MODULE 6 WITNESS STATEMENT
ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, Martin Dillon, formerly of the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on behalf of the Belfast Trust in response to a request for evidence from the MAH Inquiry Panel dated 9 December 2022. Module 6, addressing MAH reports and responses, identifies four specific reports and an intention to identify any other "key reports concerning MAH".

2. This is my second witness statement to the MAH Inquiry. My first witness statement dealt with the response of the Belfast Trust to the issues raised in respect of MAH Inquiry Module 5 (Regulation and Other Agencies).

3. As with other evidence modules, it is not possible for any one person in the Belfast Trust to address the matters the MAH Inquiry has asked the Belfast Trust to address in Module 6. Accordingly, while I am the witness statement maker on behalf of the Belfast Trust for the purposes of the MAH Inquiry Module 6 hearings, I make this statement having had the particular assistance of the following individuals:

    a. Gillian Traub

b. Dr Joanna Dougherty

c. Marie Heaney

d. Rhonda Scott

4. I have also had much material produced to me relating to the Belfast Trust responses, particularly in relation to the post 2017 period. In the time available to provide this statement it has not been feasible for me to speak to everyone who was involved in taking steps across a range of areas, or to assimilate all the relevant material, speak to it and exhibit it all to this statement. What I have been in a position to do, and which I hope will be helpful, is to provide a broad overview of the various strands of work carried out in response. It will be necessary, both for the benefit of the MAH Inquiry, and as a matter of fairness to the staff of the Belfast Trust, for a more comprehensive response to be provided in respect of what occurred in the post 2017 period.

5. Further, in respect of some of the earlier matters, in particular relating to events in 2005 and 2013, there is now, due to the passage of time, a lack of corporate memory within the Belfast Trust. The Belfast Trust can speak to the content of the available documentation, and I do that below.

6. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "MD2". The MAH Inquiry request for evidence can be found at Tab 1 in the exhibit bundle.

Qualifications and Position of the statement maker, and those who have assisted with the Module 6 statement on behalf of the Belfast Trust

7. Before retirement from the Belfast Trust, I held the position of Chief Executive from February 2017 until January 2020. At the date of retirement, I had been employed in the Health and Social care sector in Northern Ireland for almost 35 years.

8. I am a qualified accountant by profession. I held several posts within the Belfast Trust associated with that profession. Between January 2014 and February 2017, I was Deputy Chief Executive of the Belfast Trust, as well as Executive Director of Finance. From October 2010 to January 2014, I was Executive Director of Finance.

Topic 1 – December 2005 EHSSB/NWBT Review

9. I should perhaps say at the outset that I was not involved in the matters involving the December 2005 Review. There is also no one within the Belfast Trust that it has been possible for me speak to who was involved in the December 2005 Review Consequently, what I say below is drawn from the available material for the assistance of the MAH Inquiry.

10. Prior to 2007 Muckamore Abbey Hospital (MAH) was the responsibility of the then Eastern Health and Social Services Board (the Eastern Board). The Eastern Board was one of several health boards that subsequently merged to form the Health and Social Care Board (HSCB) in 2009 (now, from April 2022, the SPPG). MAH was operated on behalf of the Eastern Board, from September 1993, by the North & West Belfast Health and Social Services Trust (North and West Belfast Trust) (one of the 6 legacy trusts that would merge with others to form the Belfast Trust in 2006 and 2007).

11. In December 2005 a joint review team of some 9 individuals from the Eastern Board and the North and West Belfast Trust provided an 85-page report entitled *"Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital"*. The report can be found at Tab 2 in the exhibit bundle.

12. The work of the review team that is reflected in the report was one of a series of responses to matters that arose as a result of dealing with a litigation case brought by a former patient of MAH. The patient's initials were P242 There had also been a relevant inspection of the children's service at MAH in 2003 undertaken by the then Social Services Inspectorate (or SSI) that had produced recommendations that were being implemented around the same time (see paragraph 3.22 on internal page 10 of the December 2005 report). There had also been an unannounced inspection of MAH by the Mental Health Commission for Northern Ireland on 21 October 2004, which resulted in 4 recommendations.

13. The December 2005 report set out what was then the current practice at MAH in relation to ensuring that children (until 2010 MAH had children as well as adults on its wards) and vulnerable adults were safe during their stay in the hospital. The report detailed the policies and procedures used within the hospital, the training and support provided for staff, and the monitoring mechanisms that operated. It reflected the then governance arrangements that saw matters considered at various levels at the hospital and beyond, including incidents, complaints, and the management of risk. It described what appears to have been an innovative audit tool developed at the hospital to evaluate standards across all departments (see paragraph 5.6 on internal page 14 of the December 2005 report). The reviewers also made a series of recommendations to further improve practice.

14. In addition to examining the operative systems and the relevant policies and procedures, the reviewers considered a series of case notes of patients to ascertain the extent to which the relevant policies and procedures were being complied with. This included 3 different elements; the files of 7 children who had been treated on adult wards during 2005, a 40% sample of the files of child patients (6 children) from the Conicar children's ward, and the files of 9 patients involved in what were then referred to as Vulnerable Adult procedures during 2004 and 2005.

15. The reviewers noted the ongoing concern about young people continuing to have to be admitted to adult wards at MAH when the then children's ward (Conicar) was considered unsuitable, and when not admitting them to the adult ward would potentially have placed the child patient at greater danger (the child patient would then be on level 4 observation whilst on the adult ward). The reviewers also recorded the internal and external notification processes that were then operated when it was necessary to admit a child on to an adult ward (see paragraph 3.18 on internal page 8 of the December 2005 report). At the time there were MAH site redevelopment proposals, and those proposals did not provide for services for adolescents to be included on the MAH site.

16. The review team agreed 9 recommendations which were said, for the most part, to represent refinement of existing policies and procedures already operative at MAH (see internal page 18 of the December 2005 report).

17. The 9 recommendations were as follows:

    a. Recommendation 1. The introduction of a specific written admissions procedure for children and adolescents.

    b. Recommendation 2. That a single risk assessment sheet was utilised to record assessments, rather than the assessments being recorded in different locations within the notes of a patient.

    c. Recommendation 3. The development of guiding principles that reflected the decision-making framework/considerations around levels of supervision. This was to ensure that any change to the supervision level had been taken after all relevant matters had been considered.

    d. Recommendation 4. A review of the procedures for managing patients who absconded.

e. Recommendation 5. A reminder to placing trusts as to their responsibilities towards patients placed in MAH.

f. Recommendation 6 (see also paragraph 3.7 on internal page 6 of the December 2005 report). That MAH establish a Child Protection Committee. It was to meet at least every 6 months. It was to monitor progress with training and other aspects of what were then relatively new procedures. Further, there was to be hospital representation on the then Northern & West Belfast Trust Child Protection Panel.

g. Recommendation 7 (see also paragraph 4.4 on internal page 11 and internal Appendix 7). That MAH develop a process for outcomes of decisions in child protection and vulnerable adult processes to be documented in one clinical file to provide a single point of reference.

h. Recommendation 8. This related to a computer system then in use called EPEX and a consideration of how it could be utilised to capture MDT working and risk assessments.

i. Recommendation 9. A discussion was to take place with trusts in relation to the availability of an Advocacy service for children and adolescents who were in danger of becoming delayed discharges.

18. When the review report was provided on 10 January 2006, Ms Miriam Somerville, then Director of Hospital and Community Learning Disability Services at the North and West Belfast Trust, confirmed that Ms Mairead Mitchell, then Assistant Director of Service Improvement and Governance at the North and West Belfast Trust, would take responsibility for the implementation of the recommendations from the report that related to the North and West Belfast Trust. The intention was for Ms Mitchell to provide a report detailing progress on implementation, along

with any outstanding actions from the 2003 Social Services Inspectorate review of children's services at MAH. A copy of the communication can be found behind Tab 2 in the exhibit bundle.

19. On 31 October 2006, Richard Black, then Chief Executive of the North and West Belfast Trust, wrote to Dr McCormick, the then Permanent Secretary at what is now the Department of Health, outlining that all recommendations outlined in the report had been actioned. A copy of the letter can be found behind Tab 2 in the exhibit bundle. The action taken included:

    a. Comprehensive risk assessments had been put in place, and MAH was, in October 2006, piloting the pro forma risk assessment. This risk assessment covered the full range of challenging behaviour and detailed the likely impact on others and how the behaviour should best be managed, as recommended in the report.

    b. Appropriate Child Protection and Vulnerable Adult procedures were confirmed to be in place at MAH. Training was being delivered through a rolling programme and all new staff were subject to what were then known as POCVA checks.

    c. A Child Protection Committee had been set up and was operating. The Committee was attended by a community social worker, a child protection nurse and a community paediatrician. The Committee reported to the Trust Child Protection Panel.

    d. The Assistant Director of Hospital Services, which at the time was Eilish Steele, joined the Trust Child Protection Panel as a representative of MAH.

e. Recording and reporting mechanisms, both internal and external, were put in place and were understood and adhered to by staff. This included policies and procedures for dealing with complaints and for incident reporting.

f. Policies and procedures to prevent, detect and manage allegations of abuse or incidents had also been put in place. Within the Learning Disability Service, reports on complaints and incidents were tabled at the monthly Governance Group meeting. Reports were also taken to the North and West Belfast Trust Governance Committee. Any incidents which required investigation under Child Protection or Vulnerable Adults Procedures were noted at the weekly Hospital Management Team Meeting, as were all complaints. Once an incident or allegation occurred, a monitoring form was completed to ensure that progress was appropriately tracked.

20. The steps taken are more fully reflected in the August 2006 "Update on the Review of Child Protection & Vulnerable Adults Protocols at MAH", a copy of which is included behind Tab 2 of the exhibit bundle.

21. I have been informed by the legal representatives of the Belfast Trust that the MAH Inquiry has approached Ms Miriam Somerville in respect of this 2005 report. It may be Ms Somerville will be able to further assist with issues relating to the response at the time from the North and West Belfast Trust and the Eastern Board. The Belfast Trust appreciates that these matters are now of a considerable vintage and, in those circumstances, and for the assistance of the MAH Inquiry, the Belfast Trust is happy to make available to Ms. Somerville, and anyone else the MAH Inquiry would like to speak to these issues, the available papers in order that their memories might be refreshed.

22. I have also been informed by the legal representatives of the Belfast Trust that the MAH Inquiry has been provided with other material, including police material, that originated from the claims made in the RM litigation, and that arose as other strands of work to that of the December 2005 report.

Topic 2 – October 2013 Belfast Trust Ennis Ward Adult Safeguarding Report

23. I should say at the outset that I was not myself involved with the Ennis Ward Adult Safeguarding Investigation, or the other Belfast Trust responses to the allegations made in 2012.

24. The Belfast Trust has endeavoured to find all relevant material to try to address the response, however, many members of staff who were involved in these matters no longer work in the Belfast Trust, and, in the time available, it has not been possible to seek to engage with them to see if they can provide further information that might assist the MAH Inquiry. Beyond the provision of this statement the Belfast Trust will continue to look for relevant material, and it may also be that the MAH Inquiry will engage with individuals who may have relevant information themselves, or be able to identify specific locations where information may be found (such as, for instance, their email accounts).

25. I have been able to set out the information below by drawing on documents available to me. I have also had the benefit of a contribution from Rhonda Scott who was involved with one of the further reports discussed below.

26. In this section of the statement, endeavouring to address the Ennis Adult Safeguarding Investigation Report, and the responses to it, I have broadly approached the matter covering the following issues:

    a. Background

b. Immediate Action Plan

c. Multi Agency Meeting and the Approval of the Interim Protection Plan

d. Steps Taken in the interim

e. Safeguarding Investigation (which resulted in the subject October 2013 Belfast Trust Ennis Ward Adult Safeguarding Report)

f. PSNI action

g. Internal Investigation Reports

27. The documents that bear on these issues can be found behind Tab 3 in the exhibit bundle.

28. On 23 October 2013 an Adult Safeguarding Investigation report was completed arising from allegations of abuse on MAH Ennis Ward, a copy of which can be found behind Tab 3 of the exhibit bundle.

29. In 2012 and 2013 MAH Ennis ward was a resettlement ward which, under the resettlement agenda, was due to close in 2012. Ennis was an all-female ward. The ward was divided into two parts; the upper end was where more independent patients lived, and the lower end was where the more dependent patients lived. There were 17 patients in total; 6 in the upper end and 11 in the lower end.

30. The 11 more dependent patients, living at the lower end of Ennis ward, had transferred from Fairview ward when it closed in 2010. The allegations that were investigated in 2012 and 2013 all related to the more dependent patients living in the lower end of the Ennis Ward.

31. In MAH, in late 2012, there were approximately 14 wards at MAH, caring for approximately somewhere between 200 and 220 patients. I provide this information for context, but it has not been possible to be precise about the number of wards and patients at the specific date the allegations were first made.

32. The initial 7 allegations were raised on 8 November 2012. They were made by a care assistant, working for a private provider in one of their care homes, and who had spent time on Ennis Ward on and before 7 November 2012.

33. The matter was reported to PSNI and RQIA. An Early Alert was also filed, which alerted the then Department of Health, Social Services and Public Safety to the allegations.

34. It is perhaps important to note that the Ennis Adult Safeguarding Investigation Report, and the adult safeguarding process it summarised and reflected, is but one part of the Belfast Trust's internal procedures when an adverse incident of this type occurs. The report essentially marked the conclusion of the vulnerable adult safeguarding investigation. However, many other actions and steps were taken in the immediate aftermath of the allegations being made, and during the course of the vulnerable adult investigation.

35. The response to the Ennis Adult Safeguarding Report must therefore be seen in that context and considered in conjunction with all of the steps that had already been taken by the Belfast Trust in response to the allegations. Some of the steps were taken as part of the vulnerable adult investigation, some of the steps were taken in conjunction with RQIA, and some were taken as part of further internal investigations and actions.

36. When viewed in totality, the Belfast Trust's response to the allegations under the safeguarding investigation had essentially four broad phases, although they weren't considered or regarded as being phases at the time. However, it may assist

to use the four broad phases to help explain the Belfast Trust's actions in response to the allegations.

37. The first phase was the introduction of an immediate protection plan. This reflected the steps taken in the hours following the Belfast Trust becoming aware of the allegations. The second phase was the creation of a multi-agency strategy group, which held its first meeting the day after the allegations arose. This strategy group approved and oversaw the interim protection plan of measures put in place while the vulnerable adult safeguarding investigation took place. The third phase was the vulnerable adult safeguarding investigation itself, which took place in the months which followed the allegations. This vulnerable adult investigation culminated in the Ennis Adult Safeguarding Investigation Report, which is often now referred to as "the Ennis Report". The first three phases of the response can be seen as part of the then Belfast Trust's adult safeguarding processes. The fourth and final phase of the Belfast Trust's response was the steps taken following the recommendations of the Ennis Report, this included conducting a further detailed internal investigation as part of a potential disciplinary process.

38. The work of the PSNI and RQIA also ran simultaneously and alongside the above steps and will also be outlined in order to explain the steps taken by the Belfast Trust in conjunction with those bodies.

39. Each of these stages will now be set out in more detail below. It is not practical to detail in this witness statement every single action taken by the Belfast Trust, but I would refer the MAH Inquiry to the minutes of the multi-agency Ennis strategy meetings for a full picture of the steps that were taken by all bodies involved.

The first phase - the Belfast Trust's Immediate Action Plan

40. When the Belfast Trust became aware of the allegations, a number of immediate steps were taken. The police and RQIA were directly informed. The department

was informed through the use of an Early Alert. Incident referral forms were completed.

41. Ms Aine Morrison was appointed the Designated Officer (or "DO") for the adult safeguarding investigation into the allegations.

42. On 8 November 2012, as part of the immediate action plan, the families of each of the four named patients were contacted to inform them that allegations had been made.

43. Two members of staff and a student nurse were also placed on precautionary suspension; H159 (a healthcare assistant/support worker), H197 (a Bank Nurse); and H196 (a student Nurse). H197 was referred to the Nursing and Midwifery Council. H159 was referred to the Disclosure and Barring Service.

44. The Belfast Trust introduced 24-hour monitoring on Ennis ward. It consisted of a Band 7 and a Band 6 (at evenings/nights) staff member being moved into Ennis. These staff had no previous connection with Ennis ward. They were told that there were vulnerable adult concerns and that their role was to monitor for any concerns about practice. Their only role was to monitor what was occurring on Ennis ward. As the documents provided show, this monitoring mechanism went on over a number of months and appear to have involved the expenditure of a very significant sum of money (circa £500,000). This is an illustration that the allegations were treated very seriously.

45. Body Charts were completed for all patients during the course of their personal care.

46. Following consultation with the PSNI, a forensic medical examination was carried out on the four patients named in the allegations.

47. The Northern Health and Social Care Trust (the "Northern Trust"), who was ultimately responsible for one of the affected patients, was informed and agreed with the immediate protection plan.

48. The RQIA was also notified of the immediate protection plan by telephone by Ms Esther Rafferty, who was the then Service Manager at MAH.

The second phase- the First Multi-Agency Strategy Meeting and steps taken pursuant to the Interim Protection Plan

49. On 9 November 2012, a multi-agency strategy meeting was held under the then applicable Joint Protocol to agree the procedures for investigating the allegations. The meeting was attended by representatives of the Belfast Trust, the PSNI, the RQIA and the Northern Trust. Subsequent meetings of this group were held periodically throughout the investigation period. A copy of the minutes from this meeting can be found behind Tab 3 of the exhibit bundle.

50. At the initial meeting, the steps taken under the immediate protection plan were outlined and appear to have met with approval. At this point, the Belfast Trust had already examined the body charts of the four named patients, and it was reported to the group that the bruising and abrasions noted were not immediately clearly identifiable as non-accidental injuries.

51. Those at the meeting discussed whether there were concerns about any of the other staff on duty beyond those who had already been placed on precautionary suspension. Following a phone call made by the PSNI during the course of the meeting to the witness who made the allegations, it was agreed that there were no indicators of concern about the members of staff who had been in the other part of Ennis ward and therefore no protective action was necessary. There was concern, however, over the lack of presence of the then Nurse in Charge (**H198** on the

ward and she was therefore replaced; she was moved to another ward where she would not act as the Nurse in Charge.

52. The ongoing Protection Plan was agreed and confirmed as follows;

    a. That the three named individuals would remain on precautionary suspension.

    b. The Nurse in Charge was moved to another ward where she would have no supervisory responsibility.

    c. An additional Band 7 member of nursing staff was placed on the Ennis ward during the day to monitor for any concerns. Further, an additional Band 6 staff member was moved into Ennis ward at night to monitor for concerns. As stated above, these members of staff had no previous connection with Ennis ward. They were told that there were vulnerable adult concerns and that their role was to monitor for any concerns about practice. Behind Tab 3 the MAH Inquiry will find the guidance documents that were provided to the supervisory staff and ward managers which clearly identify the role the monitors were to play.

    d. Band 8a staff (more senior supervisory staff with responsibility for a number of wards) were to make frequent unannounced visits to the ward to again monitor for concerns.

53. On the same date, 9 November 2012, all relatives of patients on Ennis ward not directly connected to the allegations were contacted and advised of the allegations, the staff suspensions and ongoing investigation.

54. The three individuals previously placed on precautionary suspension remained on precautionary suspension throughout November 2012.

55. A further multi-agency strategy meeting was held on 15 November 2012, the minutes of which can be found behind Tab 3 of the exhibit bundle. At that meeting it was agreed that in a further protective step the former Nurse in Charge in Ennis ward, H198 would be placed on precautionary suspension as of 16 November 2012. On 20 November 2012, H198 was also referred to the Nursing and Midwifery Council by Ms Brenda Creaney, the Belfast Trust Executive Director of Nursing and User Experience.

56. Ms Moira Mannion, then Co-Director of Nursing (Education and Learning), was given a direct oversight role. Ms Mannion was one of the nursing co-directors within the Belfast Trust. Ms Mannion worked to Ms Creaney. Ms Mannion was a senior member of Belfast Trust staff, and her role in the nursing directorate would have been broad and busy. However, Ms Mannion would not normally have had a direct or operational role on the ground at MAH. Ms Mannion was effectively placed in charge of the monitoring on Ennis ward and was commissioned to:

    a. Complete ward observation of staff behaviours and patient care;

    b. Complete unannounced leadership visits;

    c. To lead the team of monitors engaged in the monitoring activity;

    d. To review all monitoring forms submitted;

    e. To provide an executive report of actions completed;

    f. To provide an improvement plan to the then Director of the Adult, Social and Primary Care, Ms Catherine McNicholl, (within whose Directorate MAH sat), the Executive Director of Nursing and User Experience and the strategy group members for discussion and agreement.

57. Ms Mannion was selected because, as was recommended by the Ralph's Close review, she was professionally independent from the service at MAH. During the monitoring role Ms Mannion performed, she completed two briefing reports to the multi-agency Strategy Meeting in respect of the work she undertook.

58. The first report was presented to the multi-agency strategy group on 20 December 2012. A copy of the report and the meeting minutes can be found behind Tab 3 of the exhibit bundle. In this report Ms Mannion outlined that she had undertaken two unannounced leadership walk arounds, each of 3 hours duration. She monitored the ward environment herself for 10 hours and she met with other monitors for 2 hours. Ms Mannion had also reviewed all monitoring forms which had been submitted by the Ennis ward monitors. Ms Mannion reviewed them using an early indicator of abuse guide and the Royal College of Nursing (or "RCN") dignity standards. By 19 December 2012, 85 monitoring forms had been submitted over the previous 5 weeks by 20 different and independent senior nursing staff which covered a total of 840 hours over a 24-hour cycle.

59. Ms Mannion's first report noted that although 24 out of 85 forms noted a concern, 61 out of the 85 forms did not identify any concerns. All 85 forms identified many examples of best practice and positive interaction by staff with patients. Ms Mannion considered that there was no indication of a culture that may be accepting of behaviours or communications that could be referred to as abusive.

60. Out of the 24 forms which noted a concern, three key themes were identified: staff levels at key times in the day, environmental issues on Ennis Ward and the impact of a male monitor on patients who removed clothing. Ms Mannion proposed a Service Action Plan, and an Action Plan following a leadership walk around with senior staff. These plans are exhibited behind Tab 3.

61. In the meantime, H196 (the student Nurse) was reinstated as there was no evidence of wrongdoing by her, apart from a possible inappropriate comment which was not thought sufficient to warrant suspension. This was discussed at the Ennis Ward Multi-Agency Investigation Meeting held on 12 December 2012 and no concerns were voiced by anyone in attendance, which included representatives from PSNI and RQIA. A copy of the minutes from the meeting can be found behind Tab 3 of the exhibit bundle.

62. The multi-agency meeting met again on 9 January 2013 and Ms Mannion presented a second briefing report. A copy of the minutes and the briefing report can be found behind Tab 3 of the exhibit bundle. By this time, Ms Mannion had:

    a. Reviewed the patients' notes, medical files and drug kardex of eight patients on the ward. These included the 4 named patients and a random selection of files from the other patients.

    b. Ms Mannion had reviewed 118 monitoring forms, covering 1,519 hours of observed practice over an eight-week period. Ms Mannion confirmed that all forms gave examples of positive care, only 67 identified concerns, the key themes of which were staff levels at key times, the challenge of keeping the curtains up with the frequency of patients pulling them down and the challenge for staff maintaining dignity for some patients with the behaviour of removal of clothes.

    c. Undertaken a further two unannounced leadership walk arounds which were each of 4 hours duration.

    d. Completed a review of the learning environment using the Learning and Assessment Standards created and regulated by the Nursing and Midwifery Council.

63. Ms Mannion also provided an update on the exhibited Service Improvement Action Plan in Ennis Ward and the Action Plan recommended following the leadership walkaround with senior staff. Under these action plans:

a. The "Productive Ward, 15 Steps Challenge" was adopted for service improvement.

b. Safeguarding material had been shared with staff, and, where required, staff were supported with training to facilitate and sustain improvements in practice.

c. It was also planned to uplift staff knowledge on the current policy relating to the environment, information governance and patient property.

d. Training to develop the knowledge of the strategic objectives of resettlement had been commissioned.

e. A ward Health and Safety Risk Assessment was undertaken in conjunction with a fire assessment.

f. A peer hygiene inspection was undertaken.

g. A de-clutter of the ward environment in discussion with ward staff, patients and carers was completed.

h. Ward spaces were re-designated with estates and ward staff.

i. Curtains were put up on windows and around beds.

j. Estates agreed to sandblast the lower windows.

k. It was agreed that the ward sister and deputy ward sister would be released for 2 weeks to implement a review of care planning and functional behavioural analysis of each patient on the ward.

l. Material on Dignity produced by the Royal College of Nursing was shared with ward staff and the monitoring team with a follow up training session on dignity issues in learning disability services on an ongoing basis.

64. Ms Mannion recommended, given the unsettling effect on patients of having external staff on the ward, and the good responses from monitoring forms, that monitoring could be ceased at that time. However, the majority view at the meeting was that it was too early to stop monitoring. It was agreed, however, that the monitoring role could be altered. From that point it would instead be performed by ward staff at the appropriate level who had not worked on Ennis ward during the period covered by the investigation.

65. At the multi-agency meeting on 29 March 2013, the PSNI advised the group that a file had been submitted to the PPS. This was in respect of two staff members: H159 and H197 A copy of the minutes for this meeting can be found behind Tab 3 of the exhibit bundle.

66. No police action was taken against H198 In and around March 2013, H198 precautionary suspension was no longer considered to be justified. H198 was permitted to return to work, following a capacity assessment, and was to be subject to close monitoring, but was not permitted to return to Ennis ward. The Nursing and Midwifery Council determined that there was no case to answer for H198 in and around 16 January 2014.

67. Throughout the Spring of 2013, the adult safeguarding investigation continued, and the protection plan remained in place. An audit, the report of which can be found behind Tab 3, of all the patients' care plans was undertaken in April 2013 and confirmed that each included a protection plan. Monitoring remained on Ennis ward until 5 July 2013 and was conducted by staff in Ennis ward who had not worked on the ward during the period covered by the investigation and who were band 5 and above.

Steps taken in conjunction with RQIA

68. RQIA held an unannounced inspection of the Ennis ward on 13 November 2012. At the end of the inspection, feedback was provided to the then Operations Manager, H377, the then Ennis Ward Manager, H491 and then then MAH Service Manager, Esther Rafferty. It was followed up by way of letter dated 15 November 2012. The main concern raised by RQIA was the staffing level on the ward. RQIA asked for an account of the plan of action to improve and monitor the situation in Ennis by 23 November 2012. The report for this inspection and the correspondence subsequent to the inspection can be found behind Tab 3 of the bundle.

69. The Belfast Trust submitted an Action Plan to RQIA on 20 November 2012, a copy of which can be found behind Tab 3. The following steps were agreed and completed when the Action Plan was submitted on 20 November 2012:

    a. Staffing in Ennis ward had been reviewed by the Senior Nurse Manager and Ward Sister.

    b. The staffing ratio was to be reviewed formally on a monthly basis for three months, or more often if the independent monitoring reports indicated a need to.

c. A minimum of six staff would be on Ennis ward during day shifts, a minimum of two of which would be registrants, and additional resources would be deployed where possible.

d. A minimum of six staff would be on night duty until 11pm and two staff would be on duty thereafter, which would also be reviewed weekly to reflect the independent monitoring reports.

e. A Deputy Ward Sister would take up post with effect from 25 November 2012.

f. An additional Ward Sister would be redeployed to Ennis Ward on 8 November 2012 for an initial period of two months.

g. Independent Senior Nurse monitoring would continue across the 24-hour span until the safeguarding concerns were addressed.

h. The Duty Nurse Hospital Co-Ordinator would undertake periodic checks to Ennis ward.

i. All other Health and Social Care Trusts would be contacted for additional resources in line with the recommendations made in the Ralph's Close Review.

j. Additional staff would be recruited through contracted nursing agencies, the Belfast Trust Nurse Bank and support from other service groups within the Belfast Trust.

k. All WTD (Working Time Directive) documentation would be reviewed to ensure compliance with Belfast Trust guidance and policy.

l. The MAH Adult Safeguarding Team would be enhanced by an additional Designated Officer on 3 December 2012.

70. Additionally, the following steps were agreed under the Action Plan, to be completed by a certain date:

a. The Belfast Trust would review the governance arrangements in place for the management and review of Vulnerable Adult Referrals in the hospital by 31 January 2013.

b. All current protection plans in place in the ward would be reviewed by 17 December 2012.

c. 30 whole time equivalent Healthcare workers (Band 3) would be appointed by 31 January 2013.

d. 18 whole time equivalent Staff Nurse posts by 28 November 2012.

71. A further unannounced inspection was undertaken by RQIA on 20 December 2012. The purpose of this inspection was to clarify the action taken by the Belfast Trust in relation to the safeguarding investigation and review the safeguarding processes in place. The issues investigated by the inspector aligned with the issues identified in the previous inspection and the action plan.

72. The recommendations that arose out of the 20 December 2012 inspection solely related to the staffing complement on the ward with two exceptions. The first exception was that the agreed actions from safeguarding strategy meetings were processed accurately and in a timely manner. The second was that the MDT team should review compliance with the special observation Trust Policy and best practice guidance.

73. Third and fourth unannounced RQIA inspections of Ennis ward took place on 29 January 2013 and 29 May 2013. Letters were exchanged after each unannounced inspection as RQIA continued to monitor improvements to the ward and in turn the Belfast Trust continued to provide RQIA with the necessary assurances of the improvements that had been made and which would be made moving forward.

74. All of the available RQIA related material connected to Ennis Ward in 2012 and 2013, including the reports and responses, is contained behind Tab 3 in the exhibit bundle.

Ennis Adult Safeguarding Investigation

75. As referred to earlier, the initial 7 allegations about conduct on Ennis ward came from a care assistant who was working for a private provider in one of their care homes. The care assistant had spent time on Ennis Ward on and before 7 November 2012. The concerns were raised on 8 November 2012. However, the Ennis Adult Safeguarding investigation that was undertaken ranged wider than the initial allegations made by the single care assistant. Interviews were conducted with:

    a. 9 staff from the private provider,

    b. with 3 patients who were directly involved in specific allegations (there were 4 patients directly involved in specific allegations whom it was not possible to interview due to capacity, and their families were engaged with instead)

    c. Family members for all patients on the ward were also spoken to on a general basis about their experience of the Ennis Ward

d. The 6 Belfast Trust staff identified in the allegations arising from the interviews with the staff of the private provider.

e. A further 36 Belfast Trust staff working on Ennis Ward.

76. Ultimately, arising from interviews conducted by PSNI and Belfast Trust, 63 allegations or concerns were considered as part of the adult safeguarding investigation.

77. The 63 allegations, or concerns, covered several different themes:

a. The physical treatment of patients.

b. The verbal treatment of patients.

c. The management of behaviours of patients.

d. The lack of supervision of patients.

e. The lack of induction on to the ward for the staff from the private provider.

f. Several other different concerns.

78. In addition, the general issue of staff shortages was raised with the adult safeguarding investigators, and Belfast Trust staff provided general views on several themes associated with working on Ennis Ward and at MAH.

79. Incident reports and adult safeguarding referrals for Ennis ward from the previous 6 months were reviewed, together with 12 months of disciplinary records relating

to ward staff. This was to look for evidence of trends or patterns of concerns about staff behaviour.

80. The report that followed the adult safeguarding investigation consisted of 72 pages, together with an 8-page Appendix which summarised the 63 allegations that were investigated.

81. The report was authored by the 3-person team who conducted the Adult Safeguarding investigation:

    a. Aine Morrison, then Service Manager for Learning Disability Community Services and later promoted to Service Manager and Associate Director of Social Work (Learning Disability). Ms Morrison was the Designated Officer for the investigation.

    b. Collette Ireland, then a Community Team leader in the Learning Disability Service, and who was a trained adult safeguarding designated officer and ABE interviewer.

    c. Carmel Drysdale, also then a Community Team leader in the Learning Disability Service, and who was also a trained adult safeguarding designated officer and ABE interviewer.

82. Ultimately the investigators reached 14 conclusions and made nine recommendations.

83. The Ennis Adult Safeguarding Investigation Report was shared in draft with the multi-agency group prior to its meeting on 5 July 2013. The recommendations and conclusions of the report were discussed at that meeting and those present were given a period of two further weeks to revert with any questions or issues.

84. Responses to individual recommendations are addressed individually below. However, on a more general level, at that meeting it was agreed that the following steps would be taken in relation to the protection plan already in place (and discussed earlier):

    a. Staff suspensions (which at that time related to H159 and H197 would remain in place and Ms Rafferty and Ms Mannion would follow up with Human Resources and check with PSNI whether the internal disciplinary investigation could proceed.

    b. 24-hour monitoring could be stepped down with immediate effect, but the senior nurse management team would continue with monitoring visits at a minimum of twice weekly to support staff and address ongoing improvements.

    c. Feedback to ward staff would be given jointly by the hospital and investigation team in August/September 2013.

85. The final version of the Ennis Adult Safeguarding Investigation Report was disseminated in October 2013. It was discussed at a multi-agency group strategy meeting on 28 October 2013. At this meeting, the individual conclusions and recommendations were discussed further. The actions required by some of the recommendations had already been completed, and, where required, further action was agreed.

86. The final multi-agency meeting occurred on 8 April 2014. All recommendations had been acted on by that date and the safeguarding investigation was concluded.

87. The recommendations made in the Ennis Adult Safeguarding Investigation Report, and the steps taken by the Belfast Trust in relation to them, are outlined below.

Recommendation 1 – Disciplinary Investigation

88. The authors said that the Belfast Trust awaited the outcome of the PPS considerations and recommendations into the matters reported to it. However, they went on to say that when those processes were concluded, the investigating team believed that there was enough evidence of concern about the behaviour of H159 and H197 to warrant a disciplinary investigation in respect of them (the adult safeguarding investigators went on to say, having commented on the conflicting evidence from the two staff groups, and difficulties with identification, that there was not enough evidence to warrant disciplinary action against anyone else).

89. The recommendation made was that MAH should pursue a disciplinary investigation in relation to the conduct of H197 and H159

90. The Belfast Trust accordingly began a disciplinary investigation. It was conducted by Rhonda Scott (then Senior Nurse Manager, Learning Disability) and Geraldine Hamilton (then Service Improvement Manager, Mental Health, and Learning Disability). This internal investigation began in September 2013, when the safeguarding investigation report was nearing formal completion and the draft recommendations of the Ennis Adult Safeguarding Investigation Report had been shared with Senior Management at MAH.

91. The Terms of Reference of the internal investigation went further than simply the disciplinary investigation into the two named members of staff. They were (in summary):

    a. To investigate matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse;

    b. To investigate the managerial processes on the ward;

c. To immediately report to the Belfast Trust any matter which may undermine the objectivity or robustness of the investigation;

d. To make recommendations on what action if any should be taken in relation to the matters investigated, including a recommendation on whether the case should be referred to a disciplinary hearing.

92. The investigation was delayed in part because it awaited the outcome of the criminal prosecutions. As stated above, a file was sent to the PPS in relation to both H159 and H197 It appears that there was a delay in the appointment of a Prosecutor, but, in November 2013, the PSNI confirmed that their investigation was complete, and the PPS had indicated they would proceed with criminal charges against H159 and H197

93. On 21 November 2014, H159 was convicted of one charge, for which she later received a suspended sentence. (H159 was later acquitted on appeal). On the same date, 21 November 2014, H197 was acquitted of all charges.

94. The disciplinary investigation was completed in February 2015 and three reports were produced by Ms Scott and Ms Hamilton. There was a report which dealt with the Terms of Reference more generally, as well as two reports which dealt specifically with each of H159 and H197

95. The 211-page investigation report which related to H159 a copy of which can be found behind Tab 3, did not support, or recommend formal disciplinary action against H159 This was because the internal disciplinary investigators were unable to substantiate the allegations based on the available evidence and the fact that three potential witnesses from the external provider were unavailable for interview.

96. H159 was advised that she was eligible to return to the workplace as a healthcare worker with effect from 14 September 2015. She did not however return to work in Ennis ward. She worked as a bank worker in Cranfield (Male) during October to December 2015. Following this, H159 was absent from the Belfast Trust due to sickness and remained on sick leave until she left the Belfast Trust.

97. The 208-page investigation report in relation to H197 a copy of which can be found behind Tab 3 did not support or recommend formal disciplinary action again H197 for the same reasons as given in relation to H159

98. H197 was advised that she was eligible to return to the workplace with effect from 4 September 2015 following the cessation of her precautionary suspension. However, H197 was a bank nurse and did not work any further shifts as a bank nurse in MAH and was subsequently processed as a leaver from the employment of the Belfast Trust.

Recommendation 2 – The Ward Environment

99. The adult safeguarding authors said that there was general agreement between all groups of staff that the Ennis Ward environment was unsatisfactory. The authors noted that management staff had already ensured significant environmental improvement both by making minor adjustments and planning major structural works but considered that it was possible for people who are accustomed to a particular environment not to notice flaws.

100. The recommendation made was that all wards in the hospital should be reviewed by staff external to the wards to see if any environmental changes were needed.

101. Environmental improvements had already been achieved by the Belfast Trust in three ways. Some environmental improvements were made pursuant to the

action plans which have been outlined above in relation to Ms Mannion's briefings and the multi-agency meeting minutes.

102. Further environmental improvements were made following an internal inspection of the Ennis ward on 12 December 2012, as updated on 19 February 2013, which can be seen from the Table arising out of the Ennis Internal Inspection behind Tab 3.

103. Thirdly, some improvements were made pursuant to the quality improvement action plan made in response to RQIA's unannounced inspection of Ennis ward, as outlined further in the discussion of the steps taken in conjunction with RQIA above.

104. In response to this recommendation in the final report, Senior Management advised the multi-agency meeting on 5 July 2013 that a review of the ward environment had been carried out and RQIA had also carried out environmental checks. At the multi-agency meeting on 28 October 2013, Ms Rafferty noted that RQIA and senior management staff regularly check wards and that this would continue.

105. At a further multi-agency meeting which took place on 8 April 2014, the group advised that Senior Management on the hospital site continue to do walk arounds and visit the wards. Operation Managers were also to do visits to other wards, as well as the wards they have managerial responsibility for. It was considered that the cost of a full refurbishment could not be justified for some wards which were due for closure, but those wards would be prioritised for closure through re-settlement and RQIA inspectors would visit all specified wards within the subsequent two months as part of the quality improvement plan. In the meantime, the minimum standards for privacy and dignity were being met in all wards.

Recommendation 3 – Staffing Concerns

106. The adult safeguarding report authors noted that the Ennis ward manager had reported her concerns about staffing levels in Ennis ward on 18 September 2012 and 23 October 2012. While acknowledging that an action plan in relation to the overall staffing crisis in MAH was in place at the time, and which would have included Ennis ward, the authors nonetheless recommended that hospital senior management review their response to the two specific incident reports from the Ennis ward manager to see if the response was appropriate.

107. The adult safeguarding authors further recognised that MAH had already made two significant improvements in relation to staffing. The first being that the Telford Formula had been used to review the appropriate levels of staffing and further staff were added in response. The second improvement was that the practice of allowing one family member to be in a supervisory position over another staff member had been discontinued. Both improvements had been addressed in December 2012 and January 2013, as reflected in the minutes of the multi-agency meetings.

108. This recommendation was accepted by hospital management and senior management reviewed the response to the two incidents. At the multi-agency meeting which occurred on 8 April 2014, Senior Management advised that the specific incidents were part of the escalation of concern about staffing levels which took place in September and October 2012 and a report had been made to RQIA at the time about what actions had been taken to ensure safe staffing levels. The duty system record showed that the incidents were taken seriously and formed part of the overall problems with staffing levels.

Recommendation 4 - External Staff Induction

109. The adult safeguarding report authors said that there was a discrepancy between Priory staff (the staff of the private provider) and MAH staff accounts

about the level of induction that was provided to Priory staff. While the authors noted that practices for inducting visiting staff had been revised since the allegations had been made, the authors recommended that the revised practice included that the following should happen:

a. An induction checklist of necessary information should be agreed between both facilities before visiting staff started in the ward.

b. A formal induction, going through the agreed necessary information, should be completed before visiting staff start to work with a patient.

c. A clear agreement should be made before each shift about the duties and responsibilities of visiting staff and MAH staff respectively and this must be shared with all staff concerned including health care and nursing assistant staff. The agreement must stipulate what supervision the visiting staff should receive.

d. Visiting staff must be informed of who they should report any issues to that they experienced whilst on shift.

e. Visiting staff should have the opportunity to discuss their experience with a nominated member of MAH staff at the end of each shift.

110. In response to this recommendation, Senior Management informed the multi-agency group on 28 October 2013 that new processes for inducting visiting staff were then in place, and the investigation recommendations had all been included in the new processes. The new induction process also included an evaluation.

Recommendation 5 – **P43** *support needs*

111. The adult safeguarding authors said that the interviews with MAH staff revealed a lack of clarity and differing views about the support needs of patient P43 when she was sitting outside on the grass. The authors therefore recommended that P43 support needs in relation to going out and sitting outside on the grass should be reviewed, following which clear guidance should be established and implemented by all staff.

112. Senior Management agreed at the multi-agency meeting on 28 October 2013 to check that this patient's care plan had been updated accordingly. By the time the next multi-agency meeting took place on 8 April 2014, Senior Management confirmed that this patient had since been resettled to Armagh and her support needs in relation to going out and sitting on the grass were reviewed and clear guidance established and implemented by all staff.

Recommendation 6 – P39

113. The adult safeguarding authors believed that it was likely that staff were at times stressed by P39 behaviour and that monitoring reports indicated that staff continued to experience challenges in managing P39 stripping behaviours. The authors considered that it would have been advisable in those circumstances to involve specialist behaviour support services for detailed assessment, care planning and review.

114. The authors therefore made recommendations relating specifically to P39 care and then more general recommendations as to the use of specialist services.

115. In relation to P39 care, the authors recommended that band 3 staff (health care assistants) were fully involved in discussions with behaviour support services about P39 The authors went on to recommend that specialist behaviour support services review the support needs of staff working with P39 and make any necessary recommendations to hospital management about how such support

could be provided. The authors further recommended that the hospital policy in relation to the approval and recording of restrictive practices should be followed in relation to the use of a swimsuit and belt, and that the hospital consider whether it would be helpful for P39 to be considered for a full-time day-care placement if it helped her behaviour.

116. More generally, the authors recommended that the hospital review for any other practices on the ward that could be deemed restrictive, and then apply the hospital policy to any such practices also.

117. In relation to the use of specialist behaviour support services, the authors recommended that the hospital review the appropriateness of the criteria ward staff used for considering referrals to specialist behaviour support services.

118. At the multi-agency meeting on 28 October 2013, hospital management accepted the recommendation that the support needs of staff, who were managing this patient, needed to be reviewed and that the hospital needed to review for any practice on Ennis ward that could be deemed restrictive. By the same date, a successful bid had been made for the input of psychology services into the resettlement wards to look at the specific needs of patients, such as P39 to address the lack of specialist support in resettlement wards.

119. By the next multi-agency meeting on 8 April 2014, P39 had also been resettled to Armagh. Senior Management at MAH also confirmed that any practice which could be regarded as restrictive at MAH had been reviewed as part of care planning and all care plans had been updated accordingly. All staff had also received training on deprivation of liberty and advised of further training opportunities.

Recommendation 7 – The sharing of information

120. The adult safeguarding authors recognised that staff were caused to feel stressed by the investigation, because the authors were unable to share significant details about the allegations, and because the investigation took a long time to complete. In passing, these are also potential issues of significance in the later investigations arising from the 6 months of CCTV from March to September 2017.

121. The authors therefore recommended that further information could be shared at the point they provided their report, which would help staff morale. The authors recommended that they, the authors, be involved in facilitating discussion with staff, after advice is taken from PSNI and Human Resources, and that as much information as possible be shared with staff about the allegations, the investigation process, and the outcome, conclusions, and recommendations.

122. Members of the hospital staff agreed that staff should be provided with detail of the investigation process and outcomes. However, at the multi-agency meeting on 28 October 2013, the PSNI highlighted the difficulty in sharing any information in relation to the information that the police were following up on but agreed that a more generic response could be given to the staff team.

123. Ms Rafferty and Ms Morrison subsequently met with the staff group from Ennis ward and shared some information in relation to the allegations about particular staff members. HR had advised that written information should not be shared until the internal investigation had completed.

Recommendation 8 - Safeguarding training

124. The adult safeguarding report authors noted that not all staff were sure if they had received safeguarding training and therefore recommended that all bands of staff working on Ennis ward, including medical staff, receive safeguarding training.

125. Following this recommendation, all staff grades were referred to complete this training. It was completed by the final multi-agency meeting held on 8 April 2014.

Recommendation 9 - Access to a full range of services

126. The adult safeguarding report authors noted that patients awaiting re-settlement and on resettlement wards do not always have access to a full range of professional services. The authors therefore recommended that this position be reviewed.

127. In response to this recommendation, the introduction of other professional services had commenced in Ennis ward by 28 October 2013.

Other Issues

128. The Belfast Trust recognises that the MAH Inquiry is not examining the adequacy or effectiveness of any response to the Ennis Adult Safeguarding Investigation report at this stage (the Belfast Trust refers to page 2 of the MAH Inquiry letter of 9 December 2022 relating to Module 6). However, the Belfast Trust, for completeness, and for the assistance of the MAH Inquiry, acknowledges that the 2020 Leadership and Governance Review (discussed further below) expressed its views on the adequacy and effectiveness of the 2013 Ennis Ward Adult Safeguarding Investigation. The 2020 Leadership and Governance Review addressed the Ennis Adult Safeguarding Investigation between pages 93 and 128 at paragraphs 8.1 through to 8.80. Whether those conclusions are justified, based on all the evidence about the response to the Ennis ward allegations, will be a matter for the MAH Inquiry to consider.

129. Further, the Belfast Trust also notes for completeness, and for the assistance of the MAH Inquiry, that in December 2019 Ms Morrison (by that time no longer with

the Belfast Trust, but employed by the Department of Health), who had been the Designated Officer (DO) for the 2013 Belfast Trust Ennis Ward Adult Safeguarding investigation, raised with the Belfast Trust various issues she had arising from her recollections of her experience acting as DO in the Ennis Adult Safeguarding investigation. Those issues were separately considered by David Bingham (one of the members of the 2020 Leadership and Governance Review team) at the time the Muckamore Abbey Hospital Review Team was conducting the 2020 Leadership and Governance Review. All available material relating to these issues has been provided to the MAH Inquiry.

130. It is perhaps relevant that I flag for the MAH Inquiry that Ms Morrison remained clear during her 2019 and 2020 representations that the Priory staff, who had raised issues about the Ennis Ward, had also been on other MAH wards. According to Ms Morrison, those same staff were adamant in their engagement with Ms. Morrison and her team that the issues that caused them concern on the Ennis Ward were not, from their experience, replicated on other wards at MAH.

Three further reports related to the events on Ennis Ward in 2012

131. The Ennis Adult Safeguarding Investigation Report was undertaken as part of the safeguarding processes of the Belfast Trust. It was conducted under the joint protocol. As discussed above, when the safeguarding investigation was nearing conclusion, management within MAH commissioned an internal report.

132. As set above, the work was undertaken by Rhonda Scott, Senior Nurse Manager in Learning Disability, and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability. The terms of reference, a copy of which can be found behind Tab 3, were (in summary):

a. To investigate matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse;

b. To investigate the managerial processes on the ward;

c. To immediately report to the Trust any matter which may undermine the objectivity or robustness of the investigation;

d. To make recommendations on what action if any should be taken in relation to the matters investigated, including a recommendation on whether the case should be referred to a disciplinary hearing.

133. Rhonda Scott and Geraldine Hamilton were originally going to compile one report which addressed all the above matters. However, Rhonda Scott has indicated that they were later asked by John Veitch, then Co-Director for Learning Disability, to separate their report into three reports (so that the reports relating to the individuals could be shared with them):

a. An internal investigation general report on the Ennis Ward allegations and surrounding circumstances.

b. An internal investigation report into the Ennis Ward allegations relating to **H159**

c. An internal investigation report into the Ennis Ward allegations relating to **H197**

134. The latter two reports have already been discussed under the first recommendation above arising from the Ennis Adult Safeguarding Report. It had recommended a disciplinary investigation be undertaken against the two individuals.

135. The 237-page general report was completed in September 2015. A copy can be found behind Tab 3. The investigation team conducted many interviews and reviewed a considerable volume of relevant material.

136. The authors described, as per internal page 6 of their report, the investigation conducted by them as "complex and lengthy". They explained that the Terms of Reference required the investigation team to look at the whole system, including the context of the Ennis ward within the wider MAH site, and also the managerial processes on the ward, staffing, practices and individual patient needs.

137. The team investigated 63 allegations or concerns in total.

138. In relation to staffing (see internal page 38) the investigators reflected the general level of difficulty with under staffing that was occurring in the sector at the time. It did not just affect Ennis, but MAH generally, and Iveagh. The authors refer to a meeting of senior staff on 24 September 2012 which was convened to try to address the staffing issues. It determined that the then Finglass ward would close sooner than anticipated to help address the problem. A subsequent meeting at the end of October 2012 agreed that staff would also be released from the then Greenan ward to help alleviate the staff shortages on Ennis.

139. The general report from Ms Scott and Ms Hamilton recommended that:

a. An overview of the report should be shared with all the staff involved.

b. There should be immediate training for all staff on the legislation and use of restrictive practice;

c. There should be refresher training for all staff on manual handling techniques;

d. All care plans should be updated to include strategies for managing behaviours;

e. Mechanisms within the ward should be introduced to ensure all staff-registered and unregistered can articulate practices and techniques to respond to patient needs;

f. There should be a review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present;

g. There should be increased supervision for a specific patient;

h. There should be stringent review and justification of any environmental changes on wards;

i. All staff should be made aware of "Here4U" and "Staffcare" services available to them for extra emotional support;

j. The Adult Safeguarding Team should consider referring the Manager of the relevant Priory establishment to the Nursing and Midwifery Counsel for her failure to report the incidents which were alleged to have taken place on 9 October 2012.

140. Unfortunately, the individuals likely to have been involved in responding to the recommendations of Ms Scott and Ms Hamilton no longer work for the Belfast Trust. Further work will be required by the Belfast Trust to be able to provide information on what specific steps were taken further to the above recommendations.

141. It would appear, although this issue is also being looked into further, that none of these three reports from Ms Scott and Ms Hamilton were considered by the 2020 Leadership and Governance Review during its work.

142. It is probably relevant that I also draw to the attention of the MAH Inquiry that prior to the Ennis Ward allegations the Ennis Ward itself was a nursing practice placement for student nurses. Consequently, the ward was audited at regular intervals by The Queen's University of Belfast in relation to being a suitable learning environment. To the best of the knowledge of the Belfast Trust, no student nurse, or visiting member of staff from The Queen's University of Belfast ever raised a concern about practices on the ward or its staff.

143. I also draw attention to the statement in the internal investigation report (see internal page 39) which appears to suggest that, at least at that time, families and other visitors were allowed to visit the ward and individual patient bedrooms.

Topics 3 to 8 – 6 further reports

144. The MAH Inquiry's topic list for Module 6 specifically referred to two further reports beyond those addressed above; the 2018 Level 3 SAI report "A Way to Go", and the 2020 Leadership and Governance Review. The MAH Inquiry also included a topic in respect of the identification of other key MAH reports.

145. In addition, in the body of the MAH Inquiry letter of 9 December 2022 the MAH Inquiry referred to, in the context of Module 6, the 2018 Report of the Independent Assurance Team and the 2022 Independent Review into the Resettlement Programme.

146. This statement will, below, address each of the above 4 specific reports, together with two further reports that the Belfast Trust considers are likely to fall

within the parameters set out by the MAH Inquiry. The reports will be addressed in chronological order.

147. As I indicated at the outset, the Belfast Trust recognises that a more detailed witness statement is likely to be necessary in respect of matters that relate to post the commencement of the 2017 CCTV investigation, for example the immediate steps taken to protect patients. What is set out below is, at this stage, a broad outline for the assistance of the MAH Inquiry.

148. The 6 reports that are addressed below are:

a. September 2018 report of the Independent Assurance Team (this is a report that was commissioned by the Belfast Trust).

b. November 2018 Level 3 SAI report "A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go" (this is an independent report commissioned by the Belfast Trust and prepared pursuant to the operative regional SAI process).

c. August 2019 East London NHS Foundation Trust review report entitled "Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust" (this was an independent review commissioned by the Belfast Trust to assist it with addressing what had occurred at MAH).

d. July 2020 report from the Muckamore Abbey Hospital Review Team (sponsored by HSCB/PHA) entitled "A Review of Leadership and Governance at Muckamore Abbey Hospital".

e. July 2021 "What is different now?" (this was a report for the Belfast Trust Board, prepared by a senior member of staff of the Belfast Trust)

f. 2022 Independent Review of the Learning Disability Resettlement Programme in Northern Ireland. This was an independent report commissioned by the then HSCB.

149. As with the reports addressed in Topics 1 and 2, the Belfast Trust has proceeded on the basis of the assurance from the MAH Inquiry that this evidence module is not addressing the effectiveness or adequacy of any response from the Belfast Trust, but rather seeking information as to what the response was.

150. The conducting of reviews, and the reports those reviews reflect, are themselves (at least in respect of those commissioned or prepared by the Belfast Trust) part of the broader response of the Belfast Trust to the events that unfolded at MAH arising from the 2017 CCTV viewing. They are part of attempts by the Belfast Trust to ensure quality care for patients, to provide reassurance to families as to the standard of care being provided, to address workforce stabilisation and the recruitment and retention of staff, and also to ensure robust investigations into what occurred.

151. Ultimately the reports, and any specific responses to them, need to be seen as part of the wider Belfast Trust responses in respect of MAH.

Topic 3 – September 2018 Report of Independent Assurance Team Muckamore Abbey Hospital

152. In December 2017, as a result of matters emerging from the 2017 CCTV viewing, the Belfast Trust Director of Nursing, Ms Brenda Creaney, and the then Director of Adult Social and Primary Care, Ms Marie Heaney, established an independent assurance team to examine a number of matters connected to MAH.

153. Two of the members of the team were from outside the Belfast Trust. The third member, whilst employed by the Belfast Trust, was not part of MAH staff.

154. The final report of the Independent Assurance Team is dated 19 September 2018. The report itself is 20 pages in length. It also has two appendices covering a further 6 pages. A copy of the final report can be found behind Tab 4 in the exhibit bundle.

155. The Independent Assurance Team comprised the following three specialists:

a. Yvonne McKnight - Adult Safeguarding specialist employed by the Belfast Trust

b. Frances Cannon - Senior Professional Officer, Northern Ireland Practice and Education Council for Nursing and Midwifery

c. Owen Barr - Professor of Nursing and Intellectual Disabilities, Ulster University

156. The Independent Assurance Team had broadly four objectives:

a. To provide a level of independence and transparency in relation to key decision-making processes relating to MAH.

b. To provide an independent view on specific key decisions that had been made to that point (December 2017) in relation to staff moved to other facilities, precautionary suspensions or restricted duties of staff involved in identified incidents.

c. To offer advice and support to lead Director(s), and, where appropriate to constructively challenge and/or make recommendations.

d. To support the Co-Director in terms of service improvement and modernisation.

157. As part of its work the Independent Assurance Team also reviewed particular Belfast Trust policies referred to on internal page 2 of the report, as well as a draft workforce paper for Learning Disabilities that was provided to the Independent Assurance Team in December 2017.

158. Prior to 4 April 2018 a draft report was shared with the Senior Nursing Management Team at Muckamore Abbey Hospital. On 4 April 2018 a draft report was provided to the Director of Nursing and then Director of Adult Social and Primary Care. A draft final report was shared in June 2018, before the final report was provided in September 2018.

159. Between December 2017 and April 2018, the Independent Assurance Team engaged with the Senior Management Team in MAH in relation to the agreed areas of work.

160. The Independent Assurance Team were asked to and did review the decision-making process and implementation of precautionary suspension or restricted duties of staff in relation to identified safeguarding incidents which occurred at MAH PICU on the 15 and 16 August 2017, an incident on 1 October 2017 in Sixmile Ward and a number of incidents associated with the swimming pool at MAH. In response, the Independent Assurance Team specifically reviewed information relating to six staff including two Registered Nurses Learning Disabilities (RNLDs) who were placed on precautionary suspension, and a further six staff, including five RNLDs, placed on restricted duties as part of the interim protection plans of staff.

161. The documents considered by the Independent Assurance Team during their work are listed in Appendix 2 to the report (on internal page 26).

162. Interviews conducted with MAH staff in a range of roles are summarised in Appendix 1 (internal page 21).

163. The work of the Independent Assurance Team included meeting with staff, viewing CCTV and reviewing decision making. The assurance team noted that they did not meet with staff known to be involved in the incidents then known to be subject to investigation by PSNI.

164. An example of the difficulty that can arise with managing staff in these circumstances is perhaps evidenced in paragraph 4.1 of the report. When the matter initially came to light, two members of staff were moved from PICU to Sixmile on the basis they may have failed to report an observed safeguarding incident. The review into that decision, reflected in the report of the Independent Assurance Team, resulted in the two staff members being moved back to PICU, but remaining subject to the described interim protection plans.

165. The consideration of MAH management interventions with staff members (arising from incidents viewed on the 2017 CCTV) were subdivided in the report into the following areas: a review of decisions made in relation to moving staff to other facilities, placing staff on precautionary suspension, and subjecting staff to restricted practice arrangements. This was further explored chronologically with a review of initial decisions, a review of ongoing restrictions, and a review of ongoing supervision provision.

166. The Independent Assurance Team considered the initial decisions to be appropriate (see paragraph 4.5 on internal pages 6 and 7), but they also indicated (whilst appreciating the difficult circumstances) that the administrative processes

around the decision making were lacking. This was a theme repeated in subsequent sections of the report.

167. The report also documented the emotional impact on both suspended staff, and those who were interacting with them (see paragraph 4.6 on internal pages 7 and 8).

168. In paragraph 4.8 (internal page 10) of the report the Independent Assurance Team set out 10 recommendations they had relating to decision making about staff involved in the 2017 CCTV investigation. These were:

a. Decisions relating to precautionary suspension of staff, or placing staff on restricted duties, should first and foremost fully take into account the expected professional conduct of all staff involved and the professional expectations of behaviour from the Nursing and Midwifery Council or other relevant professional regulators. If other factors, such as the operational role the person may have been fulfilling at the time are taken into account, the analysis of these differing factors must be clearly stated, analysed and documented in the decision-making process.

b. There should be a template aligned to the HR policy to record the initial decision taken and any subsequent review of that decision. Guidance was then given on what the template should include.

c. Records relating to staff on precautionary suspension or restricted duties, including email correspondence between Belfast Trust managers, should relate to one individual at a time i.e., comments relating to several staff members should not be clustered in one email. It was said that this would facilitate clearer communication about individual decisions and also the filing of this information in the files of individual staff members.

d. There should be a standardised approach to the review of decisions which proactively considers the relevant factors with a recognition of the possibility of amending the interim decisions.

e. When decisions are being reviewed, both the intended and unintended consequences of interim decisions, for people with learning disability, service delivery and staff members should be actively considered and reflected in the notes of the review of the decision.

f. Senior Management would benefit from more proactive and ongoing support from HR in relation to all aspects of precautionary suspensions and restrictions on practice.

g. The role of the Ward Sister/Charge Nurse should be reviewed in order to priorities the leadership aspect of the role at ward level (e.g. consideration should be given to the supernumerary status of the Ward Sister/Charge Nurse).

h. There should be clear guidance for staff in the policy about undertaking the role of the "designated contact persons" to include the areas to be covered in discussion with staff and proformas to be completed as a record of the contact.

i. In developing the "designated contact person" guidance, the opportunity should be taken by HR to explore with "designated contact persons" across the Belfast Trust, what information and preparation would have assisted them in undertaking this role in this service and other learning opportunities in the Trust.

i. "Designated contact persons" providing ongoing contact to staff on precautionary suspension or on restricted duties should be formally included in the process of reviewing these decisions, and their participation and views in the review of decisions should be noted in the record of the meeting.

169. The Independent Assurance Team also reviewed four Belfast Trust policies as they were considered relevant to the issues they were asked to address. The policies considered are set out at paragraph 5.0 on internal pages 11 and 12 of the report.

170. The Independent Assurance Team made a number of criticisms about the four policies they considered, both in terms of content, and the delay in some being reviewed.

171. The Independent Assurance Team then went on to make eight recommendations in relation to the policies (see paragraph 5.2 on internal pages 13 to 15):

a. National guidelines and the documents related to professional regulators used to underpin policies must be the current versions, and policies should be reviewed if the requirements of professional regulators change during the term of the policy. People signing off policies at different levels within the Belfast Trust should seek written assurance that this is the position for all evidence used.

b. Consideration should be given to reviewing the policies below into a single policy document, thus creating an overarching policy based on a person-centred approach and Positive Behavioural Support:

i. Levels of Supervision/Observations within Learning Disability In-Patient Services (November 2013 – said to have been out of date at the time of the report)

ii. Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure (November 2016)

c. Use of Restrictive Interventions for Children and Adult Services (May 2015). Policies that cover both Children and Adult services should provide clear direction on the specific and uniquely different requirements in relation to children and adults, where applicable and necessary. It was said that at that point, there was no clear distinction made within the policies reviewed relating to either the use of seclusion within learning disability in-patient services or the use of restrictive interventions for children and adult services across the Belfast Trust. It was the view of the Independent Assurance Team that the needs of children and adults being placed in seclusion or restrictive interventions were different and specific guidance should be provided for each.

d. With specific reference to the Belfast Trust Use of Restrictive Interventions for Children and Adult Services (May 2015), on page 8 of 22 of the policy, it was observed that it was specifically highlighted that the Belfast Trust Management of Aggression Team were not involved in training within Muckamore Abbey Hospital. The training within Muckamore Abbey Hospital was noted as being provided solely by the MAPA Training Team. To encourage collaborative working across the Belfast Trust, reduce the potential organisational and geographical isolation of staff in Muckamore Abbey Hospital from colleagues in similar services in the Belfast Trust, and the sharing of information and good practice, it was recommended that the MAPA Training team at

Muckamore Abbey Hospital should be integrated into the Belfast Trust Management of Aggression Team.

e. It was also recommended that the title of the 'Management of Aggression Team' should be reviewed to reflect a person centred ethos and recognition of the distress that people who present challenges to services and staff responding may be experiencing at that time.

f. Active engagement with people with learning disabilities, family and carer representatives should be considered as a starting point when developing policies and explicit rationale provided when the decision is taken not to involve these people in Belfast Trust policy development.

g. It was recorded that, arising from discussions, members of the Independent Assurance Team became aware that the same room was used in the Intensive Care Unit for both "Low Stimulation" and Seclusion. It was felt that from the perspective of the person with learning disabilities that the use of the same room for two different interventions, potentially resulted in mixed messages and confusion. It was recommended that separate areas were used for "Low Stimulation" and Seclusion.

h. All Belfast Trust policies relating to people with learning disabilities should be reviewed and updated within the specified timeframe. When there is an anticipated or actual delay in the review of a Belfast Trust policy, this should be formally escalated to the Belfast Trust Director who signed the policy, and a robust plan should be put in place to review the policy within an agreed revised timeframe. There should be explicit communication to staff in the Belfast Trust that the previous policy remains in place until the new policy is signed off.

172. The Independent Assurance Team also considered a draft paper on staffing levels in MAH which was provided to it in December 2017. It contained information to November 2017. The Independent Assurance Team provided a number of points of feedback on the paper, as set out in paragraph 6.1 of its report. The Independent Assurance Team did note that concerns about staffing levels had been documented on Belfast Trust risk registers since 2014 (paragraph 6.2 on internal page 17) and described the impact of the staffing issues as reflected by staff (internal page 17). The Independent Assurance team also commented on the approach to workforce planning and contractual arrangements for staff, reflecting the difficult issues created by resettlement and the consequent retraction of MAH. In paragraph 6.3 and 6.4 (internal pages 17 and 18) the Independent Assurance Team did record various measures that had already been attempted by the Belfast Trust to try to address the staffing issues.

173. In paragraph 6.5 (internal pages 19 and 20) the Independent Assurance Team set out 10 recommendations in the area of workforce:

a. The Independent Assurance Team recommended the need for clear processes for escalating concerns about staffing levels, and ability to provide safe nursing care, directly to the Director of Nursing and Director of Social and Primary Care.

b. The Belfast Trust should purposefully continue to actively recruit nursing staff through high profile regional and rolling local recruitment campaigns.

c. Clear information about the role, function and planned future of Muckamore Abbey Hospital, together with information on the complexity of abilities and needs of the people cared for in Muckamore Abbey Hospital should be articulated to support and inform workforce planning.

d. Senior managers should as a matter of urgency explore current actions aimed at retaining staff - including local induction, preceptorship for new registrants, regular supervision, career development opportunities and using staff skills for specialist practice roles for which they have been prepared.

e. In order to further understand why staff had left Muckamore Abbey Hospital, exit interviews should be conducted with all staff leaving Muckamore Abbey Hospital and Learning Disability Services in the Belfast Trust. These interviews should be conducted by a person who was not involved in the management of the staff member. It was recommended that independent exit interviews were conducted retrospectively with all staff who had left Muckamore Abbey Hospital and Learning Disability Services in the Belfast Trust to work elsewhere in the past 3 years.

f. It was the view of the Independent Assurance Team that it would be good practice to support rotation of newly qualified staff across practice areas/care environments within Muckamore Abbey Hospital in a planned and transparent manner, to support professional development and development of skills and competencies. Consideration should also be given to the rotation of staff between hospital and community services in a planned and transparent manner.

g. It was apparent, due to the shortage of RNLDs in post, that Muckamore Abbey Hospital should actively recruit nurses from Mental Health Nursing and others fields of practice to fill vacancies, the impact of this on services provided then needed to be monitored and evaluated.

h. The Belfast Trust should formally escalate concerns directly to the DoH regarding the number of commissioned places on the pre-registration nursing - learning disabilities and specialist practice programmes and request consideration of increased numbers of places as soon as possible.

i. A Task and Finish Group should be established to review and analyse the use of E rostering, which should include robust arrangements for monitoring of staff working over contacted hours.

j. The recommendations of the "Listening Groups" should be progressed with agreed timeframes.

174. The Independent Assurance team indicated that it was sharing its observations with the Level 3 SAI team led by Margaret Flynn, which it recognised would be making its own recommendations, but it made clear it was providing its observations and recommendations to assist in the development of services for people with learning disabilities and for the development of staff at MAH as a future vision for the hospital was articulated. The Independent Assurance Team concluded its report with the following statement (see internal page 20):

> *"The Members of the Independent Assurance Team believe urgent action is needed to address the observations within this report and the recommendations made in order to address important aspects of the operational culture within Muckamore Abbey Hospital. Key to taking forward these recommendations is prompt and direct action to reduce the observed geographical and organisational isolation from the wider BHSCT of the people using these services and staff working in Muckamore Abbey Hospital."*

175. It is important that I acknowledge that in preparing to provide this statement and give evidence to the MAH Inquiry it has become evident to me, as it has to other relevant personnel in the Belfast Trust, that for the post August 2017 period it is not always possible, or, where it is possible, not always entirely

straightforward, to follow a neat line between a particular recommendation from a review or report, and its subsequent implementation within the Belfast Trust.

176. This is for a variety of reasons, including the fact that various forms of scrutiny, internal (such as by relevant senior staff from within the Belfast Trust), independent (such as the work of the Independent Assurance Team or the Level 3 SAI team) and external (such as RQIA and the Department of Health), were taking place at the same time, were overlapping, or were happening very shortly after each other. The consequence of this has meant that in some cases necessary actions or changes, including those which can be said to be relevant to recommendations from a report or review, blend into one another.

177. Another reason is that some of the issues being raised in reports or reviews, such as that of the Independent Assurance Team, were already being addressed before the provision of the actual recommendations from the reviews themselves. This is reflected in in the likes of the "Summary Timeline" which was attached in a letter sent to Mr Sean Holland and Ms Charlotte McArdle at the Department of Health dated 3 November 2017, and which has been included behind Tab 4 in the exhibit bundle. It is also reflected in the various MAH Action Plans that were developed from August 2017 onwards, which do not themselves relate specifically to a particular report. For present purposes, some examples of the MAH Action Plans have been included behind Tab 4 in the exhibit bundle.

178. By way of specific example, as will be evidenced by a 16 August 2018 document attached to the copy of the subsequent Independent Assurance Team Action Plan, entitled "January 2019 first action update" and provided behind Tab 4 in the exhibit bundle (which post-dated the report of the Independent Assurance team), issues to do with staff retention were already being worked on at the same time as the Independent Assurance Team was doing its work. The Adult and Social Primary Care Directorate had already requested the Belfast Trust HR Directorate Modernisation and Workforce Planning Team to conduct exit interviews with staff

who had left MAH. A pilot exercise was undertaken by the Modernisation and Workforce Planning Team during December 2017 to April 2018 (at the same time as the Independent Assurance Team was conducting its work). This example illustrates that it is difficult to look at recommendations from reviews or reports in isolation and ask what the response to a particular recommendation was. This is because the response may be that the issue was actually identified and being addressed before the relevant recommendation was in fact made.

179. An early document that perhaps helps illustrate what I am trying to explain is the 19 April 2018 update about matters in relation to MAH provided by Belfast Trust to the Department of Health. A copy of the document can also be found behind Tab 4 in the exhibit bundle. The various workstreams reflected in that document, or matters being addressed, include issues that would subsequently also form recommendations in reports or reviews.

180. As I mentioned at the outset, given the pace and extent, the number of individuals involved, and the sequencing of actions or changes in the post August 2017 period, and the time available to prepare this statement, it has not yet been possible for the Belfast Trust to fully collate and provide a comprehensive account of all the steps taken in response to all post August 2017 recommendations. It is also likely that not all documents that would bear on the response have yet been identified; this is because there is likely to be, for instance, material within inboxes of former staff that is relevant to these issues.

181. At this point I am therefore able to give a broad overview as to the response of the Belfast Trust to various recommendations that arise from the post 2017 reports that I am addressing. However, I also have to accept that it is necessary for me, at this stage, to caveat what I say in this statement by indicating that the present response is based on best endeavours in the time available, and that it may well be necessary, as further relevant material is identified and produced, to augment or amend what can be said about the response of the Belfast Trust to the relevant

recommendations from these reports. This is so that, as a matter of fairness to the staff of the Belfast Trust, the MAH Inquiry can have a complete and comprehensive picture as to what took place.

182. I have already referred above to the Action Plan entitled "January 2019 first action update", which post-dated the report of the Independent Assurance team. That Action Plan addressed the third set of recommendations from the Independent Assurance Team, which related to workforce issues. They were essentially recommendations 19 to 28 of the 28 recommendations made by the Independent Assurance Team.

183. On 6 October 2022 the Department of Health's Director of Disability and Older People, Mark McGuicken, wrote to Dr Jack, Chief Executive of the Belfast Trust, asking for the DoH to be provided with an update on the work of the Independent Assurance Team and the outcomes arising from its work. A copy of the letter can be found behind Tab 4 in the exhibit bundle.

The present position in respect of the implementation of the recommendations is set out in a summary document provided in response to the letter from Mr McGuicken. The response was prepared on Dr Jack's behalf by the present Co Director of Intellectual Disability Services, Ms Billie Hughes (Ms Hughes had previously been the Divisional Nurse responsible for MAH). A copy of the summary document, and accompanying material, is provided for the assistance of the MAH Inquiry behind Tab 4 in the exhibit bundle. A full consideration of the summary document is necessary to try to understand the steps taken to act on the recommendations.

184. By way of example, in respect of the recommendation to merge the two Belfast Trust Accredited Training Centres for Safety Intervention training into a single accredited training centre (it appears at item 24 on Ms Hughes' table, and is recommendation IV in paragraph 5.2 of the Independence Assurance Team

report), there is a commitment and intention in the Belfast Trust to do this, but it has not happened yet. There is a draft working proposal in respect of the merger, should the MAH Inquiry wish to see it. There is also a draft business case, because the merger will involve additional resource. In respect of recommendation V in paragraph 5.2 of the Independence Assurance Team report, the team based at Knockbracken has now changed its name, from the "Management of Aggression Team" in line with the change to the new CPI branding and format. It is now known as the "Safety Intervention Team".

185. In respect of the recommendation that the Trust should purposefully continue to actively recruit nursing staff through high profile regional and rolling local recruitment campaigns, and that the Belfast Trust should actively recruit nurses from Mental Health Nursing and other fields of practice to fill vacancies, the Belfast Trust began these efforts in early 2018. For example, a Recruitment Fair took place in March 2018 with 28 final year students from The Queen's University of Belfast, being offered a post. The Belfast Trust also attended Job Fairs in QUB, UUJ, Dublin and Dundee, as well as RCN Congress Liverpool and Belfast Open Days throughout 2019. Efforts were not limited to targeting under-graduates, with the Belfast Trust holding an open file on HSC recruit and planning further recruitment events for LD Nurses in Summer 2019. These steps, and others, are outlined in the 20 June 2019 letter from Belfast Trust Director of Nursing Ms Creaney to Professor Charlotte McArdle, Chief Nursing Officer at the Department of Health. A copy can be found behind Tab 4 of the exhibit bundle.

186. The 20 June 2019 letter also outlined steps that had been taken in relation to the recommendation that there should be clear processes for escalating concerns directly to the Director of Nursing and Director of Social and Primary Care about staffing levels and the ability to provide safe nursing care at MAH. These steps included ensuring that senior nurses are available to frontline staff 24 hours per day, 7 days per week, and confirmation that all frontline staff are aware of how to contact senior nurses to escalate concerns. Additionally, various Senior Managers,

including the Director of Nursing and the Director of Social Primary Care, performed daily and weekly Senior Management Leadership walkarounds. Daily reviews of "Is Care Safe Today" were introduced, as were Daily Safety Briefings and Safety Huddles.

187. This letter also gives a short outline of the steps taken by the Belfast Trust to improve the morale, experience and wellbeing of its staff. While this is a goal in and of itself, one of the other purposes of these steps was to increase retention rates and stabilise the workforce pursuant to the general ethos of the recommendations in the Independent Assurance Team's report. The Belfast Trust would welcome the opportunity to provide a further witness statement in which it can outline all steps taken to try to deal with the staffing issues, and to improve staff experience.

188. The Belfast Trust also carried out a review of Roster Compliance and Bank Utilisation for Inpatient Learning Disability Services. In the course of this review, the E-Rostering Team was commissioned to deliver one to one training with all registered and unregistered staff on the MAH site to further engage staff in the use of the Belfast Trust's rostering employee online system. In addition, the E-Rostering Team spent time with Ward Sisters and Charge Nurses carrying out reviews of all rosters.

189. It is the case that I have sought further assistance and clarity from various parts of the Belfast Trust in respect of the response to the recommendations from the Independent Assurance Team. I will provide any further relevant information to the MAH Inquiry upon receipt.

Topic 4 – November 2018 Level 3 SAI – "*A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go*"

190. A further response to the events at MAH that emerged in August 2017 was the calling of a Level 3 Serious Adverse Incident (SAI) in accordance with the Belfast

Trust's SAI policy (which is based on the regional SAI guidance, in respect of a which a departmental review is underway). This ultimately resulted in the provision of the Level 3 SAI report of November 2018 entitled "*A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go*". A copy of the report from the Level 3 SAI can be found behind Tab 5 in the exhibit bundle.

191. In brief summary, the context of the SAI, as the MAH Inquiry may be aware, was that on 12 August 2017 a member of staff at MAH witnessed an incident on the MAH Psychiatric Intensive Care Unit (PICU) whereby a member of staff was said to have assaulted a patient. The incident was reported and the staff member said to have assaulted the patient was placed on precautionary suspension on 22 August 2017. The Belfast Trust issued an Early Alert to the Department of Health in respect of the incident on 7 September 2017. I am informed that Early Alert notices are being disclosed separately to the MAH Inquiry.

192. On 20 September 2017 management at MAH viewed CCTV footage of the incident from 12 August 2017. Upon viewing the CCTV footage, management identified additional safeguarding concerns. A safeguarding investigation was initiated, and the police were engaged in response to the concerns identified in the CCTV footage.

193. The Belfast Trust also submitted a Serious Adverse Incident (SAI) notification to HSCB and RQIA on 26 September 2017.

194. The decision to regard the SAI as a Level 3 meant that an independent panel was appointed to conduct the investigation. The Belfast Trust explained the intended course to the Department of Health in a letter from me as Chief Executive on 22 December 2017. A copy of the letter can be found behind Tab 5 in the exhibit bundle.

195. The Level 3 SAI team ultimately included:

a. Dr Margaret Flynn - Chair of the Review Team and Chair of the Wales National Independent Safeguarding Board

b. Mrs Mary Bell - parent and independent advocate

c. Professor Michael Brown – The Queen's University of Belfast, Faculty of Medicine and Life Sciences

d. Mr Bryce McMurray - former Director of Mental Health and Learning Disability and former Executive Director of Nursing at the Southern Health and Social Care Trust.

e. Dr Ashok Roy - Consultant Psychiatrist at Coventry and Warwickshire Partnership Trust, and former chair of the Faculty of Intellectual Disability Psychiatry, Royal College of Psychiatrists.

196. The Terms of Reference for the Level 3 SAI investigation that were provided to the SAI team in January 2018 are set out on internal pages 6 and 7 of the Level 3 SAI November 2018 report. They were:

1. Review the effectiveness of:

(i) the identification and timely reporting of adult safeguarding incidents in Psychiatric Intensive Care Unit (PICU) and Six Mile in August 2017 & October 2017, and subsequent communication and reporting of these incidents between the Trust, Public Health Agency (PHA)/Health and Social Care Board (HSCB) and Department of Health

(ii) adult safeguarding and the subsequent investigations in Muckamore Abbey Hospital from 2012 - 2017

(iii) adult safeguarding protection plans in Muckamore Abbey Hospital

(iv) the current advocacy arrangement in Learning Disability services

(v) governance and quality assurance and controls in relation to quality, safety and user experience of care in Learning Disability Services from 2012 to 2017

(vi) the implementation of previous recommendations following Serious Adverse Incidents (SAI), Adult Safeguarding investigations and Regulation and Quality Improvement Authority (RQIA) reports in relation to Muckamore Abbey Hospital from 2012 - 2017

(vii) using the RQIA assessment definitions of Well-Led to assess the leadership within Muckamore Abbey Hospital to include:

- Delivery of Safe, Effective and Compassionate Person-Centred Care
- Clinical supervision
- Training
- Multi-professional audit
- Communication
- Learning and improvement

2. Identify areas of good practice both at Muckamore Abbey Hospital and in related services elsewhere with a view to proposing a programme of improvement and development associated with the outcomes of the investigation.

3. Advise on, with a view to consideration of, any other relevant matters that may arise during the investigation."

197. The Belfast Trust provided the review team with patient safeguarding records concerning 69 hospital patients for the period 2012 through to 2017, as well as 61 RQIA inspections reports, and material from 12 patient experience interviews. The review team also considered, amongst other things, policies, workforce information, patient mortality information, referrals to safeguarding, seclusion reports and patient advocacy information.

198. Between January and June 2018 the review team conducted a broad range of interviews with individuals both from the Belfast Trust and from outside the Belfast Trust. The various groups are described at paragraph 6 of the report on internal page 7.

199. The review team watched 20 minutes of footage from the 2017 CCTV (see paragraph 10 on internal page 8).

200. Whilst the SAI investigation was ongoing, but before the final report was published, there continued, as referred to above, to be various workstreams within the Belfast Trust in respect of MAH. There were also various changes in management roles at MAH. For instance, on 16 August 2018 the Belfast Trust accepted the resignation of the then Acting Service Manager at MAH (BM), and, on the same date, the Belfast Trust required the then Divisional Nurse at MAH (ER) to step aside.

201. The Belfast Trust received a draft version of the "*A Way to Go*" report in September 2018. The draft report was shared with the families of patients and other key stakeholders. Marie Heaney, then Belfast Trust Director of Adult Social and Primary Care and Dr Margaret Flynn, Chair of Level 3 SAI Review Panel, arranged meetings with the families of affected patients, other Trusts, and Belfast Trust staff, to discuss the findings and draft recommendations within the report. A draft address was prepared and can be found behind Tab 5 in the exhibit bundle. Two separate feedback days were arranged, both in MAH:

a. On 24 September 2018 a morning session was held with families and carers, and the afternoon with other Trusts.

b. On 25 September 2018 a morning session was held with Belfast Trust staff, and an afternoon session with families and carers.

202. The sessions were subsequently summarised in a postscript to the final report, which can be found at its internal pages 38 to 41.

203. As part of the response to the Level 3 SAI report, and its recommendations, on 24 September 2018 the Belfast Trust issued a public statement about MAH, further to the meeting with families and in the context of receipt of the draft report (a copy of which can be found behind Tab 5 in the exhibit bundle). The Belfast Trust said:

> "*Today senior Trust staff met with families to discuss the findings and draft recommendations of the report commissioned by Belfast Trust into a Review of Safeguarding at Muckamore Abbey Hospital.*
>
> *We want to place on record our sincere apologies to those patients and their families affected by staff behaviours which fell significantly below professional standards and were unacceptable.*

An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the PSNI and Adult Safeguarding social workers.

We have taken decisive action, which included placing 13 members of staff on precautionary suspension. We are actively working on improving leadership and management arrangements at Muckamore Abbey Hospital, with the goal of ensuring that the voices of patients, family carers, advocates and others are clearly and effectively part of the future arrangements in Muckamore Abbey Hospital. A director oversight group led by the Director of Nursing and the Director of Adult, Social and Primary Care is in place.

Everyone has the right to be safe and free from harm. Safeguarding means having measures in place to protect human rights health and well-being, particularly for vulnerable people. In recognition of this, the Trust separately commissioned a fully independent team to undertake a review of the broader factors in Muckamore Abbey Hospital, to provide a clear picture as to what happened and to make recommendations on how to improve safeguarding.

The Review Team brought a wide range of experience perspectives and expertise as advocates, practitioners, clinicians, researchers and managers in service provision for people with learning disabilities and autism.

The findings of the Review Team highlighted that improvements are required in leadership and management, adult safeguarding approaches, advocacy, access to meaningful activities for patients and physical health care. We fully accept all the findings and we will now work to ensure these are delivered.

The report strongly urges the Trust and the wider health, social care and housing organisations to re-double their efforts to ensure that patients do not have to live in hospital environments. It recommends patients are enabled to live full lives in the

community, with access to the right specialist multi-disciplinary support in the right accommodation.

The key recommendations are:

- ***No one should have to live their lives out in hospital – the report recommends a renewed commitment to enabling people with learning disabilities and autism to have full lives in their communities***

- ***Deliver robust multi-disciplinary community services which recognise the full range of needs of people and families throughout their lives***

- ***Assessment and treatment units closer to home and effective long term quality accommodation options***

We are committed to ensuring patients are cared for safely in Muckamore Abbey Hospital and we recognise and pay tribute to the many highly skilled and dedicated staff who remain working in Muckamore Abbey Hospital.

We wish to emphasise our commitment to openness and transparency to families and others in relation to sharing information appropriately. We are truly sorry that we have let our patients and their families down. Our priority now and in the future is to engage with the patients, families, staff, the DoH and the HSCB to deliver a future model of care for learning disability and autism."

204. The Belfast Trust publicly committed to working on the issues identified for it in the draft Level 3 SAI report.

205. The Belfast Trust received the final version of the report of the Level 3 SAI investigation in November 2018. The report itself is some 42 pages. It also has 7 Appendices that run from internal page 43 to 87.

206. Whilst the report itself only made two formal recommendations (discussed below, and see internal page 37), there were a number of different findings, observations and learnings in the report from which actions could be, and were, developed.

207. The Level 3 SAI review team set out in its Executive Summary (see internal page 5) 19 findings arising from its investigation:

a. Safeguarding events cannot be seen in isolation. Without exception, discussions concerning safeguarding gave way to patients' compromised lives at MAH, their chronic boredom and the failure to create and offer them high quality community services;

b. MAH patients are significantly likely to be harmed by peers;

c. Irrespective of the considerable quantity of paperwork associated with safeguarding, the Review Team could not determine how closely MAH practice aligned with the safeguarding protocol and procedures;

d. The CCTV in the MAH Psychiatric Intensive Care Unit – with the highest staffing levels and ratios of qualified staff – shows patients being harmed by staff and yet no safeguarding referrals were made, and no members of staff spoke out;

e. Patients' families are distressed and angry that nobody intervened to halt the harm and that even the possibility of patients being harmed was denied and deemed implausible by MAH Managers and the RQIA;

f. There was a culture of tolerating harmful and disproportionately restrictive interventions;

g. Many families wanted to emphasise that harmful practices co-existed with skilled and compassionate practices and that there are excellent staff at MAH whose work is highly valued;

h. The CCTV evidence triggered staff suspensions, an investment in viewing many hours of CCTV footage and acknowledgement that relations with patients and their families had to be restored;

i. There is confusion about safeguarding "concerns" and "complaints";

j. The use of seclusion was not monitored. Its intensive use by a small number of patients was said to be anti-therapeutic;

k. Over a third of safeguarding files were said to state that patients have "a history of making allegations" which sacrifices patients' credibility;

l. Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training;

m. Communications with families about alleged safeguarding incidents and potential investigations were vulnerable to being construed as seeking permission to undertake safeguarding investigations;

n. The routine (and discontinued) practice of involving the Police Service of Northern Ireland in all safeguarding discussions was said to be bewildering;

o. Advocacy at MAH was said to be not as uncomfortably powerful as it should be;

p. Place-hunting for MAH patients is not working;

q. Leadership is distributed and not being used to benefit MAH patients;

r. Northern Ireland's services are poorly equipped to support infants and children with learning disabilities, autism and complex medical challenges – whose families do not view MAH as their future;

s. MAH is not being used for short term admissions and treatment. It has been historically relied upon by Trusts as the "default placement" – placing distressed and chronically bored patients together. Safeguarding at MAH should be seen against this backdrop.

208. The review team also identified what is described as five lessons from its investigation (internal page 5):

a. That safeguarding practice at MAH involved negotiating too many obstacles.

b. MAH senior managers must support staff who report harmful events and practices.

c. Patients' and their families must be treated as equal partners and must be heard on a continuous basis. Episodic contact is unhelpful.

d. MAH requires focus regarding its role and place in the future of Learning Disability services in Northern Ireland. This focus must be endorsed by all staff and managers, Trusts, the Department of Health and the Legislative Assembly;

e. A life course perspective is required to understand and realise the aspirations of patients and their families.

209. The review team made two formal recommendations (see internal page 37) which were said to underline the importance of understanding that ordinary lives require extraordinary support; and that a life course vision of services for people with learning disabilities and autism is required. The two recommendations were:

a. Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.

b. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of MAH and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services." A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale. Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home

settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.

210. Whilst the final version of the report was not provided to the Belfast Trust until November 2018, the Belfast Trust began acting on the findings of the review team upon receipt of the draft report in September 2018. The then Director of Adult Social and Primary care had responsibility for the development of an Action Plan. The action plan detailed the recommendations from both the *A Way to Go* report and the Independent Assurance report. This is the MAH Trust Action Plan 2018/2019, a copy of which can be found behind Tab 5 of the exhibit bundle.

211. On 15 November 2018 the Belfast Trust, met with a cross-party delegation of MLAs, and the PSNI, to discuss the Level 3 SAI report. During the meeting the Belfast Trust confirmed its intention to meet again with families of affected patients to share the report and discuss the learning and changes needed, including the increased involvement of families and carers in services.

212. In mid-December 2018 senior staff from the Department of Health met with MAH families to share the final SAI report, on a one-to-one basis, over a two-day period. The Belfast Trust also facilitated a series of press interviews in the context of the Level 3 SAI report, including by the Director of Nursing with the BBC, and jointly the Director of Nursing and the then Director of Adult Social and Primary Care with the Irish News. The DoH Permanent Secretary, Mr Richard Pengelly, also issued a statement. Dr Colin Milliken, then Clinical Director for Learning Disability Services, gave the BBC a further interview which included showing images of the seclusion facilities at MAH.

213. It is the case that following receipt of the Level 3 SAI report the chronology of events from 2019 onwards involves many overlapping strands of activity within and without the Belfast Trust and involving many people. Further, it is likely to

be necessary to consider and bring together the outworking of all of the overlapping strands of activity in order to fairly reflect the Belfast Trust response to the recommendations from the post 2017 reports. In the time available, and because of the number of people involved, it has not been possible to undertake that task comprehensively, and consequently, as I have said above, I am in a position at present to give a broad overview. However, the Belfast Trust will in due course need and want to provide a comprehensive account to the MAH Inquiry about all the steps taken.

214. For instance, during 2019 there was extensive inspection activity from RQIA. There were 3 Improvement Notices served in August 2019. I attach a letter behind Tab 5 of the exhibit bundle from RQIA of 16 August 2019 which summarises the themes being addressed. These themes were similar to matters addressed in various recommendations in the reports I have already referred to. There was then necessary extensive activity from the Belfast Trust in the context of the RQIA Improvement Notices. Much of that activity also bears on recommendations from the reports. The RQIA reports that followed the service of the RQIA Improvement Notices do then record the steps taken by the Belfast Trust to address the matters of concern to RQIA, and which were also matters arising in the reports. I attach behind Tab 5, by way of example, the RQIA follow up reports from December 2019, April 2020, and October 2020 which extensively document steps taken by the Belfast Trust.

215. The December 2019 RQIA report itself provides an illustrative example of work undertaken to address one of the areas that the Level 3 SAI expressed concern about; the use of seclusion. At internal page 25 of the December 2019 RQIA report RQIA had this to say on that subject:

> *"We reviewed the use of restrictive practices including seclusion at MAH and found evidence of continued reduction and improvement in relation to the use of these practices. We noted the hospital's seclusion policy and procedure had been reviewed*

and updated. We found the Trust had introduced an effective strong governance and assurance framework in relation to the use of seclusion. Restrictive practices were routinely audited and reported through the BHSCT assurance framework. We observed that restrictive practices were reviewed at ward level; by the MDT; at Live Governance meetings; by the SMT and also system wide by the MAH Directors Operational Group; by the Executive Team; and bi-monthly at the Trust Board meetings. We found the Trust had developed and implemented a restrictive practice strategy and was continuing to embed a positive behavioural support culture and practice across the hospital. As previously discussed, behaviour assistants had been recruited and patients with the most challenging behaviours had a positive behaviour support plan in place and the Purposeful Inpatient Admission (PIpA) model was introduced. There was evidence that low stimulus areas were used as a means of deescalating behaviours rather than using seclusion…. We examined the audits in relation to the use of seclusion events during this period and found good compliance with the recording of seclusion events in line with the Trust's policy and procedure, the required standards and best practice."

216. Another illustrative example is found in the April 2020 RQIA report. The Level 3 SAI report had expressed concern over safeguarding having too many hurdles. The April 2020 RQIA report, on internal pages 9 and 10, summarised actions taken in that area in the following way:

"They described to us the senior management oversight arrangements for the management of safeguarding within the hospital. They shared with us the flow chart displayed on each ward which showed the process for escalating a safeguarding incident and which highlighted the various staff roles in the process. The SMT told us about good practice improvements which have been implemented which included a comprehensive review of policies and procedures including the seclusion policy, the observation policy and the admission policy. They told us that patients are engaged in more meaningful activity on and off the hospital site in the evenings and at weekends. They also informed us that CCTV is now live across the site and learning from the Adult Safeguarding (ASG) team's viewing of the CCTV is shared at ward manager

meetings and at the ASG Forum. The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital. We were informed that a link person for contact with the Police Service Northern Ireland (PSNI) had now been established and a Service Manager with ASG responsibilities has been recruited.

The SMT told us that action had been taken by the hospital social work team to raise safeguarding awareness among patients through the Keeping Yourself Safe Programme. The programme informs patients about what safeguarding is and what actions they could take if they had a safeguarding concern. We were advised that this will be an ongoing programme for patients. We were advised that since January 2018, the Keeping Yourself Safe programme had been delivered to 45 patients in MAH and another 33 patients were either offered the programme and declined or had insufficient capacity to participate or have now been discharged from the hospital."

217. These are just two illustrative examples. The reports evidence other steps taken that bear on recommendations from the various reviews and reports available to that point in time.

218. The Belfast Trust took the decision to temporarily close the PICU in MAH over the Christmas period from 2018 into 2019.

219. In 2019 the Belfast Trust also requested the establishment of monthly meetings with the Department of Health, in addition to the monthly reporting mechanisms. The first of these meetings was scheduled for 10 April 2019.

220. During June 2019 Dr Margaret Flynn was asked by the Belfast Trust to revisit MAH. During the revisit, Dr Flynn attended ward reviews, multi-disciplinary team reviews, viewed patient activity plans and observed MAH's progress. Dr

Flynn was then invited to report her findings to the Belfast Trust Board in September 2019.

221. In the middle of 2019, the Department of Health also established the Muckamore Abbey Hospital Departmental Assurance Group (MDAG). The purpose of MDAG was to provide the Department of Health with assurance in respect of the effectiveness of responses to both '*A Way to Go*' and the December 2018 Departmental public commitment to resettlement. The first meeting of MDAG occurred on 30 August 2019. Consequently, MDAG material also bears on the issue of how recommendations were addressed.

222. MDAG was chaired jointly by the Department of Health's Chief Social Worker and Chief Nursing Officer. Its membership included representatives from each of the five HSC Trusts, the RQIA, the PHA, the HSCB and representatives from the families of affected patients. The Belfast Trust was initially represented at MDAG by the Director of Nursing and the then Director of Adult Social and Primary Care, and the Belfast Trust's Carers Consultant. Two carers were also invited to attend MDAG to represent patients and families.

223. MDAG published an action plan entitled "Muckamore Abbey Hospital HSC Action Plan". The action plan became a live document, being continually updated both with additional actions and progress. The plan outlined the measures to be taken by key stakeholders in the HSC system to address the issues raised in the Level 3 SAI report against a timeline for implementation. An example of the MAH HSC action plan can be found behind Tab 5 in the exhibit bundle. The progress and timeline in respect of the measures set out in the MAH HSC Action Plan were then monitored by MDAG.

224. The work of MDAG was complimented within the Belfast Trust by the work of the Directors Oversight Senior Co-Ordination Group. One of the purposes of this group was to identify the key work streams required to ensure that all of the

actions arising from the Level 3 SAI review of safeguarding at MAH, and the commitments to families, as publicly expressed by the Permanent Secretary of the Department of Health on the 17 December 2019, were, as far as the Belfast Trust could do so, delivered. The key work streams included "v. Implementation of SAI recommendations" and "vi. External Assurance Reports".

225. As mentioned above, on 5 September 2019 Dr Margaret Flynn attended the Belfast Trust Board meeting at Belfast City Hospital. Also in attendance at the board meeting were Mr Pat McDonald and Mr Aidan Hanna from NI Patient Voices. The Belfast Trust Board meeting minutes, which are exhibited behind Tab 5 in the exhibit bundle, contain an update from the Director of Nursing and the then Director of Adult Social and Primary Care on progress to that point, followed by a presentation by Dr Flynn.

226. The above two directors provided the Trust Board with the following updates:

a. Ongoing dialogue with the RQIA in response to the 2019 Improvement notices.

b. Introduction of a new multi-disciplinary communication (known as PIpA - Purposeful In-Patient Admission Appraisal), daily safety briefings and regular leadership walk-rounds.

c. Individual 7-day activity plans for all patients, and a program of social events involving patient families.

d. Weekly governance meetings, supported by a weekly safety report (also known as the SITREP report).

e. The appointment of a Carers' Consultant, focused on communication and building trust with patient's families.

f. The attendance and work of a team from the East London NHS Foundation Trust as a critical friend.

g. A proposed staffing model had been shared with colleagues in the PHA and Department of Health; in the interim the Belfast Trust had revised the skill mix of nursing staff in MAH. A regional workshop was planned to further revise the workforce model.

227. Dr Flynn then addressed the Trust Board, including her views:

a. That for too many years MAH has not been centre-stage in the deliberations of the Legislative Assembly, the DoH, HSCB, RQIA or Trusts. Dr Flynn emphasised that the case for major change must include all, from the Legislative Assembly downwards.

b. The disproportionate reporting to PSNI was the direct consequence of the HSCB's regional adult safeguarding policy and procedures. The frequency of PSNI attendance was not the result of out-of-control criminality, it was the result of a rigid policy requiring staff to report everything.

c. Arising from meeting families in 2018, Dr Flynn spoke to the commitment and dedication of the families, and their loved one's admission to MAH being a major and distressing event.

d. Dr Flynn spoke of the destabilising effect that staff suspensions, disciplinary proceedings, RQIA Improvement Notices, monitoring of historical CCTV, and ongoing PSNI investigations, were having on staff morale and the ability to recruit into the workforce.

e. Dr Flynn advised she was disappointed to be advised that the number of MAH patients being discharged continued to be compromised by new admissions and re-admissions. It was noted that since March 2019 the number of patients has remained at around 60.

f. Dr Flynn advised that during her June 2019 re-visits she had attended ward reviews which were illuminating and upbeat. Dr Flynn explained that the MDT meetings included a range of professionals who were focused and receptive to challenge. Plans concerning discharge arrangements were discussed in relation to each patient.

g. Dr Flynn also noted the significant improvement since the previous year in MAH advancing patient interests and activities via activity plans.

h. Dr Flynn also described a sea change in communications with carers and observed a readiness in staff to make person to person contact with hospital managers.

i. Dr Flynn also described how hospital managers were striving to promote resettlement, maintain safe staffing levels, keep patients occupied and actively repair relationships with families, without promoting MAH as the default placement, which she observed is how it continues to be perceived by some commissioners. Dr Flynn commented that there was anxiety about the loss of MAH because of the limited provider portfolio in Northern Ireland.

j. Dr Flynn concluded by advising that a bold and well formulated regional effort is required. She said that it must be pursued with energy and persistence at all levels, by the Belfast Trust, by other Health Trusts, by providers, commissioners, families, and by the Department of Health.

228. As the then Belfast Trust Chief Executive, I was present at this Trust Board meeting and the minutes record that I commented that the issues raised by Dr Flynn were also being considered by the DoH Assurance Group (MDAG). I am recorded as reiterating that it was imperative MAH continued to provide safe, compassionate care for patients pending appropriate discharge arrangements and a regional view on the future of intellectual disability hospitals. I am also recorded as having advised that contingency plans were being drafted in the event the nursing workforce became unsustainable at MAH, but I emphasised that the overriding priority and preferred option was to stabilise the service in the interests of the patients.

229. One of the themes that ran through the reports of the Independent Assurance Team and the Level 3 SAI was in respect of communication with carers and families. The fact that the post of "Carer's Consultant" had been created has already been mentioned above.

230. Newsletters were also written to update carers and families of the action that was being taken in MAH and the activities that their loved ones had been involved in. A sample of these newsletters have been provided behind Tab 5 of the exhibit bundle. We know from this material that a 10-point Communication Plan was developed by families working together with staff to be used for improvement actions on each ward. Feedback boxes were also installed in all wards, Moyola Day Service, Cosy Corner and the swimming pool building to allow families to give feedback after each visit with their relative.

231. The newsletters also advertised the dates for future meetings and opportunities for families to be involved and have their say in the work of MAH. For example, upcoming meetings of the Parents and Friends of MAH were advertised in the newsletter.

232. The newsletter also took the opportunity to introduce new postholders in Senior positions. For example, the October 2019 edition introduced, amongst others, the new Senior Improvement Manager for Hospital Services and the new GP.

233. Additionally, a Carer's Forum was established and was co-chaired by a family representative. The purpose of the forum was to include families in any new developments of services and allow families to make suggestions. The existence of the group and dates for upcoming meetings were advertised in the newsletter as well. In October 2019 the newsletter also explained the establishment of the Belfast Learning Disabilities Services Forum and the proposed structure that it would take. These meetings provided an opportunity for families to understand more about processes within MAH. For example, on 3 June 2019, H225, the then Clinical Director, attended the Forum and shared the improvements within the new PIpA pilot which was in place at Cranfield 1 at the time. H306 also took those in attendance through proposals for outdoor gym equipment, and H112 gave an overview of the Regional Project in Learning Disability Services.

234. The input that families could have appears to have been fully embraced, including, for example, having a family member and carer take part in the training of the new staff for the new Cherryhill facility. This gave staff insight from a family perspective. Mixing between staff and family members was also promoted by the organisation of social events such as a Celebration Day on 14 June 2019 where staff, patients and families attended a celebratory barbecue with food from a variety of cultures for everyone to enjoy together.

235. In a further attempt to improve communications with families and carers in MAH, a series of Communication meetings with families were held during the last week of September 2019 to reassure families that care in the hospital was safe and

that no decisions on the future of MAH would be taken without consultation with families.

Topic 5 – August 2019 report "Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust"

236. In the Spring of 2019, following the receipt of the Level 3 SAI report, the then Belfast Trust Medical Director and Deputy Chief Executive, Dr Jack, contacted the Chief Executive of the East London NHS Foundation Trust (ELFT) for support and advice in trying to tackle the problems that had arisen in MAH.

237. At that point in time, there were still 64 patients in MAH, with 46% of them being delayed discharges.

238. In August 2019 ELFT provided a 24-page report summarising its work over the previous months and making recommendations. The ELFT report was entitled "Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust". A copy of the report can be found behind Tab 6 in the exhibit bundle.

239. The areas that were to be examined by ELFT during its 2019 work are set out on internal page 4 of the report:

1. Addressing restrictive practices. This would include reviewing policy and practice in relation to seclusion and physical intervention, including appropriate metrics.

2. The development of robust community services. This would include home treatment, crisis services and long-term living arrangements. It would also include joint working with adult mental health services.

3. Provider development. Aspects to address included training to providers, models of working together, and models of commissioning and governance.

240. A 5-person team visited MAH in June 2019, having reviewed various documents that are listed on internal page 5 of the report.

241. The ELFT did find many examples of good practice at MAH. It said so in its Executive Summary on internal page 1, and then gave more detailed examples in each of the specific areas examined (see internal pages 6, 10 and 16).

242. The ELFT made 9 "key recommendations" which were set out in the Executive Summary to the report on internal pages 1 and 2. They were:

a. Develop a national service model for people with learning disabilities, which, it suggested, could be informed by the NHS England (2015) national model.

b. Develop robust and responsive multi-disciplinary community services to mitigate reliance on inpatient services.

c. Develop joint strategic health and social care commissioning policy.

d. Increase the accountability of providers supporting people with a learning disability with complex behaviours.

e. Specialist admissions due to complex/challenging behaviours should be a last resort and only agreed by an admissions panel.

f. Enable services to mainstream service provisions such as crisis teams or inpatients services if risks warrant this.

g. Review the Mental Health Order (1986) Code of Practice

h. Adopt a systematic approach to reducing restrictive practises, this could focus on improving training and development, clinical governance and policies and explicit use of quality improvement technology.

i. Visit other services to share ideas and see practice in action.

243. It will be evident from the above, that many of the key recommendations were at a more regional level, and not matters the Belfast Trust could implement or implement alone.

244. The Recommendations section of the report itself (internal pages 18 to 21) contained 8 detailed recommendations. They are set out below:

Recommendations

Community teams need to robustly challenge care and rationale for inpatient stay in hospital and facilitate discharge

An initiative developed by the Department of Health in England as part of reducing dependence on admission to hospital and facilitate faster discharges is the Care and Treatment Review (CTR). The panel consist of an independent expert clinician, an expert by experience (often a carer or parent of a person with a learning disability), and is led by the local LD health commissioner. See Care and Treatment Reviews (CTRs): Policy and Guidance (NHS England, 2017) for more information on how these meetings can be arranged, led and implemented.

These meetings can be used both when admission to a specialist hospital is being considered, and can be very effective in thinking about and getting sign up to alternatives to admission. They are also used to facilitate discharge from hospital, again

by bringing an external perspective to thinking about community support, and ensuring resources are forthcoming.

Implement risk of admission registers, flag up risks with commissions including complex case review systems

Those who may be at risk of admission should be flagged up within community LD services and added to a 'RAG' rated at-risk register (see NHS England, 2017). In England, these risk registers are the responsibility of the health commissioners but usually delegated to community learning disability teams to maintain. The risk register should be reviewed at least weekly both by the multidisciplinary community learning disability team and learning disability commissioners. Those at high risk of admission can then be considered for a CTR, involving commissioners, experts by experience and independent clinicians.

Those who have complex needs and risks associated with their presentations can benefit from regular multidisciplinary input and discussion. Therefore, establishing weekly complex case risk discussion at community learning disability team meetings can be helpful especially for enhancing responsiveness, enabling early intervention and accessing more resources. Discussions should also involve providers and families as appropriate.

Invest in co-working and improving relationships with mainstream services

Community Learning Disability teams should consider working jointly with mainstream services (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013;. NHS England, October 2015b). Such working is described in detail in the Royal College of Psychiatrists report Enabling people with mild intellectual disability and mental health problems to access healthcare services (2012).

Examples of such working are given in the Winterbourne View Review Good Practice Examples (Department of Health, 2012, see page 54 for Tower Hamlets example), and an example protocol that we use in East London Foundation Trust (ELFT) (Working together in Adult Mental Health and Learning Disabilities Services in East London). This is primarily for people with a mild to moderate learning disability experiencing the onset of a mental illness, or a relapse.

This working together should include access to crisis teams to help prevent admissions. If an admission is needed (for example, due to severity of the relapse and associated risks), then admission to mainstream mental health units should be considered. For this model to work effectively, community LD teams need to proactively co-work with inpatient teams and prioritise such cases. For example, the community psychiatrist, community learning disability clinicians and social workers should be flexible in order can attend ward rounds, and support the inpatient team in making reasonable adjustments and developing their skills in supporting people with a learning disability, as well as actively planning the discharge from the outset. We learned that the BSCHT mainstream mental health units utilise a structured discharge planning model at point of admission, known as Purposeful Inpatient Admission (PIpA), which has been shown to reduce the length of stay in hospital, and which would seem to provide a good structure for the Community LD services to proactively participate in.

Continuous professional development and share good practice

We have found it highly beneficial to share good practice and learn from other learning disability health and social care teams. To share learning and good practice we would be very pleased to welcome BSHCT learning disability services to visit LD services in London. Additionally, we would emphasise the importance of each trust developing regular regional/cross trust MDT training, learning and development programmes.

Improve relationships with commissioners and understanding local population needs

Building good relationships with those who commission learning disability services ensures better, more person centred services. In turn, this leads to improved health outcomes and reduction in unnecessary admissions to hospitals. It is important that commissioners are well informed about the needs of people with a learning disability, by working in partnership with the community LD services, service users, and families. Therefore, we recommend developing a joint health and social care commissioning strategy tailored to local population needs. Good strategic commissioning can help people be healthier, more connected and more in control. There have been a number of reports detailing on what good commissioning should look like for people with a learning disability. These reports are listed in the reference section with the relevant links (NHS England, October 2015a; Joint Commissioning Panel for Mental Health,

2013; Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists, 2007; and Royal College of Psychiatrists & British Psychological Society, 2016).

During our visit to it was very evident that community services are keen to develop further local community options from other providers. The Belfast Health and Social Care Trust seem to have some delegated commissioning responsibilities, which means they not only commission some local services but are also then involved in directly supporting these services as a community specialist service to deliver a quality service. The commissioning and provider relationships in England are very separate with clear boundaries and roles and responsibilities to hold local services to account through a framework. Further details of how local services are commissioned were requested by the Belfast Trust and this is certainly an area we can provide further information from links with our local commissioners, in addition to the national documents cited above.

Develop learning disability liaison services

A recent Confidential inquiry into the premature deaths of people with a learning disability (Heslop et al, 2013) recommended that all hospitals should have learning disability liaison nurses in acute settings. These nurses can provide necessary links between acute services, community services and providers, as well as a critical role in advocating for a person with learning disability and ensuring reasonable adjustments are being met. This can go a long way to preventing challenging behaviour in acute settings. Learning disability liaison nurses may also provide a pivotal role in MHO assessments, especially where the GP and ASW may lack appropriate expertise.

Improving quality of care by measuring meaningful outcomes for people with a learning disability

High quality care is a high priority for all health services, not just learning disability services. In Northern Ireland, health services are regulated by RQIA. We would recommend implementing national quality standards specific to learning disability (Commissioning for Quality and Innovation, CQUINS) and developing local key performance indications (KPIs). CQUINs and KPIs are systems that make a proportion of health providers income conditional on meeting a set of standards and can help ensuring quality of care. Different outcome measures should be used by both inpatient and community provisions. In England, many services have incorporated the Friends

and Family test which can be made accessible for those with learning disabilities (NHS England, March 2015). Involving people with a learning disability in inspection processes is currently being trialled in England. This is known as the NHS England Learning Disability Quality Checker programme. Further details of the Quality Checker programme can be found in the Friends and Family Test guidance (NHS England, March 2015)

Develop a National LD Service Model

The recent Winterbourne abuse scandal in England identified the need to have a national, joined up approached to care in order to reduce reliance on inpatient settings and protracted hospital stays. We would strongly recommend the development of a national service model in Northern Ireland. The national model in England is call Building the Right Support (NHS England October 2015b). It was developed with the help of people with lived experience, clinicians, providers and commissioners. It is a person centred and holistic model, and in our opinion is appropriate for all people with learning disability. Implementation of the model, by fully addressing people's needs in the first place, can go a long way to preventing challenging behaviour and mental health problems developing.

245. At the meeting of Trust Board on the 5 September 2019, referred to above in the context of the Flynn revisit, the Trust Board was advised of the ongoing action following both the ELFT report and Dr Flynn's re-visit. This included the developments outlined above, and confirmation the Belfast Trust was continuing its work to revise the seclusion policy. The minutes indicate that at that time, the Belfast Trust was considering the seclusion policy used by the Mersey Care Health Trust, as recommended by ELFT. Mersey Care Health Trust's policy had been recommended as the model of best practice. It is also noted in this meeting that the use of seclusion had already reduced significantly at MAH.

246. By September 2019:

a. A Service Framework for Learning Disability was available and was being updated and informed by a Regional Review.

b. The Mental Health (Northern Ireland) Order 1986 ("MHO") had also been reviewed in relation to the involvement that psychiatrists were to have in the community MHO assessment, with the conclusion that the law in Northern Ireland specifically does not involve psychiatrists in the community MHO assessment, but GPs and ASW can be consulted during the assessment.

c. To improve co-working and relationships with mainstream services the Belfast Trust had also progressed some joint working with Adult Mental Health in the form of inter trust meetings with Adult Mental Health Services, although this had not yet become a formalised arrangement. One set of minutes has been included behind Tab 6 of the exhibit bundle by way of example.

d. The CTR was being examined and blue light meetings had been introduced.

e. A Draft Policy had been created entitled "Adult Learning Disability Admission and Discharge Policy", a copy of which has been enclosed behind Tab 6 of the exhibit bundle.

f. Staff from Learning Disability Services were partaking in visits to other services to share ideas and see practice in other services in action.

g. Mandatory training in the use of Seclusion and the carrying out of observations was in progress.

h. Seclusion records were being embedded into PARIS.

i. The recommendation that the room used for seclusion was specifically designated and used for no other purpose or function than seclusion had been incorporated into the draft seclusion policy and training.

247. At the October 2019 Trust Board meeting discussion then moved to consideration of the Belfast Trust conducting a leadership and governance review, which is addressed further below.

Topic 6 – July 2020 report from the Muckamore Abbey Hospital Review Team (sponsored by HSCB/PHA) entitled "A Review of Leadership and Governance at Muckamore Abbey Hospital".

248. Following its establishment by the HSCB and PHA at the direction of the DoH, in February 2020 the Muckamore Abbey Hospital Review Team commenced its work. On 31 July 2020 it published its report entitled "A Review of Leadership and Governance at Muckamore Abbey Hospital" (the "2020 Leadership and Governance Report"). The report itself is 166 pages long, with 8 appendices that run from internal page 167 to 207. A copy of the report can be found behind Tab 7 in the exhibit bundle.

249. This work was conducted during the global COVID-19 pandemic.

250. Whilst this review into questions of leadership and governance was commissioned by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) at the request of the Department of Health, the Belfast Trust had itself commenced work in late 2018 with the intention of having a leadership and governance review conducted. Draft terms of reference had been prepared, but ultimately the Belfast Trust determined that the review would be better dealt with by the Department of Health and the matter was referred to it.

251. The Muckamore Abbey Hospital Review Team's Terms of Reference are 6 pages long. They are entitled "Review of Leadership and Governance at Muckamore Abbey Hospital". They are very detailed. A copy can be found at Appendix 1 to the 2020 Leadership and Governance Report from internal pages 167 to 172. The time period specified in the Terms of Reference related to the period 2012 to 2017.

252. The themes to be addressed included:

a. Strategic leadership

b. Operational management

c. Professional/clinical leadership

d. Governance;

e. Accountability

f. Hospital culture and informal leadership

g. Support to families and carers.

253. Ultimately, as per internal page 171 of the 2020 Leadership and Governance Report, the review team were to produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group (MDAG). The recommendations were to relate to the implementation of a governance and assurance framework for MAH & Belfast Trust, other Trusts with Learning Disability Hospitals and wider mental health and learning disability services.

254. The Review team consisted of 3 members, assisted by a Project Manager. The 3 panel members were:

a. David Bingham – who had retired in March 2016 as Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland.

b. Maura Devlin – registered Nurse and member of the Northern Ireland Nursing and Midwifery Council. A retired former assistant Director

from health and social care, and retired Director of Nursing and Midwifery Education in the Clinical Education Centre; and

c. Marion Reynolds MBE – independent Social Worker with prior experience in management, inspection, and commissioning of strategic services, including chairing the Board Area Child Protection Committee.

255. The methodology adopted by the review included visiting MAH, engaging with the Belfast Trust, HSCB, PHA, RQIA, families and carers, advocacy services, the Patient and Client Council, other HSC Trusts and the PSNI. The review team met with senior staff from each of these organisations. A full list of all meetings held with key personnel can be found in Appendix 4 of the 2020 Leadership and Governance Report at internal page 187.

256. The Belfast Trust provided a range of documentation to the review. This included policies, organisation charts, minutes of management, directorate, and board level meetings. A detailed list of documentation reviewed by the team can be found in Appendix 3 of the 2020 Leadership and Governance Report at internal page 183. The review team attended the meeting of the Muckamore Abbey Departmental Advisory Group (MDAG) that was held in MAH in March 2020.

257. From March 2020 the review process was inevitably impacted by the global coronavirus pandemic. This led to a short delay in publication of its report. The original agreed target date for the full report was 30 June 2020. Originally an interim report was intended to be published by 30 April 2020. However, the interim report stage did not occur.

258. The Belfast Trust did not receive a draft report prior to publication. The Belfast Trust was also not invited to engage in a factual accuracy check of the 2020

Leadership and Governance Report before publication. On 5 August 2020 the 2020 Leadership and Governance Report was published.

259. Overall, the review team concluded the Belfast Trust had adequate governance and leadership arrangements in place, but that these arrangements were not appropriately implemented at various levels within the organisation (see paragraph 14 of the Executive Summary). The review team also concluded that the failure to implement appropriate governance resulted in harm to patients. The review team did conclude that senior managers in MAH may not have been aware of what the review team termed "…*the culture of abuse*..." (see paragraph 14, internal page 8 of the Review), but that did not alter their responsibility for providing safe and compassionate care at MAH.

260. The review team did acknowledge efforts made by the Belfast Trust to promote and monitor a safe environment at MAH.

261. From internal page 163, having set out a series of conclusions between internal pages 157 and 163, the review made 12 recommendations; three recommendations each to the Department and the HSC Board/PHA, and six to the Belfast Trust. It was noted that the recommendations took account of improvements already implemented by the Belfast Trust.

262. The recommendations from the 2020 Leadership and Governance Review were as follows:

Department of Health

i. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

ii. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

iii. The Department of Health, in collaboration with patients, relatives and carers, and the HSC family, should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.

The HSC Board/PHA

i. The HSC Board/PHA should ensure that any breach of requirements brought to its attention has, in the first instance, been brought to the attention of the Trust Board.

ii. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

iii. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

i. The Trust should consider immediate action to implement disciplinary action where appropriate on suspended staff to protect the public purse.

ii. The Trust has instigated a significant number of managerial arrangements at MAH following the events from August 2017. It is

recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.

iii. Advocacy services at MAH should be reviewed and developed to ensure that are capable of providing robust challenge function for all patients and support for their relatives and/or carers.

iv. The complaint of GB of 30 August 2017 should be brought to a conclusion by the Trust's complaints department.

v. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

vi. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

263. For context, although it may now seem like a very long time ago, in the Spring and Summer of 2020 the impact of the global COVID-19 pandemic was being felt across the world. It was the time of "lockdowns". The COVID-19 pandemic had a very significant impact on the functioning of health trusts. In particular, it had a very significant impact on the Belfast Trust, which was providing the regional "nightingale" facility and had to stop a considerable amount of regional as well as local medical treatment. What occurred had a hugely detrimental impact on the staff of the Belfast Trust.

264. Following the publication of the 2020 Leadership and Governance Review Report on 5 August 2020, Dr Cathy Jack, who had taken up the role of Chief Executive of Belfast Trust in January 2020, issued a public statement in response:

"*On behalf of the Belfast Trust I welcome the publication of this review and I apologise unreservedly to those patients and their families who have been failed*

by this Trust. It is clear there were serious failings in leadership and ineffective escalation of serious matters at Muckamore despite appropriate governance structures. This contributed to an environment which enabled the serious maltreatment of vulnerable people to go unnoticed for so long. This is a matter of profound regret for that I am deeply sorry."

"…since the maltreatment of patients has come to light significant lessons have already been learned and many improvements have been put in place to protect against this happening again…Belfast Trust welcomes the publication of this review and we will give it careful and detailed consideration."

265. Following receipt of the final report the Chairman of the Belfast Trust and the Chief Executive convened a "Leadership and Governance Review Meeting" to consider the issues that needed to be dealt with following the report. It first met on 19 August 2020 via MS Teams. I understand that minutes from all of these meetings will be disclosed to the MAH Inquiry as part of the disclosure process.

266. These meetings were chaired by Dr Jack, as Chief Executive, and included the then Chairman of the Trust Board, Mr Peter McNaney, along with senior staff from the Belfast Trust.

267. As indicated in the material, one of the steps taken upon receipt of the 2020 Leadership and Governance Review involved senior staff considering their own positions, including in respect of their relevant regulators.

268. The Leadership and Governance Review Meeting put in train a "factual accuracy" checking process in respect of the 2020 Leadership and Governance Review Report. That process was managed by Ms Traub, Interim Director for Learning Disability Services, Adult Community and Older Peoples Services. All of the material arising from that process will be disclosed to the MAH Inquiry through the ongoing disclosure process. This includes a 39-page summary table

that resulted from the process, and which records what various individuals had to say about the content of the report.

269. As set out above, the 2020 Leadership and Governance Review Report made six recommendations that were directly relevant to the Belfast Trust. These were allocated for action during the meeting, as follows:

i. Ms Kennedy took lead responsibility for recommendation one, regarding disciplinary matters. This was to include advising PSNI of the Belfast Trust's intention to proceed with its own disciplinary process without delay.

ii. Ms Traub took lead responsibility for sustaining existing managerial changes.

iii. Ms Traub took lead responsibility for reviewing the provision of advocacy services in MAH (Ms Traub commissioned an independent review of advocacy services. The draft February 2023 report from Marie Roulston and Bria Mongan can be found behind tab 7 in the exhibit bundle).

iv. Ms Traub took lead responsibility for bringing Mr GB's complaint to a conclusion.

v. Ms Traub took lead responsibility for proactive use of CCTV for training and best practice developments.

vi. An exceptional Trust Board workshop was convened for September 2020 to discuss the issues.

270. The Leadership and Governance Review Meeting discussed the preparation of a business case to secure a dedicated resource for managing issues on foot of the report. There was also consideration of having some form of further independent scrutiny of the Belfast Trust in response to the report. Mr McNaney also indicated that he wanted to see a wider review of practices in areas where the Belfast Trust cared for particularly vulnerable clients and this should be escalated to Trust Board level. The MAH Leadership and Governance Review meeting reported regularly to MDAG, updating on progress.

271. It was also the case that MDAG intended to itself monitor the implementation of the recommendations from the Leadership and Governance Review Report. In the MDAG minutes of 2 September 2020, at item 5, it was confirmed that the recommendations would be added to the current HSC action plan. By way of example, in April 2021 MDAG produced a report setting out progress in respect of the MAH HSC Action Plan. The report, entitled "MAH HSC Action Plan Report" detailed that of the 53 actions required, 21 were completed, 18 were in progress and 15 required progression. A copy of the MAH HSC Action Plan is at Tab 7 of the bundle.

272. The MAH Leadership and Governance Review meeting group convened at least a further five times over the next eighteen months, notwithstanding the extraordinary events taking place and acutely felt within the Belfast Trust; on 27 November 2020, 22 April 2021, 19 July 2021, 30 November 2021 and 24 January 2022. The group monitored progress in line with the action plan. The group was disbanded into the newly establish Inquiry Oversight Group in January 2022.

273. An Extraordinary Trust Board meeting was convened on 21 September 2020 via Microsoft Teams. It concentrated on MAH and the various steps that had been and were to be taken. The minutes of all relevant meetings will be provided to the MAH Inquiry through the ongoing disclosure process.

274. Throughout the remainder of 2020 and into 2021 service provision and progress in MAH continued to remain on the monthly Trust Board agenda. Reports continued to be shared with MDAG and the MAH HSC Action plan updated with progress by Ms Traub, until her departure from post in August 2021.

275. MDAG also produced a monthly highlight report, an example of a copy from February 2021 is available at Tab 7 of the bundle. This report addressed safeguarding, family liaison, workforce stabilisation, resettlement and progress against the measures outlined in the action plan.

Topic 7 – "What is different now?" (2021)

276. Further to a question posed by the then Chairman of Trust Board, Mr McNaney, Ms Traub prepared a report dated 4 March 2021 entitled "*What is different now?*" A copy can be found behind Tab 8 in the exhibit bundle. In respect of the report, Ms Traub had input from Ms Diffin, then Executive Director of Social Work; Mr Hagan, Medical Director; and Ms Creaney, Executive Director of Nursing.

277. The *"What is different now?"* report was provided to Trust Board in April 2021. The report endeavours to summarise how care and services were provided at MAH and how that had changed since the 2017 allegations.

278. Following circulation of this report a Stakeholder Summit was convened at MAH by the Belfast Trust on 29 April 2021. This was to seek a collective approach to addressing risks in MAH. Dr Jack opened this workshop, which was attended by Belfast Trust Directors, RQIA, Department of Health, PHA, HSCB and representatives from fellow health and social care trusts. Both a presentation from this workshop and the minutes are behind Tab 8 of the exhibit bundle. It is recorded in the minutes that Dr Jack opened the workshop by explaining; there were 42 patients still resident in MAH, 4 patients were on trial settlement, with one patient actively receiving treatment for mental health. *"I, as Chief Executive, want*

and need to ensure that the Trust is doing all it should and could to provide safe and compassionate care within the resources we have available to us. The stark reality is that we are providing treatment to only one patient in the hospital which means we have 41 patients who are being cared for in the wrong place and by the wrong team – that is our biggest risk – we need to resettle our patients for their betterment."

279. The minutes of the April 2021 workshop were circulated by Ms Traub immediately after the workshop and confirmed as accurate by attendees.

280. On 6 December 2021 Mr Richard Pengelly wrote to Dr Jack expressing his "*…growing concern about the high level of risk associated with the ongoing operation of Muckamore Abbey Hospital. This coupled with the failure to develop a robust and workable regional contingency plan, should Muckamore no longer be considered a safe environment for patient care, means that I am not satisfied that, in my role as Chief Executive of the HSC I can provide the Minister with the necessary assurance he needs over the operation of the hospital."* Mr Pengelly then requests an urgent meeting with Dr Jack. A copy of the 6 December 2021 letter, and Dr Jack's initial 10 December 2021 response, can be found behind Tab 8 in the exhibit bundle.

281. Dr Jack wrote again to Mr Pengelly on 20 December 2021 providing updates and progress against the MAH HSC Action Plan, including the Leadership and Governance Review recommendations and enclosing an extract from the report "*What is different now?"* A copy of the 20 December 2021 letter can be found behind Tab 8 in the exhibit bundle.

Topic 8 – Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (2022)

282. In July 2022 the "Independent Review of the Learning Disability Resettlement Programme in Northern Ireland" was published. It is 117 pages long. The report can be found at Tab 9 in the bundle.

283. The report was commissioned in 2021 by the then Health and Social Care Board (HSCB). The review was undertaken by two experienced leaders in health and social care who were asked to focus on resettlement in Northern Ireland, with a particular focus on MAH.

284. The report authors were Bria Mongan and Ian Sutherland. Bria Mongan has a background in social work. Prior to retirement Bria was the Executive Director of Social Work and Director of Children's Services in Southeastern Health and Social Care Trust (SEHSCT). Ian Sutherland has a background in both psychology and social work. He has worked in a range of roles across both England and Northern Ireland. Most recently he was Director of Adult and Children Services in Medway Local Authority, England.

285. Work commenced on this review in November 2021. The purpose of the review was to help strengthen the existing oversight arrangements for the resettlement of long-stay patients in learning disability hospitals whose discharge plans were delayed.

286. The authors stated that leadership and governance regarding the resettlement programme in Northern Ireland was less than adequate (internal page 3 at paragraph 1.4). This was said to be compounded by significant organisational restructuring; with the HSCB regional commissioning functions transitioning back into the Department of Health under the Strategic Planning and Performance Group (with effect from 01 April 2022). The disruption caused by the pandemic was also noted. The complete terms of reference can be found within the report at subsection two, internal page 8.

287. The report identified that in the twelve-month period from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%. The trajectory for future resettlements by NHSCT and SEHSCT indicates, from

September 2022 to March 2023, that the population will reduce by approximately a further 50%, leaving around 19 people in MAH awaiting resettlement (internal page 5 at 1.7).

288. It was reported that the Belfast Trust had been scoping three new potential schemes over the preceding three years, "…*but these have never got beyond the most preliminary stages of planning.*" The report observed variations in resettlement progress across the separate health and social care trusts. The report advised that, in the authors opinion, both NHSCT and SEHSCT have demonstrated "…*a more proactive and consistent approach to planning of this provision*." (Internal page 6 at paragraph 1.10).

289. It is noted the families of patients continued to have an abiding concern, which was said to be overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. However, the report also advised that the oversight of adult safeguarding had recently been strengthened with an Interim Adult Protection Board established in 2021 (internal page 6 at paragraph 1.11).

290. The review made 25 recommendations, four specifically for the Department of Health, six to the SPPG, two jointly for the SPPG and HSC Trusts and the remaining 13 for all Health and Social Care Trusts. The recommendations were not specific to the Belfast Trust. The recommendations can be found at section 12 within the report, at internal page 113. The recommendations include:

i. The Department of Health should produce an overarching strategy for learning disability services and develop a shared workforce strategy.

ii. In the context of the above strategy, the SPPG should develop a commissioning plan for the development of services going

forward. This should include a regional Oversight Board for resettlement.

iii. The SPPG should strengthen performance management across the HSC system, moving away from performance monitoring.

iv. The SPPG and Northern Ireland Housing Executive should undertake a joint strategic needs assessment of future accommodation needs.

v. The SPPG and commissioners within health and social care should convene a summit to generate an agreed explicit project plan for regional resettlement.

vi. Trust Boards should strengthen oversight and scrutiny of plans relation to resettlement.

vii. Trust Boards should urgently collaborate with stakeholders to agree a regional pathway to support future resettlement/transition planning.

viii. All of the above needs to place patients, families and carers at the centre of these recommendations.

291. The recommendations highlighted that the resettlement services for patients with learning disabilities require a regional response, with strong strategic direction and oversight from the Department of Health, through all sectors, engaging all stakeholders and with all 5 regional Health and Social Care Trusts across Northern Ireland.

292. Unfortunately, in the time available, it has not been possible for me to collate and speak to the Belfast Trust's response to the recommendations in the July 2022 report. Whilst it is outside the primary time period of the Terms of Reference of the MAH Inquiry, I know that the Belfast Trust will want to explain what it has done, and where there may be any misunderstandings in the report itself.

Conclusion

293. I hope that what I have been in a position to say, and the material I have been able to exhibit to this statement, will assist the MAH Inquiry with its information gathering exercise. The Belfast Trust will continue to assimilate material relating to these issues, and will want to provide a more comprehensive account to the MAH Inquiry about what occurred, particularly in the post 2017 period, than it has been possible for me to do in this statement.

Declaration of Truth

294. The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which, collectively, the contributors to this statement believe are necessary to address the matters on which the MAHI Panel has requested the Belfast Trust to give evidence.

Signed: Martin Dillon

Dated: 26 April 2023

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