ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Margaret Cullen
Date: 19 April 2024

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

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I am a qualified Social Worker although I did not renew my registration when it expired in 2023. I hold a Diploma in Social Work, which I achieved in 1988 and hold a Master's Degree in Social Work, which I achieved in 1998.

2. I have held the following positions: I started work as a Mental Health Social Worker in the Southern Health and Social Care Trust ("**SHSCT**") in 1990. I became an Approved Social Worker (meaning that I had undertaken specific training under the Mental Health (Northern Ireland) Order 1986 ("**MHO**")) in 1993 and remained in the SHSCT until joining the Regulation and Quality Improvement Authority ("**RQIA**") as an inspector in 2009. I left RQIA in April 2013 when I moved to The Regional Emergency Social Work Service, Belfast Health and Social Care Trust ("**BHSCT**") where I remained until I retired in 2017.

3. I wish to state at the outset of my statement that due to the passage of time since the Ennis ward allegations and the fact that I left RQIA in 2013, my memory of events relating to both Ennis and RQIA generally is limited. I have however answered the questions to the best of my knowledge and recollection.

Module

4. I have been asked to provide a statement for the purpose of M5: RQIA and MHC.

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

6. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn, starting with the questions I have been asked personally, followed by the questions directed at RQIA.

Q1. Please explain the methodology of your visits to MAH as an RQIA Inspector throughout the time period within the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021? It would be helpful if you could include detail on matters such as (but not limited to) the following:

(i) <u>How inspector(s) were selected to conduct an inspection;</u>

7. In 2009, the Mental Health and Learning Disability ("**MHLD**") directorate of RQIA was formed to take over the role and function of the Mental Health Commission ("**MHC**") as defined within the MHO. The team included four full time inspectors. Each inspector had a specific responsibility, for example, as the Approved Social Worker I had responsibility for monitoring Guardianship

under the MHO. As well as undertaking inspections, each inspector covered office duty on separate days, reviewed Serious Adverse Incidents ("**SAI**") reports, which were submitted to RQIA by the Trusts, for quality assurance and review, and undertook Patient Experience Reviews ("**PER**") along with other pieces of work as they arose. Work was allocated by the Head of Programme (Patrick Convery) and the Director of the MHLD team (Phelim Quinn, and subsequently Theresa Nixon).

8. I cannot remember having a specific caseload of particular wards or MHLD settings allocated to me. I think that inspections were allocated according to the availability of inspectors but I cannot be certain.

9. In preparation for drafting this statement I was provided with, and reviewed, inspection reports, quality improvement plans ("**QIP**") and PER reports that I was involved in at MAH. Although I have reviewed them, I do not have any direct recollection of them and therefore most of the information provided below is taken from the reports, rather than my own recollection.

10. The information sent to me from RQIA in relation to MAH indicates that during my time working at RQIA, I was involved in:

    (a) Six PERs;

    (b) Nine announced inspections (both as lead and second inspector); and

    (c) Four unannounced inspections.

11. One of the announced inspections (RQIA-A-00121 – Oldstone 13 March 2013) was part of a pilot inspection process for Personal and Public Involvement ("**PPI**") that RQIA was conducting, whereby service users (*Experts by Experience*) were assisting inspectors in undertaking the inspections.

12. I have included at **Exhibit 1** a schedule of the inspections and PERs that I had an involvement with.

(ii) <u>The information inspectors were provided with in advance of an inspection;</u>

13. Before an inspection, we were provided with various tools to assist in preparation for the inspection. This included:

(a) Previous inspection reports, if applicable. For some of the first inspections RQIA undertook following the transfer of functions in 2009, I recall that we had access to the reports prepared by the MHC when they were available, but in some cases there were no previous reports. I cannot recall which settings had no inspection reports but where there were no reports we would look to use information collated from PERs.

(b) Previous recommendations, i.e. the Quality Improvement Plan ("**QIP**"), if there was one. A QIP was a tool devised to assist in monitoring and reviewing the progress of recommendations made during an inspection;

(c) Ward self-assessments, which were received in advance of announced inspections;

(d) Previous duty calls, if applicable;

(e) Information regarding the number of patients detained;

(f) Previous complaints, if applicable. If the inspection was as a result of a complaint then this would have been a focus of the inspection;

(g) SAI notifications, if applicable; and

(h) Safeguarding alerts, if applicable.

(iii) <u>The process of preparing for an inspection;</u>

14. The Head of Programme and Director of MHLD would allocate the inspections and agree a timetable for the inspections. During my time at RQIA, the focus of

announced inspections was on human rights themes, the plan being to start the first stage of inspections with 'Fairness'. This Human Rights theme was broken down into thirteen standards to guide the inspection process.

15. Once the inspection had been allocated to an inspector, the RQIA administration team sent out the previous QIP (if applicable) to the Ward Manager for self-assessment and questionnaires to be given to patients, relatives and staff. These were directed to be returned to RQIA within a time limit to inform the inspection process.

16. Prior to inspection, a pack was then provided to inspectors of the returned self-assessment, questionnaires and other relevant information pertaining to the ward received by RQIA. The inspection plan was confirmed by the team discussions with managers and the other inspector(s) attending the inspection. The inspection plan covered the standards we would be assessing against, date, time, issues raised about the setting and division of workload.

17. The process of preparing for an inspection varied depending on the type of inspection we were undertaking.

18. If the inspection was announced then patient, relative and staff questionnaires were sent out in advance. The Ward Manager was informed and asked to notify RQIA of the setting's compliance with the standards of inspection. All relevant personnel were informed of the date and time of the inspection and given access to the inspectors.

19. If the inspection was unannounced, no one from the setting was informed in advance, although I think that a manager in RQIA notified a manager in BHSCT on the morning of inspection.

20. For all inspections, the documents (if applicable), as set out in the response to ii) above, were reviewed. An inspection pack was also prepared, which would

have included any previous QIP or questionnaires that had been completed by patients or relatives, if applicable.

(iv) Communications with MAH and others in advance of an inspection;

21. As set out above, this would have depended on the type of inspection. For an announced inspection, the Ward Manager would have been informed, although I cannot recall how soon before an inspection this would happen. The self-assessment questionnaire and relative, patient and staff questionnaires would have also been sent to the setting.

22. For an unannounced inspection, no one from the setting would have been contacted until the morning of the inspection whereby the BHSCT would be informed.

(v) The mechanics of the inspection itself (including the approach adopted to communications with staff and patients and the inspection of records);

23. During my time at RQIA, my recollection is that there were always a minimum of two inspectors during each inspection. The workload was such that two were needed, although I do recall that there was talk of changing the inspections to one inspector. I recall feeling strongly that a minimum of two inspectors were needed, based on the amount of work required to undertake during an inspection.

24. I note from reviewing the inspection reports provided in the preparation of this statement that I was involved in one unannounced inspection on Greenan ward (RQIA-A-00077) where I am listed as the only inspector. I do not recall this and note that "inspectors" are referred to within the reports so I cannot comment as to why no other inspectors are noted to have been present, but as set out above, my recollection is that there was always a minimum of two inspectors present.

25. A typical inspection would last two days. We would arrive at approximately 9:00am and introductions would be made to the Ward Manager. We would explain the process of inspection and arrange to have interviews with patients, their relatives (if available) and staff. The interviews would take approximately half a day to a day to complete.

26. We would undertake a tour of the Ward and review the outline of the patients' days. We would always be monitoring and observing life on the ward too. Once the tour had been undertaken, we would spend time reviewing patient files (with their consent if possible), policies and procedures, staffing levels, training records, MHO forms, the Ward diary, complaints procedure, and incident and safeguarding records. If any concerns or issues were highlighted during the day then we would feed this back to our managers at RQIA. The first day would usually finish by 6:00pm.

27. Day two of the inspection would be similar but we would discuss the outcomes between inspectors and liaise with the multi-disciplinary team ("**MDT**") on the ward later in the afternoon to give an overview of the outcome. This would then be fed back to our manager.

(vi) <u>The process of reporting;</u>

28. During the inspection, I would make notes on each task that I undertook and discuss aspects of the inspection with my colleague, whoever that may have been. At the end of the inspection I drafted a summary of my findings.

29. It wouldn't be usual practice to discuss the findings with the setting staff during the inspection, unless there was something that needed to be clarified or brought to their attention straight away. However, there were feedback sessions with the Ward Manager and Responsible Medical Officer ("**RMO**") where a summary of the inspection findings was discussed.

30. Once the inspection had concluded, we discussed the findings between ourselves and the lead inspector would then compile the findings into the final prescribed report format, which would then be reviewed by the accompanying inspectors and team managers.

(vii) The time taken to complete the inspection process;

31. I cannot recall exactly how long it would have taken to complete an inspection but I estimate that it could take around six to eight weeks, particularly if it was an announced inspection where self-assessment questionnaires were sent out and needed to be returned.

(viii) Communications with MAH and others post-inspection.

32. Following completion of an inspection visit, communication with MAH and others would vary depending on the findings. There may have been discussions with the Ward Manager or RMO. It would not be standard practice to speak with patients or relatives after an inspection, unless they specifically requested to speak with us but a summary of the findings following PERs was always placed on the wards to inform the patients and relatives of the outcomes.

33. I would have also discussed the findings internally with the MHLD Team and managers.

34. In terms of any recommendations made as a result of the inspection, although I cannot recall exact timescales, the Ward Manager was given a time frame to forward an updated QIP to RQIA and the recommendations would be reviewed at the next inspection.

Q2. The Inquiry understands that you conducted inspections in respect of the Ennis Ward Adult Safeguarding Investigation. Can you assist the Panel by outlining your particular role in that process and how that process was conducted from the perspective of an RQIA inspector?

35. The Inquiry is correct in that I was involved in inspections of Ennis Ward following the allegations of abuse, however, as I set out at the beginning of my statement, my memory of that time is quite limited. I initially did not have any recollection of when the allegations were brought to RQIA's attention but in preparation for this statement I have reviewed the inspection reports of Ennis ward from November 2012 to January 2013.

36. I believe I would have been the lead inspector due to me being the most experienced inspector in the MHLD Team at the time; a number of other inspectors left the team in 2012.

37. I cannot remember who raised the allegations or who was notified at RQIA other than what is stated in the unannounced inspection report of 13 November 2012, which states "*the inspection was in response to serious concerns reported to RQIA on 8 November, by telephone, by the management of Bohill Nursing Home*".

38. I am sure that the allegations would have been discussed internally within the MHLD team and an action plan put in place but I do not recall these discussions taking place. The role and focus of the inspectors for the unannounced inspection (who were myself, Brenda Gallagher and Siobhan Rogan) would have been discussed and outlined by Patrick Convery and Theresa Nixon before the inspection took place, but again, I do not recall these discussions.

39. Although I was involved in the unannounced inspection on 13 November 2012, I do not have any specific memory of it so cannot comment in any further detail.

40. Similarly with the inspections that took place on 20 December 2012 and 29 January 2013, although I was part of the inspection team, I do not have any specific recall of these events.

41. In terms of the process of inspection, I have outlined the differences between announced and unannounced inspections above. My role as an inspector, and the process of the inspections during this time, would not have been any different to any other unannounced inspection.

42. Around this time, I was leading a pilot project requested by the Department of Health ("**DoH**") to include service users in inspections, so much of my time was taken up with that and after the January 2013 inspection, I do not recall being involved in further meetings regarding Ennis.

Q3. As a former RQIA inspector, are there other matters that you wish to bring to the Panel's attention for the purpose of its consideration of paragraph 13 of the Terms of Reference?

43. There is nothing further I wish to add that may assist the Panel's consideration of paragraph 13 of the Terms of Reference.

MAH Inquiry's Questions to RQIA

Q1: RQIA inspected individual MAH wards until in or around 2018, when it began to inspect MAH as a whole. Please explain:

(i) Why there was a change in approach?

(ii) What were the advantages and disadvantages of each approach?

44. I cannot comment on either of these points as I left RQIA in April 2013 and was not involved in any changes regarding the inspection approaches.

Q2: Before 2015, RQIA used a method of inspection that included self-assessment and pre-inspection analysis, along with ward visits. RQIA than changed this, to *exclude* self-assessment, and to use slightly different criteria (i.e. 'safe', 'effective' and 'compassionate', and later 'well-led'). Why were these changes made?

45. As set out above, I left my employment at RQIA in April 2013 so cannot comment on the changes made.

Q3: Why did some RQIA inspections involve one or two inspectors, and others involve very large numbers of inspectors?

46. During my time working as an inspector in the MHLD team, announced inspections were always done over two days with two inspectors. Unannounced inspections, particularly if they were responding to a significant complaint or allegations, tended to be undertaken within one day and therefore needed more inspectors to undertake the work identified.

Q4: How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH during the period of the Terms of Reference, that is 02 December 1999 to 14 June 2021, in:

(i) Developing key lines of inquiry.
(ii) Analysing key themes over time.
(iii) Following up on recommendations.
(iv) Responding to individual patient concerns identified at inspections.

47. I don't feel that I can respond to this other than to say that any inspections that I was involved in, I would have picked up on issues based on interviews (staff, patient and relative), observations and review of documents and records. All points of note were recorded and discussed with the Ward Manager, with recommendations made to be followed up on. If any concerns were identified or reported to me during an inspection, I would have documented it and reported it to my manager.

Q5: On average, RQIA inspections appear to have been spread over two days. In relation to these inspections:

(i) What proportion of time was spent speaking to staff?
(ii) What proportion of time was spent checking paper/electronic records?
(iii) What proportion of time was spent interviewing patients?
(iv) Was sufficient time was spent on each of the above?

48. The amount of time spent doing the above would vary but as an estimate I would have probably spent about half a day speaking to staff, over half a day reviewing records, and about half a day speaking to patients and relatives. The last couple of hours of any inspection was usually spent preparing our report and summary and it felt as though we were always rushing; there was never really enough time.

Q6: Does RQIA conduct meta-analysis of inspections to identify recurring themes? If so, please provide details:

49. I do not know if RQIA currently conducts meta-analysis of inspections to identify recurring themes.

Q7: From in or around 2015, a direct observation schedule was used ('QUIS'). In relation to this schedule:

(i) Was it useful?
(ii) What, if anything, did it reveal that other methods did not?

50. I was not employed by RQIA in 2015 so cannot answer this question.

Q8: Some RQIA inspections were announced, and some were unannounced.

(i) How was this decided, and who was this decided by?
(ii) Were there any differences in outcome? If so, what were they?

51. During my time at RQIA, inspections were allocated by managers. Unannounced inspections were usually in relation to concerns so the focus was more specific and the outcomes dependent on the issues raised.

Q9: Did RQIA inspectors who visited MAH have learning disability training? If so, please provide details.

52. I did not have specific learning disability training during my time at RQIA. There were four full time inspectors in the team (including me) and we all had our own specialist fields. I was the mental health social worker in the team. We also had a nurse from a mental health background, an occupational therapist and another social worker specialising in learning disability.

53. Upon joining RQIA, I went through an induction process, albeit I cannot recall it in detail. I also attended on inspections with other teams within RQIA to gain an understanding of their roles but again I cannot recall this in great detail.

54. I do recall that training was provided in relation to the Mental Capacity Act (NI) 2016 ("**MCA**") as, at the time, the MCA was still being devised and a team of those involved in the preparation of the MCA came to RQIA to talk to us about it.

55. A lot of the training that I received was very much "on the job" training. I learned from other inspectors, other social workers and senior managers as we all came from different backgrounds and had various skill sets.

Q10: In respect of wards which were inspected by RQIA:

(i) Were there obvious and sustained differences between wards? If so, what were those differences and what does RQIA attribute those differences to?

56. The wards differed in relation to patient need. For example, intensive nursing wards were for patients displaying high risk behaviours or there were more open wards for the less dependent patients or those being prepared for discharge. There was quite a range within the whole setting of MAH.

(ii) Were those differences in 'culture' between wards? If so, what were those differences, and how can they be explained?

57. I am not able to provide an assessment of the differences in culture between wards. If I had been concerned that a "culture" or regime on a ward was inappropriate in any way I would have addressed it by speaking to the Ward Manager and also my manager in the MHLD Team.

58. I do not recall having any concerns over culture at MAH.

(iii) How were families selected for consultation during RQIA inspections?

59. In preparation for an announced inspection, my recollection is that approximately a four to six weeks before an inspection, a pack containing self-assessment questionnaires for staff and questionnaires for patients and relatives were provided to the Ward Manager. The Ward Manager was then asked to distribute the questionnaires to patients and relatives in order to notify them that an inspection was taking place and to give them the opportunity to complete the questionnaires and return them to RQIA.

60. Families would not be informed of unannounced inspections because of the nature of the inspection. As I have explained in this statement, unannounced inspections during my time at RQIA were usually the result of a particular concern raised with RQIA and so it would not necessarily be appropriate to speak to a relative during such an inspection. That said, had a relative wished to raise concerns then we would of course have spoken with them.

Q11: Some wards and staff have been extensively criticised by families, however these criticisms do not appear in RQIA inspection reports. How can this be explained?

61. I cannot explain why this would be the case. I can only refer to my own reports where I would quote relatives' comments and summarise responses from their questionnaires, whether positive or negative.

Q12: Were inspections ever carried out because of complaints received from families of patients? If so, was an investigation ever initiated following a

single complaint, or was more than one complaint on an issue required before an inspection would be carried out?

62. Yes. Although I have no direct recollection of this particular inspection, I can see from a review of the inspection reports that I was involved in for MAH that an unannounced inspection was carried out at Sixmile ward on 5 September 2012 following a complaint made by the mother of a patient. This appears to be a single complaint made to RQIA about a series of complaints made to MAH by the patient's mother.

63. I note from the inspection report that a QIP was produced with thirteen recommendations.

Q13: How can the difference between what was seen by inspectors on the MAH wards and what happened on the CCTV in 2017 be explained?

64. I cannot give an explanation as to this.

65. I would also reiterate that I was not employed by RQIA in 2017.

Q14: Occasionally RQIA focussed inspections on topics, for example, finance or resettlement. What led to a topic focussed inspection being carried out?

66. I would say that all inspections are topic focussed. Announced inspections were focussed on particular topics; human rights is a topic that I can recall being such a focus. Unannounced inspections were focussed on the need that initiated the inspection.

67. I cannot however recall how or what would lead to a topic focussed inspection being carried out, unless it was an unannounced inspection following notifications of concerns over a setting.

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

68. As I have explained above, my memory of this time period is limited and I do not recall compiling the reports although having reviewed them as part of this exercise I can see that I attended during three inspections in the aftermath of the allegations. The details below are taken directly from the inspection reports.

69. The first unannounced inspection took place on 13 November 2012. The purpose of the inspection was to review the QIP from the last inspection on 10 and 11 November 2010, and to review the current safeguarding arrangements on the ward.

70. The second unannounced inspection took place on 20 December 2012. The purpose of this inspection was to clarify the action taken by BHSCT in relation to its safeguarding investigation and review the safeguarding processes in place on the ward.

71. The third unannounced inspection took place on 29 January 2013. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults and the governance arrangements, including the reporting of incidents and support for staff and patients in relation to safeguarding issues.

Q.16: When and how did RQIA receive the Ennis report? Please provide details.

72. I do not know. I was not employed by RQIA when the Ennis report was published.

Q17: What was RQIA's response to the Ennis report?

73. I refer to paragraph 72.

Q18: What role did RQIA have in the oversight of the implementation of recommendations arising from Ennis?

74. I refer to paragraph 72.

Q19: What steps, if any, did RQIA take to investigate other wards following the situation that arose at Ennis ward? What actions were taken following any such investigations?

75. I do not know the answer to this. I was involved in one inspection of another MAH ward following the unannounced Ennis ward inspection on 29 January 2013. From reviewing that report, which was an announced inspection of Oldstone ward (13 March 2013) it was part of the pilot programme I referred to above to involve *Experts by Experience* (service users) in inspections.

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: 19 April 2024

List of Exhibits (Margaret Cullen)

Exhibit 1: Inspection schedule.

ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

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Date: 19 April 2024

EXHIBIT 1

Table of Inspection Reports completed by Margaret Cullen

Date	Ward	Type of Inspection
06/06/2010	Donegore	PER
06/07/2010	Foybeg	PER
08/07/2010	Killead	PER
27/07/2010	Sixmile Assessment	PER
28/07/2010	Sixmile Treatment	PER
10/11/2010	Ennis	Announced
13/12/2010	Cranfield F	Announced
15/02/2011	Cranfield M	Announced
12/04/2011	Donegore	Announced
23/06/2011	Oldstone	Announced
13/10/2011	Sixmile Assessment and Treatment	PER
24/01/2012	Greenan	QIP
25/01/2012	Greenan	Announced
29/06/2012	Cranfield ICU	Announced
05/09/2012	Sixmile Treatment	Unannounced
13/11/2012	Ennis	Unannounced
20/12/2012	Ennis	Unannounced

29/01/2013	Ennis	Unannounced
13/03/2013	Oldstone	Announced
12/04/2013	Donegore	Announced