The criteria for using the Early Alert System; and

[10] NB – this was an anonymous call in relation to a service user so it is not clear whether this was a member of staff or elsewhere

(d) Operational arrangements.

116. The Department's latest circular regarding the operation of the Early Alert System is provided at **Document BD2/20**.

117. Early Alerts are submitted to the Department, which in turn disseminates the Alert to interested organisations depending upon the nature of the alert. An example of an incident that the RQIA was informed of through the Early Alert System occurred on 29 August 2019 in Cranfield Ward MAH. In this example, a MAH service manager alerted the Department of an incident where a member of staff reported being assaulted by an anonymous individual, potentially an intruder. This incident was also a 'Serious Adverse Incident', details of which have been submitted to the Inquiry by RQIA.

Factual Accuracy Feedback

118. During my evidence to the Inquiry, I was asked about the process by which HSC Trusts can provide feedback in relation to Inspectors' observations. There are two opportunities for a HSC Trust to feedback to RQIA on factual accuracy during or immediately following an inspection. Firstly, during the visit to the service, Inspectors provide oral feedback of their findings. This provides an opportunity rebut potentially negative findings with evidence that can be taken into account by the Inspectors when drafting their inspection findings. These oral feedback sessions on the day of the visit are also important to encourage remedial action being taken to resolve any identified issues as soon as possible.

119. The HSC Trust later receives a draft version of the inspection report and is invited to provide feedback on its factual accuracy. Providers can challenge only the accuracy and completeness of the evidence on which the compliance levels are based.

120. RQIA considers any feedback received via the factual accuracy process. If a HSC Trust raises evidenced concerns over the factual accuracy of an inspection report then an inspection report can be amended or updated to reflect the evidence. Following this, the inspection report will be deemed finalised and will be published on RQIA's website.

121. At the Inquiry's request, RQIA has reviewed its records dating back from 2019 to 2023 for any factual accuracy feedback from the Belfast HSC Trust in relation to MAH and has so far identified four occasions in this time frame where the wording of a record of inspection was changed as a result of feedback from the Belfast HSC Trust.

122. The first of those instances was in December 2019, when the Belfast HSC Trust queried the RQIA's wording in relation to the seclusion room at MAH.

123. The second occurrence was following the April 2020 inspection. Belfast HSC proposed an amendment to reflect the fact that the Purposeful Inpatient Admission (PIpA) is a hospital process and not relevant to community based services. RQIA made a minor change following this feedback.

124. The third occurrence was following the 2021 inspection, when Belfast HSC Trust proposed additional wording relating to new admissions and protection plans relating to adult safeguarding and historical CCTV viewing. RQIA made minor changes to the final report following this feedback.

125. The fourth occasion was following the July 2022 inspection where some minor amendments were made to the wording in sections 5.2.1 (Staffing / Workforce / Staff Profile) relating to continuity of care, planned visits, PBS models and PRN medication, sections 5.2.2 (Adult Safeguarding) regarding staff shortages and reference to the PSNI, and 5.2.8 (Governance – Leadership and Management) in relation to the night coordinator.

126. The changes referred to above were minor and on no occasion resulted in a change to RQIA's assessment of whether a quality standard had been met. **Document BD2/21** is a comparison of the draft wording and the final wording of the inspection report following the instances of factual accuracy feedback from the Belfast HSC Trust.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:

Date: 15 November 2023

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/1

The Regulation and Quality Improvement Authority

REGISTER OF INTERESTS

Name

Consultancies and/or direct employment Any paid consultancy, employment, partnership, directorship or position in (or for) any organisation either directly or indirectly related to the work of RQIA.	
Fee-paid work Any commissioned or fee-paid work for any organisation either directly or indirectly related to the work of RQIA.	
Shareholdings Any shareholdings or other financial or beneficial interests in a private company or body that may give rise to a conflict of interest.	
Fellowships/trusteeships and membership of voluntary bodies Any other outside interests which may be relevant to your role as a staff member of RQIA e.g. unremunerated posts, honorary positions and other connections, which may give rise to a conflict of interest or of trust.	
Any other personal interests not covered above	
Non-personal interests Any relevant and known interests held by your spouse, a close family member, or a member of your household, which may provide a conflict of interest with your position as a staff member of RQIA.	

Please note that it is the individual responsibility of all staff to advise the Head of Business Services in RQIA of any changes required to this form in line with RQIA Standing Orders.

Where staff are uncertain as to whether an interest should be declared, they should seek further guidance from the Head of Business Services.

Signed _____

Date _____

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/2

United Nations MAHI - STM - 185 - 31 CAT/OP/GBR/ROSP/1

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Distr.: General
31 May 2021

Original: English
English, French and Spanish only

Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the State party

Report of the Subcommittee*, **

* In accordance with article 16 (1) of the Optional Protocol, the present report was transmitted confidentially to the State party on 27 October 2020. On 21 May 2021, the State party requested the Subcommittee to publish the report, in accordance with article 16 (2) of the Optional Protocol.

** The annexes to the present document are being circulated in the language of submission only.

Please recycle

Contents

I. Introduction

1. In accordance with its mandate under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Subcommittee on Prevention of Torture carried out its first visit to the United Kingdom of Great Britain and Northern Ireland from 9 to 18 September 2019.

2. The United Kingdom became a party to the Convention against Torture on 8 December 1988 and became a party to the Optional Protocol on 10 December 2003. In 2014, the State party extended the ratification of the Optional Protocol to the territory of the Isle of Man.[1]

3. The Subcommittee members conducting the visit were: Daniel Fink (head of delegation), Satyabhooshun Gupt Domah, Susanne Jabbour, Kosta Mitrovic, June Caridad Pagaduan Lopez and Zdenka Perović. The Subcommittee was assisted by three human rights officers and two security officers from the Office of the United Nations High Commissioner for Human Rights.

4. The objectives of the visit were to:

(a) Provide advice and technical assistance to the national preventive mechanism, along with the State party, on their treaty obligations under Optional Protocol, taking into account the Subcommittee's guidelines on national preventive mechanisms (CAT/OP/12/5);

(b) Visit a range of places of deprivation of liberty, in order to assist the State party in discharging effectively its obligations under the Optional Protocol to strengthen the protection of persons deprived of their liberty from the risk of torture and ill-treatment.

5. The planning of the visit took into account the exchange of letters in June 2018 between the Subcommittee and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was aimed at enhancing the complementary nature of their respective mandates and work.[2] Bearing in mind the visits undertaken by the European Committee to the United Kingdom, especially its most recent visit,[3] the Subcommittee decided to focus its visit primarily on the functioning of the national preventive mechanism and to visit places of deprivation of liberty that had not recently been visited by the European Committee.

6. The Subcommittee conducted joint visits to places of deprivation of liberty with the national preventive mechanism (annex I), in order to observe the work of the mechanism in practice. The mechanism also chose the places visited. The visits were led by the representatives of the mechanism, with the members of the Subcommittee acting as observers. The Subcommittee also conducted visits to places of deprivation of liberty on its own (annex II). In addition, it met and interviewed persons deprived of their liberty, law enforcement and detention officers, medical personnel and others (annex III).

7. At the end of the visit, the delegation presented its confidential preliminary observations orally to government authorities and the national preventive mechanism.

8. In the present report, the Subcommittee sets out its observations, findings and recommendations relevant to the prevention of torture and ill-treatment of persons deprived of their liberty under the jurisdiction of the United Kingdom.

9. The Subcommittee reserves the right to comment further on any place visited, whether or not it is mentioned in the present report, in its discussions with the United Kingdom arising from the report. The absence of any comment in the present report relating to a specific facility or place of detention visited by the Subcommittee does not imply that it has a positive or negative opinion of it.

[1] See https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en#5.

[2] See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23407&LangID=E.

[3] See www.coe.int/en/web/cpt/united-kingdom.

10. **The Subcommittee recommends that the present report be distributed to all relevant authorities, departments and institutions, including but not limited to those to which it specifically refers.**

11. The present report will remain confidential until such time as the United Kingdom decides to make it public in accordance with article 16 (2) of the Optional Protocol. The Subcommittee firmly believes that the publication of the present report would contribute positively to the prevention of torture and ill-treatment in the United Kingdom.

12. **The Subcommittee recommends that the United Kingdom request the publication of the present report in accordance with article 16 (2) of the Optional Protocol.**

13. **In order to enhance effective regional cooperation and coherence in the prevention of torture and ill-treatment in Europe, the Subcommittee on Prevention of Torture strongly encourages the authorities of the United Kingdom to consider permitting the Subcommittee to exchange information contained in its report with the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, or to give the Committee access to the report, irrespective of whether it is made public in accordance with article 16 (2), and to inform the Subcommittee that such access has been granted.**

14. The Subcommittee draws the attention of the United Kingdom and the national preventive mechanism to the Special Fund established under the Optional Protocol (art. 26). Only recommendations contained in those Subcommittee visit reports that have been made public can form the basis of applications to the Fund, in accordance with its published criteria.

15. The Subcommittee wishes to express its gratitude to the authorities and the liaison officer for their help and assistance relating to the planning and undertaking of the visit.

II. National preventive mechanism

A. Background and structure of the national preventive mechanism

16. On 31 March 2009, the United Kingdom designated, through a ministerial statement to Parliament, 18 existing oversight bodies as the national preventive mechanism. In the statement, the Minister of State (Ministry of Justice) indicated that the requirements of Optional Protocol would be fulfilled in the United Kingdom by the collective action of existing inspection bodies. In December 2013 and January 2017, three other institutions were added to the mechanism, bringing the membership to a total of 21 bodies.

17. The current composition of the national preventive mechanism is as follows:

(a) For England and Wales:

- Care Inspectorate Wales
- Care Quality Commission
- Children's Commissioner for England
- Her Majesty's Inspectorate of Prisons
- Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
- Healthcare Inspectorate Wales
- Independent Monitoring Boards
- Independent Custody Visiting Association
- Lay observers
- Office for Standards in Education, Children's Services and Skills

(b) For Northern Ireland:

- Criminal Justice Inspection Northern Ireland

- Independent Monitoring Boards (Northern Ireland)
- Northern Ireland Policing Board (Independent Custody Visiting Scheme)
- Regulation and Quality Improvement Authority

(c) For Scotland:

- Care Inspectorate
- Her Majesty's Inspectorate of Constabulary in Scotland
- Her Majesty's Inspectorate of Prisons for Scotland
- Mental Welfare Commission for Scotland
- Scottish Human Rights Commission
- Scottish Police Authority (Independent Custody Visiting Scheme)

(d) For the whole of the United Kingdom:

- Independent Reviewer of Terrorism Legislation

18. Through the designation of numerous pre-existing bodies to form the national preventive mechanism, the Government of the United Kingdom wished to put to good use and continue an established tradition of independent inspection of places of detention. As a result, the mechanism, composed of 21 institutions, is unique and complex. Characterized by a great diversity of entities, the mechanism comprises bodies with explicit mandates in various detention settings and broad mandates in specific territorial jurisdictions of the United Kingdom. Another particularity of the mechanism is that it comprises lay and professional bodies.

19. Some members of the mechanism monitor places of detention as just one part of a much wider regulatory role, while others are dedicated to inspection functions only. For example, the Regulation and Quality Improvement Authority and the Care Quality Commission regulate and inspect the quality of all health and social care services in Northern Ireland and England, respectively. The Office for Standards in Education, Children's Services and Skills inspects and regulates all services providing education and skills (e.g., schools and colleges, and education provision in prisons) as well as services that provide care for children and young people, including secure children's centres and secure training centres. On the other hand, the key role of the Inspectorate of Prisons, the Independent Custody Visiting Association, the Independent Monitoring Board, the Inspectorates of Prisons and lay observers is to provide independent scrutiny of the conditions and treatment of persons deprived of liberty in a variety of detention settings.

20. The Subcommittee notes with great appreciation the extent of the collective work being done by the 21 members of the mechanism across the four nations of the United Kingdom. According to the figures provided by the mechanism, dedicated volunteers conducted at least 66,000 visits per year to prisons, young offender institutions, immigration detention facilities, and places of police and court custody, as well as to observe escorts. In addition, inspectors carried out 1,500 inspections annually across the United Kingdom.

21. The Government of the United Kingdom designated Her Majesty's Inspectorate of Prisons (England and Wales) to coordinate the national preventive mechanism. The Inspectorate of Prisons is an independent entity whose role is to provide independent scrutiny of the conditions for and treatment of prisoners and other detainees.[4] A mechanism secretariat was created within the Inspectorate, taking into account its coordinating function.

22. In 2016, the members and bodies of the mechanism appointed by agreement an external independent Chair to advise and support it in fulfilling its mandate pursuant to the Optional Protocol. The term in office of the Chair was renewed in October 2017 for a period of four years.

[4] See www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/.

23. The mechanism's annual report is presented to Parliament by the Lord Chancellor and Secretary of State for Justice.

B. Legislative basis

24. While each of the 21 bodies has a legal basis of its own,[5] the national preventive mechanism as a collective entity does not have a separate legal basis in the United Kingdom. Indeed, no legislation or other formal document or process was created or enacted to establish the mechanism, and to date, the ministerial statements of 2009 to Parliament constitute the only basis for the mechanism's designation. Furthermore, only 2 of the 21 members of the mechanism have a specific reference to their mandate pursuant to the Optional Protocol written into legislation that created them.[6]

25. This lack of a formal legislative text establishing the national preventive mechanism has long been a matter of concern to the Subcommittee. The Subcommittee's unequivocal view is that the situation of the mechanism in United Kingdom remains precarious as it is not underpinned by a clear legislative basis. It is vital that the law specify the roles and responsibilities of the mechanism, in particular taking into account the complexity of the model chosen by the United Kingdom to fulfil the mechanism's mandate. In that context, the Subcommittee notes with appreciation the proactive pursuit of legislative changes by the mechanism itself.[7] Recently, the Committee against Torture also recommended that the United Kingdom set out in legislation the mandate and powers of the secretariat and members of the mechanism and guarantee their operational independence.[8]

26. The Subcommittee is also concerned that the statutes of the individual members of the national preventive mechanism do not specifically mention their mandates pursuant to the Optional Protocol. As a result, the specific mechanism-related activities are not necessarily given the proper importance when members are working within their statutory mandates. The Subcommittee welcomes the dialogue between the Ministry of Justice and the mechanism on the draft protocol that would include provisions for the mechanism to issue statutory guidance with regard to amendments of the statutes of the member organizations. The Subcommittee notes, however, that the elaboration of the Protocol cannot be a substitute for a proper legislative basis for the national preventive mechanism.

27. Given the scale and multibody complexity of the mechanism, the coordination function is essential to the implementation of the Optional Protocol. However, the lack of mechanism legislation also means that the Chair of the mechanism has no official legal status, job description, powers or immunities, and is thereby prevented from fully discharging the mechanism's obligations under the Optional Protocol. Similarly, the functions and crucial coordinating role of the secretariat also need to be recognized in legislation.

28. **The Subcommittee urges the United Kingdom to provide its national preventive mechanism with a formal legislative basis[9] containing a clear definition of its powers, functions, roles and responsibilities as soon as possible, in order for the State party to comply with its international obligations under the Optional Protocol. In addition, an explicit reference to the mechanism's mandate and responsibilities under the Optional Protocol should be incorporated into the statutes of its members, in order to comply with the provisions of the Optional Protocol and with the State party's international obligations.**

[5] See www.nationalpreventivemechanism.org.uk/members/.

[6] The Police and Fire Reform (Scotland) Act 2012 refers explicitly to the Subcommittee and the Optional Protocol (sects. 93–96). The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015 introduces references to the Subcommittee and the Optional Protocol into the Prisons (Scotland) Act 1989.

[7] For instance, the Chair of the national preventive mechanism provided written and oral evidence to the Justice Committee's inquiry on prison reform in January 2017, noting that the failure to provide a legislative basis for the national preventive mechanism was in violation of the requirements of the Subcommittee.

[8] CAT/C/GBR/CO/6, para. 17.

[9] Guidelines on national preventive mechanisms, para. 7.

29. **The Subcommittee also recommends that the State party embed the functions of the mechanism's independent Chair and the supporting and coordinating role of its independent secretariat in the legislative text to be adopted.**

Access to military detention facilities and independent oversight in overseas territories and Crown dependencies

30. The Subcommittee was informed that Her Majesty's Inspectorate of Prisons inspects military facilities in the United Kingdom every two to three years. This includes the Military Corrective Training Centre and service custody facilities, which are cells where navy, air force and army police hold military personnel who have been arrested. However, the visits take place only upon agreement and by invitation from the military, which is incompatible with the purpose and objectives of the Optional Protocol.[10]

31. Moreover, no member of the national preventive mechanism has explicit powers to visit extraterritorial places of detention, including temporary detention facilities set up by the State party's military abroad,[11] the overseas territories and Crown dependencies of the United Kingdom, which leaves a significant territorial gap in the State party's obligation to protect persons deprived of their liberty from torture and ill-treatment.[12]

32. The Subcommittee notes the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment regarding the role of the national preventive mechanism in overseas territories, ensuing from the Committee's visits to the sovereign base areas on Cyprus. The Committee called on the authorities of the United Kingdom to adopt specific legislative powers for the mandate of the national preventive mechanism, which should include the automatic right to visit all places of deprivation in the United Kingdom, as well as in British overseas territories and the sovereign base areas.[13]

33. **The Subcommittee reiterates that, in order to meet the requirements of the Optional Protocol, the national preventive mechanism must have the ability to conduct unannounced visits to all places of detention, and have access to all information referring to the treatment of detainees and the conditions of their detention, and it recommends that the State party ensure that those conditions are met.**

34. **The Subcommittee echoes the recommendation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment**[14] **and urges the State party to take all the necessary measures to ensure the applicability of the Optional Protocol across all of the State party's overseas territories and Crown dependencies, including through unannounced visits to military detention facilities. In that regard, the Subcommittee calls upon the authorities of the United Kingdom to consider using the existing national preventive mechanism structure, or designating or establishing new mechanism bodies to promptly ensure full compliance with the Optional Protocol – that is, that all places of deprivation of liberty under the de jure or de facto control of the State party are visited by an independent preventive body.**

[10] Optional Protocol, art. 20.

[11] See CAT/C/GBR/CO/5, in particular para. 9. In addition, in the concluding observations on the sixth periodic report of the State party, and in reference to the State party's military interventions in Afghanistan and Iraq, the Committee against Torture expressed concern at the findings contained in the 2018 reports of the Intelligence and Security Committee of Parliament, issued following its inquiry into the actions of the United Kingdom security and intelligence agencies in relation to the handling of detainees overseas and rendition (CAT/C/GBR/CO/6, paras. 32–35).

[12] Guidelines on national preventive mechanisms, para. 10.

[13] "Report to the Government of the United Kingdom on the visit to the United Kingdom sovereign base areas on Cyprus carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 9 to 11 February 2017", p. 10 (https://rm.coe.int/pdf/168076e130).

[14] Ibid., pp. 9–10.

C. Independence

35. The independence of the national preventive mechanism and its members is a fundamental principle that enables mechanisms to effectively prevent torture and ill-treatment. [15] In this connection, the requirements under the Optional Protocol refer specifically to the responsibility of the State to ensure that it has a mechanism in place, and that the mechanism enjoys functional independence, independence of its personnel and financial autonomy.[16]

36. In order to guarantee functional independence, the national preventive mechanism must have a clear legislative basis that guarantees its structural autonomy from all government branches. In that context, the Subcommittee notes that, in January 2017, the mechanism's Chair wrote to the Ministry of Justice highlighting the lack of statutory guarantees of independence for the mechanism and its members. In its ninth annual report, the mechanism indicated that the lack of a clear legislative basis for the mechanism in the United Kingdom had resulted in the lack of statutory guarantees of independence.

37. It is worth mentioning that, in its letter to the national preventive mechanism dated 29 January 2018, the Subcommittee stated that in its experience, the situation of a mechanism remains precarious when it is not underpinned by a clear legislative basis. The Subcommittee noted having unfortunately seen too many examples of cases in which States had put pressure on national preventive mechanisms, directly or indirectly, which the mechanisms had not been able to challenge for the want of a clear basis on which to do so. It noted that practical effectiveness was dependent on functional independence, and that independence was threatened when the mechanism was vulnerable to political pressure or exigencies. Finally, the Subcommittee highlighted that its role in relation to national preventive mechanisms included ensuring that they were protected from such pressure.[17]

38. In addition, the national preventive mechanism and its secretariat lack an independent premises with offices, services and staff that are separate from those of Her Majesty's Inspectorate of Prisons.[18] This is a clear example of the material, logistical and financial dependence on a governmental structure that prevents the mechanism from being a fully independent preventive body and from being perceived as such.

39. **The Subcommittee recommends that the authorities of the United Kingdom ensure that the national preventive mechanism enjoys autonomy, independence, effectiveness and credibility as an independent preventive body,[19] in conformity with articles 17, 18 and 19 of the Optional Protocol. The independent functions of all the different members composing the structure of the mechanism must be legally guaranteed, and the State party must take all the necessary measures to that effect. In addition, its material, logistical and financial separation from governmental structure must be achieved in order to ensure its independence, including functional, as foreseen in the Optional Protocol.**

40. In addition to the lack of general national preventive mechanism legislation, the Subcommittee was informed that two members of the mechanism – the Independent Monitoring Boards and the lay observers – had raised concerns with the authorities of the United Kingdom regarding the lack of statutory underpinning for their national governance structures, which would support their independence. In January 2017, the Chair also expressed his concerns that the Independent Monitoring Boards secretariat continued to be

[15] Optional Protocol, art. 18 (1), and the guidelines on national preventive mechanisms, paras. 8, 12, 16 and 18.

[16] Guidelines on national preventive mechanisms, para. 2.

[17] *Ninth Annual Report of the United Kingdom's National Preventive Mechanism, 1 April 2017–31 March 2018*, p. 56.

[18] For example, the current email addresses of staff members of the national preventive mechanism use the "hmiprisons.gov.uk" domain.

[19] See OHCHR, *Preventing Torture: The Role of National Preventive Mechanisms*, Professional Training Series No. 21 (New York and Geneva, 2018).

line managed by civil servants of the Ministry of Justice, which also had operational responsibility for most of the places monitored by the Independent Monitoring Boards.[20]

41. **The Subcommittee recommends that the authorities of the United Kingdom review the statutes of the Independent Monitoring Boards and the lay observers to ensure their full independence and to prevent actual or potential conflicts of interest in their roles within the national preventive mechanism.**

42. The Subcommittee reiterates that the independence of the national preventive mechanism, both actual and perceived, should be fostered by a transparent process of selection and appointment of members who are independent and do not hold a position that could raise questions of conflict of interest.[21] In that regard, the Subcommittee notes that the Chief Inspector of Her Majesty's Inspectorate of Prisons is appointed by the Secretary of State upon recommendation from the Ministry of Justice. Given that the Inspectorate functions as the coordinating body of the national preventive mechanism, the perceptions of State involvement could be detrimental to the credibility of the whole mechanism. In the view of the Subcommittee, this appointment by the executive branch creates a loophole that calls for further reflection and strengthening of safeguards for independence.

43. **The Subcommittee calls upon the authorities of the United Kingdom to ensure the functional independence of Her Majesty's Inspectorate of Prisons and the independence of its personnel through a transparent process of selection and appointment of the Chief Inspector of the Inspectorate. The Subcommittee also recommends that, in compliance with the Optional Protocol, the State party ensure that members of the national preventive mechanism are independent and do not hold a position that could raise questions of actual or perceived conflict of interest.**

D. Human and financial resources

44. The Subcommittee was informed that some members of the national preventive mechanism faced challenges with the budgets necessary to carry out their mechanism functions. This was the result of a range of factors, including recent budget cuts, and budgets for the mechanism's work within the 21 bodies not being ring-fenced to carry out preventive work and thus being allocated alongside competing priorities.

45. Bearing in mind that the Optional Protocol is unequivocal on the need for the State party to allocate specific resources to national preventive mechanism (art. 18 (1) and (3)), so as to guarantee the operational independence of the mechanism,[22] and that the Subcommittee guidelines on national preventive mechanisms indicate explicitly that the mechanism should enjoy complete financial and operational autonomy,[23] the Subcommittee recommends the specific earmarked allocation of funds to the function of the mechanism for each of its members.

46. In addition, while noting that staffing for the national preventive mechanism secretariat recently increased from two part-time roles to one part-time Head of Secretariat and one full-time Assistant Coordinator, the Subcommittee believes that resources provided to the secretariat remain insufficient, the more so considering the complex institutional structure of the mechanism.

47. **The Subcommittee recommends that the State party increase the financial and human resources of the national preventive mechanism secretariat, in order to guarantee its independence, as per the Optional Protocol provisions.**

[20] *Eighth Annual Report of the United Kingdom's National Preventive Mechanism, 1 April 2016–31 March 2017*, p. 58.

[21] Guidelines on national preventive mechanisms, paras. 16 and 18.

[22] Ibid., para. 8.

[23] Ibid., para. 12.

E. Visibility

48. While noting that the bodies composing the national preventive mechanism were well known and respected by key national actors, the Subcommittee observed that the mechanism was not always perceived as such when exercising its role. During its visits, the Subcommittee observed that persons deprived of their liberty often perceived the national preventive mechanism as an oversight body and not as a preventive body, which was detrimental to the visibility of the preventive nature of the work of the mechanism under the Optional Protocol.

49. **The Subcommittee recommends that the State party ensure that its national preventive mechanism is recognized as a key component in the country's system for the prevention of torture and ill-treatment and adopt an effective strategy to raise the mechanism's visibility and profile. In this regard, the Subcommittee recommends that the State party take all necessary measures, when establishing the formal legislative basis of the national preventive mechanism, to ensure that each of the mechanism's oversight bodies exercise their preventive mandate when acting in that capacity, in order to avoid any confusion with their other functions.**

Annual report

50. The Subcommittee notes with appreciation the annual reports prepared by the national preventive mechanism bodies and the mechanism as a collective body. However, the Subcommittee notes that the Lord Chancellor and Secretary of State for Justice presents the mechanism's collective annual reports to Parliament. In this connection, the presentation of the mechanism's findings to Parliament by representatives of the executive branch is contrary to the mechanism's mandate, which is to assess independently and impartially how the Government complies with its domestic and international human rights obligation to prevent torture.

51. **The Subcommittee recommends that the State party adopt legislation enabling the national preventive mechanism to present its annual report to Parliament directly and to be accountable to Parliament for the implementation of its mandate.**

F. Conclusion

52. **The Subcommittee observes that the national preventive mechanism of the United Kingdom is composed of multiple pre-existing bodies, which represents an additional challenge for the State party in adhering to the principles enshrined in the Optional Protocol, in particular articles 17, 18 and 19. In this connection, the Subcommittee believes that a clear policy from the Government of the United Kingdom is required to ensure that the national preventive mechanism and its component bodies are compatible with the provisions of the Optional Protocol. Such a policy is needed to address the current deficiencies in the mechanism's statutory basis, ensuring the independence of each of its bodies when acting in their capacity as the mechanism. Sufficient resourcing of the mechanism is also needed. Moreover, given the scale and complexity of the mechanism's multibody structure, a robust independent coordination function is essential for the effective practical implementation of the objectives of the Protocol. In addition, in order to ensure the guarantees of independence and effectiveness in terms of prevention of torture, the independence of the mechanism's Chair and secretariat need to be recognized in law and supported in practice through the sufficient provision of resources.**

53. **The Subcommittee trusts that the present report will serve as a road map towards the State party's compliance with the Optional Protocol.**

III. Overarching issues

A. Legal and institutional framework

1. Indefinite length of immigration detention

54. The Subcommittee notes with concern the lack of progress regarding the establishment of a maximum length of immigration detention, despite repeated recommendations of the Committee against Torture, in 2013[24] and 2019,[25] and the Human Rights Committee in 2015.[26] While the State party argues that immigration detention is being used sparsely and for the shortest period possible, the Subcommittee encountered several detainees in the Heathrow Immigration Removal Centre that had been detained there for more than 12 months in a prison-like environment and with little information on the progress of their cases and/or removal. Moreover, the national preventive mechanism has been reporting on hundreds of similar cases across the United Kingdom, including a person detained for nearly five years.[27, 28]

55. The Subcommittee is concerned that the absence of a time limit may lead to de facto indefinite detention, affecting the mental health of migrants deprived of their liberty and increasing the risk of torture and ill-treatment.

56. **The Subcommittee urges the State party to establish a reasonable time limit for administrative immigration detention and ensure that detention is a measure of last resort and is justified as reasonable, necessary and proportionate.**[29]

2. Age of criminal responsibility

57. The Subcommittee notes with concern that, despite reiterated recommendations of the Committee on the Rights of the Child,[30] the Human Rights Committee[31] and the Committee against Torture,[32] the age of criminal responsibility remains at 10 years in England, Wales and Northern Ireland and at 12 years in Scotland.

58. **The Subcommittee urges the State party to raise the minimum age of criminal responsibility, in accordance with international standards.**[33]

3. Separation of remand and sentenced persons

59. In all the prisons visited, the Subcommittee observed that remand and sentenced prisoners were kept together and were subject to the same regime. Remand prisoners have the presumption of innocence and their detention must not assume the characteristics of those serving a prison sentence.

---

[24] CAT/C/GBR/CO/5, para. 30.
[25] CAT/C/GBR/CO/6, paras. 54–55.
[26] CCPR/C/GBR/CO/7, para. 21.
[27] See, for example, the submission of the national preventive mechanism of the United Kingdom, on preventing ill-treatment in detention in the United Kingdom, to the sixty-sixth session of the Committee against Torture, p. 40. Available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCAT%2FINP%2FPOL%2F35300&Lang=en.
[28] A 2018 report by Her Majesty's Inspectorate of Prisons identified one man who had been detained for more than four and a half years (Her Majesty's Inspectorate of Prisons, *Report on an Unannounced Inspection of Heathrow Immigration Removal Centre Harmondsworth Site by HM Chief Inspector of Prisons: 2–20 October 2017* (2018), p. 5).
[29] CAT/C/63/4, paras. 48–51.
[30] CRC/C/GBR/CO/5, para. 78 (a).
[31] CCPR/C/GBR/CO/7, para. 23.
[32] CAT/C/GBR/CO/6, para. 23.
[33] See Committee on the Rights of the Child, general comment No. 24 (2019), and the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules).

60. In accordance with international standards,[34] the Subcommittee recommends that the State party ensure that persons who have been remanded in custody are segregated from convicted persons and are subject to separate treatment, in conformity with their status as unconvicted persons.

4. Impact of austerity measures

61. The Subcommittee received information that the austerity measures adopted by the Government of the United Kingdom since 2010 had resulted in severe cuts in the public sector, including in the penitentiary system, and had had a negative impact on the enjoyment of the rights of persons deprived of liberty. For example, the understaffing of prisons had hampered the delivery of health services and increased waiting times for prisoners to access treatments. Staff shortages had also been linked to extended lockdowns and a lack of prisoner access to purposeful activities. Moreover, material conditions of detention had deteriorated, owing to the cuts in public funds.

62. The Subcommittee notes the information provided by the authorities that important investments are being currently made, such as staff recruitment and improvement of prison infrastructure. While welcoming these measures, the Subcommittee notes that more needs to be done to reverse the negative effects caused by the long-standing austerity measures.

63. **The Subcommittee recommends that the State party analyse the consequences of the austerity measures on the right of persons deprived of their liberty, take steps to reverse the negative impact and ensure full compliance with international standards for the treatment of prisoners, including with regards to health services, regime and other rights at all times, in accordance with the Nelson Mandela Rules.**

B. Overrepresentation of ethnic minorities in the criminal justice system

64. The Subcommittee is concerned at the overrepresentation of the ethnic minorities in the criminal justice system of the United Kingdom, as acknowledged by the authorities during meetings. The Subcommittee notes that overrepresentation of Black, Asian and minority ethnic groups is attributable to a broad range of factors requiring targeted responses, which go well beyond those currently provided by the criminal justice system.

65. In this connection, the Subcommittee is concerned about the numerous reports received that:

(a) Persons from Black, Asian and other minority ethnic groups were over four times more likely to be detained than people from White ethnic groups. Black Caribbean people experienced particularly high rates of detention;[35]

(b) Persons from ethnic minorities are more likely to be subject to restraint and other restrictive practices and to experience disproportionate numbers of deaths in custody and/or in mental health care;[36, 37]

(c) Persons from ethnic minorities, both male and female, are significantly overrepresented in prisons,[38] which has been attributed to a number of factors including discriminatory sentencing.[39] According to data collected between October and December

[34] International Covenant on Civil and Political Rights, art. 10 (a); and United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), rule 11.

[35] United Kingdom, Home Office, *Arrests (Ethnicity Facts and Figures)*, 2019.

[36] United Kingdom, Home Office, *Modernising the Mental Health Act – Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act* (December 2018).

[37] United Kingdom, Home Office, *Detentions Under the Mental Health Act (Ethnicity Facts and Figures)*, 2019.

[38] *Modernising the Mental Health Act – Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act*.

[39] David Lammy, *The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System*, September 2017.

2018, a total of 27 per cent of the prison population identified as an ethnic minority, compared with 13 per cent of the general population in the United Kingdom;[40]

(d) The proportion of the youth custody population from Black, Asian and minority ethnic groups doubled form the period 2005–2006 to the period 2017–2018, while the number of children in custody decreased overall.[41]

66. **The Subcommittee recommends that the State party take urgent measures to tackle the causes of racial disproportionality in the criminal justice system and ensure the protection of minority ethnic groups from torture and ill-treatment. The Subcommittee further recommends that the State party take necessary steps to:**

(a) **Ensure that the use of detention does not discriminate against certain groups of people and that arrests, stops and searches are not based on appearance, colour or membership of national and ethnic groups;**

(b) **Tackle the disproportionate use of restraint on individuals from ethnic minorities;**

(c) **Implement programmes for persons from ethnic minority backgrounds in prisons that are aimed at supporting reintegration, producing tangible outcomes and preventing recidivism;**

(d) **Reduce the overrepresentation of children from ethnic minorities in youth custody, including through the adoption of alternatives to detention;**

(e) **Intensify the training and awareness-raising of prosecutors, judges, lawyers and police officers in the criminal justice system.**

C. Health care in places of deprivation of liberty

1. Medical safeguards

67. The delegation is concerned that compliance with medical screening and physical examination, which are required by the Nelson Mandela Rules as a fundamental safeguard against torture, is lacking. Detainees are only examined on referral by the officer in charge or upon the request of detainees themselves.

68. In addition, poor documentation of injuries was observed, as health-care staff did not recognize an ethical responsibility to report their findings other than to submit them to their superiors. No follow-up was done with regard to the information submitted, even when further investigation was necessary.

69. The delegation is also concerned about the inadequate forensic training of medical staff, as none of the personnel interviewed was aware of the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol) or the Nelson Mandela Rules.

70. Accuracy of data records varied among the different places visited. The delegation noted the recurrent absence of inputs in the prisoner record forms regarding important information related to risk assessment. For example, the delegation encountered an undocumented case of a mentally ill detainee, with multiple head injuries allegedly sustained at the hands of prison guards.

71. **The Subcommittee recommends that the State party integrate the Nelson Mandela Rules and the Istanbul Protocol into the training curriculum, including in continuous training activities for police and health-care professionals. Medical personnel must be able to examine alleged victims of torture and ill-treatment, and to detect and report such cases in line with the provisions of the Istanbul Protocol.**

[40] Georgina Sturge, “UK prison population statistics”, briefing paper No. CBP-04334, 3 July 2020.

[41] United Kingdom, Home Office, *Young People in Custody (Ethnicity Facts and Figures)*, 2019.

2. Mental health in prisons

72. The Subcommittee notes with concern the high rates of chronic and acute mental disorders in detention, in particular within the prison population. The Subcommittee is concerned at the high prevalence of self-harm and self-inflicted deaths in prisons, including among juvenile offenders.[42]

73. The Subcommittee is concerned that prisons and police stations are being used as a "safe environment" for preventing self-harm or harm to others, while awaiting placement in a specialized psychiatric facility. The Subcommittee received ample information from civil society, the national human rights institution and the national preventive mechanism, indicating that prison personnel were not adequately trained to deal with prisoners with mental health problems and psychosocial disabilities. Delays in transfers of persons, including young offenders, from prisons to psychiatric hospitals were noted to sometimes last for several months. Such delays were caused by difficulties in retrieving data for the proper disposition and management of mentally ill detainees or by the lack of psychiatric beds, and they exacerbated mental health problems and increased the risk of ill-treatment.

74. Furthermore, the Subcommittee is alarmed at the placement of some prisoners with acute mental health conditions in segregation units. The Subcommittee is concerned that some persons, as a result of the mental health conditions they suffer, may present violent behaviour and that the response of staff in these cases is largely punitive. The Subcommittee interviewed several persons in segregation units in Her Majesty's Prisons in Risley and Manchester and concludes that the current capacity of the system to properly address the mental health of persons in detention does not match the actual needs. It is of note that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment found in 2016 that the use of segregation for inmates at serious risk of attempting self-harm or suicide was unsuitable and unacceptable.[43]

75. **The Subcommittee recommends that the State party develop a comprehensive national policy and strategy to ensure appropriate access to health-care and mental health-care services across the criminal justice system, with particular attention to juvenile offenders. It also recommends that the State party immediately transfer persons with acute mental health problems, especially children with acute mental health problems, to an appropriate psychiatric facility, and abstain from using police cells and prisons as a "safe environment". In this connection, high priority should be given to increasing the number of beds in psychiatric hospitals.**

76. **The Subcommittee echoes the recommendation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment that prisoners with severe mental health conditions should not be placed in segregation units as an alternative to normal accommodation. Instead, such prisoners should be treated in a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance.**[44]

77. **The Subcommittee also recommends that all prison staff be trained to recognize the possible symptoms of mental health problems and apply prompt and appropriate referral procedures to medical personnel.**

IV. Situation of persons deprived of their liberty

78. The Subcommittee wishes to record that it did not come across any cases of torture in the places of detention visited.

[42] Prison Reform Trust, *Prison: The Facts – Bromley Briefings Summer 2019* (2019).

[43] "Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016".

[44] Ibid., paras. 66 and 68.

A. Police detention

79. The Subcommittee wishes to put on record that the material conditions of the custody cells in the police establishments visited were generally very good. The Subcommittee commends in particular the cleanliness of the installations, sufficient size of the cells and the adequate provision of food, water and hygiene items.

80. However, the Subcommittee observed a lack of access to natural light in the cells at Bishopsgate Police Station in London and the Central Park North Police Station in Greater Manchester. Moreover, the cells at Liverpool Merseyside Police Station did not have windows.

81. The Subcommittee also notes with concern that access to showers, phone calls and other rights were only provided to detainees upon their request and not as a right. The enjoyment or denial of these rights depended on the availability of staff. While noting that the length of police detention rarely surpasses 24 hours, the Subcommittee notes with concern that most establishments visited were not equipped with exercise yards; where they did exist, they were obviously not used.

82. **The Subcommittee recommends that appropriate steps be taken to remedy the inadequacies in police stations and cells, including by improving natural light.**[45] **The Subcommittee also recommends ensuring the enjoyment of the rights to shower,**[46] **make phone calls and exercise, on a regular basis.**[47]

83. The Subcommittee notes with appreciation that all police stations visited had closed-circuit television (CCTV) monitoring and that records checked were kept in an accurate manner.

84. The Subcommittee also notes that, in general, persons deprived of their liberty by the police were afforded the safeguards laid down in the code of practice for the detention, treatment and questioning of persons by police officers of the Police and Criminal Evidence Act 1984 (PACE Code C).

85. The Subcommittee welcomes the regular presence of paramedical staff in police custody. However, it also notes the concerns of both paramedical staff and police officers, with regard to the fact that they have not been trained on how to treat detainees with mental health problems.

B. Penitentiary institutions

1. Prolonged use of segregation

86. The Subcommittee is seriously concerned about numerous reports of the prolonged use of segregation in prisons in the United Kingdom.[48, 49] In Her Majesty's Prison Manchester, for instance, the Subcommittee observed first hand that several persons had been segregated for periods of up to two months. The Subcommittee reminds the State party that the Nelson Mandela Rules prohibit the use of prolonged solitary confinement, which refers to a time period in excess of 15 consecutive days.[50]

87. It further notes that oversight of the use of segregation and safeguards to prevent long-term segregation of prisoners with mental health issues appear to be insufficient. Furthermore,

[45] The Nelson Mandela Rules, rule 14.
[46] Ibid., rules 15–16.
[47] Ibid., rules 23 and 42.
[48] For example, Her Majesty's Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales: Annual Report 2016–17*, pp. 25–26; and Her Majesty's Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales: Annual Report 2017–18*, p. 26.
[49] Independent Monitoring Boards, *Annual Report of the Independent Monitoring Board at HMP Whitemoor for the Reporting Year 1 June 2017 to 31 May 2018 (October 2018)*, p. 13, in particular the reference to prisoners who were segregated for over 100 days and one prisoner who was segregated for 200 days.
[50] The Nelson Mandela Rules, rule 44.

the Subcommittee is concerned about the long lockdowns in segregation units and about reports that persons in such units get an average of 30 minutes per day outside of the cell.

88. The Subcommittee found a particularly dramatic case of alleged excessive use of force and prolonged segregation at Her Majesty's Prison Risley. On that occasion, the Subcommittee interviewed a person who had fresh wounds in his head, a broken nose and bruises on his body. He alleged that he had been severely beaten by five prison guards the night before. The person also alleged that he suffered from diagnosed mental health problems. However, it appeared from the records that no medical help had been provided that night; no incident report had been made, including on the use of force; and none of the body cameras from the five guards had been working that night. The records also confirmed that on the day of the Subcommittee's visit, the detainee had already spent 80 days in the segregation cell. The Subcommittee communicated this case to the authorities in compliance with the principle of due diligence.

89. Subsequently, the Ministry of Justice kept the Subcommittee informed of the ongoing steps taken by the relevant authorities, including the investigation by Her Majesty's Prison and Probation Service and the investigation by the Prison and Probation Ombudsman. The Subcommittee was also invited to review video material of the incident (CCTV) at the Permanent Mission of the United Kingdom of Great Britain and Northern Ireland to the United Nations Office and other international organizations in Geneva, which a member of the Subcommittee did on 10 December 2019.

90. On the basis of the results of the investigations and the video material reviewed, the Subcommittee is unable to corroborate the detainee's version of events, and considers the matter adequately investigated. The Subcommittee notes and commends the proactive approach and seriousness of the authorities regarding this matter, including keeping the Subcommittee informed of the ongoing investigations as they progressed.

91. Similar records checked by the Subcommittee indicated that several persons had spent over two months in the segregation unit at Her Majesty's Prison Risley. While there is a formal requirement of a regular review every two weeks, several interviewed prisoners were of the view that the review was merely a box-ticking exercise.[51]

92. **The Subcommittee recommends that the State party ensure that segregation of prisoners is a last resort; that its use is for as short a time as possible, and never longer than 15 consecutive days; and that segregated prisoners are provided with a purposeful activity and meaningful human contact each day, in line with the Nelson Mandela Rules.**

2. Violence and excessive use of force

93. The Subcommittee is also seriously concerned at the reports made by the national preventive mechanism of the United Kingdom of increasing levels of violence and of use of force and restraint in a number of prisons.[52] Both Her Majesty's Inspectorate of Prisons and the Independent Monitoring Board noted that low staffing levels, inexperienced staff, the use of illicit substances, mental health issues, poor prison conditions and not enough time outside of the cells appear to have contributed to the increase.[53]

[51] See Her Majesty's Inspectorate of Prisons, *Report on an Unannounced Inspection of HMP Whitemoor by HM Chief Inspector of Prisons: 13–23 March 2017*; and Independent Monitoring Boards, *Annual Report of the Independent Monitoring Board at HMP Whitemoor for the Reporting Year 1 June 2017 to 31 May 2018 (October 2018)*, sect. 6.2. See also, for example, Her Majesty's Inspectorate of Prisons, *Report on an Unannounced Inspection of HMP Bedford by HM Chief Inspector of Prisons: 28 August–6 September 2018*; and Independent Monitoring Boards, *Annual Report of the Independent Monitoring Board at HMP Bedford for the Reporting Year 1 July 2017 to 30 June 2018 (17 October 2018)*, sect. 7.1.

[52] The submission of the national preventive mechanism of the United Kingdom, on preventing ill-treatment in detention in the United Kingdom, to the sixty-sixth session of the Committee against Torture, p. 2. Available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCAT%2fINP%2fGBR%2f34430&Lang=en.

[53] Ibid., p. 34.

94. **The Subcommittee recommends that the State party:**

(a) **Strengthen the oversight of the use of force in all detention settings to ensure that force is only used in accordance with the law and is strictly necessary and proportionate;**

(b) **Review behaviour management policies across prisons with the aim of identifying and reducing the underlying causes of violence and use of force;**

(c) **Provide mental health care that meets the needs of all detainees and consider introducing a statutory time limit on transfers of detainees to mental health inpatient facilities.**

3. Material conditions

95. The Subcommittee wishes to put on record that there were generally good material conditions in the prisons visited. There were some exceptions, however, such as Her Majesty's Prison Manchester. The prison is over 150 years old and despite ongoing refurbishment works, the Subcommittee found several cells in residential units with mould on the walls, dirty floors, broken windows, bed bugs, cockroaches and mice.

96. **The Subcommittee recommends that the State party ensure that all detainees are held in clean and sanitary conditions, and address promptly the inadequate detention conditions at Her Majesty's Prison Manchester.**

C. Institutions for juvenile offenders

97. The Subcommittee shadowed the visit made by Her Majesty's Inspectorate of Prisons and the national preventive mechanism to Her Majesty's Young Offender Institution of Cookham Wood. While the role of the Subcommittee was that of observer, it managed to gain experience relating to a grasp on a number of systemic issues pertaining to its mandate.

98. Based on the interviews observed and records consulted, the Subcommittee is concerned that children in the Bridge Section and in the Induction Unit spent long periods – up to 23.5 hours a day – locked in their cells; that the use of force had increased; and that responses to complaints did not fully address the issue or involve the child.

99. **The Subcommittee calls upon the authorities to implement fully the recommendations contained in the last visit report of Her Majesty's Inspectorate of Prisons on Her Majesty's Young Offender Institution of Cookham Wood.**

D. Immigration detention

100. The Subcommittee observed the work of the Independent Monitoring Board at the Heathrow Immigration Removal Centre and visited Dungavel House Removal Centre in Scotland. Based on these visits, the Subcommittee heard reports from several persons deprived of their liberty that criticized the quality of health care provided in these immigration detention centres, including the availability of mental health services. The Subcommittee is concerned about reports of a significant increase in deaths, especially self-inflicted deaths, in immigration detention over recent years.

101. In addition to the lack of time limit on immigration detention already addressed in paragraphs 54 to 56 of the present report, the Subcommittee spoke to individuals whose mental health was affected by the short notice of removals. The detainee's distress was greatly exacerbated by the fact that the Home Office provides detainees with notice of a removal window (usually a three-month period) rather than the specific day. At the Heathrow Immigration Removal Centre, several persons approached the Subcommittee to express their anxiety about not knowing if they would be woken up and removed the next night.

102. Furthermore, the Subcommittee endorses the concern expressed by the national preventive mechanism that the access of immigration detainees to legal aid at Heathrow Immigration Detention Centre and the quality of the legal aid available are suboptimal.[54]

103. **The Subcommittee recommends that the State party:**

(a) **Ensure that immigration detainees are detained only as a last resort and for the shortest possible time, consider replacing the current practice of removals and implement a time limit on immigration detention;**[55]

(b) **Ensure that all immigration detainees (including those in short-term holding facilities) have access to good quality, free legal advice, and ensure that all detainees have effective access to fair and accessible procedures to challenge the decision to detain and/or deport;**

(c) **Provide effective oversight, monitoring and complaints policies and procedures in the immigration detention estate to ensure that any ill-treatment is immediately identified and guarantee the effectiveness of investigations into allegations of ill-treatment;**

(d) **Introduce independent processes, both when a decision to detain is made and during detention, for the identification of people who may face a particular risk of harm in detention.**

E. Court custody

104. The Subcommittee shadowed a visit of lay observers to a temporary detention facility of the Westminster Magistrates Court in London. In its role as an observer, the Subcommittee was able to assess the situation at this facility and shared key concerns identified by the national preventive mechanism.

105. For example, the Subcommittee observed that the person escort records were incomplete. The purpose of the person escort record is to ensure that all staff transporting and receiving detainees are provided with all necessary information about them, including any risks or vulnerabilities. The lay observers identified and showed to the Subcommittee a number of person escort records that were lacking the name of the receiving officer, information on detainee's risk of self-harm and information on medication that the person was taking. Another issue brought to the attention of the Subcommittee referred to the lack of an interface between the three computer systems used by the police, the prisons and the courts, which led to inconsistent and incomplete information that could put at risk both the person deprived of liberty and the escorting officer, in cases involving previous assaults on staff. Reportedly, the escort staff treat any person in their custody as a possible risk, which often leads to the unnecessary use of means of restraint.[56] For example, the Subcommittee observed during the visit that a child was being handcuffed and escorted by three officers. The custody officer explained that this was a standard procedure for all, which meant that children and adults were treated in the same way.

106. **The Subcommittee calls on the State party to implement the recommendations of the reports of the national preventive mechanism member (lay observers) and to ensure that:**

(a) **Accurate and complete records, in particular of person escort records, are maintained;**

[54] Independent Monitoring Boards, *Annual Report of the Independent Monitoring Board at Heathrow Immigration Removal Centre for the Reporting Year January to December 2019* (April 2020).

[55] CAT/C/63/4, paras. 47–51.

[56] Her Majesty's Inspectorate of Prisons, *Report on an inspection visit to court custody facilities in North and West Yorkshire by HM Chief Inspector of Prisons: 6–16 August 2018*. See also Her Majesty's Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2017–18*, p. 88; and Her Majesty's Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, p. 86.

(b) **An individualized risk assessment is made for each person in court custody;**

(c) **Staff receives training to meet the individual needs of detainees, particularly children.**

V. Next steps

107. **The Subcommittee requests that a reply to the present report be provided within six months of the date of its transmittal to the Permanent Mission of the United Kingdom. The reply should respond directly to all the recommendations and requests for further information made in the report, giving a full account of action that has already been taken or is planned (including timescales) in order to implement the recommendations. It should include details concerning the implementation of institution-specific recommendations and concerning general policy and practice.**[57]

108. **Article 15 of the Optional Protocol prohibits all forms of sanction or reprisal, from all sources, against anyone who has been, or who has sought to be, in contact with the Subcommittee. The Subcommittee reminds the United Kingdom of its obligation to ensure that no such sanctions or reprisals take place and requests that it provide in its reply detailed information concerning the steps that it has taken to ensure that it has fulfilled that obligation.**[58]

109. **The Subcommittee recalls that prevention of torture and ill-treatment is a continuing and wide-ranging obligation.** [59] **It therefore requests that the United Kingdom inform it of any legislative, regulatory, policy or other relevant developments relating to the treatment of persons deprived of their liberty and regarding the work of the national preventive mechanism.**

110. **The Subcommittee considers both its visit and the present report to form part of an ongoing process of dialogue. The Subcommittee looks forward to assisting the United Kingdom in fulfilling its obligations under the Optional Protocol by providing further advice and technical assistance, in order to achieve the common goal of prevention of torture and ill-treatment in places of deprivation of liberty. The Subcommittee believes that the most efficient and effective way of developing the dialogue would be for it to meet with the national authorities responsible for the implementation of the Subcommittee's recommendations within six months of receiving the reply to the present report.**

111. **The Subcommittee recommends that, in accordance with article 12 (d) of the Optional Protocol, the national authorities of the United Kingdom enter into dialogue with the Subcommittee on the implementation of the Subcommittee's recommendations, within six months of the Subcommittee's receipt of the reply to the present report. The Subcommittee also recommends that the United Kingdom initiate discussions with the Subcommittee on the arrangements for such a dialogue at the time of the submission of its reply to the present report.**[60]

[57] The reply should also conform to the guidelines concerning documentation to be submitted to the United Nations human rights treaty bodies established by the General Assembly. See letters sent to permanent missions on 8 May 2014.

[58] The manner in which the Subcommittee addresses the issue of reprisals and sanctions is set out in CAT/OP/6/Rev.1.

[59] See CAT/OP/12/6 and the Committee's general comment No. 2 (2007).

[60] The United Kingdom is encouraged to consider approaching the OHCHR treaty body capacity-building programme (registry@ohchr.org), which may be able to facilitate the dialogue. The contact details of the Special Fund are available at www.ohchr.org/EN/HRBodies/OPCAT/Fund/Pages/SpecialFund.aspx.

Annex I

List of places of deprivation of liberty jointly visited by the national preventive mechanism and the Subcommittee

- Visit with the Independent Custody Visiting Association, Charing Cross Police Station, Agar Street, Charing Cross, London WC2N 4JP
- Visit with the lay observers to Westminster Magistrates' Court, 181 Marylebone Road, Marylebone, London NW1 5BR
- Visit with Mental Health Act reviewers to Bracton Centre (multi-ward hospital), Leyton Cross Road, Dartford, Kent DA2 7AF
- Visit with Independent Monitoring Board members and the National Chair of Independent Monitoring Boards to Heathrow Immigration Removal Centre
- Visit with Her Majesty's Inspectorate of Constabulary in Scotland to St. Leonard's Police Station, 14 St. Leonard's Street, Edinburgh EH8 9QW
- Visit with Her Majesty's Inspectorate of Prisons to Cookham Wood Young Offender Institution, Sir Evelyn Road, Rochester, Kent ME1 3LU

Annex II

List of places of deprivation of liberty visited by the Subcommittee

- Livingston Police Station, West Lothian Civic Centre, Howden South Road, Livingston EH54 6FF
- Dalkeith Police Station, Newbattle Road, Dalkeith EH22 3AX
- Bishopsgate Police Station, 182 Bishopsgate, London EC2M 4NP
- Dungavel House Removal Centre, Strathaven, South Lanarkshire ML10 6RF
- St. Anne Police Station, St. Anne Street, Liverpool L3 3HJ
- Central Park North Police Station, Manchester M40 5BQ
- Merseyside Police Station, 43A Ganworth Road, Speke, Liverpool L24 2XG
- Her Majesty's Prison Risley, Warrington Road, Risley, Warrington WA3 6BP
- Her Majesty's Prison Manchester, Southhall Street, Manchester M60 9AH
- Her Majesty's Prison Altcourse, Brookfield Drive, Fazakerley, Liverpool L9 7LH

Annex III

List of government officials and other interlocutors with whom the Subcommittee met[1]

Government of the United Kingdom of Great Britain and Northern Ireland

- Parliamentary Under Secretary of State for Justice
- Ministry of Justice
- Ministry of Foreign Affairs
- Ministry of Defence
- Ministry of Health
- Ministry of Education

Scottish Government

- Cabinet Secretary for Justice
- Human Rights Division
- Prison Policy Division
- Police Division
- Mental Health Division
- Police Scotland, Criminal Justice Service Division
- Scottish Prison Service
- Health & Social Care in Prisons Programme Board

Chair and secretariat of the national preventive mechanism

- Members of the national preventive mechanism
- Scottish Human Rights Commission
- Her Majesty's Inspectorate of Prisons for Scotland
- Care Inspectorate (Scotland)
- Her Majesty's Inspectorate of Constabulary in Scotland
- Independent Reviewer of Terrorism Legislation (representative)
- Care Quality Commission
- Scottish Police Authority (Independent Custody Visiting Scheme)
- Independent Custody Visiting Association
- Independent Monitoring Boards
- Her Majesty's Inspectorate of Prisons
- Care Inspectorate Wales
- Regulation and Quality Improvement Authority
- Lay observers

[1] As requested during the visit, interlocutors are listed only by their respective institutions and/or organizations.

- Children's Commissioner for England (representative)
- Chief Executive of the Mental Welfare Commission for Scotland

Equality and Human Rights Commission

- Representatives of the Commission

Civil society representatives

The delegation met with representatives from various non-governmental organizations active in the field of deprivation of liberty, including:

- Bristol University
- Howard League for Penal Reform
- Children's Rights Alliance for England
- Association of Visitors to Immigration Detainees
- INQUEST

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/3

The UK's response to the Subcommittee on the Prevention of Torture and Other Cruel Inhuman or Degrading Treatment or Punishment's visit report from October 2020.

April 2021

Contents

Introduction

The UK welcomes the report of the Subcommittee, following their visit in September 2019. The numbered recommendations below refer to the paragraphs in the SPT's October 2020 report. The report has been distributed to all relevant authorities, departments and institutions, as requested. The UK requests that this response be published alongside the SPT's report, in accordance with article 16 (2) of the Optional Protocol to the Convention Against Torture (OPCAT). Further, the UK is happy for the SPT to share information detailed in both reports with the European Committee for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CPT).

The UK has a longstanding tradition of ensuring rights and liberties are protected domestically and of fulfilling our international human rights obligations. We therefore commend the important work of the SPT as we continue to comply with our obligations under OPCAT.

National Preventive Mechanism

Legislative basis

27. The Subcommittee urges the State Party to provide as soon as possible the UK NPM with a formal legislative basis with a clear definition of its powers and its functions, its roles and responsibilities, in order for the UK to comply with its international obligations under OPCAT. In addition, an explicit reference to the NPM's mandate and OPCAT responsibilities should be incorporated into each of its members/bodies' own statutes, in order to comply with the OPCAT provisions and UK's international obligations.

28. The SPT also recommends that the functions of an independent Chairperson and the supporting and coordinating role of the NPM's independent Secretariat be embedded in the legislative text to be adopted.

The UK established an independent NPM in 2009, notifying Parliament through a Written Ministerial Statement. This Statement listed the 18 independent scrutiny bodies, now risen to 21, which collectively make up the UK's NPM. Establishing the NPM through various decentralized units, in line with Article 17 of OPCAT, ensures sufficient monitoring of various places of detention throughout the United Kingdom. Each of these 21 inspection bodies have a statutory basis and are given unlimited access to the places of detention in which it inspects. Having established an NPM, the UK considers that it fully complies with its international obligations under OPCAT and that the NPM meets the requirement under Articles 17 to 23 of OPCAT. This position was reiterated during the SPT's visit in September 2019.

The UK undertook a consultation on '*Strengthening the independent scrutiny bodies through legislation*' in 2020 which proposed options for reform to strengthen the scrutiny bodies. This included proposals to place the NPM and a number of prison scrutiny bodies on a statutory footing. We have considered the responses to the consultation and will be producing a response in due course.

Military detention and independent oversight in Overseas Territories and Crown Dependencies

31. The Subcommittee notes the CPT's recommendations regarding the role of the UK NPM in Overseas Territories, ensuing from its visits to the Sovereign Base Areas (SBA) of Cyprus and Gibraltar. The CPT called on the UK authorities to "adopt specific legislative powers for the mandate of the NPM, which should include the automatic right to visit all places of deprivation in the United Kingdom, as well as in British Overseas Territories and the SBA."[13]

32. The Subcommittee recommends that, in order to meet the requirements of OPCAT, the NPM must have the ability to conduct unannounced visits to all places of detention, as well as to have access to all information referring to the treatment of detainees and the conditions of their detention. The Subcommittee echoes the CPT's recommendation and urges the State party to take all the necessary measures to ensure the applicability of the Optional Protocol across all of the UK's Overseas Territories and Crown Dependencies, including through unannounced visits to military detention facilities. In that regard, the SPT calls upon the UK authorities to consider using the existing NPM structure or designating or establishing new NPM bodies to ensure promptly the full compliance with the OPCAT, i.e. that all places of deprivation of liberty under the UK de jure or de facto control are visited by an independent preventive body.

Sovereign base areas and Military detention facilities:

The UK takes its responsibilities to prevent torture and other cruel, inhuman or degrading treatment or punishment seriously and acknowledges the recommendations made by the SPT in its report. The Ministry of Defence currently invites independent inspections of its UK based detention facilities by Her Majesty's Inspectorate of Prisons (an NPM member) which, in the past, have been unannounced. The Ministry of Defence will carefully consider the recommendations in close collaboration with other government departments.

Overseas Territories:

The UK's ratification of OPCAT has not been extended to the Overseas Territories. Moreover, each Overseas Territory has its own legislative body, and the inhabited Territories have democratically elected governments, so it would not be appropriate for the United Kingdom Government to legislate on their behalf for the mandate of the NPM. However, if the Overseas Territories wish to have OPCAT extended to them, the United Kingdom Government will support them in this process. The United Kingdom is working with the Overseas Territories to support the development of monitoring boards, where they don't already exist, and independent review mechanisms to ensure compliance with international obligations.

Crown Dependencies:

The Crown Dependencies (CDs) are not part of the UK but are self-governing dependencies of the Crown. This means they have their own directly elected legislative assemblies, administrative, fiscal and legal systems and their own courts of law. The constitutional relationship of the Islands with the UK is maintained through the Crown and the UK Government is responsible for the defence and international relations of the Islands, and for ensuring their good government. It would not be appropriate for the UK Government to mandate extension of OPCAT to the CDs as that is a matter for their own governments to decide upon, but we would support them if any CD wished to have OPCAT extended to them.

OPCAT has been extended to the Isle of Man but not to the Bailiwick of Guernsey or Jersey. However, the Bailiwick of Jersey have indicated their intention to request the extension of UK OPCAT ratification. Progress on compliance progressed until March 2020, when resources from this, and other projects, were redirected to deal with Covid-19. The extension remains high on Jersey's priority list and will be addressed as resources become available.

Independence

37. The SPT recommends the UK authorities to ensure that the NPM enjoys autonomy, independence, effectiveness and credibility as an independent preventive body, in conformity with articles 17, 18 and 19 of the OPCAT. The NPM independent functions of all the different members/bodies composing its structure must be legally guaranteed, and the State Party must take all the necessary measures to this effect. In addition, its material, logistical and financial separation from governmental structure must be achieved in order to ensure its independence, including functional, as foreseen in the Protocol.

The UK Government notes the concerns raised by the Subcommittee on Prevention of Torture and the NPM, that whilst the individual independent members of the NPM each have a statutory basis, the NPM itself is not set out in statute. As stated above, the UK undertook a consultation on this point and will provide a response in due course. While we do not agree that the lack of a legislative base precludes compliance with articles 17, 18 and 19 of the OPCAT, we will continue to discuss any specific issues with the NPM and its members.

Further, the UK Government is mindful of its obligations under Article 18(3) OPCAT to make available the necessary resources for the functioning of the NPM. The NPM receives an annual budget through Her Majesty's Inspectorate for Prisons (HMIP), which they are free to use as they see fit. We continue to monitor and discuss resources with the NPM.

39. The SPT recommends the UK authorities to review the statutes of the Independent Monitoring Boards and the Lay Observers to ensure their full independence and prevent actual or potential conflicts of interest as NPM.

The recent consultation on '*Strengthening the independent scrutiny bodies through legislation*' also covered the issue of providing national statutory status for the Independent Monitoring Boards and the Lay Observers, and their respective Chairs. Placing these bodies in statute will strengthen their operational independence from the UK Government and we intend to bring forward this legislation when Parliamentary time allows. We have also put in place a protocol with the IMB's Management Board to set out the roles and responsibilities of the parties and to clarify IMB independence from government and we hope to publish a similar protocol shortly with the Lay Observers. We will continue to explore with both bodies how their independence can be formalised further, as well as continuing to review the wider scrutiny landscape that the Independent Monitoring Boards and Lay Observers operate in.

41. The Subcommittee calls upon the UK authorities to ensure the functional independence of the HMIP as well as the independence of its personnel through a transparent process of selection and appointment of the HMIP's Chief Inspector. The Subcommittee also recommends that, in compliance with the OPCAT, the State party ensure that NPM members are independent and do not hold a position which could raise questions of real or perceived conflict of interest.

The UK is clear that HMIP is operationally independent from the UK Government. The Chief Inspector has a fully independent voice. HMIP publishes reports in its own name, with the content

and timing solely at the discretion of the Chief Inspector. A protocol between the Ministry of Justice and HMIP sets out the roles and responsibilities of the two organisations and confirms the inspectorate's independence from Government. The protocol also confirms that the Chief Inspector has the delegated authority to appoint staff within the inspectorate. In response to our consultation on '*Strengthening the independent scrutiny bodies through legislation'* we intend to legislate to provide a stronger statutory basis for HMIP, when Parliamentary time allows.

The role of HM Chief Inspector of Prisons (HMCIP) appears in the Public Appointments Order in Council (Schedule, Article 2(2), pg.8) and the appointment is subject to regulation by the Commissioner for Public Appointments. This Order makes provision for an independent Commissioner to monitor the procedures adopted by appointing authorities when making appointments to public bodies. The recruitment process must also comply with the appointment principles set out in the Government's Governance Code on Public Appointments. This Governance Code is publicly available on gov.uk. The role criteria, tenure, time-commitment and remuneration details are all published when posts are advertised on the Public Appointments website (as a minimum), where the campaign timetable and panel membership are clearly set out. As a significant appointment, the role of HMCIP is also subject to pre-appointment scrutiny by the Justice Select Committee (JSC), who are consulted throughout the process. The pre-appointment scrutiny hearing and transcript is publicly available and the JSC may also publish other relevant documentation.

Human and financial resources

45. The Subcommittee recommends that the State party increase the financial and human resources of the NPM Secretariat, also as a guarantee of its independence, as per the OPCAT provisions.

The UK commends the important work that the NPM carries out and is keen to support its independence, as is necessary for its role in safeguarding the human rights of detainees across the UK. The UK maintains regular communication with the NPM Secretariat to ensure they are sufficiently supported, including through financial and human resources.

The NPM have been awarded a budget of £138,000 for 2020/2021. A substantial uplift to the NPM's budget was made in 2019/20 and has subsequently rolled over for the years since. This also includes funding to pay the independent Chair and is in addition to the separate funding the NPM members receive.

Visibility

47. The Subcommittee recommends that the State party ensure that its NPM is recognized as a key component in the country's system for prevention of torture and ill-treatment and adopt an effective strategy to raise the NPM's visibility and profile. In this regard, the Subcommittee recommends that the State party take all necessary measures, when establishing the formal legislative basis of the NPM, to ensure that each of its different oversight bodies/members composing the NPM exercise their mandate as NPM when they do so, in order to avoid any confusion with their other functions.

The Government regularly communicates with the NPM, providing an opportunity for any issues of concern to be raised, including on the NPM's visibility and profile. In order to ensure its independence, the Government considers that the NPM is best placed to take the lead regarding

promoting its role as a key component in preventing torture and ill-treatment. The Government publishes the NPM's annual report in Parliament on behalf of the NPM.

Those bodies which have been designated as NPM members are those whose existing powers are compatible with the criteria required under OPCAT.

49. The Subcommittee recommends that the State party adopt legislation enabling the NPM to present its annual report in Parliament directly and to be accountable to Parliament for the implementation of its NPM mandate.

The UK welcomes the NPM's annual reports and its finding on the conditions and treatment of those in places of detention across the UK. While the NPM's annual report is laid in Parliament by the Government, the content of the report is entirely a matter for the NPM. In line with Article 23 (OPCAT), the UK publishes and disseminates the report, making it available on the gov.uk website.

Conclusion

50. The SPT observes that the UK NPM's structure, composed of multiple pre-existing bodies, represents an additional challenge for the State party's adherence to the principles enshrined in the OPCAT on NPMs, especially articles 17, 18 and 19. In this connection, the SPT believes that a clear policy from the UK Government is required to ensure that the UK NPM, and all its composing members/bodies, is compatible with the provisions of the OPCAT. Such policy needs to address current deficiencies in the NPM's statutory basis, ensuring the independence of each and all of its members/bodies when acting as NPM, as well as the need for sufficient resourcing of the NPM. Moreover, given the scale and complexity of the UK NPM's multi-body structure, a robust independent coordination function is essential to the effective practical implementation of the objectives of the Protocol. In addition, in order to ensure the guarantees of independence and effectiveness in terms of prevention of torture, the independence of the NPM's Chair and Secretariat need to be recognised in law and supported in practice through sufficient provision of resources.

51. The SPT trusts that the present report will serve as a road-map towards the UK's compliance with the OPCAT.

The UK Government is clear that it is in full compliance with its obligations under OPCAT and does not consider there to be a legal requirement for an NPM to be established in statute. It should also be noted that all the individual members of the NPM each have a statutory basis with powers commensurate with OPCAT principles albeit the NPM itself is not set out in statue. Having said that, the Government recently undertook a public consultation to seek views on putting the NPM on a statutory footing. We are giving this proposal further consideration in light of the responses received.

We welcome the comments and recommendations of the SPT on the NPM and they provide useful input as we consider the issue further.

Overarching issues

Legal and Institutional Framework

54. The Subcommittee urges the State party to establish a reasonable time limit for administrative immigration detention and ensure that detention is a measure of last resort and is justified as reasonable, necessary and proportionate.

Detention and removal are essential parts of effective immigration controls and are used to ensure that those with no right to remain in the UK are returned to their home country if they will not leave voluntarily. The immigration removal estate is currently almost 40% smaller than it was five years ago, and of significantly higher quality. At any one time, 95% of individuals with no leave to remain in the UK are managed within the community rather than detained.

The UK does not detain people under immigration powers indefinitely, the law does not allow it. For detention to be lawful there must be a realistic prospect of the individual's removal within a reasonable timescale. There are well established safeguards in the immigration system to ensure that the decision to detain, and any ongoing detention considerations, are sufficiently scrutinised.

The UK Parliament has debated the introduction of a 28-day time limit and voted not to introduce one. The Government believes that such a time limit would severely constrain our ability to maintain the right balance and uphold the integrity of the immigration system. We have reviewed how time limits on detention operate in other countries and how they relate to any other protections within their systems. The review showed that very few countries had time limits.

Instead, our priority is to ensure immigration detention is used only where necessary, and for the shortest possible time, ensuring decisions to detain and subsequent decisions to maintain or release are well made with systematic safeguards and support for the vulnerable. In the year ending September 2020, data shows that the overwhelming majority of people (98%) who left detention, were detained for less than 6 months, and (76%) were detained for 28 days or less. Decisions to detain are made on a case-by-case basis and kept under constant review.

56. The Subcommittee urges the State party to raise the minimum age of criminal responsibility, in accordance with international standards.

England and Wales

Whilst the UK Government notes that the age of criminal responsibility goes beyond consideration of the conditions of those deprived of their liberty in order to prevent torture, relating instead to the wider legislative framework, the following response is provided to the SPT's recommendation.

The Government does not have any current plans to raise the age of criminal responsibility. The Government believes that children aged 10 and over can differentiate between bad behaviour and serious wrongdoing.

It is not always appropriate to make simple comparisons between countries because the youth justice and supporting social systems differ considerably. The principal aim of the youth justice system in England and Wales is to prevent offending by children. Setting the age of criminal responsibility at 10 provides flexibility in dealing with children, allowing early intervention with the aim of preventing subsequent offending. If assessment by the local multi-agency youth offending team identifies that a child has particular needs, the youth offending team can refer the child on to other services for further investigation and support (this can include Children's Services departments or Child and Adolescent Mental Health services).

The sentencing framework for children aged 10 to 17 recognises that children have their own specific needs that require a different and more tailored approach. When sentencing, the courts must take into account not only the principal aim of the youth justice system but also the welfare of the child. The age, maturity and needs of a child are always considered in determining the most appropriate response to offending by a child.

The Government believes that it is important to ensure that serious offences can be prosecuted and the public protected. However, serious crimes committed by children are rare and we do not want to see younger children prosecuted for offences unnecessarily where a better alternative may be available. Most younger children who enter the youth justice system are dealt with by way of an out-of-court disposal.

Scotland

The Age of Criminal Responsibility (Scotland) Act 2019 was passed unanimously by the Scottish Parliament. Once fully commenced, it will increase the age of criminal responsibility from 8 to 12 years of age. Votes on raising the age of criminal responsibility (ACR) to 14 years old and 16 years old were defeated by 108 votes to 11 and 110 votes to 10 respectively, by the Parliament.

Implementation of the Act is being undertaken as quickly and safely as possible. Since 29 November 2019, children under 12 can only be referred to a children's hearing on care and protection grounds, and not on offence grounds. This means that from this date, children younger than 12 have not accrued convictions or criminal records.

In Scotland there are proven approaches to confronting and correcting childhood behaviour that do not need a criminal justice response, with the great majority of children under 16 who commit offences being dealt with through the welfare-focused children's hearings system, rather than by the criminal justice system.

The increase in the age of criminal responsibility from 8 to 12 is a significant reform that will need to be carefully evaluated to identify further policy, legislative, system and practical changes that may be required to ensure that the Act has been safely implemented. The Act, therefore, provides that the Scottish Ministers must carry out a review within 3 years of the commencement of section 1 of the Act (which increases the age to 12). The review is to evaluate the operation of the Act generally as well as to consider a future age of criminal responsibility. Evaluation of the Act will ensure that operational learning and experience about how the legislation and associated change programme operates for the under-12 age group can be taken into account as part of the overall consideration of a future age of criminal responsibility in Scotland.

Northern Ireland

This issue is under active consideration in Northern Ireland. The Justice Minister has written to her Executive colleagues to seek their views on increasing the minimum age of criminal responsibility in Northern Ireland from 10 years to 12 years. While cross-party support has not been forthcoming to date, the Department of Justice will continue to pursue this issue.

58. In accordance with international standards, the Subcommittee recommends that the State party ensures that remand persons be segregated from convicted persons and be subject to a separate treatment, in conformity with their status of unconvicted persons.

England and Wales

Existing Prison Rules and policies already ensure that there is appropriate separation between unconvicted and convicted prisoners. Unconvicted prisoners must be kept out of contact with convicted prisoners as far as the Governor considers that it can reasonably be done, and unconvicted prisoners must not be made to share a cell with a convicted prisoner against their will.

Scotland

There is provision within the Prisons and Young Offenders Institution (Scotland) Rules 2011 that Governors must, so far as reasonably practical, keep civil and untried prisoners apart from other prisoners. The Rules also make provision for the regime and arrangements that apply to untried prisoner.

Northern Ireland

The majority of remand prisoners in Northern Ireland are held at Maghaberry Prison. Significant work has been taken forward to rationalise the use of the prison site to ensure that, as far as is operationally possible, unsentenced and sentenced prisoners do not share accommodation.

61. The SPT recommends that the State party analyses the consequences of the austerity measures on the right of persons deprived of their liberty, take steps to revert the negative impact, and ensure the full compliance with international standards for the treatment of prisoners, including health services, regime and other rights at all times.

The UK is fully committed to ensuring the rights of persons deprived of their liberty are fully protected.

England and Wales

Staffing

The UK is committed to ensuring a lack of staffing does not impact the treatment of prisoners. Though we recognise that we face staffing challenges, particularly related to the retention of staff, we remain committed to resolving them.

We are targeting action in prisons losing the most experienced officers to understand why this is happening. The leaving rate for band 3-5 prison officers for the year ending 30 September 2020 was 9.9%, which is a decrease of 2.4% compared to the year ending 31 March 2020. We closely monitor leaver trend data and use exit interviews to establish the drivers of attrition and target them.

New recruits leaving the prison service after less than two years is detrimental to the running of our prisons. In order to tackle this and proactively seek more closely suited candidates for the role, we have introduced a new recruitment assessment process based on current best practice which includes tests for strengths, behaviours and resilience.

We have also updated our Prison Officer Entry Level (POELT) training into an apprenticeship. This aims to improve retention by developing long-term developmental incentives for new recruits, incorporating training delivered through on-site experience to better equip them for the role. Building on the POELT course, the apprenticeship continues to support the new POELT for up to 15 months including periods of reflective learning and continued professional development.

For sites where it is hard to recruit and retain staff, we are tackling the issue of recruitment using market supplements and a tailored approach to recruitment advertising.

Delivery of health services

Health and justice partners have committed publicly to providing a standard of health care in prisons equivalent to that available in the community. This is discussed further in response to the SPT's recommendations referring to 'Healthcare in places of deprivation of liberty'.

Prisoners' access to purposeful activities

Prisons are resourced to deliver healthy regimes for prisoners, based on their core day (daily regime schedule), the agreed safe staffing levels and the maximum level of activity that can be achieved. Legislation and a framework of operational policies help structure the core day and ensure national minimum standards are met. Governors have autonomy over activity types and the way in which their staff are deployed, and central services are available to help prisons operate effectively.

Work is underway to articulate a future vision for prison regimes which applies the learning gained from Covid-19, which has shown that facilitating a quality regime and ensuring time is productive, including through offering in-cell activity, is more important than simply seeking to maximise time out-of-cell.

Material conditions of detention

As announced at the spending review in November 2020, we have committed over £4 billion to make significant progress in delivering 18,000 additional prison places across the prison estate by the mid-2020s. These 18,000 prison places include the 10,000 places being made available through the construction of four new prisons, the expansion of a further four prisons, refurbishment of the existing prison estate and the completion of our ongoing prison builds at Glen Parva and HMP Five Wells.

We are also investing a total of £315m in capital funding in 2020/21 to improve the condition of the existing estate. This will be supported by temporary units which will provide 1,000 temporary prison places to accommodate offenders during maintenance and refurbishment work, as well as support shorter-term population pressures. Construction is well underway on HMP Five Wells, the new prison at Wellingborough in Northamptonshire, and works have started at Glen Parva, Leicestershire. These prisons will provide safe, decent, and secure environments to support effective rehabilitation.

We have committed an additional £156 million in 2020/21 to address some of the most immediate maintenance and renewal issues across the prison estate. The recent spending review settlement will provide a total of £315m in capital funding in 2021/22 to invest in further improving the condition of the existing prison estate. We have recently announced that over £140m will be spent installing temporary prison cells, repairing and refurbishing prisons, approved premises and young offender institutions, and improving IT in prison.

Scotland

The Scottish Prison Service (SPS) seeks to comply with international standards of treatment for prisoners and HM Inspectorate for Prisons undertakes monitoring of prisons using Standards that focus on the upholding of human rights of those detained in prison. In publishing her most recent Annual Report (2019), HM Chief Inspector of Prisons for Scotland stated: “One of the key factors affecting the atmosphere in a prison is the quality of relationships between prisoners and those who work in prison and CCUs. I continue to be hugely impressed that despite COVID-19, the commitment of staff and their ability to care for and protect prisoners, a substantial proportion of whom are vulnerable, continued throughout.”

The Scottish Government has committed a total of £460.2 million to the SPS for 2021-2022, an increase of £18 million compared to 2020-2021 to help manage multiple pressures including a rising and increasingly complex prison population.

The SPS resource budget will increase by £12.4 million to £354.6 million - this is a 4% increase on last year. This increase will enable SPS to respond to operational challenges.

The capital investment in the prison estate this year will be £72.8m, a 7% increase on last year in order to improve and modernise critical prison infrastructure. This includes completing the majority of the work on the new female custodial estate, progressing the work on replacements for HMP Inverness and HMP Barlinnie, as well as improvement works to the existing estate.

Over-representation of ethnic minorities in the Criminal Justice System

64. The Subcommittee recommends that the State party take urgent measures to tackle the causes of racial disproportionality in the criminal justice system and ensure protection of minority ethnic groups from torture and ill treatment.

Addressing race disparities in the criminal justice system is extremely important to the UK government and we continue to prioritise this work, examining and acting on the issues highlighted in several reviews, recent independent inspections, and collecting and interrogating data in the spirit of the principle of "explain or change".

Since the Lammy Review, into the treatment of, and outcomes for, Black Asian Minority Ethnic (BAME) individuals in the criminal justice system in September 2017 we have made progress on a number of fronts. We are also doing more than ever to identify disparity in current practices and putting into place safeguards to prevent new policies from having unintended consequences that may have a cumulative impact on racial disparities.

We have made good progress towards completing actions we committed to take in relation to each recommendation and adding further actions that were not explicitly contained in the report. For example, we continue to prioritise the understanding and tackling of disproportionality within the youth justice system with a focus on preventative measures such as early interventions and diversions as well as procedural focuses in respect to remand and sentencing. Since the Review we have also made good progress in the increase of workforce diversity in HMPPS: This includes seeing an increase in the diversity of our Senior Civil Servant group and in the number of successful Black, Asian and minority ethnic applicants into the prison service.

We are keen on continuing the constructive dialogue around race and we will continue to build on the foundation of the Lammy Review adopting a wider approach that warrants an examination on the contributory factors that perpetuate the cycle of racial disparity in the criminal justice system.

The independent Commission on Race and Ethnic Disparities was launched to conduct a detailed, data-led examination of inequality across the entire population, and to set out a positive agenda for change. The Commission's report was published on 31 March 2021. The Government will now consider their recommendations in detail and assesses the implications for future government policy. The entirety of government remains fully committed to building a fairer Britain and taking the action needed to address disparities wherever they exist.

The Subcommittee further recommends that the State party take necessary steps to:

a) ensure that detention is not used discriminatorily against certain groups of people and that arrests, stops and searches are not based on appearance, colour or membership of national and ethnic groups;

England and Wales

Stop and search is a valuable policing tool that removes tens of thousands of knives from the streets each year and helps police to fight crime and protect communities as part of a broader strategy to tackle serious violence. However, no one should be subject to stop and search based on any protected characteristics including race, ethnicity and age. Safeguards exist to ensure this, including the use of body worn video (BWV) by police officers to increase accountability, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspections where force level disparities are examined and Code A of the Police and Criminal Evidence Act 1984 (PACE) which sets out the statutory requirements for conducting a stop and search. In particular, Code A states that stop and search powers must be used fairly, respectfully and without unlawful discrimination, under the Equality Act 2010. Reasonable grounds for searches can never be based on any protected characteristics, generalisations or stereotypes and local scrutiny panels ensure compliance with Code A through monitoring data sets, checking reasonable grounds and/or reviewing of BWV. The Home Office publishes force-level data on stop and search, including racial disparities, which can be used to increase accountability. The College of Policing recently updated their guidance on stop and search, to further ensure fair and proportionate use of these powers and provide better practice to forces on community engagement and scrutiny. The Home Office is working with HMICFRS and forces to monitor uptake of the updated guidance.

Police custody is governed by Code C of PACE which sets out the legal framework for the detention, treatment and questioning of persons by police officers. The operational management of custody suites is also carried out in accordance with the Authorised Professional Practise (APP) requirements as set by the College of Policing. As for Code A, Code C states that powers and procedures available to custody officers must be used fairly, without unlawful discrimination and in line with the Equality Act 2010. The integrity of police custody is maintained via HMICFRS unannounced visits and regular visits from the Independent Custody Visitors' Association (IVCA), who make unannounced visits to police custody to check on the rights and wellbeing of detainees. Independent custody visiting is one of the means to assess the UK's commitment to OPCAT. Both HMICFRS and ICVA keep the Home Office fully informed on their visits and findings. The Home Office is currently working with the National Police Chiefs' Council (NPCC) to improve the processes by which data on use of powers and procedures in police custody is shared and published, to increase transparency and understanding.

Section 24 of PACE give constables in England and Wales a power of arrest for all offences. It sets out two criteria that a constable must meet before carrying out an arrest: they must have reasonable grounds to (i) suspect an individual of having committed or be about to commit an offence and (ii) believe that the individual's arrest is necessary. The reasons for which arrest may be necessary include preventing personal injury or damage to property and to allow the prompt and effective investigation of the suspected offence. The exercise of the power is governed by Code G of PACE which, as for other PACE Codes, states that powers of arrest must be used fairly, without unlawful discrimination and in line with the Equality Act 2010.

Scotland

Intelligence-led stop and search is a valuable and effective policing tactic and contributes to the prevention, investigation and detection of crime while keeping people safe and improving community well-being.

Police Scotland's stop and search data is reported on per local authority area. Police Scotland officers understand victims of crime and the wider public have an expectation that officers will use the powers available to them, including stop and search where necessary, to bring offenders to justice. They also recognise that stopping and searching people is a significant intrusion into their

personal liberty and privacy and they remain committed to ensuring that all stop and search activity is carried out in a lawful and proportionate way and that people are treated with fairness, integrity and respect.

Police Scotland record data and carry out analysis to ascertain any disproportionality. They liaise with local divisions ensuring robust governance through first line managers, checking every single stop and search submitted to the database and then their National Stop and Search Unit carries out further review. Their stop and search processes follow the Code of Practice on Stop and Search and which have been approved by an Independent Advisory Group and the Scottish Police Authority.

b) tackle the disproportionate use of restraint on individuals from ethnic minorities;

England and Wales

We are committed to ensuring that prisons, young offenders' institutions and other custodial establishments safeguard the public as well as protecting the rights and dignity of prisoners. Prisons are challenging places to live and work. Staff and prisoners are increasingly exposed to threats including levels of violence, the impacts of substance misuse and criminal activity, all of which increase the risk for potential physical harm. Reducing violence and improving staff prisoner relationships will reduce the need for force to be used.

We are working with the Race Action Plan team to tackle disproportionality. We have accepted the Lammy recommendation that Use of Force committees should not be ethnically homogenous and involve at least one individual with explicit remit to consider interests of prisoners. We are working towards implementing this across all our prisons.

A Use of Force evaluation team has been established to conduct research into use of force in prisons, and we will use this evidence to inform our approach moving forward, so that we can use evidence-based practice to tackle disproportionality.

Scotland

In 2021, Police Scotland will engage in a consultation with community stakeholders in order to inform revised Use of Force Policy. As part of the consultation views will be sought from ethnic minority stakeholders on policies that ensure proportionate use of force.

Operational Safety Training Instructors will also undertake for the first time, additional, externally provided Equality and Diversity training in order to better inform training development and operational safety course content. The training will deepen their understanding of equality and diversity related issues in their role in the provision of advice on the proportionate use of force.

Police Scotland intend to utilise this enhanced knowledge to provide specific tactical advice to officers to counteract the effect of any biases they may hold.

c) implement programmes, which support reintegration, produce tangible outcomes and focus on preventing reoffending of persons from ethnic minority background in prisons,

Across the range of interventions and programmes that address reducing reoffending, we will need to ensure that we understand the impact across cohorts and consider how we address specific needs in all that we do. This can be observed in our evaluation programme and our work analysing the

drivers of reoffending for cohorts. We aim to carry out equality impact assessments in our programmes and work to ensure that factors such as protected characteristics, do not act as a hinderance for successful rehabilitation.

Following the HMIP 'Thematic review of Minority ethnic prisoners' experiences of rehabilitation and release planning' an action plan has been agreed to enable Her Majesty's Prison and Probation Service (HMPPS) to make the changes identified to improve matters for the identified cohort. Fundamentally, the purpose of this work is to understand the cultural needs of Black, Asian and Minority Ethnic (BAME) and Gypsy, Roma and Travellers (GRT) prisoners in order to provide improved and culturally sensitive services around rehabilitation and release planning. This will include working to identify potential areas of discrimination and embedding improvements into the services HMPPS offers so that minority ethnic prisoners' experiences are improved, aiding their rehabilitation.

d) reduce the over-representation of children from ethnic minorities in youth custody, including through adoption of alternatives to detention;

We want people to have confidence in a justice system that is fair and open - one where no person suffers discrimination of any sort. We share deeply the concerns about where we are now in terms of disproportionality. We will continue to prioritise the understanding and tackling of disproportionality within the youth justice system and recognise the absolute need for systemic change.

While there is important work to be done to improve the treatment and outcomes of these communities in the Criminal Justice System, this will only partially address the key issues linked to over-representation. This is because the 'upstream' factors that lead to crime are similarly disproportional. That is why there have been wider efforts by the Government to tackle over-representation through health, education and policing - demonstrating the significance of a holistic approach.

Several key actions are being taken by the Government to address disproportionality throughout the system and we are working to further strengthen our understanding of how we can ensure that BAME children can be diverted from custody, where appropriate.

We are investing £1m in funding to use physical activity and trauma-informed practice to improve outcomes for 11,000 BAME children at risk of entering the criminal justice system.

Our 'Chance to Change' pilots with police allow low-level offences to be addressed out of court. We understand that BAME defendants are consistently less likely to plead guilty and therefore face more punitive outcomes. This model places less emphasis on admission of guilt and more on the opportunity for diversion.

Youth Justice Board (YJB) support is in place to assist with the diversion of over-represented children through the pathfinder concept. A pathfinder to support BAME children and families impacted by Covid-19 has been developed. Payments totalling £1.4m over 3 years have been allocated to areas such as Newham and Brent with regards to Covid-19 response to provide this support to over-represented children.

We are going further to fund Black and Asian specialist voluntary sector organisations. A YJB project is in the process of being developed with around £80,000 youth-specific funding for voluntary and community sector organisations to support children who have experienced trauma and Adverse Childhood Experiences (ACEs) resulting from Serious Youth Violence

Work is ongoing in several areas with police. We have collaborated with the NPCC to tackle disproportionality in police custody. The YJB is also working on a potential pathfinder project to understand disproportionality in the out-of-court disposal system. This would identify and pilot a process for monitoring of out-of-court disposals within four police forces and make recommendations as to the process for a national approach as well as to develop a national training package specifically Community Resolutions.

We are currently reviewing the use of remand for children, with particular attention to the disproportionate representation of BAME children.

We have also worked with the Magistrates' Association to build awareness of disproportionality among sentencers. The YJB has recently held a joint roundtable with the Magistrates Association looking at over-represented children and the development of a Disproportionality Protocol and checklist for magistrates.

Within the Youth Custody Service (YCS), work is also taking place:

- Bespoke Diversity and Inclusion Plans are in place across the youth secure estate and are monitored for assurance against progress.
- Following de-biasing training for key staff, YCS are working with HMPPS to develop a bespoke training package on Diversity and Inclusion that will include cultural intelligence and best practice models.
- YCS continues to develop effective practice briefings to help upskill staff – for instance on supporting children and young people with specific personal, cultural or religious needs, and supporting conversations around difference.
- The first phase of HMPPS' Race Action Programme will review existing data, practice and provision and will be taken forward by staff member dedicated to the YCS.

Finally, we await the recommendations of the commission on race and ethnic disparities both in the criminal justice space and in its important contribution to upstream areas. We will consider this publication carefully as we shape future work in this space.

Northern Ireland

Whilst Catholics are not an ethnic minority group, Catholics are minorities in Northern Ireland. The proportion of Catholics within the Youth Justice System in Northern Ireland is higher than the current census breakdown for the 10-17-year-old age group, a trend that has been evident for the last number of years. In order to explore factors that influence over-representation generally, the Youth Justice Agency in NI has commissioned Queen's University Belfast to carry out research into this area. A report is due by the summer of 2021.

e) intensify the training and awareness-raising of prosecutors, judges, lawyers and police officers in the Criminal Justice System.

<u>England and Wales</u>

<u>Race disproportionality and training for prosecutors:</u>

Prosecutors must be fair, objective and independent. When deciding whether to prosecute a criminal case, lawyers must follow the Code for Crown Prosecutors 'The Code'. The Code gives guidance to prosecutors on the general principles to be applied when making decisions about prosecutions. These

general principles help to ensure groups, including minority groups, are treated fairly and include a number of provisions which include when making decisions, prosecutors must be fair and objective.

Training on the Public Sector Equality Duty is also a mandatory requirement for all lawyers as of February 2020. This is to ensure that prosecutors understand the importance of 'consciously considering' the needs of victims, witnesses and defendants with particular protected characteristics, including ethnic minority groups through the prosecution process.

The Crown Prosecution Service (CPS) has also put in place a structure for community engagement at national and local levels. Communities provide direct feedback on the way in which CPS decisions impact upon them, enabling the CPS to assess whether additional support for prosecutors is required to ensure that their application of the Code is not influenced by factors that may be a product of bias. This includes:

- Community Accountability Forum (CAF) meetings, chaired by the CPS Chief Executive Officer and an independent co-chair, with a diverse membership. CAF meetings focus on particular themes, enabling the CPS to hear from communities on particular issues.
- Local Scrutiny and Involvement Panels (LSIPs), chaired by Chief Crown Prosecutors, with membership drawn from local communities. LSIPs scrutinise CPS decision-making on a variety of cases, ensuring that prosecutorial decision-making is informed by an understanding of community perspectives.
- Community Conversations, chaired by Chief Crown Prosecutors, where community members can raise issues of local concern directly with the CPS.

Training for judges:

The judiciary of England and Wales is also independent of Government. The Lord Chief Justice (LCJ), the Senior President of the Tribunals, and the Chief Coroner have statutory responsibility for training, under the Constitutional Reform Act 2005, Tribunals, Courts and Enforcement Act 2007, and Coroners and Justice Act 2009 respectively. Training responsibilities are exercised through the Judicial College.

The Judicial College has a governing principle which requires diversity to be embedded into all training using examples of the social context in which judging occurs. Social context includes diversity, equality and social mobility. It is also the College's goal to integrate the topic of bias in all induction and continuation training. Judicial trainers are provided with guidance on how to integrate fair treatment and diversity into jurisdiction specific induction and continuation training programmes which are delivered to all judicial office-holders.

Social context and diversity are embedded in the competence frameworks for judges and magistrates. This all reflects the judicial oath, to 'do right to all manner of people after the laws and usages of this realm, without fear or favour, affection or ill will.'

All judges have access to the Equal Treatment Bench Book (ETBB) which is a comprehensive guide on equal treatment issues and is publicly available at: https://www.judiciary.uk/publications/new-edition-of-the-equal-treatment-bench-book-launched/. A new iteration is being published in February 2021.

Training for Legal professionals:

The legal profession in England and Wales is also independent of Government. Statutory responsibility for encouraging an independent, strong, diverse and effective legal profession sits with the approved regulators and the oversight regulator, the Legal Services Board (LSB). Accordingly, training set by regulators is done so independently. The Ministry of Justice has informed the Solicitors Regulation Authority, Bar Standards Board and Charted Institute for Legal Executives (CILEx) Regulation of these recommendations and highlighted their importance in ensuring the effective and fair delivery of justice. Regulators have informed us that they have been incorporating diversity into their approach to training and development and that they continue to consider equality and diversity as key priorities.

The UK Government has also launched an Independent Review into Criminal Legal Aid. The Review will look at how changes to Criminal Legal Aid might tackle racial disproportionality. For example, by seeking to ensure Criminal Legal Aid services are delivered through a diverse set of practitioners equipped with the right skills and expertise. The Review aims to report by the end of the year.

Training for police officers:

The College of Policing sets and maintains training standards for policing. In 2014, it introduced the Code of Ethics, which includes a set of principles for policing, including that all officers and staff should take active steps to oppose discrimination and make their decisions free from prejudice.

The College of Policing implemented the Policing Education Quality Framework (PEQF) to ensure a consistent, national education framework for police officers and staff, to equip the profession with the right skills, powers and experience. The basis for this looked at the fundamental requirements of a profession – including standards of education, specialist knowledge base and, critically, ethics. The College's foundation training for all those entering the service includes substantial coverage of police ethics and self-understanding, including the effects of personal conscious and unconscious bias. Initial training covers hate crimes, ethics and equalities and policing without bias.

The Code of Ethics is a key component of the National Decision Model (NDM), which is at heart of police decision-making and is therefore heavily incorporated into police training. Training and development are provided by forces at several different stages ranging from initial entry to leadership and is on-going to reflect and reinforce organisational values. The Metropolitan Police Service includes further inputs on this during its recruitment and promotion training as well as at other "touchpoints" and via intranet articles, forums and videos. It has also recently been seeking to introduce immersive, scenario-based training for ethical dilemmas. Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) inspections regularly include an assessment of the training that officers and staff receive.

There is an active network of ethics panels in polices forces, engaging at both a regional and national level across England and Wales. The UK Police Ethics Guidance Group provides oversight at a national level and, together, provide the opportunity to discuss ethical dilemmas.

Scotland

Police Scotland Initial Training includes a recently refreshed equality and diversity syllabus. Additionally, Police Diversity Staff Associations, including their ethnic minority staff association, are now invited to speak directly to officers in initial training to deepen their understanding of ethnic minority issues.

Significant events that impact diverse communities, such as Black or LGBTI History Month, are highlighted in initial training to students with the purpose of educating police officers on the history

of policing as it relates to diverse communities and the importance of building on relationships moving forward.

Leadership Training and Development are actively planning to increase BME representation within the instructional cadre within initial training in 2021 in order to ensure officers have access to experienced staff with a deeper personal knowledge of ethnic minority issues.

Equality and Human Rights Impact Assessment training has been developed and is being delivered throughout 2021 to ensure that policy and training accurately reflect the potential impact on diverse communities, including ethnic minorities.

Operational Training Staff, whom lead on training officers post their initial training and throughout their careers, are gaining wider access to externally delivered Equality and Diversity training to deepen their own understanding of issues faced by diverse communities.

Leadership Training and Development's Immersive Learning Unit, responsible for the delivery of Critical Incident Management training to senior Divisional Officers, is presently revising its program to ensure that it best reflects current issues faced by diverse communities, including ethnic minorities. In addition, a product will be tested in 2021 that embeds understanding of critical incident management at lower levels of leadership and supervision within Local Policing.

Healthcare in places of deprivation of liberty

69. The SPT recommends that the State Party integrate the Mandela Rules and the Istanbul protocol in the training curriculum (including in continuous exercises) of police and health care professionals. Medical personnel must be able to examine alleged victims of torture and ill-treatment, detect and report such cases in line with the provisions of the Istanbul Protocol.

Police:

In regard to specific training or awareness that is undertaken by forces to ensure their staff are well-versed in custody protocols, this would be a matter for the College of Policing and NPCC to take forward and consider what training may be appropriate. The College of Policing are an operationally independent arm's-length body of the Home Office. The College, as the professional body for policing in England and Wales, can set and improve standards for excellence in policing, to ensure police training and ethics is of the highest possible quality.

Medical personnel:

It is the responsibility of the professional regulators to set the standards and outcomes for education and training and approve training curricula to ensure newly qualified healthcare professionals are equipped with the knowledge, skills and attitudes to provide high quality patient care.

The content and standard of medical training is the responsibility of the General Medical Council (GMC), which is an independent statutory body. The GMC has the general function of promoting high standards of education and training, and co-ordinating all stages of education to ensure that medical students and newly qualified doctors are equipped with the knowledge, skills and attitudes essential for professional practice.

Health Education England works with bodies that set curricula such as the GMC and the Royal Colleges to seek to ensure training meets the required professional standards to meet patients' needs.

All registered health care staff dealing with detained persons must have competencies of the same standard as those working in the National Health Service. Additionally, these staff have access to the same NHS training programmes as part of their continuing professional development.

Scotland

The National Police Care Network has a role to improve capability and capacity in the forensic medical workforce in Scotland. Through its Education and Workforce Working Group the Network is refreshing existing training materials. The Network will ensure that the underpinning international and national legal context, including the Mandela Rules and Istanbul Protocol is included in the revised training materials. The Networks will also work with healthcare professionals working in police custody to ensure that they are aware of processes for the examination of victims of torture and ill treatment.

Neither the Mandela Rules nor the Istanbul protocol is currently referenced within the custody training curriculum. However, similar principles exist within Police Scotland's Standard Operating Procedure (SOP) relating to persons in police custody. The SOP confirms that the care and welfare of individuals in police custody is paramount.

In relation to equality and human rights considerations, guidance directs that *"it is essential that the care, welfare and security of persons held in police custody be maintained to consistently high standards. Whilst security is of paramount importance, all persons are to be treated with care and respect, ensuring that their fundamental human rights are maintained at all times. No person should receive less favourable treatment on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Each and every person must be considered as an individual with specific needs relevant to their particular circumstances, health and condition. Reasonable requests, which do not interfere with operational requirements or security, should only be refused when there are justifiable reasons."*

A Pilot for trialling "Soft Cuffs" was launched in the Falkirk area of Scotland in 2019. They are Velcro straps for the wrists, which allow a custody to be restrained but with less pain than the rigid issue cuffs. These can be used on persons who are on constant observations (in certain circumstances) where officers are sitting outside a cell with open door / glass screen and not consenting to an internal search, but otherwise totally compliant/ i.e., no hostility. Alternatively, they can be used on persons with mental health issues under the same observation regime. They are more comfortable and are a way of encouraging compliance. It is the intention to roll out this equipment nationally in due course.

Medical provision for persons in custody is the responsibility of National Health Service (NHS) Scotland. Should medical advice and / or assistance be required in relation to any person in custody, it is the responsibility of the custody supervisor to make direct contact with the Health Care Professional (HCP), however every person entering a custody environment is not routinely seen by an HCP.

In relation to examinations, interim guidance is currently in place to "*ensure that a robust and reliable healthcare service continues within police custody during the COVID-19 pandemic. The National Police Care Network has co-produced this guidance with Police Scotland and other partners*

to ensure there is minimal contact between people in police custody and/or minimal physical attendance of persons in custody, regardless of symptoms." This is to minimise the risk of infection from Covid-19 and protect people in custody and NHS and Police Scotland staff.

Current protocol advises that all cases that require clinical advice will be dealt with via telephone triage. Police Custody Officers require to phone the NHS Police Custody healthcare team in their area.

In the first instance NHS staff will triage over the phone. Healthcare professionals will attend police custody to see patients where clinically appropriate. If clinical judgement is such that attendance is not required, an explanation for this will be noted on the custody and clinical IT systems. Further follow up calls to healthcare professionals may be required if the situation changes.

73. The Subcommittee recommends that the State party develop a comprehensive national policy and strategy to ensure appropriate access to health care and mental health-care services across the criminal justice system, with particular attention to juvenile offenders. It also recommends that the State party transfer immediately persons, especially children with acute mental health problems, to an appropriate psychiatric facility and abstain from using police cells and prisons as "safe environment". In this connection, high priority should be given to increasing the number of beds in psychiatric hospitals.

England and Wales

Health and justice partners have committed to providing a standard of health care in prisons equivalent to that available in the community. The National Partnership Agreement on Prison Healthcare in England and its associated workplan set out a detailed programme of work to deliver safe, decent, effective healthcare for offenders. There is a similar agreement in place for the Children and Young People's Secure Estate between health, justice and education partners, which enables a more fully integrated approach to the commissioning and delivery of services to ensure appropriate support is available when and where children and young people need it.

The Children and Young People Mental Health Transformation Programme included a specific work programme on Health and Justice.

- SECURE STAIRS deliver a whole system approach to a Framework for Integrated Care within the children and young people secure estate. It uses a formulation-based approach and draws from evidence-based interventions like Trauma Systems Therapy, Enabling Environments and Psychologically Informed Environments. There is already positive evidence for SECURE STAIRS emerging from settings where it is fully mobilised.
- Thirteen Community Forensic Children and Young People Mental Health services (known as FCAMHS) currently provide a specialist service for high-risk young people that would not otherwise be available. The services ensure there are clear links between youth justice and welfare provision (community and custodial), hospital secure or specialist settings for high-risk young people, and core provision whether within specific children and young people mental health services (CYPMHS) or other services.

The recently published White Paper on Reforming the Mental Health Act (13 January 2021) accepts in principle that prison should not be used as a place for people who require mental health care and treatment in an inpatient setting. However, before legislative change is introduced work must first be carried out with our health partners to address the factors which lead to prison being used in this

way and ensure that there are alternative and timely pathways for sentencers to transfer people directly from court to a healthcare setting or a community sentence treatment requirement.

Scotland

The new National Secure Adolescent Inpatient Unit in North Ayrshire is scheduled to open in early 2022 which will have beds for young people with mental illness who require secure care. A National Learning Disability Inpatient Unit is also being planned, which will admit young people with moderate to severe learning disability and mental illness.

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides the police with the powers to intervene when they find someone in a public place who they believe may have a mental disorder and be in immediate need of care and treatment. Section 297 of the 2003 Act provides that the individual can be detained in a place of safety for up to 24 hours in order to be assessed by a medical practitioner, and for any necessary arrangements to be made for that person's care and treatment.

Police stations should only be used as the Place of Safety in exceptional circumstances, where it is the best option for the individual. There should be locally agreed Psychiatric Emergency Plans in place with designated Places of Safety – for example a local psychiatric hospital or Accident and Emergency Department. The aim of a Psychiatric Emergency Plan is to agree on procedures to manage the detention and transfer process in a way that minimises distress, disturbance and risk for the patient and others, and which ensures as smooth and safe a transition as possible from the site of the emergency to the appropriate assessment/treatment setting.

The police are required to notify the Mental Welfare Commission for Scotland of any person held under this power. The Commission has a statutory responsibility to monitor the use of powers in the 2003 Act and it publishes the results of its monitoring in an annual report. The number of orders in which the identified place of safety was a police station was at its highest in 2011/12 at 106 (18%) with the most recent figures showing that this percentage has dropped to 3% (35) for 2018/19

The Commission continues to monitor this activity and its relevance to the content of local psychiatric emergency plans.

Northern Ireland

Strategic direction within this healthcare remit is set out in the joint publication from the Department of Justice (DoJ) and the Department of Health (DoH) "Improving Health within Criminal Justice Strategy" and the accompanying Action Plan which were published in June 2019. Healthcare services (physical and mental) and addiction services are provided through healthcare teams based in each prison establishment.

The Juvenile Justice Centre in Northern Ireland has a range of processes and protocols in place for all young people following admission to the custodial centre. All young people are subject to a health assessment within 24 hours of admission to the facility and to a GP review within 7 days; this incorporates a physical and a mental health screen to identify issues at the earliest opportunity. This identifies any support required immediately.

Going forward, the Department of Justice is working with the Department of Health to develop an integrated Regional Care and Justice Campus for children in Northern Ireland. The new joint facility will provide a therapeutic model for meeting the health and mental health care needs of juvenile offenders. Satellite community wrap-around provision, including accommodation, will be developed

as part of this wider Campus, with the aim of keeping all but a small number of children out of secure accommodation.

74. The Subcommittee echoes the CPT recommendation that prisoners with severe mental-health conditions should not be placed in segregation units as an alternative to normal accommodation; "instead, such prisoner patients should be treated in a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance."

England and Wales

Prisoners who need to be transferred to a psychiatric unit for treatment should be moved out of prison as quickly as possible. Prison transfer and remissions guidance in relation to COVID-19 was published by HMPPS and NHS England and NHS Improvement (NHSE/I) in April 2020.

The NHS has worked with the Prison Service to collect new evidence to increase the understanding of secure hospital transfers under the Mental Health Act 1983. This evidence, published in December 2018, has increased understanding of where transfers work well and how delays arise.

NHSE/I is updating the transfer and remission guidance for prisons, and this is expected to be published later this year.

The Mental Health Act White Paper accepts in principle the introduction of a statutory time limit of 28 days from initial assessment to hospital admission for prisoners and detainees identified as requiring inpatient admission for treatment of mental health needs; and the introduction of an independent role to manage the transfer process, coordinating between the different agencies on behalf of the patient. This will be reflected in updated NHSE/I transfers and remissions guidance to be published later this year. The White Paper recognises the importance of embedding this guidance before making the time limit statutory.

Prisoners should only be held in the segregation unit under the proper authority. This is provided by the Prison (YOI) Rules:

- Under Prison Rule 45 (YOI Rule 49) – Good Order Or Discipline/Own Protection
- Under Prison Rule 46 - Close Supervision Centre of a prison.
- Under Prison Rule 53(4) (YOI Rule 58(4)) – Prisoner awaiting an adjudication to start may be kept apart from other prisoners pending the governor's first inquiry.
- Under Prison Rule 55(e) (YOI Rule 60(f)) – Cellular confinement for a prisoner found guilty of an offence against discipline. Cellular confinement is not permitted for Young People.
- Under Prison Rule 55(h) (YOI Rule 60(g)) – Removal from wing or living unit for a prisoner found guilty of an offence against discipline.
- The policy (PSO 1700) also covers the procedures to apply in relation to prisoners on dirty protest. A prisoner on dirty protest is moved to special accommodation in the segregation unit or other fit for purpose accommodation. Prisoners engaged in a dirty protest are normally held under Rule 45 (YOI Rule 49) Good Order or Discipline.

Prisoners with severe mental-health conditions should not be placed in segregation units as an alternative to normal accommodation, as per the Prison Rules above.

Scotland

Under section 136 of the Mental Health (Care and Treatment) (Scotland) Act 2003, there are arrangements that allow a prisoner suffering from a mental disorder for which treatment is available to be taken to hospital for care and treatment to keep the prisoner and others safe. Depending on

the care and treatment and the level of security required, there may be a wait until a secure bed becomes available. Once a transfer for treatment direction has been made the prisoner must be transferred to an appropriate hospital within 7 days. Clinical assessment and care within the custodial setting is carried out by NHS with health centres in all prison establishments.

The Scottish Prison Service is developing a new health and wellbeing strategy for those in their care with key stakeholders to ensure the strategy and policy within prisons provides parity with the community. The Strategy will include sections on addictions, physical health and mental health. The mental health section will have a bespoke component for children and young people.

75. The Subcommittee also recommends that all prison staff be trained to recognise the possible symptoms of mental health problems and apply prompt and appropriate referral procedures to medical personnel.

England and Wales

All prison officers have access to a range of training and guidance to support them in better understanding and supporting the mental health and wellbeing of prisoners. New and existing staff currently receive Suicide and Self-Harm Prevention training, which includes an 'Introduction to Mental Health' module. We are currently working to improve our safety training within prisons and as part of this will be looking to develop an enhanced mental health module which builds on the introductory module. As well as specific mental health training courses, key principles on this topic are also reflected in a range of other resources available to all staff.

Scotland

The Scottish Prison Service has a ‘Talk to Me’ strategy which aims to assume a shared responsibility for the care of those at risk of suicide; to work together to provide a person centred care pathway based on an individual’s needs, strengths and assets and promote a supportive environment where people in custody can ask for help. This strategy was refreshed in 2019 and has been re-issued to all staff to make clearer the circumstances in which a risk assessment and / or health care assessment should be carried out and these remain in place throughout the COVID-19 pandemic.

Northern Ireland

All prison staff and new recruits in Northern Ireland have received mental health awareness training. Staff in specific roles have received Mental Health First Aid training. All staff and new recruits are trained in SafeTalk and Managers in ASIST.

Towards Zero Suicide training is delivered to all recruits and has been made available to all staff. A procedure is in place where a prisoners themselves, or a member of staff can talk to the house nurse if they feel they may need mental health support.

All primary care healthcare nurses have received mental health training. The Healthcare team will make a referral to their mental health team if they deem it necessary. All new committals to prisons in Northern Ireland are screened by the Trust's mental health team. Staff working in Safer Custody teams can make a referral directly to the mental health team. The SEHSCT’s prison healthcare team and the NIPS work together to support training approaches across organisations. This mirrors the strategic emphasis placed on collaborative working by government departments and the newly established oversight arrangements across the and the DoJ.

The Regulation and Quality Improvement Authority (RQIA) have recently participated in inspections of prisons and custody suites, and are currently undertaking a review, commissioned by DOH, into

the specific care and treatment of Vulnerable Prisoners. For the purpose of this review, Vulnerable Prisoners are defined as those who have mental health concerns at risk of self-harm or suicide across all of Northern Ireland's prisons. The report is due to be published in the Summer.

Situation of persons deprived of their liberty

Police Detention

80. The Subcommittee recommends that appropriate steps be taken to remedy the inadequacies in police stations and cells, including by improving natural light. The Subcommittee also recommends ensuring the enjoyment of rights to shower, phone calls and exercise, on a regular basis.

England and Wales

Code C of PACE requires custody officers to inform detainees of their rights and entitlements whilst in custody, including to free independent legal advice, and in a written notice, entitlements concerning reasonable standards of physical comfort, adequate food and drink, access to toilets and washing facilities, clothing, medical attention, and exercise when practicable. Brief outdoor exercise should be offered daily if practicable.

Section 35 of PACE allows chief officers to designate stations within their force area for the detention and questioning of suspects, and they may remove this designation from stations that do not comply with the appropriate standards laid out in the Codes.

The College of Policing Authorised Professional Practice (APP) further recommends that exercise should be provided individually and be adequately supervised and notes that consideration should be given to the appropriate arrangements necessary to meet the needs of men, women and children, for example, by providing adequate clothing. Detainees should be able to access and use a toilet in privacy. Hygiene packs should be routinely offered to women on arrival and staff should take into consideration the additional needs of detainees who are menstruating or have an additional medical need on an individual basis. In July 2019 PACE Code C was amended to ensure that all women in custody are offered free menstrual products. Detainees who require a shower should, where appropriate, be offered the opportunity to do so. The APP further notes that cells should provide access to natural light.

The Police Custody Design Guide, developed in 2019, builds on the foundations of previous draft guides created by the Home Office. It includes extensive reference to the importance of exercise and natural light.

Application of Code C, the College APP and the Police Custody Design Guide are operational matters for individual forces.

The report referenced areas of concern in some specific forces. Following inquiry, Merseyside noted that the station inspected has not been used for many years as it is no longer designated as PACE-compliant, and hence does not reflect the standard of custody accommodation used in the inspected area where all cells have access to natural light. GMP made a similar observation as requirements for natural light have been in place in their force since 2000. All cells in their area have light tubes in the ceilings which provide access to natural light. City of London Police acknowledged issues which relate to design of the existing estate, noting that although the majority of cells have access to some natural light it is restricted, and cannot be amended due to the building's

configuration. However, the force is constructing an exercise yard which will allow access to natural light and is due to be completed within the next few weeks. There are further plans for new custody facilities which will be designed in compliance with the Police Custody Design Guide, including the provision of natural light, although it will be some time before this can be built.

Scotland

A number of cells within Police Scotland Custody Estate have access to natural light via glass blocks sited within the walls if they are exterior to the building. However, due to the design of some buildings, cells have interior corridors and therefore do not have this facility.

Due to the reduced time persons remain in police custody and the fact they attend court the next lawful day, therefore do not remain in police custody for excessive lengths of time, their access to exercise etc. is different in comparison to that provided when within Scottish Prison Service Establishments. Referencing the recommendation around improving inadequacies in police stations, two major projects have seen recent advancements within separate Custody Suites. Govan has seen distraction devices implemented, with chalkboard paint on the wall for custodies to doodle with chalk. Detainees are supplied with mindfulness colouring sheets and crayons, jigsaws or foam footballs/tennis balls. In addition to this, there has been an increase in the number of showers being offered, with toiletries being provided by a charity.

London Road Police Station is under construction with expected operating date in late March 2021. This will see the introduction of 6 designated children cells, not among the adult section and the introduction of two shower rooms which will improve the facilities for persons held in custody. A discreet charge bar has been built which will afford children and certain persons' privacy when being processed in/out of custody.

There are other additional schemes ongoing to demonstrate partnership commitment to assist persons in police custody:

- Link workers in Inverness (currently working remotely)
- Substance Abuse and Mental Health (SAMH) in Kittybrewster (currently working remotely)
- Crisis Intervention Workers starting in Fraserburgh Custody Centre in March/April 2021
- Arrest referral Service being explored for Dundee Custody centre
- Trial of NHS Near Me video conferencing facilities to enable remote video medical consultations to take place – trial due to start in 7 custody centres across the force in March 2021
- Custody Peer Mentors introduced in Glasgow

The current policy regarding washing, advises that:-

"where an arrested person is to be detained in custody for more than a full day, they should be offered facilities to wash and / or shave at least once per day. Any reasonable requests to wash and / or shave more often than this are to be met, where possible. Facilities are also to be made available to a person to wash and shave if they wish, prior to appearing in court." In addition, "Persons who require showering should, where appropriate, be offered the opportunity to do so. If necessary, female persons should be transferred between custody centres to ensure adequate washing/showering facilities are available".

In relation to telephone calls, a Letter of Rights for people in police custody is issued to an arrested person which includes the explanation that a right exists to have someone told that the person is at

a police station. Additionally, a video is being developed to assist with explaining a person's rights, which is in addition to the letter of rights they receive.

Penitentiary Institutions

90. The Subcommittee recommends that the State party ensure segregation of prisoners is a last resort and for as short as time as possible, and never longer that 15 consecutive days, and that segregated prisoners are provided with a purposeful activity and meaningful human contact each day in line with the Standard Minimum Rules for the Treatment of Prisoners (Mandela rules).

England and Wales

Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners. There are occasions where, for their own safety or that of others and in line with PSO 1700, prisoners are segregated from the main population of the prison. Removal from association under these circumstances is always for the shortest time necessary and the prisoner must be returned to normal location as soon as practicable or safe. Prisoners in segregation have the opportunity for daily interaction with prison and healthcare staff, chaplaincy and can speak and, if safe to do so associate with other segregated prisoners.

Prisoners can be segregated under a range of authorities, which are set out in Prison Rules. These are:

- Under Prison Rule 45 (YOI Rule 49) –Good Order or Discipline
- Under Prison Rule 45 (YOI Rule 49) – In his own interests
- Under Prison Rule 53(4) (YOI Rule 58(4)) – Prisoner awaiting an adjudication to start may be kept apart from other prisoners pending the governor's first inquiry.
- Under Prison Rule 55(1)(e) (YOI Rule 60(f)) – Cellular confinement for a prisoner found guilty of an offence against discipline
- Under Prison Rule 55(1)(h) (YOI Rule 60(g)) – Removal from wing/unit for a prisoner found guilty of an offence against discipline

A governor may authorise segregation beyond 72 hours under the Prison and YOI Rules. A Governor must obtain leave from the Secretary of State (usually the Prison Group Director (PGD) acting on behalf of the Secretary of State) to continue segregation beyond 42 days. If segregation is to continue beyond 84 days, then a further PGD Subsequent Review will take place. Segregation over 6 months must be authorised by the Director. A Segregation Review Board (SRB) must be held within the first 72 hours of a prisoner being placed in segregation, then a further SRB must be held within 14 days and every 14 days thereafter. These reviews consider carefully all of the available evidence for and against continued segregation in an impartial manner and the option of either extending segregation or removing the prisoner from segregation.

The regime for segregated prisoners (under Prison Rule 45 (YOI 49)) should be as full as possible and only those activities that involve associating with mainstream prisoners should be curtailed. In-cell education or work that could be done in cell (e.g. packing) should be encouraged. Access to activities such as domestic visits, legal visits, use of the telephone, canteen, exercise and showers should be comparable to those for a prisoner held on normal location. Certain regime elements, for example, TV, radio/CD player, association within the segregation unit, PE / gym access could be used as incentives / rewards for prisoners that comply with the targets set by the Segregation Review Boards.

Scotland

Removal from association is only used sparingly by Scottish Prison Service and for the minimum time necessary. When determining whether it is appropriate to remove an individual from association consideration is always be given as to whether it is necessary, proportionate and balanced.

Rule 95 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 enables a governor to remove a person in their care from association with other persons where they are satisfied that it is appropriate to do so to protect their safety, or that of any other person, or where there is a risk to the good order or discipline of the prison or Young Offender Institution (YOI). The rule also provides important safeguards for persons removed from association, which ensure that the reason for removal is clearly communicated to the person, they are afforded the opportunity to make representations against their removal, and they are monitored and reviewed regularly. Whilst removed from association there will normally be no unnecessary restrictions on their entitlements to time in fresh air, visits, including legal visits, access to telephones and correspondence. Additional activities can be prescribed based on assessment via the review and monitoring process. The focus throughout will be to reintegrate the person at the earliest and safest opportunity into the mainstream population, thus minimising any time spent separate from others.

Northern Ireland

A review of the operation of Care and Supervision Units (CSUs) in the Northern Ireland Prison Service (NIPS) is being undertaken by Criminal Justice Inspection Northern Ireland (CJI) in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI). The NI Prison Service will respond to any recommendations relating to segregation resultant from this review.

92. The Subcommittee recommends that the State party:

a) Strengthen the oversight of the use of force in all detention settings to ensure that force is only used in accordance with law and is strictly necessary and proportionate;

England and Wales

A digital Use of Force reporting tool is being rolled out nationally, making it easier for staff to record the reason for their use of force, and allow better local governance. The benefits of the new tool will be felt at the data entry point, for local monitoring and response, and for national assurance and understanding of use of force across the estate.

We have introduced a good governance toolkit, to support prisons with their local oversight. This includes increasing the frequency of committee meetings, so that incidents are discussed in a timelier manner, and feedback and learning provided more promptly to staff. It will also enable prisons to tackle poor and unlawful practice. To support this, we have a Practice and Assurance Lead, who provides bespoke, onsite support to prisons.

A national Use of Force committee will monitor use of force data trends nationally when the digital tool is implemented, and we have confidence in the data it brings. It will be a forum for discussion, with outside scrutiny members invited, on how we can reduce use of force more generally, and disproportionality specifically, through intervention or improving the national training syllabus where necessary.

Scotland

The Scottish Prison Service recognises that each individual has their own unique needs, and it seeks to promote equality by dealing sensitively and appropriately with all those in its care. Where force is

used, a 'Use of Force Report' requires to be completed and submitted and there is a formal process in place to review the actions taken by staff.

The Scottish Prison Service has engaged in a wide-ranging review of Control & Restraint. The review included seeking advice from an external expert in the Use of Force within criminal justice and health settings.

A comprehensive new control and restraint manual, refreshed use of force policy, and bespoke training packages are out for consultation by the prison service.

The SPS have produced a revised Use of Force Policy which continues to promote de-escalation methods at the earliest opportunity with greater emphasis on roles and responsibilities, risks of intervention and medical conditions exacerbated or impacted by force.

An accredited Control and Restraint and Control course is undertaken by all new Operations Officers with a mandatory annual refresher course. to ensure that actions taken are lawful, necessary, reasonable and proportionate to the situation presented.

A range of safety measures to reduce the risk to people being restrained have been implemented, including a focus on recognising and managing a medical emergency. Additional safety training and clarity over responsibilities for staff involved in the use of force has been included in the Control & Restraint guidance.

Northern Ireland

NI Prison Service staff are trained and will attempt to deal with any incident without the recourse to force, using de-escalation techniques. Where the use of force is unavoidable, such intervention will be reasonable, necessary and proportionate to the threat.

The NI Prison Service (NIPS) interrogate Use of Force incidents and statistics on a regular basis; trends are identified, and analysis carried out. Records of all use of force incidents are completed and held electronically on the Prism system. All incidents of alleged excessive Use of Force are investigated.

b) Review behaviour management policies across prisons with the aim of identifying and reducing the underlying causes of violence and use of force; and

England and Wales

HMPPS safety and security Head Quarters (HQ) teams are working together to provide a joined-up approach to identify and reduce the causes of violence and reduce the need for use of force. The Five-Minute Intervention (FMI) aims to train officers in turning their everyday conversations with those in their care into opportunities for change. Prison officers spend a great deal of time with prisoners and can significantly contribute to the process of rehabilitation by providing a safe and secure environment which is more likely to facilitate a rehabilitative culture and enhance the likelihood of rehabilitative relationships. FMI training is delivered over two days and involves staff practising 10 interpersonal skills to enhance their conversations with prisoners to make dialogues more rehabilitative. This has the potential to reduce tension and the likelihood of violent incidents.

The new Incentives Policy Framework was introduced in January 2020 and focuses on reinforcing positive behaviour, drawing on the principles of effective behavioural support to help people make the right choices in prison. Evidence shows that this approach can be effective at achieving positive changes in the behaviour of those in our care. The new approach provides a common framework

which governors can use to determine locally how best to support and encourage people in their care to follow the rules and engage in rehabilitative activities such as work, education and substance misuse interventions. Governors will still be able to remove privileges from those who behave poorly or refuse to engage.

Drawing on available research, the new policy focuses more on incentivising and positively reinforcing the right behaviour and introduces simple behaviour expectations for those in prison so that they understand what is expected of them, and what they can expect in return. The new policy also promotes fairness, equality and the effective implementation of local schemes by requiring every prison to have an Incentives Forum, with representation from prisoners with protected characteristics, to shape and review the local operation of incentives.

The Offender Management in Custody (OMiC) model is being implemented across the estate. Every residential officer will take on a key worker role to engage and support a small caseload of prisoners to make progress away from violence and offending. We will be monitoring the impact on the levels of force being used as prisons implement the key working scheme. Staff will have been trained in FMI as a prerequisite to OMiC roll out.

The Challenge, Support and Intervention Plan (CSIP) launched in November 2018 provides a case management model to help staff to manage violent prisoners and those identified as posing a raised risk of violence. The framework encourages a consistent, multi-partner response to people using aggression and violence in custody. Increasing numbers of prisons are adopting this framework.

Scotland

The Scottish Prison Service has a zero-tolerance approach towards violence and staff are trained to recognise and respond to the precursors of violence and manage any incidents when they do occur.

Through its national Strategic Risk and Threat Group, the prison service continues to seek to understand the changing nature of the prison population profile and the subsequent impact on violence, particularly in relation to serious organised crime.

Levels of violence within prisons is continually under review. Violence Reduction meetings take place regularly across Scottish Prisons to discuss all notable incidents, trends and identify preventative actions. CCTV cameras operate within all Scottish prisons to deter violent incidents and assist in any post-incident investigations.

In her most recent Annual Report (2019), HM Chief Inspector of Prisons for Scotland stated: "*I have been impressed by the Scottish Prison Service (SPS) efforts to manage the additional population safely, and it is reassuring to note that in all of our prison inspections, and visits in this reporting year, staff and prisoners regularly reported feeling safe*."

Northern Ireland

NIPS continue to focus on predictable, stable and effective regime delivery, and have incrementally reduced the use of cell sharing to a nominal level in all three NI prison establishments. As of February 2021, no prisoners were sharing a cell and it is the ambition of NIPS to find an affordable mechanism to maintain this position.

The prevalence of violent incidents Northern Ireland prisons (assaults on staff / people in our care) has reduced and remains at a low level. NIPS will continue to keep policies and practice under review as part of its continuous improvement programme (this includes work being progressed to develop a challenging anti-social behaviour policy).

c) Provide mental health care that meets the needs of all detainees and consider introducing a statutory time limit on transfers of detainees to mental health inpatient facilities.

England and Wales

Adults, children and young people will receive health screening on entering prison and a follow-up appointment within seven days, or sooner as required. This will be supported by the full roll-out of the health and justice digital patient record information system across all adult prisons, immigration removal centres and secure training centres for children and young people. This will include the digital transfer of patient records before custody, in custody and on release. Programmes such as Liaison and Diversion, and Community Sentencing Treatment Requirements have also been invested in with the aim of diverting people into treatment as an alternative to detention.

The recent White Paper on reforming the Mental Health Act sets out our ambition to introduce a 28-day time limit to speed up the transfer from prison or Immigration Removal Centres to mental health inpatient settings. We recognise that the practical consequences of making this time limit statutory need to be carefully monitored, and so we will not commence this legislative change until new NHSEI guidance on transfers and remissions is properly embedded in practice.

In addition, the White Paper set out a commitment establish a new designated role for a person independent of the health or criminal justice systems to manage the process of transferring people from prison to hospital when they require inpatient treatment for their mental health. This role will help ensure that institutional barriers are overcome, and the patient's needs are put first. We are seeking views in the consultation as to where this role will sit, and how it will operate.

Scotland

Transfer times are being considered as part of the independent review into the delivery of forensic mental health services. The final report will be published by the end of February after which time, the Scottish Government will consider the recommendations and confirm those that will be taken forward.

94. The Subcommittee recommends that the State party ensure all detainees are held in clean and sanitary conditions and address promptly inadequate detention conditions at HMP Manchester.

HMP Manchester is committed to improving its living conditions for all residents. This work has been escalated and evidenced throughout the pandemic. We have significantly increased the number of trained cleaners, who are paid at an enhanced rate, to maintain and improve the cleanliness of residential areas. The HMIP Short Scrutiny Visit in May 2020 highlighted the good practice we have implemented so far:

"Prisoners had regular access to cell cleaning materials. Cleaning across the prison was well organised; we saw communal areas being regularly disinfected throughout the day, including railings and door handles".

We have implemented a consistent cleaning programme throughout the establishment. Residents and Cleaning Officers work together and take responsibility in keeping their areas clean and decent. A Clean & Decent folder has been created on each Wing, to document any cleaning completed and record areas of concern, to ensure appropriate action is taken in sufficient time by Managers and stakeholders.

We have improved our working relationship with our facilities management service provider, Amey. This has helped us to action and evidence a timelier response to pest control issues. In particular, a

'riddance programme' to address any rodent issues has started. The programme involves weekly visits from Rentokil, with the ability to also have targeted additional visits if there is a specific area of concern. Staff are regularly encouraged to promote cleanliness and maintain rubbish free areas to avoid vermin, this is driven through the Residential Governors at briefings with staff.

The improved relationship and engagement with Amey has also seen higher levels of repairs for all areas including windows and broken furniture. This has been tracked through the Bed Manager role where out of action cells and spaces in the establishment are monitored daily.

It has been identified that capital investment is needed to replace some of the larger scale issues reported. Shower facility replacement work has been ongoing for some time now. Some areas that required upgrade on B, C, D and G wings are now complete. K wing is currently being upgraded and is near completion. I Wing, A Wing, the Segregation Unit and HCC are all due to start by the 22nd February 2021. This work will help with the issues of damp that were reported in a small number of the cells.

A bid for replacement safer custody windows has been submitted. This will assist in ensuring a decent standard of living is attained, however, we have a robust process in place until this is approved and achieved. Finally, work on kitchenettes has also begun which further supports our rehabilitative approach towards improving living standards.

Scotland

HM Inspectorate of Prisons for Scotland (HMIPS) assess the treatment and care of prisoners across the Scottish Prison Service (SPS) estate against a pre-defined set of Standards. These Standards are set out in the document 'Standards for Inspecting and Monitoring Prisons in Scotland', published in May 2018 which can be found at https://www.prisonsinspectoratescotland.gov.uk/standards.

Standard 2 assesses the Decency of the environment that prisoners are living and working in, In her most recent Annual Report (2019), HM Chief Inspector of Prisons for Scotland records that of the 4 full prison inspections undertaken during the year Decency was rated as being Good at 2 establishments, Generally Acceptable at 1 establishment and poor at another. The establishment given a poor rating – HMP Barlinnie- is an older style Victorian prison which has been earmarked for replacement. Scottish Ministers have also allocated £3 million to refurbish a number of areas of the prison while work takes places on developing the site for and constructing a new prison.

Institutions for Juvenile Offenders

97. The Subcommittee calls upon the authorities to implement fully the recommendations of the last visit report of HMIP on HMYOI of Cookham Wood.

Following the last visit of HMIP the actions allocated to Cookham Wood YOI have been progressed by the Youth Custody Service and by the establishment (who have updated their response to HMIP and their action plan) with the Governor providing monthly assurance reports to the YCS Prison Group Director (PGD). Following the HMIP/ SPT visit – Cookham Wood YOI appointed staff leads under each of the four Healthy Test areas that HMIP assess. Evaluation meetings are held weekly by each lead to determine progress and challenges. Actions in each area are quality assured and "signed off" by the Governor once completed with a record of all actions stored and maintained. Regarding broader assurance, we have introduced the Monthly Performance Assurance Report process where each functional head provides a report on their areas of performance. This includes an element of "competitive analysis" where reported performance is challenged to ensure its accuracy and feeds into the overall establishment report.

It should be noted that this has been taken forward alongside the need to follow physical distancing approaches, in line with national guidance, as a result of the COVID-19 pandemic. This has inevitably impacted regime delivery within all sites and has been the primary focus of all secure settings during this time. The priority has been to ensure children have had access to essential activities and enough 'time out of room' (as well as engaging activities within rooms), balanced with the need to keep children and staff safe. Whilst time out of room dropped at the start of the pandemic period, given the necessary measures taken to protect all working or living at the site, internal management information suggests that average 'time out of room' increased month on month from April to November 2020. Especially following the publication of youth-specific Exceptional Delivery Models in July 2020 which resulted in key aspects of regime such as 'face to face' education recommencing at Cookham Wood YOI and although this dropped slightly in December, increased once more in January 2021. Cookham Wood YOI continues to look to increase opportunities for children during this time, in a safe and sustainable manner, wherever local circumstances allow this to occur.

Regarding the increased usage of force, we note that levels of Use of Force (UoF) have remained relatively stable over the past twelve months with the overwhelming majority of UoF being used to prevent harm to others. We have taken steps to improve our complaints process and all complaints are quality assured to ensure that our responses address the issues raised and actions are put in place to ensure that similar issues are not repeated. The quality assurance process involves a check to ensure that the respondent to the complaint has spoken to the child as part of their investigation into the matter/s raised.

Whilst delivery will continue to be impacted by the pandemic, the Governor and the Cookham Wood team are focused on addressing the recommendations fully through ongoing recovery planning.

Immigration detention

101. The Subcommittee recommends that the State party:

a) Ensure immigration detainees are detained only as a last resort and for the shortest possible time and consider replacing the current practice of removals and implement a time limit on immigration detention;

The UK is committed to a fair and humane immigration policy that welcomes those here legally, but tackles abuse and protects the public. Immigration detention plays a limited but essential role in maintaining effective immigration controls and securing the UK's borders, by supporting the removal of people who have no right to remain in the UK but who refuse to leave voluntarily and, in some cases, present significant public risk.

The UK Borders Act 2007 requires the Home Secretary to remove foreign national offenders from the UK, and we remain committed to doing so. We maintain the detention of such individuals where it is necessary to secure their removal, it is lawful to do so and where appropriate. We will also maintain the detention for enforcing the swift removal of other individuals, who have no right to remain in the UK, but who refuse to leave voluntarily. However, we do not detain people under immigration powers indefinitely. We are always mindful of our legal obligations in respect of immigration detention, in particular in assessing that for each individual there is a realistic prospect of removal in a reasonable timescale.

We also recognise that it is vital that detention and removal are carried out with dignity and respect and we take the welfare of individuals in our care very seriously. Our priority is to ensure immigration detention is used only where necessary, and for the shortest possible time, ensuring

decisions to detain, and subsequent decisions to maintain or release, are well made, with systematic safeguards and support for the vulnerable.

Improvements to immigration detention have been made in recent years, with a systematic and ambitious programme of reforms introduced following Stephen Shaw's 2015 and 2018 reviews of welfare in detention. The overarching aim of our package of reforms is, over time, to deliver a reduction both in the numbers of those detained and their length of stay before removal, and the improved welfare of detained persons, further strengthening a culture that maintains the highest standards of professionalism. The programme of work underway includes; increasing the number of Home Office staff in immigration removal centres, so that they can work with detained individuals more closely; minimising the use of immigration detention and exploring alternatives to detention; strengthening decision-making and safeguards for the vulnerable; improving transparency; and ensuring that everyone is treated with dignity in an estate fit for purpose.

b) Ensure all immigration detainees (including those in short-term holding facilities) have access to good quality, free, legal advice. Ensure all detainees have effective access to fair and accessible procedures to challenge the decision to detain and/or deport;

People who are detained must be advised of their right to legal representation and of how they can obtain such representation within 24 hours of their arrival at an Immigration Removal Centre (IRC). To ensure this occurs, all detained people are provided with a list of the Legal Aid Agency Detained Duty Advice (DDA) scheme duty solicitors as part of their induction to the IRC and are made aware that they are eligible for a free 30-minute consultation regardless of financial eligibility or the merits of their case.

Following the outbreak of the COVID-19 pandemic, a number of changes have been introduced to ensure the welfare and safety of people who are detained and the staff in IRCs and to minimise the risk of COVID-19 spreading in the immigration detention estate. Guidance on the principles of managing COVID-19 in places of detention and during escort came into force on 5 May 2020. This includes information on vulnerability, shielding, cohorting and other preventative measures such as the cessation of social visits and adjustment of approach to legal visits. The most recent version can be found on Gov.uk.

Adapting to the change of operations in line with Government advice on social distancing, the Legal Aid Agency (LAA) DDA scheme is currently operating by phone. People in detention who wish to access this service are asked to advise centre staff, who will notify the duty solicitor under the scheme. The duty solicitor will contact individuals who wish to access this service directly. Service providers' welfare teams and on-site Home Office staff have a working knowledge of the LAA's services, with welfare teams signposting the legal support available to those in detention. At all IRCs, individuals who are detained and who already have legal representation may receive visits from their advisors by appointment. These visits take place in private, in designated interview rooms within sight (but not earshot) of detainee custody officers. Individuals detained in IRCs are also able to contact their representatives by telephone, fax, personal email and through Skype video calls and additional mobile phone credit is also being provided. In exceptional circumstances, and for individuals facing imminent removal from the UK, face to face legal visits can occur where other means of contact (video calling, telephone, email) are not feasible.

All individuals arriving at an IRC ahead of their removal receive an induction from the IRC service provider (within 24 hours) and then with a Home Office representative (within 48 hours of arrival) in which they are signposted to means of accessing legal advice, additional support and assistance. All

individuals detained in an IRC are able to engage with the on-site Home Office team for information or updates on their immigration case throughout their stay, seven days a week.

All detained individuals are entitled to the categories of immigration legal services specified in Schedule 1 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) and legal aid is available for detained individuals in prison on the basis of the same eligibility criteria for those detained in IRCs.

Individual prison establishments are required to have in place processes to ensure prisoners (including those detained under immigration powers) are provided with information and access to independent advice from their first night in custody (PSI 07/2015) and throughout their time as a prisoner (PSI 75/2011), including specific obligations on prisons to ensure that prisoners are able to access independent immigration advice when it is required (PSI 52/2011).

Publicly funded immigration advice and representation has been provided to prisons by 44 separate providers over the last three years. More generally, there are 186 firms (as of October 2020) certified to provide publicly funded immigration and asylum advice, spread across 278 offices in England and Wales (October 2020). All of these providers are authorised to provide immigration and asylum advice in prisons.

Additionally, the Courts can, and do, hold us to account on detention decisions and Judicial oversight remains an important part of the detention system, with individuals able to apply to the Tribunal for immigration bail at any time during their detention. Furthermore, there is provision for an automatic bail referral at the four-month point for those who are not foreign national offenders.

c) Ensure effective oversight, monitoring and complaints policies and procedures in the immigration detention estate to ensure that any ill-treatment is immediately identified and ensure the effectiveness of investigations into allegations of ill-treatment.

The UK operates a comprehensive complaints system for detained individuals who feel that they have not been treated in accordance with our standards. We take detained individuals' complaints very seriously and ensure that they are investigated thoroughly and in a timely manner. Complaints from detained individuals are investigated in accordance with published guidance; Detention Services Order 03/2015 Handling Complaints. Detained individuals who submit complaints are not disadvantaged in any way in relation to their treatment while in detention, or in relation to the outcome of their immigration case.

Complaints made under formal procedures are categorised as either; service delivery complaints, minor misconduct complaints or serious misconduct complaints. Complaints made by those in detention or under escort are handled by our contracted service providers. However, the process and handling is monitored and quality assured by a dedicated Home Office Detention and Escorting Services complaints team. Serious misconduct complaints are sent for investigation by the Home Office Professional Standards Unit. Detained persons who are not satisfied with the way in which their complaint has been handled may ask for it to be reviewed by the independent Prisons and Probation Ombudsman.

The needs of those held in detention are safeguarded by a robust statutory and policy framework for operating the detention estate. This includes: The Detention Centre Rules 2001; the Short-term Holding Facility Rules 2018; published operating standards for IRCs, escorting and pre-departure accommodation; and published detention services orders providing detailed operational guidance to detention and escorting service providers. In addition, the Home Office operates established

whistleblowing procedures. In July 2020, a Whistleblowing Detention Services Order was published, providing guidance to all staff working in the detention and escorting estate on the reporting of wrongdoing. All issues raised through whistleblowing are investigated and where appropriate, lessons learned recommendations are actioned and reported to the Cabinet Office.

All immigration detention facilities are subject to statutory independent scrutiny by HM Inspectorate of Prisons, which carries out a rolling programme of unannounced inspections against its published 'Expectations' framework and publishes the reports of its inspections. At a local level, Independent Monitoring Boards oversee the administration of IRCs, the state of their premises and the treatment of detainees. Board members, who are appointed from local communities, have unrestricted access to the facilities to which they are appointed and to the people detained there. They may raise any matter of concern with Home Office Ministers and publish an annual report of their findings.

d) Introduce independent processes, both when a decision to detain is made and during detention, for the identification of people who may face a particular risk of harm in detention.

There are well established safeguards in the immigration system to ensure that the decision to detain, and any ongoing detention considerations, are sufficiently scrutinised and give due regard to removability and vulnerability of each individual.

The Adults at Risk policy was placed on a statutory footing in the Immigration Act 2016. The policy increases the protections afforded to vulnerable people by strengthening the presumption against the detention of adults identified as at risk. Adults identified as at risk will be detained only when the evidence of the individual's vulnerability is outweighed by the immigration control factors in their particular case. The implementation of this policy has recently been thoroughly reviewed by the Independent Chief Inspector of Borders and Immigration.

The Detention Gatekeeper is a cross-departmental and independent function at the front end of the detention process, ensuring only suitable individuals enter the detention estate. Decisions to detain are made independently from referring teams or case owners and there is a clear focus on removability and vulnerability. Once a person is in detention, regular reviews are undertaken to ensure that their detention remains lawful, appropriate and proportionate. The Home Office has improved the approach to the review of detention with an updated 'Detention and Case Progression Review' form which brings further clarity to how a progression towards return is occurring.

Home Office Case Progression Panels provide additional assurance and challenge on the progress of cases of individuals in detention, reinforcing the consideration of removability, vulnerability and risk factors in decisions to maintain detention. Cases are reviewed when detention reaches three months and every three months thereafter, although detained cases can be referred to the panel at any time. Following the success of a recent pilot to introduce further independence into Case Progression Panels (CPP), the presence of permanent independent panel members is being formalised within the CPP process.

Home Office Detention Engagement Teams (DET) have also been introduced, in doing so, we have increased the number of Home Office staff within IRCs. DET operate, using face-to-face interaction to build relationships with those in detention, help to focus them towards return and provide an important on-site link between those in detention and their case working teams. Being based at the centres, engaging with those in detention and on-site healthcare providers and suppliers, DETs are better placed to ensure that vulnerability issues are identified and managed at the earliest opportunity.

All Immigration Removal Centres (IRCs) have dedicated health facilities run by doctors and nurses which are managed by the NHS or appropriate providers. Detained individuals arriving at IRCs are medically assessed by a nurse within two hours of their arrival and offered an appointment with a doctor within 24 hours. Individuals also have access to medical assistance whilst they are in an IRC. The Detention Service Order 08/2016 'Management of adults at risk in immigration detention' was published to ensure all staff, including healthcare staff, are aware of the additional responsibilities towards individuals identified as adults at risk and includes a range of mitigation and safeguarding actions, such as personalised and supported living care plans.

Rule 35 of the Detention Centre (DC) Rules 2001 requires doctors working in IRCs to report to the Home Office where they have concerns that an individual (i) is likely to be injuriously affected by continued detention or any conditions of detention or (ii) suspects of having suicidal intentions or (iii) may have been a victim of torture. All reports raised under DC Rule 35, or Short-Term Holding Facility Rule 32, are now considered by a single team within the Home Office which is independent from detained casework commands. The team does not manage any individual in detention, and it makes an independent decision based on the individual circumstances of the case in line with the Adults at Risk in Immigration Detention Policy. Following due consideration, a decision will be made and relayed to the individual, their appointed representative, the relevant IRC or STHF and the casework team as to whether or not continuing detention remains appropriate.

We have also restricted the circumstances in which pregnant women may be detained and placed a time limit on their detention – 72 hours, extendable to up to a week with Ministerial authority. Between January 2020 and September 2020, there were a total of 7 pregnant women that had been detained in the immigration removal estate.

We ended the routine detention of families with children in 2010, introducing the family returns process to deal with families with no right to be here, including a greater focus on voluntary return. Where it is necessary to enforce a family's departure and to do so via detention, this will be in specially designed accommodation and only for a normal maximum of 72 hours (extendable to up to a week with Ministerial authority). Key aspects of family returns process, including detention time limit, are enshrined in Immigration Act 2014.

Court Custody

104. The Subcommittee calls on the State Party to implement the recommendations of the reports of the NPM member (Lay Observers) and to ensure that:

a) the accurate and complete records, in particular of PERs, are maintained;

England and Wales

The new Prisoner Escort Custody Service (PECS) contract which commenced in August 2020 is introducing a digital solution to the PER (the DPER) which will ensure that transport for Detained Persons cannot be booked if there is insufficient information on the DPER. The DPER will automatically populate some information from existing databases and the system also includes mandatory fields which must be filled to allow completion. It is anticipated that the introduction of the new DPER will significantly improve completion rates for elements of the PER that are not completed consistently. PECS are continually working with all CJS partners to monitor and assure this process.

Northern Ireland

Prisoner Escorting and Court Custody Service (PECCS) are responsible for those held in the 17 court custody suites in Northern Ireland. PERs are completed on all persons placed in our care. These records are subsequently utilised to provide the necessary information to our reception staff within prisons and our partners should individuals be remanded or sentenced into our establishments. This information along with police custody information (PACE 15 & 16) assist PECCS staff to complete an individualised risk assessment on those held in court custody suites.

b) an individualized risk assessment is made for each person in court custody;

The new PECS contract specification introduced the requirement for suppliers to conduct a holistic risk assessment of each Detained Person at the point of arrival in custody at Courts which should be updated periodically as and when any further significant information becomes available. The individual risk assessment process considers suitability for cell sharing, risk of self-harm or suicide as well as use of restraints and searching that are proportionate and justified to the individual's assessment.

c) staff receive training to meet the individual needs of detainees, particularly children.

England and Wales

The PECS contract specification requires contractors to deliver specific training around the care and welfare of all custodies, with suppliers delivering modules in addition to the requirements to further enhance understanding. In relation to children and young people, both suppliers have a specifically trained cohort of staff who receive enhanced child/youth specific training with elements that are endorsed by external bodies to aid the delivery of the required care for this complex, vulnerable cohort whilst also assisting in the de-escalation of issues that could have otherwise presented themselves.

Northern Ireland

In Northern Ireland, PECCS staff are aware of their responsibilities in the transport/supervision and care of children being escorted and placed in the court setting. Staff have also received training in Adverse Childhood Experiences (ACE) to assist them in meeting the needs of children placed in our care.

Staff within PECCS have, in conjunction with our partners in the Juvenile Justice Centre (JJC), received training in Minimising and Managing Physical Restraint (MMPR). There is a Memorandum of Understanding (MOU) in place to ensure compliance.

Additional information

Recent developments relating to the treatment of persons deprived of their liberty

<u>England and Wales: Reforming the Mental Health Act</u>

The Government published its White Paper, Reforming the Mental Health Act on 13 January. At the same time, we launched a formal 14-week consultation, which will run until April 2021.

The White Paper contains a full response to the Independent Review of the Mental Health Act carried out in 2018 and considers each of the Review's recommendations in turn. The Government welcomed the Independent Review's final report and accepts the vast majority of these recommendations.

We will publish a response to this consultation this year and bring forward a new Mental Health Bill when parliamentary time allows.

The White Paper includes proposals to limit the scope to detain people with a learning disability or autistic people under the Act, so that neither autism nor a learning disability are grounds for detention in and of themselves.

We do not however propose to change the detention criteria for patients in contact with the criminal justice system. We want to ensure these patients can continue to be diverted away from prison, which is not able, or indeed intended, to cater for their needs.

When individuals with a learning disability, autism or both, are detained, Care and Treatment Reviews (CTRs) will be given statutory force.

The Mental Health Units (Use of Force) Act, also known as Seni's Law received Royal Assent in November 2018. The purpose of the Act is to increase the oversight, management and accountability of the use of force (restraint) in mental health units so that force is reduced to a minimum and only ever used as a last resort. Through the collection of accurate data it will allow issues around the disproportionality in the use of force to be identified and allow targeted action to tackle them.

The Act requires units to produce policies and information for patients, keep a record of how and when force (physical, mechanical, chemical and isolation) is used, and improved staff training in prevention, de-escalation and the safe use of force. It is essential that if things go wrong when force is used, it is properly investigated and learned from which is why the Act also sets out requirements for undertaking timely investigations, and the police use of body worn cameras if they are called to assist mental health staff in the use of force.

We are developing the timeline for publishing the statutory guidance and commencing the Act. We expect to consult on the statutory guidance in late Spring 2021.

<u>Northern Ireland: Bail and remand legislation for children</u>

Information available to the Department indicates that the number of children admitted to custody on remand is significantly higher than the number who subsequently receive a custodial sentence. Work is therefore underway to introduce a number of proposed changes to bail and remand legislation for children. These are planned for inclusion in the Justice (Miscellaneous Provisions) Bill, due to be introduced to the Northern Ireland Assembly in April 2021.

Proposals developed include legislative changes to introduce, amongst other things:

- a new test for bail for children to take account of their age, maturity, needs and best interests;
- unconditional bail as standard, with justifications needed for any conditions, which must be proportionate and relevant to the offences;
- a 'real prospect' test which prohibits remand of children unless there is a genuine prospect of them receiving a custodial disposal for the offence; and
- prohibition on remanding children to a Juvenile Justice Centre solely on the grounds of lack of alternative accommodation.

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/4

The Regulation and Quality Improvement Authority

HIP Medicines Management – MH/LD Acute Mental Health Wards inspection

Record of Inspection

Name of hospital/ward/department	
Name of inspector	
Date of inspection	
Person in charge	
Start and finish time of inspection	
Findings discussed with (name & title)	
Number of beds **Admin to complete**	**Occupancy**
Number of service users/representatives spoken with	**Number of staff spoken with**

Checklist - for inspector completion

Date/type of most recent medicines management inspection:	**Manager & Length in post:**
Incidents:	**Enforcement:**
Categories of Care:	

Information to be requested from Senior Team meeting	
Service level agreement – pharmacist hours	
Service level agreement – pharmacy technician hours	
Pharmacist clinical screen SOP	
POMH audits	
Medication Safety Committee – minutes of meetings	
High dose antipsychotic regional tool	

AREA FOR INSPECTION: Medicines Management

OUTCOME: Avoidable patient harm in relation to medicines management will be eliminated. (SAFE)

Pharmacist hours – actual **(including availability via email/telephone)**	
Pharmacy technician hours –actual **(including availability via email/telephone)**	
Ward Pharmacist ***Admission process:*** *Medical history, medicine reconciliation, request physical health checks/blood tests – highlighted on kardex?* ***During stay:*** *On-going review of kardex.* *Review combined antipsychotic medication daily dose for individual patients to ensure this falls within safe limits –highlighted on kardex?* *High dose antipsychotics – highlighted on kardex; monitor need/benefit; extra physical health monitoring including on-going ECGs, GASS (Glasgow Antipsychotic Side-effect Scale)* ***Home leave:*** *Clinical check and provision of medication and advice* ***Discharge:*** *Clinical check, contact GP, community pharmacist, family/patient counselling, written information*	

OOH arrangements ***Attendance at daily safety huddle/weekly MDT meetings*** *Consider medication changes, the use of when required (PRN) medicines (documented review of PRN after seven days) and additional information, such as blood tests, physical health checks and the use of high dose antipsychotics. MDT write up in clinical notes.* ***Attendance at Purposeful Inpatient Admission (PlpA) meetings/MDT meetings*** - shared decision making around care and treatment issues and risk assessment. - who attends? what is reviewed? ***(What is discussed at the daily meetings/weekly meetings? Who attends? Who is responsible for requesting physical health checks? What does good look like for this?)*** **Stock management** **Staff training** **Quality Improvement Projects** **Governance and audit** **Controlled drugs audit** **Medication Incidents** **Any SAI involving medicines**	

Pharmaceutical advice source (where there is no ward pharmacist)	
Discharge arrangements for medicines (where there is no ward pharmacist)	
OOH arrangements (where there is no ward pharmacist)	
Pharmacy technician hours *Role includes:* *stock management (ordering/disposal), expiry dates, staff training on medication ordering system*	
Where there is no pharmacy technician what are the systems for ordering/disposal of medicines.	

Governance and Audit
Provide details of any audits and quality improvement initiatives/audit schedule to provide ongoing assurance: *eg* omitted doses of medicines; standards of completion of administration records; the effectiveness and appropriateness of the administration of "when required" medicines, that are utilised to manage agitation as part of a de-escalation strategy.
Medication related incidents
How are medication related incidents identified, reported, investigated and learning shared? *Provide details of any changes to practice due to medication related incidents/SAIs*

COVID-19 Vaccine
What are the arrangements to check that patients have received their vaccine, the type and number of vaccines? Where is this recorded?

	Patient ID /Room /Bed
Patient Own Medicines	
Self-administration	
Covert administration	
Critical medicines	
Insulin	
Controlled drugs	
Clozapine	
Lithium	
Antipsychotic monitoring	
High dose antipsychotic *Highlighted on Kardex; Need/benefit; extra physical checks incl on-going ECGs; GASS adverse effect monitoring*	*Is there a standardised process? Is there a monitoring schedule in place?* *Is there pro-forma in medicines file/patient's file that will* capture all this information and be easily accessible and reviewed at ward rounds? *Paris notes – monitoring done and discussed at MDT meetings?* *Who is responsible for ensuring that blood checks are requested?* *How can you be sure that they are not missed?*

Critical medicines					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Staff know what critical medicines are.					
2. There is a list of critical medicines.					
3. Guidance on administration of critical medicines is available					
4. There is ready access to critical medicines where timeliness of administration is crucial.					

Controlled drugs					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
5. Controlled drugs are stored and administered safely (second signatory and second person at bedside for administration).	Observe Review Documentation				
6. Stock requisitions are accurately maintained.	Observe Review Documentation				
7. Controlled drug record book is maintained to the required standard.	Observe Review Documentation				
8. Ward records confirm that stock checks of controlled drugs are carried out at least once a day.	Observe Review Documentation				
9. Key control					

10. Quarterly audit					

Medicine Storage					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
11. All medicines are stored securely. Locked patient medication lockers, designated cupboards/trolley/fridges are not left unattended.	Observe				
12. All medicines are stored safely. Check systems in place to identify similar packaging and multiple strengths of the same medicine; systems for safe storage of medicines; who reviews safe storage, how is this addressed	Observe				
13. Medicines disposed of appropriately					
14. Medicine fridges appropriately maintained					
15. Resuscitation trolley Resuscitation Council UK guidance available and daily/weekly checks completed					

Medicine administration					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
16. Medication administration is safe and meets good practice guidance.	Observe				
17. Drug preparation areas are available, well lit, uncluttered and positioned appropriately to prevent unnecessary interruptions.	Observe				
18. IV medications are drawn up, checked and administered straightaway by two staff members who are both present at the bedside for administration. If there is more than one unlabelled syringe including flushes and it leaves the hand of the operator, it should be labelled.					
Medicine Records					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
19. Evidence of review of prescribed medicines by pharmacist on admission. *medicines reconciliation is performed within 24 hours by a pharmacist (as per NICE guidance)*					

20. Evidence of review of prescribed medicines by pharmacist during stay.					
21. All patients have their allergy/medicine sensitivity status documented.					
22. Patient weight is measured on admission and recorded on the kardex.					
23. VTE risk is recorded					

24. Antibiotic prescriptions included indications for use and treatment lengths were documented.					
25. Medication administered is recorded and in all cases where medicines have been delayed or omitted, the reason for the delay or omission has been documented.	Observe				
26. All instances of medicine changes and rationale for prescribing should be entered into the main clinical notes.					
27. There is evidence that patients are involved in decisions about their medicines e.g. decision making regarding new or as required medicines and receive the information they need to take their					

medicines safely and effectively.					

Insulin					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
28. When insulin is prescribed blood glucose levels are monitored at the correct frequency and before administration of insulin.	Review Documentation Kardex				
29. When outside the usual blood glucose range, appropriate action is taken.					

Clozapine (red list)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Clozapine policy/regional care pathway in place?					
Are there appropriate monitoring arrangements in place? *Registered with ZTAZ (PIN number)* *Initiation titration chart – start at 12.5mg* *Blood monitoring:* *(Weekly – weeks 0-18; fortnightly weeks 19 – 52; and 4 weekly weeks 52+)* *Missed doses –if restarting after interval of more than 48 hours, re-titrate 12.5 mg once or twice on first day (but may be feasible to increase more quickly than on initiation)— extreme caution if previous respiratory or cardiac arrest with initial dosing;* *72 hour break – revert to weekly bloods for six weeks* *28 day break – restart as new patient* *Alert: Infection, constipation*	.				
Arrangements for supply of clozapine					
Is there evidence that they are administered as prescribed?					
Recorded on NIECR					

Lithium (amber list/shared care)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Lithium policy/regional care pathway in place					
Prescribed by brand and form					
Are there appropriate monitoring arrangements in place? *Lithium levels: one week after starting treatment, one week after each dose change and weekly until levels are stable. Thereafter, every three months.* *Six monthly: TFT, eGFR, U+Es, calcium and weight* *Yearly: Full health check*					
Rationale for dosage changes recorded					
Lithium Therapy Record Book					
Is there evidence that Lithium is administered as prescribed?					

Rapid Tranquilisation (NG10)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Is rapid tranquilisation used?					
Is there a rapid tranquilisation policy? *Posters*					
Is there evidence that PRN medication is prescribed in the context of any regular prescriptions for the same medicine and that patient preferences are taken into account. *NB Maximum daily doses- lorazepam 4mg, haloperidol 20mg, promethazine 100mg, olanzapine 20mg*					
Are there records of administration?					
Is the rationale for use recorded for administration?					
Following IM administration: respiratory rate, oxygen saturation, pulse, blood pressure, temp and consciousness monitored every 15 mins for the first hour and then hourly until no further concerns.					
Staff debrief (MDT)					
Patient debrief					
Trust incident report form					

Management of distressed reactions/ PRN medicines	Comments
The care plan identifies the parameters for the administration of these medicines in the management of the distressed reactions.	
The personal medication record identifies: • the reason for the administration 1st line, 2nd line • time interval between administration of 1st line, 2nd line	
A record of the administration of any medicine for the management of distressed reactions is maintained. Staff record the symptoms of the distressed reaction and the effect of medication administered.	
There is multi-disciplinary involvement on the use of medication in the management of distressed reactions and full engagement with the patient and relatives where possible.	
The effectiveness and frequency of administration is regularly reviewed. If the medicine in administered regularly, systems should be in place to ensure this is reported to the prescriber and the reasons identified eg patterns of behaviour or triggers.	
All staff receive appropriate training and updates that includes: • an emphasis on preventative approaches, de-escalation and early intervention • a focus on physical intervention skills and skills in crisis management including alternatives to restraint and/or restrictive interventions • promoting attitudinal and cultural change among staff • implementation of recognised and evidence based models of care.	

Patient ID:	Medicine	Medicine	Medicine	Comment
Minimum interval between doses stated				
Maximum dosage in 24 hours stated				
Indication for each PRN medicine				
Total daily dose should not exceed the maximum dosage stated in BNF				
Rational for exceeding BNF dosage given				
Is 2nd PRN medicine from a different class of drug from 1st				

Is it clear when it should be given in relation to PRN 1				
Is 3rd PRN medicine from a different class of drug from 1st and 2nd				
Is it clear when it should be given in relation to PRN 1 and 2				

Patient ID:	**Medicine**	**Medicine**	**Medicine**	**Comment**
Minimum interval between doses stated				
Maximum dosage in 24 hours stated				
Indication for each PRN medicine				
Total daily dose should not exceed the maximum dosage stated in BNF				
Rational for exceeding BNF dosage given				
Is 2nd PRN medicine from a different class of drug from 1st				
Is it clear when it should be given in relation to PRN 1				
Is 3rd PRN medicine from a different class of drug from 1st and 2nd				
Is it clear when it should be given in relation to PRN 1 and 2				

RQIA ID: Inspection No:

Patient ID:	Medicine	Medicine	Medicine	Comment
Minimum interval between doses stated				
Maximum dosage in 24 hours stated				
Indication for each PRN medicine				
Total daily dose should not exceed the maximum dosage stated in BNF				
Rational for exceeding BNF dosage given				
Is 2nd PRN medicine from a different class of drug from 1st				
Is it clear when it should be given in relation to PRN 1				
Is 3rd PRN medicine from a different class of drug from 1st and 2nd				
Is it clear when it should be given in relation to PRN 1 and 2				

Patient ID:	Medicine	Medicine	Medicine	Comment
Minimum interval between doses stated				
Maximum dosage in 24 hours stated				
Indication for each PRN medicine				
Total daily dose should not exceed the maximum dosage stated in BNF				
Rational for exceeding BNF dosage given				
Is 2nd PRN medicine from a different class of drug from 1st				

Is it clear when it should be given in relation to PRN 1				
Is 3rd PRN medicine from a different class of drug from 1st and 2nd				
Is it clear when it should be given in relation to PRN 1 and 2				

Patient ID:	**Medicine**	**Medicine**	**Medicine**	**Comment**
Minimum interval between doses stated				
Maximum dosage in 24 hours stated				
Indication for each PRN medicine				
Total daily dose should not exceed the maximum dosage stated in BNF				
Rational for exceeding BNF dosage given				
Is 2nd PRN medicine from a different class of drug from 1st				
Is it clear when it should be given in relation to PRN 1				
Is 3rd PRN medicine from a different class of drug from 1st and 2nd				
Is it clear when it should be given in relation to PRN 1 and 2				

Summary for feedback/AFIs

Aide memoire:

Physical checks for MHLD

Letter from Prof Sir Michael McBride to Cl

Anti- psychotics

9781119442608.pdf

https://www.ncl-mon.nhs.uk/wp-content/uploads/Interface_prescribing/FS_Antipsychotic_Monitoring.pdf

"High-dose antipsychotic medication":

- the prescription of either a single antipsychotic medication at a dose above the recommended maximum, or
- two or more antipsychotic medications concurrently that, when expressed as a percentage of their respective maximum recommended doses and added together, result in a cumulative dose of more than 100%.

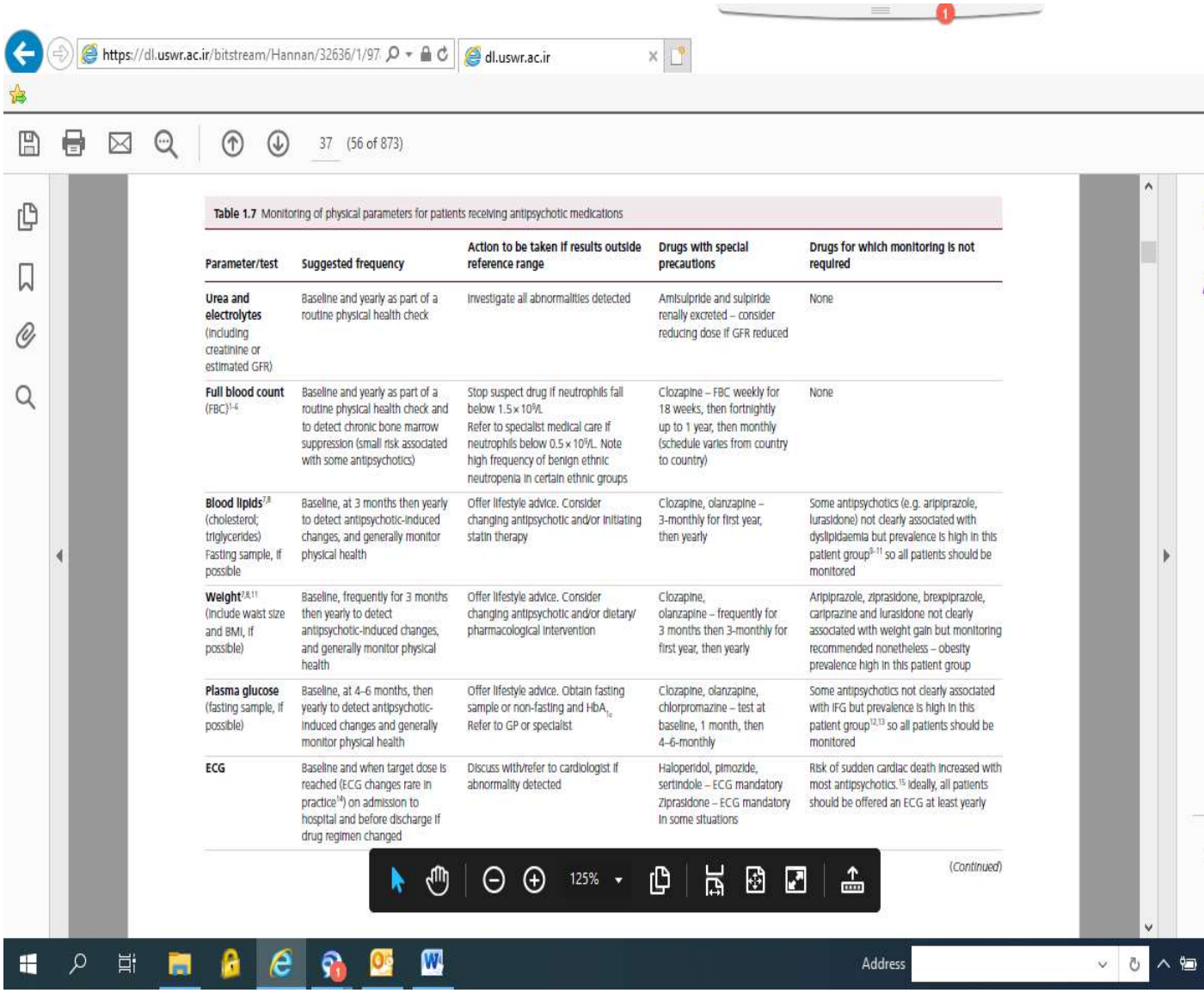
In clinical practice, antipsychotic polypharmacy and PRN anti-psychoic medication are strongly associated with high-dose prescribing.

(The Maudsley Prescribing Guidelines in Psychiatry)

Additional monitoring for high dose antipsychotic medication:

- Physical monitoring should be carried out as outlined in the section on Monitoring'- Table 17
- All patients on high doses should have regular ECGs (baseline, when steady-state serum levels have been reached after each dosage increment, and then every 6–12 months). Additional biochemical/ECG monitoring is advised if drugs that are known to cause electrolyte disturbances or QTc prolongation are subsequently co-prescribed.
- Target symptoms should be assessed after 6 weeks and 3 months. If insufficient improvement in these symptoms has occurred, the dose should be decreased to the normal range.

Monitoring Requirements: Table 1.7 Maudsley – see below



https://dl.uswr.ac.ir/bitstream/Hannan/32636/1/97 dl.uswr.ac.ir

37 (56 of 873)

Table 1.7 Monitoring of physical parameters for patients receiving antipsychotic medications

Parameter/test	Suggested frequency	Action to be taken if results outside reference range	Drugs with special precautions	Drugs for which monitoring is not required
Urea and electrolytes (including creatinine or estimated GFR)	Baseline and yearly as part of a routine physical health check	Investigate all abnormalities detected	Amisulpride and sulpiride renally excreted – consider reducing dose if GFR reduced	None
Full blood count (FBC)[1-6]	Baseline and yearly as part of a routine physical health check and to detect chronic bone marrow suppression (small risk associated with some antipsychotics)	Stop suspect drug if neutrophils fall below 1.5×10^9/L Refer to specialist medical care if neutrophils below 0.5×10^9/L. Note high frequency of benign ethnic neutropenia in certain ethnic groups	Clozapine – FBC weekly for 18 weeks, then fortnightly up to 1 year, then monthly (schedule varies from country to country)	None
Blood lipids[7,8] (cholesterol; triglycerides) Fasting sample, if possible	Baseline, at 3 months then yearly to detect antipsychotic-induced changes, and generally monitor physical health	Offer lifestyle advice. Consider changing antipsychotic and/or initiating statin therapy	Clozapine, olanzapine – 3-monthly for first year, then yearly	Some antipsychotics (e.g. aripiprazole, lurasidone) not clearly associated with dyslipidaemia but prevalence is high in this patient group[9-11] so all patients should be monitored
Weight[7,8,11] (include waist size and BMI, if possible)	Baseline, frequently for 3 months then yearly to detect antipsychotic-induced changes, and generally monitor physical health	Offer lifestyle advice. Consider changing antipsychotic and/or dietary/ pharmacological intervention	Clozapine, olanzapine – frequently for 3 months then 3-monthly for first year, then yearly	Aripiprazole, ziprasidone, brexpiprazole, cariprazine and lurasidone not clearly associated with weight gain but monitoring recommended nonetheless – obesity prevalence high in this patient group
Plasma glucose (fasting sample, if possible)	Baseline, at 4–6 months, then yearly to detect antipsychotic-induced changes and generally monitor physical health	Offer lifestyle advice. Obtain fasting sample or non-fasting and HbA_{1c} Refer to GP or specialist	Clozapine, olanzapine, chlorpromazine – test at baseline, 1 month, then 4–6-monthly	Some antipsychotics not clearly associated with IFG but prevalence is high in this patient group[12,13] so all patients should be monitored
ECG	Baseline and when target dose is reached (ECG changes rare in practice[14]) on admission to hospital and before discharge if drug regimen changed	Discuss with/refer to cardiologist if abnormality detected	Haloperidol, pimozide, sertindole – ECG mandatory Ziprasidone – ECG mandatory in some situations	Risk of sudden cardiac death increased with most antipsychotics.[15] Ideally, all patients should be offered an ECG at least yearly

(Continued)

125%

Address

https://dl.uswr.ac.ir/bitstream/Hannan/32636/1/97 dl.uswr.ac.ir
38 (57 of 873)

Table 1.7 *(Continued)*

Parameter/test	Suggested frequency	Action to be taken if results outside reference range	Drugs with special precautions	Drugs for which monitoring is not required
Blood pressure	Baseline; frequently during dose titration to detect antipsychotic-induced changes, and generally monitor physical health	If severe hypotension or hypertension (clozapine) observed, slow rate of titration. Consider switching to another antipsychotic if symptomatic postural hypotension. Treat hypertension in line with NICE guidelines	Clozapine, chlorpromazine and quetiapine most likely to be associated with postural hypotension	Amisulpride, aripiprazole, brexpiprazole, cariprazine, lurasidone, trifluoperazine, sulpiride
Prolactin	Baseline, then at 6 months, then yearly to detect antipsychotic-induced changes	Switch drugs if hyperprolactinaemia confirmed and symptomatic. Consider tests of bone mineral density (e.g. DEXA scanning) for those with chronically raised prolactin	Amisulpride, sulpiride, risperidone and paliperidone particularly associated with hyperprolactinaemia	Asenapine, aripiprazole, brexpiprazole, cariprazine, clozapine, lurasidone, quetiapine, olanzapine (<20 mg), ziprasidone usually do not elevate prolactin, but worth measuring if symptoms arise
Liver function tests (LFTs)[16–18]	Baseline, then yearly as part of a routine physical health check and to detect chronic antipsychotic-induced changes (rare)	Stop suspect drug if LFTs indicate hepatitis (transaminases × 3 normal) or functional damage (PT/albumin change)	Clozapine and chlorpromazine associated with hepatic failure	Amisulpride, sulpiride
Creatinine phosphokinase (CPK)	Baseline, then if NMS suspected	See section on 'Neuroleptic malignant syndrome' in this chapter	NMS more likely with first-generation antipsychotics	None

Other tests:
Patients on clozapine may benefit from an EEG[19,20] as this may help determine the need for anticonvulsant treatment (although interpretation is obviously complex). Those on quetiapine should have thyroid function tests yearly although the risk of abnormality is very small.[21,22]
Note: this table is a summary – see individual sections for detail and discussion.
BMI, body mass index; DEXA, dual-energy X-ray absorptiometry; ECG, electrocardiograph; EEG, electroencephalogram; GFR, glomerular filtration rate; IFG, impaired fasting glucose; NMS, neuroleptic malignant syndrome; PT, prothrombin time.

125%
Address

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/5

XXXX Hospital
Unannounced Inspection
XXXX (inspection dates)

Record of Inspection Findings

Name and ID of Hospital	XXXX
Name of Chief Executive	XXXX
Date and time of inspection	XXXX
Name of inspector(s)	XXXX
Name of Ward(s)	XXXX

_____ _____

Name of Inspector **Date**

Ward Details

Number of patients currently on the ward	
Number of patients detained	
Number of beds	
Number of patients on an ECR placement	
Number of patients on enhanced observations	
Number of staff on the ward today	
Male: Female Ratio	
Number of patients on leave	
Number of patients currently admitted to hospital	
Number of patients under seclusion	
Number of patients who are under 18 Diagnosed with a learning disability/ mental health disorder (delete as appropriate) With perinatal mental health Have an eating disorder	
Current MDT working arrangements	
Senior Staff Member On Site	

Ward Management Arrangements	
Is this a locked or open ward?	
Are there any patients with any physical healthcare needs?	
Are there any patients at risk of choking?	

Previous Areas for Improvement

<table>
<tr><td colspan="2">Quality Improvement Plan
Areas for improvement from the last inspection to XXXX Hospital /Ward
on XXXX previous inspection dates</td></tr>
<tr><td colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</td></tr>
<tr><td colspan="2">XXXX (Theme- take from previous report)</td></tr>
<tr><td rowspan="3">Area for improvement 1

Ref:

Stated:

To be completed by:</td><td>Area for improvement

Ref:</td></tr>
<tr><td>Response by the Trust detailing the actions taken:</td></tr>
<tr><td>Inspector’s validation:</td></tr>
<tr><td colspan="2">XXXX (Theme- take from previous report)</td></tr>
<tr><td>Area for improvement 2

Ref:

Stated:

To be completed by:</td><td>Area for improvement

Ref:</td></tr>
</table>

	Response by the Trust detailing the actions taken:
	Inspector's validation:
XXXX (Theme- take from previous report)	
Area for improvement 3 **Ref:** **Stated:** **To be completed by:**	**Area for improvement** **Ref:**
	Response by the Trust detailing the actions taken:
	Inspector's validation:

XXXX (Theme- take from previous report)	
Area for improvement 4 **Ref:** **Stated:** **To be completed by:**	**Area for improvement** **Ref:**
	Response by the Trust detailing the actions taken:
	Inspector's validation:

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Environment

***"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings."* Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)**

Ward physical environment observational tool / checklist.

Guidance

This inspection tool has been designed to be used as a guide to gather evidence by carrying out a ward physical environment observation.
This evidence will feed into the overall information gathered to identify whether patients on the ward are begin treated with dignity and are receiving care that is safe effective and compassionate care. This document must be fully completed along with the Quality of Interaction Schedule (QUIS). All areas of the ward should be covered when completing the tool.

Standards and Good practice

This tool has been devised from the following standards and good practice guidance:

The Quality Standards for Health and Social Care; Supporting Good Governance And Best Practice In The HPSS; (March 2006)

Health Building Note 03-01 Adult acute mental health units; Department of Health (2013)
NICE Quality Standards for service user experience in adult mental health (December 2011)

Service framework for mental health and well-being DHSSPSNI (2011)

Environmental and Therapeutic Issues in Psychiatric Design: Toward Best Practices; Karlin B, E and Zeiss R, A; Psychiatry Online (2006)

Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)

Improving the patient experience Developing Supportive Design for People with Dementia
The King's Fund's Enhancing the Healing Environment Programme 2009-2012Dementia Care Environmental Standards.

Ward environment	Checklist	Yes ✓ No X	Comments *(should cover areas for improvement as well as positive comments)*
The ward has a method for greeting patients that reflects customer service values and patient centeredness	There is information about the purpose of the ward The vision for the ward is displayed. Does the ward have a mission statement? There is a ward information / welcome booklet and all the contents are up to date and relevant. There is information about the wards performance e.g. information in relation to releasing time to care, i.e. incidents, compliments, complaints etc. The ward has a mechanism for patient feedback on service development, patient experience; areas that patients say need improved. The outcomes from patient feedback is available for patients		
Enhanced observations are carried out with dignity	Are there any patients in receipt of enhanced observations? How many? Level of Obs. Enhanced observations are carried out with respect and dignity. Staff are considerate.		

The ward is clean, tidy, well maintained and clutter free. There is good lighting and ample natural daylight. The air quality is good, there is good ventilation and neutral odours	Are your first impressions conducive to the statement? Think about it in terms of what a patient or relative sees.		
Patient bays are single sex	Patients sleeping bays are single sex. There are appropriate routes for patients to use single sex bathrooms and toilet facilities.		
Patients can access quiet private areas	There are quiet private areas for patients		
A ligature risk assessment has been completed with an action plan	The ward has a ligature risk assessment and an action plan has been implemented. Also Check all beds are ligature free/check ward environment. Patients requiring a profiling bed have an individual risk assessment Check if where ligatures are identified that patients have an individualised risk assessment and management plan in place		
Patients can meet with their visitors in private and comfort	There are visitor facilities – these are comfortable with enough seating etc.		

Ward furnishings, interior design are clean well maintained and comfortable.	Furnishings are clean, maintained, comfortable, meet the needs of the patients (where appropriate meet the needs of elderly care, LD) There is enough seating for patients and staff.		
Patients have access to a telephone	Patients can access a telephone in private.		
Patients are informed of all staff who they will come into contact with	All staff wear name badges. There is information on display about staff - that includes nursing staff and MDT team. There is information on display about who is on duty that includes the ward doctor. There is information about patients named nurse and associate nurse or key worker There is information on which staff are allocated therapeutic 1:1 time with patients. Where appropriate this information is provided in a format for patient who require support with communication.		
There is clear signage on the ward for patients and visitors	There is signage to orientate patients and visitors		

	Signage is in a format that meets the needs of patients who require support with communication.		
Patients are informed of their rights	There is information available in relation to Human Rights, complaints, advocacy, Mental Health Order, MHRT, the right to access information held about patients Information is in a format that meets the patients who require support with communication		
The ward environment promotes patients dignity and privacy	Screens, curtains used for sleeping bay area's etc. are well maintained. Patients can lock their bedroom doors (and en suite if applicable) Patients can lock bathroom / toilet doors Staff can open these if required		
Patients have open access around the ward environment and can access an outside space	Patients can access their bedrooms, bathrooms and toilet facilities. Patients can access an outside space The outside space is well maintained. There are areas to sit. Check if the ward door is locked (a risk assessment / DOLS should be in place if		

	patients do not have access) There is information displayed in relation to DOLS which will inform patients and visitors why exit from the ward is controlled by staff		
Precautions are taken to prevent information being shared inappropriately	Staff telephone conversations are not over heard, computer screens cannot be viewed, patients details are not on white boards in view of the public (except patients names) Confidential records are stored appropriately		
The medical room and its contents are clean, maintained and accessible	The medical room is clean, organised and well maintained. Medications are stored appropriately. The resuscitation trolley has been checked in accordance with trust policy.		
Patients can alert staff when needed	Staff are present in the patients communal areas Is there a call / alert system for patients and staff i.e., is there a call system in bathrooms.		
Staff alert systems	All staff have an alarm. There are extra alarms available for visiting professionals. Alarms are serviced and maintained.		

Patients know what is happening in their day	There is information on activities (i.e. OT, psychology, nursing etc.) available every day – a ward schedule. Is this all in the one place and includes the activity and the member of the MDT who is facilitating the activity. There is a good range of appropriate activities that meet the patient's needs this includes what is available during the evenings and weekends There is information on the days of the ward rounds. There is information when the advocate visits the ward. There is information on the next patient forum meetings. Do patients have individual activity schedules (where appropriate)? Do patients have a copy? Staff record if any of the above has been cancelled the reason why and there is a mechanism for informing patients.		
Patients are clean, comfortable and suitably clothed to promote dignity (applicable on wards where there are patients who require support and assistance	Patients appear to have had their personal hygiene attended to. Patients' clothing appears clean and free from food stains.		

with personal care etc.) **This is does not apply to all wards**	Use your judgement here as this may not be appropriate in all settings		
Meals are appetising and appropriate to the needs of the patients **Patients can eat their meals in a clean comfortable dining area and have safe access to fluids during the day**	The hospital menu offers a good choice of meals. The menu meets dietary requirements of the patients i.e. culture, vegetarian, coeliac, gluten free etc. Have any patients raised any concerns about the food with you or previously with staff. How have these been managed – complaints, food users group etc. Patients are informed of meal times. Meal times are protected. There is fresh water available. Is there tea and coffee making facilities There is information on the menu for the day. The dining area is clean and comfortable. There is adequate space, seating i.e. not overcrowded.		

Patients with a learning disability or who have a cognitive impairment can orientate themselves around the ward	Patients are orientated to time and space – signage, time. The ward physical environment meets the needs of patients who have dementia and patients who require support with mobility.		
Patients can control their level of social contact	There are spaces where patients can retreat, including spaces where they can form social relationships. There are no areas that are prone to overcrowding. Day rooms are open and furniture is arranged that encourages staff interaction while allowing for personal autonomy.		
The seclusion room is designed in accordance with policy and procedure and good practice guidance **This does not apply to all wards**	Seclusion must only be delivered in a room designed expressly for that purpose. The seclusion room is designed to minimize the traumatic potential of seclusion interventions. Check the following There is facility for constant observation The room is away from other patients and other areas that are the site of frequent non-clinical interaction i.e. exits.		

	• The room must be large enough to accommodate up to six staff members • The seclusion room contains limited furnishings. • The seclusion room is designed to enable protection of the patient, and prevent harm to self and others by eliminating or avoiding any weak points, ligature points, corners, edges or other safety hazards. • All features of the seclusion room are durable, tamper- and impact-resistant, washable, and can withstand significant and repeated force. • Walls and floors are of seamless construction. • Walls are painted a calm, definitive colour • The seclusion room should have an unbreakable window allowing natural light into the space, and a view of a natural or outdoor setting. The window should be large enough and placed so that a patient may be able to see out of it while sitting on the floor, and cannot kick the window sill. It should be fitted with blinds that nursing staff can operate remotely.		

	• Lighting in the seclusion room is mounted securely, unbreakable, and operated on patient request via the nurses. • The door to the seclusion room is heavy, solid-core, and opens outward on a spring loaded mechanism stalled securely with attention to preventing self-harm. The door contains a glazed observation panel with a blind on the outside to be controlled by staff. • Door locks are operated from exterior, with a mechanism that is easy to operate, and set to unlock automatically if the fire alarm is triggered. • The seclusion room is fitted with sanitary facilities including a hospital-grade toilet and sink. • The seclusion room has adequate airflow and a healthy air temperature, and should be air-conditioned. • The seclusion room is fitted with appropriate safety mechanisms. including a staff-operated alarm system. • Patients have sight of a clock. • Patients and staff can communicate at all times		

Contingency beds	Have contingency beds been risk assessed		

Incidents and Adult Safeguarding

Aid Memoire:

- Any patients subject to Adult Safeguarding processes-check incident form completed and the Trust have followed regional policy
- Staff knowledge on adult safeguarding- this includes all staff. Staff should be able to reference protection plans
- ASG training for all staff is up to date
- Potential ASG have been screened in / out appropriately with rationale recorded and appropriate
- The Adult Safeguarding incident concerned has been investigated by IO with DAPO oversight. An interim protection plan is put in place.
- At ward level, ASG champion and lead- this should be advertised to everyone.
- Information on ASG in the ward ie a flowchart
- Out of hours contact details available
- ASG information displayed on the ward- data and processes
- Availability and accessibility of protection plans- should be in physical copy for agency staff to access
- Robust governance systems in place for oversight of incident management and ASG.

Incident Management:

- DATIX- scan and look at grading and the consistency of and level, any adult safeguarding within and what has been done if it was an adult safeguarding. Process should be evident to see escalation to ASG team, police mentioned and informed where appropriate.
- Themes and trends from DATIX- assessing each of the chosen incidents to determine if an APP1 should have been completed- this will show culture on the ward.
- ASG incidents need to be triangulated with patients' records. This should be reflected in the DATIX.
- Highest two levels to be escalated to senior management. Insignificant and medium do not get escalated to senior management- may view incidents that need to be escalated. If incidents are primarily green, it may be the case that trends are not being identified by staff or the cumulative effect.
- Joint Protocol Arrangements- have police been consulted?
- Are there debriefs after significant incidents ie staff assault, patient assault, rapid tranquilisation?
- Debrief with the patient involved- good practice which should be reflected in the report and patient records
- Trends and sharing of themes and analysis
- Has there been any Serious Adverse Incidents (SAI's), Significant Event Audits (SEA's) or Early Alerts (EA's) since the last inspection?
- Is there evidence that recommendations (if any) from SAI's or SEA's have been actioned/addressed?
- Has any risks been escalated to Corporate Risk Register?
- Have staff been trained (according to their band and role) in reporting, recording, grading and identifying trends of incidents?

Evidence:
Findings:

Further Actions:

Final Judgements:

Has an area for improvement been identified: Y / N

Staffing
"Staffing arrangements are in place that meets the assessed needs of patients. Staff have the skills, knowledge and experience to deliver effective care support and treatment"

Aid Memoire:

- Staffing levels are safe and meet the needs of the patients
- Staff have the skill and knowledge to support the patients in their care and meet their needs
- Defined nursing model that supports decisions on the basis of patient acuity
- Ask about ongoing recruitment and assuring continuity of care
- Staff escalation if short staffed- there should be a DATIX for short staffing
- Staff supervision, appraisals, training and support
- Ask the staff about morale and culture- will indicate if senior staff are involved
- Look at skill mix of staff particularly of wards that have mostly registrants
- Appropriate delegation of tasks- task allocation sheet could be useful to evidence - duties assigned.
- Ask about the induction of all staff

Evidence:

Findings:

Further Actions:

Final Judgements:
Has an area for improvement been identified: Y / N

Physical Health
Aid Memoire: • Have you any patients with health care needs on the ward and if so, what are they? • Are there any patients with risk of choking? • Are there clear path ways for staff to follow with head injuries? • Can staff recognise the deteriorating patient and know what to do when a patient's physical health deteriorates? Are there assessment tools in place to help staff identify deterioration • Is there a physical health care pathway in place? • Has the patient been seen within 6 hours of admission? • Has admission bloods been completed? • Is there an increase in falls and if so, is there a falls care pathway? • Do care plans reflect physical care needs? Are they patient centred, Specific, Measurable, Achievable, Realistic and completed within the agreed Timeframe (SMART)? • Is there evidence of health care screening carried eg breast, cervical, bowel, dentist, optician etc, if appropriate. • Has the ward completed Braden Scales, Must, Skin Bundles etc? • How many patients have skin care needs? • How many patients require assistance with physical care needs, dressing, feeding, and mobilisation? • Is there evidence of BMI monitoring, fluid balance, MEWS etc? • Has there been timely referrals to specialist practitioners eg SALT, TVN, ECG? • Are SALT requirements in place? Have they been appropriately assessed? How do staff ensure patients receive the appropriate modified diet? • Any audits of physical health needs? • Are staff trained in the recognition of sepsis? • How is pain assessed and managed for patients who have difficulty communicating? • Is there evidence of GP/MDT involvement? • Is there equipment readily available to support with emergencies • Has the Trust embedded the (1) Mealtimes Matter Framework which includes (2) Mealtimes Matter Assurance Questionnaire and Audit Tool (3) Guidance notes on the completion of the Assurance/Audit Tool (4) Safety Pause Posters and (5) Nil-By-Mouth and Food Allergy signs. • Has the Trust embedded 'A picture of Health? Bridging The Gap Between Physical and Mental Healthcare in Mental Health Hoospitals'?
Evidence:

Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Restrictive Practices

Patients are cared for in the least restrictive environment possible while ensuring appropriate levels of safety. Restrictive practices are always proportionate to level of risk presented by the patient. Restrictive practices must also be necessary, the least restrictive intervention, regularly reviewed, used for the shortest time possible and be the most therapeutic intervention.

Aid Memoire:

Ensure restrictions are not used because of short staff

Examples: MHO, seclusion, restraint, MAPA, increased level of observation, locked doors, bed rails, sensor mats, CCTV, lap belts, medication including rapid tranquillisation, restrictive clothing, restricting visiting.

- Establish what restrictive practices are being used.
- Are there any blanket restrictions and how are these managed – e.g locked doors, restricted items
- Are restrictions proportionate to level of risk?
- Review number of restrictive practices over a specific time period?
- Have restrictions been discussed and agreed with MDT prior to implementation and are they reviewed weekly as a minimum to keep patients safe?
- Has the patient been consulted with and / or their family where appropriate?
- Have other less restrictive interventions been considered and is this evidenced?
- Have staff received training in restrictive practices?
- Consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests.
- Are staff aware of the FREDA principles? (Fairness, Respect, Equality, Dignity and Autonomy)
- Is there evidence of ongoing review? Is timescale for review in care plan?
- Restrictions are used for least possible time and there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice.
- What is staff knowledge of restrictive practices?
- Are staff aware of local policies? What are they?
- Are staff aware of best practice in relation to restrictive practice?
- Are staff aware of human rights considerations?
- How do staff show consideration of human rights?
- Are any visiting restrictions in place?
- How often is PRN medication used?
- How often is Rapid Tranquillisation used?
- Is there analysis of PRN use and rapid tranquillisation?
- Is there clear guidance in medication kardex for Rapid Tranquilisation use?
- Do patients have appropriate care plans in place for restriction in place?

- If bed rails are used, have they been risk assessed?
- If seclusion is used are records maintained of observation and review?
- How often has MAPA been used?
- Are there records to evidence that body maps and medical reviews have taken place post MAPA intervention?
- Review MHO documentation?
- Is the MHO being used appropriately? Think Vol patients - can they leave freely / any restrictions in place to prevent a voluntary patient leaving?
- Deprivation of Liberty Safeguards – Mental Capacity Act
- Review and observe 1:1 observations.
- Do staff have time limited periods of 1:1 – rotation, breaks.
- Are staff observed to engage with patients during enhanced observations?
- Are patients denied personal items eg: mobile phones. Is there a rational for this?
- Has there been any safeguarding incidents relating to restrictive practices?
- Is the ward committed to reducing restrictive practices?
- Eg: analysis of incidents to evidence this.
- How are patients protected from discrimination in relation to protected characteristics under the Equality Act?

- Are staff aware of the new Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And regional operational procedure for the use of Seclusion Northern Ireland March 2023? Is there a copy on the ward?
- Has the Trust appointed an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion?
- Is there evidence that the Trust policies and practices embed the use of the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions which includes seclusion?
- Restrictive practices and seclusion must include The Three Steps to Positive Practice Framework include:

1. Consider and plan
2. Implement the safeguards
3. Review and reflect

- Are there restrictive practices in place? Are they appropriate? Have they been assessed, planned, implemented and reviewed as agreed?
- Have all staff been trained in relation to restrictive practice/seclusion and safety intervention approaches?

Standards

The following Standards are available on the ward, staff have access and are aware of same?

1. All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

2. All local policies and practices must embed use of the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions.
3. Effective and person-centred communication must be central to care and treatment planning.
4. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.
5. Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.
6. Roles and responsibilities are defined in terms of monitoring, reporting and governance.
7. Any use of seclusion as a last resort intervention must follow the regional operating procedures.

Seclusion

Is there a designated seclusion room? Is it fit for purpose? (refer to the appendix in the new regional policy) Is seclusion appropriate?

Is there a Trust policy on seclusion in accordance with the new regional policy/operating procedures and the Mental Health Order (MHO) NI 1986?

Do the records include the following?

1. Seclusion maintenance rerecord
2. Record of seclusion
3. Seclusion care plan
4. Seclusion observation record
5. Seclusion review record
6. Seclusion audit form
7. Seclusion flowcharts and quick reference charts

Has FREDA (Fairness, Respect, Equality, Dignity and Autonomy) been built into the Trust policy and procedures and staff approach.

Complete the below Deprivation of Liberty Tool

Evidence:

Findings:

Further Actions:
Final Judgements:

Has an area for improvement been identified: Y / N

Mental Capacity Act (Northern Ireland) 2016

Part 1: Deprivation of Liberty Safeguarding Tool

N/A to this current service: Sign: Date:

QUESTIONS	FINDINGS AND COMMENTS
General Do you have service users (aged 16 or over) under continuous control and supervision? and; who are not free to leave?	YES/NO
Do you have service users subject to DoLS since 1 October 2019	YES/NO
Environment Considerations **See Deprivation of Liberty Safeguards and Money and Valuables and Research Aide Memoire (1a)*	
Staff Training • All staff trained at level 2 • Staff with overseeing responsibility at level 3 • Staff undertaking formal assessments at Level 4a • Level 4b training good practice	
Knowledge Do all staff demonstrate general awareness and knowledge of what a deprivation of liberty is and how to ensure the appropriate safeguards are in place to comply with the new legislation?	YES/NO
Processes • Relevant processes and procedures in place. • Governance arrangements specific to DoLS	
Systems • Staff know where to access the MCA DoLS Code of Practice. • Systems for accessing, recording, sharing, retaining forms and information in place as required under the Act	

Evaluation

Mental Capacity Act (Northern Ireland) 2016

Part 2: Money and Valuables and Research Tool

QUESTIONS	FINDINGS AND COMMENTS
1. Is the managing authority managing* money and valuables for those lacking capacity and why? I.e. have other potential alternative arrangement been explored?	YES/NO *(if no then disregard all questions below)*
a) Is there evidence of best interest decision making and regard for personal preferences?	YES/NO
b) Is money in excess of £20K being held for any one patient and if so, is there a record of RQIA consent?	YES/NO *(if no refer to finance inspector for consideration)*
c) Are there processes, policies and procedures in place for the safe and secure management of patient's money and valuables?	YES/NO
d) Is there a record of a patient's property (where appropriate)?	YES/NO
e) Are there records for transactions relating to spending? (counter-signed)	YES/NO
Research Are there any service users involved in research who lack capacity?	YES/NO *(If yes refer to Money and Valuables and Research Code of Practice)*

Under the MCA, Money and Valuables may be managed on behalf of patients, who lack capacity, by managing authorities. Inspectors should enquire as to how Managing Authorities (HSC Trusts or Registered Providers) are managing service users' money or valuables in order to identify if there is a need to escalate issues to a finance inspector or seek additional assurances.

*Where reference is made to the "managing authority" please see the Mental Capacity Act (Northern Ireland) 2016 (page 172) or a copy of the definition is also saved within the "Deprivation of Liberty Safeguards and Money and Valuables and Research Aide Memoire".

What you should expect to see for all service users:

- Robust processes, procedures and records ensuring safe and secure handling (receiving, holding, and spending) of patients money and valuables
- A record of each service user's property (where appropriate) and valuables (on deposit with the service)
- Evidence of considered decision making about how money is being spent:

Particularly relevant for those lacking capacity:

- **Decisions made in line with; principle of equality of opportunity with those not lacking capacity, best interests, regard for personal preferences and protection from unwarranted losses (e.g. safe place to store valuables, adherence to policies and procedures, financial planning).**
- **More than £20K (money and valuables) should not be held unless consent is given by RQIA. If more than £20K is being held then a record of consent should be evident.**

Completed by **Date**

Patient Experience
Aid Memoire: • What is the lived experience of the patients like? • Observe mealtime experience, activity sessions and general observations of patients and interactions with staff. Are mealtimes well organised? • Are patients relaxed in staff company? • What is patients physical appearance like? • Do staff interact with patients with respect and maintain patients dignity? • Are staff friendly and show warmth and compassion in their interactions with patients? • Do staff respond to patients in timely way and do they give an explanation when they may be a delay in their response? • How staff speak about patients is there any labelling, demeaning, patronising or negative language used? • How do staff talk about patients they are caring for? • Do staff adjust communication to meet patients' needs? • Do staff support patients if required in a dignified manner? Ie: sitting with patients, assisting 1 person at a time. • Speak to patients: Ask about their experience of the ward and staff Are they happy with the way they are cared for? Do patients know how and who to raise concerns/complaints with? Have they raised any concerns? If so were they satisfied with outcome? • Are patients involved in planning and making decisions about their care and treatment? • Are patients given information about their rights? • How are patients assured that information about them is treated as confidentiality? • How do staff ensure privacy and dignity during examinations/procedures is assured • Do staff respond in a compassionate timely and appropriate manner when patients experience pain, discomfort and distress? • Do staff understand social, cultural, diversity issues and how are these managed? • Are interpretation services available? • Advocacy available, are patients aware of it. • Is advocacy independent? • Consent to treatment and refusal? How is this documented? • Can patients raise concerns / complaints and are these actioned appropriately

Evidence:
Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Governance
"The leadership, management and governance of the organisation assures the delivery of high quality and person centred care, supports learning and innovation and promotes an open and fair culture"

Aid Memoire:

Establish the current SMT membership and collective leadership team *(note any vacancies / deficits)*

What is the governance structure in place? *(I.e. is there a daily hospital huddle; safety briefings within each ward; weekly live governance meetings?) How is information captured, shared, escalated – is there an effective system in place that provides assurance regarding staffing across the site for example?*

What are the key safety metrics for the hospital / ward? (*i.e. seclusion episodes; incident analysis meetings; staffing levels; ASG Referrals and issues; Medication issues; Rapid tranquilisation; Complaints; Compliments; Physical interventions) – **Are these being fed through the relevant governance structures and used to inform improvements?***

Are the governance systems sensitive enough to collect information and data about all the pertinent issues, including untoward incidents, safeguarding incidents, pharmacy and estates/ finance issues?

What assurance systems are in place regarding patient's physical health care needs? *Daily, weekly, monthly checks at ward level, anti-psychotic medication monitoring,*

Do Ward sister / Charge Nurse meetings happen? How often?
Capacity and Capability Do leaders have the knowledge, experience and integrity they need to deliver high quality care?
Do leaders understand the challenges to quality and sustainability and can they identify the actions to address?
Can leaders prioritise what is needed to deliver and sustain high quality care?
Are leaders visibleand approachable?
Are leaders compassionate?
Is leadership consistent – approach, staff turnover, succession planning

Vision and strategy
Is there a clear and achievable vision?
Are the values of the organisation embraced by all staff and is quality and sustainability a number one priority?
Is there a clear strategy to achieve the vision and is this well-known and embedded amongst staff
Are the actions to achieve the strategy achievable and is there a good governance mechanism in place to monitor with timely review arrangements?.

Culture
Do staff feel supported, respected and valued by the organisation and its leaders?
Is the culture centred on the needs and experiences of patients using the service?
Do staff express positivity / feel proud to work in the organisation?
Are there good performance management systems in place and is there evidence of actions taken to address behaviours when appropriate

Is there openness, transparency and honesty at all levels – governance information is shared appropriately
Can staff raise concerns with the right people at the right time without fear of retribution?
Is there good staff development and learning opportunities – ward based learning, training, appraisals and career development
Is staff safety and wellbeing in focus?
Does the staff team work well together, are conflicts detected early and addressed appropriately?
There is an inclusive culture that ensures equality and respect among staff– (any evidence of discrimination / staff conflict is promptly addressed and actions to manage same and in evidence).
Is there a supportive staff culture - one of learning and not blame when something goes wrong?
Are there any indicators of a closed staff culture i.e:

- significant management changes over a short period;
- high use of non-permanent staff;
- poor response to complaints;
- limited/ no evidence of staff supervision arrangements;
- patients more likely to be at risk of harm / dependent upon staff

Accountability
Accountability structures are in place and all staff are knowledgeable about the structure and system of accountability
Governance systems and management teams function effectively and interact appropriately – learning is shared and there is evidence of a whole systems approach
Do staff demonstrate they understand the parameters of their roles and how / when to escalate?

Risk, ASG, incidents and concerns
Are there effective governance systems in place to identify record and manage risk? Are the recorded mitigating actions in place appropriate?
Are staff knowledgeable about ASG, and incident and risk management?
Is risk escalated to the right level? How?Are current staffing levels safe? Are current staff levels affecting overall hospital stability?

Are there programmes of clinical and internal audit, with outcomes identified and appropriate actions focused on improvement taken.
Are potential risks taken into account when planning service delivery – eg seasonal, staffing.

Information governance, data usage, and performance
Is information used to measure /drive improvement and not just offer assurance - What information is brought to the weekly assurance meeting and how is this contributing to decisions / actions? *(Review minutes of meetings and discuss with relevant staff)*
Is quality and sustainability sufficiently discussed at meetings at all levels.
Are there service performance measures in place that are reported, available and monitored?
Is there a system in place to ensure the data used to measure performance is accurate, valid and timely (up to date)? What action is taken when issues are identified?
Are there effective arrangements in place to ensure data or notifications are submitted to other stakeholders i.e. SPPG, when appropriate.

PPI
Are service users views gathered and used to improve services – think about how services ensure equality and respond appropriately to diversity
Are staff actively engaged in sharing their views on service delivery?

Is there evidence of positive and collaborative relationships with other stakeholders -- is a shared understanding of challenges / needs of the population
Is there transparency and openness with all stakeholders?
Are staff actively engaged to express their views and are these reflected within planning?
Is there a robust complaints system in place – outcomes used to drive improvement?

Quality Improvement
Is there evidence of a culture of learning, innovation and continuous improvement?
Have there been any QI initiatives? - how have they made a difference to service delivery?
Have QI initiatives been shared internally and externally?

Evidence:

Findings:

Further Actions:

Final Judgements:
Has an area for improvement been identified: Y / N

Patient Flow

Aid Memoire:

Good patient flow ensures that people are getting the right care, in the right place at the right time.

Patient's participation in their own care and treatment is important. They should be consulted and informed of plans regarding discharge from hospital. Family engagement should be evidenced.

Over occupancy can be an indicator of pressures in the system. RCoP recommends maximum occupancy of 85%

Over Occupancy-what is impact on patients and the care and treatment they receive? Are the environments conducive to wellness and recovery, are they safe, comfortable and risk assessed?

Patient Flow:

- Dashboards
- Check that a bed manager is in place and their role in relation to discharge- What system is in place? Is it robust enough?
- Total number of patients admitted / male female ratio (impact of) how is this managed, How are male / female interactions managed? Is there a risk assessment in place?
- Average length of stay / longest stay. How long each patient on ward, dates of admission is there good admission to discharge rate i.e. nice patient flow.
- Appropriate admission- under 18- ensure appropriate safeguards / Child Protection
- LD diagnosis & rationale for admission / appropriate safeguards
- Number of patients detained versus voluntary
- Number of patients who are in receipt of active treatment
- Number of patients whose discharge is delayed / rationale for delayed discharge
- How many patients are prescribed enhanced supervision / observations
- Number of patients waiting on admission from community – detained/voluntary?
- Escalation process for over occupancy / Early Alerts /impact to care and treatment

Over Occupancy

- Patients on ECR placements
- Number of patients waiting in ED for admission and length of wait
- Patients who are on home leave/ on a different site
- Patients in custody or under PSNI supervision
- Use of contingency beds? Where are they in the ward? Are they suitable/converted rooms, have they been risk assessed for ligature risks

Resettlement / Discharge Planning:

- Are patients involved in their own care and treatment? Do they know what the expected outcome of admission is?

- Do all patients have discharge plans?
- Where discharge plans have been drawn up how effective are these- look at 25%
  Are the outcomes of assessment and treatment clearly stated or understood so it will be clear when hospital intervention is complete and discharge can occur?
- Are there planned dates of discharge / resettlement recorded for each patient, are these realistic, achievable?
- Is there a discharge address? Provider/family member address?
- Evidence of MDT involvement in discharge planning / resettlement, and is this reflected in Discharge planning meetings?
- Evidence of family involvement in care and treatment reviews.
- Ask family if they know admission is temporary?
- Have barriers to discharge been identified and clearly recorded?
- Is the MDT aware of these?
- Review process - how are discharge plans reviewed? Look for evidence of good active discharge planning. Is there a team who supports discharge?
- Are plans comprehensive and in line with the patient's own needs?
- Is there a risk of institutionalisation?
- Is there an appropriate 'lead in' / transition period?
- How are patients able to engage in community activities?
- Are patients able to maintain skills for independence in community?
- Are patients able to develop their skills for self-care (with or without support)?
- Are staff supporting patients to maintain or develop skills for self-care / independence or living in the community? Consider patients who require staff support to meet their needs and patients with limited capacity.
- What is the relationship with commissioning managers? How often do they visit? Are they communicating regularly to plan discharges?
- Is there in reach and outreach work? Is information shared with other providers- in-reach and out-reach. Align someone on inspection to speak with in-reach staff. Get an overview of how this work is progressing, are staff participating, shadowing, or used on ward to carry out other duties?

Evidence:

Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Medicines Management
Aid Memoire: • Are prescribed medicines administered and /or supplied to people in line with best practice guidance? • Do patients receive specific advice about their medicines in line with current best practice? • How does the service make sure that patients receive their medicines as prescribed – is there evidence of an effective audit arrangement in place? • Are patients receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with best practice / NICE guidance • Do patients have their medicines regularly reviewed including the use of PRN? • What mechanisms are in place to ensure patients' behaviours are not controlled by excessive or inappropriate use of medicines, including use of rapid tranquillisation? • Are omissions / medicines errors appropriately responded to?
Evidence:
Findings:

Further Actions:
Final Judgements:

Has an area for improvement been identified: Y / N

Mental Health

Aid Memoire:

- Are patients having their anti-psychotic medication reviewed annually as a minimum?
- Is care and treatment holistic in nature and not just medically orientated?
- Is care and treatment evidenced based?
- Are there any patients receiving ECT? If so is there a care pathway in place?
- Are there any patients on Clozapine medication? How is this monitored? Is there a care pathway?
- Are there any patients on Lithium therapy? How is this monitored? Is there a care pathway?
- Are there any patients experiencing eating disorder type illnesses on the ward? Is there input from the regional eating disorder team?
- Are there any patients with perinatal concerns? Does the patient receive specialist input?
- Are there any patients with learning disability diagnosis.
- Are there any patients with risk of self-harm or carry out self-harming behaviour?
- Are there clear behaviour plans in place for those patients who have challenging behaviours? Are there behavioural support plans in place? Does the behavioural support team provide input at ward level?
- What is the referral pathway for psychology services? Does staff provide CBT and are there any staff trained in this area?
- Is there OT input on the ward? If so, do patients attend an OT based unit on the ward?
- Is there an opportunity for patients to avail of advocacy on the ward? Who provides this service?
- Is there CMHT involvement with the patient?
- Are there patient risk assessments in place using an evidence based risk assessment tool. Do risk management plans address the risk anda re they monitored and reviewed in a way this is appropraie to the risk identified? are they used to monitor and idenfiy improvement

Evidence:

Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Opportunities to share learning – peer review – complete each other's audits

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/6

The Regulation and Quality Improvement Authority

Guidance for the completion of Prescribed Forms (Forms 1–12) under the Mental Health (NI) Order 1986

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Contents

Definitions

Consultant Psychiatrist	A medical practitioner appointed to consultant grade, who specialises in the diagnosis and treatment of mental disorders
Part II Medical Practitioner	Consultant Psychiatrist appointed to the RQIA List of Part II Medical Practitioners for the purposes of Part II of The Mental Health (Northern Ireland) Order 1986
Part IV Medical Practitioner	Consultant Psychiatrist appointed to the RQIA List of Part IV Medical Practitioners for the purposes of Part IV of The Mental Health (Northern Ireland) Order 1986
Approved Social Worker	A Social Worker who has undertaken specific training to assume duties in accordance with The Mental Health (Northern Ireland) Order 1986
Responsible Medical Officer	The Consultant Psychiatrist (usually a Part II doctor) in charge of the patient's assessment or treatment

The Regulation and Quality Improvement Authority

Who We Are

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability team (MHLD) undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. These include:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

The MHLD team talks directly to patients about their experiences. This informs the wider programme of announced and unannounced inspections.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements. Inspection report can be viewed on our website at http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability.cfm

Monitoring of Detention and other Prescribed Forms by the Mental Health and Learning Disability Directorate

Detention is defined as the deprivation of liberty or the imprisonment or placement of a person who is detained under legislation in a public or private institutional setting, which they are not permitted to leave at will. The prescribed forms used in the processes of detention for assessment or treatment in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO) provide legal justification for staff who take actions under the MHO.

Errors or defects in an application for assessment, in the medical recommendation on which it is based, or in one of the medical reports, may mean that the authority for the detention of the person is open to legal challenge and could be found to be invalid.

RQIA is required at Article 86 (2) of the MHO to scrutinise all prescribed forms associated with detention processes, and advise Health and Social Care Trusts if there are any errors or omissions which may make the detention or guardianship process improper.

Standards and General Principles

This document provides guidance and clarity for those completing prescribed forms in terms of the information that must be recorded and the manner in which the forms should be completed.
Supporting guidance and clarity for those completing prescribed forms can be found in the following documents:

- The Mental Health (NI) Order, 1986
- The Mental Health (NI) Order, 1986, A Guide
- The Mental Health (NI) Order, 1986, Code of Practice
- The GAIN Guidelines (October 2011) on the use of the Mental Health (NI) Order, 1986.

The role of hospital staff in the receipt and scrutiny of documents is described at Sections 2.52 – 2.56 of the Code of Practice. The responsibility of the receiving medical and nursing staff in assuring the validity of the documentation is explicit.
The general principles that should be applied to ensure the validity of the documentation include:

- All parts must be completed legibly
- All parts must be completed fully
- Full names of patients and all practitioners involved - **NO** use of abbreviations or initials is permitted
- Full names and addresses of Trusts and Hospital – **NO** use of abbreviations is permitted
- Addresses must include postcodes
- Doctors status should be clearly indicated where required
- Forms must be signed, dated (and timed where required) within the timescales required in the MHO
- The information recorded must contain sufficient detail to ensure the legal validity for detention

Provisions for Amendments of Errors and Omissions

It is a requirement of the legislation that prescribed forms are forwarded to RQIA by the Trusts. It is important that completed prescribed forms are forwarded to RQIA once they have been completed. These forms should be received by RQIA no later than **four** days following completion.
Article 11 of the MHO allows some amendment of prescribed forms associated with applications, recommendations and reports by the person who signed the form, providing they are received within 14 days from the date of the patient's admission to hospital.

However, errors and/or omissions noted outside of the 14 day timescale cannot be rectified. Consequently, the entire application may become invalid, and the detention deemed improper. If the patient still requires to be detained in hospital, the process must start from the beginning.

Please note that RQIA cannot accept forms which are illegible, incomplete or include errors/omissions.

Form 1

Form 1
Mental Health
(Northern Ireland)
Order 1986
Article 4

APPLICATION BY NEAREST RELATIVE FOR ADMISSION FOR ASSESSMENT

(Before completing this form please read the notes overleaf)

(name and address of responsible authority) To

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

(Full name and address of applicant) I,

Make sure the applicant's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the applicant's address is written out in FULL including postcode.

hereby apply for the admission of

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

(Name of hospital) to

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

Delete (a) or (b)

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Order. I am the patient's

(state relationship)

i.e. father, mother, sister, brother, husband, wife, etc

(b) I have been authorised by a county court to exercise the functions under the Order of the patient's nearest relative. A copy of the court order is attached to this application.

(date) I last saw the patient on

This date should be the same as or within 48 hours prior to the date at the bottom of the form

This application is founded on and accompanied by a medical recommendation in the prescribed form.
If the medical practitioner did not know the patient before making his/her recommendation, please explain why you could not get a recommendation from a medical practitioner who did know the patient: -

An explanation should ONLY be given here if the GP who signed the Form 3 is NOT from the practice the patient is registered with. Any GP from within the practice is considered to be the 'patient's medical practitioner'.

MAKE SURE FORM IS SIGNED AND DATED!

Signed: _____ Date: _____

Notes

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. (i.e.) BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of the MHO.
Full name of applicant address of applicant	Make sure the applicant's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure that the applicants address is written out in **FULL** including postcode.
Full Name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including the postcode and is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
State Relationship	i.e. father, mother, sister, brother, husband , wife, etc.
Last saw the patient on (Date)	This date should be the same as or within 48 hours prior to the date at the bottom of the form.
Reason for lack of recommendation from a medical practitioner who knew the patient	An explanation should **ONLY** be given here if the GP who signed the Form 3 is **NOT** from the practice the patient is registered with. Any GP from within the practice is considered to the

	‘patient’s medical practitioner’, as is any GP working for an Out of Hours Service
Signed and Dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 2

APPLICATION BY AN APPROVED SOCIAL WORKER FOR ADMISSION FOR ASSESSMENT

FORM 2
Mental Health
(Northern Ireland)
Order 1986
Article 4

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

Full name of applicant
address of applicant

I

Make sure the Approved Social Worker's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's OFFICE address is written out in FULL including postcode.

hereby apply for the admission of

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

(Name of hospital)

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(Name of Trust)

I am the officer d

Make sure the FULL name of the Trust is given i.e. BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST depending on whichever Trust the ASW works for.

appointed to act as an approved social worker for the purposes of the Order.

The following section should be completed if nearest relative consulted

Delete either (a) or (b) AND either (c) or (d) as appropriate

(name and address) (a)

I have consulted:

who, to the best of my knowledge and be
meaning of the Order.

OR

(name and address) (b)

(I have consulted:

The ASW has a duty to ensure that the nearest relative is correct according to the notes on the rear of the Form 1 – Articles 32-36 of the Order.
If the nearest relative IS consulted the ASW should then fill in the details IN FULL in the box at (a), and strike out option (b).
If the nearest relative has NO OBJECTION to the application, the ASW should strike out the option at box (d).
If the nearest relative HAS an objection the ASW should strike out the option at (c) and complete the appropriate deletion at (d). The ASW should then complete the section at the top of the next page.

who I understand has been authorised by a county court to exercise the functions under the Order of the patient's nearest relative.

AND

(c) That the person has not notified me or the responsible Trust that he/she objects to this application being made.

OR

(d) That the person has notified
*_____me_____ that he/she objects to this application being made and
the responsible trust

*(Delete whichever does not apply)

Please turn over

(name and office address of approved social worker)

I have consulted:

IF REQUIRED - Make sure the Approved Social Worker's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's OFFICE address is written out in FULL including postcode.

(name of Trust)

an officer of: Make sure the FULL name of the Trust is given IF REQUIRED.

appointed to act as an approved social worker for the purposes of the Order.

The following section should be completed if nearest relative not consulted

Delete (i), (ii), or (iii) as appropriate

If the nearest relative HAS NOT BEEN CONSULTED the ASW should complete this section (and should have deleted options A to D on the previous page). Two of these three options should be stricken out.
If option three applies, then ASW should fill in the details of the nearest relative IN FULL.

(i) I have been unable to ascertain who is the meaning of the Order

OR

(ii) To the best of my knowledge and belief the meaning of the Order

OR

*(Delete the phrase which does not apply)

(iii) In my opinion it * is not reasonably practicable / would involve unreasonable delay

to consult

(name and address)

*(Delete the phrase which does not apply)

who is * the patient's nearest relative / authorised to exercise the functions of the patient's nearest relative before making this application.

The following section should be completed in all cases

(DATE):

I last saw this patient on:

This date should be the same as or within 48 hours prior to the date at the bottom of the form

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

The application is founded on and accompanied by a medical recommendation in the prescribed form.

If the medical practitioner did not know the patient before making his/her recommendation, please explain why you could not get a recommendation from a medical practitioner who did know the patient:-

An explanation should ONLY be given here if the GP who signed the Form 3 is NOT from the practice the patient is registered with. Any GP from within the practice is considered to be the 'patient's medical practitioner'.

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ **Dated** _____

Notes

Approved Social Workers completing Form 2 must ensure that the application for admission for assessment is supported by a fully completed medical recommendation (Form 3) clearly stating the evidence for the detention.

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO.
Full name of applicant address of applicant	Make sure the Approved Social Worker's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the Approved Social Worker's **OFFICE** address is written out in **FULL** including postcode.
Full Name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Name of Trust	Make sure the **FULL** name of the Trust is given i.e. BELFAST HEALTH AND SOCIAL CARE TRUST or SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST depending on whichever trust the ASW works for. No abbreviations will be accepted. Ensure postcode is included.

<table>
<tr><td>Name and address (a)</td><td rowspan="4">The ASW has a duty to ensure that the nearest relative is correct according to the notes on the rear of the Form 1 – Articles 32-36 of the Order.

If the nearest relative IS consulted the ASW should then fill in the details IN FULL in the box a t (a), and strike out option (b). If the nearest relative has NO OBJECTION to the application, the ASW should strike out the option at box (d).

If the nearest relative HAS an objection the ASW should strike out the option at (C) and complete the appropriate deletion at (d). The ASW should then complete the section at the top of the next page.</td></tr>
<tr><td>Name and address (b)</td></tr>
<tr><td>Name and address (c)</td></tr>
<tr><td>Name and address (d)</td></tr>
<tr><td>Name and office address of Approved Social Worker</td><td>IF REQUIRED – Make sure the Approved Social Worker’s FULL LEGAL name is used here. NO abbreviations or initials should be used.

Ensure the Approved Social Worker’s OFFICE address is written out in FULL <u>including</u> postcode.</td></tr>
<tr><td>Name of Trust</td><td>IF REQUIRED - Make sure the FULL name of the Trust is given.</td></tr>
<tr><td>If nearest relative has not been consulted</td><td>IF REQUIRED - If the Nearest relative HAS NOT BEEN CONSULTED the ASW should complete this section (and should have deleted options A to D on the previous page). Two of these three options should be stricken out. If option three applies, then ASW should fill in the details of the nearest relative IN FULL.</td></tr>
<tr><td>Last saw this patient on (Date)</td><td>This date should be the same as or within 48 hours prior to the date at the bottom of the form.</td></tr>
<tr><td>Medical Practitioners</td><td>IF REQUIRED - An explanation should ONLY be given here if the GP who signed the Form 3 is NOT from the practice the patient is registered with. Any GP from within the practice is considered to be the patient’s medical practitioner.</td></tr>
<tr><td>Signed and Dated</td><td>MAKE SURE THE FORM IS SIGNED AND DATED</td></tr>
</table>

Form 3

MEDICAL RECOMMENDATION FOR ADMISSION FOR ASSESSMENT

FORM 3
Mental Health
(Northern Ireland)
Order 1986
Articles 4 and 6

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name and professional address of Medical practitioner)

I

Make sure the GP's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure the GP's OFFICE address is written out in FULL including postcode.

a medical practitioner, recommend that

(Full name and address of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

be admitted to hospital for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(Date) I last examined this patient on:

This date should be the same as or within 48 hours prior to the date at the bottom of the form

*(Delete if not Applicable)

*I am the patient's medical practitioner.
OR
*I had previous acquaintance with the patient before I conducted that examination.

Any GP from within the practice at which the patient is registered is considered to be the 'patient's medical practitioner' and option 2 should be deleted.
If the GP has previous acquaintance with the patient but is NOT their GP then option 1 should be deleted.
If the GP is neither the patient's GP nor has previous acquaintance with the patient an explanation should be given on whichever of the Form 1 or Form 2 is completed following this Form's completion, and both of these options should be deleted.

I am of the opinion: -

a) that the patient is suffering from mental disorder of a nature or degree which warrants his/her detention in a hospital for assessment (or for assessment followed by the medial treatment);

AND

b) that failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

My opinion at (a) above is based on the following grounds: -

(Give a clinical description of the patient's mental condition).

Ensure that the GP has provided a clinical description of the patient's mental condition. i.e. there must be some form of LEGIBLE text written here.

My opinion at (b) above is based on the following evidence: -
(Have regard only to evidence-

(i) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself;

OR

Please turn over

(ii) that the patient's judgement is so affected that he/she is, or would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(iii) that the patient has behaved violently towards other persons;

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves).

Ensure that the GP has provided evidence of the patient's mental condition. i.e. there must be some form of LEGIBLE text written here.

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ Date _____

***A doctor on the staff of the hospital in which the patient is being detained MAY ONLY sign the Form 3 following a Form 5 if the 48 hour period allowed by the Form 5 has almost elapsed and EVERY ATTEMPT to contact a community GP has been made and evidence of same is recorded in the clinical notes and on the Form 2 or 1 as applicable.**

Notes

Information Required	Guidance
Name and address of responsible Authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO.
Full name and professional address of Medical practitioner	Make sure GP's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the GP's **OFFICE** address is written out in **FULL** including Postcode. If the GP is not the patient's GP but is undertaking the assessment as part of an out of hours service which the patient's GP is part of, the GP should record the address of the out of hours office.
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Last examined patient on (Date)	This date should be the same as or within 48 hours prior to the date at the bottom of the form.
Patient relationship (Delete if not applicable)	Any GP from within the practice at which the patient is registered is considered to be the patient's 'medical practitioner' and Option 2 should be deleted. If the GP has previous acquaintance with the patient but is NOT their GP then Option 1 should be deleted.

	If the GP is neither the patient's GP nor has previous acquaintance with the patient an explanation should be given on whichever of the Form 1 or Form 2 is completed following this form's completion, and both of these options should be deleted.
Stated reason for Opinion (a)	Ensure that the GP has provided a clinical description of the patient's mental health condition, i.e. there **must** be some form of **LEGIBLE** text written here. The clinical description must describe the patient's mental condition and the patient's symptoms, **not** merely a diagnostic classification Please refer to Section 23 of The Guide.
Stated reason for Opinion (b)	Ensure that the GP has provided evidence of the patient's mental condition to support the opinion that failure to detain the patient would create a substantial likelihood of serious physical harm to himself or others. There **must** be some form of **LEGIBLE** text written here. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 3, supporting the medical opinion that the patients should be detained in hospital for medical assessment. This form must include sufficient detail to support the legal grounds for a patient's detention in hospital.
Sign and Date	**MAKE SURE THE FORM IS SIGNED AND DATED.**
Note: A doctor on the staff of the hospital in which the patient is being detained may ONLY sign the Form 3 following a Form 5 if the 48 hour period allowed by the Form 5 has almost elapsed and EVERY attempt to contact a community GP has been made. Evidence of same must be recorded in the clinical notes and on the Form 2 or 1 as applicable	

Form 4

MEDICAL CERTIFICATE TO EXTEND TIME LIMIT FOR CONVEYING PATIENT TO HOSPITAL

FORM 4
Mental Health (Northern Ireland Order1986
Article 8(1)

An application for assessment in respect of

(full name and address of patient)

Make sure the patients FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcodes and is consistent with ALL other forms completed.

has been duly completed in accordance with part II of the Mental Health (Northern Ireland) Order 1986

(full name and professional address of medical practitioner)

I

Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including Postcode

am a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission

(state the number of days) I certify that it is necessary to extend to

the time limit for conveying the patient

(name of hospital) to

Insert name of hospital here

This extension is necessary due to the following exceptional circumstances:-
[State the exceptional circumstances which make the extension necessary.]

There must be some form of LEGIBLE text written here.

Signed _____ Date _____

MAKE SURE THE FORM IS SIGNED AND DATED

Notes

Information Required	Guidance
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Full name and professional address of medical practitioner	Make sure the RMO or other Part II doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure the GP's OFFICE address is written out in **FULL** including postcode
Name of hospital	Insert name of hospital.
State exceptional circumstances of extension	There **must** be some form of **LEGIBLE** text written here.
Sign and date	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 5

MEDICAL PRACTITIONER'S REPORT ON HOSPITAL IN-PATIENT NOT LIABLE TO BE DETAINED

FORM 5
Mental Health
(Northern Ireland)
Order 1986
Article 7 (2)

(Name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used.

A medical practitioner on the staff of

(Name of Hospital)

Insert Name of Hospital

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed

is an in-patient in this hospital but is not liable to be detained there under the Mental Health (Northern Ireland) Order 1986.

I hereby report for the purposes of Article 7 (2) of the Order that it appears to me that an application for assessment ought to be made in respect of this patient for the following reasons:

(Reasons should indicate why voluntary treatment is not or is no longer appropriate).

Make sure some form of LEGIBLE text is present to explain why voluntary treatment is no longer appropriate.

MAKE SURE FORM IS SIGNED AND DATED and TIME IS STATED!

Signed _____ **Date** _____

Time _____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name (doctor)	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used.
Name of hospital	Insert name of hospital
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Reasons why voluntary treatment is no longer appropriate	Make sure some form of **LEGIBLE** text is present to explain why voluntary treatment is no longer appropriate.
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED MUST BE STATED**

Form 6

NURSE'S RECORD IN RESPECT OF HOSPITAL IN-PATIENT NOT LIABLE TO BE DETAINED

Form 6
Mental Health (Northern Ireland) Order 1986
Article 7(3)

(Name and address of responsible authority)

To

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations will be accepted.

Ensure that the word 'Authority' is stated here – not 'Board' or 'Trust'

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

is receiving treatment for mental disorder as an in-patient in

(Name of hospital)

Insert name of hospital

, but is not liable to be detained there under the Mental Health (Northern Ireland) Order 1986.

It appears to me –

(a) that an application for assessment ought to be made in respect of this patient;

AND

(b) that it is not practicable to secure the immediate attendance of a medical practitioner for the purpose of furnishing a report under Article 7(2) of the Order.

(Full name of nurse)

I am

Make sure the nurse's FULL LEGAL name is used here. No abbreviations or initials should be used.

nurse registered -

*(a) in Part 3 (first level nurse trained in the nursing of persons suffering from mental illness)

*(b) in Part 4 (second level nurse trained in the nursing of persons suffering from mental illness (England and Wales))

*(c) in Part 5 (first level nurse trained in the nursing of persons suffering from learning disabilities)

*(d) in Part 6 (second level nurse trained in the nursing of persons suffering from learning disabilities (England and Wales))

*(e) in Part 7 (second level nurse (Scotland and Northern Ireland) who is assessed as competent in the nursing of persons suffering from mental illness or learning disabilities)

*(f) in Part 13 (nurse qualified following a course of preparation in mental health nursing)

*(g) in Part 14 (nurse qualified following a course of preparation in learning disabilities nursing)

of the professional register
*(delete if not applicable)

Signed: _____

Date: _____

Time: _____

Make sure the form is signed and dated, and time is stated.

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Full name (nurse)	Make sure the nurse's **FULL LEGAL** name is used here. No abbreviations or initials should be used.
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED MUST BE STATED**

Form 7

REPORT OF MEDICAL EXAMINATION IMMEDIATELY AFTER ADMISSION FOR ASSESSMENT

FORM 7
Mental Health
(Northern Ireland)
Order 1986
Article 9 (3)

(name and address of Responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(full name and professional address of first Medical practitioner)

I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(full name and address of patient) examined:

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

immediately after he/she was admitted to

(name of hospital)

Insert Name of Hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on

Whichever date is used here becomes the patient's 'DATE OF ADMISSION' throughout the whole period of the patient's detention. This date should carry through to ALL other forms in the same period of detention.

In my opinion this patient: -

*(Delete as appropriate)

Two of these 3 options should be deleted.
If option (ii) or (iii) is left undeleted the patient is VOLUNTARY and no other forms are required

***(i) should be detained in hospital for assessment in accordance with Part II of the Order.**

***(ii) should remain in hospital for assessment and he/she has agreed to do so on a voluntary basis.**

***(iii) does not require to remain in hospital.**

My opinion is based on the following grounds: -
(Give a clinical description of the patient's mental condition).

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

I did not give the medical recommendation on which the application for assessment in respect of the patient is founded.

*(Delete if not applicable)

*I am the patient's responsible medical officer.
OR
*I am a medical practitioner appointed for the purpos
Mental Health Commission.
OR
*I am the medical practitioner on the staff of

Two of these 3 options should be deleted.
A Consultant should use option 1 or 2 and delete other options.
Junior Medical Staff should use option 3 and delete options 1 & 2

(name of hospital)

Insert Name of Hospital

MAKE SURE FORM IS SIGNED AND DATED and TIME IS STATED! (Date should be same as above)

Signed _____ Date _____ Time _____

Notes

This form must be completed by the examining medical practitioner immediately after admission for assessment. The date this form is completed is classified as **Day 1.**

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name and professional address of first Medical Practitioner	Make sure the doctors **FULL LEGAL** name is used here. No abbreviation or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Full name and address of patient examined	Make sure patient's **FULL LEGAL** name is used here. No abbreviation or initials should be used. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed.
Name of hospital	Inset name of hospital
Date	Whichever date is used here becomes the patient's '**DATE OF ADMISSION'** throughout the whole period of the patients detention. This date should carry through to **ALL** other forms in the same period of detention.
Examination findings – (Delete as appropriate)	Two of these three options should be deleted. If option (ii) or (iii) is left undeleted the patient is **VOLUNTARY** and no other forms are required.

Clinical description of patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.
Doctor patient relationship – (Delete if applicable)	Two of these three options should be deleted. A Consultant should use option 1 or 2 and delete other options. Junior Medical Staff should use option 3 and delete options 1 and 2.
Name of hospital	Insert name of hospital – ensure text is **LEGIBLE**
Signed and dated, with time stated	**MAKE SURE THE FORM IS SIGNED AND DATED. THE TIME THAT THE FORM IS COMPLETED <u>MUST</u> BE STATED**

Form 8

EXTENSION OF ASSESSMENT PERIOD FROM 48 HOURS TO 7 DAYS – MEDICAL REPORT

Form 8
Mental Health (Northern Ireland) Order 1986
Article 9(6)

(name and address of responsible authority) To

Ensure that the word 'Authority' is stated here – not 'Board' or Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations will be accepted.

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

(name of hospital)

Insert name of hospital

for assessment in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on

MUST MATCH DATE STATED ON FORM 7

The medical practitioner who examined this patient immediately after he/she was so admitted to hospital was not the responsible medical officer or a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission.

(full name and professional address of medical practitioner) I,

Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including the Postcode

(date) examined this patient on

(time) at

This date must be within 48 hours of the time and date of Form 7 – counting the time of the Form 7 as Hour 1.

***(Delete if not applicable)** *I am the patient's responsible medical officer.

OR

*It is not practicable for this examination to be carried out by the responsible medical officer. I am a medical practitioner appointed for the purposes of Part II of the Order by the Commission.

***(Delete if not applicable)** In my opinion this patient –

*(I) should be detained in hospital for assessment for a further period.

*(ii) should remain in hospital for assessment and he/she has agreed to do so on a voluntary basis.

*(iii) does not require to remain in hospital.

Please turn over

This opinion is based on the following grounds:-

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Signed _____ Date _____

MAKE SURE FORM IS SIGNED AND DATED

Notes

This form should be completed by the Medical Practitioner within 48hours of admission if the examining doctor at admission was NOT the patient's RMO.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Date	**MUST MATCH DATE STATED ON FORM 7.**
Full name and professional address of Medical practitioner	Make sure the RMO or other Part II doctor's FULL Legal name is used here. No abbreviations or initials should be used. Ensure the address is written out in FULL including the Postcode.
Date – (Patient examined on)	This date must be within **48 hours** of the time and date of Form 7 – counting the time of the Form 7 as Hour 1.
Clinical description of patients mental health condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.

Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 9

MEDICAL REPORT TO EXTEND ASSESSMENT PERIOD FOR A FURTHER 7 DAYS

FORM 9
Mental Health
(Northern Ireland)
Order 1986
Article 9 (8)

(name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was admitted to

(name of hospital) Insert Name of Hospital

in accordance with Part II of the Mental Health (Northern Ireland) Order 1986

(date) on **MUST MATCH DATE STATED ON FORM 7**

(full name and professional address of Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(date) examined this patient on

This date must be within 7 days of the date of the Form 7 – counting the date of the Form 7 as day 1

***(Delete if not applicable)**

A Consultant should indicate whether he or she is the patient's RMO or not by deleting one o f these 2 options

***I am this patient's responsible medical officer.**

OR

***It is not practicable for this examination to be carried out by the responsible medical officer. I am a medical practitioner appointed for the purposes of Part II of the Order by the Mental Health Commission.**

In my opinion this patient should be detained in hospital for assessment for a further period.

This opinion is based on the following grounds: -

(Give a clinical description of the patient's mental condition).

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed _____ **Date** _____

Notes

This form should be completed by the RMO within the **Days 3 – 7** to extend the assessment period for a second period of 7 days. The second 7 day period of assessment **does not start** until **Day 8**.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of Medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the trust is not required here.
Date – (Patient examined on)	This date must be within **7 days** of the date in Form 7 – continuing the date of the Form 7 as Day 1.
Declaration of RMO status or not. – (delete if not applicable)	A consultant should indicate whether he or she is the patient's RMO or not by deleting one of these two options.
Clinical description of	Ensure **LEGIBLE** text is written here to provide a

patient mental condition	clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. This description must provide sufficient evidence to justify the detention.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 10

Form 10
Mental Health
(Northern Ireland)
Order 1986
Article 12

MEDICAL REPORT FOR DETENTION FOR TREATMENT

(name and address of responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital)

Insert Name of Hospital

(date) on

MUST MATCH DATE STATED ON FORM 7

(full name and professional address of medical practitioner)

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

a medical practitioner appointed for the purposes of Part II Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission, examined this patient

(date) on

This date must be within 14 days of the date of the Form 7 – counting the date of the Form 7 as day 1

In my opinion –

(a) this patient is suffering from

One of these options should be deleted UNLESS both apply

* (Delete if not applicable)

* mental illness
* severe mental impairment

of a nature or degree which warrants his/her detention in hospital for medical treatment:

AND

(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons

My opinion at (a) above is based on the following grounds:

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Please turn over

My opinion at (b) above is based on the following evidence:

(Have regard only to evidence-

(1) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself:

OR

(ii) that the patient's judgement is so affected that he/she would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(III) that the patient has behaved violently towards other persons:

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves:

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate).

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed_____ Date _____

Notes

The form must be completed within the second 7 day assessment period **Days 8** to **Day 14**.

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Insert name of hospital.
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviation or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here.
Date – (Patient examined on)	This date must be within **14 days** of the date of the Form 7, in the second seven day assessment period i.e. Days 8-14 – counting the date of the Form 7 as Day 1.
Opinion of medical practitioner – (delete if not appropriate)	One of these options should be deleted – **UNLESS** both apply.
Description of	Ensure **LEGIBLE** text is written here to provide a

Opinion stated in (a) – clinical description of patients mental condition	clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms. Please refer to Section 46 of The Guide.
Opinion stated in (b) - clinical description of patients mental conditions	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 10, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital. Please refer to Section 46 of The Guide.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 11

FORM 11
Mental Health
(Northern Ireland)
Order 1986
Article 13 (2) and (5)

REPORT BY RESPONSIBLE MEDICAL OFFICER FOR RENEWAL OF AUTHORITY FOR DETENTION FOR 6 MONTHS OR ONE YEAR

(name and address of responsible Authority)

Insert Name and Address of Health and Social Care Trust

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

(full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital)

Insert Name of Hospital

(date) on

MUST MATCH DATE STATED ON FORM 7

(full name and professional address of responsible medical officer

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

examined this patient

(date) on

The first Form 11 examination date must be within 1 month prior to the expiry date of the Form 10

Later Form 11 exam dates should be within 2 months of the expiry of the previous Form

I am this patient's responsible medical officer.

One of these options should be deleted UNLESS both apply

In my opinion –
(a) this patient is suffering from *mental illness / *severe mental impairment
of a nature or degree which warrants his/her detention in hospital for medical treatment:
AND
(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

*(Delete if not applicable)

My opinion at (a) above is based on the following grounds: -

(Give a clinical description of the patient's mental condition)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Please turn over

My opinion at (b) above is based on the following evidence:

(Have regard only to evidence-

(1) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself/herself:

OR

(11) that the patient's judgement is so affected that he/she is, or would soon be unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community:

OR

(III) that the patient has behaved violently towards other persons:

OR

(IV) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves:

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate).

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED!

Signed_____ Date_____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of Hospital	Insert name of Hospital.
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of responsible medical officer	Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Date of patient examination	The first Form 11 examination date must be within **1 month** prior to the expiry date of the Form 10. Subsequent Form 11 examination dates should be within **two months** of the expiry of the previous form.
Opinion of medical practitioner – (delete if not applicable)	One of the options in (a) should be deleted unless both apply.
Opinion state in (a) – (Clinical description of the patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition.

	The clinical description must describe the patient's mental condition and the patient's symptoms.
Opinion stated in (b) – (Specifying the inappropriateness of other methods)	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 11, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital.
Signed and dated	**MAKE SURE THE FORM IS SIGNED AND DATED.**

Form 12

JOINT MEDICAL REPORT FOR FIRST RENEWAL OF AUTHORITY FOR DETENTION FOR ONE YEAR

FORM 12
Mental Health
(Northern Ireland)
Order 1986
Article 13 (3)

(name and address of Responsible Authority)

Make sure the word 'Authority' is here – not 'Board' or 'Trust'

Insert FULL LEGAL name and address of the Health and Social Care Trust here. No abbreviations !

(Full name of patient)

Make sure the patient's FULL LEGAL name is used here. No abbreviations or initials should be used. Ensure this name is consistent with ALL other forms completed.

was compulsorily admitted to

(name of hospital) **Insert Name of Hospital**

(date) on **MUST MATCH DATE STATED ON FORM 7**

(full name and professional address of first Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital he or she works in. The Name of the Trust is not required here.

(date) examined patient on

The examination date must be within 2 months prior to the expiry date of the first Form 11

I am a medical practitioner appointed for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission. I am not on the staff of the hospital in which the above named patient is detained and I have not given either the medical recommendation on which the application for assessment in relation to this patient was founded or any medical report in relation to this patient under Article 9 or 12 (1) of the order.

(full name and professional address of second Medical practitioner) I

Make sure the doctor's FULL LEGAL name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The Name of the Trust is not required here.

(date) examined this patient on

I am a medical practitioner appointed for the purposes of Part II of the Order by the Commission.

In our opinion-

One of these options should be deleted UNLESS both apply

***(Delete if not applicable)**

(a) this patient is suffering from *__mental illness__ *__severe mental impairment__

of a nature or degree which warrants his/her detention in hospital of medical treatment;

AND

(b) failure to so detain him/her would create a substantial likelihood of serious physical harm to himself/herself or to other persons.

Please Turn Over

Our opinion at (a) above is base on the following grounds: -

(Give a clinical description of the patient's mental condition.)

Ensure LEGIBLE text is written here to provide a clinical description of the patient's mental condition

Our opinion at (b) above is based on the following evidence: -

(Have regard only to evidence-

(i) that the patient has inflicted, or threatened or attempted to inflict serious physical harm on himself/herself;

OR

(ii) that the patient's judgement is so affected that he/she is, or would soon be, unable to protect himself/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community;

OR

(iii) that the patient has behaved violently towards other persons;

OR

(iv) that the patient has so behaved himself/herself that other persons were placed in reasonable fear of serious physical harm to themselves;

AND specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.)

Ensure LEGIBLE text is written here to provide evidence of the patient's mental condition

MAKE SURE FORM IS SIGNED AND DATED BY BOTH CONSULTANTS!

Signed _____ Date _____

Signed _____ Date _____

Notes

Information Required	Guidance
Name and address of responsible authority	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. For a definition of "Responsible Authority" see page 9 of MHO
Full name of patient	Make sure the patient's **FULL LEGAL** name is used here. No abbreviations or initials should be used. Ensure this name is consistent with **ALL** other forms completed.
Name of hospital	Inset name of hospital
Date	**MUST MATCH DATE STATED ON FORM 7**
Full name and professional address of **first** Medical Practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initial should be used. The doctor's address should be that of the hospital he or she works in. The name of the Trust is not required here.
Date – (patient examined on)	The examination date must be within **TWO MONTHS** prior to the expiry date of the **FIRST** Form 11.
Full name and professional address of **second** medical practitioner	Make sure the doctor's **FULL LEGAL** name is used here. No abbreviations or initials should be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. The name of the Trust is not required here.
Date – (patient examined on)	The examination date must be within **TWO MONTHS** prior to the expiry date of the **FIRST** Form 11.

Medical Opinion – (delete if not applicable)	One of these options should be deleted unless both apply
Clinical description of patients mental condition	Ensure **LEGIBLE** text is written here to provide a clinical description of the patient's mental condition. The clinical description must describe the patient's mental condition and the patient's symptoms.
Specifying the inappropriateness of other methods of dealing with patient	Ensure **LEGIBLE** text is written here to provide evidence of the patient's mental condition. The description of the patient's mental condition should include details of the patient's symptoms and behaviours relating to section i-iv noted on Form 12, supporting the medical opinion that the patient should be detained in hospital for treatment. Information as to whether other methods of treating the patient are available and why they are not appropriate must be included here. This form **must** include sufficient detail to support the legal grounds for a patient's detention in hospital.
Signed and dated	**MAKE SURE FORM IS SIGNED AND DATED BY BOTH CONSULTANTS.**

Contact information

Address:
Mental Health and Learning Disability Team
Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

E-mail: mhld.forms@rqia.org.uk

Telephone: 028 9051 7500 (Monday to Friday 10am – 4pm)

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/7

The Mental Health (Northern Ireland)

Order 1986 – List of Prescribed Forms

Form Number	Details	Mental Health Order 1986 Article
1	Application by nearest relative for admission for assessment	Article 4
2	Application by an approved social worker for admission for assessment	Article 4
3	Medical recommendation for admission for assessment	Articles 4 and 6
4	Medical certificate to extend time limit for conveying patient to hospital	Article 8 (1)
5	Medical practitioner's report on hospital in-patient not liable to be detained	Article 7 (2)
6	Nurse's record in respect of hospital in-patient not liable to be detained	Article 7 (3)
7	Report of medical examination immediately after admission for assessment	Article 9 (3)
8	Extension of assessment period from 48 hours to 7 days – medical report	Article 9 (6)
9	Medical report to extend assessment period for a further 7 days	Article 9 (8)
10	Medical report for detention for treatment	Article 12
11	Report by responsible medical officer for renewal of authority for detention for 6 months or one year	Article 13 (2) and (5)
12	Joint medical report for first renewal of authority for detention for one year	Article 13 (3)
13	Guardianship application by nearest relative	Article 18
14	Guardianship application by approved social worker	Article 18

15	Joint medical recommendation for reception into guardianship	Articles 18 and 20
16	Medical recommendation for reception into guardianship	Articles 18 and 20
17	Recommendation by an approved social worker for reception into guardianship	Article 18
18	Report by responsible medical officer for renewal of authority for guardianship	Article 23 (2) (a)
19	Report by an approved social worker for renewal of authority for guardianship	Article 23 (2) (b)
20	Assignment of functions by nearest relative	Article 35
21	Certificate of consent to treatment and second opinion	Article 63
22	Certificate of consent to treatment	Article 64 (3) (a)
23	Certificate of second opinion (Treatment requiring consent or second opinion)	Article 64 (3) (b)
24	Medical report on patient removed to Northern Ireland	Article 134 (1)

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/8

RQIA- MHO Form 10 (Detention for Treatment) Assurance checklist

Form 10 Demographics

Name of Patient-

HSC Trust and Hospital-

Signing Consultant- Date signed-

Form 10 Medical Recommendations

1. For Part A, has the doctor written a clinical description that defines the mental illness or severe mental impairment, and describes the nature (symptoms) or degree (severity) which warrants the patient's detention in hospital for Treatment?

   Yes ☒ No ☐

2. For Part B, has the doctor selected at least one of the options (i), (ii), (iii) or (iv)?

   Yes ☒ No ☐

3. Has the doctor provided evidence for all selected options?

   Yes ☒ No ☐

4. Has the doctor specified why other methods of dealing with the patient are either not available or not appropriate?

   Yes ☒ No ☐

5. ***Is all of the above information placed in the correct section of the Form? (i.e. Is Part B risk information written in Part B's section).***

   Yes ☒ No ☐

Assurance Criteria	Please Tick Applicable Category
Meets Criteria (Yes to all above Questions)	☒
Partially Meets Criteria **(No to Question 5 ONLY)**	☐
Does not Meet Criteria **(No to ANY of Questions 1-4)**	☐

If you believe the form "**Meets Criteria**" or "**Partially meets Criteria**", please sign below and then upload and check-in this Checklist alongside the Form 10 on iConnect.

Print Name: Donna O'Shea-Murie

Signed: Donna O'Shea-Murie **Date:**

Is the form completed on the new documentation following the DOH circular on 10/8/20:

Yes ☒ No ☐

If you believe the form "**Does not Meet Criteria**", please state the reason below and forward this Checklist (and a link to view the Form 10) to the RQIA Consultant Psychiatrist.

Print Name:

Signed: **Date:**

RQIA Consultant Psychiatrist- "Does not Meet Criteria"

- After review of the Form 10, do you believe that the evidence provided constitutes a valid detention for treatment period under the Mental Health (Northern Ireland) Order 1986?

  Yes ☐ No ☐

If **Yes**, please comment, sign and date below. Return checklist to MHLD Inspector/original reviewer.

Signed **Date**

If **No**, please comment, sign and date below and record that you have communicated this decision to the patient's treating consultant. Return checklist to MHLD inspector/original reviewer.

RQIA- MHO Form 10 (Detention for Treatment) Assurance checklist

RQIA Consultant Comment (outline content of conversation with patients treating consultant, name & date of Consultant you informed ,re the need to restart the detention * record if treating consultant is in agreement)

Signed | | **Date** | |

(RQIA Consultant Psychiatrist

Outline next steps for the patient following the patient's detention being invalid? (Has the patient been regraded to voluntary? Has a new period of detention commenced ?)

Please return this form to the MHLD Inspector.

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/9

Name of service Inspection ID Date of inspection

MAHI - STM - 185 - 262

Mental Capacity Act (Northern Ireland) 2016

Part 1: Deprivation of Liberty Aide Memoir

N/A to this current service: Sign: Date

QUESTIONS	FINDINGS AND COMMENTS
General Do you have service users (aged 16 or over) where a DOL has been authorised or an application has been made to Trust Panel Do you have any service users under continuous control and supervision? and; who are not free to leave? Do any of these Service users not have a DoL authorisation in place?	 YES/NO Yes/No Yes/No
Environment Considerations **See Deprivation of Liberty Safeguards and Money and Valuables and Research Aide Memoire (1a)*	 check
Staff Training • Are staff trained as part of their induction • Have staff trained to the appropriate level • Refer to Mandatory Training paper HERE • Are there staff who have not attended training • How will the service make sure they are all trained? Mandatary / trust provided? Frequency of training (every 3 years)	Comment:
Knowledge Do all staff demonstrate general awareness and knowledge of what a deprivation of liberty is and how to ensure the appropriate safeguards are in place to comply with the legislation?	YES/NO
Processes • Are relevant processes and procedures in place. • Is there a register of service users with a DoL? • For those with a DoL in place do the care plans contain information re DoLs? • Does the register of DoLS include the process for renewals • How is the service working with Trusts to make sure all service users will have authorisations where necessary from the Trust panels?	YES/NO

Systems • Staff know how to access statement of purpose/operational policy • Senior staff are able toaccess the code of practice • Systems for accessing, recording, sharing, retaining forms and information is in place as required under the MCA • Staff know who to contact in Trusts if they have issues to discuss under MCA	Comment:
Evaluation	

Mental Capacity Act (Northern Ireland) 2016

Part 2: <u>Money and Valuables and Research - Aide Memoir</u>

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/10

Summary of RQIA Inspections and

Patient Experience Reviews during the Relevant Period

Type	Ward	Date	Announced/Unannounced
Year: 2010			
PEI	Donegore	06/07/2010	-
PEI	Foybeg	06/07/2010	-
PEI	Killead	08 – 09/07/2010	-
PEI	Sixmile A	27/07/2010	-
PEI	Sixmile T	28 – 29/07/2010	-
PEI	Cranfield M	27/08/2010 – 01/09/2010	-
PEI	Cranfield ICU	01/09/2010	-
PEI	Cranfield F	01/09/2010	-
PEI	Oldstone	08/09/2010	-
PEI	Greenan	08/09/2010	-
Inspection	Sixmile A	16/10/2010	Announced
Inspection	Ennis	10 – 11/11/2010	Announced
Inspection	Greenan	18 – 19/11/2010	Announced
Inspection	Sixmile	16/11/2010	Announced
Inspection	Erne	30/11/2010 – 01/12/2010	Announced
Inspection	Cranfield F	13 – 14/12/2010	Announced
Year: 2011			
Inspection	Sixmile T	01 – 02/02/2011	Announced
Inspection	Cranfield M	15/02/2011 – 08.03.2011	Announced
Inspection	Donegore	12 – 13/04/2011	Announced
Inspection	Killead	19 – 20/05/2011	Announced

Inspection	Cranfield ICU	21/06/2011	Announced
Inspection	Rathmullan	23 – 24/06/2011	Announced
Inspection	Oldstone	23 – 24/06/2011	Announced
PEI	Cranfield M	15/08/2011	-
Inspection	Finglass	22 – 23/09/2011	Announced
PEI	Sixmile T, A	13/10/2011	-
Inspection	Moylena	14 – 15/11/2011	Announced
PEI	Killead	29/11/2011	-
PEI	Cranfield ICU	01/12/2011	-
Year: 2012			
Inspection	Finglass	04/01/2012	Unannounced
Inspection	Greenan	24 – 25/01/2012	Announced
Inspection	Donegore/ Erne	16/02/2012	Unannounced
Inspection	Erne	25/04/2012	Unannounced
Inspection	Moylena	18 – 19/06/2012	Announced
Inspection	Cranfield ICU	29/06/2012	Announced
Inspection	Finglass	25 - 26	Announced
Inspection	Sixmile	05/09/2012	Announced
Inspection	Ennis	13/11/2012	Unannounced
Inspection	Mallow	02/12/2012	Unannounced
Inspection	Ennis	20/12/2012	Unannounced
Year: 2013			
Inspection	Greenan	24 – 25/01/2013	Announced
Inspection	Ennis	29/01/2013	Unannounced
Inspection	Oldstone	13/03/2013	Announced
Inspection	Donegore	12 – 13/04/2013	Announced
Inspection	Cranfield F/ ICU	17/05/2013	Unannounced
Inspection	Ennis	29/05/2013	Unannounced

Inspection	Moylena	18 – 19/06/2012	Announced
Inspection	Finglass	25 – 26/06/2013	Announced
Inspection	Cranfield ICU	01/07/2012	Announced
Inspection	Cranfield F	09/07/2013	Announced
Inspection	Donegore	16/09/2013	Announced
PEI	Greenan	20/11/2013	-
Inspection	Cranfield M	18 – 19/11/2013	Announced
Year: 2014			
Inspection	Erne	20/01/2014	Unannounced
Inspection	Killead	21/01/2014	Announced
PEI	Greenan	06/05/2014	-
PEI	Donegore	06/05/2014	-
PEI	Sixmile	07 – 08/05/2014	-
PEI	Oldstone	07/05/2014	-
PEI	Moylena	20/05/2014	-
PEI	Cranfield ICU	03/06/2014	-
PEI	Cranfield M	03/06/2014	-
PEI	Erne	11/06/2014	-
PEI	Cranfield F	11/06/2014	-
PEI	Killead	25/06/2014	-
Inspection	Moylena	08 – 09/07/2014	Unannounced
Inspection	Cranfield ICU	25 – 26/09/2014	Announced
Inspection	Greenan	23 – 24/10/2014	Unannounced
Inspection	Donegore	18 – 19/11/2014	Announced
Inspection	Killead	24 – 25/11/2014	Unannounced
Inspection	Erne	09 – 10/12/2014	Unannounced
Year: 2015			
Inspection	Cranfield M	12 – 13/01/2015	Unannounced

Inspection	Sixmile	14 – 15/01/2015	Unannounced
Inspection	Cranfield F	02 – 03/02/2015	Unannounced
Inspection	Iveagh	02 – 03/03/2015	Unannounced
Inspection	Donegore	08/05/2015	Unannounced
Inspection	Cranfield ICU	13/05/2015	Unannounced
Inspection	Cranfield M	16/06/2015	Unannounced
Inspection	Moylena	20 – 21/05/2015	Unannounced
Inspection	Erne	23/06/2015	Unannounced
Inspection	Cranfield F	06/07/2015	Unannounced
Inspection	Sixmile	17/08/2015	Unannounced
Inspection	Moylena	18/10/2015	Unannounced
Inspection	Killead	24/04/2015	Unannounced
Inspection	Cranfield F	16 – 20/11/2015	Unannounced
Year: 2016			
Inspection	Donegore	28 – 30/06/2016	Unannounced
Inspection	Erne	19 – 21/07/2016	Unannounced
Inspection	Moylena	01/09/2016	Unannounced
Inspection	Killead	28/10/2016	Unannounced
Inspection	Cranfield M	28 – 30/11/2016	Unannounced
Inspection	Cranfield ICU	06 – 08/12/2016	Unannounced
Inspection	Erne 1, 2	21/12/2016	Unannounced
Year: 2017			
Inspection	Erne 1, 2	26/01/2017	Unannounced
Inspection	Sixmile	31/01/2017 – 02/02/2017	Unannounced
Inspection	Killead	14 – 15/02/2017	Unannounced
Inspection	Cranfield M	16 – 18/05/2017	Unannounced
Inspection	Cranfield M	13/07/2017	Unannounced

Inspection	Erne 2	04 – 05/09/2017	Unannounced
Inspection	Killead	02 – 04/10/2017	Unannounced
Inspection	Donegore	17 – 18/05/2017	Unannounced
Inspection	Erne 1	24/10/2017	Unannounced
Year: 2018			
Inspection	Cranfield	05/02/2018	Unannounced
Inspection	Sixmile	20 – 21/02/2018	Unannounced
Inspection	Cranfield M	07 – 08/03/2018	Unannounced
Inspection	Cranfield 1, 2, PICU	09 – 10/07/2018	Unannounced
Inspection	Cranfield 1	22/11/2018	Unannounced
Year 2019			
Inspection	MAH	26 – 28/02/2019	Unannounced
Inspection	MAH	15 – 16/04/2019	Unannounced
Inspection	MAH	01/07/2019	Unannounced
Inspection	MAH	10 – 12/12/2019	Unannounced
Year 2020			
Inspection	MAH	02 – 16/04/2020	Announced (Remote)
Inspection	MAH	27 – 28/10/2020	Unannounced
Year: 2021			
Inspection	MAH	28/07/2021 – 19/08/2021	Unannounced

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/11

RQIA Inspection Questionnaire - All

Inspection number

* 1. To fill in the short questionnaire, please enter the relevant inspection number in the box provided, and click 'next'

RQIA Inspection Questionnaire - All

Name of service/home

2. Name of the service you are completing this survey for?
By service; we mean the name of agency, clinic, home, hospital, hospice or practice

RQIA Inspection Questionnaire - All

Person completing

* 3. Are you a:

- ◯ Staff member
- ◯ Visiting professional
- ◯ Service user (by this we mean a patient, resident or client)
- ◯ Relative or visitor

RQIA Inspection Questionnaire - All

Staff

4. **Do you feel satisfied that service users are safe and protected from harm?**

By this we mean:
- Staff are employed in sufficient number to meet the needs of sevice users?
- Staff have been inducted and have received all mandatory training?
- Staff have received safeguarding training?
- All staff are aware of their responsibility to report any concerning or unsafe practice?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

5. **Do you feel satisfied that all service users are treated with compassion?**

By this we mean:
- All staff treat service users with kindness, dignity and respect?
- All staff engage with service users with warmth and consideration?
- Care/treatment is delivered in a person centred individual manner and not routinely?
- Staff communicate with service users about their care and treatment in a manner which is understood?
- There is a culture of reporting any concerning practice and confidence that these concerns will be dealt with?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

6. **Do you feel satisfied that care delivered to service users is effective?**

By this we mean:
- Do you believe that all service users have been assessed and their needs are being met?
- Are staff kept informed of changes to service users care/treatment plans?
- Are referrals/treatment to and from other agencies and professionals dealt with promptly? (if applicable)
- Does this service have good working relationships with other professionals/agencies? (if applicable)

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

* 7. **Do you feel that the service is managed and well led?**

By this we mean:
- There is a culture of staff empowerment and involvement in the running of the service?
- There is a culture of learning and upskilling?
- There is a culture of continuous quality improvement and all staff are encouraged to bring forward new ideas and innovations?
- Managers/leaders are approachable and open to whistleblowing or raising concerns?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

RQIA Inspection Questionnaire - All

Visiting professional

8. **Do you feel satisfied that service users are safe and protected from harm?**

By this we mean:
- There appears to be sufficient staff employed to meet the service users needs?
- The environment is always presented as safe and clean?
- There is a culture of openness and transparency and you are kept informed of any incidents that relate to service users under your care/treatment??
- Staff present as knowledgeable in safeguarding matters?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

9. **Do you feel satisfied that the care delivery in the service is effective?**

By this we mean:
- Staff are aware of service users care/tratment plans and carry out instructions contained within it?
- Staff alert you if there is a need to alter or review the service users care/treatment plan due to changes in circumstances?
- Staff inform you promptly if there are concerns relating to care/treatment plans i.e. missed appointments etc?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

10. **Do you feel satisfied that service users are treated with compassion?**

By this we mean:
- There is a culture of kindness, dignity and respect?
- Personal care needs are conducted in privacy?
- Service users are aware of their care/treatment and are encouraged to be involved in the decision making around their care?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

* 11. **Do you feel satisfied that the service is managed and well led?**

By this we mean:
- When necessary you are able to speak to the person in charge?
- The person in charge is approachable and will deal with any issues you might raise regarding the care of service users?
- Staff always present as competent in meeting the needs of service users?
- There is a relaxed atmosphere within the service no matter who is in charge?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

RQIA Inspection Questionnaire - All

Service user (by this we mean a patient, resident or client)

12. **Do you feel satisfied that the care you are provided with is safe?**

By this we mean:
- Do you feel safe and protected from harm?
- There is enough staff to help you?
- Can you talk to staff if you are unhappy?
- Do staff keep the environment clean and hygienic?
- Do you have any concerns about your medicines (if applicable)?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

13. **Do you feel satisfied that care delivered to you is effective?**

By this we mean:
- Do you get the right care, at the right time for you?
- Do staff come to you promptly when you need help?
- Do you have a say in what happens to you?
- Do staff have the right equipment to provide good care?
- The staff know your care/treatment needs?
- You are kept aware of your care/treatment plans?
- Your care meets your expectations?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied
◯ Very satisfied

14. **Do you feel satisfied that you are treated with compassion?**

By this we mean:
- Are you treated with dignity and respect and involved in decisions affecting your care?
- Can you make choices on a day to day basis about your care?
- Staff support and inform you about your care/treatment?
- Do you find staff are approachable and kind?
- Do you have privacy?
- Are there activities for you to join, if you want to? (if applicable)
- Do you have access to religious/spiritual support? (if applicable)
- Do you like the meals in the service? (if applicable)

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

* 15. **Do you feel that the service is managed and well led?**

By this we mean:
- Do you feel the service is managed well?
- Do you know who the manager is?
- You know who is managing your care/treatment?
- Your views are sought about your care/treatment and the quality of the service?
- You know how to make a complaint?
- Do you see the manager regularly? (if applicable)
- Is your opinion sought about day to day life in the service? (if applicable)

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

The Regulation and Quality Improvement Authority

RQIA Inspection Questionnaire - All

Realtive or visitor

16. **Do you feel satisfied that the care your relative is provided with is safe?**

By this we mean:

- Do you feel that your relative is safe and protected from harm?
- Are you satisfied that staff have enough time to care for your relative?
- Do you feel that you could talk to staff if something was wrong?
- Do staff keep the service clean and hygienic at all times?
- Do staff use personal protection equipment (PPE)?
- Do you have any concerns about how medicines are managed?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

17. **Do you feel satisfied that care delivered to your relative is effective?**

By this we mean:

- Does your relative get the right care, at the right time and with the best outcome for them?
- Do you feel that staff listen to you and are knowledgeable about meeting the needs of your relative?
- Are you kept up to date about the care and treatment of your relative?
- Are you satisfied that there are opportunities for you to be involved in planning your relative's care?
- Are you satisfied that staff take appropriate action if your relative's condition changes?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

18. **Do you feel satisfied that your relative is treated with compassion?**

By this we mean:

- Is your relative treated with dignity and respect and involved in decisions affecting their care?
- Are you made to feel welcome when you visit?
- Are you satisfied that staff treat your relative with dignity and respect?
- Do you and your relative have privacy?
- Are you satisfied that the care/treatment provided meets the individual needs and preferences of your relative?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

* 19. **Do you feel that the service is managed and well led?**

By this we mean

- Do you feel the service is managed well?
- Do you know who the manager is?
- Is the manager approachable?
- Is the manager available to you if you have a concern or complaint?
- Are there opportunities for you to give your opinions and suggestions for improvement in the service?

◯ Very dissatisfied ◯ Dissatisfied ◯ Neither satisfied nor dissatisfied ◯ Satisfied ◯ Very satisfied

RQIA Inspection Questionnaire - All

Comments Page

20. We would welcome any comments that you may have.

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/12

Identifying and responding to closed cultures

Supporting information for CQC staff

Published: October 2019 Valid until: April 2020

Contents

About this supporting information

This document includes advice on:

- Identifying services where there may be a high **inherent risk** of a closed culture that might lead to abuse or breaches of human rights.
- Identifying **warning signs** that there may be a closed or punitive culture, or risk of such a culture developing.
- How to **use existing regulatory policy, methods and processes** when there is a high inherent risk and/or warning signs.

1. Background

In May 2019, BBC *Panorama* exposed the culture of abuse and human rights breaches of people with a learning disability at Whorlton Hall. It reinforced how important it is for everyone involved in the care of people with a learning disability or autistic people to identify closed cultures, where abuse and human rights breaches may be taking place.

Providers have the primary responsibility for making sure that people receiving care are free from abuse and that they have their human rights upheld. As the regulator we monitor, inspect and regulate these services to ensure this is happening. In services where abuse and breaches of rights are deliberately concealed by managers or groups of staff there are additional challenges in identifying these.

Following the programme, we have commissioned two independent reviews into our regulation of Whorlton Hall. We have taken practical steps ahead of the findings of these reviews to improve our regulation and to ensure that all our hospital and social care inspectors have a consistent and shared understanding of the potential risk factors for abusive cultures, and can use this information to take action where necessary.

Policy context

Protecting people's basic human rights is at the heart of good care. Everyone involved in the care of people has a duty to act where there is a risk that a person's human rights are being breached. To prevent breaches of human rights, we would expect to see the following elements in place in a service:

- **Right model of care** (including pathway of care): people are receiving care in an appropriate place at the appropriate time. This includes models of care for specific services, such as the national service model for adult social care for people with a learning disability or autism and behaviour that challenges.
- **Right staff**: services have an appropriate number and mix of trained and skilled staff. There may be a higher risk of human rights abuses where:
    - a high proportion of staff do not have adequate training. This might include a higher use of agency staff who do not have the right skills and/or are not well supported. However, agency staff can sometimes feel more able to speak up when a service is providing poor care or the culture is poor.
    - there are recruitment challenges. For example the location or reputation may make it harder for services to maintain a staff team with the right mix of skills.

  It is important to note that abusive behaviour or human rights breaches can be carried out by permanent and/or trained staff. Ensuring that staff are trained or reducing usage of agency staff is not a solution on its own.
- **Right culture**: managers are responsible for building a culture that consistently respects human rights, which prevents abuse. This culture must be consistent from leadership through to frontline practice. This will be more challenging in some settings, but it is not impossible in any setting. A culture that respects human rights culture includes dignity, respect, zero tolerance of abuse, person-centred care and least restrictive practice. There is a large weight of evidence that a poor culture that contributes to the abuse of people using services is also more likely to be a poor

working environment for staff working in those services. Similarly, ensuring a good culture in a service, will have benefits for both people using services and for staff.

Where the culture of a service has led to abuse, this is a breach of Health and Social Care Act 2008 regulations.

Which services is this information relevant to?

This supporting information is particularly useful for regulating services for people with a learning disability or autistic people. However, the principles apply to all settings where people may be less able to self-advocate, or are less likely to have their communication needs supported or to be listened to and believed than others.

- **For CQC mental health teams:** this includes mental health wards for children and young people, mental health rehabilitation wards and wards for people with an acquired brain injury or dementia.
- **For adult social care services:** this could include services for people with dementia, mental health conditions or acquired brain injury.
- **For acute and community hospitals:** this could include wards for people with dementia or frail older people that are essentially closed environments at night time.
- **For other services:** this includes services where by nature they are more 'closed', for example healthcare services in criminal justice settings.

Why are we publishing this?

We are committed to improving our regulation of services where there is a risk of a closed, or punitive culture. This document builds on the discussion guides produced for inspection staff in July 2019. It brings together our current understanding of, and methodology for, inspecting these types of services and provides further detail to support their identification and regulation.[1]

We will be continuing to review and update this supporting information. If you would like to provide feedback, please contact closedcultures@cqc.org.uk.

[1] This supporting information is a learning resource for CQC inspectors. It provides information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics in order to assist inspection teams. It does not provide guidance to registered persons about complying with any of the regulations made pursuant to section 20 of the Health and Social Care Act 2008 nor does it include further indicators of assessment pursuant to section 46 of the Health and Social Care Act 2008.

2. Inherent risk factors

From our experience of regulating services, the likelihood that a service might develop a closed or punitive culture is higher if one or more of the inherent risk factors described in this section is present.

Experience of people receiving care

Inherent risk	Description
People who use the service are highly dependent on staff to meet their basic needs	This includes people with impaired or fluctuating capacity and/or limited ability to communicate their needs and wishes, or ability to communicate what they do not want to do, or to be done to them.
People stay in hospital for months or years rather than a shorter time	This includes, for example, wards for people with a learning disability or autism. Though this usual for adult social care services, risks in health services appear higher when people stay for longer.

Leadership and management

Inherent risk	Description
Weak or poor management of the service	Weak management can enable a culture to be set by individual staff with poor values or malign intent. It can also lead to different cultures on different shifts, for example day and night staff. Signs of risk include: • Significant changes in management over a short period of time, which may lead to less oversight. • High use of non-permanent staff at a team leader level, which may lead to less consistent role modelling in a team. • A failure to provide regular, good quality staff supervision that can have an impact on ensuring the service has a consistently good culture. • Poor response to complaints, for example from families. • **Adult social care services** that mainly employ family members in management roles. These may be prone to weak management as there can be less oversight or internal challenge.

Skills and experience of staff providing care

Inherent risk	Description
Characteristics of staff working in the service	• A high proportion of staff providing direct care that do not have enough or appropriate training. This includes, for example, understanding how to provide good support for people with a learning disability or autistic people. • Limited access to professional staff with the specialist skills to meet the specific needs of people, or little working connection between professional staff and those providing direct care. • High staff turnover, even if there is a small core of longstanding staff. • Staff suspensions or dismissals, changes in management or management absences (including of the registered manager). • High use of agency or bank staff. This may be a risk in terms of creating a consistent culture, or the level of training provided to staff. For example staff being given training on the specific communication needs of particular people using the service. • **In hospitals:** high ratios of healthcare assistants or non-registered roles with a failure to provide regular, high-quality supervision. • Staff working long hours with excessive amounts of overtime.
Feedback from staff working in services or ex-staff or people using the service, their family or friends or others who have visited the service	People sharing concerns with us such as: • an unhealthy culture within the staff team, for example, bullying, presence of cliques, disrespectful language about people using the service or about colleagues. • disrespectful treatment of people using the service. • staff spending much of their time in 'unproductive activities' rather than with people using the service, for example in the staff room. • people who 'speak up' are at risk of reprisals. • staff are encouraged to be other than totally honest when recording or reporting information about care. This includes, for example, by minimising the severity of incidents involving staff or people using the service or by presenting performance data in a manner that reduces the likelihood of external scrutiny by senior managers or outside agencies.

External oversight

Inherent risk	Description
There is a lack of meaningful external scrutiny	• The service is geographically isolated or staff in the service have little contact with other services so they are not exposed regularly to a wider, healthy culture. • People using the service are a long way from home. This may reduce how often family members or staff from their local area are able to visit them. • People using the service are isolated, rarely leaving the grounds of the service for example, to engage in meaningful activities within the local community. If they do, much engagement is with other similar services and the people in them. • Effective and independent advocacy services are non-existent. • Multiple bodies fund places, with no single commissioner taking the lead. • Commissioners do not carry out monitoring or review people's care annually or reviews are carried out remotely, by phone. • There is poor reporting of concerns, and little contact from local authority safeguarding teams.

3. Warning signs

Through our monitoring and inspection of services, we must be alert to the presence of warning signs that indicate a service might have or might be developing a closed or punitive culture.

Where warning signs are present, inspectors should follow the CQC Risk management framework, making enquiries or carrying out a responsive inspection as appropriate. Where the warning signs are caused by specific incidents, inspection staff should refer to the guidance on specific incidents.

The absence of warning signs on inspection, particularly in relation to staff behaviour, does not indicate that this type of behaviour never occurs. For example, the presence of a CQC inspection team is highly likely to change the behaviour of staff. This highlights the importance of using other intelligence, such as information from concerns raised about the service, or where abuse is being deliberately concealed. This section outlines the different types of warning signs, and what to look out for when monitoring or inspecting services.

Leadership and management

Warning sign	What to look out for	When?
Whether senior staff know what is actually happening	• Do the senior staff spend a substantial proportion of their working day interacting directly with people or are they dealing with 'management tasks'? • Is feedback from people who use services regularly gathered and used to improve the service? • Are members of the senior management team and other professionals a regular presence in the service? • **In hospitals:** are members of the senior multidisciplinary team (for example, doctors, occupational therapists, and clinical psychologists) a visible and daily presence on the ward? • **In hospitals:** are there limited or no examples of managers using information and data to monitor progress and improvement against outcomes. Is this used to identify where there may be potential changes in the quality of care?	Inspection
Willingness to acknowledge potential signs of poor culture or potential abuse	• Do managers and/or staff ignore or play down, or encourage others to ignore or play down, the significance of concerns (for example, the severity of incidents, allegations or complaints made by staff, people using the service, their family, friends or advocates)? • Do managers recognise the impact of violence on staff as well as people using the service, including the cumulative effect of violence on empathy and judgements, and what have they put in place to address this?	Inspection

	• How do managers respond to allegations of staff bullying either staff (as there is often a link between staff bullying and poor treatment of people using the service)?	

Experience of people receiving care

Warning sign	What to look out for	When?
A high proportion of people who are cared for in some form of isolation from other people using the service	• **In hospitals:** are patients subject to de-facto isolation, where there is a high staff-to-patient ratio? For example because there are many patients on 2:1 or 3:1 observation? ***Note:*** *In adult social care services, there is no mechanism for notifying use of isolation to us, but we may have other intelligence about this.*	Monitoring and inspection
Whether people using the service are comfortable with staff	• Do people using the service appear comfortable with staff or do they appear anxious? • What do people tell us about their relationships with staff? • What do we find from use of the Short Observational Framework for Inspection (SOFI)?[2]	Inspection
How people using the service behave towards one another	• Do staff tolerate abusive language by, or inappropriate physical contact between, people using the service?	Inspection
How staff behave towards people using the service	• Do staff tease, make fun of or play jokes on people who are under their care? • Do staff touch people in inappropriate ways – overly rough or too intimate? • Do staff ignore people using the service or prioritise 'routine' tasks over time spent interacting with them? • Do staff appear impatient or intolerant of people's behaviour, rather than seeking to understand the causes of the behaviour? • Do they sometimes use physical restraint when it is not absolutely necessary to protect the person or others? • Do they understand the impact they have on people's behaviour and how this can escalate it?	Inspection

[2] Note that we have further development work planned on assessing the experience of people using services who do not use verbal communication

	• Are medical interventions carried out in the least restrictive manner appropriate? For example, are people with epilepsy are only given rectal diazepam instead of Buccal Midazolam if there is a clear clinical reason? • Is the focus behaviour control or therapeutic interactions? • **In hospital settings:** is there low level of engagement with people using the service when under observation. For example, members of staff sitting outside the person's room for long periods of time observing them with no interaction with the person? • Are punitive measures taken? For example, in inpatient care are personal possessions confiscated or people put into hospital clothing, without a legitimate reason to do so, such as protecting people from harm? Is an assessment made about whether this is the least restrictive option?	

Skills and experience of staff providing care

Warning sign	What to look out for	When?
Whether the staff who provide the majority of direct care know what they are doing	• Do the staff know the people that they are working with on that shift well? • Do they know what is in the person's care plan/positive behaviour support plan, and exactly how to act when situations arise that are covered by the plans? • Have they had the training required to work with the group and particular individuals to undertake the tasks they have been given? For example, in autism, positive behaviour support, basic/intermediate life support). • Is there an emphasis on creating a communicative environment for people who use the service? For example, appropriate use of personalised communication aids?	Inspection
How staff talk about people with a learning disability or autistic people	• Do they use disrespectful language and talk as if people with a learning disability or autistic people are of less value than other people? • Do staff talk about people in terms of the problems they pose to staff; rather than as individuals? • Do written care records indicate that staff view people with respect and treat them as individuals (for example shift handover notes)?	Inspection

Whether staff have done all in their power to help/enable people to attend to their basic needs	• Are people using the service poorly dressed? • Are they wearing their own clothes? Is their personal hygiene poor? • Are there signs of poor physical healthcare (including poor dentition)? • Would you be willing to eat the food?	Inspection

Use of restrictions (including blanket restrictions)

Warning sign	What to look out for	When?
Imposed restrictions	Are there imposed restrictions in place? Are these reviewed to see if they are for a legitimate reason and the least restrictive option? I.e. are they a proportionate response to a risk, especially blanket restrictions. Examples include: • kitchen locked, other rooms locked and off limits so people have limited control over their living space. • Is access to equipment, such as books, activities, CDs, restricted for people using the service as it is locked away and staff have the key? • Are there restrictions on leaving the building that are not the least restrictive option? For example, leaving the building to smoke. • Are physical restrictions of individual people to prevent self-harm are not regularly reviewed? • Are people in segregation restricted to “finger food” or denied access to phone calls, music, the internet or other activities without assessment of whether this is proportionate response to risk? • Is application of the Mental Capacity Act poor? For example, failing to apply for a deprivation of liberty safeguards (DoLS) or not meeting the conditions within a DoLS.	Inspection

Use of restraint

Warning sign	What to look out for	When?
High, or increasing, recorded or reported use of restraint, seclusion or segregation	• **In hospitals:** as well as looking for an increase in notifications, is there is a complete absence of these notifications? Or is there evidence in the national data of potential under-reporting about the use of restrictive interventions? • **In adult social care services:** currently there is no mechanism for notifying these to us, unless the restraint triggers another notification such as serious injury, but we may have other intelligence about the level of restraint, seclusion or segregation.	Monitoring

Physical environment

Warning sign	What to look out for	When?
Whether the condition of the building shows that people using the service are respected.	• Is it dirty or in a poor state of repair? • Would you be prepared to live there? • But be aware that unhealthy cultures can also take place where the physical environment of the service is good. • Have people been allowed to personalise their own rooms?	Inspection
Physical factors	• What is layout of the service like? Does it have lots of small rooms or rooms leading off rooms, areas that could pose greater risk of abuse going unobserved?	Inspection

External oversight

Warning sign	What to look out for	When?
A high, or increasing, number of safeguarding incidents, complaints or other notifications[3]	This is especially of concern if the incidents, complaints or notifications are: • any form of inappropriate behaviour by staff towards people using the service. • injuries to people that cannot be fully explained, even when safeguarding investigations do not find any abuse. • an increase in incidents where people using the service are violent towards staff • involvement of the police. • complaints by people using the service, their family and friends, including those that are withdrawn subsequently. • complaints that family members, or others such as advocates, are being prevented from visiting or receive a hostile response from the service. • complaints that family members or visiting professionals are not enabled to see someone in private (unless there is a legitimate reason why this would be a risk and this is the least restrictive option to enable the person to receive a visitor). ***Note**: if notifications specifically refer to people previously having made "false allegations" then these people may be vulnerable to deliberate abuse, as perpetrators know that the complainant is less likely to be believed.*	Monitoring

[3] The caveats are that:

- low numbers, and particularly an absence of notifications and reported incidents, might indicate poor recording or failure to notify or submit data externally as required; this can be checked by operations colleagues through the available Insight tools
- services that have a healthy culture may have a low threshold for reporting and so be high reporters and vice versa,
- a step change in the patterns or frequency of reports could indicate a change in process, management and reporting culture.

4. Responding to closed cultures

The presence of one or more inherent risk factors is not proof that there is an abusive or punitive culture, but could be a sign that there is an increased chance of one developing. This section highlights potential areas of concern that inspectors need to consider when monitoring, planning an inspection, and inspecting services. These refer to all types of services unless otherwise indicated.

Monitoring

Area of concern	Action
Are people able to self-advocate?	Where people are in circumstances where they are not able to advocate for themselves, pay particular attention to how we can get evidence of people's experience of care and how their human rights are protected, regardless of whether there are other inherent risk factors or warning signs.
Is there a high inherent risk?	Pay particular attention to services where all or most people cannot communicate their basic needs.
	Look at the information that we have about management and leadership, staffing and external oversight to monitor the inherent risk of a closed culture developing in the service. This includes looking at staff turnover including leadership turnover.
	Consider current regulatory compliance and breach history.
	If you are unclear on the level of inherent risk for a service, use support from others through the escalation process in the risk management framework to help come to a decision. Inspection managers should offer support to inspectors to help make these decisions, as inherent risk may not be a clear-cut issue.
Are there any warning signs?	Be alert to the warning signs that the service is developing an abusive or punitive culture or is at risk of one developing. Focus particularly on the nature and volume of whistleblowing, complaints, safeguarding incidents and other notifications.
	Where you have concerns, handle these through our usual decision-making processes, including the risk management framework and our safeguarding guidance, especially the inspector's safeguarding handbook. Where there is a high inherent risk in a service and warning signs are developing, there should be a low threshold for deciding to carry out a responsive inspection.
	Prioritise gathering evidence that could provide additional information about the areas of concern. Consider whether there is a need to trigger the emerging concerns protocol, a strengthening and formalising of existing arrangements for sharing emerging concerns between regulators.

Inspection and Mental Health Act review visit planning

Area of concern	Action
Is there an inherent risk?	Carry out a desktop review of evidence about the culture. This includes a review of available Insight tools such as concerns raised with CQC by whistleblowers, safeguarding notifications and notifications of deaths. Look at the provider's response/actions taken and themes from the evidence. This review might flag both inherent risks and warning signs.
	Look at the previous three years' inspection reports (and the previous two Mental Health Act (MHA) monitoring reports for mental health services) to identify breaches and action points. Look at whether these have been met and if there are any recurrent themes.
	Speak with inspection colleagues who have visited the service, and for mental health inspection, recent MHA reviewers.
	Contact other professionals, commissioners and Healthwatch Enter and View. If possible, talk to commissioners, so that their views and any concerns can influence can influence our course of action and inspection planning, also other professionals who might visit the service more regularly.
	Adult social care for people with a learning disability or autistic people only: • A large number of people using adult social care services are highly dependent on staff to meet their basic needs, which is one factor in inherent risk. • **If, in addition, a service has a high inherent risk in relation to management, staffing or lack of external scrutiny then carry out a comprehensive inspection**. Do not use the 'return to good' methodology, regardless of whether any warning signs are present. This is a matter of judgement based on the factors in the section on inherent risk above.
	Mental health hospitals for people with a learning disability or autistic people: • Consider carrying out a focused inspection, focused MHA visit or increasing the frequency of MHA visits. • If a decision is made to carry out a focused inspection, plan the resource for the site visit to include Experts by Experience to talk to patients and family members, meeting access requirements of patients and whether the inspection team needs people with particular skills, such as a specialist advisor or inspector trained in SOFI methodology. • Talk to any relatives where we have contact details, so that their views, experiences and any concerns can influence our course of action and inspection planning.

Area of concern	Action
Are there warning signs?	Ensure that you have an up to date picture of any concerns raised by any staff or ex-staff in the service or others such as relatives, so that this can influence inspection planning. Where necessary and possible, contact people to ensure that you have the most recent information.
	Prioritise gathering evidence that could provide additional information about the areas of concern.
Focus of the inspection or MHA review?	Plan the inspection or review to focus on the culture of the service, how this impacts on the quality of care and experience of the people using/living in the service. Focus on whether human rights are being upheld and promoted. The Equality and human rights FAQ page on the intranet gives more information about human rights in our regulation. **This is the key point for planning MHA reviews**.
Resourcing for the inspection?	Consider the skills and competencies needed in your inspection team and whether you are the right person to lead the team. Agree the team with your inspection manager.
	Make gathering the experiences of people who use services a priority. Request an Expert by Experience join the team, either a person with a learning disability or an autistic person or a family carer. ***Note:*** *Depending on the urgency of the inspection or the availability of an Expert by Experience this may not always be possible, but a request should always be made*.
	Plan for the communication needs of people using the service, for example by booking interpreters.
	Adult social care services for people with a learning disability or autistic people only: Inspectors can request an additional team member if there are warning signs, even if it is a small service. For example, a second inspector could also be involved either on the same day or a different day if having two people in the service at the same time might not work well. If the warning signs have been uncovered during an inspection, then additional resource may be required for another inspection day which includes a second inspector.

On inspection

Area of focus	Action
Gathering the views of people who use services and their family	It is very important to have adequate time to speak informally with people using the service, so that they are at their ease, alongside time for general observations of the care given in the service. This might mean that more time is needed for the inspection. MHA review visits are also a valuable way of gathering general observations and more informal feedback from staff as well as patients.

Area of focus	Action
	All discussions with people should take place in private wherever possible. For example, staff should not be present when asking people using the service or their relatives and friends about their experiences. We have powers under the National Preventive Mechanism and Health and Social Care Act 2008 to do this, with the individuals' consent.
	Use the Expert by Experience to support talking to people using services and families on the day of the inspection wherever possible, as well as before and after the inspection. This ensures that any concerns from families can be followed through by gathering additional evidence on site.
	If there are known, specific concerns that might need corroboration or follow up by talking to families or people using the service, it might be more appropriate for the inspector carry out the interviews. If an Expert by Experience flags an issue of concern from an interview, then an inspector may need to do a follow-up interview.
	Ensure contact is made with any advocates working with people in the service, where these are known.
	Adult social care and mental health hospitals for people with a learning disability or autistic people only: • If there are blanket restrictions or restrictions in place for particular people, check compliance with human rights-related responsibilities. Questions to ask include: o Is the restriction for a legitimate aim? o Has the provider considered different options to meet that aim? o Is there evidence that the restriction in place is the least restrictive option? o Have decisions been made in line with requirements of Mental Capacity Act, if this applies? o Pay particular attention to any assessments or best interests decisions under the Mental Capacity Act, are staff observing principle 1 of the Act, to assume capacity? o Are the decisions regularly reviewed? • Review medication management, including how the service is reducing overmedication through STOMP aims and practice.
Staff	All staff interviews should take place in private. Under section 63 of the Health and Social Care Act 2008 we have powers to interview in private anyone working in the service. Interviewing support staff, such as domestic staff, housekeepers and porters, is also important as they have observed what is going on in a service day-to-day.
	Ask follow up questions, especially when staff give reasons for why people are restricted. For example, if a member of staff says "a person doesn't go out because they get anxious", a follow-up

Area of focus	Action
	question could be “what are you doing to support them to go out if they want to?”
	For mental health hospital inspections of services for people with a learning disability or autistic people: see appendix B for key themes to explore for different staff groups.
Observation	Case tracking should be used to see whether care plans are delivered in practice in frontline care delivery. Inspection teams should also check that the care plan is personalised and need to be alert to ‘copy and paste’ in plans. Care plans should include what gives the person joy or meaning in life and not be over focused on behaviour control. Inspection teams should choose who to case track, rather than asking the provider to select people. Prioritise case tracking of people who might be more vulnerable to human rights breaches. This includes: • anyone currently in long-term segregation • people a long way from home or without regular visitors • people who have been abused in other settings or have ‘allegation risk assessments’ in place • people who face significant barriers in giving feedback themselves, for example people who are non-verbal. (***Note:*** *In some services, this might be the majority of people using the service. In this case inspectors should use their judgement about who might be most vulnerable to human rights breaches.*) Case tracking should include speaking to or communicating with the person if possible and to their relatives or friends, advocates and commissioners either during or after the inspection visit.
	If anyone using the service is autistic, consider whether the service specifically considered reasonable adjustments and meeting the needs of individual autistic people, for example in relation to communication, sensory overload and reducing distress? Does the service meet the Accessible Information Standard? The National Autistic Taskforce (comprised entirely of autistic people) has produced an independent guide to the quality of care for autistic people which highlights many relevant issues. If the needs of autistic people are not met, there is a higher risk of a culture reliant on excessive restraint developing.
	Adult social care services for people with a learning disability or autistic people only: • Always use SOFI where this will work, including in case tracking. There may be services where SOFI is not the best observation method, for example if the service is provided to small numbers

Area of focus	Action
	of people in small rooms. In these situations, a similar time should be allowed for other ways of observing care.
	Mental health hospital services for people with a learning disability or autistic people only: • Consider using SOFI and general observations, including for case tracking. MHA review visits are also a valuable way of gathering general observations and more informal feedback from staff as well as patients.

5. After the inspection or MHA visit

- Following the inspection or MHA visit, if you have concerns about the safety of individuals using the service, report this using safeguarding procedures and consider taking urgent action (see responses section below).
- The inspection team needs time to reflect on evidence gathered, in an open and responsive way that allows the team to challenge each other about what was found. This could include someone from CQC, who is independent of the inspection, facilitating these discussions. Additional time may be needed, beyond the usual corroboration and management review meeting processes.
- Mental Health Act (MHA) reviewers visit services on their own. Reflective practice after a visit is therefore particularly important. If you are an MHA reviewer and the service has a particularly high inherent risk, or you have concerns after a visit, managers should support you to have a reflective practice discussion.
- Line managers need to check the wellbeing of all those associated with the inspection or MHA visit, if the inspection or visit has dealt with particularly difficult issues.

Responses to consider if concerns are identified on inspection

When we have identified closed cultures where there is a high risk of abuse, human rights breaches or poor care, the following should be considered:

- Is there is a need to raise a safeguarding alert?
- Where concerns are serious, do concerns need escalating within CQC management structures, in line with enforcement and risk management processes?
- Is a multi-agency strategy meeting is required? If so, discuss with the local authority and police. If there are concerns that there is a criminal element involved, this needs to be reported to the police as well as the local authority. Decide how quickly a multi-agency strategy meeting is required to ensure the welfare and safety of people.
- If not already triggered in monitoring, is there is a need to trigger the emerging concerns protocol?
- Do any issues need to be taken forward into ongoing engagement activity? For example, with commissioners or at a local area level, including providing briefings for other CQC staff who attend these meetings if necessary.
- Does any regulatory activity need to be taken at a provider-level? Further information can be found on the intranet about Reactive provider level well-led assessments. Criteria for reviewing concerns about a provider include, but are not limited to the following:
    - a significant number of the provider's locations were rated as 'inadequate' across the provider as a whole
    - on location inspections, risks were identified that appear to have stemmed from a failing in or an issue with, corporate policies, procedures, or governance arrangements

- whistleblowing concerns were raised, which were of a serious nature and suggested systemic failings at provider level
- there has been a lack of active engagement post location inspections from the provider.

If there are other issue(s) that suggest a reactive provider level well-led assessment may be required, contact the Policy and Strategy team to discuss.

6. Enforcement

When warning signs are identified, and evidence is found of breaches of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, consider whether enforcement action is required. This action may be civil, criminal or both. It could include taking urgent action under section 31 of the Health and Social Care Act 2008 to impose, vary or remove conditions or suspend registration if people are, or may be, at risk of harm. In some cases, it could include taking urgent action under section 30 to cancel a provider's registration if there is a serious risk to life, health or wellbeing.

Where urgent action needs to be considered, it is important to schedule a management review meeting including the Legal Services team as soon as possible.

Abuse does not need to have occurred for us to take enforcement action. A failure to have systems and processes in place giving rise to risks that might lead to abuse or human rights breaches could be a breach of regulation 17 – good governance (see appendix C). There may also be a breach of regulation 12 – safe care and treatment.

To meet the requirements of regulation 13 – safeguarding service users from abuse and improper treatment, providers must have a zero-tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint.

Enforcement subsequent to any regulatory breaches should follow our enforcement guidance, including our enforcement handbook, enforcement decision tree and enforcement policy. See appendix C.

If there have been regulatory breaches, we should not rely simply on asking the provider to give assurances about how they will address concerns, we should seek assurance by way of independent verification for ourselves. In relation to closed cultures, providers and managers may be part of the problem. Rather than relying on what they tell us, we need to be asking the provider to demonstrate change or improvement objectively, in a way that can be measured, or we should be assessing change or improvement in a different but independent way.

Potential breaches of human rights should be considered in enforcement decision making, in line with the enforcement decision tree. This includes breaches of specific rights such as

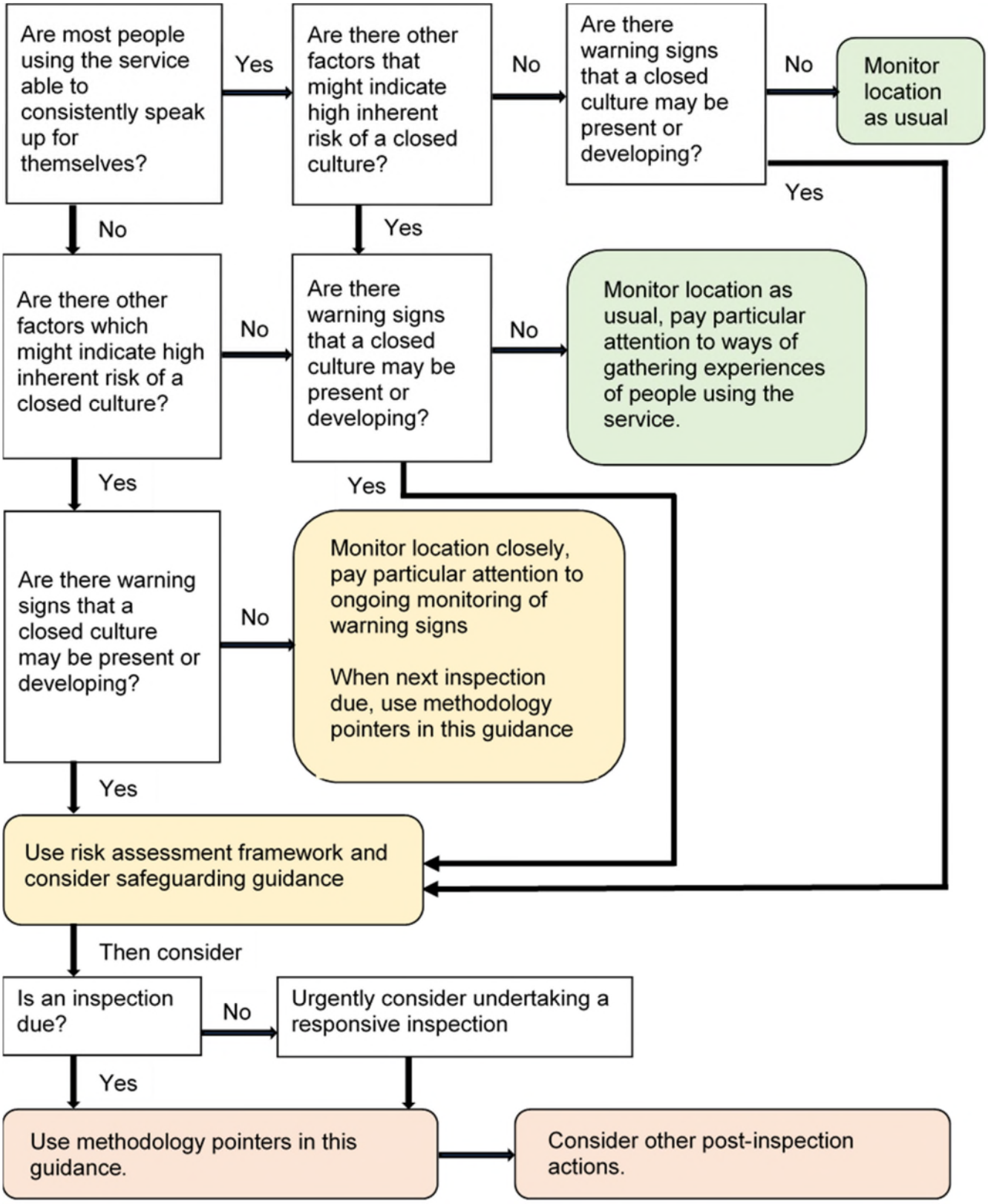
rights under the Mental Capacity Act or Mental Health Act. It also includes rights under the Human Rights Act such as:

- the right to be free from inhuman or degrading treatment (Article 3)
- the right to home, private life and correspondence. (Article 8) This is a wide-ranging right. Where people have restrictions placed on them without these being lawful, for a legitimate aim and the least restrictive way of meeting that aim, this may breach Article 8. These restrictions go beyond restraint and could include, for example, restricted access to visitors or other people, to food and drink, to their own possessions, to moving around within a service or to going outside. Any restrictions should be regularly reviewed to ensure that they meet these criteria.

Further guidance on the links between our regulations and human rights law is available the Equality and human rights FAQ page on the intranet.

7. Appendices

Appendix A: identifying and responding to closed cultures (summary)



Appendix B: additional prompts for mental health services

Prompt	Action
Desktop review in monitoring or pre-inspection	Consider the following intelligence: • safeguarding notifications – look for actions, provider response and themes. • whistleblowers – actions taken, provider response and themes. • involvement of police – links to safeguarding, whistleblowing. • deaths – actions, provider response including Mental Health Act (MHA) deaths notified through regulation 17 • previous two MHA monitoring reports and provider action statements • MHA complaints received for the service over last three years • Second Opinion Appointed Doctor Service (SOAD) – activity including notification of concerns from visiting SOADs • staff interviews on inspection – key themes to explore • talk to local advocacy provider service to identify any concerns • Look for any recent Local Healthwatch reports
On inspection or MHA visit	Follow up areas identified as themes or requiring follow up from pre-inspection or pre-MHA visit review. • If there are known, specific concerns that might need corroboration or follow up by talking to patients or families, it might be more appropriate for the inspector or MHA reviewer to lead the interviews. If an Expert by Experience flags an issue of concern from an interview, then an inspector or MHA reviewer may need to do a follow up interview. • **Cross reference safeguarding notifications** with local authority and against provider records. • **Ward tour** – including look for the potential indicators of closed cultures listed above. • **Review staffing rotas** for last 3 months – agency use, skill mix, length of shifts, weekly total hours, shifts not covered etc. • **Review of restraint/safeguarding/serious incidents** – select incidents: cross reference notification, incident report, care notes entry and consider whether to look at CCTV footage where available, in line with our existing guidance on this. • Look at **Long term segregation safeguards**.

Prompt	Action
Staff interviews	**Care assistants/support workers** • Focus on care plan of an individual patient (for example, someone from case tracking). Talk through the care plan and their understanding of what they do and examples from practice. Build in questions regarding training and support. • Talk through understanding of restrictive practices and talk through recent restraint being used, for example, why, when, who provided oversight, and debrief. • Explore their knowledge of how to raise concerns.
	Registered nurses • Focus on development of care plan/positive behaviour support (PBS) plan, evidence used, involvement of patient, families and staff – including complying with the Accessible Information Standard (identify, record, flag, share and meet the information and communication needs of each person using the service). Explore knowledge of PBS approach. How are staff aware of care plan. When are care plans reviewed and who is involved. How are patients enabled to maintain contact with family and friends? • For people in assessment and treatment settings, ask: What is the end goal of this person's assessment and treatment? What are they doing to make sure this person can leave hospital? How often do people see their consultant? (also check in case tracking) • Incident analysis, review of use of restrictive practices and learning, how do they ensure that any restrictive practice is lawful, for a legitimate aim and the least restrictive option (this is a requirement to avoid breaches of the Human Rights Act). • How do they ensure compliance and good practice with MCA and MHA, including access to advocacy?. • How do they ensure staff are following plans? • Training provided to them, supervision and professional development.
	Other members of multidisciplinary team • Involvement in care planning. • Time with team delivering care, observing practice. • Similar themes to registered nurse and managers - approach dependent on role. • Where possible, case tracking should also include MDT meeting notes to see the involvement of different people, including families.

Prompt	Action
	Managers • Staffing levels, skills and training, agency use, supervision, support and appraisal. • Presence on ward, assurance regarding quality of care delivery. • MCA and MHA. Restrictive practices (see questions above). Restraint reduction – overall strategy and concrete examples of restraint reduction for individual people at high risk of being restrained. • Incident, concerns monitoring, analysis and monitoring. Safeguarding incidents on ward, actions and learning. Understanding of Duty of Candour. The number of people with "allegations risk assessments/ plans" and how allegations made by these people are followed through.
Supporting information	There are several Brief Guides that relate to topics covered in this appendix, including guides on inspecting safeguarding, long term segregation, restraint, rapid tranquilisation, seclusion rooms, assessing how providers use the MCA, use of blanket restrictions on mental health wards, discharge planning in Learning Disability services, good communication standards for people with a learning disability or autism, positive behaviour support for people with behaviours that challenge.

Appendix C: Link to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each situation of a closed and punitive culture must be assessed to determine whether there are any breaches of regulations. The following are examples of where certain evidence may indicate a breach, but you should always consider the wording of the regulation itself when determining if a breach has occurred.

Regulation	Description
Regulation 9: Person-centred care	This can be used if people are not receiving person-centred care. For example, if frontline staff are not following care plans (including Positive Behaviour Support plans) or care planning has not been carried out appropriately to meet needs and preferences.
Regulation 10: Dignity and respect	This can be used if care is not being provided with dignity and respect or there is not due regard to people's equality characteristics. One example would be where observations of people in seclusion are undertaken in a way which breaches rights to privacy, when this is not the least restrictive way of ensuring people or staff remain safe.
Regulation 11: Need for consent	This can be used if lawful consent to treatment is not obtained – this includes correct use of the Mental Capacity Act and Mental Health Act
Regulation 12: Safe care and treatment	This can be used if the care and treatment of people using the service is not safe, including where the culture has an impact on the safety of the care or treatment and if the failure to follow care plans results in unsafe care.
Regulation 13: Safeguarding service users from abuse and improper treatment	This can be used if the service does not protect people from abuse or improper treatment, such as verbal abuse and psychological abuse, including taunting people, ill-treatment, unnecessary or disproportionate restraint or inappropriate deprivation of liberty, such as using seclusion as a punishment.
Regulation 16: Receiving and acting on complaints	This can be used if complaints from patients or their families and informal carers have not been adequately investigated or addressed – and also where a provider does not give information to CQC about complaints, when requested, within a 28-day limit.
Regulation 17: Good governance	This can be used if there is inadequate management oversight of the culture in a service, where there are inadequate systems and processes to ensure compliance, including where the registered person does not have adequate assurance that risks to the health, safety and welfare of patients are being mitigated or that other regulations are being met.
Regulation 18: Staffing	This can be used if there are not enough staff with the skills and competencies required to meet the needs of people on the ward or staff are not provided with adequate training.

Regulation	Description
Regulation 19: Fit and proper persons employed	This can be used if the provider employs, or continues to employ people who are unfit to carry out their role – for example if they are not suitably qualified or experienced, or are not of good character. This could put people at the risk of harm or abuse.
Regulation 20: Duty of candour	This can be used if the provider is has not acted in an open and transparent way in relation to providing care and treatment, in particular when something has gone wrong and caused physical or psychological harm to someone using the service. The provider must follow a specific set of duties as outlined within the regulation.

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/13

UNIVERSITY OF HULL

Early Indicators of Concern Residential and Nursing Homes for Older People

The *Abuse in Care*? Project

Dave Marsland
Peter Oakes
Caroline White

Centre for Applied Research and Evaluation

October 2012

Introduction

The *Abuse in Care?* Project

The *Abuse in Care? Project* is a long term research and development initiative focused on the abuse and mistreatment of people who receive support in staffed settings such as residential and nursing homes. To date, the project has concentrated on services for older people and people with learning disabilities.

The aim of the project has been to help to prevent abuse by enabling health and social care practitioners to reflect on the feelings of concern that they may have about a particular service and to take appropriate actions. Health and social care practitioners are skilled at noticing problems and subtle changes in services. With hindsight, such practitioners can describe complex patterns of concern that they had about services where abuse was later found to have taken place. The challenge for researchers and practitioners alike is to try to understand and use such patterns of concern to identify high-risk services and environments *before* the actual abuse or neglect occurs.

There are two main objectives in the context of this aim of prevention. First, the research project has sought to identify and understand the 'early indicators' of concern that are associated with situations where abuse and harm occur. These 'early indicators' are the aspects of support services that gave practitioners cause for concern, prior to, or at the same time as the actual abuse occurred or was discovered.

Secondly, the project has sought to apply the research findings by producing guides or reflective practice tools that might help practitioners to identify and address important problems at an early stage.

Information developed as a result of these two objectives is presented for both older people and people with learning disabilities. For each client group there is a document containing the full list of early indicators and a corresponding guide. These guides help people to record what they have seen and encourage them to reflect on their concerns, share their observations and take appropriate actions.

The guide can be found here.

Early Indicators of Concern in Residential and Nursing Homes for Older People

This document presents the full list of Early Indicators of Concern for older people in residential and nursing Homes. These Early Indicators reflect the findings from research and development work undertaken in two local authorities in the UK between 2010 and 2012. The research comprised a series of interviews and focus groups with practitioners who had been regular visitors to residential and nursing

homes where abuse had subsequently been found to have occurred. Findings from this research were found to be consistent with results from comparable studies, such as that published by Brooker et al in 2011[1].

It is important to note that the scope of the investigation did not extend to hospital based acute services or day care facilities, though the findings and principles may be of interest to those working in or with such services.

Commonly occurring areas of concern

The research enabled the identification of over 90 individual indicators or warning signs that were readily observed by the practitioners who were interviewed. Perhaps more importantly, analysis revealed that the indicators fall into a number of distinct areas of concern:

- Concerns about management and leadership
- Concerns about staff skills, knowledge and practice
- Concerns about residents' behaviours and wellbeing
- Concerns about the service resisting the involvement of external people and isolating individuals
- Concerns about the way services are planned and delivered
- Concerns about the quality of basic care and the environment

(These six areas are described in detail on pages 4 -12.)

Abuse was found to be associated with a *spread or range* of indicators

Analysis of the findings suggests that abuse or neglect was associated with situations where practitioners had identified a number of indicators of concern spread over a range of these areas of concern. For example, a practitioner may have noted concerns about the manager, together with concerns about staff knowledge and concerns about the quality of basic care and the environment. The findings from this project suggest that we should be most concerned when such a spread or range of indicators is identified.

When practitioners notice indicators of concern in one single area this is less likely to be associated with a high risk of abuse or neglect. This does not mean that action should not be considered or taken with regard to the concerns identified, but it does suggest that the level of actual risk may be lower.

[1] Brooker, D et al (2011) *How can I tell you what's going on here: The Development of PIECE-dem: An observational framework to bring to light the perspective of residents with advanced dementia living in care homes.*

Identifying a spread or range of indicators is not *proof* of abuse

Where a spread of indicators is revealed, suggesting a pattern of concerns, this is not, in itself, proof that people have been abused or neglected and, abuse can happen when concerns are not apparent. However, such a pattern of indicators of concerns does suggest that actions need to be taken to change and improve the service delivered and lower the risk that abuse or neglect will take place.
In addition, using the information in this document and the corresponding Guide does not replace listening directly to people in services. On the contrary it gives an important reason to listen more closely before and after concerns are raised.

Dave Marsland
Peter Oakes
Caroline White

Centre for Applied Research and Evaluation
University of Hull

The Early Indicators

There are six main areas to think about:

1. Concerns about management and leadership

This is about the people who manage the home or service and other managers in the organisation. What are they doing, or not doing that gives you cause for concern?

2. Concerns about staff skills, knowledge and practice

This is about people who work in the home or service. What are their skills and practice like? What are they doing, or not doing that gives you cause for concern? This is not just people who work as care workers or nursing staff but also includes for example cleaners, catering staff and managers performing care tasks.

3. Concerns about residents' behaviours and wellbeing

This is about the people who live in the home or service. How are they? Are they behaving in ways which suggest that their support is ineffective or inappropriate? Are there noticeable changes in people's presentation or their appearance?

4. Concerns about the service resisting the involvement of external people and isolating individuals

Are the people in the home cut off from other people? Is it a "closed" or an "open" sort of place? Does the service resist support from external agencies or professionals?

5. Concerns about the way services are planned and delivered

This is about the ways in which the service is planned and whether what is actually delivered reflects these plans. For example, are people receiving the levels of care which have been agreed? Are the residents a compatible group? Is the service clear about the kind of support they are able to deliver?

6. Concerns about the quality of basic care and the environment

Are basic needs being met? What is the quality of the accommodation like?

1. Concerns about management and leadership

The first section is about the people who manage the home (or service) and other managers in the organisation. What are they doing, or not doing, that gives you cause for concern?

Is there evidence that:

- There is a lack of leadership by managers, for example managers do not make decisions and set priorities
- The service is not being managed in a planned way, but reacts to problems and crises
- The manager is unable to ensure that plans are put into action
- The managers know what outcomes should be delivered for older people, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'
- Managers appear unaware of serious problems in the service
- The service does not respond appropriately when a serious incident has taken place. They do not appear to be taking steps to reduce the risk of a similar incident happening again
- Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through
- Managers do not appear to be paying attention to risk assessments or are not ensuring that risk assessments have been carried out properly
- Managers do not appear to have made sure that staff have information about individual residents' needs and potential risks to residents
- The manager leaves staff to get on with things and gives little active guidance
- The manager is not role-modelling good practice to the staff team. They are not involved in practice with residents
- The manager is very controlling
- The managers have low expectations of the staff
- The manager is new
- There is a high turnover of managers
- The service is experiencing difficulty in recruiting and appointing managers
- The manager leaves suddenly and unexpectedly
- The manager is new *and* doesn't appear to understand what the service is set up to do

- A responsible manager is not apparent or available within the service, for example they may be:
  - On holiday
  - Covering other services

- Arrangements to cover the service whilst the manager is away are not working well

- The services' resources are not being deployed effectively to meet the needs of theresidents. For example....

  - There is a high turnover of staff

  - Staff are working long hours

  - Staff are working when they are ill

  - There is poor staff morale

2. Concerns about staff skills, knowledge and practice

This section is about the people who work in the home or service. What are they like? What are they doing or not doing, that gives you cause for concern?

Is there evidence that:

- Staff appear to lack the information, knowledge and skills needed to support older people and/or people with dementia
- Staff appear challenged by some residents' behaviours and do not know how to support them effectively
- Staff do not manage residents' behaviours in a safe, professional or dignified way. For example staff;
  - Send residents to their rooms
  - Use medication inappropriately or as a first resort
  - Ignore residents
- Members of staff perceive the behaviours of residents as a problem – and blame the residents
- Staff blame residents' confusion or dementia for all their difficulties, needs and behaviours; other explanations do not appear to be considered
- Members of staff are controlling of residents
- Residents are punished for behaviours which are seen to be inappropriate
- Staff treat residents roughly or forcefully
- Staff ignore residents
- Staff shout at residents and are impatient
- Staff shout or swear at residents
- Staff talk to residents in ways which are not complimentary or are derogatory
- Staff do not alter their communication style to meet individual needs. For example they speak to people as if they are children, they 'jolly people along'
- Members of staff use negative or judgemental language when talking about residents
- Staff do not see residents as individuals and do not appear aware of their life history
- Staff do not ensure privacy for older people when providing personal care
- Record keeping by staff is poor
- Staff do not appear to see keeping records as important

- Risk assessments are not completed or are of poor quality. For example, they lack details or do not identify significant risks
- Incident reports are not being completed
- There is a particular group of staff who strongly influence how things happen in the service
- Staff informally complain about the managers to visiting professionals
- Staff lack training in how to use equipment

3. Concerns about residents' behaviours and wellbeing

This section is about the people who live in the home or service. How are they? Is there anything about their behaviour or presentation that gives you cause for concern?

Is there evidence that one or more of the residents?

- Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs carefully or properly)
- Appear frightened or show signs of fear
- Behaviours have changed
- Appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance
- Moods or psychological presentation have changed
- Behaviour is different with certain members of staff/when certain members of staff are away
- Engage in inappropriate sexualised behaviours
- Do not progress as would be expected

Is there evidence that;

- The overall atmosphere is flat, gloomy or miserable?

4. Concerns about the service resisting the involvement of external people and isolating individuals

Are the people in the home or service cut off from other people? Is it a "closed" or an "open" sort of place?

Is there evidence that:

- Managers and/or staff do not respond to advice or guidance from practitioners and families who visit the service
- The service is not reporting concerns or serious incidents to families, external practitioners or agencies
- The service does not pass on information and communicate with residents' families and external practitioners
- Managers do not appear to provide staff with information about residents from meetings with external people, for example review meetings
- Staff or managers appear defensive or hostile when questions or problems are raised by external practitioners or families
- Staff are hostile towards or ignore practitioners and families who visit the service
- The service does not liaise with families and ignores their offers of help and support
- Managers or staff are defensive and concerned to avoid blame when things go wrong or there are problems
- Staff or managers give inconsistent responses or account of situations
- There are residents who have little contact with people from outside the service
- There are residents who are not receiving active monitoring or reviewing (e.g. people who are self-funding)
- Residents are being kept isolated in their rooms and are unable to move to other parts of the building independently ('enforced isolation')

5. Concerns about the way services are planned and delivered

This is about the way in which the service is planned and delivered to individuals and to groups.

Is there evidence that:

- There is a lack of clarity about the purpose and the nature of the service
- The service does not appear able to deliver the service or support it is commissioned to provide. For example it is unable to deliver effective support to people with distressed or aggressive behaviour
- Decisions about where residents are placed are influenced by a lack of suitable alternatives
- The service is accepting residents whose needs and/or behaviours are different to those of the residents previously or usually admitted
- The service is accepting residents whose needs they appear unable to meet
- There appear to be insufficient staff to support residents appropriately
- Residents' needs as identified in assessments, care plans or risk assessments are not being met. For example residents are not being supported to attend specific activities or provided with specific support to enable them to remain safe
- The layout of the building does not easily allow residents to socialise and be with other people

6. Concerns about the quality of basic care and the environment

Are basic needs being met? What is the environment like?

Is there evidence that:

- There appear to be insufficient staff to meet residents' needs
- There is poor or inadequate support for residents who have health problems or who need medical attention
- Residents are not getting the support they need with eating and drinking, or are not getting enough to eat or drink
- The service is not providing a safe environment
- Staff are not checking that people are safe and well
- There are a lack of activities or social opportunities for residents
- Residents do not have as much money as would be expected
- Residents lack basic things such as clothes, toiletries
- Support for residents to maintain personal hygiene and cleanliness is poor
- There is a lack of care for residents' property and clothing
- The service does not have the equipment needed to support residents
- Equipment is not being used or is not being used correctly
- Equipment or furniture is broken
- The service is not providing equipment to keep residents safe
- Staff are not using wheelchairs safely and correctly
- The home is dirty and shows signs of poor hygiene
- The quality of the environment has deteriorated noticeably
- Levels of activity for service users have declined noticeably

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/14

Inspection Report

01 - 29 July 2022

Belfast Health and Social Care Trust

Mental Health & Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel no: 028 9446 3333

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

<table>
<tr>
<td>Organisation/Registered Provider:
Belfast Health and Social Care Trust (BHSCT)</td>
<td>Responsible Individual:
Dr. Cathy Jack
Chief Executive, BHSCT</td>
</tr>
<tr>
<td>Person in charge at the time of inspection:
Natalie Magee, Co-Director, LD Services</td>
<td>Number of registered places:
There are five wards operating within Muckamore Abbey Hospital
<table>
<tr><th>Name of ward:</th><th>No of patient's accommodated:</th></tr>
<tr><td>Cranfield 1</td><td>Seven</td></tr>
<tr><td>Cranfield 2</td><td>Eight</td></tr>
<tr><td>Six Mile</td><td>Nine</td></tr>
<tr><td>Killead</td><td>Seven</td></tr>
<tr><td>Donegore</td><td>Six</td></tr>
</table>
</td>
</tr>
<tr>
<td>Categories of care:
Acute Mental Health and Learning Disability</td>
<td>Number of beds occupied in the wards on the day of this inspection:
37</td>
</tr>
<tr>
<td colspan="2">Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged 18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH is a regional service and as such provides a service to people with a Learning Disability from across Northern Ireland. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admission to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.</td>
</tr>
</table>

2.0 Inspection summary

An unannounced inspection of MAH commenced on 01 July 2022 at 04:00am and concluded on 29 July 2022, with feedback to the Trust's Senior Leadership Team (SLT). All wards were inspected at least once during this period. The inspection team comprised of care inspectors, a senior inspector, assistant directors and a director.

The decision to undertake this inspection (following so soon after the inspection in March 2022) was based on intelligence detailed in Early Alerts received by RQIA in June 2022.

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property.

The inspection identified limited progress towards meeting the areas for improvement (AFI) identified during the inspection in March 2022. Additionally, RQIA found that staffing/workforce and adult safeguarding arrangements were inadequate and had impacted on the care and treatment of patients. RQIA escalated these concerns to the Trust's Chief Executive and SLT at the conclusion of the inspection. The Trust accepted RQIA's findings. RQIA has also escalated these concerns to the Department of Health and with the Strategic Performance and Planning Group. A number of AFI have been made.

MAH continues to experience a number of challenges to maintaining service delivery. The Public Inquiry into the historical abuse of patients in MAH is ongoing, the impact of which is felt by patients, families and staff. There are continued challenges with high levels of staff vacancies, a lack of skilled and experienced learning disability speciality staff, and the ongoing management of adult safeguarding incidents.

Following this inspection, RQIA met with the Trust's Chief Executive and SLT on 4 August 2022 to discuss our intention to issue two Improvement Notices relating to staffing/workforce and adult safeguarding. During this meeting RQIA received assurances as to the actions taken and planned by the Trust to address each of the areas of concern. RQIA will closely monitor the Trust's progress in this regard. Further information is detailed in sections 5.2.1 and 5.2.2 of this report.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect performance at the time of our inspection, highlighting both good practice and any AFI. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection focused on eight key themes: staffing/workforce; adult safeguarding; governance and leadership; assessment and treatment/resettlement; patient experience; patient engagement; family engagement; and staff engagement.

During the inspection we observed patient care and treatment, and the lived experience of patients in the wards. We conducted unannounced visits at different times of day and night to ensure patient care was observed on every ward across the full 24 hour period. We observed staff practice and reviewed staffing arrangements in all wards, including the profile of staff. We engaged with the multi-disciplinary team (MDT) and Senior Leadership Team and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to supplement the intelligence already gained through the contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We received two completed questionnaires from patients, both which reflected that they thought care was good and staff were kind, however, they stated the ward was not organised, nor did they feel safe. We shared this feedback with staff on duty. We spoke with a small group of patients on one ward and with four patients who requested to speak with inspectors. Some patients expressed concern about staffing while others expressed anxiety about the behaviours of other patients.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we were supported by ward staff to make direct telephone contact with patients' relatives. Twelve families availed of this opportunity and provided a range of views based on their experiences of visiting the wards and engaging with hospital staff. While some relatives expressed high levels of satisfaction with the standard of care provided, others advised of their concern about staffing levels, communication, safeguarding and availability of activities.

Several staff requested to speak with inspectors in private and other opportunities were taken to speak with staff during visits to each of the wards. Staff spoke openly about the concerns they had. We did not receive any completed staff questionnaires; however, staff did contact us following the inspection to discuss concerns they had in relation to the safety of patients and staff.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The previous inspection to MAH was undertaken on 02 – 31 March 2022. We assessed the progress made towards achieving compliance with the six AFI identified at the last inspection and identified that insufficient progress had been made to meet the Quality Standards. Our findings are as follows:

Areas for improvement from the last inspection to Muckamore Abbey Hospital 02 – 31 March 2022		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Second time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH.	**Not met**
	Action taken as confirmed during the inspection: An agency specific training programme had not been developed. Additional concerns were also identified in relation to the skills and competencies of agency staff. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure and support a collaborative approach to nursing care, and promote working well together. Agency staff should be embedded within the staff teams and their skills effectively utilised in the delivery of patient care.	**Not met**
	Action taken as confirmed during the inspection: There was insufficient evidence that efforts had been made to embed agency staff within staff teams and further evidence indicated continued relationship difficulties amongst staff groups. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI	

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop an effective mechanism to monitor staff compliance with relevant training requirements and take the necessary actions to address any identified deficits.	**Not met**
	Action taken as confirmed during the inspection: Issues were identified in relation to compliance with mandatory and service specific staff training. Effective mechanisms to monitor staffs' compliance with relevant training and take necessary actions to address deficits were not in place. This was concerning given the risks associated with the competence, skills and knowledge of staff. Further detail is provided in Sections 5.2.1 and 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should review the role of the Nurse Development Leads (NDL) and consider the utilisation of this resource to strengthen leadership and management at ward level and support the development of nursing staff within each ward.	**Not met**
	Action taken as confirmed during the inspection: The NDL resource had reduced since the last inspection. As a result it was not possible to determine the impact the NDL role was having. This is discussed further in Section 5.2.8. This AFI has not been met and has been subsumed into a new AFI.	

Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust Senior Management Team for MAH should seek opportunities to engage with staff to determine how best to support them. Consideration should be given to: 1. A schedule of leadership walk rounds with a report to evaluate the outcome of the visit. 2. ASM & ST having a visible presence across all wards to support staff and govern practice.	**Partially met**
	Action taken as confirmed during the inspection: The presence of the SLT on wards to support staff during incidents was noted. We identified gaps in provision of consistent and continuous support to staff at ward level from the middle management team which was having a direct impact on the effective delivery of care. This is discussed further in Section 5.2.8. This AFI has been partially met and has been subsumed into a new AFI.	
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure the Adult Safeguarding Regional Policy is adhered to by staff at all levels, including the SMT. Consideration should be given to: 1. A review of operational adult safeguarding processes and if required steps to address any identified gaps. 2. Prioritising team building sessions between operational and adult safeguarding team to promote a collective approach to patient safety and protection in line with the Adult Safeguarding Regional Policy.	**Not met**
	Action taken as confirmed during the inspection: Issues in relation to implementing effective and suitably protective adult safeguarding arrangements continue. This is discussed further in Section 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	

5.2 Inspection findings

5.2.1 Staffing / Workforce / Staff Profile

The staffing arrangements at MAH were reviewed through the analysis of staffing rotas, discussions with staff, observation of staff on shift, and review of the staffing model. Staffing levels on the MAH site have been determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity.

The safety and well-being of patients in MAH was directly affected by the current staffing arrangements. The staffing concerns were not, in the main, related to the numbers of staff on duty. MAH as a site, was operating continuously with 83% to 85% agency nursing and health care staff in addition to ad hoc shifts being covered by bank staff and staff from other areas, across all of the wards. This had an impact on the continuity of care for patients.

There were significant gaps in the level of competence, skills and knowledge required to support patients who have a learning disability, who require support with communication, and present with complex and distressing behaviours.

We noted that staffing levels, in line with the Telford model, was often not being achieved and that the rotas did not accurately reflect the actual staff on shift.
Staffing was not based on the assessed needs of the current patient population. Staffing levels had reached a critical point with difficulty in retaining and recruiting appropriately experienced staff, across all grades.

Staffing levels were not adequate to respond to temporary or unplanned variations in the assessed needs of patients and staff were frequently redeployed to provide cover in other wards when incidents occurred. Some planned visits and outings with family members had been cancelled at short notice due to staffing arrangements.

Robust arrangements were not in place to oversee and assure the supply and deployment of agency staff across the site. This directly impacts patients' safety and contributes to poor patient outcomes. There was evidence that agency and other staff were self-selecting shifts and not following the correct procedure for booking shifts leading to inadequate oversight of the staffing arrangements and in one instance significant safeguarding concerns. The Trust took immediate action to address this risk when highlighted.

Agency staff were working excessively long shifts, often consecutively and without any breaks or sufficient rest periods between shifts. We have taken separate actions to address these concerns with the registered providers of the relevant agencies. Such working patterns are known to impact adversely on both the health and wellbeing of the staff, and on the quality and safety of care provided to patients. We found that staff morale was poor and there was evidence of conflict amongst staff groups.

The current staffing arrangements were detrimentally affecting the resilience and wellbeing of staff and their ability to provide safe, effective and compassionate care, often in very challenging circumstances and therefore must be urgently taken into account in organising staffing at MAH.

Staff training records for Trust and agency staff identified deficits in a number of areas including; Adult Safeguarding Training, Positive Behaviour Support (prn) and Management of Actual or Potential Aggression (MAPA). There was no agency specific training programme to develop agency staff knowledge and skills to support them to safely and effectively meet the specific needs of the patients in MAH. There was limited evidence of an effective mechanism to monitor staff compliance with relevant training requirements or actions taken to address any identified deficits. Individual staff training records were not up to date and an accurate summary of staff training compliance was not available.

There was no evidence of the promotion of a PBS culture in wards. PBS is a person centred approach to supporting people with a learning disability; it is based on assessment of the social and physical environment in which the behaviour happens and includes the views of the individual. A PBS model if used effectively would contribute to a reduction in incidents. Bespoke PBS plans were available and documented in patient care records; however, staff had limited understanding of these and were reluctant to implement the PBS model. This increases the risk of a reliance on the use of restrictive practices to manage patients' behaviours.

Staff reflected feelings of fear and an inability to safely manage patients when they present with distressed or challenging behaviours. Staff were focused on managing and predicating the outcome of distressed or challenging behaviours rather than on proactive action to avoid escalation of behaviours

There was evidence, on occasions, of an over-reliance on the use of PRN medication (PRN medication is medication administered as needed, to support patients with regulating their behaviours) to manage the presentation of some patients and we were concerned to note that some administration times coincided with shifts where there were staffing deficits, and when staff on duty were not familiar with the patients' needs. The Trust committed to undertaking an urgent review of all patients' prescribed medications.

Effective post-incident debrief and support was lacking and as a result opportunities to reflect on and learn from incidents are missed. Some staff reported that their behaviour support staff colleagues did not visit the wards.

Staff providing front-line care displayed resilience and should be commended for their dedicated service to patients and patients' families.

On 8 August 2022 RQIA wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to inform the DoH of the significant concerns in relation to workforce and staffing arrangements, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the staffing/workforce arrangements. This meeting was attended by the Trust's Chief Executive and members of the SLT.
At this meeting the Trust's Executive Management Team, presented a comprehensive action plan describing their plans to address the staffing/workforce concerns arising from the inspection. They informed us of the recent recruitment of nine new staff, five of which are newly qualified registrants, and gave an overview of further plans to recruit and retain staff at all levels.

Additional workforce resources have been secured from within the Trust including senior and middle management levels, a significant number of who will work within the adult safeguarding team. The Trust provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.2 Adult Safeguarding

Adult safeguarding is the term used for activities which prevent harm from taking place and which protects adults at risk (where harm has occurred or likely to occur without intervention).

In some instances ward staff demonstrated a poor understanding and knowledge of adult safeguarding processes, including the threshold for making a referral to the adult safeguarding team. There was limited evidence regarding adult safeguarding training delivered to substantive staff members and we could not assess if agency staff had the necessary adult safeguarding training as training records for this group were not readily available.

There was limited assurance that incidents of a safeguarding nature were being responded to in a timely way. Delays in reporting incidents to the adult safeguarding team have resulted in delayed patient protection planning.

Staffing shortages within the adult safeguarding team have led to delays in the adult safeguarding process, with a large volume of adult safeguarding investigations not completed. A lack of Designated Adult Protection Officers (DAPOs) is leading to ineffective management of new adult safeguarding concerns, ongoing adult safeguarding concerns and any actions as a result of the ongoing historical safeguarding concerns.

Patients involved in adult safeguarding incidents were subject to a protection plan, however; there was no evidence that the protection plans were reviewed or updated regularly. Staff involved in adult safeguarding incidents were also subject to protection plans which we found in some cases to be unrealistic with poor oversight and management. Staff told us they feel at risk due to the level of scrutiny and are fearful for their professional registration.

There were fewer than expected occasions of debrief and robust incident management oversight resulting in insufficient learning and improvement post incident. There was limited evidence of the effectiveness of audit and analysis of incidents with opportunities to reduce risk and improve patient care missed.

As a result of our significant concerns we wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to advise the DoH of serious concerns we identified in relation to adult safeguarding, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the adult safeguarding arrangements. This meeting was attended by the Trust's Chief Executive and members of the Trust's SLT. At this meeting the Trust presented a comprehensive action plan describing their plans to address the adult safeguarding concerns arising from the inspection. They advised additional adult safeguarding team resources that have been secured and additional managerial oversight was in place to enable outstanding adult safeguarding work to progress.

The Trust has provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided by the Trust, and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.3 Assessment and Treatment / Resettlement

Assessment and treatment for patients was assessed through the observation of patient care, discussions with patients, and their relatives, with ward staff and from the review of patients' care documentation.

There were 37 patients in MAH, a small number of whom are receiving active care and treatment. This is a reduction from 39 (-2) since January 2022.

A lack of suitable community placements with appropriately skilled staff are some of the contributing factors that have hindered discharge plans for several patients. Some patients, who were preparing for discharge, had in reach staff.
In reach staff are supplied from a prospective care provider, to support patient care on site to enable patients to have a smoother transition into the community when they are discharged.

Assessments for those patients in receipt of active care and treatment were of poor quality and had not been regularly reviewed; some assessments were incomplete. This has led to ineffective care and treatment planning. Care delivered was based on a medical model and MDT meetings were focused on describing incidents and lacked evidence of meaningful decision making about changes in care planning. This has impacted on the effectiveness of the MDT's input into patient care.

Restrictive practices were not being effectively reviewed and patients were subject to restrictions that impacted on their freedom of movement. Enhanced observations (used when staff have assessed that the risk of self-harm or risk to others is increased) were not being reviewed regularly and there was no evidence that consideration had been given to reduce observation levels in a timely manner.

5.2.4 Patient Experience

Patient experience was assessed by directly observing patients lived experiences on the wards and by speaking with patients, ward staff and patients' relatives. Observations were completed across a range of day and night time periods.

The focus on patients' human rights was limited. Care, at times, lacked dignity and respect, and there was little consideration for patients' right to a private and family life. Communal living alongside other patients with complex needs created difficulties for some patients, for which there were very limited options.

Ward environments were for the most part, noisy with limited quieter spaces available for patients to avail of. Some patients who were trying to rest or sleep were disturbed by others. Noise levels on some wards were noted to be high and persistent. This had the potential to cause other patients to not want to use communal spaces. Other noise impacts include the staff alarm system, the patient mix and environmental factors associated with communal living. This is not a therapeutic environment that supports patients' mental wellbeing and their enjoyment of private and family life.

Two patients stated they were concerned about staff safety, and about the impact of the behaviours of other patients on their own wellbeing.

All of the wards visited are locked wards; and patients rely on staff availability and cooperation to support any off ward activity. While some patients were noted to have regular access to the grounds, day care and outings, not all patients can avail of these. Staffing shortages were noted to impact on a planned outing, a family visit and on individualised work with patients.

Staffing arrangements impacted directly on patient activities as not all patients received the necessary support to structure their day, promote their independence, and develop skills enabling them to manage and self-regulate their emotional wellbeing.
Patient Activity Schedules were, for the most part, not implemented, with patients largely dependent on day care staff for activities. Staff demonstrated limited purposeful engagement with patients and tended to stand in groups with, or talk to other staff.

There was no structure to the patients' day or ward based activities resulting in boredom and an increase in incidents of challenging behaviour.

In line with some patients assessed needs and to support their individual care they have been allocated a pod area within the ward footprint. Pod areas are a suite of rooms allocated specifically for one patient, and closed off to other patients. The configuration of some pod areas creates a heavily reliance on staff availability and cooperation to support the patients to access required areas outside of their pod. Staffing shortages and patient acuity were impacting staff's ability to provide individualised care. This has the potential to impact patient dignity, their physical and mental health and their ability to retain their independence and personal care skills.

We observed meal time experiences for patients. Staff demonstrated limited interaction with patients and did not provide a dignified meal time experience for some. Staff stood beside seated patients whilst assisting them with their meal and spoke to other staff rather than the patient they were assisting.

We observed examples of compassionate care to individual patients. This included supporting patients to participate in activities of their choosing both on site and off site. Staff were also observed responding compassionately to patients who were experiencing distress, offering them comfort and reassurance.

5.2.5 Patient Engagement

We observed patients seeking out and engaging with some staff in a positive way. Some patients called for staff by name, whilst others smiled and looked happy to see staff who were familiar to them. We observed patients responding negatively to staff who were unfamiliar to them.

Four patients requested to meet with inspectors. One patient expressed concerns about the safety and wellbeing of ward staff and reported that staff had been assaulted by other patients. Three patients expressed anxiety relating to the behaviours of other patients and reported feeling bullied by other patients. A small group of patients on one ward expressed concerns about the inconsistency in staffing.

Two patients completed questionnaires; both reflected that care was good and staff were kind, however, they both stated the ward they were in was not organised, nor did they feel safe there.

5.2.6 Family Engagement

We sought contact with all families/carers of patients to establish their opinions about the care their relative received. Twelve families/carers gave their opinions. Common themes are detailed as follows:

Staffing
Families had mixed views on staffing. Several reported wards were short staffed and staff had poor understanding of patient needs, while others praised staff, stated they were doing the best they could under difficult circumstances and felt staff were not recognised enough for the good work they do. Several families praised individual staff and identified them by name.

Communication
Several families raised poor communication with staff at all levels as an issue. They raised concerns about site management and the lack of contact they had with them. Additionally, some families described good communication with ward staff and commended staff.

Adult Safeguarding
Several families spoke of their concerns in relation to adult safeguarding processes. They stated they were not provided with updates about ongoing investigations and had no confidence that they would be informed of any outcome from the investigations. Some families stated that it was positive that issues were being reported to the adult safeguarding team.

Food
A small number of families had concerns about food supplied to the patients. They did not think the food was of a good standard and some felt the need to provide take away food to supplement the meals provided.

Activities
The majority of families stated there were not enough activities for patients and had concerns about how patients spent their day. Some families correlated the lack of activities with incidents of challenging behaviours. Several families stated they would like increased use of the onsite swimming pool for the patients.

Visiting
Families expressed an understanding and appreciation of the restrictions in place during the Covid-19 pandemic; however, they raised issues not impacted by these restrictions. Some had negative experiences when attempting to visit including a pre-planned visit cancelled at short notice due to staffing shortages.

5.2.7 Staff Engagement

We met with a number of staff who spoke openly about the concerns they had.

Some staff stated morale was poor and they did not feel supported. They spoke about the high level of injuries sustained by staff during incidents that occurred during their shifts, the impact this had on them, and the lack of debrief and opportunity to discuss it.

Staff were confused and concerned about the future of the hospital and what this would mean for patients and themselves. They reported feeling traumatised, anxious and on edge in relation to the level of scrutiny the hospital was under and the negative portrayal of the hospital in the media.

Despite the issues described by some staff, the staff continue to work at the site and show commitment and dedication to the patients, many providing additional hours beyond their contracted hours and some working whilst retired.

5.2.8 Governance – Leadership and Management

Governance arrangements were assessed through a review of SLT meeting records, discussions with senior staff and observations of care delivery.

Leadership, management and overall governance arrangements need to be strengthened. We determined that poor patient outcomes in relation to patient safety, quality of life, and experience were attributed to a lack of leadership at a middle management level across the site, and suitable management arrangements on the wards. Some wards did not have a dedicated manager, and the 'nurse in charge' was responsible for overall management of the ward, in addition to fulfilling their duties as a member of the team on shift. Staff described disharmony amongst teams and lack of cohesion between substantive and agency staff. There was limited evidence of the effectiveness of the NDL role to support shortfalls in staff development and ward management.

The Trust's oversight of agency staff supply and deployment across the site was not robust, which resulted in discrepancies between staff on rota to work and the actual staffing on shift. The staffing records provided were not a reliable source of information to determine the activity and location of staff members on any given shift, day or night.

They did not clearly or accurately outline the deployment of staff, as observed and did not provide an overview of staff movement across the site during shifts. We evidenced that the fluidity of staffing across the site has impacted on the delivery of safe and effective care to patients.

There is one night coordinator on site, with access to senior management through on call arrangements. The Trust have clarified that the night co-ordinator resource is proportionate to the number of patients accommodated in the hospital.

Staff who were involved in, or who had witnessed incidents of challenging behaviour were not routinely in receipt of a post incident de-brief. This reduces the opportunities to learn from incidents, and to provide necessary emotional support to staff, some of whom have sustained significant injuries while at work.

The absence of appropriate oversight of the staffing arrangements has impacted on patient safety and on the quality of care patients received. We observed staffing levels on the wards to be focussed on the numbers of staff; the skills and experience of staff members was a secondary consideration.

The Trust presented a comprehensive action plan describing their plans to address the leadership and management concerns raised with them during the inspection feedback meeting. They gave an overview of plans to recruit and retain staff at all levels, and described additional workforce resources that have been secured from within the Trust, including senior and middle management levels.

The Trust must provide strong operational leadership to bring stability to the service. The wider Health and Social Care system could support the Trust in achieving stabilisation, which RQIA recommend should be driven by a clear and transparently communicated vision for the future of MAH, shared with all stakeholders, with a fixed period of transition to its achievement. A commitment to assisting with workforce needs during that transition should be secured from other HSC providers with access to appropriately skilled and experienced staff.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
	N/A	9

Areas for improvement and details of the Quality Improvement Plan were discussed with the SLT, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Third time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently undertake a review of the induction, training and ongoing development needs of all staff supplied to work in MAH, including those who are supplied at short notice. A training and development plan must be implemented that sets out the range of mandatory and other relevant training to be undertaken by staff. Training plans must be specific and records maintained of when training was provided, by whom and the date of any update or refresher.
	Response by registered person detailing the actions taken: A senior nurse has been authorised to lead on induction of all staff and the E-Roster is reviewed weekly by the Lead Nurse in line with patients' needs and locked down as "agreed". E-roster training and management for Lead Nurse, Ward Sisters and Charge Nurses has been completed to ensure effective roster management to meet the needs of the patients. The process for booking agency staff has been circulated to all registrants regarding the agreed process to book agency staff and the clear message no one is to be booked outside of this process. Work continues with BHSCT Nurse Bank to replace Agency staff who have moved. Consistent regular review of staffing resource is ongoing in line with patient needs. The daily staffing template is reviewed by the Assistant Service Managers.

	A presentation and a Question & Answer session was delivered to the newly appointed Band 6 and Acting Band 7 staff in relation to roles and responsibilities associated with Good Rostering Practice, Policy and clear Key Performance Indicators to reinforce training. Evidence of induction is signed off by Lead nurses prior to undertaking any "nurse in charge" role. Leadership training is being arranged with BHSCT & Leadership Centre. The Nurse Development Lead (NDL) is coordinating training schedules consisting of LD skills, relational security and Positive Behaviour Support (PBS), bespoke ASG with a combination of direct teaching and ward based coaching on engagement. PBS training is included as standard in the Safety Intervention Training as part of the induction and SI update. Training plan: • Introduction to LD and key concepts • Behavioural approaches in LD care • Communication styles • Ethical and legal considerations in LD care • Forensic Nursing in LD • ASD in adults with LD • Relational Security This will close gaps in PBS, relational security, safety intervention training. Training needs analysis for safety interventions is underway and will be completed in line with the action plana specific training and development plan will be put in place with Crisis management plans for each patient, and plan shared when complete. Safeguarding training assisted by Central Nursing Team and ASG Link Nurses have been identified per ward across site. ASG training level 3 provided for senior staff 4 in July and 4 in September 2022 This will increase confidence and prevent staff from "feeling unsafe" to deliver necessary interventions. Value based training is being rolled out as above and a Service plan being produced. As part of the contract with Direct HealthCare one of the essential components of the contract is that each individual staff member has completed level 2 AS training prior to commencement of working on the ward and production of evidence of a programme and training data.

	. Band 7 role authorised to manage all new starts, complete inductions and alert all staff to new starts (agency and trust-deployed staff) to allocated wards. This information is shared with the site coordinators to ensure they are aware of all new starts. Five newly qualified RNLD nurses have commenced preceptorship, induction and training on 19th September 2022 (commencing with Safety Intervention training). There is consistent support throughout their induction and preceptorship, including a Psychology led staff support group presently in place. A “Going Home” checklist is in place in each ward for staff and Occupational health referrals are made where appropriate. Band 6 Deputy Ward Sister/s due to commence Mid October 2022.

Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently review the staffing arrangements to ensure there are at all times sufficient numbers of adequately skilled and experienced staff available to meet the needs of patients. The Trust must implement a staffing model to determine staffing levels which must be consistent with the changing needs of patients and the challenges associated with the use of agency staff.
	Response by registered person detailing the actions taken: Ongoing staff recruitment & induction of staff new staff supported by band 7 senior nurse an Nurse development lead. Five new registered RNLDs have taken up post, they will be supported in perceptership by lead nurses and our clinical tutor. these staff will have the opportunity to rotate in community teams to enhance skills for the future workforce community model . There are ongoing Listening sessions by Chief Executive, Director of Nursing and Director with Trade Union colleagues open to all staff. A "Going home" checklist is in place in each ward. Staff support groups are being rolled out on each ward. The Ward Sister/Charge Nurse or Deputy Ward Sister/Deputy Charge Nurse advertisements have yielded no appointments in the past however we have recently recruited 2 band 6 psots from our contracted agency. Lead nurses have been supported to deliver on agreed work plans due to the reduced number of senior ward based staff on site. The Lead nurses also deliver direct support to ward based staff. The Senior nurse managers are providing direct leadership, coaching and mentoring on site in line with Trust values and a focussing on patient safety. Leadership training being completed by all middle management staff and training in relation to roles and responsibilities associated with Good Rostering Practice, policy and KPIs delivered. Staffing pressures are identified and escalated to BHSCT and with the other HSCT through the workforce appeal process. There is consistent monitoring of staffing both daily and weekly. 4 Nurse Agency registrants commenced employment 8th August 2022. 4 additional Nurse Agency registrants are due to commence post in October 2022. At the Weekly review of overall staffing, staff are reminded of Staff care, Occupational Health and on site counselling with a tools guide or with support developed and shared. Additional staff will need time for induction and upskilling. Lead nurses and Senior site staff have reached out to all staff over the

	summer months. The Senior staff are visible on site, and there is a rota in place over 7 day period & on call senior manager with links to Clinical Director and Director on call Band 7 site coordinators are to be increased x 2 due to vacancies. it is important to note that student nurses on placement in the hospital consistently report an effective and well supported learning environment in routine educational audits. they are supported by the NDL and the practice education team and our clinical lecturer jointly appointed with QUB There is ongoing patient experience and patient safety thermometer audits completed and shared fortnightly with CLT and staff. Service plan to be produced and Site co-coordinators offer senior support to the wards out of hours. On Call rota, On Call rota/Daily Huddles are in place. Staff deployment Is managed in advance but review is carried out daily by site coordinator and further at site wide morning safety huddles for the site each day to cover unexpected gaps. Daily safety brief reviews and plan patient safety issues across site using Charles Vincent model for safety through the implementation of Daily Huddles/Staff planning/Daily Safety Briefs. The ward staff have been engaged in patient focused activity. The patient observation policy is under review in line with care and support themes. An increase in day care provision planned for onsite residents as currently day care is 40% below capacity due to staff sickness and vacancies and there is currently a sickness absence management process in place. Replacement posts have been offered and appointees took up posts September 2022. Protection plans are shared with night coordinators for patient safety reasons but respecting confidentiality. Site coordinators on site 7 nights per week and days at the weekend, current gaps due to vacant posts are filled with additional Hours/Bank staff. 2 site coordinator posts re-advertised in Oct 2022 with closing date 20 October 2022. Day and night shift safety briefs shared with all staff. The rationale for any staff movement across site/service is documented and reviewed on the staff shift allocation sheet daily and reviewed by lead nurse. There is currently a Daily staff monitoring spreadsheet. The Senior Nurse Managers took up post 19th September 2022 to providing direct leadership and support to all staff. Unfortunately the Ward sister/charge Nurse interview 12th September 22 was not successful and is being readvertised Oct

	2022. Recruitment & induction of Staff continues despite challenges. Review of staffing and structure takes place as resettlements progress. The Staffing report with deficits is sent to senior staff and CLT daily, reviewed and actions taken to maintain safety on site.
Area for improvement 3 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 August 2022	The Belfast Health and Social Care Trust must put in place arrangements for the effective oversight of staff supply and deployment across the site. This will include the establishment and implementation of robust protocols relating to the supply of agency and new staff, their fitness and suitability to practice, and the management and oversight of records relating to staff supplied.
	Response by registered person detailing the actions taken: Roster management by 8A lead nurses in line with E-roster Policy. A Lead Nurse (8A) has been recruited for 6 months to specifically lead on patient safety and training matrix in a specific ward. Model of care for all individuals is under review in line with resettlement. Through the appointment of 2 Senior Nurse roles, additional support is being provided to staff through enhanced onsite visibility of management team. Process to strengthen Incident Management review and learning is to be implemented. A senior nurse has been allocated to lead on induction of all staff and the E-Roster is reviewed weekly by the Lead Nurse in line with patients' needs and locked down as "agreed". E-roster training and management for Lead Nurse, Ward Sisters and Charge Nurses has been completed to ensure effective roster management to meet the needs of the patients. Sickness absence management process in place Leadership training to be completed by all middle management staff. HR to facilitate Values based team development to be carried out. System settings re-configured to facilitate Ward management teams to assign block booked agency staff direct to the roster, Documentation and guidance in relation to this has been shared and communicated with ASM's for dissemination to ward teams.Safety Interventions Training: Training need analysis for safety interventions to be completed and a plan out in place with Crisis management plans for each patients and plan will be shared when complete. Management structure has been reviewed and shared with RQIA.

Area for improvement 4 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 November 2022	The Belfast Health and Social Care Trust must urgently review the care and treatment plans of all patients to ensure that their assessed needs are adequately outlined and that a plan is in place to meet their needs. The Trust must ensure that appropriately skilled staff have oversight of each patient's plan, that the patient and their relatives are involved in its development, and that there are arrangements in place for plans to be reviewed regularly by the multi-disciplinary team.
	Response by registered person detailing the actions taken: All PBS plans are under review with the TSS team taking a lead in this with the MDT and in line with individual resettlement plans. PBS plans are discussed at weekly PIPa meetings and in nurse handovers. Patient Activity audit sheet developed and circulated. Model of care for all individuals is under review in line with resettlement. All assessments have been indexed and reviewed as part of accelerated resettlement plans. An increase in day care provision planned for onsite residents as currently day care is 40% below capacity due to staff sickness and vacancies. A project plan lead by divisional nurse and chair of Division which includes: • The Trust have commissioned a review of the use of PRN by consultant psychiatrist and lead nurse from outside the care delivery Unit commenced July 2022. Terms of reference have been shared. *The clinical lecturer and psychologist provides weekly reflective practice to allow staff the space to consider on PBS approaches.

Area for improvement 5 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	With the current focus on resettlement of patients from MAH resulting in a reduction in numbers of patients across each of the five wards, the Belfast Health and Social Care Trust must keep under review each patient's living areas to ensure that patients are receiving care and treatment in the most therapeutic environment. The review should take account of matters relating to excessive noise, restrictions in freedom of movement, or incompatibility with other patients and should be developed with the patient and where appropriate, their relatives.
	Response by registered person detailing the actions taken: There is review of staffing and structure as resettlements progress. Model of care for all individuals is under review in line with resettlement Review of staffing and structure as resettlements progress The senior nurse mangers meeting with the Lead nurses weekly to review environmental and governance issues moving patients as appropriate to make the best use of space to reduce incompatibility issues and restrictions.
Area for improvement 6 **Ref:** Standard 7.1 Criteria: 7.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must put in place arrangements to promote the wellbeing of all staff. A staff wellbeing plan must be developed which sets out the Trust's arrangements for staff to access and receive support and guidance.
	Response by registered person detailing the actions taken: Listening sessions by Chief Executive, Director of Nursing and Director with Trade Union colleagues open to all staff.Going home checklist in place in each ward. Staff support groups to be rolled out on each ward. Lead nurses have support provided to deliver on agreed work plans due to the reduced number of senior ward based staff on site Lead nurses are delivering direct support to ward based staff Senior nurse managers are providing direct leadership coaching and mentoring on site in line with Trust values and a focus on patient safety. Leadership training to be completed by all middle management staff. page tiger for self care and sign posting has been developed and shared Staff are reminded of Staff care, Occupational Health and on site counsellor with a tools guide or support developed and shared. Through the appointment of 2 Senior Nurse roles additional support is being provided to staff through enhanced onsite visibility of management team. Staff sessions with psychology have provided a safe space for staff. The staff induction role is led by one senior staff member, this is their main job role.

	A “Going Home” checklist is in place in each ward for staff and Occupational health referrals are made where appropriate.
Area for improvement 7 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** Second time	The Belfast Health and Social Care Trust must urgently undertake a review of the Adult Safeguarding Operational Procedures in Muckamore Abbey Hospital in line with Regional Policy. An action plan must be developed to address the deficits in the implementation of the regional Policy, the measures to be taken to address these, and the timescales for completion.
To be completed by: 30 September 2022	**Response by registered person detailing the actions taken:** The Belfast Health and Social Care Trust has put in an action plan, and has taken the following action: -Put in place a single point of referral for all adult safeguarding referrals in MAH, this ensures compliance with AS Policy, consistency of thresholds, proportionate alternative safeguarding responses and timely protection planning. -RQIA are invited to all strategy meetings -System in place for the ongoing review of protection plans -Audit systems in place to monitor timeliness of referrals -Plan for the management of 4 workstreams underway -Undertaken a piece of work to clarify thresholds and processes for managing alternative safeguarding responses. The Trust has reviewed its guidance to staff in relation to threshold, and has commenced training with all ward staff in relation thresholds and the use of PARIS. -Redeployment of DAPO's and recruitment of administrative staff has occurred -Adult Safeguarding Service Manager has been appointed -Full implementation of the use of APP1 PARIS forms under way -Updated datasets and monthly oversight meeting in place for the review of Adult Safeguarding Trends A programme of AS training is being rolled out as part of an action plan supported by central nursing and the CEC. Review process for all Form 2s in place with RQIA Inspector and ASG Service manager The Trust is still bound by regionally agreed criteria that requires a lower threshold for referral to AS Team for incidents involving staff in that all incidents involving staff must be reffered to the AS team and there is no discretion for the line manager to screen the refferal. once received by the AS team the regional policy applies. this results in occassions in refferals that in other settings may not reach the threshold for refferal to the team. the impact in staff feeling that the threshold is unfair. However, the AS Team have been working to bring a proportionate response to Adult Safeguarding referrals, with a view to increasing Alternative Safeguarding Responses.

Area for improvement 8 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must put in place suitable arrangements for the effective delivery and oversight of adult safeguarding policy and procedures. These arrangements should include an ongoing evaluation of the effectiveness of the safeguarding arrangements on MAH site and the impact the adult safeguarding process has on patients, relatives and staff.
To be completed by: 30 September 2022	**Response by registered person detailing the actions taken:** Adult Safeguarding action plan in place for the strengthening of the Adult Safeguarding Team which includes: -Monthly oversight arrangements in place, to identify trends, risk and analysis of Adult Safeguarding with oversight arrangements by the EDSW And NED commencing -New data sets established for the purpose of analysing trends, informing actions and areas of focus - Mechanisms developed to collect patient and service user experience in relation to Adult Safeguarding -Live Governance arrangements in place for review of incidents for ASG and incidents moderate or above -A single point of referral for all adult safeguarding referrals in MAH, enables more contemporaneous identification of emerging themes and trends -Audit undertaken to identify those patients most at risk of Adult Safeguarding referrrals with ongoing development of a peer review system to enable second line assurance of efficacy of protection plans -Six monthly audit process in relation to Adult Safeguarding has been put in place -System in place for the ongoing review of protection plans -Audit systems in place to monitor timeliness of referrals -Redeployment of DAPO's and recruitment of administrative staff has occurred -Adult Safeguarding Service Manager has been appointed -Full implementation of the use of APP1 PARIS forms under way which assists in reporting and analysis

Area for improvement 9 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently take steps to strengthen the leadership and governance arrangements in MAH taking account of the clinical leadership and middle management structures. The outcome of this process must be shared with RQIA and must set out clearly any revisions to the management structure, roles and responsibilities and accountability arrangements.
	Response by registered person detailing the actions taken: Lead nurses have support provided to deliver on agreed work plans due to the reduced number of senior ward based staff on site. Lead nurses are delivering direct support to ward based staff. Senior nurse managers are providing direct leadership, coaching and mentoring on site in line with Trust values with a focus on patient safety.Senior Nurse Mangers to took up post 19 September 2022 to provide direct leadership and support to all staff nurse structure revised and in place with additional leadership posts this has been shared with RQIA with the last action plan Clinical structure in place with Clinical director and Chair of Division

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/15

The Regulation and Quality Improvement Authority

MAHI - STM - 185 - 351

Induction Timetable – Week One

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date
Day 1	**9.30am – 5pm** Welcome to RQIA and to the MHLD Team. Meet with line manager, Senior Inspector Welcome and familiarisation of RQIA. • Outline the induction process • What to expect in the first week • Receive equipment; log-ins, codes, mobile pass, ID etc. • Orientation of office / environment – kitchen, bathrooms, fire exits, office space etc. health and safety policies • Familiarisation / Getting to know the MHLD Team • Admin set up & function including telephone protocol, using email, outlook etc. • How to book a desk / room at James House RQIA Intranet Alerts - How to Book a Desk in James House (hscni.net) RQIA Intranet Alerts - How to book a room in James House (hscni.net) • Meet staff from various roles / depts.					

DRAFT

	• MHLD Weekly Safety Brief • MHLD Monthly Team Meeting					
Day 2	**9am-10am** • Probationary Period Management of Probationary Periods (BSO).pdf (hscni.net) • Organisational structure • PPE • COVID Guidance RQIA Intranet Alerts - COVID Guidance (hscni.net) **10.30-11am** • MHLD Team Introductions with Consultant Psychiatrist RQIA Learning Alert – email and e-signatures • Health & Well-being CALENDAR Health and Wellbeing Calendar 2023 - 1 (pagetiger.com) • RQIA Learning & Development Calendar RQIA Learning and Development Calendar_September 2023.pdf (hscni.net) • Attendance at Work Policy Attendance at Work Policy (BSO).pdf (hscni.net) Attendance at Work Procedure (BSO).pdf (hscni.net) **3pm – 4pm** MAH Project Group meeting (observe)					
Day 3	**9.30am-11am**					

DRAFT

	• RQIA's role in context of the MHO (NI) 1986 • Explain role of RQIA in relation to management of ASG concerns. Microsoft Word - HOLD - Adult Safeguarding Policy for Publication (hscni.net) **3.30-4.30pm** Review of Week 1 Induction					

Week 1 Induction Reflections / Review of Progress

Inductee: Band 7 Inspector	
Signed:	Date:
Line manager comments:	
Signed:	Date:

DRAFT

MAHI - STM - 185 - 354

Induction Timetable – Week Two

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date
	9am – 1pm Shadow inspector Introduction to Dashboard / Supervision Dashboard • iConnect – 1. Early Alerts 2. Enforcement module / records • Navigate iconnect / familiarise with safety brief content and layout / familiarise with MHLD inspection reports **2pm – 5pm** • Mandatory training via HSC Learning Centre ✓ Fraud Awareness ✓ Fire Safety Awareness ✓ Display Screen Equipment Awareness ✓ Cyber Security Awareness					

MAHI - STM - 185 - 355

	9am – 1pm Prison Inspection Preparation with Inspection Team – • observe inspection planning for upcoming prison inspection • Key roles • Familiarise with inspection methodology, Record of Inspection **2pm -5pm** Commence GAIN Modules eLearning (MHO) – email with link provided 16.10.23 eLearning Hub (rcpsych.ac.uk)					
	9am – 10am Weekly MHLD Safety Brief **11.30-12.30pm** RQIA Monthly Staff meeting **2pm-5pm** GAIN Modules eLearning (MHO) – email with link provided 16.10.23 eLearning Hub (rcpsych.ac.uk)					
	10am-12noon RQIA Nursing Forum **12 – 1pm** Supervision arrangements **2pm – 5pm** Continue / finalise any outstanding mandatory training: ✓ Risk Management Awareness					

	✓ Information Governance ✓ Engage and Involve: Personal and Public Awareness Involvement (PPI)					
	Make appointments to meet other specialist teams in RQIA, Director LL, Assistant Directors Familiarise with iconnect, location of specific records; completion of Form 10 detention audits etc **4pm – 5pm** Week 2 reflections / review with line manager					

Week 2 Induction Reflections / Review of Progress

Inductee: Band 7 Inspector	
Signed:	Date:
Line manager comments:	
Signed:	Date:

MAHI - STM - 185 - 357

Induction Timetable – Week Three

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date

	9am – 5pm
	• Shadow audit of Detention Form 10s
	• Navigate iconnect – familiarise with pathways / location of key documents etc.
	• HSC eLEARN
	  ○ Display Screen Equipment
	  ○ Cyber Security Awareness
	• Prepare for inspection (shadow another inspector)
	  ○ Pre-inspection Risk Assessment Tool
	  ○ Most recent Inspection Report and QIP
	  ○ Record of Inspection
	  ○ Inspection Folders on iconnect
	  ○ Relevant Regulations and Minimum Standards					

	9am – 5pm • Shadow inspection					
	9am – 5pm • Shadow inspection					

MAHI - STM - 185 - 358

Week 3 Induction Reflections / Review of Progress

Inductee: Band 7 Inspector	
Signed:	Date:
Line manager comments:	
Signed:	Date:

MAHI - STM - 185 - 359

Induction Timetable – Week Four

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date
	9am – 5pm • Attend Team huddle – agree priorities for week ahead Complete mandatory Elearning training: • Risk management awareness • Information governance awareness • Engage and involve – personal and public awareness • Shadow Inspector colleague re audit of Form 10 Detentions (Microsoft Teams)	**Shadow inspector**				
	9am – 5pm (Personal appointment 10-11am - approved) • Modules 3&4 GAIN training (ELearning) • Shadow Inspector colleague re logging of and review of SAI Initial Notifications on iconnect module (Microsoft Teams) • Familiarise with Regional Procedure for the Reporting and Follow-up of Serious Adverse	**Self-directed / Shadow inspector**				

	Incidents (HSCB, Nov 2016) and RQIA Communique (April 2023) re Management of SAIs.					
	9am – 5pm • MHLD Team Safety Brief (weekly meeting) • Familiarise with key concerns and regulatory actions taken to address concerns / secure improvement. • Attend MHLD Team Meeting	**Shadow inspector**				
	9am – 5pm Shadow Aligned Inspector to review SEHSCT caseload including o services of interest / concern o Inspection activity within SEHSCT o IPT (Risk) scores o Inspection reports and QIPs o Adult Safeguarding o Intelligence Case load familiarisation – What is involved, role in liaising with allocated Trust, kinds of issues to be followed up, monitor. The different wards within the Trust and greater understanding of their functions	**Shadow inspector**				
	9am – 5pm • Shadow lead inspector for SAIs. Familiarise with draft SAI Policy and procedure and application of same through working examples. • Inspectors role in managing SAI's • Where and how to find SAI's on iconnect • What should or shouldn't be included in a report • When should learning from an SAI be a recommendation? • How to update the SAI module at both initial notification and full report stages	**Shadow inspector**				

	• Examples of good SAI reports and others that causes inspector to seek clarification • Familiarise with process to be followed when SAI relates to a registered service. Meet with line manager – Review Week 4 and agree Week 5 areas of focus.	**Meet with Line manager**				

Week 4 Induction Reflections / Review of Progress

Inductee: **(Band 7 Inspector)**
Signed: Date:
Line manager comments:
Signed: Date:

MAHI - STM - 185 - 362

Induction Timetable – Week Five

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date
	9am – 5pm • Attend Team huddle – agree priorities for week ahead • Familiarise with 'Making an Inquiry' Guidance (draft) and application to two recent examples – Inspector aligned to explain guidance and process applied. •	**Shadow inspector**				
	9am – 5pm • **MHO Training –** 1. Role of Part II Doctors 2. Role of Part IV Doctors 3. Detention process 4. Prescribed Forms 5. Part III – Prisons 6. TDO's 7. Warrants 8. Transfers Note: Formal MHO training to be delivered by Dr McMahon (January 2024)	**Shadow inspector**				

	• **Mental Capacity Act Training (DoLS)** **1. Monies and Valuables**					
	9am – 5pm • MHLD Team Safety Brief (weekly meeting) 1. The reason for safety brief discussions 2. Where to access 3. What meets the criteria for discussion at safety brief	**Shadow inspector**				
	9am – 5pm • Introduction to Inspector Supervision template and Supervision process • Introduction to Appraisal process • **Management plan - RQIA (legislative basis)** Management Plan_2023-24_Final.pdf (hscni.net) • **RQIA Strategic Plan** RQIA Strategic Plan 2022-28.pdf (hscni.net) • Reports - expectations • Inspections - expectations • Inspection schedule / planning • Review Week 5 Induction / Reflections 1. Revisit any areas of induction 2. Visit reflective accounts on areas of induction 3. Complete employee induction questionnaire – Appendix C	**Meet with Line Manager**				
	9am – 5pm • **Inspection Process (Planning and on-site including feedback)** ○ Where to find the schedule ○ Where to find the inspection homepage	**Shadow inspector**				

	○ Pre-inspection tool ○ SBAR ○ Record of Inspection and key themes ○ IPT ○ Briefing meetings ○ Letter to Trust ○ Inspection Team required ○ Completion of records ○ Outline of days on-site may look like ○ Feedback					

Week 5 Induction Reflections / Review of Progress

Inductee: **(Band 7 Inspector)**
Signed: Date:
Line manager comments:
Signed: Date:

MAHI - STM - 185 - 365

Induction Timetable – Week Six

Name:	**Team:** Mental Health, Learning Disability and Prison Healthcare (MHLD) **Directorate:** Mental Health, Learning Disability, Children's Services and Prison Healthcare
Start Date:	**Director:** **Assistant Director:** **Senior Inspector:**

	Subject	Supported for the day by	Location	Signature (Inductor)	Signature (Inductee)	Date
w/c	• Attend Team huddle – agree priorities for week ahead **Understanding the Inspection process - continued** ○ Report writing ○ Iconnect information to be uploaded following the inspection ○ Upload of packs ○ Peer review process ○ Senior review ○ KPIs - Twenty eight day for issue of report and QIP if appropriate ○ iconnect – fields for completion / when ○ How to monitor return and approval of QIP ○ Responsibility in contacting Trusts for late QIP returns and how to escalate to senior inspector Inspection shadowing opportunities to be identified / agreed Guidance Team shadowing to be agreed					

Week 6 Induction Reflections / Review of Progress

Inductee:	**(Band 7 Inspector)**
Signed:	Date:
Line manager comments:	
Signed:	Date:

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/16

MHLD Team Development Day

DATE:	Friday 04 November 2022
TIME:	9:30 am
VENUE:	HSC Leadership Centre, 12 Hampton Drive, Belfast, BT7 3EN
CHAIR:	Wendy McGregor, Assistant Director, Mental Health, Learning Disability and Prison Healthcare

AGENDA

Welcome		
Time		**Owner**
9:30 – 10:00	'Healthcare through the RQIA lens' - Opening remarks: What do we hope to achieve? / Plans for the day and next steps	Wendy McGregor
10:00 – 10:20	The Quality Standards for Health and Social Care - Supporting Good Governance and Best Practice in the HPSS (March 2006)	Wendy McGregor
10:20 – 11:15	Pre-inspection - Intelligence - Pre-inspection Assessment & Decision Tool Inspection Planning - Team - Methodology / Themes - Itinerary and discipline - Communication - Pre-inspection Brief / Planning meeting - Documents request on inspection - Packs	
11:15 – 11:30	Comfort break (15 mins)	
11:30 – 13:00	Record of Inspection (ROI) - Aide memoire - Fieldwork notes - Analysis and judgement	
13:00 – 13:30	Lunch (30 mins)	
13:30 – 14:00	Record of Inspection (ROI) continued… - Aide memoire - Fieldwork notes - Analysis and judgement	
14:00 – 14:30	The importance of patient engagement; staff engagement; family engagement - what to consider	
14:30 – 15:00	Debriefing v. deliberation	
15:00 – 15:15	Comfort break (15 mins)	
15:15 – 16:30	Feedback script and Inspection report writing – key messages	
16:30 – 17:00	Next Steps/ Actions	

MHLD Team Development Day

DATE:	Thursday 01 December 2022
TIME:	9:30 am
VENUE:	Boardroom, Victoria House, 15-27 Gloucester Street, Belfast, BT1 4LS
CHAIR:	Wendy McGregor, Assistant Director, Mental Health, Learning Disability and Prison Healthcare

AGENDA

Welcome		
Time		**Owner**
10:00 – 10:15	Review rules and expectations from previous development day	Wendy McGregor
10:15 – 11.30	Share and agree ROI theme aide memoires: ○ Medicines ○ Governance and leadership ○ Restrictive Practice ○ Staffing ○ Care and Treatment (incl. perinatal, Eating Disorders; ECT) ○ Physical Health ○ Patient Flow ○ Patient comfort and experience (*Incident Management and ASG, and Environment completed at 04 November session)	All
11:30 – 11:45	Comfort break (15 mins)	
11:45 – 13:00	Escalation Procedure ○ When to escalate and what	Wendy McGregor
13:00 – 13:30	Lunch (30 mins)	
13:30 – 14:10	Learning from SAI systematic review and the new procedure	Phil Hughes MBE Associate
14:10 – 14:30	Resuming SAI role within MHLD	Wendy McGregor
14:30 – 15:00	Inspection feedback script	Wendy McGregor
15:00 – 15:15	Comfort break (15 mins)	
15:15 – 16:30	Report writing – key messages	Wendy McGregor
16:30 – 17:00	Reflections and close	All

MHLD Team Development Day

DATE:	Thursday 26 January 2023
TIME:	9:30 am
VENUE:	HSC Leadership Centre, 12 Hampton Drive, Belfast, BT7 3EN
CHAIR:	Wendy McGregor, Assistant Director, Mental Health, Learning Disability and Prison Healthcare

AGENDA

Welcome		
Time		**Owner**
09:30 – 10:00	Review rules and expectations from Team development days 1 and 2 (04 November and 01 December 2022)	Wendy McGregor
10:00 – 11:00	Serious Adverse Incidents	Phil Hughes MBE
11:00 - 11:15	Break	
11:15 - 12:30	Inspection Reports	Nicola McCann
12:30 - 13:15	Quality Assurance Process	Nicola McCann
13:15 – 13:45	Lunch	
13:45 - 15:00	Discipline on Inspection	Nicola McCann
15:00 – 15:15	Break	
15:15 – 16:15	Risk Management and Safety Brief	Wendy McGregor
16:15 – 16:30	Reflections of the day	Nicola McCann

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/17

Pre-Inspection Assessment

Please select type of inspection

For Part IV services under 2003 Order: lookback timescale will be determined at time of inspection planning.

General			
Name of establishment/agency		RQIA ID	
Name of provider(s)		No. of approved places	
Provider type *(in iconnect, click on provider to see type and companies house info – if discrepancies discuss with aligned inspector and reg team)*	Choose an item.	Companies house/charity registration number	
Any changes in provider status since last inspection?			
Categories of registration		Name of conducting inspector	
Intelligence suggesting activity outside categories of care or registration/ inappropriate placement/breach of Statement of Purpose?			
Name of RI		Any changes to RI arrangements since last care inspection?	
Name of registered manager		Date manager registered	
Does the manager have responsibility for any other registered service?	Insert	If yes please list the name and type of service	
If manager NOT registered – did we receive NOA? If yes when? If no application is this significant?	Insert ***If yes, please comment:***		
How long have they been acting?	Insert		
Has an application to register been made? If yes when?	Insert ***If yes, please comment:***		

What is the impact of the management arrangements on quality of care?	Insert ***Additional information:***
Should registration changes/variations/ conditions/registered person/manager applications be examined during this inspection, if yes should pharmacy/ finance/estates/other disciplines be involved?	Insert
IPT/REWS score	
What is the current IPT/REWs score, date it was completed and main issues it identifies?	
Are there other indications of concerns and issues arising *Hull early indicators of concern tool* Hull early-indicators-of-concern-for-learning-disabilities (hull.ac.uk) *CQC closed cultures/signs of safety* CQC Closed Cultures Identifying and responding to closed cultures: Guidance for CQC staff	

Previous inspection/s			
Date of previous inspection		Type of previous inspection	Insert
Any issues to be followed up from QIP if not relating to your team?		Insert	
If yes, please comment:			
From current QIP, how many Areas For Improvement (regulations) have been stated more than once?	Insert number	How many Areas For Improvement (standards) have been stated more than once?	Insert number
Describe the restated AFIs			
Has there been enforcement activity in the last five years? What impact does this have on decision making?			

Review of RQIA intelligence since the last inspection			
How many notifications since previous care inspection? For pharmacy/estates/finance – how many relevant notifications since last specialism inspection		Are there any patterns/trends?	Insert
If yes, please comment: *Please remember to flag if NO notifications have been received since previous inspection as a potential area of concern*			
Any third party information relevant *e.g. Trust, NISCC, NMC, PCC, Ombudsman, NIAS, HSCB, DOH, PHA, other?*	Insert	***If yes, please comment:***	
Any SAI/SEA investigations/ Early alerts in the last 5 years	Insert	***If yes, please comment:***	
Have there been any safeguarding allegations/investigations?	Insert	***If yes, please comment:***	
Have there been any allegations of staff misconduct?	Insert	***If yes, please comment:***	
Have there been any other concerns/whistleblowing logged since the last inspection?	Insert	Is there anything you need to follow up on during inspection?	Insert
If yes, please comment: *Consider do you need to gather any more information from a third party prior to inspection?*			
Summary and analysis of information. Inspection focus and/or key lines of inquiry? Any other relevant information			
Reminder - Date Field completed on iconnect and form uploaded			
Date completed		**Name of conducting inspector**	

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/18

The Regulation and Quality Improvement Authority

XXXX Hospital
Unannounced Inspection
XXXX (inspection dates)

Record of Inspection Findings

Name and ID of Hospital	XXXX
Name of Chief Executive	XXXX
Date and time of inspection	XXXX
Name of inspector(s)	XXXX
Name of Ward(s)	XXXX

_____ _____

Name of Inspector **Date**

Ward Details

Number of patients currently on the ward	
Number of patients detained	
Number of beds	
Number of patients on an ECR placement	
Number of patients on enhanced observations	
Number of staff on the ward today	
Male: Female Ratio	
Number of patients on leave	
Number of patients currently admitted to hospital	
Number of patients under seclusion	
Number of patients who are under 18 Diagnosed with a learning disability/ mental health disorder (delete as appropriate) With perinatal mental health Have an eating disorder	
Current MDT working arrangements	
Senior Staff Member On Site	

Ward Management Arrangements	
Is this a locked or open ward?	
Are there any patients with any physical healthcare needs?	
Are there any patients at risk of choking?	

Previous Areas for Improvement

<table>
<tr><td colspan="2">Quality Improvement Plan
Areas for improvement from the last inspection to XXXX Hospital /Ward
on XXXX previous inspection dates</td></tr>
<tr><td colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</td></tr>
<tr><td colspan="2">XXXX (Theme- take from previous report)</td></tr>
<tr><td rowspan="3">Area for improvement 1

Ref:

Stated:

To be completed by:</td><td>Area for improvement

Ref:</td></tr>
<tr><td>Response by the Trust detailing the actions taken:</td></tr>
<tr><td>Inspector’s validation:</td></tr>
<tr><td colspan="2">XXXX (Theme- take from previous report)</td></tr>
<tr><td>Area for improvement 2

Ref:

Stated:

To be completed by:</td><td>Area for improvement

Ref:</td></tr>
</table>

	Response by the Trust detailing the actions taken:
	Inspector's validation:
XXXX (Theme- take from previous report)	
Area for improvement 3 **Ref:** **Stated:** **To be completed by:**	**Area for improvement** **Ref:**
	Response by the Trust detailing the actions taken:
	Inspector's validation:

<table>
<tr><th colspan="2">XXXX (Theme- take from previous report)</th></tr>
<tr><td rowspan="3">Area for improvement 4

Ref:

Stated:

To be completed by:</td><td>Area for improvement

Ref:</td></tr>
<tr><td>Response by the Trust detailing the actions taken:</td></tr>
<tr><td>Inspector’s validation:</td></tr>
</table>

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Environment

***"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings."* Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)**

Ward physical environment observational tool / checklist.

Guidance

This inspection tool has been designed to be used as a guide to gather evidence by carrying out a ward physical environment observation.
This evidence will feed into the overall information gathered to identify whether patients on the ward are begin treated with dignity and are receiving care that is safe effective and compassionate care.
This document must be fully completed along with the Quality of Interaction Schedule (QUIS). All areas of the ward should be covered when completing the tool.

Standards and Good practice

This tool has been devised from the following standards and good practice guidance:

The Quality Standards for Health and Social Care; Supporting Good Governance And Best Practice In The HPSS; (March 2006)

Health Building Note 03-01 Adult acute mental health units; Department of Health (2013)
NICE Quality Standards for service user experience in adult mental health (December 2011)

Service framework for mental health and well-being DHSSPSNI (2011)

Environmental and Therapeutic Issues in Psychiatric Design: Toward Best Practices; Karlin B, E and Zeiss R, A; Psychiatry Online (2006)

Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)

Improving the patient experience Developing Supportive Design for People with Dementia
The King's Fund's Enhancing the Healing Environment Programme 2009-2012Dementia Care Environmental Standards.

Ward environment	Checklist	Yes ✓ No X	Comments *(should cover areas for improvement as well as positive comments)*
The ward has a method for greeting patients that reflects customer service values and patient centeredness	There is information about the purpose of the ward The vision for the ward is displayed. Does the ward have a mission statement? There is a ward information / welcome booklet and all the contents are up to date and relevant. There is information about the wards performance e.g. information in relation to releasing time to care, i.e. incidents, compliments, complaints etc. The ward has a mechanism for patient feedback on service development, patient experience; areas that patients say need improved. The outcomes from patient feedback is available for patients		
Enhanced observations are carried out with dignity	Are there any patients in receipt of enhanced observations? How many? Level of Obs. Enhanced observations are carried out with respect and dignity. Staff are considerate.		

The ward is clean, tidy, well maintained and clutter free. There is good lighting and ample natural daylight. The air quality is good, there is good ventilation and neutral odours	Are your first impressions conducive to the statement? Think about it in terms of what a patient or relative sees.		
Patient bays are single sex	Patients sleeping bays are single sex. There are appropriate routes for patients to use single sex bathrooms and toilet facilities.		
Patients can access quiet private areas	There are quiet private areas for patients		
A ligature risk assessment has been completed with an action plan	The ward has a ligature risk assessment and an action plan has been implemented. Also Check all beds are ligature free/check ward environment. Patients requiring a profiling bed have an individual risk assessment Check if where ligatures are identified that patients have an individualised risk assessment and management plan in place		
Patients can meet with their visitors in private and comfort	There are visitor facilities – these are comfortable with enough seating etc.		

Ward furnishings, interior design are clean well maintained and comfortable.	Furnishings are clean, maintained, comfortable, meet the needs of the patients (where appropriate meet the needs of elderly care, LD) There is enough seating for patients and staff.		
Patients have access to a telephone	Patients can access a telephone in private.		
Patients are informed of all staff who they will come into contact with	All staff wear name badges. There is information on display about staff - that includes nursing staff and MDT team. There is information on display about who is on duty that includes the ward doctor. There is information about patients named nurse and associate nurse or key worker There is information on which staff are allocated therapeutic 1:1 time with patients. Where appropriate this information is provided in a format for patient who require support with communication.		
There is clear signage on the ward for patients and visitors	There is signage to orientate patients and visitors		

	Signage is in a format that meets the needs of patients who require support with communication.		
Patients are informed of their rights	There is information available in relation to Human Rights, complaints, advocacy, Mental Health Order, MHRT, the right to access information held about patients Information is in a format that meets the patients who require support with communication		
The ward environment promotes patients dignity and privacy	Screens, curtains used for sleeping bay area's etc. are well maintained. Patients can lock their bedroom doors (and en suite if applicable) Patients can lock bathroom / toilet doors Staff can open these if required		
Patients have open access around the ward environment and can access an outside space	Patients can access their bedrooms, bathrooms and toilet facilities. Patients can access an outside space The outside space is well maintained. There are areas to sit. Check if the ward door is locked (a risk assessment / DOLS should be in place if patients do not have		

	access) There is information displayed in relation to DOLS which will inform patients and visitors why exit from the ward is controlled by staff		
Precautions are taken to prevent information being shared inappropriately	Staff telephone conversations are not over heard, computer screens cannot be viewed, patients details are not on white boards in view of the public (except patients names) Confidential records are stored appropriately		
The medical room and its contents are clean, maintained and accessible	The medical room is clean, organised and well maintained. Medications are stored appropriately. The resuscitation trolley has been checked in accordance with trust policy.		
Patients can alert staff when needed	Staff are present in the patients communal areas Is there a call / alert system for patients and staff i.e., is there a call system in bathrooms.		
Staff alert systems	All staff have an alarm. There are extra alarms available for visiting professionals. Alarms are serviced and maintained.		

Patients know what is happening in their day	There is information on activities (i.e. OT, psychology, nursing etc.) available every day – a ward schedule. Is this all in the one place and includes the activity and the member of the MDT who is facilitating the activity. There is a good range of appropriate activities that meet the patient's needs this includes what is available during the evenings and weekends There is information on the days of the ward rounds. There is information when the advocate visits the ward. There is information on the next patient forum meetings. Do patients have individual activity schedules (where appropriate)? Do patients have a copy? Staff record if any of the above has been cancelled the reason why and there is a mechanism for informing patients.		
Patients are clean, comfortable and suitably clothed to promote dignity (applicable on wards where there are patients who require support and assistance	Patients appear to have had their personal hygiene attended to. Patients' clothing appears clean and free from food stains.		

with personal care etc.) **This is does not apply to all wards**	Use your judgement here as this may not be appropriate in all settings		
Meals are appetising and appropriate to the needs of the patients **Patients can eat their meals in a clean comfortable dining area and have safe access to fluids during the day**	The hospital menu offers a good choice of meals. The menu meets dietary requirements of the patients i.e. culture, vegetarian, coeliac, gluten free etc. Have any patients raised any concerns about the food with you or previously with staff. How have these been managed – complaints, food users group etc. Patients are informed of meal times. Meal times are protected. There is fresh water available. Is there tea and coffee making facilities There is information on the menu for the day. The dining area is clean and comfortable. There is adequate space, seating i.e. not overcrowded.		

Patients with a learning disability or who have a cognitive impairment can orientate themselves around the ward	Patients are orientated to time and space – signage, time. The ward physical environment meets the needs of patients who have dementia and patients who require support with mobility.		
Patients can control their level of social contact	There are spaces where patients can retreat, including spaces where they can form social relationships. There are no areas that are prone to overcrowding. Day rooms are open and furniture is arranged that encourages staff interaction while allowing for personal autonomy.		
The seclusion room is designed in accordance with policy and procedure and good practice guidance **This does not apply to all wards**	Seclusion must only be delivered in a room designed expressly for that purpose. The seclusion room is designed to minimize the traumatic potential of seclusion interventions. Check the following There is facility for constant observation The room is away from other patients and other areas that are the site of frequent non-clinical interaction i.e. exits.		

	• The room must be large enough to accommodate up to six staff members • The seclusion room contains limited furnishings. • The seclusion room is designed to enable protection of the patient, and prevent harm to self and others by eliminating or avoiding any weak points, ligature points, corners, edges or other safety hazards. • All features of the seclusion room are durable, tamper- and impact-resistant, washable, and can withstand significant and repeated force. • Walls and floors are of seamless construction. • Walls are painted a calm, definitive colour • The seclusion room should have an unbreakable window allowing natural light into the space, and a view of a natural or outdoor setting. The window should be large enough and placed so that a patient may be able to see out of it while sitting on the floor, and cannot kick the window sill. It should be fitted with blinds that nursing staff can operate remotely.		

	• Lighting in the seclusion room is mounted securely, unbreakable, and operated on patient request via the nurses. • The door to the seclusion room is heavy, solid-core, and opens outward on a spring loaded mechanism stalled securely with attention to preventing self-harm. The door contains a glazed observation panel with a blind on the outside to be controlled by staff. • Door locks are operated from exterior, with a mechanism that is easy to operate, and set to unlock automatically if the fire alarm is triggered. • The seclusion room is fitted with sanitary facilities including a hospital-grade toilet and sink. • The seclusion room has adequate airflow and a healthy air temperature, and should be air-conditioned. • The seclusion room is fitted with appropriate safety mechanisms. including a staff-operated alarm system. • Patients have sight of a clock. • Patients and staff can communicate at all times		

Contingency beds	Have contingency beds been risk assessed		

Incidents and Adult Safeguarding
Aid Memoire: • Any patients subject to Adult Safeguarding processes-check incident form completed and the Trust have followed regional policy • Staff knowledge on adult safeguarding- this includes all staff. Staff should be able to reference protection plans • ASG training for all staff is up to date • Potential ASG have been screened in / out appropriately with rationale recorded and appropriate • The Adult Safeguarding incident concerned has been investigated by IO with DAPO oversight. An interim protection plan is put in place. • At ward level, ASG champion and lead- this should be advertised to everyone. • Information on ASG in the ward ie a flowchart • Out of hours contact details available • ASG information displayed on the ward- data and processes • Availability and accessibility of protection plans- should be in physical copy for agency staff to access • Robust governance systems in place for oversight of incident management and ASG. **Incident Management:** • DATIX- scan and look at grading and the consistency of and level, any adult safeguarding within and what has been done if it was an adult safeguarding. Process should be evident to see escalation to ASG team, police mentioned and informed where appropriate. • Themes and trends from DATIX- assessing each of the chosen incidents to determine if an APP1 should have been completed- this will show culture on the ward. • ASG incidents need to be triangulated with patients' records. This should be reflected in the DATIX. • Highest two levels to be escalated to senior management. Insignificant and medium do not get escalated to senior management- may view incidents that need to be escalated. If incidents are primarily green, it may be the case that trends are not being identified by staff or the cumulative effect. • Joint Protocol Arrangements- have police been consulted? • Are there debriefs after significant incidents ie staff assault, patient assault, rapid tranquilisation? • Debrief with the patient involved- good practice which should be reflected in the report and patient records • Trends and sharing of themes and analysis

Evidence:
Findings:

Further Actions:

Final Judgements:

Has an area for improvement been identified: Y / N

Staffing **"Staffing arrangements are in place that meets the assessed needs of patients. Staff have the skills, knowledge and experience to deliver effective care support and treatment"**
Aid Memoire: • Staffing levels are safe and meet the needs of the patients • Staff have the skill and knowledge to support the patients in their care and meet their needs • Defined nursing model that supports decisions on the basis of patient acuity • Ask about ongoing recruitment and assuring continuity of care • Staff escalation if short staffed- there should be a DATIX for short staffing • Staff supervision, appraisals, training and support • Ask the staff about morale and culture- will indicate if senior staff are involved • Look at skill mix of staff particularly of wards that have mostly registrants • Appropriate delegation of tasks- task allocation sheet could be useful to evidence - duties assigned. • Ask about the induction of all staff
Evidence:
Findings:

Further Actions:

Final Judgements:
Has an area for improvement been identified: Y / N

Physical Health
Aid Memoire: • Have you any patients with health care needs on the ward and if so, what are they? • Are there any patients with risk of choking? • Are there clear path ways for staff to follow with head injuries? • Can staff recognise the deteriorating patient and know what to do when a patient's physical health deteriorates? Are there assessment tools in place to help staff identify deterioration • Is there a physical health care pathway in place? • Has the patient been seen within 6 hours of admission? • Has admission bloods been completed? • Is there an increase in falls and if so, is there a falls care pathway? • Do care plans reflect physical care needs? Are they patient centred, Specific, Measurable, Achievable, Realistic and completed within the agreed Timeframe (SMART)? • Is there evidence of health care screening carried eg breast, cervical, bowel, dentist, optician etc, if appropriate. • Has the ward completed Braden Scales, Must, Skin Bundles etc? • How many patients have skin care needs? • How many patients require assistance with physical care needs, dressing, feeding, and mobilisation? • Is there evidence of BMI monitoring, fluid balance, MEWS etc? • Has there been timely referrals to specialist practitioners eg SALT, TVN, ECG? • Are SALT requirements in place? Have they been appropriately assessed? How do staff ensure patients receive the appropriate modified diet? • Any audits of physical health needs? • Are staff trained in the recognition of sepsis? • How is pain assessed and managed for patients who have difficulty communicating? • Is there evidence of GP/MDT involvement? • Is there equipment readily available to support with emergencies
Evidence:

Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Restrictive Practices

Patients are cared for in the least restrictive environment possible while ensuring appropriate levels of safety. Restrictive practices are always proportionate to level of risk presented by the patient. Restrictive practices must also be necessary, the least restrictive intervention, regularly reviewed, used for the shortest time possible and be the most therapeutic intervention.

Aid Memoire:

Ensure restrictions are not used because of short staff

Examples: MHO, seclusion, restraint, MAPA, increased level of observation, locked doors, bed rails, sensor mats, CCTV, lap belts, medication including rapid tranquillisation, restrictive clothing, restricting visiting.

- Establish what restrictive practices are being used.
- Are there any blanket restrictions and how are these managed – e.g locked doors, restricted items
- Are restrictions proportionate to level of risk?
- Review number of restrictive practices over a specific time period?
- Have restrictions been discussed and agreed with MDT prior to implementation and are they reviewed weekly as a minimum to keep patients safe?
- Has the patient been consulted with and / or their family where appropriate?
- Have other less restrictive interventions been considered and is this evidenced?
- Have staff received training in restrictive practices?
- Consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests.
- Are staff aware of the FREDA principles? (Fairness, Respect, Equality, Dignity and Autonomy)
- Is there evidence of ongoing review? Is timescale for review in care plan?
- Restrictions are used for least possible time and there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice.
- What is staff knowledge of restrictive practices?
- Are staff aware of local policies? What are they?
- Are staff aware of best practice in relation to restrictive practice?
- Are staff aware of human rights considerations?
- How do staff show consideration of human rights?
- Are any visiting restrictions in place?
- How often is PRN medication used?
- How often is Rapid Tranquillisation used?
- Is there analysis of PRN use and rapid tranquillisation?
- Is there clear guidance in medication kardex for Rapid Tranquilisation use?
- Do patients have appropriate care plans in place for restriction in place?
- If bed rails are used, have they been risk assessed?
- If seclusion is used are records maintained of observation and review?

- How often has MAPA been used?
- Are there records to evidence that body maps and medical reviews have taken place post MAPA intervention?
- Review MHO documentation?
- Is the MHO being used appropriately? Think Vol patients - can they leave freely / any restrictions in place to prevent a voluntary patient leaving?
- Deprivation of Liberty Safeguards – Mental Capacity Act
- Review and observe 1:1 observations.
- Do staff have time limited periods of 1:1 – rotation, breaks.
- Are staff observed to engage with patients during enhanced observations?
- Are patients denied personal items eg: mobile phones. Is there a rational for this?
- Has there been any safeguarding incidents relating to restrictive practices?
- Is the ward committed to reducing restrictive practices?
- Eg: analysis of incidents to evidence this.
- How are patients protected from discrimination in relation to protected characteristics under the Equality Act?

- Are staff aware of the new Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And regional operational procedure for the use of Seclusion Northern Ireland March 2023? Is there a copy on the ward?
- Has the Trust appointed an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion?
- Is there evidence that the Trust policies and practices embed the use of the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions which includes seclusion?
- Restrictive practices and seclusion must include The Three Steps to Positive Practice Framework include:

1. Consider and plan
2. Implement the safeguards
3. Review and reflect

- Are there restrictive practices in place? Are they appropriate? Have they been assessed, planned, implemented and reviewed as agreed?
- Have all staff been trained in relation to restrictive practice/seclusion and safety intervention approaches?

Standards

The following Standards are available on the ward, staff have access and are aware of same?

1. All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

2. All local policies and practices must embed use of the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions.

3. Effective and person-centred communication must be central to care and treatment planning.
4. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.
5. Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.
6. Roles and responsibilities are defined in terms of monitoring, reporting and governance.
7. Any use of seclusion as a last resort intervention must follow the regional operating procedures.

Seclusion

Is there a designated seclusion room? Is it fit for purpose? (refer to the appendix in the new regional policy) Is seclusion appropriate?

Is there a Trust policy on seclusion in accordance with the new regional policy/operating procedures and the Mental Health Order (MHO) NI 1986?

Do the records include the following?

1. Seclusion maintenance rerecord
2. Record of seclusion
3. Seclusion care plan
4. Seclusion observation record
5. Seclusion review record
6. Seclusion audit form
7. Seclusion flowcharts and quick reference charts

Has FREDA (Fairness, Respect, Equality, Dignity and Autonomy) been built into the Trust policy and procedures and staff approach.

Evidence:

Findings:

Further Actions:
Final Judgements:

Has an area for improvement been identified: Y / N

Patient Experience

Aid Memoire:

- What is the lived experience of the patients like?
- Observe mealtime experience, activity sessions and general observations of patients and interactions with staff. Are mealtimes well organised?
- Are patients relaxed in staff company?
- What is patients physical appearance like?
- Do staff interact with patients with respect and maintain patients dignity?
- Are staff friendly and show warmth and compassion in their interactions with patients?
- Do staff respond to patients in timely way and do they give an explanation when they may be a delay in their response?
- How staff speak about patients is there any labelling, demeaning, patronising or negative language used?
- How do staff talk about patients they are caring for?
- Do staff adjust communication to meet patients' needs?
- Do staff support patients if required in a dignified manner? Ie: sitting with patients, assisting 1 person at a time.
- Speak to patients:
  - Ask about their experience of the ward and staff
  - Are they happy with the way they are cared for?
  - Do patients know how and who to raise concerns/complaints with?
  - Have they raised any concerns?
  - If so were they satisfied with outcome?
- Are patients involved in planning and making decisions about their care and treatment?
- Are patients given information about their rights?
- How are patients assured that information about them is treated as confidentiality?
- How do staff ensure privacy and dignity during examinations/procedures is assured
- Do staff respond in a compassionate timely and appropriate manner when patients experience pain, discomfort and distress?
- Do staff understand social, cultural, diversity issues and how are these managed?

- Are interpretation services available?
- Advocacy available, are patients aware of it.
- Is advocacy independent?
- Consent to treatment and refusal? How is this documented?
- Can patients raise concerns / complaints and are these actioned appropriately

Evidence:
Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Governance
"The leadership, management and governance of the organisation assures the delivery of high quality and person centred care, supports learning and innovation and promotes an open and fair culture"

Aid Memoire:

Establish the current SMT membership and collective leadership team *(note any vacancies / deficits)*

What is the governance structure in place? *(I.e. is there a daily hospital huddle; safety briefings within each ward; weekly live governance meetings?) How is information captured, shared, escalated – is there an effective system in place that provides assurance regarding staffing across the site for example?*

What are the key safety metrics for the hospital / ward? (*i.e. seclusion episodes; incident analysis meetings; staffing levels; ASG Referrals and issues; Medication issues; Rapid tranquilisation; Complaints; Compliments; Physical interventions) –* ***Are these being fed through the relevant governance structures and used to inform improvements?***

Are the governance systems sensitive enough to collect information and data about all the pertinent issues, including untoward incidents, safeguarding incidents, pharmacy and estates/ finance issues?

What assurance systems are in place regarding patient's physical health care needs? *Daily, weekly, monthly checks at ward level, anti-psychotic medication monitoring,*

Do Ward sister / Charge Nurse meetings happen? How often?
Capacity and Capability Do leaders have the knowledge, experience and integrity they need to deliver high quality care?
Do leaders understand the challenges to quality and sustainability and can they identify the actions to address?
Can leaders prioritise what is needed to deliver and sustain high quality care?
Are leaders visibleand approachable?
Are leaders compassionate?
Is leadership consistent – approach, staff turnover, succession planning

Vision and strategy
Is there a clear and achievable vision?
Are the values of the organisation embraced by all staff and is quality and sustainability a number one priority?
Is there a clear strategy to achieve the vision and is this well-known and embedded amongst staff
Are the actions to achieve the strategy achievable and is there a good governance mechanism in place to monitor with timely review arrangements?.

Culture
Do staff feel supported, respected and valued by the organisation and its leaders?
Is the culture centred on the needs and experiences of patients using the service?
Do staff express positivity / feel proud to work in the organisation?
Are there good performance management systems in place and is there evidence of actions taken to address behaviours when appropriate

Is there openness, transparency and honesty at all levels – governance information is shared appropriately
Can staff raise concerns with the right people at the right time without fear of retribution?
Is there good staff development and learning opportunities – ward based learning, training, appraisals and career development
Is staff safety and wellbeing in focus?
Does the staff team work well together, are conflicts detected early and addressed appropriately?
There is an inclusive culture that ensures equality and respect among staff– (any evidence of discrimination / staff conflict is promptly addressed and actions to manage same and in evidence).
Is there a supportive staff culture - one of learning and not blame when something goes wrong?
Are there any indicators of a closed staff culture i.e:

- significant management changes over a short period;
- high use of non-permanent staff;
- poor response to complaints;
- limited/ no evidence of staff supervision arrangements;
- patients more likely to be at risk of harm / dependent upon staff

Accountability
Accountability structures are in place and all staff are knowledgeable about the structure and system of accountability
Governance systems and management teams function effectively and interact appropriately – learning is shared and there is evidence of a whole systems approach
Do staff demonstrate they understand the parameters of their roles and how / when to escalate?

Risk, ASG, incidents and concerns
Are there effective governance systems in place to identify record and manage risk? Are the recorded mitigating actions in place appropriate?
Are staff knowledgeable about ASG, and incident and risk management?
Is risk escalated to the right level? How?Are current staffing levels safe? Are current staff levels affecting overall hospital stability?

Are there programmes of clinical and internal audit, with outcomes identified and appropriate actions focused on improvement taken.
Are potential risks taken into account when planning service delivery – eg seasonal, staffing.

Information governance, data usage, and performance
Is information used to measure /drive improvement and not just offer assurance - What information is brought to the weekly assurance meeting and how is this contributing to decisions / actions? *(Review minutes of meetings and discuss with relevant staff)*
Is quality and sustainability sufficiently discussed at meetings at all levels.
Are there service performance measures in place that are reported, available and monitored?
Is there a system in place to ensure the data used to measure performance is accurate, valid and timely (up to date)? What action is taken when issues are identified?
Are there effective arrangements in place to ensure data or notifications are submitted to other stakeholders i.e. SPPG, when appropriate.

PPI
Are service users views gathered and used to improve services – think about how services ensure equality and respond appropriately to diversity
Are staff actively engaged in sharing their views on service delivery?

Is there evidence of positive and collaborative relationships with other stakeholders -- is a shared understanding of challenges / needs of the population
Is there transparency and openness with all stakeholders?
Are staff actively engaged to express their views and are these reflected within planning?
Is there a robust complaints system in place – outcomes used to drive improvement?

Quality Improvement
Is there evidence of a culture of learning, innovation and continuous improvement?
Have there been any QI initiatives? - how have they made a difference to service delivery?
Have QI initiatives been shared internally and externally?

Evidence:

Findings:

Further Actions:

Final Judgements:
Has an area for improvement been identified: Y / N

Patient Flow

Aid Memoire:

Good patient flow ensures that people are getting the right care, in the right place at the right time.

Patient's participation in their own care and treatment is important. They should be consulted and informed of plans regarding discharge from hospital. Family engagement should be evidenced.

Over occupancy can be an indicator of pressures in the system. RCoP recommends maximum occupancy of 85%

Over Occupancy-what is impact on patients and the care and treatment they receive? Are the environments conducive to wellness and recovery, are they safe, comfortable and risk assessed?

Patient Flow:

- Dashboards
- Check that a bed manager is in place and their role in relation to discharge- What system is in place? Is it robust enough?
- Total number of patients admitted / male female ratio (impact of) how is this managed, How are male / female interactions managed? Is there a risk assessment in place?
- Average length of stay / longest stay. How long each patient on ward, dates of admission is there good admission to discharge rate i.e. nice patient flow.
- Appropriate admission- under 18- ensure appropriate safeguards / Child Protection
- LD diagnosis & rationale for admission / appropriate safeguards
- Number of patients detained versus voluntary
- Number of patients who are in receipt of active treatment
- Number of patients whose discharge is delayed / rationale for delayed discharge
- How many patients are prescribed enhanced supervision / observations
- Number of patients waiting on admission from community – detained/voluntary?
- Escalation process for over occupancy / Early Alerts /impact to care and treatment

Over Occupancy

- Patients on ECR placements
- Number of patients waiting in ED for admission and length of wait
- Patients who are on home leave/ on a different site
- Patients in custody or under PSNI supervision
- Use of contingency beds? Where are they in the ward? Are they suitable/converted rooms, have they been risk assessed for ligature risks

Resettlement / Discharge Planning:

- Are patients involved in their own care and treatment? Do they know what the expected outcome of admission is?

- Do all patients have discharge plans?
- Where discharge plans have been drawn up how effective are these- look at 25%
  Are the outcomes of assessment and treatment clearly stated or understood so it will be clear when hospital intervention is complete and discharge can occur?
- Are there planned dates of discharge / resettlement recorded for each patient, are these realistic, achievable?
- Is there a discharge address? Provider/family member address?
- Evidence of MDT involvement in discharge planning / resettlement, and is this reflected in Discharge planning meetings?
- Evidence of family involvement in care and treatment reviews.
- Ask family if they know admission is temporary?
- Have barriers to discharge been identified and clearly recorded?
- Is the MDT aware of these?
- Review process - how are discharge plans reviewed? Look for evidence of good active discharge planning. Is there a team who supports discharge?
- Are plans comprehensive and in line with the patient's own needs?
- Is there a risk of institutionalisation?
- Is there an appropriate 'lead in' / transition period?
- How are patients able to engage in community activities?
- Are patients able to maintain skills for independence in community?
- Are patients able to develop their skills for self-care (with or without support)?
- Are staff supporting patients to maintain or develop skills for self-care / independence or living in the community? Consider patients who require staff support to meet their needs and patients with limited capacity.
- What is the relationship with commissioning managers? How often do they visit? Are they communicating regularly to plan discharges?
- Is there in reach and outreach work? Is information shared with other providers- in-reach and out-reach. Align someone on inspection to speak with in-reach staff. Get an overview of how this work is progressing, are staff participating, shadowing, or used on ward to carry out other duties?

Evidence:

Findings:

Further Actions:
Final Judgements:
Has an area for improvement been identified: Y / N

Medicines Management
Aid Memoire: • Are prescribed medicines administered and /or supplied to people in line with best practice guidance? • Do patients receive specific advice about their medicines in line with current best practice? • How does the service make sure that patients receive their medicines as prescribed – is there evidence of an effective audit arrangement in place? • Are patients receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with best practice / NICE guidance • Do patients have their medicines regularly reviewed including the use of PRN? • What mechanisms are in place to ensure patients' behaviours are not controlled by excessive or inappropriate use of medicines, including use of rapid tranquillisation? • Are omissions / medicines errors appropriately responded to?
Evidence:
Findings:

Further Actions:
Final Judgements:

Has an area for improvement been identified: Y / N

Mental Health

Aid Memoire:

- Are patients having their anti-psychotic medication reviewed annually as a minimum?
- Is care and treatment holistic in nature and not just medically orientated?
- Is care and treatment evidenced based?
- Are there any patients receiving ECT? If so is there a care pathway in place?
- Are there any patients on Clozapine medication? How is this monitored? Is there a care pathway?
- Are there any patients on Lithium therapy? How is this monitored? Is there a care pathway?
- Are there any patients experiencing eating disorder type illnesses on the ward? Is there input from the regional eating disorder team?
- Are there any patients with perinatal concerns? Does the patient receive specialist input?
- Are there any patients with learning disability diagnosis.
- Are there any patients with risk of self-harm or carry out self-harming behaviour?
- Are there clear behaviour plans in place for those patients who have challenging behaviours? Are there behavioural support plans in place? Does the behavioural support team provide input at ward level?
- What is the referral pathway for psychology services? Does staff provide CBT and are there any staff trained in this area?
- Is there OT input on the ward? If so, do patients attend an OT based unit on the ward?
- Is there an opportunity for patients to avail of advocacy on the ward? Who provides this service?
- Is there CMHT involvement with the patient?
- Are there patient risk assessments in place using an evidence based risk assessment tool. Do risk management plans address the risk anda re they monitored and reviewed in a way this is appropraie to the risk identified? are they used to monitor and idenfiy improvement

Evidence:

Findings:

Further Actions:

Final Judgements:
Has an area for improvement been identified: Y / N

Opportunities to share learning – peer review – complete each other's audits

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/19

Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Early Alert system

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management and Service Improvement, HSC Board
- Directors of Social Care and Children in HSC Board and HSC Trusts
- Directors of Nursing and AHP in PHA and HSC Trusts
- Director of Integrated Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The Circular provides guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations.

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D1
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 8561
E-mail: sean.scullion@dhsspsni.gov.uk

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: **28 May 2010**

Related documents

HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

HSC (SQSD) 08/2010: Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

Status of Contents:

Action

Implementation:

From 1 June 2010

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

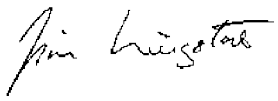
In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

Circular HSC (SQSD) 08/2010, which issued on 30 April 2010, advised of the transfer of responsibility for managing SAIs from the Department to the HSC Board and Public Health Agency with effect from 1st May 2010, and the revised reporting arrangements which will be in place until the new RAIL system is fully implemented.

The purpose of this circular is to provide specific guidance on the arrangements which should be followed with effect from 1st June to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely



Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Introduction of an Early Alert System

Purpose of the Early Alert System

1.1 The Early Alert System will provide a channel which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

1.2 While it is likely that some of the notifications reported as Early Alerts will also require to be managed as adverse incidents by HSC organisations**, many adverse incidents will NOT need to be reported through this channel.**

Criteria for using the Early Alert System

1.3 The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. ***Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;***

2. ***The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;***

3. ***The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;***

4. ***The media have inquired about the event;***

5. ***The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;***
    - ***i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or***
    - ***ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or***
    - ***iii. the Coroner's inquest is likely to attract media interest.***

6. ***The following should always be notified:***
    i. ***the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;***
    ii. ***the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;***
    iii. ***allegations that a child accommodated in a children's home has committed a serious offence; and***
    iv. ***any serious complaint about a children's home or persons working there.***

7. ***There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.***

1.4 Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

1.5 It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

1.6 It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

1.7 The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

ANNEX A

☒ **Initial call made to** _____ **(DHSSPS) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details: Telephone (work or home) ……

Mobile (work or home) ……..

Email address (work or home) …….

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

---

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: ….....

Detail of follow-up action (if applicable) …….

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/20

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Reference: HSC (SQSD) 5/19

Date of Issue: 12 November 2020

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive, PHA
Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents**:**

HSC (SQSD) 64/16: Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This updated circular advises on the use of the Early Alert System with respect to COVID 19 incidents/outbreaks and also serves as a reminder to the operation of the Early Alert system. COVID 19 incidents/outbreaks that are being managed as part of a normal operational response (usual business) should not be routinely reported through the Early Alert system. Such outbreaks/incidents should continue to be reported to Health Protection Team in the PHA as notifiable disease and HSC organisations should continue to provide regular updates to HSCB through established SITREP arrangements.

Action

Chief Executives of HSCB and PHA should:

- Disseminate this circular to all relevant HSCB and PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant staff and all relevant independent sector providers.

Chief Executive of NIMDTA should:

- Disseminate this circular to all relevant staff and doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The Early Alert protocol is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events, which may require the attention of the Minister, Chief Professional Officers and/or policy leads. The purpose of this circular is to clarify arrangements with respect to COVID 19 incidents/outbreaks and re-issue updated guidance for the procedure to be followed if an Early Alert is appropriate.

This updated circular will also serve as a reminder to HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department. The protocol, criteria and operational arrangements for the Early Alert system are provided at **Annex A**, an updated summary of departmental contact numbers is provided at **Annex B**, amendments to these guidance documents, last issued 27 February 2019, are highlighted in yellow for your attention.

During this current surge of COVID-19 incidents/outbreaks have become more prevalent across all HSC organisations, and the handling and management of many of these has become embedded in usual operational business arrangements across HSC organisations. Healthcare outbreaks that are being actively managed as part of an organisation's normal operational response should not be routinely reported

through the Early Alert System. These incidents/outbreaks in health and social care settings should instead continue to be reported to the Health Protection Team within the PHA through established processes for notifiable diseases. Such incidents/outbreaks will subsequently be notified to the Department via daily SITREPs collated by HSCB and via daily update reports shared by PHA's Health Protection service with the Chief Medical Officer's office.

It is important to note that certain COVID-19 incidents/outbreaks, including where there is a serious impact on service delivery, that are not being handled through normal operational response may fall within some of the criteria listed below in **Annex A** and therefore they may warrant an Early Alert. HSC organisations should assess events as they occur/emerge and should they determine that one or more of the criteria listed in Annexe A is met they should report through the Early Alert system as appropriate.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr David Wilson
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ

qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;*
iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex B** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at **Annex C**, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

It is important that, when completing the proforma, the information about the person making the notification to the Department, the person who received the information within the Department and the date on which the information is exchanged, is accurate (for recording purposes).

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), the Safeguarding Board for Northern Ireland, Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial/personnel changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

ANNEX B

EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST NOVEMBER 2020

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston 028 9052 3724

Primary Care/Out of Hours Services
Chris Matthews 028 9052 2123

Secondary Care
Ryan Wilson 028 9052 0265

Workforce Policy/Human Resources
Preeta Miller 028 9052 0504

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly 028 90522667

Infrastructure Investment
Andrew Dawson 028 9052 2388

Information Breaches/Data Protection
La'Verne Montgomery 028 9052 0501

Finance Director
Brigitte Worth 028 9052 3184

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland 028 9052 0561

Child Protection/Looked After Children (LAC's)
Eilis McDaniel 028 9052 3263

Mental Health Learning Disability/Elderly & Community Care
Mark Lee 028 9052 0724

Social Services
Jackie McIlroy 028 9052 0704

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride 028 9052 0563

Deputy Chief Medical Officers
Dr Naresh Chada 028 9052 2049
Dr Lourda Geoghegan 028 9052 8173

Population Health Director
Liz Redmond 028 9052 2045

Chief Dental Officer
Simon Reid 028 9052 2940

Chief Pharmaceutical Officer
Cathy Harrison 028 9052 3219

Senior Medical Officer
Dr Carol Beattie 028 9052 0717

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle 028 9052 0562

Deputy Chief Nursing Officer
Heather Finlay 028 9052 0007

ANNEX C

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria under which event is being notified (mark as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children/young people in care or receiving after care support***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: * ***If this relates to a child please specify DOB, legal status, placement detail If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of the Safeguarding Board for Northern Ireland (SBNI).***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Second Statement of Briege Donaghy
Regulation and Quality Improvement Authority ("RQIA")
Date: 15 November 2023

Exhibit BD2/21

RQIA Comparison of Draft and Final

Record of Inspection Wording following

Factual Accuracy Responses

Date of Inspection	Page and Paragraph	Draft Report Wording	Amended Report Wording
December 2019	Page 26, Paragraph 2	However, we established that the seclusion room within MAH was accommodated in the PICU which remains closed to its previous function so if a patient requires seclusion, the safe, humane and least restrictive transfer of the patient is a challenge. The safety of accompanying staff is a further challenge. The Trust should complete a review of how seclusion is provided on the site taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. An area for improvement was made in this regard.	However, we established that the seclusion room within MAH was accommodated in the PICU. As the PICU remains closed to its previous function the environments currently used for seclusion do not meet required standards. To manage some challenging behaviours in line with best practice the hospital requires access to an operational seclusion room when necessary for patient safety. The Trust should complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. An area for improvement was made in this regard.
December 2019	Page 31, Paragraph 6.32	The Belfast Health and Social Care Trust shall complete a review of how seclusion is provided on the site taking into account the safety of both patients and staff. The Trust should also take into account the dignity of patients and best practice guidance.	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance.
April 2020	Page 9	The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each	The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each

		patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital and within the Community Intensive Treatment team.	patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital.
July/August 2021	Page 2 Paragraph 1.0	Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH provides a service to people with a Learning Disability from the BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). Patients were admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The hospital remains closed to admissions and the Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018	Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH provides a service to people with a Learning Disability from the BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). Patients were admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admissions to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.
July/August 2021	Page 13, Paragraph 5.2.6	RQIA recognise that there is a growing number of staff on protection plans which, from an operational perspective, is challenging. The protection	RQIA recognise that there is a growing number of staff on protection plans which, from an operational perspective, is challenging. The recent

		plans are reviewed by The Muckamore Abbey Hospital Safeguarding Operational Working Group and by the ASM on site regularly.	protection plans are reviewed regularly by the ASM and the DAPO on site and protection plans relating to Historical CCTV investigations are reviewed 3 weekly at the Muckamore Abbey Hospital Operational Group meeting
July 2022	Page 7 Paragraph 2	Continuity and consistency amongst staff team was limited with a limited number of staff taking responsibility and accountability for the delivery of care	This had an impact on the continuity of care for patients
July 2022	Page 7 Paragraph 5	There is a statement that planned visits were cancelled. Planned visits were cancelled on occasion only and as a last resort.	Some planned visits and outings with family members had been cancelled at short notice due to staffing arrangements
July 2022	Page 8 Paragraph 3	Staff were not equipped or skilled to deliver a PBS model resulting in an over-reliance on the use of restrictive practices such as the use of pro re nata (PRN) medication, and MAPA.	Staff had limited understanding of these and were reluctant to implement the PBS model. This increases the risk of a reliance on the use of restrictive practices to manage patients' behaviours'
July 2022	Page 8 Paragraph 5	There was evidence, in one ward, of an over-reliance on the use of PRN medication to manage the presentation of some patients and we were concerned to note that some administration times coincided with shifts where there were staffing deficits, and when staff on duty were not familiar with the patients' needs.	There was evidence, on occasions, of an over-reliance on the use of PRN medication (PRN medication is medication administered as needed, to support patients with regulating their behaviours) to manage the presentation of some patients and we were concerned to note that some administration times coincided with shifts where there were staffing deficits, and when staff on duty were not familiar with the patients' needs.
July 2022	Page 9	Staffing shortages within the adult safeguarding team have	Staffing shortages within the adult safeguarding team have led

	Paragraph 4	led to delays in the adult safeguarding process, with a large volume of adult safeguarding investigations not progressed.	to delays in the adult safeguarding process, with a large volume of adult safeguarding investigations not completed.
July 2022	Page 9 Paragraph 6	The PSNI were regularly called to attend the site in response to incidents. There were fewer than expected occasions of debrief and robust incident management oversight resulting in insufficient learning and improvement post incident. There was limited evidence of the effectiveness of audit and analysis of incidents with opportunities to reduce risk and improve patient care missed.	There were fewer than expected occasions of debrief and robust incident management oversight resulting in insufficient learning and improvement post incident. There was limited evidence of the effectiveness of audit and analysis of incidents with opportunities to reduce risk and improve patient care missed.
July 2022	Page 10 Paragraph 2	They advised additional adult safeguarding team resources that have been secured and the additional managerial oversight that has been planned to enable outstanding adult safeguarding work to progress.	They advised additional adult safeguarding team resources that have been secured and additional managerial oversight was in place to enable outstanding adult safeguarding work to progress.
July 2022	Page 14 Paragraph 2	Management arrangements overnight are often depleted, with one night coordinator responsible for overseeing the whole site. They are responsible for the allocation of staff across the site, the redeployment of staff as necessary during the shift, and supporting staff. The depletion of the night coordinator role has resulted in new staff, unfamiliar with patients and their needs, working at ward level, with limited support available. This contributes risks in relation to patient and staff safety.	There is one night coordinator on site, with access to senior management through on call arrangements. The Trust have clarified that the night co-ordinator resource is proportionate to the number of patients accommodated in the hospital.