MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Esther Rafferty
Dated this 13th day of April 2024

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

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. I commenced my employment at MAH on 02 January 2012 as a Service Manager and I was also the Associate Director of Nursing for MAH and Community Learning Disability Services for the Belfast Health and Social Care Trust ("the Belfast Trust"). I was in these positions at the time of the Ennis investigation in November 2012.

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

3. I recall receiving a call from RQIA on 08 November 2012, I cannot recall whom I spoke with, however I recall it being someone senior. I was advised that the manager of Bohill Care Home ("Bohill"), B1, had made contact with RQIA regarding safeguarding concerns that had been reported to her by Bohill staff concerning Ennis Ward. The person from RQIA advised me that they had been informed by B1 that she had telephoned MAH directly and asked to speak to the safeguarding team and the switchboard operator advised B1 B1 to call the Belfast Trust safeguarding team instead. It was after this that B1 telephoned RQIA. From my recall, I think that it was the representative of RQIA who gave me two first names of staff called H159 and H197 who had allegedly been subjecting abuse on patients on Ennis Ward.

4. I recall that I was in a supervision meeting with Eileen McLarnon, band 8A senior nurse manager, when the call came through to me. Eileen and I immediately commenced safeguarding procedures.

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

5. This was not the first time that I had dealt with an allegation involving staff on patient abuse in my post at MAH. I recall dealing with an allegation on my very first day at MAH. I was therefore aware of the procedure to be followed as I had done so before on a number of occasions on receiving an allegation of abuse.

6. Eileen McLarnon and I immediately met the nursing duty officer and I would have informed the MAH safeguarding designated officer, H92, Senior Social Worker if he was on site whose office was located close to my office. The senior nurse managers' band 8a were also designated officers in the absence of the senior social worker. I asked Eileen McLarnon to check the staff rota to confirm whether either of the members of staff who were the subject of the allegations were on duty to see whether I needed staff to leave the site immediately. I telephoned John Veitch, Co-Director of MAH and Catherine McNicholl, Director of Adult, Social and Primary Care to advise them. I also telephoned Brenda Creaney, Director of Nursing. I recall that the rota advised

that only one member of staff was on duty however I recall when Eileen McLarnon went to Ennis Ward, actually both members of staff were on duty and both were sent home immediately. I think the other staff member was there on a bank shift. I discussed placing both members of staff on precautionary suspension with human resources, I cannot recall who I spoke to. Human resources confirmed that I was taking the necessary steps and precautionary suspension was an appropriate response to the concerns raised. I invited H159 H159 and H197 to a meeting with their staff side representatives where they were both advised that they were being placed on precautionary suspension. I provided them with a letter confirming this and also gave them a copy of the disciplinary policy. I arranged for both of them to be referred to occupational health and gave them a name of a nurse who would keep in regular contact with them during their suspension period. I recall a further member of staff, H196 student nurse was also suspended around this time possibly, following a safeguarding meeting. The designated officer, Aine Morrison, Operations Manager, who had been appointed to investigate the allegations, had also asked me to suspend the nurse in charge of duty on the day of the allegations following a safeguarding meeting..

7. I recall H491, the ward sister for Ennis Ward, was on annual leave at the time of the allegations. The duty nursing officer was ward sister, H214 H214. She was working on 08 November 2012 and she assisted me and the team in collating information. As we had taken H197 and H159 off the ward and sent them home, therefore we needed to deploy additional staff to cover for them. Every action had a consequence.

8. H214 was asked to support the ward staff to commence body charts on the patients who were named in the allegations being P40, P213 P213 and P214. This was to be done when these patients were receiving personal care. Any marks on the patients were recorded on the body chart. Body charts were also completed for all of the patients on Ennis Ward. I recall one of the patients was bleeding in her mouth and H214 I believe arranged a dental appointment. H214 was being very thorough with the patients and picking up on any issues to see if it needed followed up further.

9. The relatives of the patients were notified by the senior nurse managers, Eileen McLarnon, Clinton Stewart, Barry Mills and Rhonda Scott. It was a shared responsibility as there were a number of people to be contacted and this was done, I think, on 08 and 09 November 2012.

10. I also contacted David Robinson, Co-Director of Governance Central Nursing and he made the early alert to the Department of Health. Normally when an early alert is made, a serious adverse incident report is also completed. John Veitch Co-Director would have spoken with Mairead Mitchell, Head of Governance in Adult, Social and Primary Care Directorate concerning this. From reading the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, it does not appear that a serious adverse incident report was completed. I do not recall why, it would have been considered and advice sought from the governance lead.. An early alert was made because the allegation involved more than one staff member and involved more than one patient. There was a delay between the incident occurring and the reporting of the incident.

11. I recall that I also spoke to [redacted] B1 [redacted], the Bohill manager at some time in and around the allegations for further information as MAH had plans to move patients to Bohill. The complaint from the Bohill staff I understand was made on the last day that the Bohill staff were working in MAH for in-reach, which came as a bit of a surprise. Bohill staff had been conducting in-reach on Ennis Ward and on other wards at MAH also. There were no complaints received during this in-reach period regarding those other wards or Ennis Ward up to the 07 November 2012, I believe. The following week, staff from Ennis Ward were due to commence out-reach to the care home at Bohill to settle the patients into their new home.

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.**

12. My immediate response was to start safeguarding procedures and to coordinate the precautionary suspensions of staff. John Veitch Co-Director, through Barney McNeaney, Service Manager for the Community and Associate Director of Social Work, would have arranged the appointment of a designated officer, which was Aine Morrison, Operations Manager, to conduct the investigation into the allegations. When allegations related to a staff member in MAH, MAH staff did not conduct the investigation. It was outsourced to one of the community social work teams in the Trust from which the patient originated. Barney McNeaney, Service Manager and Associate Director of Social Work, would have appointed or requested Aine Morrison, Operations Manager.

13. Aine Morrison had organised a strategy meeting the day after the allegations had been made. I had worked with Aine Morrison professionally previously in community learning disability services as she managed the community teams and care management, but I did not see her that often at MAH. I recall that Aine Morrison asked that no one from MAH's clinical or management teams should attend the strategy meeting. Consultant, Doctor Milliken wanted to attend the meeting and he had asked me to speak to Aine Morrison, which I did. Doctor Milliken was the clinical Lead Consultant for the whole MAH site. Aine Morrison advised me that she did not want anyone from MAH to attend the meeting however she was happy for me to attend. I told her that either she did not want anyone from MAH or she did. Aine Morrison and I had a discussion regarding this and I rang Catherine McNicholl to get her thoughts on the situation, as there was an impasse. Catherine McNicholl advised that no one, including me should attend the strategy meeting and Aine Morrison was advised of this. The meeting went ahead and then Aine Morrison updated me on the outcome of the meeting.

14. I did not attend any strategy meetings until a later date and after Moira Mannion, Assistant Director of Nursing, came on board. Moira Mannion was commissioned by Brenda Creaney to support the process around the

investigation and to ensure that nursing in MAH implemented any recommendations coming out of the investigation. I had the support of Brenda Creaney and her team, including Moira Mannion. I see from Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, that the first strategy meeting that I attended was on 20 December 2012. After each earlier strategy meeting, Aine Morrison would provide me with a list of actions points that had been agreed by the strategy team and I was to work through and feed back to her once I had arranged for them to be completed, which I did. Action points were things such as;

- Suspending the alleged staff.
- Keeping all senior team members informed of protection plans and the coordination of twenty-four hour supernumerary staffing through my team in MAH
- Putting up telephone numbers for PSNI, staff care and patient advocates on notice boards to make sure they were visible.
- Liaising with my speech and language colleagues to confirm when they were available to attend interviews with patients.
- Engaging with Doctor Milliken regarding concerns coming from Ennis Ward as he was the aligned consultant for the ward.
- Drafting a guidance note for staff around the implementation of twenty-four hour monitoring of staff, which was a recommendation of Aine Morrison designated officer and agreed by the strategy team meeting.
- Submitting reports to RQIA relating to staffing and any other issues which I believed needed to be notified.
- Drafting a guidance note with human resources regarding family members working together.
- Reviewing monitoring reports and follow up actions.

15. The decision to introduce twenty-four hour monitoring of staff, on a supernumerary basis, on Ennis Ward was very challenging for the management of the hospital. MAH already had a staffing crisis in August and September 2012. Staffing was on the risk register. The staff were being depleted and there had been a moratorium on recruitment prior to me taking up my post in January

2012, as the hospital was supposed to be retracting due to resettlement. I had already started recruitment processes earlier in the year and staffing was on the risk register from March 2012 but staffing remained a serious concern. In September 2012, I had further escalated my concerns around staffing in MAH to John Veitch, Catherine McNicholl, Brenda Creaney and Nikki Patterson, Co-Director of Central Nursing to try to come up with a plan to address this serious issue following incident reports. (Exhibit 1)

16. I had submitted a report to RQIA identifying the crisis just weeks before the Ennis Ward allegations were made and the actions considered and agreed. I attach a copy of this report at Exhibit 1 to this statement.

17. In order to meet the protection plan requirements around twenty-four hour monitoring, I had to find approximately another ten staff members to work in Ennis Ward. Staff from around the hospital site were being redeployed to support the protection plan for Ennis Ward. Each member of staff who were undertaking the monitoring role agreed to undertake the work on an overtime basis which helped in providing additional available shifts. The staff member had to be a band 6 or above. Staffing the wards was still a challenge during the period whilst the investigation was being completed. I sent a request for staff out to the community teams and other directorates in the Belfast Trust but only a couple of people came forward. It was not that I did not want to provide the twenty-four hour monitoring, I believed this was a very appropriate short term protection plan however, operationally it was a huge challenge for the management team in the hospital. From March 2013, Aine agreed with the strategy team that the monitoring no longer needed to be supernumerary and that assisted a little in the delivery of the protection plan The staff team had also experienced changes so new staff members were also in post as well as additional leadership roles on the ward to strengthen the protection plan in place.

18. In total, the monitoring role was maintained for eight to eight and a half months. There was a financial cost of approximately five hundred thousand pounds to provide this due to the overtime and additional costs involved. I discussed costs

and operational challenges with my line manager, John Veitch and with the Corporate Nursing Team at monthly meetings attended by Brendan Creaney and her Associate Directors of nursing including her Deputy Directors Moira Mannion and David Robinson. The Health and Social Care Board representatives (Aidan Murray and Adrian Walsh) for resettlement and budget management of resettlement was also kept informed through regular monthly meetings chaired by Aidan Murray and John Veitch, regarding the investigation and of the delays to individual patient's discharge plans due to the ongoing investigation.

19. Later, following the allegations made by Bohill staff, Bohill no longer felt that the identified patients on Ennis Ward were suitable to be resettled into Bohill. Out-reach to Bohill had been due to start week commencing 10th November 2012, but this was put on hold due to the investigation. Ennis Ward was due for closure but this did not occur during the investigation as the patients did not transfer to Bohill.

20. The patients had become very unsettled when Bohill staff had started visiting Ennis Ward as part of the resettlement programme but the patients were getting used to some of the new faces. Bohill advised that on reflection, they did not believe that their staff had enough experience in caring for these patients' specific needs on Ennis ward. This was very unfortunate as the time and cost spent in preparing these patients for resettlement was lost and Bohill had been felt by the clinical team to be a good suitable placement. The Priory Group which owned Bohill had an alternative placement being developed in Armagh and their manager, Rosemary Dillworth, worked with MAH to facilitate the patients' future placements and move to this facility in Armagh, which was successfully completed a number of months later.

21. I supported the senior nurses, meeting them on a weekly basis to deal with any issues. This was a regular meeting that I held with senior nurse managers. I was meeting Aine Morrison's requests around Ennis Ward and the investigation as well as managing the hospital service. Managers were struggling with each other because they were all trying to maintain safe staffing levels on the wards

that they were responsible for as well as propping up the staffing in Ennis Ward for the monitoring requirement.

22. I attended central nursing monthly meetings with Brenda Creaney, Director of Nursing and I reported to Ms Creaney at these meetings on nursing matters, including the progress of the Ennis investigation and MAH generally. I also attended a meeting which took place every three months where we discussed nurses that were in difficulty, which included nurses who were the subject of investigation. This meeting was chaired by Brenda Creaney at that time. I reported in writing and verbally on any nurses in MAH which were suspended or under investigation.

23. I also attended a meeting with Brenda Creaney and members of her executive nursing team with the Health and Social Care Board in relation to Ennis ward and its investigation.

24. I worked with Moira Mannion, Assistant Director of Nursing. We completed the fifteen step challenge into Ennis Ward to support nurses and staff working on the ward. Moira and I had a plan of what we could achieve each week. Moira had her work plan and was monitoring patient care plans. I liaised with Brendan Ingram, Senior Business Service Manager regarding capital and estate's expenditure for improvements necessary to implement recommendations made by the strategy team throughout the investigation and final report. We both reviewed the monitoring reports and actioned same as issues arose. Numerous visits were undertaken to Ennis Ward.

25. I worked with Rosemary Wilson, the Team Leader for House Keepers and Cleaners to ensure that Ennis Ward had extra support in these services to free up some nursing hours for the ward. On taking up my post in January 2012, I noted that as MAH was a retracting hospital, the older resettlement wards did not have the same allocated hours within their budget for house-keeping and cleaning by domestic staff compared to the new treatment wards. There were distinct funding differences between the resettlement wards and the new wards. These funding issues did create pressures for the nursing teams on resettlement wards as the nursing teams on those wards had additional house-

keeping and cleaning work to do which was carried out by domestic staff on new wards.

26. I reported any issue to RQIA that I thought was necessary. If something needed reporting concerning Ennis Ward, I recall that I telephoned Patrick Convery, the senior inspector at RQIA.

27. I reported to John Veitch, Brendan Creaney Catherine McNicholl and Moira Mannion. Aine Morrison was the chair of the strategy meetings and in this position, she had the right to ask me to perform and coordinate tasks and duties, even though I held a more senior position to her. Aine Morrison was and still is very good on adult safeguarding, she knows it inside out. I delegated tasks to appropriate members of the management team that I managed.

28. As the investigation progressed, I linked in with John Veitch and human resources to commence preparations for the disciplinary investigations into H197 and H159. I will provide some further detail around this in response to question seven below.

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

29. The report was received and read by senior management. We all accepted that a lot of issues had been reported. This was difficult reading for all of us and I personally felt and feel that every one of our patients deserved and should have received good care and treatment. The Ennis Report did not reflect that. The report is a bit disjointed. It contains a lot of information and lists a lot of issues. I believe that there is little drill down on evidence and at times, no evidence was produced to substantiate or collaborate information or findings. I felt these issues however could be resolved through the disciplinary investigations which followed.

30. I recall Doctor Milliken, the MAH clinical lead, was shocked at the allegations that were made. Doctor Milliken advised that he had personally never witnessed

any ill treatment. He also made the point to me that how could the allegations be so widespread when Ennis Ward was open to family members who had the door access code and could enter onto the ward at any time without prior appointment.

31. There were incidents in the report that could end up in a criminal investigation and definitely disciplinary investigations were needed in respect of H159 and H197. There were no surprises in the final report however, because having been involved in the later strategy meetings, we were given the information throughout the process. I was keen to progress to full disciplinary investigations with human resources to deal with the issues addressed in Aine Morrison's report for the staff involved. I understood that Moira Mannion gave the report to Brenda Creaney and John Veitch shared it with Catherine McNicholl. I do not know if the report was shared any further than that to the other members of the Belfast Trust Board. The investigation was thorough but was lengthy and protracted and I recall discussing this with Moira Mannion.

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

32. Aine Morrison asked me to arrange a meeting with the staff on Ennis Ward after the report came out and I did so. I attended the meeting with Aine Morrison. I recall there were around twenty-five members of staff who attended. There were mixed reactions from the staff who attended the meeting. Some of the staff appeared upset and some were quiet. The staff were also expressing dismay as to why the Bohill staff did not make the complaint as soon as they allegedly witnessed what they said that they saw and delayed in reporting their concerns. Some of the staff who attended this meeting had moved jobs and I felt that possibly they were a little more subdued and there to listen, learn and put the matter behind them. Some of the staff were still working on the ward and they voiced that they felt like eyes were still on them. Only two staff members were still on suspension but there were over fifty incidents recorded in the report.

33. There was already some negativity from staff based in MAH regarding the resettlement processes being rolled out and against working on resettlement wards such as Ennis Ward. This meant that some of the staff appeared resistant to change and some feedback from managers previously would have indicated that they were annoyed that patients were leaving the hospital and being resettled which was putting their jobs in the hospital at risk. I also received feedback from other senior team members that they would understand a certain degree of upset at the meeting because the staff were monitored twenty-four hours a day for eight and a half months. Whilst Aine stated at this meeting that there was not enough evidence in relation to some of the incidents, she believed that they had occurred.

34. During the ongoing investigation, it was reported that the ward sister, had allegedly delayed to respond appropriately to a safeguarding concern. This was of significance because she was going to be placed on precautionary suspension whilst the alleged incident was investigated. This is referenced in the evidence bundle. The ward sister then went on sick leave. This meant the precautionary suspension was put on hold. I commissioned for this alleged incident relating to ward sister to be investigated which was completed. Sister Margaret O'Boyle had been deployed to Ennis Ward at the commencement of the investigation to offer additional support to the current ward sister H491 H491. Margaret O'Boyle was acting as ward manager when H491 was off on sick leave. The other staff on Ennis Ward wanted Sister Margaret O'Boyle to remain as ward sister when H491 was returning from sick leave as the staff said that Margaret O'Boyle was a more supportive ward manager to the team as a whole. Following her period of sick leave, H491's manager, Eileen McLarnon, redeployed H491 to leave Ennis Ward.

35. My contribution in the meeting was limited as the meeting was led by Aine Morrison. The purpose of the meeting was for Aine Morrison to advise the staff on Ennis Ward of the findings in her report. She read from her report at the meeting and imparted the information stating that while she did not have enough evidence for all the concerns listed, she felt that the information that the

Bohill staff had reported was believable. I advised the staff during this meeting that there would be further disciplinary investigations to be conducted but I could not disclose any more information to the staff about individuals subject to a disciplinary investigation. The staff were responding with things like "*so your not going to tell us anything new then.*"

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.**

36. A lot of the recommendations in the report were completed by the time the report was finished as we put the recommendations in place as the investigation was taking place instead of waiting for the report to be produced. Most of the capital and environmental recommendations were implemented, supported by Brendan Ingram who helped me access capital funding within the Belfast Trust. Induction processes for visiting care staff were reviewed. Training on restrictive practices was arranged and carried out by, I think, the Nurse Development Lead, Michael McBride. I reviewed staff's mandatory training generally, with the senior nurse managers, and NDL to make sure it was up to date. Where it was not up to date, I arranged for managers to ensure that staff were sent on the necessary courses to make sure that the training was up to date. An e-rostering system was introduced for the timetabling of working shifts. Through central nursing, I kept staffing under review and made sure that supervision sessions for staff were being conducted through my regular meetings with my managers.

37. Aine Morrison's report was produced in draft format in July 2013 and was finalised in and around October/November 2013. Around this time, the PSNI were asked if MAH could commence its disciplinary investigation given that the PSNI were conducting a criminal investigation and the PSNI allowed us to

proceed. The outcome of the criminal investigation was that both staff members were charged. The outcome of the trial was that one staff member was found guilty and the other was found not guilty. The staff member who was found guilty appealed the conviction and was found not guilty on appeal, meaning ultimately both staff members were found not to be guilty of criminal conduct.

38. I commissioned the disciplinary investigations following discussion and agreement with John Veitch and appointed Rhonda Scott, senior nurse manager and Geraldine Hamilton, senior occupational therapist from adult mental health services. Ms Scott and Ms Hamilton conducted the investigation together. They reported to me as to how they were getting on with the investigation. They advised me that some Bohill staff would not engage with them, this included B1 the Bohill manager. They interviewed a number of MAH staff. The lack of engagement may have had something to do with the timing of the commencement of the disciplinary investigation. As a result of the length of time that it took Aine Morrison to finalise her report, the disciplinary investigation did not start until September 2013, which was ten months after the allegations. The disciplinary investigations were thorough and took into account the issues raised in Aine Morrison's report.

39. The disciplinary investigations team made numerous attempts to engage Bohill staff to document and record the concerns. However a number of staff declined to give evidence which hampered the overall investigation.

40. The outcome of the disciplinary investigation was reviewed by myself, John Veitch and human resources but there was not enough evidence in the investigation to proceed with a formal disciplinary process. H197 did not continue to work in MAH. H159 left her post at a later date.

41. I also undertook actions to make improvements which were not contained in the recommendations in Aine Morrison's report. For example, I asked John Veitch for funding for two additional full time senior social workers being Michael Creaney and Aine McMahon who came from mental health and learning disability backgrounds to act as designated officers in MAH for a period of six

months. The mental health directorate were supportive and released the two staff quickly on secondment to MAH. The designated officers arranged training for all staff on the reporting of safeguarding incidents, completing safeguarding referrals and to offer advice and support to staff on safeguarding. We eventually got funding for one full time post from the Health and Social Care Board. Michael Creaney continued on in this post, as an experienced senior social worker.

42. It was flagged in the Ennis Report that the ward sister's mother also worked on Ennis Ward. Following the Ennis Report, I introduced guidance for the MAH site for family members who worked together on the same wards. It was guidance only, not a policy which I discussed with human resources. It was approved and supported by human resources. At the time I discovered that there could have been eight family members working in the same ward. The guidance recommended that if a patient required two to one care, that the two members of staff should not be from the same family. Another example, if two members of staff became engaged to be married, as quite often occurred, the guidance applied to them also.

43. Wards had to review the family connections and discuss with the aligned senior nurse manager how to deploy the staff to reduce the risk of members of the same family working on the same shifts on a ward.

44. A safeguarding meeting was held weekly or twice weekly with Tracey Hawthorne of PSNI to discuss safeguarding referrals with designated officers to ensure for a timely and appropriate safeguarding response to any concerns raised or reported.

45. Moira Mannion had some of her central nursing team visit MAH and explore clinical exchange development programmes, e-rostering and service improvement, all of which was very supportive to me in my role.

46. Decluttering of wards and improvement works were undertaken to ensure patient's environments were enhanced.

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?

47. As noted above in my answer to question four, it was challenging to deliver the staff that Aine Morrison was requesting for the monitoring, on top of what already was a staffing crisis in the overall hospital. As a result of the pressure on staffing for me and the senior nurse managers, it was difficult at times to keep some of the senior nurse managers on board. They were responsible for their wards and had staffing concerns as well. The senior nurse managers were not allowed to attend the strategy meetings by Aine Morrison, therefore they were not brought along and involved in the discussions and decision making which created the action points following each strategy meeting. I was therefore reporting to them on what had been agreed at the strategy meeting, some of which was challenging to deliver on. Aine Morrison wanted to keep information around the investigation as confidential as possible. Senior nurse managers were advised that they were not allowed to attend the strategy meetings as they were managers in the hospital that was the subject of the investigation. The senior nurse managers' feedback to me at the time that they felt like they were being treated by Aine Morrison as if they were colluding in the alleged abuse. I was trying to maintain a functioning team but implement challenging recommendations from Aine Morrison which were difficult to deliver, mainly on staffing. We did however deliver on the protection plan together as a team as the senior nurse managers were committed to good care and treatment of the patients and professional in their duties.

48. The patients on Ennis Ward had become very unsettled due to new staff and new faces on the ward as part of the I reach and resettlement program. After the allegations were made and the twenty-four hour monitoring was put in place, this meant more new faces on the ward. This did contribute to a period of further instability for patients whose normal day to day routine and environment was changed or disrupted. The clinical team in Ennis Ward expressed concern of the impact on the patients' wellbeing and behaviours. As a management team it was challenging for us to balance these actions and their

consequences. The inreach staff from Bohill were working in a new build nursing home which were six en-suite beded bunglows which was designed to provide betterment for those being resettled from long stay hospital care. This was a sharp contrast to a ward environment which had 4 patients to a bedroom with limited personal space.

49. Ennis Ward had been getting ready for closure within a few weeks but due to the patients not proceeding with their discharge plans to Bohill but we were also spending money on the ward to improve the environment and implementing recommendations from the strategy group and Aine Morrison. I felt like I was at times in an impossible situation. I was being told by John Veitch to balance my budget and not to spend money on resettlement wards because the wards were getting ready to close but I needed to implement the recommendations of the designated officer of the adult safeguarding investigation which involved making improvements and reviewing all areas which costed money. I recall a meetings of the core management team at MAH where all of these issues were tabled and discussed. The core management meetings were held fortnightly and chaired by John Veitch and attended by Dr Milliken, lead consultant; Mairead Mitchell, Governance; H92, Senior Social Worker; myself and Barney McNeaney, service manager, on occasion. My secretary Grainne O'Neill created minutes of these meetings for John Veitch. Ennis remained open for another year before being merged with Erne as one ward due to significant reduction in patient numbers in both ward areas and internal capitol works.

50. Ward managers were asking for funds to improve wards which were staying open, but money was being allocated and used on improving wards which were closing to bring them up to the standard to meet recommendations. The resettlement wards which were open, were not fit for purpose and this was documented at Health and Social Care Board meetings as part of the resettlement programme. They were old villas and wards and the layout and facilities were out of date, institutional and over crowded. Discharging patients from these environments was the best outcome for patients living in these wards but this took time to get the placement right. This was caused further

frustration from some ward managers which in turn I and senior nurse managers had to manage.

51. Another issue was some staff were reluctant to work with new members of in reach staff and staff did not want to work on their own in case they were accused of something. The staff were nervous because they were being investigated and I was in charge of the senior nurse managers who were managing these staff members. The whole experience was challenging.

52. One of the biggest hurdles that I faced when I joined MAH in 2012, which continued during the Ennis Investigation, was that some staff questioned my ability to work in learning disability when I came from a mental health nursing background. I did however have extensive experience to undertake the role of Service Manager due to my previous roles working in hospital and community teams' management, leadership roles, lead nurse experience, care management experience and project management. I also recognised that I had an excellent team of senior learning disability nurses who could fill in the gaps in my knowledge base of learning disability. Alongside this one of the senior nurse managers had applied for the role and had been unsuccessful; there was certainly some challenges in managing this situation, his disappointment and that of some of his colleagues and staff because he did not get the post.

53. There were positives which came out of the Ennis investigation. We had the attention and time of Moira Mannion and her training team, which was invaluable. We undertook nurse swaps in different wards so that nurses had the experience of preparing patients for resettlement. Moira Mannion also assisted me with development of plans I had for specialist learning disability nurse roles and training opportunities. This lead to me requesting the NDL Michael McBride to work with UoU to develop the specialist practice course and my work with other Trusts to ensure the viability of the course once commissioned.

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?

54. Following the setting up of the independent inquiry, I was contacted to respond to a complaint made by Aine Morrison about myself and other professionals involved at the time. I was very surprised to receive this complaint many years (eight) after the Ennis investigation was completed. Aine Morrison had held a senior role as Associate Director of Social Work after the Ennis investigation as well as a senior role at the Department of Health, Social Services and Public Safety Northern Ireland since then. These concerns were only voiced when inquiry was announced. I formally responded to the complaint and attached a copy of my response at Exhibit 2.

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.

55. I do not believe that the incidents on the Ennis Ward which lead to the investigation and the Ennis Report should be viewed in isolation or as a standalone incident. There are broader intertwining issues on the MAH site generally. There were many decisions taken years prior to the Ennis allegations such as the choice of, mix of and number of patients placed in Ennis Ward prior to 2010 leading to the lower part of the ward being overcrowded. Wards and buildings continued to be used and accepted which were not fit for purpose, but even with substantial investment were still not suitable environments. The mix and ratios of registered and unregistered staff who worked on Ennis Ward, the availability of specialist support and professional multidisciplinary input to the budget makeup of the ward and overall hospital. Decisions taken due to efficiency savings and retraction which removed funding and posts from the hospital which meant there was less leadership roles on resettlement wards. All of which clearly had an impact on the culmination of the Ennis allegations in

November 2012. These issues were not isolated to just Ennis ward but across the MAH site.

56. The Ennis allegations were not just one event, it was the accumulating effect of processes and systems in different areas of the hospital. MAH is a big institution and sometimes institutions are unyielding and actions taken to improve things can be slow to bed in. There were ongoing service improvement plans in wards and across the hospital. These took time to implement and progress as it involved changing practice and taking staff along this journey. Staff may not be in the jobs that they should be in but the team was exploring development opportunities and training which would help move service improvement forward. Visits and reports from RQIA helped move resistant staffs' mind set and create opportunities for progress. The management team engaged with QNLD to learn from other LD hospital environments and to later become accredited.

57. There were patients in MAH who were ready for resettlement but a decision was taken, long before I started in MAH, that resettlement would be done on a ward by ward basis. Therefore, patients who were ready for resettlement remained as patients, delayed in their discharge, simply because they were not on a ward which was designated next for resettlement. This made no sense to me. Surely it would have been better to resettle patients on their ability to be resettled, not on what ward they were on. This was changed so that resettlement became a requirement and process on all wards.

58. I worked in MAH from 2012 to 2018 as a Service Manager. I have only been asked by the Inquiry to date to provide a statement specific to the Ennis allegations, however I am happy to provide further statements around the general day to day running of MAH during my time in MAH. If the Inquiry would like me to share this information, I am happy to do so.

Giving Evidence

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

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

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

62. I would like it to be noted that since I left MAH, I have been subjected to negative personal social media comments from a parents and friend's MAH group which included complaints on my career choice after I left MAH. This has had a detrimental impact on my mental health and I would wish to minimise further risk of this. I would like to discuss this with the Inquiry around whether or not my name will be provided.

Section 8: 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: Esther Rafferty

Date: 13th Apr 2024

List of Exhibits of Esther Rafferty

Exhibit 1 – Report to RQIA

Exhibit 2 – Esther Rafferty's response to Aine Morrison's complaint

Exhibit 1

Patient Safety Situation 21st September 2012
Muckamore Abbey Hospital

On Friday 21st September B Mills, E McLarnon and C Stewart informed me that staffing in the hospital was dangerously low. The duty nursing office was trying to fill an excessive number of shifts and that this was proving increasingly difficult. Terms such it has never been this bad and this is now every week were being used by the senior nurse managers in their language. Immediately asked them to try the nurse bank office to see if other grades of staff i.e. RGN/ RMN agency was available.

- Never this bad before
- Not being able to get any posts through scrutiny before I took up post
- Over reliance on banking from substantive post holders
- No longer having seasonal staff
- The number of staff resignations of 12 over the summer (these posts were submitted for approval in August as letters of resignation already in)
- 5 more resignations over the pat week
- Staff saying they were taking job opportunities now to leave in case not available later on - this was even staff in Rathmullan
- All ward managers concerned and want to put their concerns in writing to Service manager
- Ward managers seeing it from all wards now no continuity as staff redeployed daily.
- Staff saying they don't know where they will be working when they come into work
- Staff ,morale very low across the site
- Staff in day care feel undervalued as always targeted, daycare no longer important
- No availability of agency or other bank staff / number of requested shift unfilled is rising
- Bank staff holding wards to "ransom" and picking their own places which is displacing core staff
- Increased number of staff on suspension / under investigation
- Staff working excessive hours with no breaks if ward short
- More challenging environments with the easiest patients are leaving
- Some wards today have unsafe staffing at 4pm today
- No emergency response staff will be available in afternoon
- Staff asking trade union to relay their concerns about feeling safe.

Training session was held this morning but majority over 50% of attendees were PCSS staff, and admin. Those nurses/ NA who were in attendance were on bank hours. Previous email sent to indicate that off duty rotas not to be disrupted to encourage staff on leave and day off to avail of training hours in child protection and VA training and they would receive payment for the hours worked as bank.

(this was to address the long term failure of some staff to attend mandatory training in these areas/ highlighted to an outside trainer at a recent training event. A staff member had feedback she had worked in MAH a number of

years and never had received VA training.- Following this an audit of training in these two key areas revealed a substantial number of staff needed the training as well as those outside of timescales for VA as well as child protection. This was in the context of recent RQIA inspection on safeguarding, and recent known investigations into other serious VA concerns in LD of abuse and restriction practice concerns. (WT, Winterborne, Maine PNH, Historical issues on site)

B Mills proposed a potential solution regarding the staffing difficulties.
He had prepared a number of steps to address immediate issues which consisted of the following steps which we discussed in detail with the rest of the Senior Nursing Team on site

Day-care on site
To redeploy all the NA staff in day care to the wards
To redeploy those band 5 who also work as NA staff to the wards
Remaining day care staff to provide a skeleton service, day care is set presently at maximum of 5 sessions per patient except in exceptional circumstance to manage severer challenging behaviour. This would be a reduction below the 5 sessions for all patients on site.

To redeploy the Behavioural Team and trained Nursing staff to the wards

EQC audit ceased for a period of three months
Looking also at staffing cover in swimming pool and reducing sessions

Training cancelled where possible for three months

MAPA training to continue but restrict trainers to C Stewart, D O'KAne and M McBride to minimise impact on wards.

Ward managers to come of duty system

Operations managers to take over duty system again

(this was felt to be of no benefit as ward managers reverted back to ward once time in office over, this would mean operations managers tied up all day with finding bank over to detriment of overall hospital management, already increased workload of VA investigations, overall staff performance issues and key duties under pressure.)

There was also discussion about the amount of staff time taken up with resettlement and this may have to be discussed especially in resettlement wards as this was having a detrimental impact on staffing numbers.

This would be for a set period to the closure of Finglass ward mid to end of

November until staff released.

Also discussed the resettlement plans in Finglass and how many of the patients would have been resettled by November and the actual probability of some of the proposals for resettlement.

Discussion was held about the consequences of the actions if taken and what alternatives if any. All agreed that day care is already being targeted every week to try and manage the staffing deficits with closures of rooms and redeployment of staff to wards. This is very ad hoc and with no consistency.

Major concern noted of taking the action to close and severely reduce the service in day care was the likely effect of an increase in challenging behaviours on the wards and therefore increase the risk to staff of aggression and actual violence. Also this would likely increase the risk to other patients of aggression and actual violence. This will increase the number of Vulnerable adult reporting on site (it was noted that this has went up more over the summer ? Due to ad-hoc closure of day care sessions, reduced staff availability to intervene in a timely manner in interpersonal interactions between patients)

Other issue discussed was will targeting the day care staffing realistically provide the number of staff and skill mix required to address the current deficits in the system

Also some wards are feeling more targeted than others , those wards who staffing is more stable is being negatively impacted upon by the overall issues and this is leading to unsafe staffing levels , always working under agreed staffing levels and loss of continuity.
Concern was discussed about bank staff knowing how stretched the service is dictating the wards they will work in or refuse to transfer to another ward displacing experienced staff who know the patient in their own wards which all managers agreed was totally unacceptable.

Telford assessments of each ward have been completed - these need reviewd , validate immediately and any changes to the staffing compliments to each ward to be communicated to the duty nurse office.

Senior Nursing team to finalise this work quickly - outstanding issue

I raised that we could still be in this position in November as whilst there is no further funding to operate Finglass ward post November we do not have definite plans for a number of patients in this ward.

Nurse Bank - no further feedback

Contact already made to nurse bank on a number of occasions now and to senior nurse managing Nurse bank M Devlin to request other staffing to supplement the skilled workforce. Unfortunately all areas are under recruitment drives.

Mental Health - Mel Carney ADoN mental Health recruiting and no available resource to redeploy.

Also spoke to N Kelly Senior Nurse Operations Manager - no availability from a community LD nursing workforce. Discussed also that supported living was also under continued pressure and relied heavily on bank and daycare relied on agency with some of their staff working in supported living bank.

Action Plan

- Immediate notification of all patient safety concerns and possible options to be discussed with corporate nursing Ms N Patterson Co Director Workforce immediately - E Rafferty

- Immediate Meeting on Patient Safety with Dr Milliken Clinical Medical Lead - B Mills / E Rafferty

- Immediate Brief on Patient Safety to Mr Veitch Co Director

- Brief trade union representation on patient safety concerns

Outcome of Briefings

1. Ms Patterson agreed that bringing forward the closure of Finglass ward was a more balanced approach to safeguarding patients and staff.
a) standing down daycare as proposed would increase risk to patients and staff
b) standing down daycare would cause distress to all patients on site as all would have a reduced service
c) daycare is a respite for patients and staff
d) patient safety is currently compromised and immediate action is required that is sustainable to bring the hospital back to safe staffing levels to maintain patient safety
e) closure of the ward is already planned, September was the original date, and staff expect this to happen in the near future already.
f) contingency planning is already in place for a number of the patients already in this ward to internally transfer wards.
g) Ms Patterson agreed to keep B Creaney Director of Nursing briefed.
h) this staffing crisis could not have been predicted as robust steps had been put in place to address recognised concerns but that a high number of staff left (12) and the imminent departure of another group of staff (5) was critical to the escalation of the staffing situation.

I)

Mr Veitch
Discussed patient safety concerns and issues regarding the staffing crisis. It was noted that this was not unique in trying to find a lot of shifts but it was now very frequent I.e. happening every week and that staff morale low and working excessive hours.
staff reporting feeling obliged to remain to keep patients safe

Discussed options and possible outcomes, informed meeting now with Dr Milliken to brief him of the patient safety concerns. Agreed that both options posed operational difficulties but my recommendation was to bring forward the planned closure of the ward to safeguard the patient and staff safety of the hospital.

Mr Veitch to brief
Director of Adult Social and Primary Care Ms C McNicholl,
Dr O'Kane Associate Medical Director

Meeting with Dr Milliken
Full outline of concerns
Options discussed
1. Daycare and limitations and expected consequences - Dr Milliken agreed that this could lead to increase in risks
2. Bringing forward the closure of Finglass - E Rafferty stated that this was likely to assist in reducing the risk to patient safety across the site but would affect the patients in Finglass. This was balancing the risk present and limiting the detrimental impact on patients Dr Milliken expressed his concern that this would cause harm to patients in his care. Dr Milliken to discuss his concerns with Mr Veitch

All agreed to review over weekend to determine if any other option available to resolve patient safety concerns. Management cover reviewed for weekend and next week.
Meeting on Monday with Dr O'Kane / Dr Milliken / Mr Veitch / E Rafferty to examine options and agree way forward.

Meeting 24th September
Present
Mr Veitch,
Dr O'Kane,

Dr Milliken
Mrs E McLarnon
Mrs E Rafferty

Patient Safety Concerns outlined

Options Discussed
Day care redeployment of available Nursing Auxiliaries and band 5 where appropriate and all trained nurses to wards.

Bringing forward the closure of Finglass ward to original date.

No other option available

No other ward will have a lesser impact on patients

Patients in Finglass are expecting a ward closure

Dr Milliken reiterated that he feels this option will cause patients harm

Dr O'Kane agreed that bringing forward the closure of Finglass to its original date was least worst option, and along with Dr Milliken will brief Dr T Stevens Medical Director.

Action Plan
Dr O'Kane to brief Dr T Stevens
Mrs Rafferty to brief Senior Nursing Team - closure over next week to 10 days.
Redraft potential patient transfers and discuss with Dr Milliken to finalise over next few days
Mrs Rafferty / Mr Veitch to brief trade unions Tuesday 25th September

Tuesday 25th

NT pre-planned contingency meeting held - outline of patient safety concerns

and potential bring forward of the closure of Finglass to original date outlined.

Meeting with Unison and local representatives - information held in confidence till ward managers briefing

Redraft of patient transfers (draft 2)

26th September
Ward managers meeting

Meeting with RCN / Nipsa 26th September

26th September R Wilson PCSS services notified of planned closure

Ward staff notified following ward managers briefing - Iveagh patient safety issue highlighted

Redraft of patient transfers (draft 3) Moylena option

Ms N Patterson Co Director Nursing updated on progress

Patient safety issue Iveagh reported to Dr Milliken - action to contact consultant cover for Iveagh and discuss a resolution.

27th September
Meeting ward staff, Dr Milliken, B Mills, B Ingram, E Rafferty, M Lee to discuss patient transfers

Number agreed

RQIA informed (E Rafferty left meeting to take phone call P Convery already on site - updated)

Redraft (4) following visit to wards

Dr Milliken agreed final placements with B Mills / ward staff

Relatives contact commenced (some patients moves previously agreed as part of original contingency plan)

Trusts, Board and DHSSPS notified

H40 informed of patient safety issue relevance to Iveagh centre - agreed to postpone admission / Service manager to contact parents and advise of issue and alternative timing for admission. - completed

28th September

Iveagh notified of deferred admission

Senior Nursing Management Team in Belfast Trust updated on MAH staffing concerns and patient safety issues and action plan tom address

Nurse Bank notified SNM of agency availability - actioned

SNM and ward staff continued contact with relatives

Sequence of patient transfer and staff allocations circulated

E Rafferty contacted Patient advocate

Corporate Communications updated.

Exhibit 2

Statement in relation to Complaint by AM

I took up post as Service Manager in January 2012 for Muckamore Abbey Hospital, I was also designated as Associate Director of Nursing. On taking up these roles I worked closely with the management team in learning disability services and central nursing to deliver on the care and treatment of patients in MAH.
The hospital consisted of a range of new wards for assessment and treatment of patients with a learning disability with mental health and behavioural challenges alongside a number of resettlement wards which were historical to the site and assessed as no longer fit for purpose. On taking up post I noted and shared my views that these wards were outdated, characterised by poor environmental standards, lack of privacy and overcrowding. Staffing in all wards was limited and the qualified nurse ratio was not appropriate for the acuity levels of patients. These issues I highlighted and a range of actions were identified to support staged improvements to areas of the hospital which also included changes to the community integrated programme to expedite appropriate discharges and provide easement to some of the challenges. As MAH a large institution a number of improvements were introduced alongside planned discharges.

One of these actions was placing staffing of the hospital on the risk register.

During my initial tenure in MAH I addressed incidents whereby safeguarding events were reported, these were proactively addressed using safeguarding processes with PSNI, and followed up with Trust disciplinary processes.

In early November 2012 RQIA notified me directly of safeguarding concerns in Ennis ward to which I immediately actioned a protection plan of precautionary suspension of two staff. I ensured the matter was communicated to the co-director and Director of AS& PC as well as Director of Nursing. This involved communicating with key personnel in central nursing and Hr to progress the precautionary measures and early alerts.

In line with adult safeguarding AM undertook the role of Designated officer and she coordinated the multi agency meeting. AM expressed her view that the hospital management team should not be involved in the strategy meeting or anyone from the ward. AM expressed her view that widespread abuse was present. In discussion and consultation with the Director of AS& PC the hospital management team stood back as requested. I was included in this action however I met with AM after the strategy meetings and actioned all agreed plans in a timely manner.

This included 24 hour monitoring of the ward by identified staff supernummery to the ward team and who were of band 6 and above internal or external to the hospital. The monitors were provided with guidance which AM and I agreed upon and shared with the staff undertaking this role. Ward staff were issued with separate guidance. The monitors from the beginning were band 6 and above and were not only band 8 a staff as referred to in the complaint. My recollection of the monitoring is that on only a small number of shifts were covered by non MAH staff as few were identified as willing to assist with same.

MM coDirector was identified to support the investigation process, and learning from the processes and this also included supervision in Ennis ward, engagement in improvement methodologies in the ward and support for myself as Service Manager. MM attended the strategy meetings and represented nursing on same providing her expert view and opinion on situation and progress.

At no time did my non involvement in the strategy meeting impact on protection planning for the patients in Ennis ward. AM requested further suspensions which I actioned as well as lifting of suspensions.

Providing 24 hour monitoring on a supernumerary basis to the ward was very challenging and impacted on a range of available services to this ward as well as the hospital. This protective measure which was reviewed every month continued until July 2013 almost 9 months. Feedback from professional staff involved in the ward indicated that the new staff deployed in the wake of those suspended alongside the monitors did have an impact on patients who due to their known presentations did not respond well to transition or abrupt changes to routines.

During this period and afterwards the hospital management team and other wards continued to work proactively with Bohill private nursing home staff owned by Priory group and managed to progress discharges from other wards to their facility. Unfortunately the patients in Ennis did not eventually move to Bohill however the hospital management team continued to work with Priory group to discharge the patients to one of their facilities in Armagh.

When AM requested a meeting to provide feedback to the nursing team in Ennis I made all necessary arrangements for same. Staff present were distressed being informed by AM that she believed there was likely more abuse than she had evidence for or could prove.
I my role I had commissioned an Trust disciplinary investigation into the allegations following completion of the adult safeguarding investigation and this was a live investigation at the time of the meeting.

I finally would like to express concern at the 8 year delay in AM raises her concerns having ample opportunity to do so with the Co director JV who attended the strategy meetings at the time of the investigation as well as being appointed Associate Director of Social Work for learning disability in the intervening years.