MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Margaret Flynn
Date: May 2023

I, Margaret Flynn, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry (the Inquiry).

The statement is made by me in response to a request for evidence by the Inquiry Panel. This is my second statement to the Inquiry.

In exhibiting any documents, I will use my initials "MF".

1. Module 6(c) will address the report of 'A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go', published in November 2018.

2. I was Chair of the Review Team whose work culminated in the Report. My oral evidence to the Inquiry is scheduled for Thursday 25 May 2023.

3. The MAH Inquiry has provided me with an extract from the minutes of a meeting of the Belfast Health and Social Care Trust Board held on 05 September 2019. The extract is the note of an oral report that I gave to the Board at the meeting. I refer to a copy of the extract that I have exhibited at MF/2. I confirm that I will be in a position to speak about the issues that I addressed in my oral report to the Board.

Section 7: Declaration of Truth

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

Signed: Margaret C. Stern

Date: 24 May 2023

List of Exhibits (Margaret Flynn)

MF/2 Extract from Minutes of the Trust Board Meeting Held on 05 September 2019.

Belfast Health and Social Care Trust
caring supporting improving together

Minutes of the Trust Board Meeting
Held on 05 September 2019 at 11.00 am
in the Boardroom, Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director - Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Greaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director of Finance

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Charlene Stoops	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Brenagh Dalzell	Head of Communications
Mrs Orla Barron	Equality Lead and Corporate Planning
Dr Margaret Flynn	Chair, SAi Panel, Muckamore Abbey Hospital

Apologies

Dr Patrick Loughran	Non-Executive Director
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development

Mr McNaney welcomed everyone to the meeting, particularly Mr Aidan Hanna and Mr Pat McDonald, NI Patient Voices, who had requested and been, granted Speaking Rights in respect of Muckamore Abbey Hospital.

- **Dr Margaret Flynn, Chair SAi Panel**

Mr McNaney invited Dr Flynn, Chair of SAi Panel to report on her recent review visit to MAH and to update the Trust Board on changes since the SAi review.

Dr Flynn then addressed the Board and stated she wanted to be candid in highlighting a number of issues and take a broader systems view of some of the issues.

Dr Flynn quoted the MAH website which states: *There are a number of people living in hospital who do not need to be there. They are waiting for community living arrangements to be funded so that they can leave hospital.* She said this statement underlines a principal finding of the 2018 review concerning safeguarding at MAH, she emphasised safeguarding could not be seen in isolation since custom and practice are shaped by the Hospital's history and culture, by BHSCT and the histories and cultures of other Trusts, the DoH and the Legislative Assembly. MAH is an isolated hospital, which is disconnected from community services. It is based on an acute-care model that does not work for people with life-long support needs.

Dr Flynn stated that for too many years, MAH has not been center-stage in the deliberations of the Legislative Assembly, DoH, HSCB, RQIA, or Trusts. She emphasised the case for major change must include all, from the Legislative Assembly downwards (i.e. politicians, Trust directors, Board members and inspectors) and must engage with people with learning disabilities and their families if they are to address the absence of home-treatment, supported living and provider expertise. All of these are associated with crisis admissions, which should be time limited.

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

The PSNI is continuing their investigation and staff suspensions are the result of scrutiny of massive number of hours of CCTV films captured by 90 cameras.

In parts of the hospital, work practices in 2017 were harmful and disproportionate; for example, the intensive use of seclusion was not challenged. Dr Flynn pointed out that the low ratio of registered staff to patients was not a factor in those areas of the hospital where CCTV evidences patients being harmed.

Dr Flynn advised during December 2018 she had accompanied Mrs. Heaney to meetings with families to share copies of the SAi Review report she had chaired, following which she had shared the following observations with Mrs. Heaney:

- Some families revisited their experiences of caring for their daughters and sons before they were admitted to the MAH. Their accounts demonstrated their life-long commitment to their adult children, a deep desire to demonstrate their worth to others and a common singularity of purpose that they should not be harmed.
- Families shared the ways that they see their relatives and the ways in which they had negotiated their family lives. Their descriptions do not use the language of professional carers and are remote from the negative associations of "challenging behavior."
- Family routines involved parents dividing their time between their disabled adult children and their non-disabled children. Some explained that in the family home they were unable to eat together as a family or even be in the same room.
- Their loved ones admission to MAH was a major and distressing life event. It did not herald the end of family caring, but the beginning of very stressful times, as visits were not reassuring. Some envisaged entering into collaborative relationships with staff and sought to share their knowledge of their adult children, their biographies and preferences with ward managers and staff. This was not always valued. Although the families were keen to state that there are individual staff who "go the extra mile" and those who are "advocating strongly" on behalf of their relatives, they all acknowledged that their trust in professional managers and staff was eroded.
- The families described a range of scenarios, which they could not fathom. Decision-making appeared arbitrary and beyond negotiation. Some changes in their daughters and sons' lives were abrupt and promises concerning discharge placements were not realised.
- Increasing doses of patients' medication troubled families.
- The families' low expectations of MAH were realised. The efforts of "some brilliant staff' were overshadowed by the emergence of the CCTV footage and the PSNI investigation. The PSNI had visited most families and so some family members had seen images of their relatives being harmed.
- The families' aspirations are modest: "you have to take your moments - X has had a hard deal in life... to have a better life...to see X settled... to be able to visit and have dinner with **X...**the right people and the right environment, effective boundaries... supported by people who will treat them like family... a more hopeful future... "

Dr Flynn referred to the Permanent Secretary's statement "..... *action is urgently needed by the health and social care system as a whole.... no one should have to call Muckamore their home in future, when there are better options for their care....Muckamore will return to being a hospital providing*

acute care, and not simply a residential facility .... I fully recognise that the December 2019 deadline for the resettlement process will be challenging, but the Department owes it to patients and their families to be demanding ... / remain very concerned about the HSC system's cu"ent structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong."

Dr Flynn reflected on an evening meeting hosted by BHSCT in February 2019, following which Mrs. Aaroy, Carers' Coordinator circulated a note of the discussion to families. The note set out a checklist of what families expect, i.e.:

- evidence of "honesty" and "action"
- not leaving problems unattended and contacts initiated by families without a reply; and ensuring that the lessons identified feature in the Trust's staff and management training
- reiterating clearly to the hospital and Trusts responsible for placing people how vital it is to listen to people with learning disabilities and their relatives; and to engage in ways which are mutually respectful
- purposeful engagement with families
- the clear intention to cease placing people in seclusion
- "better options" for people currently stuck at the Hospital
- ensuring that every family has information about who to contact in the event of any questions, objections or doubts they have concerning the care, support and treatment of their relatives
- staff members being required to "declare" whether or not they are working with relatives, in-laws and partners because this should not happen
- staff supervised by managers who are demonstrably engaged, knowledgeable, competent and accountable
- relatives being and feeling welcomed [it was acknowledged that "This has happened... It has changed already"]; and being respected as knowledgeable advocates and leaders
- a drive to improve the quality of community-based service provision that is planned on the basis of accurate information about individuals as well as being responsive to people's care and support needs
- precise RQIA registration and inspections which ask searching questions; evidence of a greater readiness to de-register homes which are failing people with learning disabilities and/ or have no track record in using information from families and knowledgeable front-line staff to achieve valued outcomes; a professional and credible response from the regulator when families report distressing events
- being respectfully offered timely information, most particularly when measures need to be taken in uncertain situations e.g. media coverage of events concerning our relatives.

Dr Flynn referred to a Trust adult safeguarding event for staff she had participated in. The purpose hinged on safeguarding practice. "Loss of focus" was a recurring theme. It was recognised that dovetailing

safeguarding procedures with inspections, contract monitoring, Mental Capacity and other legislation, professional regulation, complaints, clinical governance, internal disciplinary arrangements and serious adverse incidents is a critical task for professional leaders across the region.

Dr Flynn outlined five levels and contexts of adult safeguarding - from the individual level the Commissioner of the service to the Legislative Assembly from attending to a person's immediate safety to regional policy to introduce legislation. It is clear that "safeguarding practice" alone cannot achieve these outcomes because the levels are interconnected.

Dr Flynn referred to the number of staff suspensions and disciplinary proceedings; the RQIA notices; monitoring of historical CCTV footage; drafting of a CCTV viewing policy; and the ongoing PSNI investigation. All of which had a destabilising impact on morale and the hospital's ability to recruit to the workforce. She said there was no sense that these interventions arose from a coherent, whole system approach where multiple organisations and agencies worked in a collective sense of responsibility to achieve the best possible outcomes for citizens with learning disabilities.

Dr Flynn advised she was disappointed to be advised that the numbers of **MHA** patients being discharged continued to be compromised by new admissions, including re-admissions. Since March 2019, the number of patients has remained at "around 60," irrespective of BHSCT's "statutory supported housing scheme" and plans to discharge almost 20 people.

Dr Flynn said that during her return visit in June she had attended ward reviews, which were illuminating and upbeat. The multi-disciplinary team ward processes provided information about patients over the preceding week. The MDT included nurses, day support staff, psychologists, psychiatrists and a pharmacist who were focused and receptive to challenge. Plans concerning discharge arrangements were discussed in relation to each patient.

Dr Flynn noted patient's interests and activities are being advanced via activity plans. This is a significant improvement since the previous year given that the lifestyles of many adults with learning disabilities resemble those of sedentary older people.

Dr Flynn stated there has been a sea change in communications with carers and an observed readiness to make person-to-person contact with the hospital's managers - which can only be enhanced by the new Carers' Forum, co-chaired by a relative. Families need the reassurance that the provision of supported housing is changing the lives of discharged patients.

Dr Flynn said if there is a regional commissioning model concerning the support of people with learning disabilities and autism over the life cycle, its priorities remain to be set out. Adults with autism appear to be

especially vulnerable to being overlooked since there are so few providers with expertise in delivering valued support in Northern Ireland. She referenced the MAH's website, which is a stark reminder that BHSCT cannot deliver community placements. Hospital managers are striving to promote resettlement, maintain safe staffing levels, keep patients occupied and active and repair relationships with families, without promoting the MAH as "the default placement" which, remarkably, is how it continues to be perceived by some commissioners.

Dr Flynn advised that in July 2019 she had been disappointed to learn the upbeat references to "collective commissioning" during 2018 and the importance of taking collective action had no impact on MAH or those who were being returned to MAH due to "failed" placements. Although the WHSCT and SHSCT have Assessment and Treatment Units, BHSCT, NHSCT and SEHSCT have relied heavily on access to MAH. Meetings with managers responsible for "procuring" community services in three HSC Trusts confirmed that work with the Learning Disability Forum, for example, does not connect with the "ad hoc" purchase of services. Some providers have increased fees by as much as 40%. This has not resulted in improved services. Closer notice needs to be paid to whether what is being commissioned is value for money. There is no consensus on the way forward with some investments taking months to expedite and there are issues when people move from one Trust to another regarding what services they can access.

Dr Flynn stated there is no procurement as such, with commissioners looking to providers to come up with solutions and options. There is anxiety about the loss of the MAH because of the limited provider portfolio in Northern Ireland.

Dr Flynn referred to the all-purpose services of "day centres", which are out of step with people's aspirations, with considerable resources in transporting people at the beginning and end of each weekday. Yet these are critically important for families of people who would struggle to manage in the absence of this form of support. She had spoken to Managers who were seeking a Departmental commitment to the outcome of the Regional Adult and Learning Model; clear pathways in and out of acute, specialist provision, security of tenure for people moving into supported accommodation, consequences for providers who take patients and then quickly return them to hospital, greater investment and flexibility from housing providers and he support of society in demonstrating collective responsibility to house people with learning disabilities within communities.

Dr Flynn pointed out that the Carers' Coordinator is attuned to the fragility of families, particularly those who were assured of placements, which did not materialise or were terminated within weeks. The investment in working with families is integral to developments at the hospital because their involvement is enduring and changing. Many spend a great deal of time visiting their relatives.

Dr Flynn referenced the RQIA IN issued in August concerning staffing and nurse provision, adult safeguarding and patients' finances. Alongside this the PSNI reported "1500 crimes" had been committed within the Psychiatric Intensive Care Unit with a Detective Chief Inspector was quoted as describing this as PSNI's "largest adult safeguarding case of its kind." The RQIA's actions and the PSNI claims have placed an unreasonable burden on patients, their families and staff. The Stephen Nolan show of 28 August devoted part of the morning programme to MAH specifically the "1500 potential crimes." He asked: "why did the Hospital install CCTV if it did not intend to use it immediately? Whose job was it to view the CCTV? Are people at the top of BHSCT still going to work? Is there any accountability?" Dr Flynn said it was important that peoples questions should answered.

In concluding her presentation, Dr Flynn made the following points:

- BHSCT should respond to the allegations made in the media, initially to the families of patients who remain in MAH and to those who have left during the last two years. It should be clear about the actions (i) it has taken (ii) the MAH has taken since the CCTV images were viewed. Openness about the actions taken are paramount
- Muckamore Abbey Hospital requires a redefined *Statement of* Purpose hinging on the assessment and treatment for people with teaming learning x disabilities and autism with mental health problems. It has never been a single-purpose Hospital providing acute care
- a closure date and programme leading to this for Muckamore Abbey Hospital remains to be set out It is essential that this decision involves people with learning disabilities and their families
- as an interim measure consideration should be given to NHSCT and SEHSCT being allocated their own acute care resources – separate buildings on the MAH site for which these Trusts have total responsibility in terms of admission and discharge, staffing and therapeutic input. This will "shadow" the creation of specialist, short term facilities within their own Trusts
- an acute care resource for the BHSCT should be in Belfast
- in the event of RQIA issuing further notices, the MAH should draft a Business Contingency Plan addressing (i) Hospital closure and (ii) transfer of responsibility for the MAH from the BHSCT
- A bold and well formulated regional effort is required. It must be pursed pursued x with energy and persistence at all levels, by Belfast Trust, by other Health Trusts. by providers, self-advocates, commissioners and families, by the DoH and society

Mr. McNaney thanked Dr Flynn for her very comprehensive feedback and agreed the importance of a regional agreement for a more appropriate care provision for people with complex learning disability needs.