MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 28TH MAY 2024 - DAY 84

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THE INQUIRY RESUMED ON TUESDAY, 28TH MAY 2024 AS FOLLOWS

CHAIRPERSON: Good morning. Right. So, this morning obviously we begin our organisational modules, and at the beginning of each, counsel is going to set out for you the material that's been received in summary and then explain which witness is going to be giving evidence. There is, of course, more now on the Inquiry's website, and the schedule has been published and the statements also have been put onto the website, so everybody who has an interest can look at that. Because we're not calling staff at the moment, we are able to stream these sessions live, and we will continue to do so for all organisational modules unless exceptions apply. 09:55 09:55 09:56

Next week we'll be reverting to staff evidence, and I just want to say a word or two about that. First of all I want to apologise for the late service of some of that material, and I know that CPs are still, I'm afraid, getting schedules which simply say "staff witness" which isn't hugely enlightening. 09:56

Some witnesses have been very co-operative, others slightly less so, and then once a statement is received applications for either ciphering or anonymity are often received immediately after them. I have to consider each application individually. I try to deal with each application within 48 hours, normally much 09:56

quicker than that if I can. But the Panel also has to consider each statement and assess what additional value might be served by calling instead of reading the witness into the record. Where a decision is made to call a witness they have to be scheduled and told. I'm 09:57
afraid that personal considerations, although taken into consideration, are a secondary factor to keeping to a schedule and keeping this Inquiry moving. Where a witness has got good reasons not to be able to attend, of course I will consider those, but being on holiday 09:57
and out of the jurisdiction, or sighting work commitments, is rarely going to suffice, we do have to keep pressing forward, as best we can.

So, Ms. Bergin, are you going to introduce the first 09:58
module to us?
MS. BERGIN: Yes. Good morning Chair and Panel. We are beginning this morning the organisational modules, with Module 1, Patient Advocacy and Representation.
09:58
The purpose of this module is to examine the role and effectiveness of bodies and organisations with responsibility for representing the interests of patients, including the work of the patient and client counsel, the PCC, and groups such as Bryson Care, 09:58
Mencap, and the National Autistic Society.
The module also considers the process of communication with patients and their families and involvement in review tribunals.

This module is of particular relevance to paragraph 10 of the Terms of Reference, which requires the Inquiry to examine the adequacy of methods available to communicate concerns, including allegations of abuse, by staff, patients, relatives and others, about the treatment of patients at MAH.

The Panel will also note that the PCC is one of the bodies referenced in paragraph 13 of the Terms of Reference, which considers the effectiveness of response to reports of alleged abuse at the hospital.

The Panel requested statements from five individuals for the purpose of this module. First, Jo Marley, Director of Bryson Care. Secondly, Caroline Stevens, Chief Executive of the National Autistic Society. Thirdly, Grainne Close, Director of Mencap. Fourthly, Attracta Wilson, Chair of the Review Tribunal for Northern Ireland. And, finally, Meadhbha Monaghan Chief Executive of the Patient Client Council. All of those statements have been published on the Inquiry's website, and having considered the statements, the Panel wish to hear oral evidence from Jo Marley, who will be called to give evidence shortly. Before we hear from the witness, it would perhaps be helpful if I highlight some of the salient features of the written statements of the witnesses from whom we will not be hearing oral evidence this morning.

CHAIRPERSON: Yes.

INTRODUCTION TO ORGANISATIONAL MODULE 1

MS. BERGIN: Beginning with Caroline Stevens, Chief Executive of the National Autistic Society, who provided a statement dated 25th April 2024 on behalf of the Society. 10:00

She outlines that there were only two patients affiliated with MAH who were in the care of the National Autistic Society. The Society completed some observations of one patient in MAH to ascertain how staff communicated and worked with them so that they could establish a suitable placement for that individual, but they had no direct interaction with MAH staff. 10:00 10:01

The other patient was not at MAH when the Society were involved with them.

Contracts for the National Autistic Society to provide support are agreed with the funding authority responsible for the person they are supporting and the support package is tailored to the needs of the individual, based on discussion with the funding authority, social worker, and relatives, and Ms. Stevens also outlines the Society's internal safeguarding and risk escalation process. 10:01 10:01

The next statement is from Grainne Close, Director of

Mencap, who provided a statement dated the 8th May 2024 on behalf of Mencap. She outlines that from 2008 Mencap offered a specialist independent advocacy service supporting people with learning disabilities, and their families, through court proceedings and resettlement into the community across all Health and Social Care Trusts. Patients and families could self-refer and referrals would have come from resettlement teams also. 10:02

Advocacy advisers accompanied patients and relatives at multidisciplinary team meetings and resettlement meetings. She outlines the reporting procedures that Mencap have to deal with concerns and that Mencap advocacy workers provide monthly monitoring reports to Mencap's senior management team and to the northern Health and Social Care Trust. 10:02

She states that Mencap previously had a well-established presence, visibility and accessibility for patients and families. The Mencap Advocacy Service would have been integral to resettlement planning and it would have been well known to friends of Muckamore, families,would have been made aware of it by community disability teams, and there were posters and leaflets at MAH, so staff would have also known the purpose of the service. 10:03

However, since 2018, a loss of funding for the service

has reduced the capacity and level of their independent advocacy services.

Ms. Close took up her role as Director in August 2021. She wanted to ensure ongoing support and advocacy services were being provided to people affected by the allegations at Muckamore, and Mencap arranged meetings with people they supported, and their families, and encouraged them to participate in the Inquiry. 10:03

In her role as Director of Mencap, Ms. Close sits on the Muckamore Departmental Assurance Group as an observer and she contributed to the 2022 Independent Review of the Learning Disability Resettlement Programme in Northern Ireland. 10:04

10:04

The third statement is from Attracta Wilson, Chair of the Review Tribunal, who provided a statement dated the 16th May 2024 on behalf of the Review Tribunal.

Ms. Wilson provides a detailed statement outlining the legal context of the Review Tribunal, which was established under the Mental Health (Northern Ireland) Order 1986, and had its jurisdiction extended under the Mental Capacity Act (Northern Ireland) 2016. 10:04

Ms. Wilson outlines the various routes by which a patient's detention under the Order may come before the Review Tribunal. 10:05

She states that patients detained in Muckamore were, for the most part, detained under the Order and were

typically patients suffering from severe mental impairment, as defined in the Order, although it is also possible that there were patients detained under the Act.

Patients detained under the Order are detained in a hospital initially for assessment under Article 9 and, thereafter, for medical treatment under Article 12, if the test for detention is met. Those patients are presumed to have capacity to apply to the Review Tribunal in relation to their detention unless the contrary is established. 10:05

Ms. Wilson states that patients would be made aware of the Review Tribunal process by the Trust. The Tribunal is an independent judicial body and it has no role in making patients or relatives aware of the processes involved in the application process to the Tribunal. It would only have contact with a patient or their relative after an application is received from the patient or legal representative or via a referral from the Trust. 10:06

Ms. Wilson highlights the contact that the Review Tribunal has with patients or their legal representatives after an application or referral has been made to the Tribunal. This includes notifying the patient of the hearing date and usually contact thereafter is via a patient's legal representative. 10:06

The Panel, comprising a legally qualified Chair, referred to as the President, a psychiatrist, and another member, are provided with all of the relevant documents for hearing. The psychiatrist member of the Panel examines the patient, although this is not a physical examination, and has access to patient notes and records. If a patient is not legally represented, the Chair may appoint someone to represent them, and Ms. Wilson states that it would be highly unusual to have a hearing where a patient is not legally represented and, where this occurs, it is incumbent on the Tribunal to minimise any potential disadvantage to the patient. 10:07 10:07

Except during Covid 19 restrictions, hearings occur in the hospital setting and are held in private, and whilst they can be held in public, Ms. Wilson states that she is not aware of any having occurred in that way. 10:08

Patients generally attend hearings, although there may be occasions where their legal representatives may proceed in their absence. Patients are frequently accompanied to Tribunals by nurses, and Ms. Wilson states that on some occasions, although infrequent in her experience, a patient advocate will attend to support the patient. 10:08

The Tribunal has powers to admit people to attend the hearing, and this is the basis on which relatives are permitted to attend hearings.

The President has to explain the proceedings in a manner in which the patient can understand, and patients may give evidence, and even where they do not, the patient will always be given the opportunity to address the Review Tribunal once the evidence is given, and Ms. Wilson states that she also asks any family members present whether they would like to address the Tribunal also. 10:08 10:08

Ms. Wilson concludes by saying that she has been Chair of the Review Tribunal since 2015, and was previously a member of the Mental Health Review Tribunal, as it was then called, from 2008, and she does not recall any allegations or suspicions of abuse at MAH being raised with the Tribunal by anyone. 10:09

10:09

CHAIRPERSON: Thank you.

MS. BERGIN: The final statement then is from Meadhbha Monaghan, Chief Executive of the Patient and Client Council, the PCC, who has also provided a lengthy statement to the Inquiry dated 4th March 2024, with a number of exhibits also. 10:09

Ms. Monaghan refers to the previous statement made to the Inquiry by her predecessor Ms. Vivian McConvey,

which outlined the roles, functions and powers of the PCC, including their role in providing advocacy in the context of Muckamore.

CHAIRPERSON: Yes. And, of course, we heard all of that as part of the evidential module some time ago. 10:10

MS. BERGIN: Yes, Chair. Exactly. Ms. Monaghan outlines that the PCC has a statutory function to assist people wishing to make a complaint about health and social care services. They provide universal advocacy services for users of the health and social 10:10 care system. Advocacy is typically provided in the context of service users and families raising issues and making complaints about the care they have received and in relation to serious adverse incident, SAI reviews. 10:10

The PCC also support public engagement through policy advocacy, and this includes assisting the public to become involved in departmental or Trust policy improvement initiatives. 10:11

Ms. Monaghan says that the majority of the public who seek support from the PCC describe a negative and distressing experience trying to resolve their issues and complaints. In some cases distress has been 10:11 reported by patients and families in how they have experienced complaints resolution or SAI review processes, and this includes how the resolution process was actually undertaken and also the relationship they

experience with various Trust staff.

Ms. Monaghan states that in real terms the PCC budget represents a 40% decrease from when the organisation was set up and the extent to which the PCC is able to meet its statutory functions is impacted by resources. Over the last five years the number of complaints has remained static, but the complexity of complaints has increased. 10:11

10:12

Throughout her statement Ms. Monaghan outlines a number of initiatives that the PCC has already engaged in, and she has also suggested changes that the PCC believe will improve the experience of patients and families in the health and social care system, and support Trusts to improve their complaints and review processes, increase public confidence in complaints management, and increase the efficacy of advocacy and representation. 10:12

10:12

Ms. Monaghan states that the current complaints system is underpinned by a combination of legislation, Department of Health guidance and standards. The PCC suggests a reduction in the complexity of the complaint system, clarifying the complaint pathways and fully resourcing advocacy provision for serious adverse incident reviews. They suggest a clear escalation process for safeguarding concerns being investigated in each Trust being provided on a one page document, and 10:13

that Trusts should appoint an independent senior designated officer, to whom matters are escalated, with reporting to the Trust Board about Trust compliance with standards and guidance.

10:13

The PCC suggests that Trust staff training should include familiarity with complaints processes and an understanding of the role of advocacy in safeguarding vulnerable people, including joint training with advocacy providers to ensure that patients and families 10:13 are fully informed about the process.

The PCC suggests improvements to complaints data pathways, including improved feedback routes between the PCC and Health and Social Care Boards mandated by 10:14 departmental policy to provide greater Board oversight.

In April 2023, the PCC launched its Positive Passporting Initiative, which it developed in partnership with a range of statutory bodies and a 10:14 range of third sector partners, some of whom have specialist experience related to specific conditions or experience. This initiative aims to connect advocacy service provision across the region to make it easier for the public to understand their rights to complain 10:14 and the support available, and to foster collaboration across the voluntary and statutory sectors to reduce fragmentation of advocacy services.

The PCC has statutory powers, but it also works with and in conjunction with advocates and professionals across the voluntary and community sector. The key added value, Ms. Monaghan says, of the PCC, is its independence and its statutory functions and powers, which include the ability to escalate issues in individual cases to various statutory bodies, including the PSNI, RQIA and Trusts. She states that the commissioning of advocacy services by individual Trusts is fragmented and has resulted in a lack of co-ordination of advocacy services provided by the voluntary and community sectors, and the PCC, and in Muckamore there were three separate organisations providing advocacy services. The PCC were not clear about how management at Muckamore had an overall picture of any issues coming from the advocacy services. The PCC, therefore, propose improvements by advocacy providers, collaborating and agreeing a memorandum of understanding, holding regular meetings with Trust management. 10:15 10:15 10:16 10:16

The PCC suggest changes to the commissioning of advocacy services, including that advocacy services should be commissioned independently of the Trusts at a regional level, independently from service providers, and be structurally, financially and psychologically independent, and that advocacy services should be placed on a statutory footing, subject to some form of memorandum of understanding between organisations to 10:16

ensure co-ordination and consistency.

And, finally, Ms. Monaghan highlights on behalf of the PCC, issues with the serious adverse incident processes generally, not specific to MAH, which are resource intensive: 10:17

"The PCC highlights issues with the serious adverse incident processes generally, not specific to MAH, which are resource intensive for the PCC who have seen a 100% increase in demand for independent advocacy support since 2019." 10:17

So Chair and Panel, that concludes a summary of those statements. 10:18

CHAIRPERSON: Thank you.

MS. BERGIN: And I should say that this evidence ought not to be considered in isolation. As you've already indicated, Chair, the Inquiry has heard from witnesses during the patient experience and the staff evidence experience that has touched on the matters of advocacy and representation, and that also applies to the evidence heard in the course of the evidence modules last year, including the very detailed written and oral evidence from the PCC previously. 10:18 10:18

As I have said, all of the statements that I've referred to are published now on the Inquiry website, and the Panel will now hear from Jo Marley.

CHAIRPERSON: Okay. Thank you. Shall we bring Ms. Marley in?

MS. BERGIN: I should say that the statement reference is STM-250, and as it is on the Inquiry website I will not be reading it aloud. 10:18

CHAIRPERSON: Good morning. You're just about to be sworn by the secretary to the Inquiry, but can I just welcome you to the Inquiry. Thank you for your statement and thank you for the evidence you're about to give. 10:19

MS. JO MARLEY, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: Ms. Bergin. 10:19

MS. BERGIN: Thank you, Chair. Good morning, Ms. Marley.

A. Good morning.

1 Q. We met briefly this morning and I explained how I'll be dealing with your evidence, and I should say for the benefit of the Panel that I understand that in front of you, you also have a copy of your statement with some notes? 10:20

A. Yes, that's right.

2 Q. So you have provided a statement to the Inquiry, and you should have a copy from the Inquiry in front of you, and it is dated the 15th March 2024, and you have attached a number of exhibits to your statement, and on the last page of your statement you sign the 10:20

Declaration of Truth. Now, you have also helpfully provided the Inquiry with a further table to supplement Exhibit 8, is that correct?

A. That's correct, yes.

3 Q. And we will come to that in due course. So with the addition of that supplementary document for Exhibit 8, are you content to adopt your statement to the Inquiry as your evidence? 10:20

A. I am.

CHAIRPERSON: Can I just confirm that supplementary document, has that been uploaded to Box so that CPs can see it yet, or not? 10:21

MS. BERGIN: I understand that it is -- if it has not done so already, it is in the process of being done.

CHAIRPERSON: Okay. 10:21

INQUIRY SECRETARY: Chair it has been. If we need to bring it up on the screen we can.

CHAIRPERSON: And then we can put it on the website in due course.

MS. BERGIN: Yes. Thank you. Ms. Marley, as you know, your statement is now on the Inquiry website so I will not be reading it aloud this morning. You have been asked to give evidence to the Inquiry in relation to Organisational Module 1, Patient Advocacy and Representation, and also in respect of Module 6, Resettlement, and your statement deals with both of those topics, and I'm going to ask you about both of them, and the Panel may also have some questions. Right? 10:21 10:21

A. Thank you.

4 Q. Between 1994 and 2003 you were the Assistant Director of Social Services at Bryson House, now called Bryson Care, and then from 2003 until the end of March 2024 you were the Director of Bryson Care? 10:22

A. That's correct.

5 Q. Is that correct?

A. Mhm-mhm.

6 Q. And could you explain, I suppose at a higher level, what does Bryson Care do generally in terms of us 10:22 understanding where the role of Bryson Care with Muckamore fits?

A. Okay. So Bryson Care is a subsidiary of the Bryson Charitable Group. So there are three distinct companies within the group; Bryson Recycling, Bryson 10:22 Energy, and then Bryson Care. Bryson Care has the responsibility, I guess, of social care issues. So it includes family and child care services, it includes advocacy services, it includes a very large domiciliary care service for people living at home who are 10:23 dependent. It has a turnover of roughly about £11 million. It has a staff of roughly again about 500, just over 500 people. So, in -- I guess, in the context of the Bryson Care Company and the Bryson Group, advocacy was a sort of discrete unique type 10:23 service. Yeah.

7 Q. Thank you. That's very helpful. If I could then ask you to turn first of all to paragraph 6 of your statement, please? And I want to begin by making sure

that we understand the chronology of Bryson Care's involvement at Muckamore in terms of providing advocacy services. So you say here that:

"Bryson Care provided advocacy services throughout the Belfast Trust since 2003, initially a long-term advocacy service, and that from 2005 part of that contract was in relation to MAH patients who were listed on the priority target list identified for resettlement in the community." 10:24

So to begin with, prior to 2003, do you know anything about what advocacy arrangements were in place at Muckamore? Did Bryson have any involvement at all?

A. No, none. None whatsoever. 10:24

8 Q. And in 2003, is that when then Bryson were first contracted to provide the services to Muckamore?

A. Well, 2003, it was services across the Trust, which was then a unit of management or some such like.

9 Q. Sorry. I'm going to interrupt you very briefly. 10:25 Apologies, Ms. Marley. If I could ask you to just try and slow down a little bit just because our stenographer needs to keep pace? All right.

A. Okay. Thank you. Thank you. So in 2003, the advocacy service would have been a Trust service, more community 10:25 based, and then 2005 is when we would have become more involved with and including Muckamore Abbey Hospital. The reason we found ourselves interested in the provision of advocacy was we had had a number of

projects which worked with people with learning disability, more in a sort of socialising, volunteering type work, so it seemed to be a reasonable, a reasonable step then to become more involved with advocacy per se.

DR. MAXWELL: Can I just check? So I think the Belfast -- by the legacy Belfast Trust, do you mean the North-West Belfast Community Trust?

A. Yes.

DR. MAXWELL: Because I think the Belfast Trust we know was created in 2007.

A. Yes.

DR. MAXWELL: So were you providing advocacy to the whole of the North-West Belfast Trust?

A. Community wise, yes. Yes, we would have been.

DR. MAXWELL: So that would have been all of the services, not limited to learning disability at that time?

A. Oh, no, sorry, just for learning disability across the Trust.

DR. MAXWELL: Okay. So from 2003 you were providing advocacy services for learning disability services in the hospital and community?

A. Yes.

DR. MAXWELL: For the former North-West Belfast HSST.

A. Yes.

DR. MAXWELL: Thank you. And then, and I'm sure you're coming to this, are you then saying that that then continued from 2007 when it became Belfast Health and

Social Care Trust?

A. Yes.

DR. MAXWELL: From 2007 when there was a reorganisation.

A. Yep. 10:26

DR. MAXWELL: Was that still only in learning disabilities?

A. Yes. Yes. Only learning disability. There was a small project with older people in residential care, but it was kind of a discrete pilot type project which 10:27 ran for a couple of years but then ceased.

DR. MAXWELL: But not, for example, in Mental Health Services.

A. No. No, definitely not. Definitely not.

DR. MAXWELL: Okay. Thank you. 10:27

10 Q. MS. BERGIN: Thank you. And you go on to say that in 2005, part of the long-term advocacy service included specific work in relation to patients at Muckamore. So is 2005 the date when the work at Muckamore first began? 10:27

A. Yes. Yes. There was -- in the previous year there was sort of negotiations and building and developing a model of care, but it wasn't actually active until 2005.

11 Q. Could you explain to the Inquiry what you mean by 10:27 long-term advocacy in this context?

A. So long-term advocacy would be more relational, building relationships, and helping to get to know a person and their kind, their of sense of themselves if

you want, as opposed to some shorter term targeted advocacy, perhaps, in respect of court proceedings or something that had a specific beginning, middle and end.

12 Q. And the focus in this context, I think I'm right in saying, was resettlement? 10:28

A. Yes.

13 Q. And so that brings us then 2005 to 2009, and I think as you've already indicated with Panel questions, that service continued, and then in 2009, Bryson were successful in a tender bid to the Trust, the Belfast Trust, and then continued to provided advocacy, but this was then through a revised independent advocacy services, and at that stage all patients admitted to Muckamore under the Mental Health (Northern Ireland) Order 1986, were to be asked during admission whether they wanted to see an advocate, is that correct? 10:28 10:29

A. That's correct, yes.

14 Q. Yes.

CHAIRPERSON: Sorry, I'm being -- I just want to get the chronology right because I'm still not sure I understand it. 2003, you're providing advocacy service for learning disability patients at the hospital? 10:29

A. No, in 2003 we were doing advocacy service with people with a learning disability but in the community. 10:29

CHAIRPERSON: Right. But for the Trust, but within the community through the Trust. Yes.

DR. MAXWELL: But not for any of the patients in hospital at that time?

A. Not at that time.

CHAIRPERSON: Right.

MS. BERGIN: And that began in 2005?

A. 2005.

15 Q. Is when the work of Bryson Care Advocacy Services, they were first contracted to Muckamore? 10:29

A. To Muckamore.

16 Q. To provide long-term advocacy, is that correct?

A. That's correct.

CHAIRPERSON: So then in 2007 there was, as we know, reorganisation, but did that actually change your services or not? 10:29

A. No, no.

CHAIRPERSON: Right. So we can kind of ignore the 2007 so far as you're concerned. Then in 2009 you re-tendered to BHSCT, and what was the revised service that you were then providing? 10:30

A. So it was a similar, it was a similar service, it was more of a contractual change but, again, it was emphasising the resettlement element, but it was really driven by financial implications, I think, more than anything else. 10:30

CHAIRPERSON: Does that mean the envelope went downwards?

A. Yes. 10:30

CHAIRPERSON: Right. So. But at that stage you're providing assistance to patients within the hospital and also in the community?

A. Yes.

CHAIRPERSON: Right. And then I think we're going to come on to 2016.

DR. MAXWELL: Just before we go there. So from 2005 you have a contract to provide this long-term advocacy for people who had been identified for resettlement, but presumably you had to get some sort of consent from them, how did that work? How did you approach the patients and see if they wanted to use this service? 10:31

A. In terms of the?

DR. MAXWELL: The long-term advocacy for those who were on the priority list for resettlement? Did you just assume that you would take on that role? Did you speak to them? Did you speak to their families? 10:31

A. I think -- well we certainly, we certainly spoke to patients in terms of making an offer of advocacy to them, but the offer had already been constructed, I think it is fair to say. So I don't -- we didn't, we didn't take advice from patients as to what the offer of advocacy might look like. But then we had various ways to ensure that patients understood what was on offer and how they could access that offer if they required. 10:31 10:32

DR. MAXWELL: What sort of engagement did you have with families at that time?

A. It wouldn't have been as structured as it was in later times, but we would have -- where a family were accessible and available, we would have spoken with family, yes. 10:32

DR. MAXWELL: Thank you.

17 Q. MS. BERGIN: Thank you. And I think I'm correct in saying that around 2009, staying with this same time period, that you've said all patients admitted to MAH under the Mental Health Order were asked whether they wanted to see an advocate. So did that then change the nature or expand upon the nature of the service you were providing then in addition to the longer term resettlement advocacy at all? 10:32

A. I think the advocacy model, to be honest, in 2009, it had a couple of different elements to it, but fundamentally it remained a similar model. Obviously we had to make adjustments in terms of resources and staffing, et cetera, but I think the approach to advocacy continued to be very much, which was patient-centred, person-centred, that we took time to understand the needs of patients and their wishes and regards, but obviously the reporting and the priority was set by the, was set by the Trust. 10:33 10:33

18 Q. And if we keep moving chronologically then. In March 2014, the Belfast Trust provided further funding to Bryson to complete quality of life assessment, QOLs, with patients who had been identified for resettlement. Could you -- you have explained in your statement what those are. Could you provide the Panel with a little bit more information about what Bryson really did at that time in relation to those QOL assessments, how they engaged with patients, any processes around that? 10:33 10:34

A. Yeah. I have some evidence and some exhibits on that. So the quality of life assessments I think for us, from

our perspective, helped us become more a lot more, a lot more structured and focused as to how we approached this. It gave us -- I think we took time to again construct a helpful way to first of all ensure that patients and families understood what was happening, and about the resettlement, and about what they could expect from us, but from an organisational point of view I think it helped us be very clear about the steps that we would take in building quality of life assessments, and we were able to see that we stepped through each step and that each patient would have received the support that was required by them.

19 Q. And what was that in terms of what were the steps? What was the quality of life assessment? What did that entail?

A. So the steps would have been obviously ensuring that we were in discussion with the Trust to ensure that we got to see the people who were relevant and eligible for this service. So first of all making sure we got to see them. Then meeting with them on a regular basis, ensuring they understood our role, understood who we were, what we were trying to do, that we were there for them, for the duration of this journey, if you want, and that we would be there when they left Muckamore and were trying to establish themselves in a new home environment, we would continue to be there to support them. So it really was quite intensive work with individual patients so that we could ensure that they had confidence in what was happening and confidence in

us being alongside them.

20 Q. You've referred to it being intensive sort of engagement. I want to ask you, and we'll continue to move chronologically in a moment, but I want to ask you about the level of involvement of Bryson Care staff or advocates at Muckamore. So, for example, in relation to the QOL life assessments, could you give the Panel some idea of -- I mean how many times a week or a month would staff meet with individual patients? How regular would the contact be outside of those meetings, or were they all face to face meetings? In terms of the team of Bryson advocates, how many advocates were there? Just a sense of what the actual service looked like at that time? 10:36 10:37

A. Yeah. The advocates, it was a small number of advocates for Muckamore, it's a small team anyway, but the good thing about the advocates in Muckamore is that they were sort of long-standing staff, they had been there for some time, so they understood Muckamore, they understood the environment of Muckamore, and they understood the patient care in Muckamore. People would have -- the way it tended to work was that you -- there was frequent contact, but not necessarily always very lengthy contact, because it was easier for people to concentrate for shorter periods of time. So we had two advocates who were sort of more or less always in Muckamore, with the exception, obviously, of during Covid, yeah. 10:37 10:37 10:38

21 Q. And do you mean during the week Monday to Friday?

A. Yes, just Monday to Friday.

22 Q. Yes. And would that have been an all day thing and they would have gone back to Bryson, or would they have been based largely in Muckamore?

A. So certainly before Covid there would have been an advocate who basically had like a hot desk in Muckamore and would have spent most of the time there. Since Covid it is very much kind of, because it's still a balance of working from home, working at the office and working in the hospital, so it's a bit more disjointed. 10:38

23 Q. And you've said that there were a small number of advocates. You may have heard that I, before you began to give evidence I provided a summary to the Inquiry of some of the other statements in this module which outlines some of the other advocacy services provided at Muckamore, can you give the Panel an idea of any sort of interaction or awareness that there was between Bryson advocates and other types of advocates working at the same time at Muckamore, and perhaps the differences in the services that were being provided, please? 10:39

A. Yeah. I think our closest working relationship would be with -- the organisation has just gone out of my head -- Mencap. Mencap. So. And really from the start, and you'll see again from some of the exhibits that, you know, the way we tried to construct advocacy, the common understanding of what it would be, we worked very closely with Mencap on that and would have continued that relationship with Mencap, probably a bit 10:39

more fractured with others. And, again, Mencap and Bryson were more or less looking after the same Trust areas, where some of the other providers would have been Trust areas that we would not have been involved in.

24 Q. And when you say that you were working very closely, your advocates were working very closely with the other advocacy providers, can you provide us with a bit more information about what you mean by that? Do you mean, for example, that they were in contact with each other in terms of making sure one understood what the other was doing, or was there sort of more collaborative working in terms of sitting down together and working on, I suppose, a patient advocacy together?

A. Yeah. Not -- I think initially when the advocacy service was set up there would have been very much a collaborative approach, but since the service became established it's much more of a working relationship. It wouldn't have any formal meetings, or regular, necessarily regular oversight meetings or anything like that, no.

CHAIRPERSON: Sorry, pre-Covid you had two advocates mostly in the hospital?

A. Who were -- who spent most of their time in Muckamore Abbey, yeah.

CHAIRPERSON: And post Covid you mention people working at home. I'm not sure how that works in an advocacy service?

A. So the advocates in Muckamore -- so obviously the team

of advocates is covering the advocacy service in the community and in the hospital.

CHAIRPERSON: Sure.

A. However, there are two of the team who would specialise, if you want, in the hospital. Now, one of whom pre-Covid would have been literally more or less working out of Muckamore, and another who would have spent the majority of their time there. Now that doesn't mean to say that some of the other advocates wouldn't be going in and doing certain tasks within the hospital, but since Covid, the way the team itself works is that there is a sort of a balance now of working from home, out in the field, and sometimes in the Bryson office. So I don't think the presence in Muckamore would have been as -- isn't as sort of full-time as it would have been prior to Covid.

CHAIRPERSON: And is that because of the reduced number of patients or...

A. It's partly because of the reduced number of patients and it's partly because since Covid staff would feel that they like hybrid working and they continue to do that.

DR. MAXWELL: So are you saying that pre-Covid they would do their administration and paperwork at a hot-desk in Muckamore and now they're doing that in their own home?

A. Yes. That's it, really.

25 Q. MS. BERGIN: Thank you. In sticking with the theme of I suppose staff numbers and what the resource looked

like that Bryson Advocacy were providing at Muckamore. I think at paragraph 8 and also Exhibit 3, you referred to the contract in terms of the extension of Bryson's work at Muckamore, and I think at Exhibit 3 you refer to some of the particulars of the contract, about 75 hours per week recurrent activity and 16 hours per week for quality of life assessments. Now I don't need you to necessarily go to that, my question really is around the time or the resource allocation. Can you tell us a bit about -- you've said you had two advocates mostly on site, did you feel that throughout your time, and I appreciate this is a broad question, but throughout your time at Bryson that the -- I suppose the resource was sufficient to meet the need in terms of the patient advocacy requirements? 10:43 10:44 10:44

A. I think had the Belfast Trust been in the position where they could have given us extra funding, and we could have had extra staff, I think we could have utilised that. I think, again it's in the statement, that the way it kind of worked was that advocates had to be invited in to meetings, into wards, into -- and I guess because that was a filter then the staff we had, we made sure that whoever we got invited to see we got to see. However, had the culture been slightly different and had there been enough funding for additional advocacy, I think we could have been in discussion with more patients. 10:44 10:45

26 Q. I'm going to come back to the topic that you've just raised about access for advocates in just a moment. If

we can just stay then -- we were dealing, before my questions there we were dealing with March 2014 in terms of the changes to the Bryson service at that time, and then looking to paragraph 8 here you say that:

"From April 2016, Bryson began providing advocacy and representation to carers and relatives of MAH patients."

So from 2005, when Bryson's involvement at MAH began, until 2016, was there no engagement with families and relatives?

A. No. No, formal engagement.

27 Q. Okay.

A. We would have talked to families who were -- and carers of patients. It was just it became more of a -- it was a funded activity, so that gave us more access to families.

28 Q. Could you tell us a bit more about what that actually looked like in practice in terms of how it compared to the situation as it was before that formal system?

A. Yeah. I mean I think it's fair, again it's fair to say that it allowed us to spend more time with families, in planning terms, in discussing the situation of their family member, and I suppose it gave us a focus also on that perspective of the work.

29 Q. And in terms then of the -- whether you can say anything about the levels of complaints or concerns

that were reported to Bryson advocates after that engagement with families began, perhaps now is a convenient time to look at Exhibit 8. Do you have a copy there in front of you?

A. Yes, I do. 10:47

30 Q. Yes. Now I'm looking at the, I suppose the original Exhibit 8 that you provided to me, not the additional document. Yes. That's correct?

A. Yeah.

31 Q. And I don't propose to spend very long at this stage with this exhibit, but your evidence has been that the engagement, formal engagement services with families began in April 2016, and if we look at the table in terms of engagement with Bryson at Exhibit 8, between April 2017 and March 2018, there were 344 engagements. 10:47 10:48 And prior to that -- and I appreciate there is some data that we don't have -- but prior to that the nearest available data we have is 2008 to 2009, when there were 83 engagements. So what I'd like to begin by asking you is, can you explain to the Inquiry Panel 10:48 what does this table show? And I appreciate that you and I may have different copies that are perhaps easier to read than the copies that the Panel may have, but when we look in the second column, which shows either no service being provided, or numbers of engagements, 10:48 does this represent the number of patients?

CHAIRPERSON: Sorry, I need to try and follow this. Are you -- sorry, you're on page 61. And then you've got to jump to the next page to see the --

MS. BERGIN: I think that's right.
CHAIRPERSON: We can't put these side by side?
MS. BERGIN: In fact, Chair, unhelpfully I have a copy of it side by side, but I don't know that the Panel do.
CHAIRPERSON: All right. Okay. Okay, I'll let you carry on. 10:49
MS. BERGIN: What I can do is, if we are taking a break I can perhaps return to this section with a copy of that table uploaded? That might be an easier way through? 10:49
CHAIRPERSON: We can use this.
DR. MAXWELL: Can we look at the one that was been tabled this morning?
MS. BERGIN: Yes. I am in fact referring to just the copy of the table that's already within Exhibit 8. 10:49
DR. MAXWELL: No, I appreciate that.
CHAIRPERSON: Do they show -- let's just deal with it in stages. Looking at Exhibit 8, if we were to put them side by side, does it demonstrate on a year-by-year basis when service was being provided and to how many patients? 10:50
DR. MAXWELL: The data is slightly different on the two tables. But maybe a better question is, what does this figure mean? So the figure was 83, then no returns, then 344. 83 what? 10:50
A. Yes. I -- I -- I think -- well, not I think. The exhibit, the original Exhibit 8 is not accurate, I will now say, and really prompted by a question that I received late last week, I re-visited the data. So the

more reliable data is actually the recently uploaded.
CHAIRPERSON: Right. So shall we ignore Exhibit 8 for the moment?
MS. BERGIN: That in fact simplifies matters significantly. 10:51

A. Yeah. And I think the original Exhibit 8 is incorrect because I think we misunderstood the question that was being asked.

32 Q. So if we can turn then to the new Exhibit 8.

A. To the new exhibit. 10:51

33 Q. And if you could explain to the Panel what those figures mean?

A. So I think this is more helpful information and accurate information. So it really relates to 2017 forward, because I mean the original, the original 10:51 exhibit did show that we didn't have specific data on Muckamore, and we still don't, and the earlier information couldn't really find anything terribly helpful on. So the information from April 2017/18 up to April '21, June '21, shows the number of sessions 10:51 that were provided to a number of attendees. So a number of attenders would be patients from --

34 Q. Just to clarify this is only related to Muckamore?

A. Muckamore only.

35 Q. This is Muckamore specific. Okay. 10:52

A. Purely Muckamore.

DR. MAXWELL: And what do you mean by "session"?

A. So a session -- well, again, this is defined by the Trust, but our understanding of a session would be a

consultation, a communication, a contact with...

DR. MAXWELL: So is this -- so to me a session might mean you might put an advert and say 'We'll be here on this date anybody who wants to can turn up and speak', is that what it means? 10:52

A. No.

DR. MAXWELL: Or does it mean a specific appointment with somebody?

A. It's a specific appointment.

DR. MAXWELL: So there were -- so if we take April 2020 to March 2021, there were 393 sessions. So that was 393 separate appointments? 10:52

A. Over the year, yes. Yep.

DR. MAXWELL: And then you have another column which is the number of attenders. 10:53

A. Yeah.

DR. MAXWELL: Which is 184. So you've got 393 appointments which involved 184 attenders?

A. But my understanding is the attenders are not unique numbers. So it could be that people within the 184 got more than one appointment. 10:53

DR. MAXWELL: Yes.

PROFESSOR MURPHY: But lots of the sessions it looks like had no attendance?

A. Sorry? 10:53

PROFESSOR MURPHY: Lots of the sessions it looks like had no attenders. Does that mean your advocates were turning up but nobody was coming to meet them?

A. I'm not sure. I can't be clear about that.

DR. MAXWELL: Do you know how many patients were being represented at these sessions?

A. Well an attender would be a patient, but as I say.

DR. MAXWELL: But as you've said that's not unique, and we know by this date there were certainly less than 60 patients there, so it couldn't have been 184 patients. 10:54

A. No, but it could be -- so each session -- so if I had a session with you, but I had three sessions with you, you'd still be counted as an attender.

DR. MAXWELL: No, I understand that, which is my question: Do you know how many unique patients? Is that not how you collect the data? 10:54

A. It's not how we were asked to collect --

DR. MAXWELL: So we don't know how many patients were being represented by Bryson from this data? We just know how many contacts the staff had. 10:54

A. Yeah, that's correct, we don't.

DR. MAXWELL: Thank you.

CHAIRPERSON: And also in terms of sessions, sorry, you said two things. A consultation, I understand. You also said the communication. So does that just mean an e-mail or a letter? 10:54

A. No, sorry, a communication, by that I mean...

CHAIRPERSON: Face to face?

A. Yes, a face to face communication. 10:55

CHAIRPERSON: Okay.

A. Yes.

36 Q. MS. BERGIN: If I can refer you, just to finish the point that I began with back to the original Exhibit 8,

and I appreciate you've indicated to the Panel that some of the figures are incorrect, but what I wanted to ask you about specifically is I suppose the trend or pattern, and specifically what appears to be an increase in the number of engagements. So I previously 10:55
referred, and we're looking at the first page of Exhibit 8, please? Thank you. So I think we can see, sort of the middle section shows that there was no specific MAH data between 2009 to 2017, but in terms of the data that we do have there, and I appreciate you 10:56
have said there may be some error in terms of specific numbers, in 2009 there were around it says 83, so around 80 engagements, and by 2017/2018, on this table there were 344, or by the updated figure there were 222 sessions or 139 attenders. Would it be correct to say 10:56
that the number or the volume of engagement by patients increased over time?

A. Yes, that's correct.

37 Q. In terms of what you might attribute that to, can you give any explanation? Is that due to issues 10:56
increasing, or an increased awareness of the existence or provision of the advocacy services? Can you assist us with that?

A. Yeah. I mean I think it was an indication of the advocacy service being well bedded in then and that 10:57
patients were more aware of it. Staff had gone through -- we had gone through kind of joint sessions of understanding advocacy, so staff were more aware of it. And I think we had, from memory, I think we would have

had additional resource added to that as well. So we did have extra hours available in Muckamore.

DR. MAXWELL: Were these sessions still mostly about resettlement?

A. Yes. Yep. Most of them were resettlement. Some sessions may have been about activities within the hospital or, you know, requests for different activities, but generally speaking resettlement. 10:57

DR. MAXWELL: We have heard from some witnesses that as the resettlement programme continued, in later years the patients who were still in the hospital were more complex, so their resettlement was more complex. Was that reflected in Bryson's experience? 10:57

A. Yes, it would have been. Yes.

38 Q. MS. BERGIN: Thank you. If you could turn now to paragraph 9, please? And I've already touched on this, and this is in relation to the revised independent advocacy service, and as you've already confirmed that patients then admitted newly to MAH under the Mental Health Order were asked during admission whether they wanted to see an advocate. Was there a difference in terms of how Bryson delivered its services or how it engaged with patients who were voluntary admissions versus detained patients? 10:58 10:58

A. No. 10:58

39 Q. No. And in terms then of determining whether a patient might see a Bryson advocate as opposed to another type of advocate, how would that have worked?

A. My understanding of that is that we basically -- we saw

who we had referred to us.

40 Q. Okay.

A. So again -- now we did, to be fair we did have, we did have drop in sessions that we provided, where literally somebody did sit and wait to see did anyone come along, and that proved very ineffective, you know. So the most effective way of finding patients and supporting patients was through referral from wards, ward staff and others. 10:59

41 Q. So just is it correct to say then that it was more common that you would receive referrals from, I suppose a staff member, rather than patients self referring? 10:59

A. Yes.

42 Q. Yes. And if I can ask you at paragraph 11, please, you refer to Bryson Care employing trained advocates and also training advocates, and elsewhere in your statement at paragraph 15, you refer to non-instructed advocacy, which is advocacy involving patients with a degree of incapacity. What types of training would Bryson advocates have had? Would that have included learning disability? 11:00 11:00

A. Yes. Oh, yes, the advocates were all trained with learning disability, and the minimum standard -- this is why I have this because I have notes -- the minimum standard was City and Guilds Level 3, which was sort of and industry standard, if you want, of training. Yes, City and Guilds Level 3, independent mental capacity advocacy. And the training for that has mandatory, has mandatory units, and then optional units. So advocates 11:00

would have been trained in the mandatory units and then there was a kind of rolling training where optional units would have been provided as well.

43 Q. And would there have been degrees in terms of, I suppose experience or expertise of particular advocates? For example, would some advocates have been able to deal with patients by themselves, but other advocates, for example, required the use of a registered intermediary? Or was there a base level of, I suppose, ability in terms of the advocate's expertise? 11:01 11:01

A. I think the basic, the basic standard of training and experience of advocates was good. I think, however, again going back to the fact that there were a couple of advocates who spent a lot of time in Muckamore, they developed additional skills, to be fair and, also, as I say, there were optional units. So some advocates chose to do units that would have been Muckamore appropriate, where others may have chosen different units. But everyone who was involved with patients in Muckamore would have had the competency to deal with the issues. 11:02 11:02

44 Q. Okay. And if I could ask you to move to paragraph 16 now, please, and here you have outlined the various ways that patients were made aware of the advocacy services provided by Bryson, and in and around 2009 you refer to various measures being in place. Prior to 2009, so between 2005 to 2009, that initial period, can you tell us what ways patients were made aware of the 11:02

existence of Bryson? And I appreciate you've indicated that there wasn't a lot of patient self-referral, but if we could just understand that, please?

A. Yeah. I can't -- I mean obviously I can't be very specific because I didn't, I wasn't in situ, I didn't service Muckamore. However, my understanding would be that we had -- we actually had very good relationships with staff in Muckamore. There were still steering group meetings at that stage. We had a good joined up approach to how our advocacy would be communicated within the hospital. So we did go to ward meetings, we did go to training sessions with staff from Muckamore, made sure everybody understood what was on offer and how to access it. We would have had our sort of open meetings, drop-ins centres, where we could, you know, if we weren't having patients we could go and talk to staff. There were meetings where if we felt we weren't accessing the numbers that we thought we should be, then we could, at the steering group we could raise that and people would, senior people, senior operational people would kind of go into wards and kind of drum up enthusiasm for the service.

11:03

11:03

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11:04

CHAIRPERSON: You may have covered this, but did you attend MDTs?

A. Sorry?

11:04

CHAIRPERSON: Multidisciplinary team meetings in relation to patients?

A. Yes, we did. When we were invited we did, yeah.

MS. BERGIN: We'll come to that in a moment, Chair, or

we can deal with it now?

CHAIRPERSON: No, no, no, no, come to it in your own time.

45 Q. MS. BERGIN: Thank you. So just, I think you were just dealing with pre-2009 measures. If I can just -- I am going to move to then the measures that were in place after 2009. But if I could just pick up briefly, you said that at that stage, I suppose pre-2009 perhaps or around that stage, relations between, professional relations between Bryson Care advocates and Muckamore staff were positive and you were still attending steering group meetings. Can you give us an idea of what you mean by that in terms of, you appear to be suggesting that relations with staff then deteriorated. I don't want to put words in your mouth, but I think that seems to be the suggestion, and also then when the steering group attendances then stopped? 11:05 11:05 11:05

A. Yeah. The steering group attendances stopped around 2010/11.

46 Q. And why was that? 11:06

A. Well, again my understanding was that the person who was driving those meetings, who would have been taking responsibility in terms of an employee at Muckamore, left the post, and things kind of didn't get replaced.

47 Q. Okay. 11:06

A. Structures didn't get replaced.

DR. MAXWELL: So can I just ask, are you suggesting that you stopped attending or the meetings stopped happening?

A. The meetings stopped happening.
DR. MAXWELL: So it wasn't that you were excluded, it was that the meeting just stopped happening?
A. Yes.
MS. BERGIN: And does that correlate with the deterioration in, I suppose, working relationships with staff, or can you tell us more about that? That seems to have, in your evidence, been one of the positive sources of making patients aware and staff aware about the advocacy services? 11:06
A. Yeah. I think deterioration in relationships would be too strong.
48 Q. Okay.
A. I do think that there just didn't seem to be the same collaboration, collaborative approach, and I think advocates found that they had to maybe work a bit harder at building relations and sustaining those relationships as well. And, you know, I mean I think there was some understanding that wards were very pressurised that, you know, there were staff shortages, changes, but it just seemed to be slightly less a joint effort than it had been prior to that. 11:07
49 Q. Okay. And then if we then move to 2009? So staying with the theme of how Bryson made staff and patients aware of the existence of their services. So in and around 2009 you say in your statement that there were posters and leaflets in Muckamore, and I think the proforma checklist that you've provided to the Inquiry is dated 2009, so would it be correct that advocates 11:08

were invited to attend ward rounds around 2009?

A. Yes.

50 Q. Can you help us understand, if I go through very briefly the other measures, can you give us an idea of whether these were all in place at the same time, or one came after the other, or one replaced the other? So for example, patients that we've referred to already, new patient's lists being forwarded to advocates weekly so that initial meetings could be set up, weekly advocate drop-in sessions, advocates participating in induction programmes for new ward staff, and lists of new patients being sent to advocates on a weekly basis. Can you give us an idea of when or at what stage those various measures were in place? 11:08 11:08 11:09

A. Again, my understanding would be that was -- that happened as a sort of series of measures, but I would have to say that -- so they would have been all implemented around the same time.

51 Q. And that would have been around 2009, is that correct? 11:09

A. Nine. Yeah, yeah, about that. And -- but I think it was rolled out, but it was a bit more patchy than perhaps it sounds. So, again, advocates had to work at, you know, ensuring they got lists and they didn't miss anybody, and they had to -- so it still, yep, still needed work. 11:10

52 Q. Okay. And in terms of making relatives aware of advocacy services, how was that done? I know we have already referred to 2016 formal engagement, but how was

that done then in the context of all of that?

A. Again that was done informally. I mean there would have been posters and stuff, so families would have been aware just by being in the environment of Muckamore. But it was more likely that family engagement was specific to a particular patient, and the engagement with the family was very much linked to the engagement of the family or the carer with the patient.

53 Q. And would, in your experience insofar as you can say, would it have been the experience of Bryson advocates that family members would have contacted them separately to, maybe not to make a referral, but certainly to raise concerns or issues? 11:10

A. I think the advocates would have had a fair degree of communication with the families and carers, significant people, yeah. 11:11

DR. MAXWELL: Can I just ask? You've talked about some changes around 2010/11 when it became harder to work more collaboratively and that might have been for a number of reasons. You talked about the pressures on the ward. Presumably Bryson Care had a contract review meeting with the Trust. Who would have attended those and would this sort of issue have come up at those? 11:11

A. Yeah, contract -- there would have been annual contract meetings, and sometimes there would have been a sort of six month review of the contract. They would have been attended by the Assistant Director and the Service Manager. 11:11

DR. MAXWELL: The Assistant Director in the Trust?

A. No, sorry, the Assistant Director of Bryson.

DR. MAXWELL: Of Bryson.

A. Bryson.

DR. MAXWELL: With who in the Trust? 11:12

A. No, with the Service Manager from Bryson as well.

DR. MAXWELL: Okay. And who would you be meeting from the Trust?

A. So it would have been director level.

DR. MAXWELL: So at the Directorate level. 11:12

A. Yes. Yes.

DR. MAXWELL: So it would have been the Director. So you would have made them aware that actually this collaborative relationship seemed to be more difficult than it had previously been? 11:12

A. Yes, we would have made them aware of that.

54 Q. MS. BERGIN: So picking up on that. So were the issues -- for example you've referenced I think at paragraphs 22 to 24 of your statement and you've referred to in your evidence the issues around Bryson advocates not 11:12 being invited to meetings, for example. Were they formally then raised with, or informally even, with Trust staff?

A. Yes.

55 Q. And, if so, I mean were those issues resolved or what 11:12 was the outcome of that?

A. They would have been raised with -- both formally at contract meetings and also by telephone contact with certain levels. So if we felt we were being

particularly frustrated by a particular ward, or a particular person, that would have been taken up by our Assistant Director at Assistant Director level within the Trust. And sometimes, sometimes that resolved things, and it was genuinely pressure on a ward or whatever. And at other times there would have been pushback to us as well saying "well, you know, it's not possible, it's not possible."

56 Q. I appreciate we're dealing with quite a long period of time, but if you can assist at all, can you say at all whether these issues in terms of not being invited to meetings, or not being told about things by staff, were they things that, I suppose, got better or worse over time? 11:13

A. I think, and again this is just from a more kind of oversight strategic positions of what was being reported to me, I think things weren't so good. Certainly around 2012 there were difficulties, and I actually was involved in some of the resolutions around that, and then things seemed to settle again and they got better, I have to say. And then I think -- so really from that time on until we come on to the bit where, you know, issues around abuse, et cetera, were beginning to come out, I think things were actually, were good. Still individuals, still pockets of things. Now, I would also say that we had some advocacy, we had some advocate changes, and perhaps initially some of our advocates were overly enthusiastic and just had to, you know, we had to sort of reshape things a bit. But, 11:14 11:14 11:15

yeah, I think really from 2000 -- after 2012/13, things improved again.

MS. BERGIN: Thank you.

CHAIRPERSON: Just before we take a break, when you say "overly enthusiastic", do you mean too aggressive or how did that manifest itself? 11:15

A. Not so much aggressive, but maybe overly -- how do I describe it? Overly persistent in -- yeah, just overly zealous really I think.

CHAIRPERSON: That might be a good thing for an advocacy service? 11:16

A. In some occasions it was definitely a good thing. In others it was perhaps much more of a personal kind of thing.

CHAIRPERSON: Yes. Okay. 11:16

DR. MAXWELL: Can I ask about the issue about patient confidentiality, because obviously it's really, really important to have patient views represented, but the ward round or the MDT meeting discussed all patients on the ward, and there was quite a lot of confidential information. Was there a clear understanding about, or was there any understanding about how much of the meeting advocates should attend? Would they only attend when their client was being discussed, or would they expect to be there for the whole meeting? 11:16 11:16

A. I can't actually answer whether they were allowed to stay for the whole meeting. When they were invited they were certainly invited obviously to talk about their particular patient, but I can't say operationally

if they stayed on or not, sorry.

MS. BERGIN: Chair, we don't have very much further to go but I think maybe it is time for a break.

CHAIRPERSON: Yes. The witness has been going for over an hour, so we'll take a short break for about 15 minutes. Thank you very much. And you'll be looked after by the Inquiry secretary. Thank you. 11:17

SHORT ADJOURNMENT

11:17

THE INQUIRY RESUMED AFTER THE SHORT ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you very much. Welcome back. Thank you. Yes. 11:36

57 Q. MS. BERGIN: Yes, thank you, Chair. I only have a few more questions for you, but before I begin those, I just want to very briefly, and I'm not going to dwell on this point, go back to the new Exhibit 8, if I may, very briefly? And one thing that occurs, which might be of particular interest to families of patients, is just to clarify -- so from the figures there is it correct that you can't say how many patients engaged with Bryson or how many individual sessions a patient had? 11:36 11:36

A. At this moment in time I can't confirm either of those actually.

58 Q. Is that something that maybe Bryson could be asked to provide?

A. I -- I can certainly request and have a look at that.
CHAIRPERSON: I think it would help us to know how many patients you were representing, certainly.
MS. BERGIN: Yes. Thank you, Chair.
A. Okay. 11:37
59 Q. If I can ask you then to turn to paragraph 20, please? And here you say that:

"Bryson does not keep a central register of the types of complaints made by patients, but concerns are 11:37
documented on a contact sheet and then discussed with the Service Manager of the Independent Advocacy Service at weekly debrief meetings to ensure that the Belfast Trust team has been made aware of these and that an appropriate action plan has been put in place." 11:37

Was there any follow up by Bryson to ensure that those action plans, rather, were put in place?
A. So, it would have been practice that if there was an issue raised that there would be feedback and that we 11:38
would be satisfied that some action had been, had been taken.
60 Q. And was there a formal process for that, or was that simply someone checking in?
A. That would have been -- that would have been the 11:38
requirement of the Service Manager to check that and record that there had been a resolution to whatever the issue was.
61 Q. And if there, for example, hadn't been an issue, what

sort of steps might Bryson advocates have been able to take?

A. So we would have had, and we do have, an escalation procedure, so that if the advocate wasn't satisfied, and the Service Manager wasn't satisfied, that would have been escalated to the Assistant Director, who would have been very active in raising that at a senior level within the Trust, and should it not then be resolved it would have come to my attention, but that wouldn't have been the case very often. 11:38 11:39

62 Q. And in terms of contextualising when that practice began or evolved, is that something that's been longstanding as far back as 2009?

A. Yes.

63 Q. Yes. 11:39

A. It would have been. It would have been, yeah.

64 Q. Does Bryson keep a copy of those contact sheets?

A. It would. I mean it would have been part of the service user record. We wouldn't -- we don't -- my understanding is we wouldn't have a register as such of those. 11:39

DR. MAXWELL: Do you mean Bryson's record of the service user or the Trust's record?

A. No, our. We would have a --

DR. MAXWELL: So Bryson would have a file on each service user? 11:39

A. Yes.

DR. MAXWELL: And would those files still be in existence? Presumably the seven year rule would still

apply to keeping documents?

A. Yeah, there would be some. Yeah.

DR. MAXWELL: So potentially it would be possible to look at those?

A. It would be -- 11:40

DR. MAXWELL: It would be a big piece of work, but potentially possible.

A. A big manual job, but potentially possible.

DR. MAXWELL: Yeah.

A. Yeah. 11:40

65 Q. MS. BERGIN: And I think you've referred at paragraph 20 in your statement also to escalation and potentially involving ASP1 Forms being completed. Are those also kept on the Bryson Care patient file?

A. I would expect them to be, yep. 11:40

66 Q. Okay. And do you have any idea or can you assist us at all in terms of the volume of those serious types of incidents or issues that would have been referred or required in ASP1?

A. I don't have a sense that it would have been very 11:40 large, but...

67 Q. Thank you. And if you can now look at paragraph 24, please, and here you say that:

"After "A Way to go Report 2019 was published, Bryson 11:41 advocates were then able to visit the hospital unannounced. Prior to this they had to arrange visits."

How was it decided that Bryson should be able to make those unscheduled visits to MAH after "A Way to go"?

A. So that would have been agreed at the contract meeting and then we would have been actively following that up. Service Manager would have been at the contract meetings, so she would have ensured then that our practice changed accordingly.

68 Q. And can you tell us anything about whether there was any noticeable difference in terms of that change in practice? Did that result in different levels of engagement or outcomes in relation to patients? 11:41

A. I think it was difficult in practice. I think the sense from the team would have been that the access was still difficult. There were times when people would have been told they can't have access at that particular moment in time. There would have been occasions when people got access but, you know, the routine of the ward would have made it difficult to have a qualitative interaction with a patient. Now having said that, some other advocates had exceptionally good experience of the access, but I'm not sure that it actually changed necessarily the volume of people we got to see. 11:42

69 Q. And those issues --

DR. MAXWELL: Sorry can I just ask -- 11:42

70 Q. Apologies.

DR. MAXWELL: So it was agreed at a contract meeting there would be unannounced visits. Do you know if that was requested by the Trust or by Bryson?

A. No, that came from the Trust.

DR. MAXWELL: So the Trust was requesting that you make unannounced visits?

A. Changed, yeah. Changed its protocol. Yeah.

71 Q. MS. BERGIN: Then just picking up on Dr. Maxwell's question then. The Trust, having been the ones who requested that, were the issues in terms of actually implementing those unannounced visits ever raised or escalated to the Trust and resolved? 11:43

A. I'm sure, I'm sure that the Assistant Director would have raised them with the Trust at a particular level. It was -- I suppose the practice was more at the hospital level. But, yes, the issues of that would have been raised. 11:43

72 Q. And this is obviously a relatively new feature around 2019, and I appreciate that you've recently retired from your role as Director in Bryson, but in terms of those issues with the unannounced visits, do you have a sense at all of whether they, between 2019 onwards improved, or did they remain the same, or have access issues worsened? 11:43 11:44

A. No, I think obviously then we had the, you know, the Covid bit, which made access to the hospital full stop difficult. But since that, and since the world is kind of reverting to it's usual practices, I think it has improved, and I think from talking to operational staff they're kind of more positive about the relationships, and frustrations now are more around the lack of, the lack of move on resources, but I think they'd like to 11:44

see more in the community, but the relationships in Muckamore I think are good.

DR. MAXWELL: Can I ask? This initial difficulty with unannounced visits, you did say that sometimes it was because things were going on on the ward, and we've heard other people talk about it's not always in the patient's best interest to have a lot of new people entering the environment, but did the advocates perceive that there was resistance from hospital staff to unannounced visits? 11:45

A. I think honestly different advocates would have different opinions on that.

DR. MAXWELL: All right.

A. And whether that was to do with the individual relationship with the ward, I don't know, but... 11:45

DR. MAXWELL: Were the advocates attached to specific wards? So did they have different experiences because they were working with different wards?

A. No, no.

DR. MAXWELL: So they would work across all wards? 11:45

A. Yeah, they're more associated with the patient than the ward.

DR. MAXWELL: So they would cross all wards?

A. Yep.

DR. MAXWELL: Okay. Thank you. 11:46

CHAIRPERSON: Could I just ask, because you keep mentioning Covid, and I can understand why, but what happened during Covid? Was that a complete stop to all visits to the hospital, or did you find ways of still

performing your function while --

A. I think it was -- the majority of contact during Covid would have been telephone type contact, which wasn't, wasn't satisfactory.

CHAIRPERSON: No. 11:46

A. But it was very limited access to the hospital.

CHAIRPERSON: So really no or very few visits to see what was actually going on?

A. Yep.

CHAIRPERSON: For a two to three year period? 11:46

A. Well, no, not the whole period, but certainly at the height, you know, from probably 20 -- I think it's even reflected in the numbers, isn't it, yeah, that sort of '20/'21.

73 Q. MS. BERGIN: If I can ask you then to move to paragraph 25, please? And here you say that: 11:47

"The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which dilutes the true independence of the service." 11:47

And that it:

"...needs total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome." 11:47

Can you expand on that, please?

A. Yeah. Well, I think it was reflected in some of the earlier statements from some of my colleagues in the sector, and I think it would be our position that if you're receiving your funding and you're contractually -- you're in a contractual relationship with the Trust, it does make it difficult to feel totally independent of them, and we would much prefer to have some kind of arm's length arrangement where the funder or the commissioner is not the Trust. I mean, there would have been nuances at times, I would have to say, contractually, where, you know, you would be reminded that it was a contract with the Trust. So I think -- I do think for true independence it should have a different commissioner. 11:47 11:48

CHAIRPERSON: Well -- I'm so sorry, Ms. Bergin. When you say you would be reminded that there was a contract with the Trust, in what sense would you be reminded of that? 11:48

A. Well it would be a comment that, you know, this is a Trust contract. So if you -- 11:48

CHAIRPERSON: Is that when you're raising issues?

A. If you were raising kind of issues, yes.

CHAIRPERSON: So hold on, you're raising an issue with the Trust and they say "Well, bear in mind this is a Trust contract"? 11:49

A. It happened on occasion.

DR. MAXWELL: So what sort of issues? Was it when you were raising issues about patient care or when you were raising issues about funding and ways of working?

A. It would have been about the advocacy approach.

DR. MAXWELL: So it was about how you do your work, not about a particular concern you had raised on behalf of a patient?

A. Yes. No. No. No. No, definitely not. 11:49

74 Q. MS. BERGIN: Thank you. Paragraph 27 then. Here you state that:

"Bryson Care first became aware of allegations of abuse by staff at Muckamore in late 2017, and this was 11:49 through hearing information informally from hospital staff and not, for example, otherwise, including through the Trust itself."

So Bryson Care advocates were engaging with patients 11:50 and relatives, we've heard, long before these allegations came to light. Can you assist the Inquiry with why these allegations of abuse were not known to Bryson advocates through their engagements with service users at MAH? It may be that you're unable to, but -- 11:50

A. Yeah. Well, yeah, I'm not really able to comment or to confirm that, but I know certainly there were no, there was no formal communication to Bryson that there was any such issues going on, and what we were picking up was just basically people talking on site. 11:50

75 Q. But in terms then specifically of the work that Bryson advocates were doing, engaging face to face with patients and potentially with relatives throughout the time of its service provision, I just want to be very

clear; are you saying that advocates, to the best of your knowledge, weren't made aware of any allegations of abuse?

A. Yes.

76 Q. Or -- 11:51

A. Genuinely. Genuinely.

77 Q. By those service users?

A. No, genuinely not. And had there even been a whisper of it, a sense of it, then, you know, we would have escalated that immediately. So I'm content that staff, 11:51 advocates that we would have had in Muckamore were totally unaware of anything that serious.

78 Q. In terms of, I suppose, the role of the advocates, the Bryson advocates, and I know your evidence has been that they were primarily focused on resettlement, can 11:51 you provide us with some sense of whether allegations by patients, for example, would be the sorts of things that you would expect patients to be bringing to the advocates who were assisting them, or why they might not have done so, given that these were advocates who 11:52 were there to assist and engage with these patients?

A. Yeah. I mean certainly our advocacy was, is person-centred, and relationships were really important, and we do think that we have very constructive relationships with patients, and families, 11:52 carers. So I can't honestly answer that. I mean had there been anything, anything that gave our advocates any indication of such serious allegations, we definitely would have -- they would have report it to

management and management would have escalated it. So I can't really explain why not, but it didn't happen.

CHAIRPERSON: Can I just ask this question and could you answer this "yes" or "no"? Are you aware of any detail about the current police investigation? Can you just answer that "yes" or "no"? 11:53

A. No.

CHAIRPERSON: And do you have any agreement with the police or the Prosecution Service to keep you up to speed, as it were, with their investigation or who they've arrested or anything like that? 11:53

A. No.

CHAIRPERSON: Right. I won't take that any further. Thank you.

79 Q. MS. BERGIN: Thank you. If we can move on then to paragraph 31, please? Now at the start of your evidence I indicated that there are two topics, the first we've dealt with, which is patient advocacy and representation, and I now very briefly just want to deal with the issue of resettlement. Okay. So at paragraphs 31 to 33, you outline that: 11:53 11:54

"Bryson Care's engagement with patients who have been identified for resettlement begins with in-hospital assessments..." 11:54

- using the Quality-of-Life assessment tool that we've discussed, and then right through to resettlement in the community, engagement at 3, 6 and 12 months post

discharge. So once a patient was resettled, how often would you expect that patient to have been spoken to or have had contact with one of the Bryson advocates?

A. That would be at least, at least once a month, and certainly in the early stages more frequently, and then as people are settled, you know, less frequently. But regular and, you know, that would be planned. 11:54

80 Q. And the 3, 6, and 12 month reviews, were they more formalised reviews?

A. Yes. 11:55

81 Q. And I think you've referred to, you know, issues being referred back to Muckamore through advocates. So can you give us a sense, a little bit more of a sense of what advocates were doing in terms of patient resettlement once they were discharged? 11:55

A. So it would have been or it is very much where an advocate visits the resident now in situ. There has been a plan. So the plan is reviewed. Is progress being made? If progress has not been made, why not? Is there anything that we can do to help the system unblocking anything? And just feeding back and taking a level of, I suppose, contentment of people, that they're in the right place, they're doing the right things, and they are as independent as they possibly can be. 11:55 11:55

82 Q. And you've indicated that after 12 months post discharge, if a new issue arose for a former patient, then a new referral would be triggered to Bryson Care Community Advocacy Services?

A. Yep.

83 Q. So would that mean if a patient was working with a particular advocate for the 12 months post discharge and something new arose, they might not be then having continuity with that same advocate, they would potentially have to start the, I suppose, the process of engaging with an advocate again, or could you explain to us just that? 11:56

A. Yeah. I think we would try to keep the continuity of the relationship insofar as we can. It's a small team. The likelihood is it will be the same advocate. It would be a kind of rare circumstance that it wouldn't be. 11:56

84 Q. Okay. And as Director of Bryson Care, and I appreciate you've just very recently retired from that post, but what sort of relationship did you have during that time with the Chair or the Chief Executive of each of the Trusts in Northern Ireland, not just the Belfast Trust? 11:56

A. It certainly wouldn't have been at the level of Chief Executive or Chair, but at kind of directorial level, and it would have been -- they would have been professional. I would say, however, that the real relationship between Bryson and the Trust would have sat with the Assistant Director, who would have been basically looking after the contract as such. So I really only became involved with senior staff in the Trust if there was an issue of some kind, but would have known them professionally through other forums. 11:57

85 Q. And in terms, I suppose in your role as Director, again 11:57

speaking, I suppose, at a higher level of engagement, in terms of your engagement with the providers of other advocacy services at Muckamore, did you have any at your level?

A. No. To be honest, no. 11:58

86 Q. No. Just the Panel may have some questions, but before that, I just wanted to give you the opportunity to, I suppose, add anything that you might want to make the Panel or the Inquiry aware of in relation to the role of Bryson advocates at Muckamore? 11:58

A. I don't have anything to add. Thank you.

CHAIRPERSON: Dr. Maxwell.

MS. MARLEY WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS: 11:58

87 Q. DR. MAXWELL: Yeah. So you've talked about Quality-of-life assessment, and you helpfully included that, and if I understand that that's completed when the patient is in Muckamore and then at various points after they've been resettled, is that correct? 11:58

A. Yes.

88 Q. DR. MAXWELL: So there's an audit really of the patient experience through this journey. Have these been analysed and collated in any way so we can see the experience of a group of patients rather than just an individual? 11:58

A. I'm not aware that it has been.

89 Q. DR. MAXWELL: But potentially that might be possible?

A. Potentially that might be possible.

90 Q. DR. MAXWELL: Yes. So we've heard quite a lot about the challenges of resettlement, and actually we've heard about a number of patients who have had failed resettlements, they've gone out into the community, their experience hasn't actually been better and they've been re-admitted. In your experience can you say anything about how often that would happen?

A. I'm not sure how often, but it certainly has happened. And I think, I think from talking to Bryson advocates, part of the issue is that the opportunity for resettlement is limited, and sometimes in order to get people from Muckamore to somewhere, they're maybe not placed in the best environment, which then I think does have a knock-on effect to having to have people returned to Muckamore. So I do think it's driven by resource rather, or the lack of resource, rather than any kind of professional issue. I think it is just a --

91 Q. DR. MAXWELL: So there's a lack of appropriate places --

A. Yes.

DR. MAXWELL: -- for people to be resettled. And so some people -- well, it's a bit of a loaded question but I'll ask it anyhow. Was there any sense amongst the advocates that some of the planned resettlements weren't going to work because they weren't meeting the patient's needs, but they went ahead anyhow?

A. Yeah. I can't give a frequency to that, but certainly in talking to advocates there is frustration that

sometimes it's kind of not the best placement, but the need to vacate Muckamore takes precedence over that.

92 Q. DR. MAXWELL: So it's not a best interests decision in all cases?

A. No. 12:01

93 Q. DR. MAXWELL: Thank you.

CHAIRPERSON: Prof. Murphy.

PROFESSOR MURPHY: Those were exactly my questions, so that's fine.

94 Q. CHAIRPERSON: Just going back to one thing that 12:01 Dr. Maxwell asked you earlier. You said you would have a record of each service user?

A. That's my understanding, yes.

95 Q. CHAIRPERSON: Who is also a service user of Muckamore Abbey? 12:01

A. Mhm-mhm.

96 Q. CHAIRPERSON: But you said that to get hold of those documents would be a big job. Can you just explain a bit about the filing system?

A. Well, I suppose, obviously the Inquiry scope is many 12:01 many years.

97 Q. CHAIRPERSON: Yep.

A. So there would have been a lack of kind of technological information management systems in the earlier days. We have material archived, it is 12:02 archived off-site. We have also had a move, a major move from our original building in Bedford Street to a new premises.

98 Q. CHAIRPERSON: When did the files become digital?

A. Probably 2000 and -- it's quite late, probably 2018/19. Well, maybe '17. Yep.

99 Q. CHAIRPERSON: And if anyone wanted to see a sample of those files, just to see what sort of interaction you were having, would that be a difficult thing to provide? 12:02

A. I think that should be possible, yep.

100 Q. DR. MAXWELL: Are you saying the paper records pre-2017 are archived somewhere or microfiched?

A. No, it would be physical hard copy. 12:02

101 Q. DR. MAXWELL: So they are potentially accessible?

A. Yeah, within the retention period they should be.

102 Q. CHAIRPERSON: So sitting in a basement somewhere?

A. Sitting in a lock-up.

CHAIRPERSON: All right. All right. Unless my colleagues have got anything else? Can I thank you very much for coming to assist the Inquiry and informing us about Bryson Care. Thank you. All right. I think the next witness is 2:00 o'clock? 12:03

MS. BERGIN: Yes. Ms. Tang will be dealing with Module 2. 12:03

CHAIRPERSON: Super. Thank you very much.

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Ms. Tang.

MS. TANG: Good afternoon, Chair and members of the Panel. We are now moving onto the Organisation, Module 2, which deals with professional education. 13:56

The purpose of this module is to examine the evidence from the University sector on issues arising from professional education in the field of learning disability. 13:56

This module is of particular relevance to paragraphs 9 and 17 of the Terms of Reference. Paragraph 9 requires the Inquiry to examine the policies and practices relating to recruitment, retention, training and support of staff and management at all levels within MAH and, where necessary, within other facilities offering comparable services. 13:56

Paragraph 17 requires the Inquiry to consider the adequacy of financial resources to ensure appropriate numbers, skills, quality and training of staff, and appropriate care, treatment and accommodation for patients with mental health conditions and/or learning disabilities treated or cared for at MAH. 13:57

Ulster University and Queen's University Belfast

provide professional education for students who may enter the field of learning disability care, this includes training for future nurses, doctors, psychologists, allied health care professionals and social care practitioners. 13:57

The Panel requested statements from three individuals for the purpose of this module. The first was Professor Donna Fitzsimons of Queen's University Belfast. Secondly, Professor Neal Cook of Ulster 13:57 University and, finally, Professor Pauline Adair of Queen's University Belfast. Of those statements have been published on the Inquiry's website.

Having considered the statements, the Panel wished to 13:57 hear oral evidence from Professor Fitzsimons who will be called to give evidence shortly. Before we move on to hear from the witness it would perhaps be helpful if I draw attention to some of the salient features of the written statement from Professor Cook, from whom we 13:58 will not be hearing oral evidence.

Professor Cook provided a statement to the Inquiry dated 8th April 2024, which has been published, as I have stated, on the Inquiry's website. His statement 13:58 outlines the structure of professional education with regard to learning disability for post-registration nurses and that the Department of Health and Health and Social Care Trusts jointly commission this.

Professor Cook outlines some of the modules provided by Ulster University, including one looking at principles of assessing people with learning disability and mental health problems. This module is not run every year, but did most recently in 2023 for 8 students. 13:58

There is also a specialist nursing practice qualification which covers both community nursing care for people with learning disabilities and learning disability nursing generally. The second element was 13:59 provided up until September 2023. That module is an NMC recognised specialist nursing practice programme. These courses were delivered either as a one year programme full-time or a two year part-time programme. There are post-graduate modules focusing on 13:59 demonstrating impact in nursing care for learning disability, delivering new perspectives in specialist learning disability practice and practice based learning. The programme was last commissioned as full-time course in 2016 and is now commissioned as 13:59 part-time only.

In relation to specialist programmes for RNLDs, re management of distressed and challenging behaviours, Professor Cook has stated that there are currently 13:59 opportunities for students to undertake programmes which cover this area in two of the modules mentioned above. In the previous model of specialist practice nursing for learning disability there was some access

to training for these competencies, although this programme has not been revalidated since January 2024 as it has not been requested by the Health and Social Care Trusts.

14:00

The new specialist practice nursing programme focusing on community learning disability nursing care will give students the chance to develop knowledge and skills in dealing with distressed and challenging behaviours. Professor Cook sets out that between 2004 and 2007, 14:00
Ulster University provided some short courses and practice based learning programmes for nurses focusing on supporting people with learning disability who had mental illness or challenging behaviours. This was accessed by a total of nine RNLDs between 2004 and 14:00
2008.

Professor Cook also advised that the University of Ulster has an active research programme in relation to intellectual disability, and he provided some details 14:01
of three pieces of research or studies that Ulster University had undertaken or were ongoing in relation to models of care for people with learning disability.

In a statement, Professor Cook also provides detail on 14:01
the systems for students placed in care settings to raise concerns, if they have them, about placements. He states that there were no concerns raised by students placed at MAH. He advised that the University

of Ulster School of Nursing became aware of concerns about the quality of care in MAH in December 2017. At that time his colleague, Professor Owen Barr, from whom the Inquiry has already heard evidence, was asked, along with others, to be part of an independent assurance team to make recommendations. A report on that was provided to Brenda Creaney, the Belfast Health and Social Care Executive Director of Nursing, on 25th September 2018. 14:01

14:02

I should say that a second statement has been requested from Professor Cook, rather than asking him to attend in person. The Panel will recall that his statement has been published on the Inquiry's website and whenever his second statement is received it will also be published in due course. 14:02

CHAIRPERSON: Yeah, and that's in relation to some further questions that the Panel wanted him to answer.

MS. TANG: Yes, that's correct, Chair. That's correct. The Panel will hear evidence from Professor Adair tomorrow morning, and of course we should say that it is important to note that the evidence in this organisational module ought not to be considered in isolation. The Inquiry has heard from witnesses during patient experience and staff evidence to date which may at times have touched on issues relating to professional education. That also applies to evidence heard in the course of the evidence modules last year, including the very detailed written and oral evidence 14:02 14:02

received from other organisations, such as the Health and Social Care Trusts, Department of Health, et cetera.

I hope this brief overview of Organisational Module 2 has been helpful and, of course, as I say, these statements are all published on the website and accessible to all parties. 14:02

The Panel will now hear from Professor Donna Fitzsimons who gave a statement dated the 6th March 2024. And, Chair, if there are no other issues could the witness be called? 14:03

CHAIRPERSON: No. Thank you. Is it Fitzsimons not Fitzsimmons? It is spelt that way. 14:03

MS. TANG: Yes. We should probably check. Thank you, Chair. I just say Fitzsimons.

<u>PROF. DONNA FITZSIMONS, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:</u> 14:04

CHAIRPERSON: Can I just welcome you to the Inquiry. The first question is how I pronounce your surname?

A. That's an easy one, Fitzsimons.

CHAIRPERSON: It is Fitzsimons. Okay. Well, Professor Fitzsimons, can I thank you very much for making your statement and coming to assist us and I'll hand you over to Ms. Tang. 14:04

MS. TANG: Hello again, Professor Fitzsimons. Thank

you for clarifying how we should say your name. As you know I'm Shirley Tang, I'm one of the counsel to the Inquiry team and I'm going to be taking you through your evidence this afternoon.

14:04

You gave a statement to the Inquiry which was dated the 6th March 2024, and you should have a copy of that on the screen in front of you, and I understand you have a hard copy in front of you also.

A. Mhm-mhm. 14:04

103 Q. The Panel can find that statement at internal page reference 208. Can I confirm that you are content to adopt that statement as your evidence to the Inquiry?

A. I am.

104 Q. Thank you. So with your statement, you've also 14:05 provided an exhibit, which was a copy of the Practice Learning Handbook. Thank you for that.

So turning to your statement, looking at paragraphs 1 and 2, you've told us that you are currently Head of 14:05 the School of Nursery and Midwifery at Queen's University, and that you first qualified as a registered general nurse in 1987. You undertook an additional course in coronary care in 1989 and you completed your PhD in 1998 through the University of 14:05 Ulster. Is it correct to say that your focus in nursing has been adult nursing rather than mental health?

A. Yes. My focus has been adult nursing, and specifically

cardiology. Most of my career has been spent as a clinical academic half time in clinical practice and half time in university.

105 Q. Thank you. So I'm thinking now about the nurse education that's provided by Queen's University, do I understand correctly that Queen's University can provide course in both pre-registration training and post-registration for nurses? 14:06

A. Yes, that's correct. We are the only university provider of pre-registration education for learning disability nurses. 14:06

DR. MAXWELL: Doesn't the Open University?

A. Oh, sorry. Well I mean of the two HEIs in Northern Ireland and Northern Ireland orientated programmes.

DR. MAXWELL: But there's two institutions, one being Open University and the other being you providing pre-reg training. 14:06

A. Yes. Yes, that's right.

106 Q. MS. TANG: So thinking about the pre-registration element. Sorry, Dr. Maxwell. 14:06

DR. MAXWELL: No, it's okay.

MS. TANG: Thinking about the pre-registration training aspect of what's delivered at Queens, looking at paragraph 7 of your statement, which is on page 2, and it was mentioned there that you've said that: 14:07

"The pre-registration curriculum was co-designed with people with learning disabilities, their families, professionals and service providers."

Can you tell me when that design actually happened?

A. So, the curriculum, the Nursing and Midwifery Council revalidate curriculum, you know, on a regular basis, and the last of those was in 2019. So that is to update the curriculum with new proficiencies and make sure it's fit for contemporary practice. 14:07

DR. MAXWELL: Can I just ask? Has Queen's been the provider since Project 2000 when it moved into -- nurse education moved into university? 14:07

A. That's correct. That's right.

107 Q. MS. TANG: So just to follow up on that. Since 2000, the nursing education has been provided at Queens as well as --

A. Yes. Yes, that's correct. 14:07

108 Q. I just wanted to make sure I had that clear. So the new design, am I right in understanding that that new design that involved all these different groups happened in 2019?

A. It was quite a protracted process. So it was probably 18 to 24 months before that we were working with all our stakeholders, our partners in practice. Very importantly we have a long-standing patient and carer educational partnership who were highly involved in that, as well as our commissioners and Department of Health. 14:08 14:08

109 Q. Okay. So while it took effect in -- what did we say?

A. 2019.

110 Q. 2019. It started some time before that, maybe -- from

what you're saying maybe around 2017 or some time after that?

A. That's right.

111 Q. Okay. So are you able to say what kind of changes actually were brought in as a result that of design process? How did the programme change? 14:08

A. It changed in relation I think to the philosophy and orientation of it, focusing on health much more and health assessment. Also in making specialist fields like mental health or learning disability more accessible to people right through the curriculum, realising that people who are studying adult nursing or children's nursing would also need to have detailed knowledge of those areas of practice. So it was about really making the fields more fit for purpose. There was also a significant enhancement in nursing skill set with additional competencies to be provided for registrants. 14:09 14:09

112 Q. Okay. So if I'm picking you up correctly, what -- the way that learning disability, people who are affected by learning disability or their families may have input to that would be perhaps to help make nursing care more generally more learning disability friendly? 14:09

A. Yes. So there are four fields and four distinct curricula in relation to nursing; one ini adult nursing, one in mental health, one in children's and young people's nursing, and one in learning disabilities. So those four fields maintain their integrity within the overall process of a 14:10

pre-registration curriculum.

DR. MAXWELL: Can I just check? When you get approval or reapproval from the NMC, is that for each field or do you get one approval for all four fields?

A. Okay. To the best of my knowledge, the approval is field specific as well as -- because we derive the curricula on that basis, you know. So I would be -- but I can check that. I certainly remember the approval event very -- it was two days of great rigorous evaluation by the McDonald Group, who were taking on the evaluation process for the Nursing and Midwifery Council. 14:10 14:10

113 Q. MS. TANG: I just want to make sure I'm clear on the input from folks with learning disabilities or their families to those four fields, was that input right across the board to all of those fields? 14:11

A. Absolutely.

114 Q. Or would it have been to the learning disability specific one?

A. No, it was right across the board to all of the fields, and I can assure you that there are people within the patient care educational partnership who do have intellectual disabilities themselves, as well as those who care for them. 14:11

115 Q. At paragraphs 8 and 9 of your statement you make reference to educational programmes that deal with distressed and challenging behaviours in the different settings, including in-patient care and how students are taught to apply the Positive Behaviour Framework as 14:11

a means of supporting people. Can you tell me how pre-registration students are taught the practice skills to manage distressed or challenging behaviours?

A. Yeah. So if you understand the three year programme, these skill set are specifically introduced in Year 2 after they've got a foundation in the field. So, obviously new students in the area need to be supported and prepared to deal with such challenging behaviour, so they will have a framework and a repertoire of knowledge, theoretical knowledge to prepare them for that, and then a skill set that will be developed within our simulation centre, we've got an interprofessional simulation centre, and in clinical practice, to enable them to perform at their stage of education. So this is not to say that in Year 2 they're expected to be totally proficient, but that at the end of the three year programme they would need to display competencies in that respect. 14:12 14:12 14:12

116 Q. And has that training been informed by the exercise we spoke about before in terms of the -- was that part of the redesign as well? 14:13

A. The whole curricula has been refreshed. But you have to, I suppose just to clarify, we have always had a Nursing and Midwifery Council approved programme, it is just that the standards for that programme did change in that period of time, and they were really just updated and refreshed to reflect contemporary nursing professional practice. 14:13

117 Q. Yes. Thank you. I want to move down to paragraph 14

of your statement, and you mention there about the physical care training that nurses going through that programme would get. So they would have training in personal physical care, eating, drinking, continence care, moving and handling, et cetera, and some I think would say basic clinical skills as well around physical health, about checking blood pressures, et cetera. As a result of this, would you expect a nurse who had gone through that training and was working in the learning disability area to be competent in spotting and seeking intervention of an appropriate kind if they noticed, for instance, a patient seemed to be losing weight? 14:13 14:14

A. Yes, that assessment is incorporated into the complete physical assessment that our students will be required to demonstrate. 14:14

118 Q. At paragraph 15 you make reference to structured observations, and I note that you say there that student nurses wouldn't be expected to be involved in restrictive practices, and that would include structured observations. Can I ask, given the low number of people with learning disability who typically become in-patients, how much of the pre-registration course is actually focused on in-patient care? 14:14

A. So I think that again is one of the things that has transitioned with the new Nursing and Midwifery Council standards, because there is obviously a greater focus on community dwelling facilities. And, indeed, over this period of time the focus that we would have had on acute facilities, such as Muckamore, would have 14:15

changed, and there would be many more placements conducted in the community setting. So I hope that answers your question all right?

119 Q. Yes. Yes, it does. Thank you. Can I ask if you feel that registered nurses in learning disabilities are competent on registration to work in specialist learning disability in-patient units, such as Psychiatric Intensive Care, or would they typically need more specialist training in order to give them the specialist skills they would need for that kind of setting? 14:15 14:15

A. I mean that is a question that is very dependent on the competencies and proficiencies of each individual Registrant. Certainly they would be competent to work and provide care in that environment. The level of care and the complexity may need to be supported by subsequent education and training and practised based learning. So, professional practice within our profession is regarded as a continuum and, you know, we are continuously learning throughout our professional journey. So a new Registrant would not have the experience or demonstrate the level of competence that you would expect of someone with, you know, more years of experience. However, they are expected to demonstrate the competencies required for registration, which does include that assessment. 14:16 14:16 14:16

DR. MAXWELL: So if we take your own background for example, of coronary care, you wouldn't expect a new adult Registrant to be competent in coronary care,

you'd expect them to be supervised working on -- say with Intensive Care, and a number of adult specialities, and you've already said the NMC standards have changed the focused community based care. So I think the question is, yes, they are competent to be registrants, but are they competent to work in what is actually a very specialist area of LD, without additional training? And certainly would they be competent to take charge without additional training?

A. Okay. And, you know, I can reflect on that and relate it to my own area of expertise. I certainly think that supervision in practice is really important for our new registrants and that we work very closely with practice partners to ensure that especially in those early years our new registrants are supported to develop and enhance their skill set and competencies in that respect. It is an incremental journey. So while you maybe working in an environment, such as a coronary care or Intensive Care facility within a learning disability setting, you will not be, you know, have the level of competence of someone with more experience, you will be working with their supervision and support up to the point were you are deemed competent to take on extra responsibilities, and to take charge of the unit might be something that would be assessed at a future date. It will all depend on the individual capabilities of that Registrant.

CHAIRPERSON: And is it the individual's own assessment of that or is it the supervisor's assessment?

A. Well, from a professional standards point of view we are all required to, as a Registrant, to reflect on our practice and make sure that we do not undertake any skills or skills that are beyond our area of expertise or competence, that's an individual responsibility. But then collectively the environment and the clinical setting is required to support us as registrants to develop that complex skill set through our experience.

DR. MAXWELL: If I can bring you back to the example of coronary care? There is formally recognised post registration and qualification as there is for physical health intensive care units. As far as I'm aware none of the HEIs in Northern Ireland, including Open University, runs a post-registration course for this very specific specialist area of in-patient LD care. Is that correct?

A. So currently, Ms. Maxwell, we actually have a programme in professional practice, a Master's level programme, approved in the field of intellectual disabilities, but that has been recently developed in the last two years in response to the practice providers expressed needs and in conjunction with them and with our patient and care educational partners, but that has not been commissioned so that programme has not run. That is not to say that registrants with a learning disability qualification are not availing of other modules and other programmes of study, but none specific from Queen's in intellectual disabilities at this point in time.

DR. MAXWELL: So just to take that point further, what is the university's role in commissioning education? Because as I understand it, you contribute to the Education Commissioning Group.

A. I do. 14:21

DR. MAXWELL: So how does the decision about what sort of post-registration education's commission get discussed?

A. So that's a very important aspect of our role as educational providers, we need to have strong 14:21 relationships with our practice partners and continually be up-to-date with their intelligence and how the workforce is changing, what future workforce needs would be, and how we should be updating our programmes to meet those in advance. So that's a 14:21 discussion that happens between Commissioners, the practice partners, and the HEIs.

DR. MAXWELL: As I understand it, the Education Commissioning Group actually sits under the Chief Nursing Officer. 14:21

A. That's right.

DR. MAXWELL: And actually the commissioning comes from there.

A. That's true.

DR. MAXWELL: So if you have identified a need and 14:22 created and got approval for a course and it's still not being commissioned, does that get discussed at the ECG?

A. Yes, I've discussed that with the chief nurse quite

recently, that very issue, I've brought it to her attention. It's in a suite of programmes at post-registration level, and there are other modules that relate to those skill sets in health assessment, for instance, or in complex communication. But, yes, I have brought that to the attention of CNO. 14:22

DR. MAXWELL: If I can just carry on, on that theme? We know that people with a learning disability actually have a shorter life expectancy than other people. We know that they are more likely to have co-morbidities. To what extent are pre-registration students or, indeed, post-registration students taught about managing complex co-morbidities, including epilepsy, neuro-diversity, mental health, which are all what we're seeing at Muckamore, a lot of these patients have this complex co-morbidity. How is managing that taught? 14:22 14:23

A. That is taught in both an undergraduate programme and at post-registration level, because that's really important in terms of the demographic that we're dealing with at this particular moment in time. For instance, to speak from my own area of expertise, people with learning disability will demonstrate higher mortality from cardiovascular disease than the general population. We know that they very often have unchecked risk factors and, you know, you would have healthy living focused programmes that allow us to assess cardiovascular risk and take appropriate action for people with a range of different conditions right 14:23 14:23

across the spectrum, from children right through to people with mental health and learning disabilities. So those are now incorporated much more securely in the curriculum from the new standards were introduced.

DR. MAXWELL: Would they have been included in the old curriculum? Is this a change from the 2019 curriculum? 14:24

A. It's a further improvement, but I do recall research at doctoral level where, you know, faculty at Queen's were, you know, really doing research on the cardiovascular risk factors and measures to address them. One of our colleagues definitely did that many years ago, maybe two decades ago, and I think won an award for the project, which was about enhancing the health and well-being of people with intellectual disabilities in terms of reducing their risk factors for heart disease, like high blood pressure and obesity. 14:24 14:24

DR. MAXWELL: Thank you.

120 Q. MS. TANG: Just staying with the pre-registration curriculum, can I ask: does it also provide students with any kind of training in what interventions can be used to protect patients from abuse? 14:25

A. It does.

121 Q. What is the nature of that?

A. So all of our students are equipped to assess the psychological state of an individual patient or service user and they're equipped with the skills to address those challenges at a level commensurate with their experience. So throughout the programme that many 14:25

students would have undertaken, there is a MAPA course that they would have previously have had access to that would give them training and experience in managing aggression and de-escalating those situations through enhanced communication skills and interventions that enable a more supportive and calming environment for the patient.

122 Q. In terms of -- thinking about protecting patients from abuse, does the programme specifically deal with things like safeguarding? 14:25 14:26

A. Absolutely.

123 Q. Signs and indicators of abuse?

A. Absolutely. And that is something that in light of the Inquiry we have been really focused on, because it's hugely important that safeguarding issues are at the forefront of our professional practice in order to maintain public safety. So I mean that has always been a Nursing and Midwifery Council standard, but it certainly has been enhanced in the new curriculum, and safeguarding is a core tenet of every field of professional practice. 14:26 14:26

124 Q. Okay. Can I go down to paragraph 19, which is on page 8? You use interesting phrase that I've picked up on, which is "courageous conversations", and I wanted to understand first of all what is courageous conversation? 14:27

A. Yes. So that is a situation whereby a student or a member of the public observes a level of practice that they potentially do not feel is appropriate, and that

they can address those in a professional manner. So it's about having a standard of care firmly, a professional standard of care firmly within their frame of reference as a yardstick by which they can observe practice and make informed decisions around the acceptability of that. 14:27

125 Q. So there's -- in other words they have something in their head that let's them know what sort of things might require a courageous conversation? And when it comes time to actually have those conversations, how does the university envisage that students would -- what would they do? 14:28

A. So in terms of that process, students, even before their very first placement, are made aware of this process, because we realise that it is an important aspect of supporting them in clinical practice in any setting. So there is a process by which they can escalate concerns, and they've two avenues for that in clinical practice, they have their own practice supervisor now, but it previously would have been a mentor, and they also have their link lecturer, and then they have access, of course, to the field specifically lead for learning disabilities in this instance. So that's the place that they would have -- the link lecturer will be in touch with students on placement either electronically, or by telephone, or in person, and they are responsible for making them aware of the opportunity to raise any concerns in this respect, and then also to support them in beginning to 14:28 14:28 14:28

escalate those concerns and verbalise those themselves.

126 Q. So in practical terms, if a student was placed in a facility that was looking after adults with learning disabilities as in-patients and they saw something they weren't comfortable with, they didn't like the way a patient was being handled, for instance, would the first person they speak to be their link lecturer, or their practice supervisor, or is there any expectation that they would raise it on site with someone on the clinical care team there? 14:29

A. They can choose. I think it is -- depending on the individual situation and the relationship that they would have with their practice supervisor, it would be entirely appropriate for them to question that in an appropriate way in the field. But they also have recourse to their link lecturer, and they have got recourse to the field specific lead for learning disabilities as well. This is a small programme of around 40 students, 40/50 students. So they know these people, they have good access to them, and they will have met them. 14:30

127 Q. And is there a focus on the kind of things that students should pick up on? So, you know, examples of what might be counted inappropriate behaviour or --

A. Yeah. I mean, yes, we would -- our education is replete, you know, our theoretical education will give -- use examples and case studies on a regular basis to try and give our students the scale of different behaviours and their appropriateness so that they can 14:30

really help to understand that the standard of care that they observe or walk past as a professional person is the standard of care that they as a would be Registrant are accepting for a client in line with the NMC standards. So those values and standards are very inherent in all of our professional practice, and we embody those, we think, with our students in our dealings on their educational journey, we role model those, and we certainly discuss them in tutorial groups and small group teaching as well and give them the chance to role play. 14:31 14:31

128 Q. Would it be the case that when students are going through their pre-registration training, that if they -- are they told "if in doubt speak to somebody", or are there times when they're expected to use their own judgment? 14:31

A. No, if in doubt they should definitely escalate a concern to their link lecturer. That's the appropriate -- I mean if they don't do it directly there and then. You know, if the patient is in pain or there's something, you know, that they are immediately concerned about, obviously they should be addressing that there and then if they don't think it's being effectively handled. But then they have the availability and contact details of their link lecturer. 14:32 14:32

129 Q. Okay. I want to ask you some questions now about the post-registration nurse training that you've spoken about in your statement. At paragraph 23 on page 9 you

give some details of the courses that are available, and you refer to an MSc programme in advanced professional practice, and that that has two specific intellectual disability modules. Can I just clarify that that's not an intellectual disability MSc as such, is it? Is it more of a general --

A. So they applied - and this is the programme that I spoke to Ms. Maxwell about just recently.

130 Q. Okay.

A. So that has not been commissioned. It's been approved for almost two years, but not been commissioned. But, yes, the application of, for instance, so there would be four core modules that would be maybe leadership or evidence based practice, but they would be related to the learning disability field practice in a Registrant's case. Whereas the two specific modules would enhance their knowledge and understanding of the field of intellectual disability or learning disability.

131 Q. So is this programme designed for people then who either already work in that field and who want an academic qualification, or somebody who wants to move into it and want something specific to learning disability?

A. Okay. So there is another programme that we have also got approved by the Nursing and Midwifery Council, which is called a Graduate Entry MSc. So if you had a Registrant, for instance, working in adult nursing in an Emergency Department who felt it would be

appropriate, because of the volume of people who present with a learning disability in that environment to get further training, they could undertake what we call a Graduate Entry MSc Programme, their background degree could be in any subject, it could be psychology, it could be pharmacy, it could be law. We've had applicants from all kinds of different disciplines. And they come on a two year compressed programme where they meet all of the Nursing and Midwifery Council's practice hours, but they have a compressed programme that enables them to study at MSc level as opposed to a BSc level. 14:34 14:34

DR. MAXWELL: That is a pre-registration programme, isn't it? It's for somebody who hasn't got the registration. So it is at a Master's level, but it is pre-registration with the NMC unless it is somebody from another field moving in -- 14:34

A. Which it can be, which I thought your colleague was referring to, Ms. Maxwell. I thought that, you know, if you had -- it's absolutely appropriate to have an additional registration using that methodology. 14:35

DR. MAXWELL: Okay. Whereas this one, advanced practice, you have to have already practised in the field --

A. You need to be a Registrant. 14:35

DR. MAXWELL: -- to move to advanced practice.

A. Yes.

132 Q. MS. TANG: Is it correct then that Queen's doesn't actually offer any post-registration courses in nursing

care people with learning disabilities and complex co-morbidities? I think that's picking up on one of Dr. Maxwell's comments.

A. That is not in a -- we have not been, you know, we have not developed that because this programme that we have has not been commissioned, and the appetite for that would need to be gauged in terms of the field of practice. 14:35

DR. MAXWELL: Are you surprised? Because we've heard also from Ulster University that they have had courses approved that don't get commissioned. Are you surprised when, as academics, you've identified a need and tried to fill it, that they, that Trusts don't, or actually the ECG doesn't commission these courses? 14:35

A. Yes, I think that is -- you will appreciate the degree of effort and work that goes into an approval event through the Nursing and Midwifery Council, that's a substantial piece of work, and there is -- you know, it is interesting that in some cases, despite the appetite and the effort, we do not have these programmes commissioned, you know. However, I think it's also important to state that people with a registration in intellectual disabilities might be availing of other programmes that we, you know, in health assessment or in complex communication or leadership, that we do not, you know, that we don't -- we're not using their registration in learning disabilities to really address. But the other point to just bring into that conversation is that we know at this point in time 14:36 14:36

right throughout the UK there is a downturn in applications for pre-registration programmes in particular, and learning disabilities is certainly one of those fields that isn't as -- doesn't receive as many applications, as for instance children's and young people's nursing, and I think there is more work to do to make this specific field of nursing visible and attractive to potential applicants. 14:37

133 Q. MS. TANG: Can I move on now to look at something in the last paragraph of the exhibit that you have provided to the Inquiry? It's on page 21. Sorry, the second last paragraph of page 21? 14:37

A. So in the?

134 Q. In Exhibit 1, your practice handbook.

A. Yes. 14:38

135 Q. It should come up on the screen in front of you there, I think?

A. Yep.

136 Q. And if you could go down to the second last paragraph on page 21, please? 14:38

A. The reflective accounts.

137 Q. Yes, it deals with reflections. Sorry, you don't have that page?

INQUIRY SECRETARY: It's at page 21 of the document?

MS. TANG: Of the document itself, yes. Internal page, my apologies, internal pages 36. 20836. Thank you. Yes, that's it there. The paragraph starts with the phrase, "Students will have particular reflective accounts", and I just want to pick up on some of the 14:38

wording that's used there:

"When undertaking these reflections, students can use any recognised model for reflection. All reflections must be authenticated in practice and students are accountable for what is disclosed in the reflections. To encourage truthfulness, practice supervisors and link lecturers (practice tutors) are encouraged to embrace the opportunity for positive development from reflections within a culture of learning." 14:39

I want to ask if you could explain just in practical terms what that means students would do?

A. So students will be accountable:

"...to ensure truthfulness, practise supervisors and link lecturers (practise tutors) are encouraged to embrace the opportunity for positive development from reflections within a culture of learning." 14:39

Okay. So where an issue is discussed and reflected upon in one of these documents, we would encourage people to think about the totality of the incident, the holistic context in which it has occurred. We would look at, you know, typically what went well and what didn't go so well, and reflect on both aspects, and encourage the students to be open and honest. Obviously candour is one of the main professional values. So we encourage them to be honest and open in 14:40

that reflection and to critically appraise their own input and that of the wider team involved so that they can be discerning in terms of those values and the standards of care that we were talking about earlier. So I think that reflection should take them from what has happened, to what went well, to what we could improve, and then how we would do it? Depending on the model it will have a slightly different process, but that's ultimately where you need to get to, where you're continuously asking: Is this the best care that we can give this patient or client at this moment in time? What could I or should I do to enhance that?

138 Q. And is that reflection that the student is engaged in something that they would document in their E-learning, their E -- remind me again?

A. E-portfolio.

139 Q. E-portfolio. Are they expected to write all of that up there?

A. That's the place where reflection is documented. And they also do this in tutorial groups, they also do it in classroom settings where they're, you know, facilitated by registered staff members who will, you know, reflect on the NMC values and discuss those in light of any particular situation and encourage reflection around enhancements or things that you can learn from that environment. If there were really positive aspects of it, for instance, we would try to help them embrace that into their own clinical practice, and if there's things that did not go well we

would be encouraging them to think around what could be done, and looking for evidence to support that enhancement and their ongoing development through that continuous cycle of professional education.

140 Q. Does the university keep any record of those concerns that come out as a result of the reflections? 14:42

A. Absolutely, yes.

141 Q. And how does the university use that information?

A. So we use that -- every placement is assessed, the quality of the placement is assessed through the NIPAD and, you know, we use that to feedback within the audit cycle to our placement facility. So this is an anonymous process that the students can undertake, and the feedback then can be decoupled from the individual student so that it goes back to the practice learning environment in a way that doesn't, how would you say, expose any student to that. So you're always trying to quality assure the actual learning environment. We conduct audits there regularly as well and we have to satisfy ourselves that the level and standard of care is suitable and appropriate for our students to work in and to learn in. So it's really important that we have close audit and evaluation and that we are updated of any changes in practice, and we continuously assess this. And in relation to that I can assure the Panel that I have had discussions, one-to-one discussions with the Royal College of Nursing and with the Nursing and Midwifery Council directly about the concerns that were raised in Muckamore. 14:42 14:43 14:43 14:43

142 Q. Can I move on to paragraph 31 and focus in on some of the allegations of abuse and how that came to light, more so particularly with the university? What, if any change, has happened as a result of those? You tell us at paragraph 31 that the abuse allegations came to light in November 2021 that you were made aware of, and you refer to audits undertaken of each placement following that. Are those the same audits that you have just spoken about a short time ago or is that a different style of audit? 14:44

A. It's the same process, but we updated those audits. Dr. Marsh was on site within 24-hours of us being made aware of the allegations, and each of the facilities was audited within five working days of that. So we also debriefed the students who had recently been in practice in the area. We met with them in a very supportive environment. I met them myself. 14:45

CHAIRPERSON: Sorry, when you say "in the area", do you mean in Muckamore?

A. In Muckamore. Yes. And I met with them myself, and members of the learning disability team met with them and had supportive conversations around that reflection on practice and their evaluation around how they could draw to our attention any concerns that they had. 14:45

DR. MAXWELL: This was November 2017?

A. Yes, as soon as we became aware of the situation. Prior to that we had no knowledge that there was any concerns.

DR. MAXWELL: And so the students that you spoke to,

debriefed, had been in placement in Muckamore in the second half of 2017?

A. Mhm-mhm. That's true.

DR. MAXWELL: And when you debriefed them, had they any concerns then? 14:46

A. There was not one single student. And they had the opportunity to come to us in the group situation or independently and privately to raise concerns by whatever medium they chose to do it, even anonymously, and we had nothing that indicated a problem, and we 14:46 took steps to review the practice assessment documentation on the portfolios that we had at the time to reassure ourselves, and myself as a professional, I reviewed some of those documents and I could find no evidence of any concerns, either subtle or explicit. 14:46

143 Q. MS. TANG: So when you -- you reviewed the documentation. When you spoke to the students did you get any sense that the students themselves were somewhat surprised by the allegations or how did they --- 14:47

A. They had no knowledge that anything untoward was happening in practice and, you know, this wasn't a one-off event, this was a process by which we built up, you know, obviously the teaching staff within the school and the academic staff have a trusting 14:47 relationship with them, but we all gave them plenty of time, including -- I mean the Deputy Director of Nursing in the Belfast Trust at that time, who is a colleague of mine, I know that she met with the

students quite regularly and her door was always open should they have wished to raise any concerns with her. She has a background in counselling and, you know, we were very comfortable with the situation and the opportunities to raise concerns that the students were given at that point in time, and for that reason, and under continuous evaluation, at that point we did not withdraw any students from the setting, because we had no evidence to suggest from our students that there was any wrongdoing. 14:47 14:48

PROFESSOR MURPHY: Can I ask how you explain that discrepancy?

A. So I've reflected on that and I have asked myself that question as a Registrant on the NMC Register. I think the only plausible explanation that I can come to is that this, like any other form of criminal activity, is not something you do in sight of people who are not embedded in the environment. The students probably would have been regarded somewhat as outsiders. They would have been seen as people who may not have been indoctrinated into a system where this was normalised and, therefore, just with any other type of criminal behaviour this may not have been something that happened under plain sight of our students. 14:48 14:48

DR. MAXWELL: I was just going to say, were any of those students working as health care assistants on the bank? So were they in Muckamore on two roles? 14:49

A. I do not know that to be a fact, but it may well be the case.

PROFESSOR MURPHY: Sorry, I was just wondering, the students would work in all sorts of wards, so they weren't prevented because they were still in training from working on what we now know where the more difficult wards? 14:49

A. No, they would have been supported in all of those environments. So if you think about it, this is an incremental journey through their clinical setting. It would be the same for mental health facilities for children's and young person's, and adult as well. So 14:49 by nature of the way placements are organised and structured, they will always have a practice supervisor, they will always have a link lecturer, and they will always have a professional lead for that area of nursing, as well as their own personal tutor that 14:50 goes through the entire programme with them, you know. So there is a range of different professional support systems in place.

PROFESSOR MURPHY: So they could have been on any wards? Could they also have been there at any time of 14:50 the week? So, you know, possibly weekends would have been more difficult times, but might they be there over weekends as well?

A. So I genuinely wouldn't -- there were small numbers of our students in Muckamore at any given time. 14:50

CHAIRPERSON: That's what I wanted to ask actually as part of the same question. How many students? You may have given this information somewhere, but do you know how many?

A. Single figures at any one placement. I can recall back to incidences when we had five or six students there and then, you know -- but then it might have been other students at a different time, because we're using a range of different facilities, including day care, including residential facilities in the community.

CHAIRPERSON: And over what sort of period of time would they be there?

A. Most of the placements are 6 or 12-week placement. It depends on the stage of the programme. 14:51

DR. MAXWELL: And they work shifts. They're supposed to work alongside their --

A. Oh, they work shifts right across the entire roster.

DR. MAXWELL: Yes. So they're supposed to work with their mentor and do a whole shift. So they don't sort of come in for a period. 14:51

A. Monday to Friday. No, they don't.

DR. MAXWELL: So they will be doing -- they'd be there in the evening, they'd be there at weekends.

A. It's not a 9:00 to 5:00 placement facility. So they would come in on duty at 7:30/7:45 and remain there. 14:51

DR. MAXWELL: Did they do night duty?

A. Yes, there is an opportunity to do night duty within our programme. I don't know if they specifically did it in Muckamore at that time, but I do know that they would have been available to be rostered at weekends and nights. 14:52

DR. MAXWELL: And as part of your placement audit, each individual ward is assessed. So if a ward was felt to

be unsuitable, that would have been documented in the audit?

A. Absolutely.

DR. MAXWELL: And as far as you recall none of the wards were excluded by the placement audit. 14:52

A. Were deemed unsuitable.

DR. MAXWELL: So they could have been on the Intensive Care PICU.

A. Yes. So the audits that were conducted after 1st November 2017, did not indicate concerns in any of the 14:52 placement areas. So that would have included the more acute facilities as well. And that is, you know, that is a conundrum, I don't perfectly understand it myself, but the only explanation I can give to myself is the one that I've have offered to the Panel, but it may or 14:52 may not be correct.

From our part what we did was we undertook a range of different discussions at every level within the organised structures of Belfast Trust. In particular, 14:53 I meet regularly with the senior management team there and the Director of Nursing, and as a result of these issues we introduced a joint appointment, which is based in clinical practice but has an academic role as well, 50/50, as one of the supportive measures to try 14:53 and enhance the standard of care and the quality of that environment. We've also, you know, offered a lot of opportunities to engage with the team there around educational upskilling, if that's necessary.

And just to say as well, that we have really enhanced our learning disability team within the school over the last seven or eight years. You know, they have multiplied by about three in terms of the numbers, and we do introduce all of the fields of nursing to the specialism of learning disabilities as well, you know, it's not something that's restricted only to that field of practice. 14:54

DR. MAXWELL: Can I ask about staffing, because when you're assessing whether an environment is a suitable place for a student, you've already said, you know, they have to be well supported and supervised. We've heard a lot about problems with staffing, in fact going back possibly before your time to 2012, when one of the wards alerted the university that they didn't have enough staff to take students, and we certainly heard more latterly that there have almost continuously been staffing concerns, not enough registered nurses and more latterly not enough LD nurses, I understand a lot of the nurses working there now are mental health nurses. Does that factor into your assessment, in your audits? 14:54 14:55

A. Yes, absolutely, those ratios are taken into account. And on occasion we don't use a particular placement if they're having a particular crisis in staffing, and that happens quite regularly. And, yes, the students also, you know, have a code of conduct that they're expected to adhere to at all times, and we have, you 14:55

know, internal fitness to practise mechanisms by which we can quality assure those individual students in settings. So if there are any concerns about their competencies as they go through the programme, those go through rigorous process of evaluation so that we are able to assure the Nursing and Midwifery Council that they are, in terms of good health and conduct, able to be registered on the NMC register at the end of the three year programme. 14:56

144 Q. MS. TANG: Can I ask you about the moves that have been made to try and increase the number of nurses coming through the system, whether applying to nursing and in particular going into learning disability. Have the universities been party to that in thinking through how to increase interest in it? What's been tried? 14:56

A. So a number of different measures have been tried. We realise that there are particular difficulties for some of the smaller fields in nursing, like learning disabilities and mental health specifically, and so we have had sort of campaigns targeted at those areas in which we use student testimonies, and we use video clips to really focus on what that field of practice means. And, you know, in the last week I have been in further discussion with Chief Nurse and the team at the Department of Health in order to enhance that going forward specific to learning disabilities. 14:56 14:57

We are very proud of most of the students in learning disabilities. They are enormously passionate. They're

award winning students. They very often receive national awards and, you know, it is a source of reassurance to us that the standard at which they leave the programme is really high. They are very committed and passionate in their field of practice, and they demonstrate a wonderful aptitude for enhancing the quality of care within that environment. So, yeah, I think we are constantly trying to attract more students into those smaller fields, but that's in common with the rest of the UK and it is quite a widespread problem. 14:57 14:58

145 Q. Can I clarify just in terms of some of the structural things that might help. Do the Northern Irish nursing students still get a bursary?

A. They do. 14:58

146 Q. And is that likely to continue or is there any discussion around that?

A. I mean it's under continuous evaluation I think it's fair to say, but there has been no specific threat to the bursary in my tenure over the last eight years in Queen's. 14:58

DR. MAXWELL: And the fees are still paid?

A. Yes.

DR. MAXWELL: Which is different to England.

A. That's true. So it's quite an attractive option if they're minded to work in that area. But the bursary system in and of itself does preclude them from some benefits and student loans, et cetera, which can present different difficulties. So I know the 14:58

Department of Health are in a consultation around really looking at the bursary system and the fee paying system to see if it remains fit for purpose. Because as I recall, it hasn't changed in my tenure of eight years, you know there hasn't been any cost of living increase in that bursary. I think it's about £450 a month or something like that.

CHAIRPERSON: I was going to say. But the bursary covers all education, does it? Does the bursary cover the whole of the nurse's education? 14:59

A. So the bursary is like a cost of living expenses, whereas they get their fees completely paid as well. So there's --

CHAIRPERSON: Yes, so it's not -- it's as it were on top of the fees that are paid? 14:59

A. It is, but it is given to the individual student. So students' fees are paid to the university and they also get access to the bursary which is administered by the Business Service Organisation on behalf of the Department of Health and they, you know, assess the 14:59 appropriateness of each student's circumstances in terms of, you know, do they live in Northern Ireland? Have they been domiciled here for the previous three years, et cetera? And then they will be offered a bursary that will be administered directly to them for, 15:00 you know, cost of living expenses.

CHAIRPERSON: And have you been - in that context have you been aware of any sort of fall off in the number of people wanting to come along and train?

A. Yes, within the university we have a student hardship fund, and we know that our Nursing and Midwifery students have a disproportionate requirement for that fund than other schools within the university. They do access it more frequently. They do raise cost of 15:00
living issues with us on a continuous basis. We have taken a wide variety of steps to try and address this in-house, albeit trying to give them access to tea rooms and facilities for self-prepping food, things like that, to try and offset some of the costs 15:01
associated with it.

CHAIRPERSON: But I was trying to ask you, has there been a downturn, as it were, in the number of students --

A. Applications. 15:01

CHAIRPERSON: Applications.

A. There is. There has been a downturn. Now we haven't assessed it overall this year, but I know last year it was in the region of 20%, 22%. But that was in line with the rest of the UK. Some places or some HEIs were 15:01
recording much more of a downturn than that.

CHAIRPERSON: Where they lost their bursary in about 2017 I think.

A. Yeah.

CHAIRPERSON: And if there has been a downturn, has 15:01
there been any greater downturn in those wanting to specialise in LD, or are you not able to tell us?

A. My recent intelligence would suggest, yes, from this year's application process. I mean admissions is very

much a year long process, it just doesn't happen in the Spring for the September intake. We are constantly, you know, working on admissions. So this year I do know that concerns have been expressed about the -- if we'll get enough applicants who are suitably qualified for the places within the learning disability field that have been commissioned? I think it's 45 places that have been commissioned for September '24.

DR. MAXWELL: Are you saying there's a risk that it might not be viable to run the course at all? 15:02

A. I'm not saying that, no.

DR. MAXWELL: No.

A. And we will continue to run the course. Queen's is committed to running the programme. But, you know, we are working pretty hard to ensure we have the volume of applicants to ensure that all of the 45 commissioned places will be successfully taken up. 15:02

PROFESSOR MURPHY: But given that Muckamore Abbey is closing, and given that community services on the whole employ fewer nurses because they're employing more social care staff, do you think it's predictable that applicants will go down within Northern Ireland? 15:03

A. So to the best of my knowledge all of our qualifying students, especially in learning disabilities, have - in the last few years have got employment that uses their registration. I'm not aware of any student being forced outside Northern Ireland to get a job. That said, the field of practice is supported by a range of professionals, not just nurses, and we are cognisant of 15:03

that, and that was one of the reasons why we opened up a Master's level pre-registration programme, because we recognised that people could be working in this field, in this area of practice from a wide variety of different backgrounds, maybe psychology, maybe social work, and if they were interested in a career in learning disability nursing, this was the whole focus of developing a graduate entry MSc programme for them. So in a compressed two year period, they could achieve a Nursing and Midwifery registration as well as the Master's degree. 15:04 15:04

DR. MAXWELL: So does Queen's still see a role for nurses in learning disability, even if all the provision is in the community?

A. Absolutely. Absolutely. And very committed to providing that standard of care. As I say we have really invested particularly in the learning disability and children's teams, because we realise -- and mental health teams, sorry, I should have said -- because we realise that those two particular areas of practice can go across the whole life span from children's to adult and to palliative and end of life care, so it's really important that we have registrants in practice with those competencies and experience. 15:04 15:05

CHAIRPERSON: And finally before we go back to Ms. Tang, you say you think there has been a downturn in those who want to specialise in learning disability, and I don't want to lead you so I'm simply going to ask you a very open question, have you been able to put 15:05

your finger on why there might have been a downturn?

A. Yes, certainly. We have undertaken sort of a market research with our admissions team, and we do know that some people express doubt that because they know Muckamore is closing now, that there will be jobs for them. Clearly this is not positive publicity for any field of practice and there may be concerns about entering a field of practice such as learning disability where issues like this can occur. And there's a range of different issues right across the spectrum I think relating -- because there is an overall downturn in applications to the profession right across all fields of practice. But we do -- it is more acute in learning disability and mental health. 15:06

CHAIRPERSON: Thank you. Ms. Tang, sorry. 15:06

147 Q. MS. TANG: No, that's fine. Thank you. Professor, thank you for answering my questions. I have reached the end of them. I will hand over to the Panel in case there's anything that they haven't picked up on.

CHAIRPERSON: Can you just give me a moment? 15:06

MS. TANG: Of course.

<u>PROF. FITZSIMONS WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:</u>

15:07

DR. MAXWELL: Can I just ask one? So you've talked very eloquently about the effort Queen's has put in, and I'm sure it is an excellent programme, the NMC standards are based on principles rather than specific

skills, so would it be possible that people who trained at a different university would come out with different skills competencies?

A. So I think it's a difficult question to answer Ms. Maxwell. It is within the realms of possibility, but there is a portfolio, as you can see here, that supplements the curriculum, in which there are competencies that, you know, we need to demonstrate that they not only have academically passed an assessment in that area, knowledge or expertise, but that they also demonstrate the competencies. Every university will have its own ethos and value system and some of them focus on different areas more closely. I think the ethos within Queen's of service user and carer involvement in every stage of the process is quite distinctive. We have, you know, our service users and carers set up the questions for us for which applicants are interviewed and they're with them at every stage of the educational journey, they give lectures to the class, they are involved in small group discussion, they assess some of their clinical competencies with us in the university setting. So that would be a strength within our university. I know we have been commended by the NMC for that and we have certainly won awards at a national level for it. 15:07 15:07 15:08 15:08 15:08

My expectation would be that there should be a standard proficiency around core competencies that all registrants should display at the point of entry onto

the Register and that then through your experience you're continuously enhancing that and developing your skill set.

DR. MAXWELL: So can you just say a little bit more about how service users with intellectual disabilities are involved in assessing the competencies of your students? 15:09

A. Yes. Yes. I can say that the -- so we have a variety of different assessments, OSCEs, that occur at different times. Observed, structured, clinical assessments. 15:09

CHAIRPERSON: Can you just -- because a lot of people who are listening to this have got a vague idea of what an OSCE is.

A. So it's an observed form of structured clinical assessment that enables an individual to demonstrate competencies against a range of criteria. So, for instance, if you're taking a blood pressure, that you follow the correct procedure, but also that you demonstrate the communication skills and explain things and reassure and advise on the basis of the procedure that you've just undertaken. 15:09 15:10

DR. MAXWELL: So it's a simulation exercise?

CHAIRPERSON: It's done like a role play.

A. Role play and simulation. 15:10

CHAIRPERSON: Sorry, I cut you off. I was saying we have a variety of --

A. So I've lost track of your question. I think I've lost --

CHAIRPERSON: So the question was, can you say a little bit more about how a service user --

A. Oh, service users and carers are involved in the assessment. So during, for instance, an OSCE on maybe levels of agitation or levels of distress, you know, there will be a structured assessment process that the student will be expected to go through, and they will, during that, have to demonstrate the appropriate explanation and communication and reassurance skills that take not a real patient, sort of a simulated patient through that procedure. So our service users will be on the OSCE Panel assessing the students, and some of those individuals have acquired brain injury, for instance, or some level of intellectual disability on the spectrum, you would say, that enables them to proficiently undertake this, but also display insight to that field of practice. We have regularly got service users and carers who, for instance, have cognitive decline on these panels because, you know, if you're dealing with someone with dementia or cognitive decline, if it is complicated, for instance, by a learning disability, you need to be able to display that range of skills that enables you to safely and proficiently undertake that assessment.

15:10 15:10 15:11 15:11

CHAIRPERSON: Do you have anything else? No?

15:12

DR. MAXWELL: No, thank you.

CHAIRPERSON: I think we've asked a lot of questions of you as we've gone along, but that completes our questions. So Professor Fitzsimons, can I thank you

very much indeed for giving up your afternoon, but also I expect giving up rather more time to the creation of your statement. So thank you very much for coming to assist us.

A. I would do anything to assist the Inquiry. Thank you very much for your consideration. 15:12

CHAIRPERSON: Thank you. Right. Yes, 10:00 o'clock tomorrow.

MS. TANG: Yes. Thank you, Chair.

CHAIRPERSON: Thank you everybody very much, see you tomorrow at 10:00. 15:12

THE INQUIRY ADJOURNED UNTIL 10:00AM ON WEDNESDAY, 29TH MAY 2024 AT 10:00 A.M.

15:13