ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Alan Guthrie
Date: 28 March 2024

I, Alan Guthrie, make the following statement for the purpose of the Muckamore Abbey Hospital ("**MAH**") Inquiry.

The statement is provided by me in my capacity as a former employee of the Regulation and Quality Improvement Authority ("**RQIA**") in response to a request for evidence by the Inquiry Panel.

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. I hold a Diploma in Higher Education for Social Work from the University of Ulster awarded in 1995. I hold a Professional Development Degree in Social Work from the University of Ulster awarded in 2001. I hold a Masters degree in Advanced Social Work from Queens University awarded in 2007. I have been an Approved Social Worker since 2011. I hold a Postgraduate Diploma in Applied Social Sciences (Mental Health) from Queens University awarded in 2011. I hold a Post Graduate Diploma in Health and Social Care Management from the University of Ulster awarded in 2018.

2. I have held the following positions. From 1988 to 1992, I was a Care Assistant and Acting Senior Care Assistant working in the Loughside Unit of Management. I worked in a residential home supporting individuals with a learning disability. From 1995 to 2001, I was a Probation Officer working for the Northern Ireland Probation Service. From 2001 to 2004, I was a Social Worker working with the North and West Belfast Health and Social Trust Addiction Service. From 2004 to 2012, I was a Senior Social Work Practitioner ("**SSWP**") with the Northern Health and Social Care Trust Addiction Service. From 2012 to 2013, I was a SSWP with the Northern Health and Social Care Trust Mental Health Service. From 2013 to April 2020, I worked with the Regulation and Quality Improvement Authority ("**RQIA**") as a Mental Health and Learning Disability ("**MHLD**") Inspector and Acting Senior Inspector. This included working as an acting Senior Inspector ("**SI**") within the MHLD team for approximately five weeks between November and December 2019. I currently work in the Belfast Health and Social Care Trust as a Social Work Lead within the Trust's Primary Care Social Work Service.

Module

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

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

5. 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.

Q1. Please explain the methodology of your visits to MAH as an RQIA Inspector throughout the time 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. How inspector(s) were selected to conduct an inspection

6. Upon commencing my position as an RQIA MHLD Inspector, and following my induction to RQIA, the MHLD Senior Inspector and the Head of Programme ("**HOP**") allocated me a caseload of MHLD wards. This included wards within MAH. My responsibilities as an inspector involved organising at least one inspection visit of each ward on my caseload every twelve months. The SI/HOP reviewed and realigned inspector caseloads annually in March each year. Subsequently, with exception to the Six Mile ward, I did not maintain a consistent caseload of wards in MAH. I have included at **Exhibit 1** a schedule of the inspection visits to MAH that was involved with in my role as an RQIA inspector.

7. Alongside managing a caseload, the SI/HOP selected me to conduct inspection visits when deemed necessary following receipt of information regarding an MAH ward from a relative, member of staff or anonymous caller. Between February 2013 and April 2020, I completed three inspection visits of MAH wards following receipt of information from anonymous callers:
    a. Killead Ward 28 October 2016;
    b. Cranfield Male 17 July 2017; and-
    c. Cranfield Male 1 – 22 November 2018.

8. I was the second inspector during the inspection visit of Cranfield Male Ward on the 22 November 2018. This inspection visit took place following receipt of information, of a safeguarding nature, in respect of a specific patient being brought to the attention of RQIA's MHLD team.

9. Between February and December 2019, following a request by the MHLD SI/HOP, I was selected to be part of a large inspection team to complete three inspections of MAH.

10. Inspectors were also selected to conduct inspection visits of facilities in accordance with RQIA's role as a National Preventative Mechanism organisation. Between March 2013 and December 2019, I was selected to be a part of inspection teams when inspection visits were conducted within Northern Ireland prisons.

ii. The information inspectors were provided with in advance of an inspection

11. Prior to completing an inspection visit to a ward in MAH, I accessed a broad range of information relevant to the ward. The information I assessed and considered prior to an inspection visit included:
    a. previous inspection reports and previous recommendations made following the last inspection;
    b. ward self-assessments and returned patient, relative and staff questionnaires (1 February 2013 – March 2015);
    c. the wards Inspection Planning tool (Red/Amber/Green rating);
    d. previous duty calls that may have been received by RQIA MHLD regarding the ward;
    e. information regarding the ward's application of procedures carried out in accordance to the Mental Health (Northern Ireland Order) 1986 (MH(NI)O1986);
    f. information on complaints or concerns about the ward;
    g. serious adverse incident notifications;
    h. information regarding safeguarding alerts.

iii. The process of preparing for an inspection

12. RQIA's MHLD annual inspection timetable commenced on the 1st April of each year. At the start of each inspection year, I agreed a timetable of inspection visits for the preceding year with the SI/HOP. Preparation for each inspection was dependant on the type of inspection visit required and the inspection methodology being implemented.

13. The inspections I completed of the Oldstone, Donegore and Six Mile wards between 23 July 2013 and the 29 October 2013 were care inspections. Care inspections were designed to review the care and treatment provided to patients

and to assess the overall standard of care provided within the ward. Care inspection methodology applied during this period had three key parts: self-assessment, pre-inspection analysis and the inspection visit. Self-assessment involved the Ward Manager completing a self-assessment questionnaire and distributing questionnaires to patients, relatives and ward staff. The self – assessment and questionnaires were then returned to me at RQIA prior to the completion of the inspection visit. In preparation for the subsequent inspection visit, I completed the following tasks:

a. I reviewed the wards self-assessment completed by the Ward Manager;
b. I reviewed questionnaires returned by patients, relatives and ward staff;
c. I completed a review of the information available to RQIA MHLD as detailed in paragraph 11 above;
d. I discussed and agreed my inspection visit plan with the SI/HOP. This included reviewing and categorising any issues or concerns raised by patients, relatives and staff as detailed in returned questionnaires. The potential need for a second or specialist inspector was also assessed and agreed; and
e. I prepared my inspection pack(s). The pack(s) included inspection visit posters to place on the ward during the inspection, copies of the information available as detailed in paragraph 11, blank copies of patient, relative and staff questionnaires and the wards self-assessment. I prepared packs for second inspectors.
f. Unlike Health and Social Care regulated settings, there are no specific regulations that detail the expectations of MHLD hospitals. I worked against the broad concept quality standards when inspecting and, to assist with assessing the finer details of a service, I carried/had access to copies of the RQIA MHLD reference documents relevant to the needs of patients admitted to the ward. I have exhibited a table of those reference documents at **Exhibit 2.**

14. My inspection visit of the Six Mile Ward completed on the 12 November 2013 was a patient experience interview ("**PEI**") inspection. In preparation for the inspection

visit, I reviewed all the information available to RQIA MHLD as detailed in paragraph 11. I prepared my inspection pack, which included inspection visit posters, patient questionnaires, the ward's last PEI report and the wards last care inspection report. I did not follow up on the previous recommendations made following the ward's most recent care inspection. This was not part of the PEI inspection methodology. Recommendations made following the most recent care inspection visit were assessed at the next care inspection visit. I also carried copies of/had access to RQIA MHLD reference documents relevant to the needs of patients admitted to the ward.

15. During my inspection visit of the Oldstone Ward on the 23 July 2013, an MHLD nursing inspector accompanied me. Their role was to assist me, as this was my first care inspection of a ward in MAH.

16. An MHLD nursing inspector supported my inspection visit of the Donegore ward on the 16 September 2013. The nursing inspector was shadowing me as part of their induction.

17. Following the introduction of new inspection methodology on the 1 April 2015 all care inspection visits were unannounced. The process of preparing for an inspection visit from 2015 onwards was similar to the preparation as detailed in paragraph 13 with exception to reviewing the ward's self-assessment and pre-inspection questionnaires completed by patients, relatives and staff. The pre-inspection self-assessment and pre-inspection questionnaires were withdrawn. From 2015 onwards patient, relative and staff experiences were captured as part of the care inspection visit. PEI inspection visits also continued. Lay assessors commenced joining inspection visits from 2015 onwards. Lay assessors were volunteers who joined inspectors on inspection visits to assist in capturing patients and relatives' experiences of the ward. Lay assessors received training from RQIA prior to commencing their role.

iv. Communications with MAH and others in advance of an inspection

18. The RQIA MHLD care inspection methodology applied during the period 1 April 2013 to 31 March 2015 included a pre inspection self-assessment of the ward. The Ward Manager completed this prior to the inspection visit. Subsequently, before completing an inspection visit, I contacted the Ward Manager/MAH approximately four weeks before an inspection visit took place. I advised the Ward Manager that a self-assessment report and questionnaires would be sent to the ward. Self-assessment reports and questionnaires had return by dates attached to them. The Ward Manager returned the self-assessment and questionnaires prior to the inspection visit taking place.

19. In keeping with the inspection methodology, ward managers were not informed of the date the inspection visit would take place. During this period PEI inspection visits were also completed. Prior to a PEI inspection, the Ward Manager/MAH were contacted and advised that a PEI inspection would take place. Prior to a PEI inspection taking place, I contacted the Ward Manager approximately a week before the visit and advised them of the purpose of the inspection visit and the date and time it would take place.

20. Following the introduction of new inspection methodology on the 1 April 2015 all care inspection visits were unannounced. Subsequently, I made no contact with the Ward Manager/MAH prior to a care inspection visit taking place. A number of PEI inspections continued during May and June 2015. Ward Mangers /MAH were informed that a PEI inspection visit would take place approximately one week before the visit took place.

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

21. Please refer to **Exhibit 3.** Exhibit 3 provides a brief summary of how I managed my inspection visits.

VI. The process of reporting

22. Pre- inspection visit: Please refer to paragraph 13 (above) and my role to report my inspection plan to the RQIA MHLD SI/HOP.

    a. During inspection: Please refer to Exhibit 3 and reporting I completed during the inspection visit.

    b. Post inspection: Please refer to Exhibit 3 and the process of reporting post inspection. Please see paragraphs 25-29.

VII. The time taken to complete the inspection process

23. The time taken to complete the inspection process was approximately thirteen weeks for an announced care inspection, (allowing four weeks for issuing and return of the self-assessment and questionnaires), and nine weeks for an unannounced care inspection (from 2015 onwards). The time taken included, pre-inspection planning, the inspection visit and the time allotted to have the draft report completed and forwarded to the ward/MAH (28 days) and the time allotted in which the report be returned (28 Days). The time taken would vary should the ward be subject to a serious concerns meeting.

VIII. Communications with MAH and others post-inspection.

24. Following completion of an inspection visit communication with MAH and others was dependent upon the findings from the inspection. On occasion, the Ward Manager would provide any outstanding information that I may not have been able to access during the inspection. In these circumstances, I discussed this with the SI/HOP. If agreed, the Ward Manager would have been given an extra working day to return the information. The provision of an extra day to return information related to evidence that the Ward Manager may not have been able to access at

the time of the inspection visit. For example, a draft of an updated policy that may have been with a MAH senior manager in another part of MAH.

25. If the outcome of the inspection visit did not evidence any serious concerns post inspection contact with MAH and others would follow the procedure as detailed from Exhibit 3 paragraph 28. If the outcome of the inspection visit noted serious concerns members of the Ward's senior leadership team, MAH Senior Management team and the Trust Senior Management Team were requested to attend a serious concerns meeting at RQIA. This would delay the issuing of the inspection report whilst awaiting the outcome of the serious concerns meeting.

Q2: 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?

26. To the best of my knowledge and belief, I do not have any other matters to draw to the attention of the Panel that may assist the Panel's consideration of paragraph 13 of the Terms of Reference.

The MAH Inquiry's Questions to RQIA

27. The Inquiry has provided to me a list of questions that have been sent to RQIA for a corporate response. Where possible, I have provided my own responses to those questions in the remainder of this statement.

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?

28. The decision to change the inspection methodology was made by RQIA's MHLD Senior Management Team. I recall that RQIA began to inspect MAH as one service following recommendations made in the 'A Way to Go' report completed by an

independent team chaired by Dr Margaret Flynn. The 'A Way to Go' report was published at the end of 2018.

II. What were the advantages and disadvantages of each approach?

29. Inspecting individual wards:

    a. Advantages:
        i. The opportunity to assess the ward and the care provided from the perspective of patients, relatives ward staff and the ward's MDT.
        ii. The opportunity to review the ward's systems and assess the quality of care provided to patients.

    b. Disadvantages:
        i. The inspection of an individual ward could not facilitate a full review the ward's position and integration within the wider MAH.
        ii. Inspecting individual wards required a greater number of inspection visits across MAH bringing greater disruption to MAH, patients and staff.

30. Inspecting MAH as a whole:

    c. Advantages:
        i. The opportunity to complete in-depth assessment of the care and treatment provided to patients admitted to each ward across the MAH site.
        ii. The availability of a greater number of specialist inspectors ensuring a more comprehensive review of MAH processes, systems and governance arrangements.

    d. Disadvantages:
        i. A large inspection team brought greater disruption to MAH and to patients, relatives and staff.

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?

31. The RQIA Senior Management Team made the decision to change the method of inspection to exclude self-assessment and to introduce different inspection criteria. Prior to the introduction of the new criteria, I was consulted and my view was sought. I recall that in my feedback to the SI/HOP, I expressed my view that the inspection criteria I used between February 2013 and the end of 2014 presented some challenges.

32. In my experience, the self-assessment did not always present an accurate reflection of a ward's position. Self-assessments did not always reflect my findings following an inspection visit. In addition, the emphasis on the Ward Manager to complete the self-assessment required the Ward Manager to assess the effectiveness of the ward's multidisciplinary team ("**MDT**"). I also noted that the issuing of a self-assessment and questionnaires prior to an inspection informed the Ward Manager that an inspection visit was pending. I believed that this had the potential to put the Ward Manager and ward staff under unnecessary pressure.

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

33. RQIA MHLD inspection methodology implemented before 2018 involved inspection visits of individual wards. The number of inspectors completing inspection visits using this methodology generally did not exceed two inspectors and a lay assessor.

34. In 2018, RQIA MHLD introduced a new inspection methodology. This methodology involved inspection visits that considered MAH as a whole. A larger number of

inspectors were involved to facilitate inspection visits to each ward and to focus on other areas of MAH including, pharmacy provision, finance management, estates management, primary care medical provision and Senior Management Team structures.

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

I. Developing key lines of inquiry.

35. In my role as an MHLD inspector, between February 2013 and April 2020, I was involved in continuous review of RQIA's role and inspections carried out in MAH. Through individual supervision, team meetings, training, inspection planning days and team training, I assisted in identifying key lines of inquiry relevant to wards in MAH and as evidenced in findings from my inspection visits. The key lines of inquiry identified, and followed up in subsequent inspection visits, included:
    a. management of restrictive practices;
    b. patients experiencing a delay in their discharge from hospital;
    c. safeguarding processes;
    d. staffing levels;
    e. skill mix within ward Multi-disciplinary Teams;
    f. management of processes in accordance to the MH(NI)O (1986).

36. The most challenging area for me as an inspector in managing key lines of enquiry, was the lack of community resources and support for those patients whose discharge from MAH was delayed. During most of my care inspection visits, I identified a number of patients in this situation. Whilst I reviewed this as part of my inspection, and reported my findings, there was no immediate solution to address this gap in patient care. Following inspection visits, I relayed my findings to the SI/HOP. I understood that the issue of patients experiencing a delay in their discharge from MAH was being reported to, and monitored by, the Northern Ireland Health and Social Care Board.

II. Analysing key themes over time.

37. In my experience as an MHLD inspector, RQIA MHLD's effectiveness at analysing key themes over time was good. During my inspection visits, I reviewed those themes identified as key. Key themes continued to be assessed and analysed to ensure that MHLD inspection methodology objectively measured how a ward(s) was performing in delivering these practices. Inspection indicators used to measure the ward(s) performance were informed by best practice guidance. I made a number of recommendations related to these themes.

III. Following up on recommendations

38. During my role as an MHLD inspector, I found RQIA MHLD's systems for following up on recommendations, made following care inspection visits, to be robust. Recommendations previously stated in an inspection report were followed up at the next inspection visit. Recommendations were restated as required and only removed once the ward had met/implemented the recommendation. When wards closed, the recommendations made at the last visit of that ward would 'follow' the patient group and should be considered at the next inspection of the ward that included that patient group.

IV. Responding to individual patient concerns identified at inspections.

39. During my inspection visits, I actively sought input from patients where patients were able to do so. I observed the care and treatment provided to all patients. When I identified a patient concern, or a patient concern was shared with me, I reviewed that concern and followed it up during the inspection visit. As an inspector, I prioritised patient concerns and discussed the action I would take with the patient. I discussed patient concerns with the Ward Manger and the MDT and

ensured that any concern was managed in accordance with policy and procedure. I recorded the concern and the action taken in the inspection report.

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

I. What proportion of time was spent speaking to staff?

40. Please refer to Exhibit 3. Exhibit 3 provides an overview as to how I conducted my inspection visits. This includes the proportion of time I spent speaking with staff.

II. What proportion of time was spent checking paper/electronic records?

41. Please refer to Exhibit 3. Exhibit 3 provides an overview as to how I conducted my inspection visits. This includes the proportion of time I spent checking paper/electronic records.

III. What proportion of time was spent interviewing patients?

42. Please refer to Exhibit 3. Exhibit 3 provides an overview as to how I conducted my inspection visits. This includes the proportion of time I spent interviewing patients.

IV. Was sufficient time spent on each of the above?

43. During my inspection visits to wards in MAH, sufficient time was spent interviewing patients and interviewing staff. I would have interviewed all patients and staff who wished to speak with me. If required, I would have arranged with the MHLD SI/HOP to extend inspection visits by a further day/half day to complete interviews. I had sufficient time to check paper and electronic records specific to the ward I was inspecting.

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

44. I do not know if RQIA currently conducts meta-analysis of inspections to identify recurring themes. In my role as an MHLD inspector, I was involved in meta-analysis reviews in relation to inspection visits of MAH wards. During team meetings, inspection planning days and team training, the MHLD team continually reviewed outcomes from inspection visits completed of MAH wards. Recurring themes were identified these included:

    a. management of restrictive practices
    b. patients experiencing a delay in their discharge from hospital
    c. safeguarding processes
    d. staffing levels
    e. skill mix within ward Multi-disciplinary Teams (MDT)
    f. management of processes in accordance to the MH(NI)O 1986.

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

I. Was it useful?

45. Please refer to Exhibit 3. I have provided a summary of my application and experience of using the QUIS tool in paragraph 11.

II. What, if anything, did it reveal that other methods did not?

46. Please refer to Exhibit 3. I have provided a summary of my application and experience of using the QUIS tool in paragraph 11.

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

I. How was this decided, and who was this decided by?

47. The RQIA MHLD senior management team, through its application of inspection methodology, made the decision as to whether an RQIA MHLD inspection should be announced or unannounced.

II. Were there any differences in outcome? If so, what were they?

48. In my experience as an MHLD inspector I noted key differences in outcomes between an inspection visit that was announced and an inspection visit that was unannounced:

   a. Unannounced inspection visits provided a more objective insight into the quality of care delivered. There was no preparation for an inspection visit completed by the ward staff;
   b. Unannounced inspections gave me the opportunity to assess patient, relative and staff experiences and views of the ward on a typical day;
   c. Unannounced inspections resulted in less contact with relatives. I believe this was largely due to the timings of inspection visits being outside natural visiting times. Announced inspections included the issuing of pre inspection questionnaires to relatives. This helped to promote relatives' involvement during the inspection process.

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

49. Prior to commencing my role as an RQIA MHLD inspector, I had completed a range of training relevant to working with and supporting people who had a learning disability. I previously worked as a care assistant in a residential setting. During this role I completed continuous in-service training including: understanding learning disability, communication, empowerment and person-centred care, wellbeing and independence, managing epilepsy, nutrition and hydration, equality and promoting independence and supporting people with profound and multi learning disabilities.

50. In 2009, I commenced training as an approved social worker (ASW). During my ASW training, I completed a placement in a community social work team supporting people with a learning disability. I assessed people and developed care and support plans alongside individuals and their families. I developed my knowledge and skills in the management of risk, application of the law, and safeguarding. I assessed people with a learning disability under the MH(NI)O (1986) and implemented care plans to meet the individual's presenting needs, promote wellbeing and minimise risk.

51. As an MHLD inspector, I was provided with a broad range of training relevant to working with people who had a learning disability. Alongside annual mandatory training, relevant to my role, I recall completing the following training with RQIA:

    a. Human rights training;
    b. ASW refresher training;
    c. Training in monitoring nutrition, hydration and dysphagia;
    d. MH(NI)O1986 and Mental Capacity Act (Northern Ireland) 2016 training;
    e. Mental Health first aid training;
    f. Supporting people with a learning disability and autism training;
    g. Training in the management and monitoring of use of restrictive practices;
    h. Supporting people at risk of behaviours that challenge;
    i. Serious adverse incident and incident management training;
    j. Risk management training;
    k. Reporting writing and completing easy to read reports;
    l. Advocacy training;
    m. Managing challenging behaviour and positive behaviour support planning;
    n. Adult Safeguarding training;
    o. Quality improvement training (Lean Methodology and audit); and
    p. Training in completing inspections and application of inspection methodology.

52. Between 2016 and 2018, I completed a post Graduate Diploma in Health and Social Care Management. RQIA seconded and supported me to complete the course.

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?

53. There were obvious and sustained differences between wards. The differences included the use of restrictive practices, the differences in the levels of care and treatment being provided to meet patient needs and the challenges for wards providing care and treatment to patients who were unwell whilst, at the same time, supporting patients whose discharge from MAH had been delayed.

54. In my experience, there were three key reasons for the sustained differences between wards. Firstly, the ward's role and function. For example, the Six Mile ward was an all-male regional low secure ward for people with a learning disability who may have also been involved with the judicial system. Subsequently, restrictive practices (locked front door, removal of mobile phones and other items) were implemented in accordance with the ward's function.

55. Secondly, the levels of care being provided by a ward. For example, Cranfield male and female wards provided care and treatment to patients who were acutely unwell. Subsequently, the wards used a greater level of one-to-one observations and supported a larger number of patients who were initially ward based.

56. Finally, a number of the wards I inspected from mid-2015 onwards, were providing care to patients whose discharge from MAH had been delayed. This was particularly evident in my inspections of Cranfield female ward, Killead ward and Cranfield male ward. The sustained difference for these wards was the continued challenge for the ward's MDT in balancing the needs of those patients who were unwell, against the needs of those patients who had completed their acute care treatment and were ready to be discharged form MAH. During my inspection visits,

I assessed that those patients who were ready for discharge from MAH required a high level of care and support that, I was informed, was not available in the patient's local community.

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

57. As an MHLD inspector, I spent between two and three days each year inspecting a ward. On occasion, I would visit a ward more than once a year. This was usually to complete an inspection visit following intelligence received by the RQIA MHLD team. Given the limited time I spent on a ward and that the Six Mile ward was the only ward I visited consistently each year between 2013 and 2017, I cannot provide an accurate assessment of potential differences in culture between wards.

III. How were families selected for consultation during RQIA inspections?

58. Between 2013 and late 2014 families were consulted during RQIA MHLD inspections through the distribution of pre-inspection questionnaires and, when relatives were available, through face-to-face interviews with the inspector during an inspection visit. During this period, the Ward Manger distributed the questionnaires to families. Form 2015 onwards families could consult with an inspector during an inspection visit. During my inspection visits, I would have met with relatives on the ward. I also asked the Ward Manager to inform relatives that I was completing an inspection and would be available to meet with relatives. (Please see Exhibit 3 paragraph 4).

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?

59. I cannot explain as to why families' criticisms of some wards and staff do not appear in RQIA inspection reports. During my pre-inspection preparation, I considered all of the information available to RQIA regarding a ward. This included intelligence RQIA may have received from relatives and relatives' questionnaires returned to

RQIA before an inspection visit took place (2013 - 2014 inspection methodology). During my inspection visits, I welcomed the opportunity to meet with relatives. Unfortunately, I was not able to meet with relatives during each inspection visit as relatives were not always available. This may have been due to the timings of inspection visits. Inspection visits generally took place Monday and Friday between 9am and 6pm.

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?

60. When a relative/family of a patient raised a concern or made a complaint about a service, MHLD inspectors and the SI/HOP assessed the information provided and took appropriate steps to follow up on the concerns raised. This included completing inspections. Whilst RQIA did not manage formal complaints about a service, inspectors used the information provided by relatives and families as intelligence to help inform inspectors about the current position of the ward.

61. To the best of my knowledge, inspections were carried out following intelligence received from the families of patients. Investigations were also initiated following the receipt of a single episode of intelligence being shared. Between February 2013 and April 2020, I carried out three inspection visits following intelligence being shared regarding a ward in MAH. Inspection visits were completed within one working day of receiving the intelligence. The intelligence sources which led to me completing the inspections were anonymous. I cannot confirm if families of relatives shared the intelligence. From my review of inspection reports, I note that the inspections undertaken by me based on intelligence received in this way were:

    a. Killead ward, 28 October 2016;
    b. Cranfield Male 1, 13 July 2017; and
    c. Cranfield Male 1 – 22 November 2018.

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?

62. I cannot explain the difference between what I saw during my inspection visits to MAH wards and what happened on the CCTV in 2017. During my inspection visits, I never witnessed MAH staff being abusive or demonstrating abusive behaviour toward a patient(s). Had I witnessed such behaviours, I would have addressed them immediately and directly and ensured that the appropriate action was taken to stop the behaviour and to protect the patient(s). Had I have witnessed any abusive behaviour during an inspection visit, my response would have included the involvement of the Police Service for Northern Ireland.

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

63. Topic focussed inspections were planned and implemented by the MHLD Senior Management Team. I recall that finance inspections were arranged to ensure appropriate oversight of RQIA's duties in accordance with the MH(NI)O (1986).

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

64. I commenced working as an RQIA MHLD inspector in February 2013. I was not involved in the investigation into the allegations in November 2012 arising from Ennis ward. I was not involved in RQIA's role in the investigation nor was I involved in RQIA's response to the Ennis report and therefore am not able to comment in response to the Inquiry's questions in relation to the Ennis ward.

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

65. I refer to paragraph 64 above.

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

66. I refer to paragraph 64, above.

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

67. I refer to paragraph 64, above.

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?

68. I refer to paragraph 64, above.

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: 28 March 2024

List of Exhibits (Alan Guthrie)

Exhibit 1: Inspection visits of MAH completed by Alan Guthrie.

Exhibit 2: RQIA MHLD reference documents.

Exhibit 3: The mechanics of completing an inspection.

ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Alan Guthrie
Date: 28 March 2024

EXHIBIT 1

Inspections of MAH completed by/involving Alan Guthrie between 1 February 2013 and 1 April 2020

The information detailed below is true to the best of my knowledge and based on the information available to me.

1. 1 April 2013 – 31 March 2014

   During this period, I completed four inspection visits of wards in MAH:

   1. Oldstone Ward 23 and 24 July 2013
   2. Donegore Ward 16 September 2013
   3. Six Mile Ward 29 and 30 October 2013

2. 1 April 2014 – 31 March 2015

During this period, I completed four inspection visits of wards in MAH:

1. Oldstone Ward 7 May 2014
2. Six Mile Ward 7 and 8 May 2014
3. Erne Ward 9 and 10 December 2014
4. Six Mile Ward 14 and 15 January 2015.

5. 1 April 2015 – 31 March 2016

During this period, I completed four inspection visits of wards in MAH:

1. Moylena Ward 20 and 21 May 2015
2. Six Mile Ward 17 June 2015
3. Erne Ward 23 June 2015
4. Cranfield Female Ward 16 – 20 November 2015.

6. 1 April 2016 – 31 March 2017

During this period, I completed two inspection visits of wards in MAH:

1. Killead Ward 28 October 2016
2. Six Mile Ward 31 January – 2 February 2017.

N.B. I completed a limited number of inspection visits of wards in MAH during this period as I was seconded into another RQIA team as an acting Senior Inspector. My secondment was between March and June 2016 (approx.).

7. 1 April 2017 – 31 March 2018

During this period, I completed two inspection visits of wards in MAH:

1. Cranfield Male Ward 16 May – 18 May 2017
2. Cranfield Male Ward 13 July 2017.

8. 1 April 2018 – 31 March 2019

During this period, I participated in two inspection visits of wards in MAH:

1. Cranfield Male Ward 22 November 2018 (second inspector)
2. MAH all wards 26 – 28 February 2019 (Large inspection team).

9. 1 April 2019 – 31 March 2020

During this period, I participated in two inspection visits of wards in MAH:

1. MAH all wards 15 – 16 April 2019 (Large inspection team)
2. MAH all ward 10 – 12 December 2019(Large inspection team).

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MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Alan Guthrie
Date: 28 March 2024

EXHIBIT 2

RQIA MHLD reference documents

MHLD Document Number	Legislation Title
1	AIMS – Older People 2009)
2	AIMS Working Age Adults (2009)
3	AIMS Learning Disabilities (2010)
4	Circular HSS (F) 57/2009 – Residents Monies
5	Complaints in HSC Resolution and Learning (2009)
6	DHSSPS Interim Guidance – Deprivation of Liberty (2010)
7	DHSSPS Guidance – Restraint and Seclusion (2005)
8	Human Rights Act (1998)
9	Improving Dementia Services Reg' Strategy (2011)
10	Learning Disability Service Framework (2012)
11	Mental Health (NI) Order (1986)
12	NICE Quality Standard 14 – User Experience (2011)
13	NICE Clinical Guideline 136 - User Experience (2011)
14	OPCAT (2002)
15	Procedure for Reporting and Follow Up of SAIs (2010)
16	Promoting Quality Care (2009)
17	Quality Standards for HSC (2006)
18	Safeguarding VA's – Shared Responsibility (2010)
19	Safeguarding Vas – Protection Policy and Guidance (2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention – Person with Disabilities (2006)
22	UN Convention – Rights of the Child (1989)
23	UTEC Guidance(2007)

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MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

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EXHIBIT 3

The mechanics of completing an inspection including my approach to communications with staff and patients and the inspection of records.

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1. The detail contained within this exhibit describes the structure and routine I applied when completing/leading inspection visits. The timings are approximate. The order in which I conducted the inspection visit was subject to change (for example interviewing ward MDT staff when they were available). The structure remained the same for each inspection visit I completed in MAH as the lead inspector. When a second inspector and or a lay assessor joined me, I agreed their role and adjusted my plan. A lay assessor had a set role involving meeting with patients and completing patient experience interviews ("**PEI**").

Day 1

2. On the first day of an inspection visit, I arrived at the ward at approximately 9am. I entered the ward; I identified myself to staff and stated my purpose for

entering the ward. I then proceeded to the ward's main office to introduce myself to the Ward Manager or the Charge Nurse. I would explain to the Ward Manager/Charge Nurse ("**WM/CN**") the purpose of my visit.

3. Following introductions, I would meet with the WM/CN to review the ward's circumstances on the day and to discuss how I would conduct the inspection visit. I ensured that the WM/CN notified the MAH senior managers that an inspection visit was taking place. I also completed a verification form regarding the ward's function. The verification form also included, the ward's contact details, the number of patients admitted to the ward, the number of patients admitted in accordance to Mental Health (Northern Ireland) Order 1986 (MH(NI)O 1986), the number of staff on duty and details regarding any current incident notifications or safeguarding concerns. I advised the WM/CN of the type of the inspection visit I was completing and the inspection methodology I was using.

4. Following completion of the verification form, and having received an update regarding the current circumstances of the ward, I requested the WM/CN inform other ward professionals, within the wards multi-disciplinary team (MDT), that I would be contacting them during the next two days to interview them regarding the ward and staff. The WM/CN supported me to arrange interviews with MDT staff and those commenced on the afternoon of the first day of the inspection visit. I detailed that I would also conduct interviews/observations with patients. I asked the WM/CN to offer all patients the opportunity to meet with me. I requested that the WM/CN inform relatives that I was conducting an inspection visit. I told the WM/CN that I would introduce myself to any relatives present in the ward during the inspection.

5. I informed the WM/CN that I would be examining ward records. I provided the WM/CN with a list of the information that I required. This included:

- at least four patient files to review (selected by me at random);
- the ward's staff training records;
- supervision dates and arrangements for staff;

- the wards incident reports;
- access to the wards Datix system;
- access to the ward's patient information system (PARIS);
- recent safeguarding referrals and associated records;
- ward multi-disciplinary team (MDT) meeting records;
- staff team meeting records;
- patient meeting records;
- discharge meeting records;
- records of activities taking place for patients on the ward;
- estate services reviews of equipment including fire-fighting equipment;
- fridge and domestic services monitoring records;
- the wards safe record and financial records;
- the wards complaints book;
- information available and accessible to patients and relatives;
- use of Managing Actual and Potential Aggression records and incident reports;
- restrictive practice assessments including the records detailing the management of blanket restrictions;
- the staff rota;
- information relevant to the wards/Trusts policies and procedures;
- shift hand over records; and
- any other record relative to my findings during the inspection visit.

6. I informed the WM/CN that I would keep them updated throughout the inspection visit. I agreed with the WM/CN to meet with them at the start and end of each day of the inspection visit. I detailed that I would also speak with them as required during the inspection visit. I agreed a time to complete feedback regarding my findings. The feedback session took place at the end of the inspection. The WM/CN and MAH senior management team were invited to attend. The WM/CN also invited other members of the ward staff team. Feedback sessions following my inspection visits in MAH were generally attended by the following staff members:

- The WM/CN
- The MAH Service Manager
- The MAH Nursing Manager
- MAH Assistant Director for Service Improvement and Governance
- Other staff also attended feedback sessions on occasions.

7. Until around 2019, a feedback session would be held with MAH staff at this stage. Escalation beyond MAH staff to senior employees of the Trust would be managed via RQIA's escalation procedure.

8. I provided assurances to the WM/CN that I would attempt to minimise disruption to the ward's routine and in particular minimise disruption to patients, relatives and staff. I took advice and adhered to any guidance given to me by the WM/CN regarding health and safety on the ward including, the routine for any patient(s) who were unwell or unsettled. I adhered to safety plans in place within the ward. As required, I would carry a ward personal alarm. I also requested a set of keys to ensure I could access all areas of the ward.

9. Having met with the WM/CN and explained the inspection visit plan. I conducted the inspection as follows (timings varied).

10. 10.00am: I completed a walk around of the ward with the WM/CN. I would visit all areas of the ward and ask the WM/CN to open any locked doors. I placed inspection posters on the ward's main entrance door and the ward's main notice board. As the walk around progressed, I would introduce myself to patients and staff. During the walk around, I commenced my assessment of the ward's environment. I completed my assessment of the ward's environment using a checklist based on the Ten Standards for adult-in-patient mental health care Tool, produced by the Royal College of Psychiatrists (2011). I spoke directly to the ward's support staff including catering and cleaning staff to assess their experience and view of the ward.

11. 11.00am: Following a walk around, environmental assessment and informal conversations/introductions with patients and staff, I commenced meeting with patients who consented to meet with me. I would meet with all of the patients

who wished to speak with me. In circumstances were patients could not communicate with me verbally, I would observe interactions between these patients and staff. With patient and staff consent, I also used the Quality of Interaction Schedule (QUIS) observation tool introduced to MHLD inspection methodology in late 2013 (approx.). I found the QUIS helpful in assessing the quality of patient staff interactions. The tool guided me to look at the levels to which staff involved the patient, sought permission from the patients and included the patient in decision-making. It also helped me to measure a staff member's ability to manage relationships with patients and, at the same time, complete the required care tasks. The QUIS tool also assisted me by providing a broader assessment of what life on the ward was like for patients.

12. I continued general observations throughout the inspection visit when I was in the presence of patients. This included having lunch with patients in the ward's dining area. I completed questionnaires with patients, with patient consent and appropriate to a patient's needs, to capture their understanding, reflections and experiences of the ward.

13. 12.30pm: I commenced meeting with nursing staff. I ensured I met with all grades of nursing staff (Bands 4, 5 and 6 staff). I completed questionnaires with nursing staff to capture their reflections and experience of the ward. I would meet with any member of nursing staff who requested to meet with me. I aimed to meet with at least four members of the nursing staff team during each inspection visit.

14. 14.00pm: I commenced reviewing ward records, the progress made, and the implementation of the recommendations made following the previous inspection visit. In consultation with the WM/CN, I would identify a suitable room within the ward to complete my review. I updated the WM/CN regarding my findings and discuss any queries or concerns I may have had. I would also request any further specific information I may require following my interviews, observations and environment assessment.

15. The WM/CN would provide me with access to review the ward's patient information systems (including Datix and PARIS). These systems were secure

and required login credentials and a password. The WM/CN remained with me as I accessed the systems. In 2014/15, the RQIA MHLD senior management team secured PARIS login credentials (read only) for MHLD inspectors. This allowed me to access the PARIS system independently.

16. In the afternoon of the first day of the inspection visit, I agreed interview times with the WM/CN to meet with members of the ward's MDT. Interviews took place from approx. 15.30pm onwards. I would adjust the day and times of interviews with MDT staff to suit their availability. Ward MDT staff would make themselves available to meet with me. Exceptions being, if staff were on leave or off the MAH site.

17. 15.30pm: I would meet with MDT staff and conduct interviews using the staff questionnaire. I requested meetings with the ward's Consultant Psychiatrist/medical staff, the behavioural nurse, the psychologist, the ward social worker and the MAH Nursing Manager. By this stage I had completed a number of interviews/observations with patients and staff. I had reviewed patients' records and key ward records (staff rota, safeguarding referrals, Datix system etc.). Subsequently, I could raise any queries or concerns I may have had with staff.

18. 17.00pm: I reviewed my notes and prepared to give the WM/CN feedback on my findings on the first day of the inspection visit. I gave the feedback directly in an appropriate room. I highlighted positive findings, areas of concern and areas where I required further information. I ensured that my findings and feedback was factual, objective and supported by evidence. Where I did not have sufficient evidence, I requested further information and gave the WM/CN the opportunity to respond.

19. 18.00pm: I confirmed with the WM/CN that I would return tomorrow and I thanked them for their support. I returned the ward personal alarm and keys and left the ward.

20. I contacted the SI/HOP to seek any assistance I may require and or to update the SI/HOP regarding inspection visit progress and findings. In circumstances

were I may have identified significant concerns, I agreed to keep in touch with the SI/HOP during the second day. This provided me with support and assisted me in working through actions to address the concerns. If required the SI/HOP made themselves available to attend the ward during the second day of the inspection visit.

Day 2

21. On the second day of an inspection visit, I arrived at the ward at approximately 9.00am. I entered the ward; I identified myself to staff and stated my purpose for entering the ward. I then proceeded to the ward's main office to inform the WM/CN that I was on the ward. I discussed my inspection plan for the day and followed up on any requests I made during my feedback to the WM/CN the previous evening.

22. I summarised my findings from the previous day and confirmed what MDT staff interviews I needed to complete on day two. I asked the WM/CN to check with patients and nursing staff if anyone wished to speak or meet with me. I also checked with the WM/CN if any relatives had requested to meet or to have contact with me. My inspection visits took place between Monday and Fridays and generally ended no later than 19.00pm in the evening. The inspection visit periods did not always coincide with times when relatives would visit patients. I did and would meet with relatives during my inspection visits, although this did not happen on every inspection.

23. I agreed the time for feedback with the WM/CN. A number of my inspection visits to MAH required that feedback was arranged on a third day, by agreement in the morning, dependant on inspection visit findings and any follow up that may have been required. If a third day was required, I, the WM/CN and the MHLD SI/HOP, agreed the introduction of a third day to complete my inspection visit.

24. 10.00 am: I completed any remaining interviews with ward and MDT staff. I followed up on any further requests for interview from patients or ward staff. I completed a second environment review of the ward.

25. 12.00pm: I completed my review of ward records. I would finish any outstanding reviews of ward paperwork and systems that I had not completed on the first day of the inspection visit. I used this time to follow up on any concerns or issues I identified. I would consult with the WM/CN or other MDT staff members to check my findings and request clarification or further detail regarding any issues I had identified.

26. 15.00pm: I prepared for feedback. I reviewed my findings and checked the evidence I had gathered. I prepared evidence demonstrating good practice and positive outcomes and evidence demonstrating concerns or practices that did not meet the required standards. I double-checked my findings and then discussed these with WM/CN prior to meeting for feedback. This gave the WM/CN the opportunity to challenge my findings and to provide me with further information or evidence that I had not reviewed. I stated my recommendations and noted any previous recommendations that had not implemented.

27. Having prepared for feedback, I assessed if there were any serious concerns regarding the delivery of care and treatment to patients admitted to the ward. In circumstances where I had significant concerns, I could request that the SI/HOP programme attend the inspection or feedback session. I only recall doing this once as part of the intelligence based inspection of Killead ward in October 2016.

28. 16.00pm: I delivered feedback to the ward management team (please see paragraph six). I presented my findings as evidenced through patient, staff and relative interviews, my observations with patients and observations of the ward, my findings using the QUIS tool, my environmental assessment and my review of ward's systems and patient and ward records. I presented my findings regarding the implementation of previous recommendations made following the ward's last inspection visit.

29. The feedback session facilitated the ward's management team with the opportunity to challenge my findings and to provide any further information or evidence. Following feedback and discussion regarding my findings, I detailed the RQIA MHLD reporting process. I advised that a draft report and quality improvement plan ("**QIP**") would be returned to the ward and the Trust's Chief Executive within the following 28 days. I explained to the WM/CN and the MAH staff that following receipt of the draft report, a signed copy of the QIP must be returned to MHLD RQIA with the following 28 days. I thanked the WM/CN, the ward's patients, the MDT and MAH staff attending the feedback session, for their support during the inspection visit. I returned the ward keys and the wards personal alarm. I removed the inspection posters and left the ward.