ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Lynn Long
Date: 29 March 2024

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1. I, Lynn Long, make the following statement for the purpose of the Muckamore Abbey Hospital ("**MAH**") Inquiry.

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

3. This is my first statement to the Inquiry.

4. There are no documents produced with my statement.

Qualifications and positions

5. I am currently a Director within RQIA with responsibility for Mental Health, Learning Disability, Children's Services and Prison Healthcare.

6. I commenced my professional nursing career in 1992 having qualified as a mental health nurse. During my registered nurse training I was required to undertake placements in various service types including a period of time working with patients with a learning disability.

7. Between 1993 and 2005, I worked in the independent sector in various care homes for patients with dementia and other mental illness. I held various positions over this time period at the conclusion of which I was operating as a Registered Manager of a 52 bedded nursing home for patients with dementia.

8. From 2005 until 2009, I was a Care Manager with Mental Health Services for Older People in the South Eastern HSC (Health and Social Care) Trust. I had responsibility for a caseload of approx. 150 patients with mental health needs, some of whom were being cared for in their own homes, with a suitable package of care, and some who were placed in care homes.

9. In 2009, I joined RQIA as an inspector and I worked in the Nursing Homes team, as it was known at that time. In 2010, having been requested to do so as a result of my professional background and knowledge of regulation, I spent a brief period of time supporting colleagues in the Mental Health Directorate of RQIA to develop and operationalise their inspection methodology.

10. From 2011 until 2013 (March) I worked as an inspector in the Independent Health Care team. From March 2013 until April 2018, I worked as a Senior Inspector in RQIA's Independent Health Care Team.

11. From April 2018, I worked as an Assistant Director. This was initially for a period of acting up in the Residential Care Homes team under the former director Theresa Nixon and laterally as the Assistant Director (from December 2018) with responsibility for the Mental Health and Learning Disability Team, Independent Healthcare Team and Hospitals Programme Team.

12. Following restructuring of the organisation in 2021-22, I was successful in being promoted to the post of Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare from December 2022.

13. I gained a BSc in Health Studies (First Class Honours) in July 2017 and a Post Graduate Diploma in Health and Social Care Leadership (with Distinction) in 2023. I am currently in the final stages of my Masters in Public Administration.

Module

14. I have been asked to provide a statement for the purpose of **Module 5: RQIA and MHC**.

15. The Inquiry's request has been split into two parts; one of which relates to the effectiveness of RQIA's inspection processes and the other relates to the adult safeguarding investigation of 2012 and 2013 in relation to the Ennis ward. This statement addresses the questions regarding the Ennis ward and answers questions 15 to 20 of the Inquiry's Rule 9 request. The Inquiry's questions 1 to 14 will be addressed in my second statement to the Inquiry.

16. My evidence relates to paragraph 13 of the Inquiry's Terms of Reference.

17. I have been asked to address a number of questions/issues for the purpose of my statement. I will address those in turn.

18. In preparation for providing this statement to the Inquiry, I have been supported by colleagues in the search for, and review of, documentation from 2012 and 2013. I have also been assisted by previous and current employees of RQIA who undertook inspections and/or attended at the various safeguarding meetings relating to Ennis during 2012 and 2013, being:

    a. Theresa Nixon (Director of Mental Health, Learning Disability and Social Work);
    b. Patrick Convery (Lead Inspector / Head of Programme Mental Health and Learning Disability);
    c. Siobhan Rogan (Inspector); and
    d. Rosaline Kelly (Inspector).

Q15. What role did RQIA have in the investigation into the allegations in November 2012 arising from Ennis ward?

19. RQIA's powers and duties in respect of mental health and learning disability services, such as MAH, are primarily set out in the Mental Health (Northern Ireland) Order 1986, the Health and Personal Social Services (Quality,

Improvement and Regulation) (Northern Ireland) Order 2003 ("**the 2003 Order**"), and the Health and Social Care (Reform) Act (Northern Ireland) 2009. Those duties and powers and the history relating to the transfer of functions from the Mental Health Commission to RQIA have been described within RQIA's Chief Executive's (Mrs. Briege Donaghy) first and second statements to the Inquiry.

20. In addition to the legislation referred to, a Regional protocol is in place that sets out the procedures for the reporting, assessment and investigation of allegations of abuse of vulnerable adults. The lead organisation in this process is the appropriate HSC Trust, and those cases that meet the threshold for a Joint Investigation will also involve the PSNI. RQIA does not investigate such allegations but can be called upon by the HSC Trust to be involved, drawing on our regulatory role set out in legislation.

21. I have set out in this part of my statement evidence in respect of the RQIA's role following the allegations of abuse in Ennis ward from 2012 onwards.

22. I consider that it would be useful at the outset of this statement to provide an explanation of the various meetings that are referred to in the body of this statement:

    a. Vulnerable Adult Strategy Meetings: these were an external meeting involving RQIA, Belfast HSC Trust ("**BHSCT**"), hospital staff, Public Protection Unit, the Northern HSC Trust ("**NHSCT**") and the South Eastern HSC Trust ("**SEHSCT**"). These meetings were convened under the provisions of the Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance (September 2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) ("**Joint Protocol**") and were convened to discuss and update in relation to the allegations raised on 8 November 2012.

b. Bi-monthly meetings: these are general update meetings between the Department of Health and RQIA for updates to be provided to the Department of Health regarding care settings, safeguarding concerns, aspects of regulation, on-going reviews, enforcements and escalations. These bi-monthly meetings form part of the dialogue between the Department of Health and RQIA, and provide a means by which RQIA keeps the Department informed about the availability and quality of services (see Article 4 of the 2003 Order) and provides the Department with advice, reports and information about the provision of services (see Article 5 of the 2003 Order).

c. Serious Concerns and Complaints Group ("**SCCG**") meetings: these are internal RQIA meetings attended by RQIA's Chief Executive, the Director of Operations, the Director of Quality Assurance and the Complaints Manager. The Heads of Programmes or other relevant staff may be required to attend meetings of the SCCG to discuss cases within their remit, as appropriate. The purpose of the meetings is to discuss any safeguarding concerns, enforcement action, complaints, whistleblowing and any other related matters as necessary.

Timeline of events

23. The following timeline of events sets out the communications, correspondences and inspections undertaken by RQIA following the allegations raised in November 2012 through to June 2013.

24. RQIA first became aware of allegations of physical assault and degrading practices along with concerns over staffing levels in Ennis Ward on 8 November 2012. Deborah Oktar Campbell, the Operations Manager for the Priory Group, reported her concerns to RQIA in the course of a telephone call. Shortly after this telephone call was received and escalated to Patrick Convery, Mr. Convery contacted Margaret Cullen (Inspector) who in turn contacted Ms. Campbell to discuss the allegations in more detail. It is understood that Ms. Oktar Campbell

had attempted to speak to senior MAH staff prior to contacting RQIA but had been unable to reach them.

25. Ms. Cullen attempted to contact senior staff at MAH without initial success but eventually spoke with Esther Rafferty (MAH Hospital Services Resettlement Manager). Ms. Rafferty informed Ms. Cullen that she would "*deal with the matter immediately*" and would inform RQIA of the MAH safeguarding procedures following an allegation of abuse.

26. A Vulnerable Adult Strategy Meeting then took place on 9 November 2012, attended by RQIA (Audrey Murphy, Learning Disability Inspector) along with BHSCT and PSNI. Immediate steps were taken, including suspensions of three staff members and additional staff from other wards were diverted to work on Ennis ward. There were a further eight of these strategy meetings, RQIA were in attendance at six.

27. As a result of the allegations, RQIA undertook an unannounced inspection of Ennis ward on 13 November 2012. The Inspectors involved were Margaret Cullen, Siobhan Rogan and Brenda Gallagher. The inspection involved a review of the Quality Improvement Plan ("**QIP**") and the seven recommendations from the previous inspection in November 2010. The seven recommendations were re-stated and the following eleven additional recommendations were made:

    a. A clear pathway for reporting safeguarding issues on a 24-hour basis to be implemented and maintained;

    b. Patient care to reflect the Trust's implementation of the DHSSP Deprivation of Liberty Safeguards Interim Guidance 2010;

    c. Practice and policy in relation to observation levels is reviewed and clarified;

    d. Staffing levels for the ward are reviewed regularly, a clear system of governance in place to audit and respond to alerts by Ward Managers,

outcomes of assessments for staffing are clear and disseminated accurately to the Ward Manager and the allocation of responsibilities to staff on duty are clearly recorded;

e. Current governance arrangements for safeguarding are reviewed and the outcome forwarded to RQIA;

f. Dignity of patients on the ward is reviewed and guidance in relation to preserving the dignity of patients is provided to staff;

g. The system for work allocation is reviewed;

h. Activities as part of resettlement preparation are clearly outlined in individual care plans;

i. Care plans should detail presenting behaviours and how to address individual behaviours;

j. Functional communication systems are developed and implemented for all patients with communication deficits; and

k. The Trust considers the recommendations of RQIA's review of the Western HSC Trust Safeguarding Arrangements for Ralphs Close Residential Care Home in its investigation.

28. On 15 November 2012, representatives from RQIA (Siobhan Rogan and Margaret Cullen) attended at the Second Vulnerable Adult Strategy meeting with the Designated Officer and Professional Lead of the BHSCT, Maura Mannion, to discuss safeguarding arrangements. RQIA raised concerns that although discussions had taken place over staffing on the day of the alleged abuse, the actual number of staff on the ward and their areas of responsibility remained unclear. RQIA also raised concerns that using relief staff to reach the agreed staffing complement may be detrimental to patient care and safety in other wards. It was agreed that Aine Morrison (Operations Manager at the BHSCT) would update RQIA as to staffing and the role of the appointed monitor by 16 November 2012. For clarity, monitors are members of staff who are supernumerary (meaning that they are not counted as part of the staffing

required for safe and effective care) and put in place following concerns raised over safeguarding. Their role is primarily one of observation and reporting.

29. Theresa Nixon also wrote to Esther Rafferty on 15 November 2012 outlining RQIA's concerns following the unannounced inspection on 13 November 2012. Mrs. Nixon set out that she wanted an action plan to improve and monitor the situation at MAH, particularly in relation to staffing levels, by 23 November 2012. A response was received on 23 November 2012 providing assurances and setting out an action plan, with a number of actions already having been completed. The outstanding actions were:

    a. Vulnerable Adult Referrals:

        i. The Trust will review the governance arrangements in place for the management and review of Vulnerable Adult Referrals in the hospital. Action by 31 January 2013; and

        ii. A review of all current protection plans in place in this ward will be undertaken to ensure robust arrangements in place for each patient. Action by 17 December 2012.

    b. Hospital Staffing:

        i. Thirty whole time equivalent Healthcare workers band 3 appointed awaiting access NI checks and Health checks. Action by 31 January 2013; and

        ii. 18 whole time equivalent Staff Nurse posts advertised 27th November 2012 to include those due to register with NMC in February 2012. Action by 28 February 2013.

30. A bi-monthly meeting was held on 16 November 2012 between RQIA and the Department of Health, Social Services and Public Safety ("**DHSSPS**") where an update was given, by Mrs. Nixon, as to the alleged abuse and subsequent safeguarding vulnerable adults and police investigation.

31. RQIA received an email from the BHSCT (Aine Morrison) later that afternoon attaching guidance written for Supervising Staff and the Ward Manager at Ennis ward for continuing to monitor activity on the ward. The additional staff were to be supernumerary and were to observe for indicators of concern about poor care practice. Supervising staff were asked to prepare a daily report detailing who was on shift, what their duties were, what role they played and any aspects of good or concerning practice.

32. Mrs. Nixon spoke with Molly Kane (Regional Lead Nurse Consultant, MHLD, Public Health Authority ("**PHA**") in mid-November 2012 with regard to concerns over staffing at MAH. Mrs. Nixon asked Ms. Kane to raise these concerns directly with Esther Rafferty, which she did via email on 20 November 2012. Ms. Kane set out that she required clarification over two nurse precautionary suspensions and an update regarding staffing across MAH by 26 November 2012.

33. A SCCG meeting was held on 20 November 2012. Ennis Ward was discussed and an update was given by Mrs. Nixon.

34. A further Vulnerable Adults Strategy meeting was held on 28 November 2012, attended by RQIA, PSNI, NHSC, SEHSCT and the BHSCT, including Aine Morrison. Updates on safeguarding were provided and the main concerns being brought to Ms. Morrison's attention were related to staffing levels. Discussions were had around obtaining statements from the patients involved in the alleged abuse and it was confirmed that the analysis of training records had begun. PSNI confirmed that interviews of Bohill Care Home staff (who had been working on Ennis ward, one of whom made the initial allegations of abuse) would commence in the next two weeks and a further strategy meeting was scheduled for 20 December 2012.

35. Mrs. Nixon wrote to Esther Rafferty on 3 December 2012, in response to her letter of 23 November 2012, setting out continued concerns over staffing shortages, concerns over the dignity of a particular patient who removes her clothes, and asking for further clarification about this along with concerns raised

over engagement with Bohill Staff. Mrs. Nixon asked for a response to this by 10 December 2012.

36. A SCCG meeting was held on 6 December 2012 where an update was given as to the concerns raised by Bohill Staff and the progress of the current investigation. RQIA's correspondence of 3 December 2012 was shared with the Group. Mrs. Nixon advised that a Vulnerable Adults Strategy Meeting had taken place and staff had been suspended.

37. Ms. Rafferty responded to Mrs. Nixon's letter on 12 December 2012. She set out assurances to RQIA that appropriate staffing levels were being maintained, and that specialist behavioral support and guidance had been provided with regard to the patient who removes her clothes. She provided assurance that a number of meetings were held prior to Bohill staff working on wards to agree shifts, span of shifts, identified patients to be worked with and for completion of person centre assessment and discharge plans.

38. A further Vulnerable Adults Strategy Meeting was held on 12 December 2012. This was attended by Margaret Cullen and Siobhan Rogan from RQIA along with representatives from PSNI, NHSCT, SEHSCT and the BHSCT. RQIA raised concerns over staffing levels in that one of the staff allocated to level 3 observations were considered to be part of the routine staff complement, which in RQIA's submission was contradictory to MAH's policy. RQIA was informed that there were no specific staffing requirements for the Ennis ward.

39. During this time, RQIA was also reviewing and considering the response provided by Ms. Rafferty on 12 December 2012. RQIA continued to have concerns over adequate staffing levels, reporting mechanisms of patient safety concerns and clarification over the roles of Bohill staff. Mrs. Nixon contacted Margaret Cullen, Siobhan Rogan and Patrick Convery by email on 18 December 2012 in respect of an upcoming unannounced inspection of Ennis ward and areas to focus on at that inspection, which included:

    a. Staffing rotas;

b. Supervision observations;
c. Staffing levels;
d. Closure of Finglass Ward; and
e. Induction of Bohill staff.

40. At the SCCG meeting on 18 December 2012, it was confirmed that a further Vulnerable Adults Strategy Meeting would take place on 20 December 2012 along with an unannounced inspection during the week of 17 December 2012. It was also confirmed that more staff members from Bohill had raised new allegations regarding general care at MAH, which the Health and Social Care Board ("**HSCB**") had been made aware of.

41. The unannounced inspection of Ennis ward took place on 20 December 2012. The Inspectors involved were Margaret Cullen, Siobhan Rogan and Brenda Gallagher. The purpose of the inspection was to clarify the action taken by the BHSCT in relation to the safeguarding investigation and review the safeguarding processes in place in Ennis ward. The following eight recommendations were made in a QIP:

a. Clearly define and monitor staffing complement (second time this was raised);
b. The ward manager should be involved in agreeing staffing complement;
c. Clearly define staffing requirements in relation to special observations (second time this was raised);
d. Inform RQIA of deficits in staffing (second time this was raised);
e. Ensure adequate staffing levels;
f. Process actions from safeguarding strategy meetings accurately and in timely manner;
g. MDT to review compliance with special observation Trust policy; and
h. Any learning from induction of external/internal staff to be documented and shared.

42. A further Vulnerable Adults Strategy Meeting was held on 20 December 2012. RQIA does not have a copy of the meeting minutes but is aware from

discussions that took place during the SCCG meeting on 5 April 2013 that Margaret Cullen attended and an update was given at the Strategy Meeting as to the unannounced inspection seeking further assurances regarding staffing.

43. As instigated by RQIA, a Proposal for Service Improvement Action Plan in Ennis ward and Briefing Note were received on 20 December 2012. This was prepared by Maura Mannion and set out the actions required to improve the service.

44. Around the same time, RQIA received a document from H491, a Ward Sister at the Ennis ward. This document is understood to have been requested by Maura Mannion and set out H491's views on Ennis ward, a history of the ward and the investigation into the allegations raised in November 2012. H491 set out that she was on annual leave on 8 November 2012 and that she was informed by her nurse manager of the allegations and that three staff had been suspended. H491 stated that it came as a "*total shock*" to her.

45. A further Vulnerable Adults Strategy Meeting was held on 9 January 2013. RQIA does not have a copy of the meeting minutes from this date but through the SCCG that took place on 5 April 2013, RQIA understands that Margaret Cullen and Siobhan Rogan attended the meeting and that the BHSCT suggested that there was "*no evidence of a culture tolerant of behaviours currently that could be defined as abusive or support systemic abuse*". The BHSCT also gave assurances that a full complement of staff would be available for each shift on the Ennis ward.

46. An SCCG meeting took place on 10 January 2013 although no further developments were noted from the previous SCCG meeting on 18 December 2012. RQIA (Margaret Cullen) did, however, contact the Ward Manager of Ennis ward on 10 January 2013 to discuss staffing levels. She was advised that there were still periods where the ward was understaffed, which contradicted the assurances given by the BHSCT at the Vulnerable Adults

Strategy Meeting the day before. Ms. Cullen advised that this would be something that RQIA would check at the next unannounced inspection.

47. On 21 January 2013, RQIA was informed by Esther Rafferty that a patient had made an allegation that a member of nursing staff had assaulted the patient on the ward. RQIA has been unable to find a call log or record of this incident, however, it is referred to in the SCCG minutes from 5 April 2013. The individual against whom the allegations were made was placed on precautionary suspension. RQIA was later informed on 25 January 2013 that PSNI had investigated and there was no case to answer (again this is referenced within the SCCG minutes from 5 April 2013).

48. An SCCG meeting took place on 22 January 2013 where an update was given about the Ennis ward. Mrs. Nixon advised the SCCG that a further unannounced inspection would take place within the next two weeks. It was also agreed that MAH would remain on the SCCG agenda until improvements had been made.

49. Due to the continued concerns over staffing levels in Ennis ward, Mrs. Nixon wrote to Maura Briscoe, DHSSPS, on 23 January 2013 highlighting RQIA's concerns.

50. RQIA held a team meeting on 28 January 2013, attended by Patrick Convery, Brenda Gallagher, Siobhan Rogan, Margaret Cullen and Rosaline Kelly. Discussion took place over Ennis ward and it was noted that RQIA remained dissatisfied with the assurances provided by the BHSCT. As a result, a further follow up unannounced inspection was to take place on 29 January 2013.

51. As well as the unannounced inspection on 29 January, the bi-monthly meeting between the DHSSPS and RQIA took place. RQIA provided an update on the police investigation and informed the DHSSPS that the three suspended staff had returned to work and that RQIA was in the process of undertaking an unannounced inspection.

52. The unannounced inspection was undertaken by Patrick Convery, Margaret Cullen, Siobhan Rogan, Rosaline Kelly and Brenda Gallagher. The purpose of the inspection was to assess the arrangements and procedures for safeguarding vulnerable adults given that despite requests for information from the BHSCT, RQIA had still not received assurances that the safeguarding was adequate.

53. A QIP was issued with eight recommendations, two of which had been stated for the third time, three had been stated for the second time and the remainder were additional:

    a. Clearly define and monitor staffing complement (stated for the third time);
    b. Clearly define staffing requirements in relation to special observations (stated for the third time);
    c. Ensure adequate staffing levels (stated for the second time);
    d. Process actions from safeguarding strategy meetings accurately and in timely manner (stated for the second time);
    e. Any learning from induction of external/internal staff to be documented and shared (stated for the second time);
    f. Update individual behaviour support plans regularly:
    g. Allow opportunity for therapeutic activities; and
    h. Consider upgrading ward or alternative accommodation.

54. On 31 January 2013, Patrick Convery wrote to Ms. Rafferty (copying Mrs. Catherine McNicoll, Director of Adult Social and Primary Care Services, and Mr. John Veitch, Co-Director Social and Primary Care Services the BHSCT) following a conversation on 29 January 2013 and requested that Ms. Rafferty provide the following information:
    a. A detailed chronology of actions taken by the BHSCT;
    b. A copy of individual protection plans;
    c. Confirmation of who has ward manager responsibility:
    d. Copies of independent monitoring reports: and
    e. A list of all referrals to Adult Behaviour Services.

55. On 31 January 2013, RQIA's Chief Executive (Glenn Houston) wrote to the Chief Executive of the BHSCT escalating RQIA's concerns relating to staffing, behavioural support, environment and protection plans and requesting that a meeting be arranged for 11 February 2013 to discuss the concerns and for the BHSCT to provide assurances to RQIA in relation to patient care and safeguarding.

56. An SCCG meeting was held on 7 February 2013 where an update on Ennis ward was given. It was confirmed that a meeting would be taking place on 11 February 2013 between RQIA and the BHSCT and would involve Patrick Convery, Mr. John Veitch, and Ms. Rafferty. RQIA has not been able to locate meeting minutes from this meeting but the notes from the SCCG meeting on 5 April 2013 set out that the purpose of the meeting on 11 February 2013 was to discuss RQIA's on-going concerns and for the BHSCT to provide further information regarding staffing and action taken.

57. RQIA wrote to the Consultant Psychiatrist at MAH (Dr. H50) on 21 February 2013 raising concerns and queries over the medication and treatment plan of a particular patient on the Ennis ward, P44. RQIA had concerns over the levels of Lorazepam being dispensed and asked for Dr. H50's comments by 4 March 2013. In preparation for providing this statement to the Inquiry, RQIA has been unable to find a response to this letter.

58. A response from Ms. Rafferty to RQIA's letter of 31 January 2013 was received by RQIA on 25 February 2013. This correspondence enclosed copies of monitoring reports for Ennis ward, a timeline of the events from the date of notification of the allegations and confirmation of an acting Ward Sister for Ennis ward H851 .

59. A further SCCG meeting was held on 26 February 2013 although no updates were provided regarding the Ennis ward.

60. In addition to the meetings that took place in February 2013, RQIA also published its Overview Report of Safeguarding Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland.

61. This report was commissioned by DHSSPS in 2011. Whilst it was not therefore undertaken as a result of the allegations made in November 2012, the report demonstrates RQIA's continuing work in relation to the safeguarding and protection of children and vulnerable adults. As part of this review, RQIA considered the arrangements in place within the MHLD hospital across the five HSC Trusts in Northern Ireland, including MAH[1].

62. The review process involved RQIA interviewing 113 patients across 33 MHLD wards. As a result of this review, RQIA made a total of 22 recommendations to the five HSC Trusts.

63. The follow up review published in 2015 (again included inspection of five MAH wards; Killead, Sixmile, Cranfield Male, Greenan and Oldstone between August and September 2014) demonstrated that all of the HSC Trusts had made progress in establishing effective safeguarding arrangements but a number of the recommendations had not been met. The BHSCT had fully met 13 recommendations, substantially met three recommendations, partially met eight recommendations and had not met one recommendation.

64. As part of RQIA's ongoing monitoring of staffing levels at MAH, RQIA required to be notified whenever staffing levels were below requirement. RQIA (Margaret Cullen) was notified of such an occasion on 8 March 2013 by H377 [redacted] at the BHSCT. H377 [redacted] confirmed that on 2 March 2013 Ennis ward was short by one staff member, however, two patients were on leave at the time and "*all avenues to address this deficit were taken*".

65. A further SCCG meeting took place on 8 March 2013 where an update was given and it was noted that the PHA and DHSSPS had been informed of RQIA's

[1] Greenan, Cranfield ICU, Moylena and Finglass

concerns and that the report following the unannounced inspection from the 29 January 2013 would be distributed in due course.

66. An RQIA Board Meeting took place on 14 March 2013 and an overview of the concerns in Ennis ward were discussed and an update given following the meeting on 11 February 2013. The RQIA Board were informed that RQIA was in discussion with the BHSCT regarding its QIP and that the DHSSPS had been informed.

67. A Safeguarding meeting was held on 29 March 2013. This meeting was attended by the BHSCT, PSNI, and NHSCT. RQIA was not in attendance but has a copy of the minutes and notes that Mr. Veitch, who was in attendance, suggested that "*there is no evidence of institutional abuse*" within the Ennis ward.

68. At the SCCG meeting on 05 April 2013 it was confirmed that Ennis ward would remain on the agenda until the QIP had been returned by BHSCT. The QIP was due to be returned by 12 April 2013.

69. RQIA received a copy of the PSNI investigation report into the allegations of abuse at MAH on 29 April 2013. The report highlighted the concerns noted by the PSNI and confirms that the matter had been referred to the Public Prosecution Service ("**PPS**") with a recommendation of prosecution of two individuals.

70. At the RQIA Board Meeting on 9 May 2013, an update was given on the PSNI investigation and the recent correspondence from RQIA to the BHSCT (letter from Mrs. Nixon to Mr. Veitch dated 9 May 2013) where RQIA asked for assurances to be given in relation to the care, treatment and culture within Ennis and other wards at MAH. RQIA asked for a response to be given by 17 May 2013.

71. Mrs. Nixon updated Maura Briscoe (DHSSPS) on 15 May 2013 to confirm that RQIA was continuing to inspect Ennis ward and following up on the BHSCT's last QIP.

72. Mrs. Nixon wrote again to Mr. Veitch on 28 May 2013 requesting a response to her original letter of 9 May 2013 by no later than 3 June 2013.

73. RQIA undertook a further unannounced inspection of Ennis ward on 29 May 2013. The following eight recommendations were made:

    a. Ensure any agreed action from safeguarding strategy meetings are processed accurately, appropriately and in a timely manner (stated for the third time);
    b. Ensure designated officer includes details of protection plans screening of vulnerable adult referral forms and related strategy meetings;
    c. Develop system for reviewing protection plans returned to the ward by the designated officer;
    d. Review the monitoring role (put in place following allegations);
    e. Refer patients with challenging behaviour for specialist behavioural support services;
    f. Any learning from induction of external/internal staff to be documented and shared (stated for the second time);
    g. Develop individual and group activity programs and allow patients opportunity to engage in therapeutic and recreational activity (stated for the second time); and
    h. Upgrade the Ward's internal and external environments (stated for the second time).

74. RQIA received a response to its letter of 9 May 2013 on 6 June 2013. Mr. Veitch set out in his response that:
    a. the BHSCT immediately initiated a thorough investigation through the joint protocol arrangements;
    b. the BHSCT shared information with all appropriate staff and addressed immediate and ongoing protection needs of the patients within the ward;

c. monitoring arrangements remain in place. "*Action included putting in place a protection plan which involved independent daily monitoring of staff interventions and the quality of care delivered on the ward. I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture*";
d. the PSNI investigation is complete and the BHSCT is awaiting the PPS decision;
e. the BHSCT concluded its own adult safeguarding processes and no issues remain outstanding; and
f. further quality improvements of ward environment had been planned "*in the coming weeks*" as outlined in the recent QIP.

75. Mrs. Nixon wrote again to Mr. Veitch on 28 June 2013 noting his comments and also requesting that a copy of the BHSCT investigation report be provided.

76. As can be seen from the timeline above, RQIA was heavily involved in Ennis ward following the allegations made in November 2012, through continuing unannounced inspections, liaising with the BHSCT, DHSSPS and PHA to monitor whether the recommendations set out as a result of the various unannounced inspections were being or in the process of being implemented. RQIA took the allegations extremely seriously, as it does with any allegation of this nature.

Q16. When and how did RQIA receive the Ennis Report?

77. As set out above, RQIA requested a copy of the BHSCT's investigation report upon conclusion (Mrs. Nixon's letter to Mr. Veitch on 28 June 2013).

78. In preparation for the Inquiry, RQIA has been unable to find correspondence from the BHSCT providing RQIA with a copy of the Ennis Safeguarding Report. However, RQIA has located Board Meeting minutes from November 2013 that make reference to a Strategy meeting on 5 July 2013, attended by RQIA. From a review of the *Review of Leadership and Governance at Muckamore Abbey*

Hospital prepared by David Bingham, RQIA notes that a draft final version of the Ennis Report was circulated at a meeting on 5 July 2013.

79. RQIA's Patrick Convery and Rosaline Kelly prepared a response to a draft of the Ennis Safeguarding Report. RQIA has not been able to locate correspondence providing this detail to the BHSCT but having considered the final draft of the Ennis Report, RQIA's comments appear to have been taken on board. RQIA notes from the minutes of a meeting held on 28 October 2013 (discussed below) in the opening of the meeting minutes that a copy of the amended report was emailed to the *meeting participants,* of which RQIA was one. RQIA has not been able to locate this correspondence.

80. A bi-monthly meeting was held on 8 October 2013 between RQIA and DHSSPS. Mrs. Nixon confirmed that recommendations for improvement on Ennis ward had not been implemented and that the Southern HSC Trust was taking action, which is understood to have been as a result of patients under their care remaining on the ward.

81. The Ennis Report, which RQIA understands to be the final report, is dated 23 October 2013 and RQIA understands that the report was discussed at the final Vulnerable Adults Strategy meeting on 28 October 2013. This meeting was attended by Rosaline Kelly.

82. In terms of RQIA's position on the Ennis Report, Ms. Kelly agreed in terms of the comments made about staff training in regard to Adult Safeguarding Policy, induction training, child protection training and whistleblowing training and that RQIA would expect this to be in place and to be reinforced with staff. Ms. Kelly also asserted that whilst it had not been possible to reach a conclusion in the report about whether there had been institutional abuse, it was RQIA's position that there was enough evidence to justify some concern about wider practice on the ward.

83. A meeting took place on 11 November 2013 between RQIA, the PHA and the HSCB. RQIA updated that there had been two members of staff referred to the

PPS and that the BHSCT did not accept that there was an evidence of "culture" leading to the abuse allegations. RQIA's view on the matter was that this may not have been an isolated case and that this was supported by Aine Morrison. It is also noted in the minutes of this meeting that "*the investigation report is nearly finished*".

84. The Ennis ward was amalgamated with Erne and Mallow wards in December 2013 to become Erne ward.

Q17. What was RQIA's Response to the Ennis Report?

85. In preparation for the Inquiry, we have not located a formal response by RQIA to the Ennis Report. As set out above, inspectors were involved in a review of the first draft of the report and provided comment, which appear to have been taken into consideration in the final publication of the report. Further to this, Rosaline Kelly attended at the Vulnerable Adults Strategy meeting on 28 October 2013 where the report along with the recommendations were discussed.

Q18. What role did RQIA have in implementing the recommendations arising out of the Ennis Report?

86. The primary statutory responsibility for implementing the specific recommendations of the Ennis Report rested with the BHSCT. However, most of the recommendations (some were not applicable to RQIA) were matters that RQIA ordinarily considered during ongoing inspections including: safeguarding, staffing, inductions, patient care plans and access to services. These continued (and continue) to be observed through subsequent inspections at MAH and across all of the services inspected by RQIA.

87. Whilst RQIA's inspection methodology has been discussed at length in Mrs. Donaghy's first and second statements to the Inquiry, it is important to emphasise that adult safeguarding has been a feature of RQIA inspection methodology since the transfer of functions from the Mental Health Commission

in 2009, and remained so following the Ennis Report and recommendations. For example, the focus and purpose of inspections undertaken on Greenan ward on 25 January 2012 and Cranfield ward on 26 June 2012, which pre-date the Ennis abuse allegations, were to assess the wards' procedures and arrangements for safeguarding vulnerable adults.

88. An unannounced inspection of the amalgamated Erne ward took place on 29 January 2014. The purpose of this inspection was to follow up on the BHSCT's progress in implementing recommendations following inspections of Erne (30 November and 1 December 2010) Mallow (3 December 2013) and Ennis (29 May 2013). It was noted by the inspector that progress had been made in a number of key areas and that all of the recommendations made in the unannounced inspection of Ennis ward on 29 May 2013 had been met.

89. An update was provided to DHSSPS following the amalgamation of the wards, where it was confirmed that the recommendations had been met and that following patient experience interviews in June 2014, the new Erne ward was found to be "*in keeping with the five standards of respect, attitude, behaviour, communication privacy and dignity*".

90. As set out above (paragraphs 60 and 61) RQIA was requested, by DHSSPS in 2011, to undertake a review into Safeguarding of Children and Vulnerable Adults in MHLD hospitals in Northern Ireland. The review was not as a result of the Ennis Report or the allegations made in November 2012 but demonstrates that RQIA had an on-going role in reviewing safeguarding.

Q19. What steps if any did RQIA take to investigate other wards following the situation that arose at Ennis ward?

91. RQIA continued with its program of announced and unannounced inspections at MAH (and other inpatient facilities for adults with MHLD). Following the publication of the Ennis Report in October 2013, RQIA conducted inspections of Six Mile, Greenan, Cranfield Male, Moylena, Cranfield Female, Cranfield Male 2, Donegore and Oldstone.

92. The inspections relating to Donegore (16 September 2013), Six Mile (29 – 30 October 2013), Cranfield Male (18-19 November 2013) and Killead (20-21 January 2014) were specifically to assess the arrangements and procedures for safeguarding vulnerable adults.

93. Through these inspections, RQIA was documenting concerns and monitoring whether recommendations from previous inspections were being met. All findings and reports of the inspections were shared with the BHSCT and if necessary through the implementation of a QIP requiring response from the BHSCT stating how it intended to make the required improvements.

Q20. What actions were taken following any such investigations?

94. Whenever RQIA was made aware of allegations of abuse of vulnerable adults the BHSCT was asked to confirm that appropriate steps were being taken to immediately safeguard patients. In some cases, the PSNI were involved and there may have been a precautionary suspension of the staff member. RQIA also monitored whether the BHSCT's actions were in line with the regional procedures set out in the Joint Protocol in force at the time.

95. By way of an example, during an inspection in January 2014, a disclosure was made to the inspector that a patient did not feel safe and that a male member of staff had been "bad to him". This was notified to the BHSCT's Safeguarding Officer, Michael Creaney, and to the PSNI. As a result of the allegation, the staff member was placed on another ward and supervised when on duty and a witness statement was given to the PSNI.

96. A further example is in relation to Greenan Ward in June 2014. An allegation was made by a relative that her brother had been "*dragged/pulled and cursed at*" by members of staff and then had water thrown in his face on a later date. PSNI were notified and both staff members were removed from the ward and another was suspended as a precaution. A strategy meeting with the NHSCT

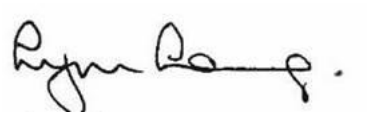
was to be convened and the ward was subject to observational protocols and received three unannounced visits per day.

97. RQIA takes any allegations extremely seriously. Patient safeguarding and wellbeing is at the centre of all that RQIA does.

Declaration of Truth

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

Signed:



Date: 29 March 2024

Appendix 1

Glossary of Terms

BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
HSC	Health and Social Care
HSCB	Health and Social Care Board
MAH	Muckamore Abbey Hospital
NHSCT	Northern HSC Trust
PHA	Public Health Authority
PPS	Public Prosecution Service
PSNI	Police Service Northern Ireland
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SCCG	Serious Concerns and Complaints Group
SEHSCT	South Eastern HSC Trust