# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Moira Mannion**
**Dated this 19 day of January 2024**

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I, Moira Mannion, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry. This is my second statement to the Inquiry, having provided a previous statement to the Inquiry dated 19 September 2023.

In exhibiting any documents, I will number my documents so my first document will be "Exhibit 1".

1. I have been asked to make a statement for the purpose of the Inquiry's examination of the Ennis Ward Adult Safeguarding Report and its outworking's. I have specifically been asked to address ten questions and I now set out my responses to those questions in sequence.

**Q1. What was your job title and role in November 2012, the time of the allegations which gave rise to the Ennis investigation?**

2. In November 2012, at the time of the allegations which gave rise to the Ennis Investigation, I was Co-Director for Nursing, Education and Learning at the Belfast Health and Social Care Trust ("the Belfast Trust").

**Q2. When and in what circumstances did you first become aware of the allegations?**

3. I was not aware of the safeguarding allegations as I was focused on my role on education and learning. I recall I was invited to a meeting with Brenda Creaney, Executive Director of Nursing at the beginning of December 2012 in her office

at the Belfast City Hospital. Catherine McNicholl, the Director of MAH at the time and Marie Mallon, who was both Deputy Chief Executive and Director of Human Resources also attended the meeting. During that meeting, I was advised of the external allegations involving the Ennis Ward at MAH and was further advised that relationships within staff at MAH were difficult as a result of the allegations and the safeguarding investigation. I was asked to attend MAH. The expectation was that I would continue my current role and I would take on a role of supporting engagement with the investigation process in MAH as an added responsibility. I was advised that the senior management at MAH would have the responsibility for service delivery, continuity of service and adherence to policy and guidance around the provision of services. I was expected to review and have an overview from a senior nursing perspective offering guidance, support, and mediation. This was predicated upon the executive team's understanding of my professional skillset of communication skills and of bringing about calm and resetting direction. I came away from that meeting understanding that I would be expected to engage in and complete planned activities at MAH and continue to focus on my current role in education and learning.

**Q3. What actions did you take on first becoming aware of the allegations?**

4. I met with my existing team of staff to let them know that I would be less available for a period. I refocused on the set team goals that I wanted them to achieve in my absence and gave them my contact details for when I would be off site at MAH. I was ensuring that the services I was responsible for were being implemented in my absence. I then visited MAH. I met with John Veitch, Co-Director of MAH. I also met with Aine Morrison the designated adult protection officer who was investigating the safeguarding allegations concerning Ennis Ward. She had two individuals working with her, which were less known to me and I cannot recall their names. I met with Esther Rafferty, Associate Director for Nursing. She was appointed to project manage the integration of MAH patients into the community. She was also managing the staff at MAH. I was clear on the roles of John Veitch and Esther Rafferty,

however I was not clear about other aspects of Aine Morrison's role separate from the investigating officer. Ms Morrison seemed to think that she would be telling me what to do. At my first visit to MAH in December 2012, I did not have the terms of reference which could reference the role I was commissioned to engage in. My first meeting with Aine Morrison was a difficult one but we agreed that we would get clarity from Co-Director John Veitch, which we did in a subsequent meeting with John Veitch at the Fairview Building at the Mater Hospital Belfast, which was where John Veitch was based.

5. When I was assigned into a role which involves meeting new people for the first time, such as the assignment in December 2012 to MAH, I wanted to communicate my role clearly to others that I may work with during this commissioned activity. I wanted to establish a relationship based on trust. I met with the staff on Ennis Ward. Esther Rafferty attended this meeting with me. The Ennis Ward sister H491, Band 7, was off on sick leave. The meeting was attended by the Band 6 nurse, and whoever was on shift at the time of the meeting. I do not recall any of the names of the staff who attended the meeting. It was clear that the staff were distressed. Staff stated that some senior staff were not very visible on site at MAH. An example offered was that, John Veitch's office was not at MAH. I recall one of the nurses saying jokingly, "the gods have come to visit us" at this first meeting. Staff seemed to perceive that senior staff visits were linked to negative experiences. I spent around one hour with the staff during this meeting. I felt that the staff were less stressed after our meeting. The staff had a lot of questions. There were questions that I could answer and did, there were questions that I did not know the answer to which I told them I did not have the answers and there were questions which I did know the answer to but could not tell them due to the sensitivities of the ongoing adult safeguarding investigation. The staff were disengaging from the investigation in their perception of being poorly treated and lack of communication. The staff advised me that Aine Morrison was aggravating the situation due to her insistence that the staff were to be monitored twenty four hours per day and that staff who were family members were not to act as a monitor if another member of their family were on shift. The staff advised me

they believed Aine Morrison to be overreaching the parameters of her role as a designated adult protection officer investigating the allegations.

6. To put matters into further context, the staff in Ennis Ward were already concerned about their job security as Ennis Ward was due to close within six months because of the strategy for resettlement and the number of patients were retracting. There was already a lot of anxiety and disquiet even before the safeguarding allegations. After the meeting, I asked Esther Rafferty to speak to John Veitch to get a projection on the closure of Ennis Ward and also to involve human resources so that they were aware of what was happening. If staff left because they were concerned about job security, then MAH would not have the skills and resources needed to look after the patients. Nikki Patterson was the Nursing and Midwifery workforce lead at that time in Belfast Trust. Only temporary positions were being offered for MAH staff at that time. These roles are difficult to fill as people need job security which was not something MAH was able to offer to them at that time.

**Q4. What was your role in the Belfast Trust's safeguarding investigation into the allegations made about incidents on Ennis ward on 08 November 2012? It is anticipated that the answer to this question will include, but not be limited to:**

- **A detailed explanation of your specific role(s) and actions taken;**
- **If you worked with others, an explanation of who they were;**
- **An explanation of who you reported to in respect of any actions.**

7. The role I was commissioned to complete at MAH in December 2012 is set out in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 86 in a document called "Briefing by M Mannion - 19 December 2012" which was as follows;

- Commit time to engage in and complete ward observations of staff behaviours, patient care as professionally independent from the service.
- To complete unannounced leadership visits.
- To lead the team of monitors engaged in the monitoring activity.

- To review all of the monitoring forms submitted.
- To provide an executive report of all actions completed.
- To provide an improvement plan to the Director of the Adult, Social and Primary Care Directorate and the Executive Director of Nursing and User Experience and the strategy group for discussion and agreement.

8. I worked closely with Esther Rafferty, who was the most senior nurse in MAH and she had responsibility for all MAH nurses. Ms Rafferty and I reported to Brendan Creaney on the activities that we engaged in pursuant to my terms of reference above and the outcome of those activities. Occasionally, Ms Creaney would ask us to engage in specific activities, for example, on one occasion she asked Ms Rafferty and I to carry out a review of patient Kardex and nursing notes on Ennis Ward as RQIA had noted some concerns about record keeping on Ennis Ward. Esther and I conducted the review accordingly. The Director, Catherine McNicholl and Executive Director of Nursing, Brenda Creaney met with me on a fortnightly basis at the Director of Nursing Office at the Belfast City Hospital so that I could update them on the activities I was commissioned to do at MAH. There were no minutes of these meetings. Brenda Creaney also had a meeting once a month with all of the Associate Directors of Nursing in the Belfast Trust which Esther Rafferty would have attended to update the Executive Director of Nursing. I also attended these meetings providing updates on my substantive work in education and learning activities. There were minutes of these meetings but I do not have them, these minutes would be retained in the Belfast Trust. Esther Rafferty would have updated Ms Creaney on the position at MAH during these monthly meetings.

**Q5. How, in your perception, was the Ennis report received by senior management and how did they respond?**

9. I was not on the executive team at the time the Ennis Report following the investigation was produced. I left MAH in and around June/July 2013 to return to my main role in education and learning. I recall being at one strategy meeting on 05 July 2013, the minutes of this meeting can be found at pages 67 to 70 of

the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses. We were due to review a final draft of the report at this meeting and I recall John Veitch being very annoyed as Aine Morrison only produced the draft on the morning of the scheduled meeting. Mr Veitch said to me that the strategy team would not have had the opportunity to review the report in advance of the meeting and another meeting would have to be arranged.

10. The final draft report for the Ennis investigation was quite vague and formed no definitive conclusions. I felt it was a poorly constructed report. I recall John Veitch discussing this with me and he was concerned of the vagueness of the report and how this would be perceived by the families of the patients. Mr Veitch wanted to be open and clear with the families, but the report did not assist him with this.

**Q6. How, in your perception, was the Ennis report received by ward staff and how did they respond?**

11. Whilst I was not on the executive team or at MAH when the report was delivered, I recall that Esther Rafferty and I visited the Ennis Ward after the report was prepared. I believe this was some time in November 2013. The staff on the Ennis Ward advised me that they felt that there was still an element of suspicion around their conduct. I met the staff by way of a farewell meeting. The staff advised me that the experience of the investigation was negative. The staff said that Aine Morrison was very vocal during her investigation about staff family members working with each other. Esther and I felt that the staff should have been better supported. Staff needed support through counselling and human resources to mitigate perceived harm.

**Q7. What was your role in the implementation of the recommendations made by the Ennis Report? It is anticipated that the answer to this question will include, but not be limited to:**

- **A detailed explanation of your specific role(s) and actions taken;**
- **An explanation of who you reported to in respect of any actions;**

- **If you worked with others, an explanation of who they were and the role(s) they carried out.**

12. As noted above, I was not working in MAH when the report was finalised. However there was an improvement plan made during the investigation and implementation of the same was being monitored by Esther Rafferty. This is recorded in the 2nd briefing report dated 09 January 2013 and Proposal for Service Improvement Plan in Ennis Ward which can be found at pages 88 to 108 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses. I am happy to answer any questions put to me by the Inquiry regarding these documents however I believe they are self-explanatory and do not need to be rehearsed in the body of this statement. After I finished the role I was commissioned for, I left MAH. I continued to hear updates from Esther Rafferty during the monthly meetings chaired by Brenda Creaney with the Belfast Trust Associate Directors of Nursing which I also attended.

**Q8. Did you encounter any challenges or difficulties in your role in the Ennis Investigation or the response to it? If so, please explain what they were?**

13. Aine Morrison and I engaged in a number of robust conversations during my time at MAH from December 2012 to June/July 2013. Aine Morrison was vocal about her views of nursing and monitoring. I asked Ms Morrison to articulate clearly so that I could put her plans into action. Often I did not get the clarity that I required. I met with Ms Morrison on occasion and I was supportive of her and her protection plans involving the nursing staff. My sense is that Ms Morrison did not receive all of the support that she needed in a difficult situation. I was not there to support Ms Morrison, I was there to support her decisions and put them into place. I sometimes asked Ms Morrison for clarity on her reasoning for making certain decisions such as that she did not want any family members carrying out the staff monitoring role whilst a member of their family were on shift. I had to deliver this message to the staff on the Ennis Ward which was not well received because the staff believed it showed that they could not be trusted. I explained that the monitoring needed to be objective. I have been

involved in a number of inquiries and it is not unusual for there to be challenges and for high emotive behaviours and language to be used at times. Inquiries and investigations are stressful environments. Overall my time in MAH was not the easiest situation to be in but the challenges were not insurmountable. My professional strategy is that I always tell staff to speak to me first if they have any concerns. There were a number of occasions when Ms Morrison and I disagreed and had robust discussion but I believed that we talked through any issues that were forthcoming, creating solutions and diffused any difficulties. We were working in a highly charged environment.

**Q9. Having received and considered the bundle of documents provided by the Inquiry relating to Ennis, do you wish to provide further detail or comment on any issue(s) arising in the documents?**

14. I retired from my substantive role in the Belfast Trust in October 2019. In November 2019, I was commissioned to return to act as Senior Nurse Advisor to the MAH 2017 Historical Abuse Investigation Team for two days per week. I was a member of the investigating team reviewing CCTV footage providing a professional nursing opinion. I was also working with Marie Curran, Senior Human Resources Officer with the Belfast Trust in advising staff of suspension, education or supervision requirements for protection planning. In February 2020 I was invited to a meeting with Carol Diffen, Executive Director of Social Work and I believed that she was asking to meet me concerning the work I was doing at MAH on the 2017 investigation. At this meeting, Carol Diffen produced to me an annotated set of allegations made against me by Aine Morrison relating to her investigation into the allegations on the Ennis Ward in November 2012. I was not given any notice that this is what Carol Diffen wanted to discuss with me. I did not know anything about these allegations before these were presented to me at this meeting. I could not understand why someone was complaining eight years later. If Ms Morrison had concerns why were these not raised at the time or raised when she knew that I was coming out of retirement to take on a role in the 2017 investigation. I attach a copy of this annotated list of allegations at Exhibit 1 to this statement.

15. I was shocked and upset and I voluntarily stood back from my work on the 2017 investigation as the work was so important and I felt that I could not continue if there were concerns about my professional behaviour. I advised Carol Diffen that she needed to find an immediate replacement as the PSNI were very annoyed that the Belfast Trust was not acting quickly enough. I was left feeling unprotected at that time by the Belfast Trust and that my professional conduct was in doubt. I provided a written response to the allegations made against me by Aine Morrison dated 6 April 2020. I attach a copy of that written response at Exhibit 2. I received a letter from Cathy Jack, Chief Executive of Belfast Trust dated 27 August 2020, I enclose a copy of same at Exhibit 3, enclosing a report into allegations made against me produced by David Bingham in August 2020 which appears at pages 802 – 804 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses which concluded that there was no evidence to uphold the allegations made by Aine Morrison against me.

**Q10. Please provide details of any matters in respect of Ennis not covered by the above or your experience of Muckamore Abbey Hospital generally that you feel will assist the Panel in addressing the Terms of Reference.**

16. I felt that there was poor visibility of senior staff at MAH which was not helpful. This was in and around September 2018 when I was commissioned to attend MAH two days per week. I was never provided with terms of reference as to what my specific role was at this time, however I understood I was to be a visible senior person on site at MAH; to support staff who were concerned and try to get staff to engage and cooperate with the MAH 2017 Historical Abuse Investigation Team. Esther Rafferty had stood back from her substantive role at this time. Brendan Ingram, Service Manager had left. It would not be unusual on a Friday afternoon for no senior staff to be on site at MAH. No Service Managers, Co-Directors or Directors. This perception I brought to Brenda Creaney, Executive Director of Nursing; Jacqui Kennedy, the Human Resources Director and Marie Heaney, the Service Director. It got to the stage

in 2018 that I conducted all, including my work in workforce, informatics, education and learning from MAH. Thus supporting a senior presence on the site and Marie Heaney did likewise.

17. When Esther Rafferty started at MAH, it was not explained to the staff at MAH what Ms Rafferty's role was, again this was unhelpful as the staff did not know why she was there. The perception at departmental level was and continues to be that MAH is more of a social care environment but it is in fact a hospital environment and this creates a tension. It also feeds down to staff ratios because the ratios in a social care environment are different to ratios in a hospital environment. Social care requires care workers to have a social care background and social care workers are paid more than health care support workers. Health care support workers however require more supervision by registered nurses. All of this leads to staffing problems which has been a real concern at MAH for a long time.

**Giving Evidence**

18. I am happy to give oral evidence to the Inquiry if that would be of assistance.

19. If I am asked to give evidence, I do not require any special arrangements.

20. I do not require a supporter to attend the Inquiry hearing with me.

21. I am happy to give my name.

**Section 5: 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 relevant to the Inquiry's terms of reference.

Signed: [illegible]

Date: 19/1/24

**List of Exhibits of Moira Mannion**

Exhibit 1 - Annotated list of allegations made by Aine Morrison against me presented to me by Carol Diffen, Executive Director of Social Work at the Belfast Trust.

Exhibit 2 – My response to allegations made against me by Aine Morrison dated 06 April 2020.

Exhibit 3 – Letter from Cathy Jack, Chief Executive of the Belfast Trust to me dated 27 August 2020.

Exhibit 1

**Excerpt in relation to MM**

A further difficulty arose when making protection plans to ensure the patients were safe while an investigation was underway. While a number of staff had been suspended, I believed that the concerns were such that 24 hr monitoring of the ward by external staff was also necessary.

It was agreed that the 24 hour monitoring would largely be provided by Band 8A senior nursing staff from MAH. I believe that MM, Co-Director for Nursing also did some monitoring herself, she also made unannounced ward visits and I think she also arranged for other staff external to MAH to participate in some of the monitoring. I think that over time, Band 7 staff from other areas both within and outside MAH also provided monitoring but I cannot remember all the details.

From the outset, I experienced significant opposition from hospital staff to the part of the protection plan that required 24 hour monitoring. There were some initial difficulties with ensuring that it was happening as stipulated. RQIA found on at least one occasion that the agreed arrangements were not in place when they visited the ward. I needed to restate the expectation of 24hr monitoring on a number of occasions. Then, there were repeated requests made to me to stand down the monitoring. These requests started at an early stage of the investigation and continued for quite some time. I was repeatedly told that the presence of a monitoring member of staff was causing disruption and distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion. I believed that the presence of one unfamiliar member of staff amongst a team of familiar staff who were doing most of the hands on care was unlikely to be so significant that it outweighed the need to protect from the possibility of wider abuse on the ward. I did not accede to any of the requests to step down the monitoring. I do not remember who exactly voiced the opposition to the protection plan but my memory is that it came from MM, █ and other hospital management staff. The minutes of various meetings may record the details of this.

During one of the earlier meetings where MM and █ were both present. MM was extremely hostile towards me. She berated me for daring to

suggest that nurses would be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own professional practice. The level of hostility and confrontation was such that a number of people external to the BT who were present at the meeting contacted me afterwards to see if I was ok. While this incident was the most direct and confrontational, I continued to feel that I was not receiving adequate support from [redacted] and MM. During much of the investigation, I felt like an unwelcome outsider. I did not get any sense of a collaborative approach between myself and hospital management, instead feeling that I was having to regularly challenge.

While it was not unusual for a Designated Officer to experience some resistance from a service under investigation, this was beyond the norm.

There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was criticism of their level of experience, expertise, perception of events and in particular their failure to speak out at the time of witnessing the alleged abuse. This was portrayed as poor practice on their part and used as an argument to doubt their credibility. While a lot of this criticism came from ward level staff, my memory is that it was also voiced by [redacted] and MM. There appeared to be a lack of understanding about the difficult position the Bohill staff were in, the power differentials, the lack of immediate support for them in that setting and the fact that at least two of them had reported their concerns very soon afterwards.

MM and I had very different views on the care plans for individual patients on the ward. While acknowledging that I was not familiar with nursing care plans, they appeared to me to be lacking detail, particularly in relation to managing challenging behaviours. MM's view was that the care plans were satisfactory.

Exhibit 2

**Statement**

**Name:** **Mrs Moira Mannion**

**Job title:** **Senior Nurse Advisor to HR. (prev. Deputy Director of Nursing)**

**Professional address: HR Dept, McKinney House, Musgrave Park Hospital**

**Subject of statement:**

**Statement of response to allegations contained in the document titled "Excerpt in relation to MM" at the request of Carol Diffen, Executive Director of Social Work**

1 I am employed by Belfast HSC Trust. I qualified as a nurse in 1980. My previous experience
2 includes working in the HSC as an enrolled nurse, RMN, Specialist CAMHS Nurse, CAMHS
3 Clinical Lead, Co-director and Deputy Director. I have also worked for Royal College of
4 Nursing as Practice Development Fellow and Interim Head of Education. I was seconded to
5 the Department of Health as a Nursing Officer.

6 I retired from my substantive position as Deputy Director of Nursing on 31st October 2019
7 after 12 years service with BHSCT. I am on the BHSCT Nursing Bank and had been
8 retained by the BHSCT HR Dept as a Senior Nurse Advisor from November 2019 to support
9 Muckamore Abbey Hospital (MAH) investigations. I voluntarily stood aside from this work as
10 a result of these allegations. I have been told that had I not stood aside, I would have been
11 required to do so.

12 This statement is based on my personal recollection. I have not been facilitated access to
13 documents, emails or files which I would have created and used in the course of my
14 employment as Deputy Director to allow me to give a more detailed response. I note that the
15 allegations relate to events seven to eight years ago. I have not been advised of which
16 process or policy these allegations are being investigated under so as to shape this
17 statement.

18 I am responding to allegations contained in the document "Excerpt in relation to MM" made
19 by a person unidentified in that document.

**The potential allegations appear to be;**

1 A. *"I believe that MM, Co-Director for Nursing also did some monitoring herself, she*
2 *also made unannounced ward visits and I think she also arranged for other staff*
3 *external to MAH to participate in some of the monitoring. I think that over time, Band*
4 *7 staff from other areas both within and outside MAH also provided monitoring but I*
5 *cannot remember all the details."*

6 B. *"From the outset, I experienced significant opposition from hospital staff to the part of*
7 *the protection plan that required 24 hour monitoring."*

8 C. *"RQIA found on at least one occasion that the agreed arrangements were not in*
9 *place when they visited the ward."*

10 D. *"Then, there were repeated requests made to me to stand down the monitoring.*
11 *These requests started at an early stage of the investigation and continued for quite*
12 *some time. I was repeatedly told that the presence of a monitoring member of staff*
13 *was causing disruption and distress to the patients and that it was having a*
14 *detrimental impact on staff morale as they felt they were under suspicion."*

15 E. *"I do not remember who exactly voiced the opposition to the protection plan but my*
16 *memory is that it came from MM, … and other hospital management staff."*

17 F. *"During one of the earlier meetings where MM and … were both present. MM was*
18 *extremely hostile towards me. She berated me for daring to suggest that nurses*
19 *would be involved in abuse, pointing to their professional registration, their*
20 *professional codes of conduct, their duty to uphold their code of conduct and*
21 *accountability for their own professional practice."*

22 G. *"The level of hostility and confrontation was such that a number of people external to*
23 *the BT who were present at the meeting contacted me afterwards to see if I was ok.*

1 *While this incident was the most direct and confrontational, I continued to feel that I*
2 *was not receiving adequate support from … and MM."*

3 H. *"During much of the investigation, I felt like an unwelcome outsider. I did not get any*
4 *sense of a collaborative approach between myself and hospital management,*
5 *instead feeling that I was having to regularly challenge."*

6 I. *"There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was*
7 *criticism of their level of experience, expertise, perception of events and in particular*
8 *their failure to speak out at the time of witnessing the alleged abuse. This was*
9 *portrayed as poor practice on their part and used as an argument to doubt their*
10 *credibility. While a lot of this criticism came from ward level staff, my memory is that it*
11 *was also voiced by … and MM. There appeared to be a lack of understanding about*
12 *the difficult position the Bohill staff were in, the power differentials, the lack of*
13 *immediate support for them in that setting and the fact that at least two of them had*
14 *reported their concerns very soon afterwards."*

15 J. *"MM and I had very different views on the care plans for individual patients on the*
16 *ward. While acknowledging that I was not familiar with nursing care plans, they*
17 *appeared to me to be lacking detail, particularly in relation to managing challenging*
18 *behaviours. MM's view was that the care plans were satisfactory."*

## Statement of Response

### Context

19 I have a track record of being deployed to many contentious situations across the BHSCT
20 over the last 12 years. I have experience in many improvement projects, enabling and
21 supporting staff who had needed to use whistle blowing. I know such work does not make
22 me popular but I have acted openly in a framework of high challenge / high support with

1 integrity. I practice with a strong personal value base, the values of the NMC and the Trust.
2 This has meant I have often needed to take action and bring forward information to the
3 executive team. My experience is that such projects are fluid and need revised strategies
4 throughout their duration, but such strategies are not always the easy option. I have always
5 focused on the safety and care for patients first, staff next.

6 I have extensive experience as a psychotherapist (behavioural, individual, family and group),
7 with advanced communication skills, extensive knowledge of systems and functionality,
8 analysis of behaviour interactions across teams, along with facilitation, mediation and
9 coaching skills. I have prior experience with assurance mechanisms to support
10 investigations, governance frameworks and ensuring that such is proportionate and in line
11 with Trust guidance and policy.

12 I have worked in mental health services and in Child and Adolescent Mental Health Services
13 (CAMHS). I have extensive experience in safeguarding and have led on safeguarding
14 interventions in previous employment in SHSCT at great personal risk and in the face of
15 threat from those who may have been involved in subversive activities. My work in CAMHS
16 and mental health has involved challenge of the "status quo" where this has been needed to
17 empower the disadvantaged. I do not stand up for poor practice and have led on many
18 initiatives to promote good practice. I have maintained good standing for professional
19 education and trust mandatory training, including safeguarding.

## Involvement

20 I recall that when Ester Rafferty (ER) took up post in MAH in spring/summer 2012, she
21 placed the site on the BHSCT risk register and would have had a discussion with the then
22 workforce lead Nicki Patterson (NP).

23 I recall that David Robinson and I were updated by ER that she had precautionary

1 suspended two staff and required an early alert to Chief Nursing Officer in November 2012.
2 The Director of Nursing was also briefed about these concerns. Around this time, I had been
3 requested by the Director of Nursing to take charge of the BHSCT nursing workforce
4 portfolio (as NP had moved to SEHSCT) and ER had been advised to seek guidance and
5 support from myself.

6 In mid to late November 2012, I was requested by Director of HR, the service Director and
7 the Director of Nursing to provide assurance to the executive team on the Muckamore
8 Abbey Hospital (Ennis Ward) investigation. I was informed that staff from an external agency
9 had reported abuse of patients in Ennis ward to RQIA. At that time, I was advised by the
10 Directors that there were dysfunctional working relationships in the ward under investigation
11 and in the service team. They reported a need for full multi-disciplinary team working. I was
12 advised that an investigation had already been commenced, led by the DAPO and their
13 team. I was informed that a follow-up RQIA visit had occurred, which noted further concerns
14 with adherence to the management plan in Ennis. I was deployed to MAH to provide
15 assurance (in addition to my other duties).

16 When I arrived, it was evident that there had been conflict in Ennis ward in MAH. I recall that
17 ward staff reported concern with the approach that had been adopted by the investigation
18 team. I recall that staff reported that they had received no communication of the context or
19 nature of the investigation by the investigation team. There also appeared to be difficult
20 working relationships between and within the service management and clinical teams.

21 I was requested by the Directors to mediate and support resolution in the relationships to
22 enable the investigation to be completed. I am not sure if this had been communicated to the
23 investigation team. I informed the co-director and the investigation team why I was there. My
24 recollection is that the DAPO did not respond in a positive manner to my becoming involved
25 in the process. I recall she had concerns about membership of the strategy group
26 progressing the investigation.

1 I had regular supervision with the Director of Nursing over the duration of my deployment. I
2 raised any issues of concern and discussed strategies, policies and interventions. I would
3 have discussed issues, attitudes, behaviours and culture encountered.

4 The Nursing and Improvement Model applied during this work was the Productive Ward
5 Methodology. The First Fifteen Steps were used to complete the initial assessment of the
6 ward. The Nursing Model of Critical Companionship (A Titchen) was also used. This model
7 is helpful in understanding fractured relationships and promoting resolution. The NI
8 safeguarding framework had recently been updated and not all staff across the team were
9 as familiar as the Trust would have wished them to be.

10 There was little evidence of adequate induction for staff who were joining the ward team.
11 This was urgently addressed by ER. The student nurse environment learning audits required
12 to be updated and the student placement and learning outcome be addressed which were
13 actioned by ER.

14 A review of staffing, care planning and audits of monitoring were undertaken. Staffing was
15 enhanced. Supervision, appraisal and training were reviewed with remediation as required.

16 RQIA noted a poor ward environment. An environmental review was undertaken. The ward
17 area was overcrowded, cluttered, outdated and posed a fire risk. Patient areas had been
18 converted for the use of staff reducing care space. A wide range of remedial actions were
19 undertaken as result of this.

## Response to Potential Allegations

### Allegation A

1 *"I believe that MM, Co-Director for Nursing also did some monitoring herself, she*
2 *also made unannounced ward visits and I think she also arranged for other staff*
3 *external to MAH to participate in some of the monitoring. I think that over time, Band*
4 *7 staff from other areas both within and outside MAH also provided monitoring but I*
5 *cannot remember all the details."*

6 I did not undertake the monitoring.

7 I did engage in the clinical supervision of staff on the ward alongside **review** of the
8 monitoring process which had been agreed to be completed by a range of staff, from the
9 band six, seven and the assistant service managers, internal and external to MAH.

10 I led leadership visits, planned and also unannounced, to the ward across the shift patterns
11 to observe practice, review documentation and operational practice / processes that
12 registrants and HCSW were delivering. Staff **were** expected to adhere to the management /
13 protection plans.

14 I completed an analysis of the completed monitoring forms and processes. This was
15 presented to the MAH Strategy group and to the MAH Improvement group.

### Allegations B, D and E

16 B. *"From the outset, I experienced significant opposition from hospital staff to the part of*
17 *the protection plan that required 24 hour monitoring."*

18 D. *"Then, there were repeated requests made to me to stand down the monitoring.*
19 *These requests started at an early stage of the investigation and continued for quite*
20 *some time. I was repeatedly told that the presence of a monitoring member of staff*

1 *was causing disruption and distress to the patients and that it was having a*
2 *detrimental impact on staff morale as they felt they were under suspicion."*

3 E. *"I do not remember who exactly voiced the opposition to the protection plan but my*
4 *memory is that it came from MM, … and other hospital management staff."*

5 I am unable to confirm or refute Allegation B with regard to hospital staff.

6 I am unable to confirm or refute if there were repeated requests to stand down monitoring
7 from early in the investigation by others (Allegation D).

8 I was not a member of the hospital staff. I held no opposition the protection plan nor to the
9 part of the protection plan that required 24-hour monitoring. In fact, much of my work was to
10 assure compliance with the protection / monitoring plan. I did however ensure that the need
11 for 24-hour monitoring was reviewed.

12 As I have stated above, I led leadership visits to the ward to observe practice, review
13 documentation and operational processes that staff were delivering. I expected staff to
14 adhere to the management / protection plans.

15 I completed an analysis of the completed monitoring forms and processes. This was
16 presented to the MAH Strategy group and also to the MAH improvement group. The
17 monitoring activity was continued over a period of a minimum of six months, maybe more. I
18 and other members of the team would have made requests for review as would be expected
19 as part of improvement planning. At no time did I request the monitoring to be stood down. I
20 did question the rationale for continuing 24-hour monitoring after some months given the
21 large proportion of new staff and the outcome of monitoring to that date. I fully facilitated the
22 continuation of monitoring when the decision was taken.

**Allegation C**

1 *"RQIA found on at least one occasion that the agreed arrangements were not in*
2 *place when they visited the ward."*

3 I can confirm that I was made aware of the RQIA visit prior to my involvement in MAH. This,
4 in part, led to my deployment to provide assurance to the executive team.

**Allegation F**

5 *"During one of the earlier meetings where MM and … were both present. MM was*
6 *extremely hostile towards me. She berated me for daring to suggest that nurses*
7 *would be involved in abuse, pointing to their professional registration, their*
8 *professional codes of conduct, their duty to uphold their code of conduct and*
9 *accountability for their own professional practice."*

10 I was not hostile to the DAPO.

11 I recall that the precautionary suspension (which I fully supported) of the alleged
12 perpetrators of abuse (reported by Bohill staff) had taken place prior to my involvement. I
13 recall that, I would have appropriately challenged any expressed views of abuse by
14 significant numbers of additional staff **in the absence of evidence** from investigation and/or
15 monitoring (so as not to prejudge the findings). Such constructive challenge is a normal part
16 of assurance and intervention in circumstances such as this. As part of this deployment, I
17 was also involved in constructive challenge of the management team, clinical staff, ward
18 staff and support staff where appropriate.

19 I completely refute that I would have suggested that nurses could not be involved in abuse.
20 Historically there have been high profile cases of health and social care staff (including
21 nurses) who abused others and abused the positions they held. I have a track record of
22 addressing and reporting practice that was poor / wilful neglect / abuse across the 40 years

1 of my professional practice.

2 I am fully aware of my professional duty to report misconduct, support investigation and be
3 held accountable for practice in accord with NMC requirements, Nolan principles and
4 HSC/Trust values. I am also familiar with regulatory standards applying across the HSC staff
5 family and have supported the investigation, remediation, mediation and practice
6 improvement involving staff of various professional groupings.

7 I, as Co-Director and Deputy Director, have ensured that staff were held to account for
8 misconduct. I have overseen investigations and disciplinary sanctions involving nursing staff
9 on behalf of the Director of Nursing. I have ensured the involvement of regulatory bodies
10 where indicated. I have had oversight of a wide range of disciplinary actions involving staff.

**Allegation G**

11 *"The level of hostility and confrontation was such that a number of people external to*
12 *the BT who were present at the meeting contacted me afterwards to see if I was ok.*
13 *While this incident was the most direct and confrontational, I continued to feel that I*
14 *was not receiving adequate support from … and MM."*

15 I am unable to confirm or refute if a number of people external to the trust contacted the
16 individual making the allegations to see "if they were ok".

17 My role was to provide assurance to the executive team. I have an established track record
18 of supporting and of working well with others, even in circumstances of significant challenge.
19 Where I am made aware of a need for further support, I endeavour to provide it or to see
20 that it is provided. I however do fully recognise the need for appropriate supervision, this is
21 normally provided by professional line management.

**Allegation H**

1 *"During much of the investigation, I felt like an unwelcome outsider. I did not get any*
2 *sense of a collaborative approach between myself and hospital management,*
3 *instead feeling that I was having to regularly challenge."*

4 I was not a member of the "hospital management" team. I recall actively trying to work
5 collaboratively with the DAPO, the investigation team, service management and clinical
6 teams.

7 I would however note that it has been my experience that individuals undertaking
8 investigations, overseeing remediation or trying to bring about change are often initially seen
9 as outsiders. I have found, that in these situations, I have been able to overcome this
10 distance, to develop a collaborative approach. I also recall that, in this deployment, I initially
11 was an unwelcome outsider though this changed over time. I did receive active support from
12 the Directors and ER throughout the deployment.

**Allegation I**

13 *"There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was*
14 *criticism of their level of experience, expertise, perception of events and in particular*
15 *their failure to speak out at the time of witnessing the alleged abuse. This was*
16 *portrayed as poor practice on their part and used as an argument to doubt their*
17 *credibility. While a lot of this criticism came from ward level staff, my memory is that it*
18 *was also voiced by … and MM. There appeared to be a lack of understanding about*
19 *the difficult position the Bohill staff were in, the power differentials, the lack of*
20 *immediate support for them in that setting and the fact that at least two of them had*
21 *reported their concerns very soon afterwards."*

22 I did not and do not criticise staff who whistle blow. Across my many years of practice, I have

1 been involved in enabling staff to raise concerns early, thereby reducing the opportunity for
2 neglect, poor or abusive practice. I have undertaken interventions for the BHSCT to facilitate
3 staff at all levels to bring forward concerns. These include RVH Emergency Dept, RVH ICU
4 and RVH Paediatric ICU, RVH Orthopaedics, Neurology, Iveagh (review by the children's
5 commissioner), and CAMHS services.

6 I can state that at no time have I berated staff who took the courageous action of whistle
7 blowing the concerns they have had. I would not be hostile toward staff who felt unsafe to
8 have such discussions.

9 I have been a whistle blower on a number of occasions and know the personal and
10 professional cost of raising concerns. These experiences have shaped my career and
11 informed my approach in improving professional practice. I also seek feedback and expect
12 to held to account for any work that I have engaged in.

**Allegation J**

13 *"MM and I had very different views on the care plans for individual patients on the*
14 *ward. While acknowledging that I was not familiar with nursing care plans, they*
15 *appeared to me to be lacking detail, particularly in relation to managing challenging*
16 *behaviours. MM's view was that the care plans were satisfactory."*

17 I **did not** regard the care plans as satisfactory.

18 I recall that the wards were using a nursing model of care with uni-disciplinary notes. There
19 was a desire to introduce a full multi-disciplinary model of care. This had not been
20 implemented or resourced at the time. I also recall that there were limitations on multi
21 professional involvement. The model of care planning in use was Roper–Logan–Tierney
22 Activities of Living (for Intellectual Disability). When completed appropriately, with

1 individualised activity plans, this results in a positive care experience. PARIS electronic
2 record (which facilitates multi-disciplinary recording) had not been implemented at this time.

3 I recall that I was not satisfied with the care planning record on the ward. The assessments
4 were incomplete. They had not been regularly reviewed by the nursing and medical staff. All
5 patients did not have activity plans to enable them to participate fully in meaningful activity. I
6 undertook a random sample review of charts, none had been updated. Record keeping was
7 poor and needed to be improved by all involved in the provision of care. Staff where held
8 accountable for this. Accurate and timely recording being an essential part of nursing
9 practice (NMC Standard 10; 2015). An action plan to redress and improve this was put into
10 place by ER. The medical staff were also required to review their records. This led to a
11 project to review care planning across all wards in line with the regional project for acute
12 hospitals.

This statement is true to the best of my knowledge and belief, based on the information available to me at this time.

Name: Moira Mannion

Job title: Senior Nursing Advisor

Signature:

Date: 6th April 2020

 Exhibit 3

Belfast Health and Social Care Trust
caring supporting improving together

**Chief Executive**
Dr Cathy Jack

**Chairman**
Mr Peter McNaney, CBE

27 August 2020

Via e-mail: [redacted]

**Private and Confidential**
Mrs Moira Mannion

Dear Moira,

**Re: Investigation Report**

Following on from our recent conversation, please find enclosed the Investigation Report from Mr David Bingham into Aine Morrison's complaint against you. You will note that there are several paragraphs redacted in the report. These paragraphs pertain only to Ms Morrison and have been redacted in line with data protection legislation.

Mr Bingham has concluded that he did not find any evidence to uphold Ms Morrison's complaint against you and he found that you exercised both professional leadership and professionalism throughout your role in the Ennis investigation. I can confirm that the Trust fully accepts Mr Bingham's report and its conclusions and that no further action is required.

Further to our discussion I understand that Jacqui Kennedy has spoken to you and that there is no further action required by the Trust at this time.

I understand the impact Ms Morrison's complaint, and the subsequent process to investigate it, has had on you. I would like to thank you for your patience and cooperation with the investigation process over the last number of months and I also want to take the opportunity again to thank you for all your hard work on behalf of the Trust throughout your years of service.

With my best wishes for the future

Yours sincerely

Cathy Jack

Dr Cathy Jack
**Chief Executive**

Enc

Copy Mrs Jacqui Kennedy, Director of HR and OD