MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Third Statement of Briege Donaghy
Date: 8 December 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**").

This is my third statement to the Inquiry and is a short supplementary statement to correct information provided in my second statement to the Inquiry in relation to (1) whistleblowing reports and (2) serious concerns meetings with Belfast HSCT ("**BHSCT**").

Serious Concerns Meetings

1. Information about the purpose of serious concerns meetings can be found at paragraphs 60 to 62 of my first statement to the Inquiry.

2. In my second statement to the Inquiry, at paragraph 82, I explained that in reviewing records in preparation for the Inquiry, RQIA had identified 14 occasions where RQIA met with BHSCT, constituting a ‘Serious Concerns Meeting’ or further escalation meeting, such as an "Intention to Serve' meeting. Since providing my second statement to the Inquiry, I have become aware of another Serious Concerns Meeting between RQIA and BHSCT, which was not included in my statement.

3. This Serious Concerns Meeting was held in August 2014 and related to Moylena Ward. This meeting followed concerns identified during an inspection of Moylena ward on 8 July 2014.

Whistleblowing Reports

4. At paragraphs 106 to 114 of my second statement to the Inquiry, I outlined details of protected disclosures/whistleblowing records that had been identified following a review of RQIA's records. I apologise that the summary provided in my second statement included only those whistleblowing reports newly identified in continued searches for such material. The statement omitted details of records that were held electronically as whistle blowing records, and which had already been provided to the Inquiry last year.

5. Paragraphs 109 to 114 of my second statement to the Inquiry should read as follows:

    a. To date, RQIA's searches have identified a total of 26 instances that may amount to protected disclosures reported to the RQIA between 2009 and the end of 2021.

    b. The reports identified by RQIA relate to a number of MAH wards. Thirteen reports relate to the Cranfield wards. Four reports relate to the Erne ward. The remainder include reports in relation to the Ennis, Sixmile, Greenan, and Moylena wards, in addition to reports that were not ward-specific.

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

    d. The searches have identified three reports for the period from 2012 to 2015. These disclosures included the following themes:

i. Inappropriate behaviour of staff - waking and dressing patients at 6am, confidential patient information being shared with other patients and staff on staff bullying;

ii. Physical abuse of patients – patient being dragged by her ankles and another patient leaving a bathroom with a bloody nose; and

iii. Poor processes – inadequate incident recording, unsafe staffing levels, management not addressing concerns when raised, inadequate investigation as to whether two patients engaging in sexual activity were able to give informed consent.

e. The searches identified 10 reports for the period from 2016 to 2018. These disclosures comprised themes of:

i. poor staffing levels and over-reliance on agency staff, leading to unsafe practice and poor morale;

ii. Ward environmental conditions;

iii. Over occupancy;

iv. Poor ward management, concerns not appropriately addressed when raised; and

v. Lack of candour with RQIA.

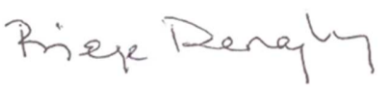
f. An example of a report from this time period states that senior management ignored concerns of staff in relation to (1) wards being short staffed to the point it was "critically dangerous"; (2) staff being "highly stressed", "crying", and "anxious" and (3) emergency procedures not being followed properly due to lack of staff.

6. The searches identified thirteen reports for the period from 2019 to 2021. These disclosures comprised themes of:

    g. poor staffing levels, skill mix, and over-reliance on agency staff, leading to unsafe practice;
    h. Severity of patient's challenging behaviour compromising staff safety, including sexual assault;
    i. Poor ward environmental conditions;
    j. Inappropriate behaviour of staff – sexual acts and substance use on shift, racism;
    k. Improper handling restraint of patients – staff member incorrectly restraining a dysregulated patient, undocumented restrictive practice.
    l. Negligence of staff – patients being left in urine soaked beds, 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.
    m. Concerns over senior management leadership – lack of experience of senior management, failure of senior management to communicate with ward staff and senior management dismissing staff concerns; governance issues such as adequate recording and training; and
    n. Abuse of patients – staff shouting at patients and threatening them, mimicking staff, physically struggling with a patient to retrieve a face mask, un-therapeutic 'bantering' style of communication with patients. Culture described as "toxic".

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:



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