MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 11TH JUNE 2024 - DAY 91

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THE INQUIRY RESUMED ON TUESDAY, 11TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Good morning, thank you very much.

MR. DORAN: Good morning, Chair, Panel. 09:52

As I indicated yesterday, this morning's witness is Brenda Creaney. Ms. Creaney will be dealing with the Trust evidence in respect of Ennis.

CHAIRPERSON: Yes.

MR. DORAN: Just before we call the witness, Mr Maguire 09:52 has indicated that he would like to say a few brief words.

CHAIRPERSON: Yes, I understand Mr Maguire wants to say a few words about the sad news yesterday, in relation to Geraldine O'Hagan. So that it's heard, would you 09:53 mind going to the podium.

STATEMENT BY MR. MAGUIRE ON THE DEATH OF MS. GERALDINE O'HAGAN:

MR. MAGUIRE: Yes, Chair, thank you. We learned yesterday of the sad passing of Geraldine O'Hagan, who was significantly and integrally involved with many of the CP3 clients, whom we represent. Chair, on behalf of the CP3 clients and the legal team at O'Reilly 09:53 Stewart, and indeed on my own behalf --

CHAIRPERSON: Hold on one second, sorry.

MR. MAGUIRE: On behalf of the CP3 clients, the legal team at O'Reilly Stewart Solicitors who worked with

Ms. O'Hagan and indeed myself, Mr. Anderson and Ms. Ross, can I place on the record our sympathy to Geraldine's family and state our gratitude for the work that she did for our clients.

09:54

Chair, without Geraldine, many of the CP3 clients would have been reluctant to involve themselves in the process. Her support to them was evident in our interactions with our clients and she attended with our clients when they consulted with us. They were helped by her at times of significant trauma and anxiety, and just last week, or a couple of weeks ago, I should say, when Geraldine came to give her evidence to the Inquiry, despite her illness she was lifted up by many of those clients from within the CP3 group and other groups that came to hear her evidence and supported her through that, and she was carried along by them, Chair.

09:54

09:55

We're grateful to you for permitting us the opportunity to make this brief, short statement.

09:55

Geraldine's family is very much in our thoughts and, again, we pass on the condolences of our CP3 clients to Geraldine's family.

CHAIRPERSON: Well, can I say thank you very much for those comments. I'm sure there are many in the room that would wish to reflect the same. And I should say really, on behalf of the Inquiry, that I'm aware how much she did assist the Inquiry in terms of easing the

09:55

way for families and witnesses to come to speak to us, so it's right that that should be reflected on the record. So can I thank you very much indeed.

MR. MAGUIRE: Thank you.

CHAIRPERSON: Okay. Right, thank you. Shall we move on to the witness? 09:56

MR. DORAN: Yes, Chair, if Ms. Creaney could be called, please.

MS. BRENDA CREANEY, HAVING BEEN SWORN, WAS EXAMINED BY MR. DORAN AS FOLLOWS: 09:57

CHAIRPERSON: Good morning, Ms. Creaney. Thank you very much for coming along to assist the Inquiry and I'm going to hand you over to Mr. Doran. 09:57

A. Thank you.

1 Q. MR. DORAN: Yes. Ms. Creaney, I am Sean Doran KC, and, as you know, we met briefly earlier today, and I thank you also for attending to give evidence. 09:57

We're dealing specifically today with the Ennis Ward safeguarding process and related matters, and I think it's correct to say you made a statement in relation to these matters on 22nd of February of this year, isn't that right? 09:58

A. Yes, that's correct.

2 Q. And for the record, Chair, the reference to the statement is MAHI STM-206, and have you got a copy of your statement with you, Ms. Creaney?

A. Yes, I do, yes.

3 Q. And are you content to adopt your statement as the basis of your evidence to the Inquiry?

A. Yes, I am content.

4 Q. I should have mentioned to you earlier, actually, there is just one very minor point I picked up on at paragraph 102, and we may as well deal with it now. If you go to paragraph 102, it says: 09:58

"No member of Bohill staff, including those who did not themselves volunteer concerns but who were, nonetheless, spoken to as part of the investigation process, did not have any concerns about any other ward at MAH beyond Ennis." 09:59

Now, presumably that should read: "It appears that no member of Bohill staff had any concerns about any other ward"?

A. Yes, that's what that means, thank you.

5 Q. Yes, indeed, thanks. As I say, I should have mentioned that to you earlier, but it's good to have it cleared up now. Now, of course, your statement is made on behalf of the Trust, isn't that right? 09:59

A. Yes, that's right.

6 Q. You say at paragraph 3 that you've been assisted by others in compiling the statement? 09:59

A. Yes, that's correct.

7 Q. And you give a list of those who have helped. I'm not going to go through the list of names, but you say that

you weren't able to speak to everyone who might have been able to help. Can I just ask, are there any significant gaps; is there someone you thought you really needed to speak to but weren't able to?

A. No, there are no significant gaps, but there are people who have left the Trust some time, but they are mentioned in this evidence and I'm aware that some of those individuals are giving evidence next week. 10:00

8 Q. That's very helpful. And you feel you're content, or that you're well-placed to address these issues, these particular issues on behalf of the Trust? 10:00

A. Yes, I am.

9 Q. And in your statement at paragraph 11, you also draw attention to the earlier Trust statement of Martin Dillon dated 26th April 2023, isn't that right? 10:00

A. Yes.

10 Q. And I think Mr. Dillon was a former Chief Executive of the Trust?

A. That's correct.

11 Q. And his statement runs right across the issues in Evidence Module 6, isn't that correct? 10:00

A. Yes, that's correct.

12 Q. And for the record, Chair, the reference to that statement is MAHI STM-107. We may touch upon that statement briefly in the course of the evidence. 10:01

A. Okay.

13 Q. And, of course, both you and Mr. Dillon have been asked to make statements also for the later organisational module on the Trust Board, isn't that right?

A. Yes, that's right.

14 Q. So you may also be giving evidence on a broad range of issues after the summer?

A. Yes, I expect to, yes.

15 Q. Now, if there are outstanding issues in relation to Ennis, obviously we can revisit those at a later juncture. 10:01

A. Okay.

16 Q. And, in fact, I think you indicated that, if need be, you would come back straight after the main body of the Ennis evidence and assist the Inquiry again by sweeping up on any matters that may need to be attended to? 10:01

A. Yeah, that's correct. Originally, I was going to be out of the country, but I am no longer out of the country in the next few weeks. 10:02

17 Q. Well, that's very helpful. I think, in fairness, the likelihood is that we will deal with any outstanding matters at a later stage when you come to assist with the organisational modules, but it's helpful to know that if there is anything outstanding, we can return to it at a later stage. 10:02

Now, in the course of your evidence or at the outset of your evidence, I want to mention some other documents that are associated with your statement? 10:02

A. Yes.

18 Q. And I don't want to spend too much time on this, I really don't want to labour it, but let's just put these on the record and hopefully then move swiftly on.

So, there's also a bundle of documentation known as 'the Ennis Bundle', isn't that right?

A. Yes, that's correct.

19 Q. And that was compiled by the Inquiry and you were provided with a copy of that when you were making your statement, isn't that right? 10:03

A. Yes, that's correct.

20 Q. And, Chair, for the record, that's MAHI Ennis-1 and I may be referring to that document as we -- or that collection of documents, as we proceed. 10:03

Now --

CHAIRPERSON: Sorry to interrupt, but just to make it clear to anybody who is watching, all of that is actually on our website, I think.

MR. DORAN: It is indeed, or if it hasn't yet been posted, it certainly will be, Chair. 10:03

Now, you also mention a number of documents in your statement from the Trust disclosure to the Inquiry, isn't that right? 10:03

A. Yes, I do.

21 Q. And the Inquiry then compiled a supplementary bundle to provide a compilation of that material, isn't that right?

A. Yes, that's correct, and I have a copy here. 10:04

22 Q. You've got a copy with you, that's helpful. And again, Chair, for the record, that bundle is called 'MAHI Creaney B, Supplementary Bundle'.

Now, just to complete this exercise. On Friday of last week, the Trust also provided the Inquiry with another bundle of materials that they say were mentioned in the statement but that didn't appear in the documentation that had been provided to Core Participants? 10:04

A. That's correct, yes.

23 Q. And I'm not going to ask you about that bundle of material today, I'm not going to display it on screen; it will be processed for disclosure in an appropriate way to Core Participants. If you need to refer to any 10:05 of those documents, please do so in general terms and we can deal with them later, but I am not going to refer to those documents today.

A. I also have a copy of those.

24 Q. Thank you, that's very helpful. And finally, then, 10:05 there's also a set of documents that weren't identified at the time that you made your statement, but they would have been exhibited if they had been identified at the time, isn't that right?

A. Yes, that's correct. 10:05

25 Q. And those -- that bundle can safely be displayed on the screen, no redaction issues arise in relation to those materials, and we have labelled that bundle temporarily 'Creaney B, New Bundle'. Now, I can say, at this stage, I am going to show you one document from that 10:05 bundle.

A. Yes.

26 Q. Which is the minute of a Trust Board meeting back in 2013.

A. Okay.

27 Q. So, that's the tricky business of documentation dealt with now, and hopefully it won't come back to trip us up in the course of the evidence.
I want to move on to deal with your role, Ms. Creaney, and you set that out at paragraph 15 of the statement, and you say you have been Executive Director of Nursing and User Experience since January 2010? 10:06

A. Yes.

28 Q. And you refer to that comprising two extensive portfolios: Nursing, Midwifery and Allied Health Professionals and also Patient and Client Support Services? 10:06

A. Yes.

29 Q. Can you just give us a general flavour of what your role within the Trust involves? 10:06

A. In relation to Nursing, Midwifery and Allied Health Professionals, I provide assurances to the Trust Board and to the Chief Executive in relation to safety and quality, regulation, education and Nursing, Midwifery and Allied Health Professionals workforce. That is a relatively small group of individuals because we have substructures who report to me across all of the divisions in the Trust. Patient and Client Support Services is all of our non-clinical support services, so that's catering, cleaning, security, portering, waste and all of -- chaplains, volunteers, so all of the services who provide frontline care to patients in line with patient experience, but they would not be a 10:07 10:07

group of professional regulated staff, but they provide all of those core frontline services. And I have three deputies who take each of those portfolios I describe and they report directly to me.

30 Q. Yes. So you're at a fairly high level within an upward reporting structure, if I can put it like that? 10:08

A. Yes, yes, I am.

31 Q. And your role presumably then extends right across the Belfast Trust?

A. Yes, my role extends to all of the acute and community services, and I also have a group of, now they're called divisional nurses, at this time they were called associate directors of nursing, who report to me on professional parts of Nursing, Midwifery and Allied Health Professionals I have described. 10:08

32 Q. Yes. So, of course, your role isn't confined to the fields of learning disability and mental health?

A. No.

33 Q. It extends right across the spectrum of nursing?

A. Yes. And we have approximately seven-and-a-half thousand nursing and nursing support staff in the Belfast Trust - nurses and midwives, I should say - and two-and-a-half thousand Allied Health Professionals. 10:08

34 Q. And in that role, you would also be a member of the Trust Board, is that right? 10:09

A. Yes, I am an executive member of the Trust Board.

35 Q. And just in your role, I take the point that it's a very extensive portfolio, but, in that role, would you visit individual facilities?

A. Yes, I do. I aim to visit all facilities across the Trust in all of our areas at least once a year and I co-ordinate that through the divisional nurses or associate directors of nursing. I am in some areas more frequently than others if there are issues, and certainly I have spent a lot of time in Muckamore, but --

36 Q. When you -- sorry to interrupt you, but when you say "a lot of time", would that tend to be more recently or right throughout the years? 10:09

A. No, throughout the years, I would have been in Muckamore at least once or twice a year attending their sisters' meetings or going to visit. I also went to Muckamore as part of my induction and met staff and patients. I did a particular piece of work with the nurses in Muckamore around prevention of choking, for example, as a result of an incident which occurred, but I do aim to be in all areas at least once a year and I try to be there more frequently if I can. 10:10

37 Q. Yes. 10:10

DR. MAXWELL: Can I ask what year that piece of work about choking was, roughly?

A. Oh, I may have to come back to you. I think it was 2013, but I will have to confirm that. It was on the back of an incident. 10:10

DR. MAXWELL: Okay.

38 Q. MR. DORAN: Can I ask, just aside from Ennis specifically, which we're dealing with today, and obviously the period following what occurred in 2017,

would Muckamore have featured prominently in the issues that you had to deal with within your role across the years?

A. Issues would have been brought to me about Muckamore by the associate director of nursing, now divisional nurse, largely in relation to safeguarding or staffing. There were also particular issues in relation to catering and choking, as I've said, so specific issues would have been brought to me monthly by the associate director of nursing or divisional nurse. 10:10 10:11

39 Q. And not only specific issues, but maybe more general issues like staffing?

A. Yes, yes.

40 Q. It's fair to say that there have been difficulties over the years, right across the years of your tenure in staffing at Muckamore? 10:11

A. Yes, there have, and certainly the associate director of nursing would have escalated her concerns, not only to me but the Service Director.

41 Q. Yes. 10:11

A. And certainly we did particular recruitment, for example, for learning disability, because you'll be aware, at the time of Ennis, Muckamore was retracting in size because of the requirement to resettle parents into the community, but we had come to a point where the staffing was destabilised and we put in place permanent recruitment, whereas, prior to that, it had been temporary, and I was concerned it was destabilising the site. 10:12

42 Q. Just when you say 'we came to a point in time when staffing was destabilised', what would that point in time have been, would you say?

A. Actually, after Ennis, certainly the ward sister had raised particular issues, but we had done specific learning disability recruitment prior to that as well and we were able to commission additional education for learning disability nurses. You'll be aware learning disability nurses are a particular part of the nursing register and it was the balance of retracting the site but also keeping the patients safe with the right skill-mix of staff. 10:12 10:12

CHAIRPERSON: Could I just ask what you mean by "destabilise", because are you saying there had not been issues with staffing prior to Ennis which then destabilised the nursing cadre, as it were, or were there problems with staffing before but it came destabilised because of the investigation? 10:13

A. Well, it's two-fold. There were problems with staffing before the Ennis situation came to light and that was the balance of retracting the requirements for the site but also having the right skill-mix of nurses, because as the patient numbers reduced in Muckamore, the complexity of the patients actually increased, so we had to reconsider what the staffing levels were, and that was on an ongoing basis before Ennis, but certainly there were particular issues, and you'll be aware that Ennis Ward was preparing to close over the time of this, but there were concerns that we were 10:13 10:13

using too much -- too many temporary staff, too much bank and agency, and that, in itself, for me, is a safety issue.

CHAIRPERSON: Sorry to interrupt.

MR. DORAN: Not at all, Chair. In fact, I can say that I am going to return to the pre-staffing issue later. 10:14

CHAIRPERSON: You are going to touch on issues --

MR. DORAN: Yes, indeed.

CHAIRPERSON: Okay.

DR. MAXWELL: Maybe you want to cover it then, but were you aware of the multiple attempts by the ward manager of Ennis from June 2012 onwards to raise her concerns, not about temporary but about the total number of nurses on the ward? 10:14

A. They had been brought to my attention by the associate director of nursing. I can't recall the specific time frame, but they were brought to me both formally and informally. 10:14

CHAIRPERSON: I suspect Mr. Doran is going to deal with this. 10:14

43 Q. MR. DORAN: I'll have another look at that later, Ms. Creaney. But just looking at Ennis Ward itself at the time, you, helpfully, provide some statistics on the hospital generally and Ennis Ward as things stood in November 2012, from paragraph 17 onwards in your statement, and I just wanted to look briefly at the tables that you provide at paragraphs 19 and 20. You see there the first table that relates to Muckamore at the end of March 2012 and there's a reference to the 10:15

number of staff in the different areas: 43, admin and clerical; 13, estate services; 6, medical; 398, nursing; 3, professional and technical; 36, social care; and 106, support services, and that's a total of 605. And then you provide the equivalent figures for 2013 at paragraph 20. Just looking at those figures, do the figures relate to full-time members of staff or are those full-time equivalent figures? 10:15

A. They would be whole-time equivalent figures. Some of those staff may be part-time, some may have worked particular shifts, but that's the overall whole-time equivalent of staff. 10:16

DR. MAXWELL: Can I ask, is that the establishments or the hours worked?

A. No, that's the establishments in numbers. 10:16

DR. MAXWELL: So this may include vacant posts?

A. It may include vacant posts.

DR. MAXWELL: Do you have the figures about how many hours were actually worked?

A. I don't have them with me, but I can certainly provide them to the Inquiry. 10:16

DR. MAXWELL: Thank you.

44 Q. MR. DORAN: And I wonder, do the figures include Allied Health Professionals, whom you have mentioned? Which category would they be included in? 10:16

A. The Allied Health Professionals are not included in the nursing numbers. They would be included in professional and technical, those numbers. However, there would have been other Allied Health Professionals

who may have been in the community who would not be included in these numbers.

PROFESSOR MURPHY: There's very small numbers --

A. Yes.

PROFESSOR MURPHY: -- in the professional and technical. But that includes speech and language therapists, psychologists, OTs? 10:17

A. Yeah, those numbers are very small, and I would need to go back and give you the breakdown of who those individuals are. 10:17

DR. MAXWELL: Are you saying these are people who are in the MAH budget because speech and language therapists may be in a budget outside MAH?

A. Yeah, that's what I was saying, they may not be particularly in that budget and they may work in from the community or other services. 10:17

DR. MAXWELL: So it doesn't mean there was only one professional and technical worker --

A. No, it doesn't.

DR. MAXWELL: It means they were in a budget that wasn't managed by -- 10:17

A. By learning disability, yes, that's correct.

PROFESSOR MURPHY: But that, presumably, was implying that they would be part-time in the community and part-time in MAH? 10:18

A. Or they could be in another part of the Trust and have done sessions in Muckamore. I can get to you the details, but we certainly had physiotherapists, occupational therapists and speech and language

therapists and dieticians.

45 Q. MR. DORAN: And just more generally - you may not be best placed to answer this question - but looking at a ward such as Ennis, how does the Trust or hospital management determine how many staff ought to be on a ward such as Ennis? 10:18

A. Well, you look at the -- you look at the patient cohort, and certainly it's a piece of work done with the ward sister as well as the lead nurses. They were called senior nurses in Muckamore and they would work with my workforce team to determine levels per shift required, and that's how we actually increased the numbers for Muckamore. 10:18

46 Q. Yes, but just in relation to Ennis, you say there were 20 members of staff on the ward at the relevant time? 10:18

A. Yeah.

47 Q. Would that have been regarded as the correct number?

A. The ward sister's view was that that was not enough staff, so we worked to increase that.

DR. MAXWELL: And again, is that 20 in the establishment or 20 whole-time equivalents worked? 10:19

A. That was 20 people on the ward at the time. I would have to go back and check the specific establishment. Within Muckamore, the establishments were at the original budget, but the staffing was reduced in line with the patient numbers. 10:19

PROFESSOR MURPHY: Does that mean 20 in every shift?

A. No, that's 20 in total.

PROFESSOR MURPHY: Right.

DR. MAXWELL: So you have establishments that are agreed and funded, the number of patients on the ward is reducing as people are resettled, but that establishment isn't dynamic; you're not saying, every month or every quarter, that we need to adjust this establishment?

A. That establishment was adjusted, but it wouldn't have been adjusted as frequently as every month. However, the ward sister would have worked with her senior colleagues to bring in additional staff to meet the needs of the patients.

10:19

10:20

DR. MAXWELL: So if the establishment hadn't been adjusted, presumably they were still funding. If the ward sister felt that because of the increasing complexity that you mentioned with the patients who were left, if you had the original establishment, i.e. funded posts, why couldn't that be used? Why wasn't that used?

A. It was used latterly, but it was used -- it was used to fund the additional staff we brought in, but it took some time to do that, and that was based on recruitment and availability of staff. We did bring in bank and agency staff as well.

10:20

10:20

DR. MAXWELL: But this was after the Ennis incident had happened?

A. Well, beforehand as well, but there was an absolute focus afterwards and it was one of the recommendations of my colleague who went in on my behalf.

10:21

DR. MAXWELL: Thank you.

48 Q. MR. DORAN: In paragraphs 23 and 24, you give some statistics on adult safeguarding referrals.

A. Yes.

49 Q. And you say at paragraph 23:

10:21

"In terms of adult safeguarding within Muckamore Abbey Hospital itself, between 1st January 2012 and 31st December 2012, there appeared to have been 565 referrals, and then between January 2013 and 31st December 2013 there were some 804 adult safeguarding referrals."

10:21

Now, I must say, to the lay person those figures seem very high.

A. Yeah.

10:21

50 Q. Can you explain how statistics of that nature can come to pass in a facility such as Muckamore?

A. Certainly, the adult safeguarding policy changed between 2012 and 2013 and there was an increase in referrals, which we were aware of. I would say that the staff in Muckamore were very, very keen to uncover where there were issues and this was a range of referrals and there was subsequent discussion around the application of the new policy and was it appropriate, and we had discussions -- well, I personally didn't, but the team in Muckamore had those discussions with colleagues in Safeguarding, but also in the Health and Social Care Board as well, because there were concerns that we were applying the policy

10:22

10:22

incredibly stringently, which caused an increase in the numbers. I also am aware at the time there was an increase in the numbers across all of Northern Ireland, so a piece of work was happening around the application of the new policy. 10:23

51 Q. Just when you say applying the policy "stringently", what do you mean by that?

A. I am not an absolute expert in adult safeguarding, but certainly, from what I understood from the team, they felt that there was very little room for discussion and 10:23 that they tended to raise a safeguarding concern and screen it out rather than look at other issues. I actually think that's probably a good thing, certainly, to be inquiring about the safeguarding risks for vulnerable people. 10:23

52 Q. And presumably those figures cover a wide range of incidents and issues?

A. Oh, yes, that's the total figure. And I think, you know - I'm certainly happy to get this information for the Inquiry - the detail around this and the numbers of 10:24 cases either screened out or who go for further investigation, I feel is very important in these numbers.

53 Q. And so one could drill down, for example, to find out how many of those referrals related to concerns about 10:24 staff conduct towards patients?

A. Yes, that's one of the categories.

54 Q. Now, in paragraph 25, you seek to put the Ennis episode in some context, and I'll just read that paragraph in:

"In considering the response of the Belfast Trust to the allegations made about some staff on Ennis Ward in November 2012, this overall context indicates that the allegations related to a small number of the overall staff complement of the hospital and were said to relate to a small number of patients of the hospital. When these two facts are considered against the extent of the steps that were taken in response to the allegations, the position of the Belfast Trust is that the response demonstrates that the matter was taken very seriously."

Now, you refer to the small number of staff and the small number of patients, but I take it you would accept that it's very important not to trivialise those incidents in any way?

A. No, absolutely. Any safeguarding issue is taken very seriously, and that was not my intent in the statement.

55 Q. No, indeed, and would you accept that these allegations, in particular, were quite different in nature from the majority of complaints that one might receive in a hospital setting?

A. They weren't different, in my experience, but they were different from what I would have been aware of about Muckamore.

56 Q. I mean, one had the inclusion within the allegations, matters of physical assault?

A. Yes, which is most concerning.

57 Q. And the allegations related to the conduct of staff towards patients?

A. Yes.

58 Q. And perhaps importantly, also, perhaps critically in fact, the conduct was observed by individuals who didn't work at the hospital? 10:26

A. Yes, that's right.

59 Q. In paragraph 26, you go on to refer to the various policies in play at the relevant time. I'm not going to drill into the detail of those now, you will be glad to know, but is it fair to say that adult protection or safeguarding procedures are not intended to run entirely independently of other processes such as complaints and disciplinary processes? 10:26

A. The investigation does run in tandem, but one informs the other, and certainly in the case here we initiated Joint Protocol and involved the police as well. 10:27

60 Q. Yes. So they are not standalone procedures, so to speak?

A. No, they are not standalone procedures. However, some take precedence over others. For example, a police inquiry would take precedence over a disciplinary investigation, so -- but the Adult Safeguarding Investigation is important in informing next steps, and certainly, in the case of Ennis, this was brought to the attention of the police through Joint Protocol very early on. 10:27

61 Q. So you have the adult safeguarding procedure in train and you also have the police investigation ongoing?

A. Yes.

62 Q. And then you have the two processes perhaps meeting by way of the safeguarding meetings or the strategy meetings?

A. Yeah, through the Joint Protocol strategy meetings. 10:28

DR. MAXWELL: Do the policies actually explicitly lay out how different processes run concurrently?

A. It's usually, in my experience, it's usually agreed at the Joint Protocol meeting. So, for example, the police may ask that information is not shared in the 10:28 detail they require so it doesn't prejudice their investigation, but they can run in tandem. The disciplinary process, however, is the outworking of that, and that -- that happened slightly later in this case. So, the one area where we wouldn't wait, 10:28 however, is in referral to the regulator, because safeguarding is one area where we refer immediately where we have a concern.

DR. MAXWELL: Thank you.

63 Q. MR. DORAN: Do you know did such references take place 10:29 in this case in respect of all of the individuals concerned?

A. Sorry, I don't understand.

64 Q. You said "referral to the regulator". Did referral refer -- 10:29

A. No, we can only refer registrants to the regulator, okay, and, yes, that did happen in this case. We can only refer non-registrant staff if they are -- if they are registered with the Northern Ireland Social Care

Council, which I don't recall being the case here. However, if we have a concern, we can also refer to the vetting and barring service as well.

65 Q. And I think that was, in fact, done in respect of one of the staff -- 10:29

A. Yes, it was.

66 Q. -- involved.

A. Yeah.

67 Q. We'll come back a little bit later to look at the SAI issue, the serious adverse incident reporting, and the 10:30 fact that this wasn't dealt with through that mechanism. But can I just ask you, at this stage, about how adult protection and safeguarding procedures operate alongside serious adverse incident procedures; you know, is there any or was there any guidance on 10:30 when a matter subject to a safeguarding procedure should, in fact, be reported as an SAI?

A. The criteria for the SAI could cover an adult safeguarding issue. The criteria in 2012 changed in 2016, and is changing again as we speak, but there is 10:30 criteria within an SAI which could also apply to an adult safeguarding and that's where someone has encountered harm.

68 Q. Yes, we'll look at that a little bit later. But I take it there was nothing within the guidance on 10:31 safeguarding procedures to say, in these circumstances, one should give thought to the SAI referral?

A. No, not within the safeguarding - well, they were called adult protection procedures at that time.

69 Q. Yes. I want to move on to ask you some questions about the awareness within the Trust of what had occurred in Ennis or the allegations that had been made in November 2012, and you were asked a number of questions about this for the purpose of your statement. At paragraph 34, you say: 10:31

"Unfortunately, it is not now possible for the Trust to be absolutely sure who the Ennis Ward safeguarding report was provided to within the Belfast Trust." 10:32

And that's a matter perhaps we can pick up on with other witnesses. But just at this point in your evidence, I want to consider the matter that you go on to look at, and that may be a more significant one, and 10:32 that is who was aware of the allegations and how the allegations were being dealt with at the time.

Now, in paragraph 38, you say, in relation to provision of the report to the Board, you say: 10:32

"This is different from who was aware of the Ennis Ward allegations, the steps that were taken in response and what the ultimate outcome was. For instance, senior members of the Belfast Trust will have known about the 10:32 allegations, the fact of the vulnerable adult, Adult Safeguarding Investigation, and the prosecution and eventual acquittal of two members of staff."

And you go on to give details in subsequent paragraphs about who was aware at the time, including the Chief Executive, who I think was Colm Donaghy at the time, isn't that right?

A. Yes. 10:33

70 Q. So he would have been aware of the allegations that had been made?

A. Yes, he would have.

71 Q. Now, at this point I want to refer to the document that I mentioned earlier on, which is the Trust Board minutes document, and that appears in the bundle which we have titled, for convenience, 'MAHI Creaney B, New Bundle', and I want to go straight to page 3 of that bundle. Now, if you look at the top of the page, you have "Minutes of the confidential Trust Board meeting, Thursday, 11th April 2013, at 10 a.m. at the Royal Victoria Hospital." 10:33 10:34

You have a list of attendees, including yourself as Director of Nursing and User Experience; Mr. Dillon, who was Director of Finance at the time; Dr. Stevens, who was the Medical Director; Mr. Worthington, who was the Director of Social Work and Children's Community Services; and, of course, the Chief Executive, Mr. Donaghy, as well as the non-executive directors. 10:34 10:34

And if you could just scroll down, please. Can we then move to the next page, please, that's page 4, and can we have paragraph F on screen, please, the entirety of

F. Yes. Now, F relates to public prosecution cases, and "Ms. McNicholl briefed members on two imminent public prosecution cases which may be the subject of media coverage."
Sorry, that was Catherine McNicholl, wasn't it? 10:35

A. Yes, that's correct.

72 Q. And what was her position at the time?

A. She was the director responsible for Muckamore Abbey Hospital as well as other services.

73 Q. Yes. And the minutes then refer to two matters that had been with the PPS, and I'll just go straight to the second one, which is about halfway down the middle paragraph, and it reads: 10:35

"The PSNI had also investigated an alleged case of ill-treatment of patients in Muckamore Abbey Hospital by two members of staff and they had recommended prosecution to the PPS. It will take some considerable time for the PPS to confirm their decision regarding this incident. 10:35 10:36

In response to a question from Mr. Hartley, Ms. McNicholl advised that the Trust had policies and procedures in place in respect of safeguarding vulnerable adults. She further advised that the Trust had to wait for the PSNI to complete their investigations before implementing disciplinary proceedings." 10:36

And the decision is recorded as:

"Report of Chief Executive noted."

And then there is a reference to the directors withdrawing from the meeting at this stage. 10:36

So that's helpful because one can categorically say that the issue was formally brought to the attention of the Board in April 2013, isn't that right? 10:36

A. Yes, that's correct.

74 Q. And that was about six months after the -- maybe -- yes, six months after the initial allegations?

A. Yes, that's correct.

75 Q. And it was very much a case of bringing the matter to the attention of the Board rather than asking for proactive consideration to be given to it, is that fair to say? 10:36

A. Yes, but the actual process in relation to the allegations and the staff, had started earlier, as you note, yeah. 10:37

76 Q. Yes, yes, indeed. But this wasn't a case of someone coming along to the Board and saying, "right, what do we need to do next?"

A. No. 10:37

77 Q. It was a case of reporting, essentially?

A. Yes, that's correct.

78 Q. And if we go back to the statement, please - that's STM-206 - and scrolling down to paragraph 40. Now,

just two-thirds of the way down that paragraph, you properly say:

"I was obviously aware of the allegations shortly after they were made." 10:38

So you would have been aware, at a very early stage, of the allegations?

A. Oh, yes, I was. And my deputy actually raised an Early Alert to the Department of Health on my behalf in relation to the suspension of the staff involved. 10:38

79 Q. Yes. You refer to the Early Alert document, in fact, in paragraphs 41 and 42. Who was your deputy at the time?

A. At that time it was Dr. David Robinson. So, within my service, I had two deputies for nursing, and he was in the Safety, Quality and Regulation side of my nursing directorate. 10:38

80 Q. Yes. And I think his name, in fact, appears on the Early Alert document itself. We can have a look at that, it appears at MAHI Ennis-1 page 82. So that's a follow-up pro forma for Early Alert communication. What exactly happens when an Early Alert is triggered? 10:38

A. Well, an Early Alert is to advise the Department in relation to the matters noted in the criteria and it's a first line where a concern has arisen and it may go a number of directions after that, but this is really our first line of raising our concern with Department of Health colleagues, and, where it's a nursing issue, 10:39

either I or one of my team would alert the chief nursing officer's office. Then, the alert goes through a formal process into both the Department of Health and at that time it was the Health and Social Care Board.

DR. MAXWELL: Can I just clarify, are you saying there is two different processes, one is to formally complete the Early Alert, but, also, there is a separate notification of the chief nursing officer? 10:39

A. This is a notification to the chief nursing officer, but there was also a separate -- we had, at that time, an alert mechanism through the chief nursing officer's office, but that is separate to this Early Alert process. That was a professional alert process where we had a concern and we would ask the chief nursing officer to consider sending an alert out to other Trusts in Northern Ireland. That usually happens later in the process. So they are two separate things. 10:40 10:40

DR. MAXWELL: Are you saying they both happened?

A. Yes, they did, but not at this time. This was the original indication. 10:40

DR. MAXWELL: Thank you.

81 Q. MR. DORAN: Can we just scroll down, please, just to read the entry:

"On 7th November 2012, a member of staff reported that two staff, one staff nurse and one healthcare support worker and one student nurse had physically abused four patients in Ennis Ward in Muckamore Abbey Hospital. These staff have been suspended pending the outcome of 10:40

investigations. The PSNI have been informed. The Trust is in the process of referring the staff to the Independent Safeguarding Authority. The Nursing and Midwifery Council has been notified of the precautionary suspension of the registered nurse involved in this incident."

A. Yes.

82 Q. Now, I note that there's no mention there of the fact that the observations were made by external staff. Now, you didn't write the document, but does it surprise you that there was no mention of that fact? 10:41

A. Usually, these are immediate alerts. They don't contain all of the information. This would have been preceded by a phone call explaining the circumstances. It, ideally, would have said that, but it doesn't. 10:41

83 Q. Arguably, it would have been an important point to include --

A. Yeah.

84 Q. -- in the text. And just if one goes then to the next page, that's page 83, thank you. You can see there the list of individuals who were copied into the Early Alert notification: yourself, David Robinson, Catherine McNicholl, Tony Stevens, June Champion and Claire Cairns. So, again, back to my point, there was an awareness of this issue at a fairly high level within the Trust? 10:42 10:42

A. Yes.

85 Q. And as regards ongoing information as to what was happening, you say in paragraph 42 of your statement,

if we can go back to the statement, please, that you were getting regular updates from Moira Mannion?

A. Well, not at this point. The updates I was receiving were from the Associate Director of Nursing, Esther Rafferty, and the Service Director, but I was also involved in asking Moira Mannion to go in. The Deputy Chief Executive said "Brenda, we need to get some external monitoring, are you happy to ask one of your team?" 10:42

86 Q. Who was the Deputy Chief Executive again, sorry? 10:43

A. Oh, that was Marie Mallon, and she is mentioned in my statement at the start.

87 Q. Yes. So she asked you to appoint someone, essentially?

A. Yes, yes.

88 Q. And were you then instrumental in the appointment of Moira Mannion? 10:43

A. Yes, Catherine McNicholl and myself met with Moira and gave her an outline of what was required and asked her -- Moira Mannion has a background in, not learning disability, but in mental health, and her role at that time was nurse education, but she has a background in mental health and I asked her to go to Muckamore and provide some additional monitoring and assurance. 10:43

89 Q. Yes. And did you regard her as your voice on the ground at that time, so to speak? 10:43

A. Yes, yes. And I also felt it was important to keep the regulatory part of my department separate from the monitoring part.

90 Q. And you refer to the updates that she was giving you.

A. Yes.
91 Q. Do you recall her raising any concerns with you at the time about how the allegations were being managed?
A. She didn't raise concerns about how the allegations were managed, but -- 10:44
92 Q. Sorry, she didn't or she did?
A. She didn't.
93 Q. She didn't.
A. She didn't. But certainly it was difficult for Moira to go into Muckamore and -- but Moira has a very 10:44
gracious style and she worked closely with the associate director of nursing to support her and also to support the staff in Ennis, but it was a very difficult time having these staff suspended.
94 Q. We will, of course, hear from Ms. Mannion in the course 10:44
of the evidence. Now, at paragraph 44 you talk about meetings and discussions that you would have had with Catherine McNicholl about the progress of the action plan that was developed after the allegations?
A. Yes. 10:45
95 Q. And as you've said, Ms. McNicholl was Director of Adult and Social and Primary Care at the time. You give one example then at paragraph 44 and that's a meeting that occurred on 10th of April 2013. Now, I needn't go to
the document itself, but basically that's just a diary 10:45
entry, isn't it?
A. Yes, it is, yeah.
96 Q. It basically indicates that you met with Ms. McNicholl on that occasion, but there is no further detail around

that?

A. No, it wasn't a minuted meeting.

97 Q. Yes. And were any of those meetings minuted?

A. No, but I would have received -- I received some written reports from Moira, I also met with her regularly in what we called one-to-one meetings, so she would have updated me on the progress. There were a number of issues. You'll also be aware RQIA did an inspection, so there were a number of recommendations on the back of that inspection as well. But certainly in relation to the monitoring, the physical layout of the ward, the approach to the monitoring, Moira was advising the team in Muckamore around how that should be, and used different methods to provide assurances. 10:45 10:46

98 Q. It just occurs, actually, that the diary entry to which you've referred was the day before the Board meeting. Is it possible that there was some nexus between those two? 10:46

A. I don't think so, I think that was coincidental, because I would have discussed the issues with Catherine quite regularly. 10:46

99 Q. And you've mentioned the RQIA, and in paragraphs 45 to 47 you talk about the communication of the unannounced RQIA inspections to the Chief Executive, Colm Donaghy, in early 2013? 10:47

A. Yes.

100 Q. And I then just wanted to read in paragraph 48, where you say:

"Whilst senior people, both within the Belfast Trust and outside of it, were aware of the allegations of abuse on Ennis Ward, and of the steps being taken to address them, it would not be normal for those individuals to receive a copy of the final adult safeguarding report. That would still not occur today. I try to explain why that is the case below."

And we will go on to look at that, as to how the report itself didn't find itself being presented to the Board. But I just want to go back to that point in time again in late 2012 and early 2013 when the allegations had emerged but the safeguarding process hadn't been completed. Might one not have expected a more proactive approach to be taken by individuals at a senior level, Board level, to this particular issue at the time? 10:47 10:47 10:48

A. That wouldn't have been the role of the Board at that time. The role of adult safeguarding, any safeguarding, is as close to the frontline as possible, and certainly the role of the designated adult protection officer, the associate director of nursing at the time and the co-director of the service, were key in overseeing this issue. That wouldn't necessarily have come to the Board at that time. 10:48 10:49

101 Q. But granted, the Trust is a -- it's a very large organisation, obviously?

A. Yes.

102 Q. But in this situation, as we've discussed, there was a

report of alleged assault by staff on patients --

A. Yeah.

103 Q. -- at a facility for individuals with severe learning disabilities. The conduct was said to be observed by external staff? 10:49

A. Yes.

104 Q. How would you answer the suggestion, if made, that the Executive Team on the Board really ought to have been actively scrutinising the approach that was being taken, rather than allowing the procedures to take 10:49 their course?

A. I don't -- I wouldn't agree with that statement. It is the role of the director of the service to ensure the processes are in place within their division, which was the case here. There were ongoing investigations 10:50 happening, and we were managing the adult safeguarding issues, the staffing issues and the regulatory issues together, but I wouldn't expect that to come to Trust Board.

105 Q. So essentially would it be the position that the Board 10:50 makes sure that the necessary procedures are in place but then let's them take their course?

A. Well, they would seek assurances that the processes are in place, which is referred to in the minutes we've seen, but, also, the director of the service, and 10:50 indeed me if I felt I needed to, I could escalate concerns or issues to the Board, but there was a process in place happening here, and we had -- I was -- I was confident in Moira's role to provide me with

assurances on the ground.

106 Q. But there was no specific escalation of those concerns to the Board at that time?

A. No, there weren't, apart from indications around the PPS. 10:51

DR. MAXWELL: Can I just ask, I accept that not all safeguarding reports will go to the Board because there just wouldn't be time to do that, but would you not have expected the report to be presented at some sort of governance committee? 10:51

A. It would have been presented at the -- at the time it was called the Adult Protection Committee, now our Adult Safeguarding Board, so it would have found its way there on completion.

DR. MAXWELL: When you say "would have", do you mean it did or it should have? 10:51

A. I believe it did, I believe it did, but I don't have --

DR. MAXWELL: So there would be minutes of a discussion of the safeguarding report and that is the point at which it might have been escalated further up the governance framework? 10:51

A. I would expect that to have happened, but I don't have that information here, but I can check for you and come back to you.

DR. MAXWELL: But, potentially, anything that needs to be escalated to the Board would have been highlighted there? 10:51

A. Yes, within our structures, the governance structures go from the directorate or division to the specific

area, in this case Adult Safeguarding, so there was an overarching Trust committee. Then, it could escalate to Trust Board if required, but this wasn't in this case.

DR. MAXWELL: And that we could see the minutes where that was discussed? 10:52

A. Yes, I would hope so, yes.

DR. MAXWELL: I think that would be very useful.

107 Q. MR. DORAN: And I am going to come back and deal with some of the other committees as well in due course, but I want to go on now just to consider this question of why the report itself wasn't presented to the Executive Team or the Trust Board. You say in paragraph 40 that your co-director of nursing didn't provide it to you at the time. Given your role, does that seem surprising, looking back at the situation? 10:52 10:53

A. No, it doesn't seem surprising to me because, while she was there and providing me with assurances, she was not the author of this report; it was the Designated Adult Protection Officer. 10:53

108 Q. But you wouldn't have expected to receive a report of this nature immediately on its production?

A. No, I wouldn't.

109 Q. Not even given the exceptional nature of the report as we've considered, or the circumstances, should I say? 10:53

A. No, I wouldn't have expected to receive it because my assurances were that we had all of the safeguards in place to protect patients on the ground, to support the staff, and then we took the appropriate safeguarding,

disciplinary and regulatory action.

CHAIRPERSON: Could I just ask a very basic question. I understand what you say about not everything can go to the Board, and you have explained why this report actually wouldn't have gone to the Board, but the Chief Executive would have known about the report, presumably? 10:54

A. Yes.

CHAIRPERSON: Just suppose if I was Chair of an organisation such as the Belfast Trust, I would want to know about anything that was potentially reputationally damaging, which the -- what had been going on here, or what was alleged to have been going on with patients, clearly was. Would the Chair have been told? 10:54

A. The Chair was told in relation to the PPS and the prosecutions. I am not aware the Chair was told the particular detail at that time, but I obviously can't speak for the director or Mr. Donaghy. 10:54

CHAIRPERSON: And would you have regarded this as potentially reputationally damaging to the Trust or does it not reach that level? 10:54

A. Well, that's why the issues around the prosecutions was brought to Trust Board, to advise that this, potentially, was going to be in the media, so it was advised to the Board but the details, as such, were not. 10:55

CHAIRPERSON: So, really, you're waiting to see if it hits the press or if there's a prosecution?

A. No, no, we advised it was happening and this was likely

to be reputationally significant, I suppose, for the Trust, but the overarching detail could have gone to the Board, but didn't in this case.

CHAIRPERSON: Okay.

PROFESSOR MURPHY: So was it common then for incidents like this to reach PPS, for example, within the Belfast Trust? 10:55

A. It wasn't common, it was unusual, but escalation to the PPS is obviously from the police, so that would be significant, that would be unusual. 10:56

110 Q. MR. DORAN: Now, Ms. Creaney, you provide a very detailed explanation in paragraphs 49 to 82 of how the report was not escalated to the Executive Team or the Board. I'm not going to move across all of the detail, but, in fairness to you, I want to make sure that your explanation is brought fully to the Inquiry's attention. I think it's fair to say you make six key points - you can correct me if I have got any of these wrong or if you want to add any to the list yourself - but the first point you make is that the relevant policies at the time did not actually require a formal report to be prepared at all as a result of an adult safeguarding process, and I think you make that point at paragraph 60. Is that a fair summary of the point that you're making? 10:56 10:56 10:57

A. Yes, it is.

111 Q. And secondly, then, if a report was created, there was no guidance in the relevant policies about with whom it should be shared?

A. That's correct.

112 Q. And you say, and you have said:

"A report of this kind would not normally be escalated to the Executive Team or the Board." 10:57

And you wouldn't have expected that to happen?

A. That's correct.

113 Q. And fourthly, then, just because the report wasn't referred to the Executive Team or the Board, doesn't mean that the Trust failed to treat the issue very seriously? 10:57

A. Yeah, we treated it very seriously.

114 Q. My fifth point then points to the various steps that were taken. You point in your statement to the safeguarding process involving the input of a number of designated officers, the police investigation, the disciplinary investigation and the response to the various RQIA reports. And finally, my final point, and I think you make this point, it's fair to say, with some hesitation at paragraph 76, you say: 10:57 10:58

"Even if the matter was escalated, it is difficult to see what steps could realistically have been taken." 10:58

Is that a fair assessment -- or a fair summary of the point you're making?

A. I think my point there is that we had taken all appropriate steps within the adult safeguarding,

disciplinary and regulatory processes. So, I'm not -- what I'm saying there is, I don't think we would have done anything else at that point.

115 Q. Even if the reported had been escalated, it's difficult to see what else would have been done, is that the point? 10:59

A. Yes, that's what I'm saying.

116 Q. Now, do you think that the absence of guidance in the relevant policy documents on the circumstances in which a report of this kind should be escalated, was a defect in the relevant policies at the time? 10:59

A. I'm not certain I would use the terminology "a defect". However, in my experience, these policies do run in parallel at times and it is important that they are cross-referenced. Should it be in the guidance? Well, if it were more explicit, yes, potentially. I don't know if I can say it's a defect, but it would be more supportive if it was clearer. 10:59

117 Q. But for someone in your position and with your professional experience, would you say there ought to have been a requirement to escalate a report of this kind? 11:00

A. I don't know if it would have made it -- as I have said already, I don't know if it would have made the actions any different. I take the point about the reputational impact, but I was assured that we had done everything we should and I don't believe anything different would have happened had this gone to Trust Board, but I take your point, and we obviously function very differently 11:00

today, but I do take your point that advising the Chair and advising the non-executives would have been helpful to them to have the knowledge. I don't believe anything different would have happened, however.

DR. MAXWELL: Can I just ask then, in 2013, '14, '15, did you have Controls Assurance Framework? 11:00

A. We had an assurance framework; we didn't call it a Controls Assurance Framework.

DR. MAXWELL: So, having identified that something serious happened, taken steps to mitigate that, did it not remain a significant risk; it had happened once, it could happen again, and, if so, did it appear anywhere on the assurance framework, because it was a known risk? 11:01

A. Do you mean the assurance framework or the risk register? 11:01

DR. MAXWELL: I mean the assurance framework.

A. Yes.

DR. MAXWELL: So the assurance framework is, as I understand it, there to assure you that risks are being managed. 11:01

A. Yes, that's correct.

DR. MAXWELL: So was it on the assurance framework? Because this was not only a risk, it had actually happened and so was significant, and surely the Board would have wanted regular assurance that it wouldn't happen again? 11:01

A. But that is the role of the Adult Safeguarding Committee, which does report up to the Trust Board

through the Assurance Committee, so, yes, that would have been part of that process. But the specifics of this, I would need to refer back to those minutes.

DR. MAXWELL: So, I think, we've talked about the system of exception reporting, which is various committees assess things and report them up by exception. 11:02

A. Yes.

DR. MAXWELL: The controls assurance or assurance frameworks are supposed to actively seek assurance and not wait for voluntary exception reporting; you know, one is bottom up and the other one is top down. So my question is, having had an incident that did happen, notwithstanding the fact that you had taken a wide range of steps, did the Board not consider we need a top down, actively seeking assurance rather than waiting for an exception report? 11:02 11:02

A. And that is the role of the Adult Safeguarding Committee, so that covers not just learning disability; that covers the entire Trust. 11:03

DR. MAXWELL: But if the Safeguarding Committee chooses not to escalate something to the Board, the Board don't know what they don't know, whereas if they actively seek assurance, they do know, though, to ask the question and being positively told there is no risk. It's a different approach to risk management. 11:03

A. Yeah, but I certainly don't think, in this circumstance, we can say there is no risk. You know, we were aware with the increase in incidents in

Muckamore, so certainly that was -- that was a feature of those meetings, not the specifics of Ennis, but certainly a feature that our number of referrals had increased.

DR. MAXWELL: So the assurance framework, whatever you were using at the time, did not have on it risk of staff abuse of patients at Muckamore as an item? 11:03

A. No, it did, that was one of our categories, so that would have been something we would have looked at. There were a number of categories within the adult protection policy, one of which was, and it's actually called that, "staff on patient". 11:04

DR. MAXWELL: So that was one of the things?

A. That was one of the categories --

DR. MAXWELL: That was one of the things that was there after the Ennis incident? 11:04

A. No, that was there before as well.

DR. MAXWELL: And it was before?

A. Yeah.

DR. MAXWELL: Okay, thank you. 11:04

118 Q. MR. DORAN: I just wanted to go back briefly to paragraph 53, and it's a related point really about escalating matters to Board and Executive Team. You set out statistics at paragraph 53, and if we could scroll down, please, around about 10 lines down, you say: 11:04

"In the 2011-2012 financial year, there were 3,586 safeguarding referrals in total in Northern Ireland.

514 of these referrals came from the learning disability service area within the Belfast Trust. This figure grew to 1,010 referrals in the learning disability service area within the Belfast Trust between April 2012 and March 2013. 71% of the referrals were from Muckamore Abbey Hospital and 29% were from the community. Regionally, referrals grew to 7,747 adult safeguarding referrals in 2015-2016 financial year. The point I am trying to make is that the Belfast Trust did regard vulnerable adult, adult protection processes as important. It did promote and encourage amongst staff the reporting of matters of concern." 11:05 11:05

But I'm just thinking about those statistics alone, the reference there to the figures for referrals within the learning disability service area and 71% of those referrals being from Muckamore Abbey Hospital itself. Forgetting about Ennis and the Ennis projects and the Ennis report, even if individual reports were not escalated to the Board, would those statistics, collectively perhaps, not have justified escalation to the Executive Team or the Board? 11:05 11:06

A. I can't recall specifically if it was discussed at Executive Team, but I know it wasn't escalated to the Board. I know it is significant, and certainly it was -- it was an issue of discussion within the team in Muckamore and would have been raised by the associate director of nursing, her concern about the number of 11:06

referrals, and she would have raised that through her governance processes within learning disability and to my team, but, you know, it was not -- it was not escalated to the Board at that time.

119 Q. No, but -- 11:07

PROFESSOR MURPHY: It is very disproportionate, isn't it, for so many of them, such a large percentage, to have come from MAH, given there are only 200-odd patients in MAH at the time and the numbers in the community must have been far, far more? 11:07

A. No, I mean, it is a significant increase and it is something that both the director and myself were aware of, but there were discussions with colleagues outside of the Trust about how we were managing adult safeguarding as well, because whilst we encouraged 11:07 reporting, and we do to this day, I do think it's important to look at those figures in terms of categories and the number of cases which preceded, and I don't have that information today, but I can provide it. 11:08

DR. MAXWELL: Can I ask, those statistics come from the Local Adult Safeguarding Partnership reports that you have referenced?

A. Yes.

DR. MAXWELL: So, two questions: Presumably, that 11:08 report would contain how many had been screened out because, as I understand it, you're suggesting there was a high level of referrals, which was actually good practice, and we don't actually know from these figures

what the number was that were investigated that weren't screened out as over-reporting. Did that report get presented to the Board, or would that have been managed at the Safeguarding Committee that you mentioned earlier and only escalated to you if there was a concern?

A. Yeah, it would have been managed at the Safeguarding Committee.

DR. MAXWELL: But presumably, if the Inquiry wanted, we could see those reports, which presumably would help us make some sense of how many of these referrals were screened out?

A. Yes, no, absolutely, and we can provide those to the Inquiry.

120 Q. MR. DORAN: And just going back to my earlier questions about the allegations when they first emerged in the early stages of the safeguarding process, even though the report was not formally escalated, could the report itself -- or, sorry, could the Board itself or the Executive Team have asked for it to be escalated?

A. Yes, they could have, yes -- we could have, I should say.

121 Q. But you can tell us if this is not how things work, but what if a member of the public asked, given the nature of these allegations, was no one at senior level saying when this report is completed, we really need to receive a formal briefing about it; in other words, a more hands-on approach? How would you respond to that suggestion that a more hands-on approach by the Board

would have been appropriate?

A. I think we have to -- we have to consider the size and scale of the Trust as well. I take your point in relation to where we are today, but certainly I am -- I was assured by the processes we had in place and, as I said, I don't know if bringing it to the Board or Executive Team would have changed that; I personally don't believe it would have. But certainly, as our Board stands today, this is something we would bring, but I think that's our learning in recent years. I don't think; I know. 11:10 11:10

122 Q. Yes. I just wanted to touch, as well, on the assurance framework. Dr. Maxwell has mentioned this. In paragraph 67, you refer to this particular route through which the report might have been escalated, and you say: 11:11

"It is also the case that, within the applicable Belfast Trust assurance framework structure that operated at the time, there was a Vulnerable Adults Protection Panel that reported to the assurance group through the Social Care Steering Group." 11:11

A. Yeah.

123 Q. "The Social Care Steering Group was a formal subcommittee of the Assurance Committee. In turn, the assurance group reported through the executive to the Assurance Committee of the Trust Board. The Belfast Trust has not, as yet, found evidence that the report was escalated through this means." 11:11

Looking back, would you have expected it to be escalated through those means?

A. Not necessarily, unless we weren't able to address the issues. Certainly, that was an option for both myself and the director of the service. I think it is important that I let the Inquiry know that Assurance Committee is Trust Board and the assurance group at that time was Executive Team, but they were our assurance mechanisms, but I have no evidence and I can locate no evidence that it was, apart from the information we have shared, this issue was brought to Executive Team and to Trust Board once, and we have provided those minutes, but not in any other -- not in any other meeting. 11:12

124 Q. Yes, now, you also refer to the Audit Committee in paragraphs 81 and 82, and are you essentially suggesting that the Audit Committee wouldn't typically have dealt with issues of this kind?

A. No, it wouldn't. 11:13

125 Q. In no circumstances?

A. No.

DR. MAXWELL: Can I ask then, the Assurance Committee reported through the executive, is that right?

A. No, no, the Assurance Committee is Trust Board, and our structure at the time - I haven't got the diagram with me - but our structure at the time was, Assurance Committee was a subcommittee of Trust Board, so --

DR. MAXWELL: So it wasn't Trust Board, it was a

subcommittee?

A. Well, it was a committee of Trust Board, but it was populated by the members of Trust Board.

DR. MAXWELL: All of the Board?

A. Yes, yes. And the assurance group, similarly, was populated by all of the members of Executive Team, and the subcommittees, some of whom are referred to here, reported to the Assurance Committee, which was effectively Trust Board for assurance matters. 11:13

DR. MAXWELL: And the audit committees, which follow on originally from the Cadbury recommendations on corporate governance, are -- the members are non-execs; although execs may attend to provide information, it is the principal way in which non-executives hold the executive part of the Board to account? 11:13 11:14

A. That's correct.

DR. MAXWELL: And their purpose is to audit that the risks are being managed?

A. Yes, that's right.

DR. MAXWELL: So why would it not have considered whether the risk of staff-on-patient abuse was effectively being managed? 11:14

A. My view of that would be that there was another process in place. Our Audit Committee did not typically receive reports along these lines. They tended to receive, and still receive, reports around audit functions, where our internal and external audit have provided reports about a variety of issues, not just financial, but I am not aware at this time. There have 11:14

subsequently been audits of adult safeguarding, but not at this time.

DR. MAXWELL: But the Audit Committee sets the agenda for the internal audit programme --

A. Yes, that's right. 11:15

DR. MAXWELL: -- so if it had concerns about safeguarding processes, it could have directed internal audit to audit the safeguarding process?

A. That's correct, yes.

DR. MAXWELL: And it is the only committee that is only 11:15 non-executives; all the other mechanisms you had report up through executives?

A. Yes, that's right.

DR. MAXWELL: So you didn't have independent non-executive oversight of safeguarding at that time? 11:15

A. Not at that time. We do now, but not at that time.

CHAIRPERSON: Just thinking about the timing. Are we moving on to other topics?

MR. DORAN: Yes, Chair, I am going to move on to a different topic. Just one matter: Ms. Creaney 11:16 referred to a diagram setting out the structures at the relevant time. I am not proposing to bring that on screen, unless the witness would like me to at this point.

A. No, no. 11:16

MR. DORAN: But for the record, it's in the 'Creaney B, Supplementary Bundle' at page 37, and, if need be, we can look at that later.

CHAIRPERSON: We can going to take a break. Just

before we do, can I ask this, because I think we are going to move away from the Trust Board after the break. But the Trust Board would meet -- I think in 2012, it would meet almost monthly?

A. Yes, at that time the Trust Board met monthly. One month was a confidential and public Trust Board and then the second month would have been a workshop with the Trust Board. We also met quarterly as Assurance Committee. And I can't recall the frequency of the Audit Committee, but I think that's also quarterly. 11:16 11:17

CHAIRPERSON: And this is a very basic question, but apart from what was on the agenda for those meetings, was there any other system of bringing matters to the attention of the Board as a whole?

A. Yes, we would have had a method to escalate, you know, pertinent issues at the start of the Board, normally in the confidential section. 11:17

CHAIRPERSON: But that would rely on there being a meeting. What I'm asking is, apart from meetings and whatever was discussed at those meetings, there's -- that was the system by which the Board would be informed, presumably, of what was going on in the Trust? 11:17

A. Yes.

CHAIRPERSON: Rather than there being any other external system to the meetings? 11:17

A. Well, there was the opportunity to speak to people individually as well, but usually the business was done through those processes. In the new structure referred

to, the new governance structure, non-executive directors are now members of those reporting subcommittees. That wasn't the case in 2012.

CHAIRPERSON: Right, right. We'll take a break. You will be offered, I expect, a cup of tea or coffee or something, and we'll come back in about 15 minutes. 11:18

A. Okay.

CHAIRPERSON: Thank you very much indeed. Fifteen minutes.

11:18

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Yes, Mr. Doran.

126 Q. MR. DORAN: Ms. Creaney, I am now going to touch on how the report and its recommendations were dealt with. 11:36 I'm not going to address this matter in detail with you today; in fact, it's fair to say that you refer in your statement to the earlier Trust statement of Mr. Dillon in this regard --

A. Yes. 11:36

127 Q. -- isn't that right?

A. Yes.

128 Q. And Mr. Dillon's statement goes through, in detail, the various steps that were taken by the Trust in response to the allegations and following on from the 11:36 recommendations, isn't that right?

A. Yes, that's correct.

129 Q. At paragraph 96 of your statement, you say - it's at Statement 206, page 33:

"By the time the Ennis Ward Adult Safeguarding Report was completed, the Belfast Trust had already undertaken a series of actions as part of its overall response to what occurred. These included, amongst others, environmental changes to the ward, changes to the staffing arrangements on the ward and substantial and prolonged monitoring of the care provided on the ward. I refer to the detail set out in paragraphs 23 to 143 of Mr. Dillon's statement." 11:37

Now, at the risk of generalising, is it fair to say that the point you're making is that it is important for the Inquiry not just to look at the report and its recommendations in isolation, but to look at what was going on beforehand as well and the broader safeguarding process? 11:37

A. Yeah, that is important because we had the RQIA report and the actions we took prior to the completion of all of the reports, which I described earlier. 11:38

130 Q. Yes. So there were a number of interlocking processes going on at the same time, if I can put it like that?

A. Yes.

131 Q. And I'm not, again, not going to bring it up on screen, but, for the record, this matter is dealt with in summary at paragraphs 36 to 38 of Martin Dillon's statement, at MAHI STM-107, page 12. There are just a couple of things that I wanted to pick up on in relation to the safeguarding report and recommendations 11:38

and one goes back to the staffing crisis that was said to exist at the time, and we mentioned this briefly earlier, and I wonder can I have on screen page 288 of the Ennis Bundle - that's MAHI Ennis-1 288. And if you could scroll down, please, to the recommendation. If you scroll down a little bit further, please. Thank you. So, the recommendation says: 11:39

"The investigating team recognise that there was an action plan in relation to the overall staffing crisis in MAH at the time, which would have included Ennis, but recommend that hospital senior management review their response to these two specific incident reports to see if this was appropriate. The Telford formula was used on the ward prior to the allegations to determine staffing levels. However, further review of appropriate staffing levels following the allegation confirmed that additional staffing was necessary. The team would, therefore, question the appropriateness of the Telford model. The team recognises that MAH now have adapted their use of this model. 11:39 11:39

The investigating team did have concerns about the appropriateness of a daughter being in a position of having to supervise her mother. When this came to light, the investigating team recommended that the management team review this practice. This has now been done and the practice discontinued." 11:40

A. Mm-hmm.

132 Q. So that, perhaps, is an example of a specific action that was taken in response to the concerns at the time.

A. Yes.

133 Q. But looking at this general staffing issue and the reference to an "overall staffing crisis", I don't want to get into the technical aspects of the Telford formula with you, but I think you'd fairly accept that, in your role at that time you, were aware of there being a crisis, to use the language of the report? 11:40

A. Yes, I was aware of the staffing issues in Muckamore, and another of my deputies at the time, who worked alongside Moira Mannion, was assisting the team in the review of the staffing levels. The formula used, we used Telford, which is noted here, but it is also the clinical opinion of the ward sister and the senior team. As I described earlier, even though the number of patients was reducing, their complexity increased. There was also an ageing population amongst the patients in Muckamore who had the usual physical ailments of ageing, so that was part of the discussion as well, around the development of a model that met the needs of the patients holistically, not just from a learning disability or behaviour management support. 11:40 11:41 11:41

134 Q. So, ascertaining the appropriate number of staff then was maybe a more challenging exercise than in other hospital environments, is that fair to say? 11:41

A. Yes, it was a more challenging exercise because there wasn't a model for learning disability we could use easily and, as I said, the patient population were

quite complex in Ennis, like they were in a number of the wards in Muckamore at that time.

135 Q. I just wanted to touch again on the earlier awareness of this staffing issue, even prior to the Ennis allegations. I take it you have had the opportunity of looking at the other statements made in respect of the Ennis process? 11:42

A. Yes, I have.

136 Q. And specifically the statement of Esther Rafferty?

A. Yes. 11:42

137 Q. Now, you will be aware that she, in paragraphs 15 and 16 of her statement, draws specific attention to her reporting of staffing issues to the RQIA?

A. Yes.

138 Q. In September 2012 -- 11:42

A. Yes.

139 Q. -- I think I'm correct in saying it was.

A. Yes. And Esther had also raised her concerns with me about the staffing, so I had spoken to Catherine McNicholl and, indeed, John Veitch about the need to review the staffing and increase it, prior to this happening. 11:43

140 Q. Yes. And Ms. Rafferty refers to her report to the RQIA that I've mentioned, and we don't need to go to the report now, but it refers to staffing levels being dangerously low at the time, isn't that right? 11:43

A. I can't recall the specifics because I haven't it in front of me, but the staffing levels were concerning to Esther.

141 Q. Yes. We could actually have a quick look at that, Chair. It's at MAHI STM-229-24, or perhaps, actually, just to complete the picture, can we go to STM-229, page 6, please, and this is the statement of Esther Rafferty, from whom the Inquiry will hear in the context of the Ennis evidence. And if you go down to paragraph 15, please. Yes. So, now, again, I emphasise this is Esther Rafferty's statement. We will deal with her evidence next week. What she says is: 11:44

"The decision to introduce 24-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 Nicky Patterson, Co-director of Central Nursing, to try to come up with a plan to address this serious issue following incident reports." 11:44 11:45 11:45

And there is a reference there to Exhibit 1.

Paragraph 16, then:

"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 the statement." 11:45

Could you move then, please, to page 24. Sorry, if you could scroll up again slightly, please. This is the report to which Ms. Rafferty refers. It's titled: 11:46

"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 officer was trying to fill an excessive number of shifts and that this was proving increasingly difficult. Terms such as 'it has never been this bad' and 'this is now every week' were being used by the senior nurse managers in their language. We, I immediately asked them to try the Nurse Bank Office to see if other grades of staff - i.e. RGN, RMN, agency - was available." 11:46 11:46

Now, I am not going to go through all the detail, but it is fair to say that the staffing situation at the hospital at that time was very serious indeed?

A. Yeah. No, I would agree that's the case. I think I referred to it earlier and -- but the issue wasn't that the staffing wasn't permitted; it was actually getting the appropriate staff to fill the vacant shifts, and the team led by Esther had been working very hard to try and fill the shifts, but, unfortunately, the learning disability staff were not available. So, subsequent to this, we put in place substantive recruitment of learning disability staff because people wouldn't wish to work in temporary roles, which we understood. 11:47 11:47

142 Q. And clearly that report wasn't confined to Ennis; that related to the hospital more generally?

A. No, that was the entire hospital.

PROFESSOR MURPHY: So at that time - sorry to interrupt - but at that time, were they temporary posts that were being offered? 11:47

A. They were temporary posts or bank and agency posts because of the resettlement.

PROFESSOR MURPHY: Because of the resettlement? 11:48

A. Yes. But we stopped that to bring in substantive staff. The other difficulty is, learning disability nurses are small in number in Northern Ireland and there is a small pool and, at this time, learning disability nurses were not choosing to work in Muckamore, so we did a specific recruitment drive for Muckamore, which was led by Esther. 11:48

DR. MAXWELL: Can I just clarify that, because in her statement she doesn't say you were recruiting temporary

staff; she said there was a moratorium on recruiting. That's the first point. And the second point is, we have heard from a number of staff witnesses that they were only recruiting temporary staff at a later date, I think it was 2014. So (a) were they using temporary staff in 2012 and, if they were and you decided that that wasn't working, why was that policy reintroduced later? 11:48

A. They were using bank and agency staff or the staff who worked there were doing additional hours. 11:49

DR. MAXWELL: Ah, so you weren't recruiting staff; you were using bank and agency?

A. Bank and agency, yes.

DR. MAXWELL: And at a later date, staff -- we have heard people, newly qualified nurses, saying they were on a three-month rolling contract? 11:49

A. Yes, there were also -- I think it's important I'm clear. Temporary staff is of two types: one, bank or agency staff; but the other, people on short-term contracts, which, again, was not attractive. 11:49

DR. MAXWELL: But having been aware of this situation in 2012 and made these attempts to recruit, why were temporary rolling contracts reintroduced in, I think it was, 2014?

A. They were also permanent contracts introduced at a later date, but it was really to try and encourage people to come and work, because the view was, this service was retracting, so we had a number of ways to recruit nursing staff, but certainly I was very keen 11:49

that we put in place substantive recruitment and made my views very clear to the directorate team about that, but it took a while to get the posts in place.

DR. MAXWELL: Are you saying the decision was made by the Directorate team rather than being a Trust policy? 11:50

A. Yes. We had no moratorium on nursing recruitment over that time generally across the Trust.

DR. MAXWELL: Okay.

143 Q. MR. DORAN: Back to my escalation theme. Would the existence of a staffing crisis at a facility such as 11:50 Muckamore not have been a matter that ought to have been escalated to Board level?

A. Not hugely at that time, it wouldn't have been, because we had put plans in place to address it, but subsequently it has been, but not at that time. 11:51

144 Q. And that would happen now, presumably?

A. It would happen now; in fact, we have just completed a very successful recruitment plan, which I had the support of the Board to bring in a large number of overseas nurses to address our current - well, they are 11:51 no longer our current - our staffing issues over the past two years.

145 Q. And I am just thinking of the use of those words "crisis" and terms like "dangerously low" in the period late 2012. Do you think the situation had ever been 11:51 properly resolved between 2012 and 2017?

A. It was resolved somewhat, but it was -- we had a real issue with recruiting to Muckamore Abbey. We also had other nearby facilities who were recruiting learning

disability staff, so it was a balance, and we did look at bringing in non-learning disability staff, which, again, was a balance because we needed to have the correct level of skill mix and speciality mix of the nurses.

146 Q. Yes. So the crisis may not have entirely abated, but improvements were made?

A. No, no, it didn't -- there were improvements at a point in time, but certainly it was a very fragile environment, I would describe it as, and remains so to this day.

147 Q. Just looking again at paragraph 96 that we touched on earlier and reflecting on the various actions that were taken, including the changes to the ward and changes to staffing arrangements, which we haven't gone into in detail, but can I ask, what evidence was there, if any, that those actions had actually been effective in safeguarding vulnerable patients?

A. Well, we had the evidence of our governance arrangements within Muckamore. We also had a number of RQIA reports at that time which considered where the recommendations were implemented, either fully implemented or partially implemented, and we worked very closely with our colleagues in RQIA to support the implementation of the quality and improvement plan, but it took a while, it did take a while.

148 Q. But would you say that the measures taken had been actually effective in safeguarding patients?

A. I would say they were in part effective, but there were

still safeguarding issues being escalated and raised.

149 Q. Now, the next point I want to look at is a relatively discrete one, and you deal with this at paragraphs 98 to 109 of your statement. Can we go back to Statement 206, please. And you were asked: 11:54

"What steps were taken by the Trust to investigate whether the culture that was found to exist on Ennis Ward existed in other wards at the hospital?" 11:54

Now, you fairly say that one needs to be cautious about what was actually found when the report was ultimately completed?

A. Yes.

150 Q. But I take it you'll accept that there was genuine concern, at the time of these allegations, about what could be described as an uncaring culture within the ward? 11:54

A. Yes.

151 Q. And there are multiple references to that within the various strategy meetings that took place at the time. Again, we won't visit the detail, but just in the first strategy meeting it was said: 11:54

"All present agreed that the allegations were of significant concern both in relation to the individual reported incidents and the potential culture on the ward which would allow staff to act openly in the manner alleged." 11:55

So it seems clear that all of this discussion was going on in the context of the Ennis Ward?

A. Yes.

152 Q. And not in the context of the hospital in general? 11:55

A. Yes, that's correct.

153 Q. I think you point out in your statement that Aine Morrison herself, who was the designated officer, observed that the Bohill staff who had raised the issues, did not raise issues about other wards and, in 11:56 fact, said they had observed compassionate care elsewhere in the hospital?

A. Yes, that's correct.

154 Q. Now, again, you may say we're operating with the benefit of hindsight, but were the allegations not 11:56 serious enough to prompt a wider review of practice within the hospital at that time?

A. Well, certainly at the time, there would have been other oversight arrangements across all of the wards - now, not in the context of Ennis particularly, but 11:56 overarching governance processes, escalation within the hospital setting around adult safeguarding issues, which were arising in other areas as well, but given, you know, other reports we had received from both internal arrangements and external bodies, we didn't 11:57 have any reason to look at other wards. However, we always consider that within the escalation of arrangements. So certainly the issues around staffing, the issues around practice and individual patient

needs, were part and parcel of the overarching governance arrangements across all of the wards.

155 Q. Now, this question might be better addressed to those involved in the actual safeguarding investigation, but given the fact that staff tended to work on different wards within the hospital, was any attempt made at the time to check whether the particular staff involved here had been working on other wards beforehand and whether there were any concerns about their conduct? 11:57

A. Not that I'm aware of, no. And you are aware we've already stated these staff were precautionary suspended at the time, but no concerns were raised with me. 11:57

156 Q. But you can see, for example --

A. I can.

157 Q. -- how evidence of similar conduct elsewhere might have prompted a wider review of practice within the hospital? 11:58

A. Although there are other factors which would indicate practice issues which we look at on an ongoing basis; obviously, adult safeguarding, but complaints, other quality issues, and there had been none, certainly, escalated at that time through the arrangements we have in place. 11:58

158 Q. Yes, but the allegations themselves didn't prompt anything beyond -- 11:58

A. No.

159 Q. -- Ennis at the time?

PROFESSOR MURPHY: Could I just ask, obviously staff did sometimes work on other wards, but was that quite

unusual? Was there usually a cadre of people who generally worked all on one ward, so that, very occasionally, people would be called off to work on other wards, or was that --

A. Each ward had its core staffing, which would be the same people, but if there were issues such as short-term absence, sickness or issues around an increase in, you'll understand the word 'acuity' - I can't think of another word for 'acuity' - increase in complexity of the patients, then staff may be moved. Staff, also, would have chosen to work additional shifts where they were required. So a large number of the staff in Muckamore were also members of the nurse bank, so they could have either done overtime or worked bank, because you only get paid overtime if you are full-time, so there would have been some movement in that way. Also, the Nurse Manager on duty every day would have assessed the safeness of the staffing and potentially reallocated staff where she -- he or she felt they were best required. 11:59 11:59 12:00

PROFESSOR MURPHY: And is it possible to estimate, just very roughly, what percentage of staff's time in the core staff on Ennis would have been always on Ennis, so, like, 70% of the time they would be on Ennis or 90% of the time they would be on Ennis? 12:00

A. I'm sorry, I wouldn't be able to estimate that, but I could get the information for you.

160 Q. MR. DORAN: Just before we leave this topic, I just wanted to flag up one of the points that were made by

the RQIA in correspondence to the Trust in May 2013. This appears at the Ennis Bundle, page 217. If you could just enlarge that, please. So that's a letter of 9th May 2013 and, in fairness, it's a letter to Mr. Veitch --

A. Yes.

161 Q. -- from whom the Inquiry will hear, so we can address this matter with him. But if you scroll down, please. It's a reference to:

12:01

"The police investigation - allegations of abuse, Ennis Ward.

I refer to the recent police investigation report regarding the allegations of abuse in Ennis Ward."

12:01

And I won't read the detail in the next paragraph, but going down, scrolling down, please:

"I wish to seek assurances that this report has been shared with key staff and that the poor care practices highlighted and incidents of a non-criminal nature identified involving some other staff members, are being addressed by the Trust currently."

12:01

12:02

And if you scroll down, please, to the next page, just the first bullet point there:

"RQIA would like to seek assurances from the Trust in

relation to the following: that issues in relation to the care, treatment and culture both within Ennis and other wards have been addressed by the Trust."

Now, if one scrolls down then to the next page, you can see the response from Mr. Veitch dated 6th of June 2013. Now, the Inquiry can ask Mr. Veitch about this, of course, but it is a response that was made on behalf of the Trust at the time, but I think it's fair to say that the issue of potential investigation of matters relating to culture on other wards, wasn't addressed specifically in the response. 12:02 12:02

A. Okay.

162 Q. In fairness to you, maybe we should scroll down. Can you just have a look, please, at the text of the letter. So the letter says: 12:03

"I refer to your correspondence and wish to sincerely apologise for our delay in providing this response, which was partly due to my own absence on annual leave last week. 12:03

I can now confirm that the Trust immediately initiated a thorough investigation, through the Joint Protocol arrangements, into the allegations raised by the visiting care worker to Ennis Ward on 8th November 2012. I can also assure you that the Trust acted swiftly and diligently, immediately sharing information with all appropriate staff and in addressing the 12:03

immediate and ongoing protection needs of the patients within this ward. A total of four staff were initially placed on precautionary suspension as part of the protection plan and two staff remain on suspension from the workplace; namely, a healthcare worker Band 3 and a member of bank staff at Band 5." 12:03

If you scroll down, please. There is a reference there to "the investigation, the strategy and the monitoring". And if you scroll down further, please: 12:04

"I am pleased to confirm this these measures have not provided any evidence of concern in relation to institutional abuse, but, in fact, has provided evidence of positive practice and culture." 12:04

And we can address these matters with Mr. Veitch and the other witnesses, of course.

"Support from behavioural services has also been provided to assist staff in their ongoing care of patients on the ward. Environmental challenges have also been identified and are now part of the improvement plan for the ward." 12:04

And if you scroll down again, please. There is discussion of the feedback, then:

"... key personnel within the Trust working proactively

to progress improvements for patients in this ward and for all patients on site."

And scroll down again, please.

"The Trust has also improved the ward environment, invested in new fixtures and fittings and continued to review staffing ratios within the ward."

So, again, it's perhaps not fair to ask you about this letter because it wasn't penned by you, but it is written on behalf of the Trust and there doesn't seem to be any engagement with this issue of possible negative culture elsewhere within the hospital? 12:05

A. I thought I did see a referral to that earlier in the letter. 12:05

CHAIRPERSON: Can I take you back. I think, if you go back to the paragraph which starts on the page above, "As you should be aware", and you see the sentence - this maybe what you're thinking of I don't know -- 12:05

A. Yes.

CHAIRPERSON: "This investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse."

A. Yes. 12:06

CHAIRPERSON: Now, I just wonder what you think that refers to?

A. Well, I read that to mean the site, but it doesn't specifically say it.

CHAIRPERSON: So when you refer to "the site", you don't just mean Ennis?

A. Yes.

CHAIRPERSON: You do mean Ennis?

A. No, I mean Muckamore. 12:06

CHAIRPERSON: The whole hospital?

A. Yes, yeah.

163 Q. MR. DORAN: That's interesting, Ms. Creaney. Certainly, the evidence from the other witnesses suggest that the issue of institutional abuse was being 12:06 considered solely within the context of Ennis --

A. Right.

164 Q. -- as such, and not the broader hospital?

A. That's not personally how I would view -- for me, the institution is Muckamore Abbey Hospital. 12:06

165 Q. Yes.

A. And certainly, I mean, I note that letter is copied to Esther Rafferty and Mairead Mitchell, both of whom are nurses, and, you know, I would have expected them to have that overview of the entire site. I appreciate 12:07 it's not specific, but that's how I read that.

166 Q. Yes, we can explore the matter further with them.

A. Yeah.

167 Q. But I think it's fair to say that the actual safeguarding process was really confined to the 12:07 allegations relating to the Ennis Ward, isn't that right?

A. Oh, yeah, no, that's correct, that is correct.

168 Q. So it didn't prompt an investigation into culture

elsewhere in the hospital?
A. No, it didn't, but it would have -- I believe it prompted that overview and oversight, and certainly Moira from my team would have been present at meetings with the ward sisters and with other members of staff in Muckamore, not solely Ennis. 12:07
DR. MAXWELL: Can I just ask you, because you start your response to question 8 with the fact that the questions infer that there was a culture that tolerated abuse at Ennis. What's very clear from your evidence is that Moira Mannion's briefings, both at paragraph 104 and 105, is just that there is no indication of a culture of abuse. So, on the one hand, you have the designated officer looking at an incident, safeguarding incident, who has some concerns, and then you have a different report saying there is no evidence of this, so we can't decide which of them is correct here, but I wonder what was done to resolve the fact that you were getting two very different opinions? 12:08 12:08
A. Well, for me, the concerns raised by the external staff were very serious -- 12:08
DR. MAXWELL: Yes.
A. -- and we needed to look at those, but I know, for example, Moira met with all of the team in Ennis, and it was a very challenging meeting for Moira because they talked about, you know -- they had to be careful, obviously, because of the ongoing police investigation and the individuals concerned, but, also, the monitoring exercise provided those assurances. Now, I 12:09

am also aware if people are being monitored - Hawthorne effect - they may not -- they may not behave inappropriately, but Moira did a lot of work with those staff and she didn't perceive that culture.

DR. MAXWELL: No, I understand that. So you arrived at a point of time where two quite senior members of staff had come to different conclusions, and I don't -- as I say, we can't actually determine which of those is correct. What I am asking is, when you became aware that two quite senior staff had quite a different perception about whether there was a culture, was anything done to try and resolve this? Because it appears from the documents I have seen that that was, well, you know, they think differently, move on. Was anything done to say, "well, how could two equally senior" - well, actually, not quite equally senior, but "two senior people come to such different opinion? This is a risk. We need to resolve this difference"? 12:09 12:09 12:10

A. Well, obviously I can't speak for the individuals concerned, but from the information I have, they worked closely together, not always agreeing professionally, but we also have evidence where they commended each other's work as well, and I think the difficulty here with the -- particularly with the safeguarding report and the disciplinary report, is that it was very difficult to reach, you know, a concrete conclusion, and that was the real difficulty here, but certainly, I do believe the actions we took in relation to the people where allegations were made, were appropriate at 12:10 12:10

that time, and, you know, there were also other people who were working there who appeared to be working satisfactorily and Moira was able to provide me with that assurance, you know. But there were professional differences of opinion, absolutely.

DR. MAXWELL: And so, was it fair to say then that, because of the 24-hour monitoring, the decision was made that, actually, there wasn't evidence to substantiate concerns about the culture on the ward?

A. That was correct, yes. 12:11

169 Q. MR. DORAN: I am going to return to this theme in the context of the leadership and governance report, but, first, I wanted to look at the SAI issue again. We mentioned this earlier and you address this in your statement at paragraphs 110 and 123 and you make it clear that you yourself weren't involved in the decision as to whether or not this should be an SAI and you also say that this was one process available to the Trust, but the view taken at the time was that the adult protection process was the best way of addressing the allegations. 12:12 12:12

A. Yes.

170 Q. And you refer then at paragraph 112 to the individuals likely to have been involved in the decision, including Mairead Mitchell, Catherine McNicholl and Aine Morrison, and the Inquiry will, of course, be able to ask those individuals about the decision. I am not going to get into the technicalities of what may have qualified as an SAI and what may not have so qualified, 12:12

but you make the point that the allegations might not have fallen easily within the earlier definition which was set out in the 2010 procedure, is that correct?

A. Yes, that's correct.

171 Q. But I wanted to ask you this, and other witnesses may be able to provide more direct assistance; is there any evidence of that matter having been the subject of discussion or analysis at the time? In other words, someone looking at the definition of SAI, looking at the facts or the allegations relating to Ennis and deciding does this justify an SAI, is there any evidence of that kind of analysis and discussion going on at the time? 12:13 12:13

A. I am aware of discussions because I have seen subsequent correspondence, but those discussions did not take place with me, but I have seen correspondence from colleagues in the - I am going to say the Health and Social Care Board, not the Trust Board, and the team in Muckamore, about whether or not this should be an SAI, but that was not progressed, and they came through the team in Muckamore, including the governance manager. 12:14 12:14

172 Q. And was that with reference to the definition of SAI or was it with reference to the fact that there was a safeguarding process ongoing and one didn't need to have an SAI process? 12:14

A. Well, that was the initial view, that the safeguarding process was sufficient, and that's what I've seen in the correspondence. I'm not totally comfortable

discussing this correspondence because I wasn't the author of it, but certainly I have subsequently seen correspondence where the Health and Social Care Board did not agree with that.

173 Q. Yes. And you mention in paragraph 118 the request from the Health and Social Care Board to have the matter progressed as an SAI. And looking back now, again from your professional position, do you think the Trust ought to have acted on that request? Would that not have provided an additional assurance measure? 12:15

A. It is difficult to say, given that I know what the outcome of the investigations were. However, if this were today, this would have been an SAI, yeah.

174 Q. And again, I appreciate it's very difficult, but in your own professional opinion and with your professional experience, would the triggering of an SAI procedure have made a difference? 12:15

A. I don't know if it made a difference, but I think it would have added potentially more rigour to the investigation. And usually within an Early Alert, you have the option to open an SAI. It could have been closed. That would have been the process. But that didn't happen. 12:16

CHAIRPERSON: Would it now be an SAI because of a change in the policy or -- 12:16

A. Yes, yes, it would. The policy changed in 2013, 2016 and is about to change, it's just changing at the minute. So the management of SAIs at this time was relatively -- a relatively new process, a learning

process. However, the purpose of an SAI, as you will be aware, is for regional learning. It wouldn't have -- it wouldn't have stopped the safeguarding investigation or, indeed, the disciplinary investigation.

175 Q. MR. DORAN: So is it fair to say one could perhaps have a debate about whether the matters constituted an SAI under the 2010 procedure, but there is no doubt that they would constitute an SAI under the present procedure? 12:16 12:17

A. It would and, as you know, there are different -- sorry, you may know, there are different levels of SAI, and certainly, today, we would be swifter to use that process and step it down rather than not commence it.

176 Q. Yes. I want to ask you briefly about the disciplinary investigation, and you deal with this at paragraphs 148 to 168. You yourself weren't involved in the disciplinary investigation, obviously. And the Inquiry Panel and Core Participants have the lengthy reports that were produced as a result of the investigation and will have the opportunity of considering those. Now, as you say, that process was separate from and independent of the safeguarding process, is that right? And I think you're saying it is an entirely separate process? 12:17 12:17 12:18

A. It is a separate process, yes.

177 Q. And you make the point at paragraph 151 that one wouldn't necessarily expect the outcome to be the same. Just, what you say at 151:

"In 2013, the policy of the Trust was that the vulnerable adult, adult safeguarding investigations and disciplinary investigations were to be conducted separately and by different personnel. They were two distinct processes with different purposes. Each process, while capable of being informed by the other, not bound to reach the same conclusion as the other. Each process was ultimately independent of the other. Consequently, the outcome from one would not necessarily be the same for the other." 12:18 12:19

And basically, the internal investigation was unable to substantiate the allegations based on the available evidence, isn't that right? 12:19

A. That's correct.

178 Q. And again, at the risk of generalising, the main difficulty was that the key witnesses from the Bohill staff either did not engage or could not be contacted?

A. That's correct. 12:19

179 Q. Now, again, I'm not asking you to revisit the details of the investigation, but is there any evidence of its outcome having been considered at a higher level within the Trust?

A. No, it was considered within the Directorate team. However, it was shared with the regulator in respect of the registrant, but given the -- given the findings, they were unable to proceed with any further actions. 12:19

180 Q. And again, you may point me to the benefit of

hindsight, but someone might ask was anyone on the Executive Team or the Board saying whatever became of those allegations that arose at Muckamore? Was there no evidence of a kind of proactive approach to finding out how these matters were ultimately resolved? 12:20

A. Well, certainly the team would have updated their director, and Esther updated me on the outcome, but there was no further outworkings of the -- well, apart from the update to the regulator, there was no further outworkings. There was also the, as you're aware, the 12:20 process through the courts as well.

181 Q. Do you know if there was any reporting to the Board following on from the outworking of the disciplinary process?

A. There wasn't. 12:21

182 Q. There wasn't.

PROFESSOR MURPHY: Could I just ask, if -- it seems to me very unsatisfactory that the Bohill staff wouldn't be interviewed or couldn't be interviewed. I mean, if they had been interviewed and they had said, "no, no, 12:21 we didn't see any of it and that was all wrong", that's one thing, but not wishing to be interviewed is quite another, I would say. Did you think that was very unsatisfactory?

A. Yes, I did think it was unsatisfactory, and I know the 12:21 investigating team were very keen to speak to them. I am aware that one person was abroad, but certainly I felt it would have aided their investigation had they -- had they complied with our request to meet.

PROFESSOR MURPHY: Why do you think it was? I mean, was it just the pressure of having already been interviewed before, under the safeguarding investigation, that they thought, "oh, we just can't face it again", which would perhaps lead you to consider the extent to which the disciplinary procedures and the safeguarding procedures were, at least at the initial stages, kind of more amalgamated, or was it something quite different? 12:22

A. I couldn't speak for the individuals, why they chose not to participate. My personal view is, these are very serious allegations and, you know -- but we couldn't compel non-employees to participate. 12:22

CHAIRPERSON: I think somewhere in the bundle, and I can't find it, there is reference to why each refused to participate further. 12:22

A. That's correct.

CHAIRPERSON: 160, I'm told.

MR. DORAN: There is detailed consideration by the investigation reports. 12:23

CHAIRPERSON: Okay.

183 Q. MR. DORAN: Now, I want to look at how the Ennis episode resurfaced, so to speak, a number of years after the allegations first emerged, and you deal with this, first of all, in paragraphs 124 to 128 of your statement. You say at 124: 12:23

"I understand that during Marie Heaney's time as Director of Adult and Social Primary Care, Ms. Heaney

had taken up the post in September 2017. She became aware that there had been safeguarding concerns in the Ennis Ward several years earlier. Ms. Heaney considered the corporate memory surrounding the allegations and subsequent investigation was insufficient and, therefore, set about trying to learn about it. The need for this learning was accelerated when the issue of the Ennis investigation arose at MDAG meetings in the Autumn of 2017." [Sic]

12:24

Now, again --

A. 2019.

184 Q. Sorry, 2019, my apologies. Now, we can ask Ms. Heaney about this, but I take it you're saying that her desire to become familiar with exactly what had happened, arose prior to the issue being raised at MDAG?

12:24

A. Yes, that's my understanding, that's correct, yes.

185 Q. And do you recall the circumstances in which the issue resurfaced for attention; was it prompted by the 2017 revelations?

12:25

A. Well, September 2017 was when the issues came to our attention. I obviously can't speak for Marie, but as a new director, you know, she wanted to --

186 Q. Yes.

A. -- get a sense of what was happening. I was at MDAG when this issue was raised as well.

12:25

187 Q. That's interesting. Can you recall exactly how it was raised and by whom?

A. I understand it was raised by Marie, Marie Heaney, and

I can't recall for definite, but I can look at the minutes if Aine Morrison also raised it.

188 Q. Yes. Well, we can look at that in more detail at a later stage, but you then say that Jolene Welsh was asked to draft a review and a timeline, isn't that right? 12:25

A. Yes, that's correct.

189 Q. And that was all in preparation for a proposed meeting with the families, but you think that meeting didn't occur because of Covid? 12:26

A. Yes, that's correct, yes.

190 Q. Just so that we are sure that these are the right documents, can we have a quick look at them, please. The review, first of all, is at page 810 of the Ennis Bundle, and that's described in its heading: "Review of Ennis Investigation 2012": 12:26

"In November 2012, medical record reports show that there were 31 patients staying on Ennis Ward. This review showed evidence of..." 12:26

And I won't read out the further detail. But is that the review document that you were talking about that was compiled by Jolene Welsh?

A. No, it's not. The document complied by Jolene Welsh was in preparation for information to go to MDAG in 2019. 12:26

191 Q. Was it the timeline document then?

A. Yes, it was, yes.

192 Q. Just, could you bring that up on screen, please, at 577. Don't be alarmed, I am not going to drill into the detail of the timeline document because it is a very detailed document indeed, but you're saying that's the document that Jolene Welsh prepared for the purposes of MDAG? 12:27

A. I believe so, yes.

193 Q. Yes. And can we just go back then to the review document at 801, and could you scroll down, please, to the next page. I just wanted to refer you to the -- or I take it you aren't familiar with this document at all? 12:27

A. No.

194 Q. So when you --

CHAIRPERSON: I am sorry, what page is that? I know it's on the screen, but I want to find it. 12:28

MR. DORAN: Oh, yes, that's at -- in the Ennis Bundle, that is at page 810.

CHAIRPERSON: Sorry.

195 Q. MR. DORAN: It's just when you refer in your statement to Ms. Heaney seeking a review of the investigation, that's not the resulting review document? 12:28

A. No, it's not, no. That review was sought by Marie Heaney in 2019.

196 Q. And do you have any idea what this review document is? 12:28

A. No. To me, it looks like a summary of actions, but I'm sorry, I couldn't say for certain what it is.

197 Q. I just wanted to read the second bullet point. It says:

"The safeguarding report does not reflect a picture of the seriousness of the concerns raised by Bohill staff, but it is evident that the investigating team faced challenges regarding their use of Bohill staff statements as evidence. There was a push to focus on the positive changes that had happened since the allegations and there were requests made to remove monitoring within the ward a matter of weeks after the allegations. From the outset, there appeared to be a reluctance to consider the possibility that there were cultural issues within the ward and that institutional abuse was a possibility. It is not possible from the records made available to track feedback on the various drafts of the report and what changes were made." 12:29 12:29 12:29

We can, of course, ask those who were involved in preparing the report to comment on this, but would you like to comment on that characterisation of the report from the perspective of the Trust? 12:29

A. I'm afraid I am struggling to understand the purpose of this.

198 Q. Well, I'm not going to spend too much time on it now.

A. Okay.

199 Q. It's clearly something that we can look at at a later stage. If you can scroll down to the end of that document please, and further, please. You can see there is no signature at the bottom or, indeed, date at the bottom, but we'll look into that matter separately. 12:30

There is just one other document that I wondered if you could help us with and that's a document titled "Synopsis" and it's at page 805, and I'm not raising any issue about this at all, except to try to identify who compiled it and where it comes from and what purpose it was compiled for. It is just, basically, a synopsis of the Ennis report itself. Does that look familiar? 12:31

A. It doesn't look familiar, but is there a date? Oh, yeah... 12:31

200 Q. If we again scroll down to the bottom, please, of the synopsis. There is no date at the bottom, but again, Ms. Creaney, let's not spend time on this now. We can deal with these matters at a later stage. 12:31

I want to move on from Ennis being considered at MDAG and by Ms. Heaney in or around that time. The matter was, of course, then reviewed within the context of the Leadership and Governance Review?

A. Yeah. 12:32

201 Q. And you discuss this at paragraphs 169 to 189 of your statement. And you were asked, in broad terms, by the Inquiry, to consider whether the Trust accepts that what were described as the findings in the leadership -- in the governance report, that Ennis was a missed opportunity and had the potential to identify other institutional malpractice at an early stage. You focus then on two sentences within the review. First of all, at paragraph 174, you refer to the sentence in 12:32

which the Leadership and Governance Review stated:

"The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board for wider learning and training purposes." 12:33

And then, at paragraph 178, you focus in on the sentence:

12:33

"Learning from Ennis, therefore, had the potential to identify any other institutional malpractice at an earlier stage."

And you go on then in paragraph 179 to say: 12:33

"While the statement is made within the executive summary, it does not seem to appear in the body of the report and is not subject to any further elaboration."

12:33

And if you scroll down, please.

"The natural reading of the sentence appears to presume that there was institutional malpractice ongoing elsewhere in MAHI at the time that learning from Ennis would have assisted in identifying. It is difficult for the Belfast Trust to understand the basis for this statement." 12:33

And I just wanted you to look at one passage in the body of the report itself, and that is at MAHI Ennis-1 700. And this starts at paragraph 8.34, and this is within the context of a discussion about why an SAI procedure wasn't followed. Sorry, paragraph 8.34 reads:

"The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed offsite. In discussions with Trust Board members, the Review Team was told that MAH was not in their line of sight of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. 12:34 12:34 12:34 12:35

The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and well-being of patients. While the 2018 to 2020 period falls outside of the Review Team's terms of reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions." 12:35

And if you scroll down, please. Paragraph 8.35:

"Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies, which, in turn, could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017."

12:35

12:36

Now, just reflecting on those paragraphs. Of course, the Inquiry can ask Mr. Bingham himself what he meant when he was referring to the term "wider structural accountability"; was he referring to the SAI procedure or was he referring more generally to the need for matters such as Ennis to be escalated to a higher level? But can I just ask, from a Trust perspective, would you now take issue in any way with paragraph 8.35?

12:36

12:36

A. I don't understand what you mean by "take issue". We, as the Trust, accepted this report. It was a very difficult report to receive for the organisation. Certainly, I do believe we had a number of mitigating strategies in place. Could we have done more? It's difficult to say with the benefit of hindsight. Obviously, the events of 2017 are very, very difficult

12:37

for us as an organisation. Certainly, we have done a lot of learning. I don't know if I agree with "deficient governance and leadership arrangements" because there were a number of actions which took place, and I suppose knowing from other reports as well as what we now know, there is the potential for institutional abuse, which we need to be aware of. So it's difficult for me to give you a more definite answer. But certainly, the leadership and governance review was -- it was a very difficult report for us to receive, and certainly we've taken the points it makes on board and, as this says, we've made a series of remedial actions. We did consider it, as a Trust Board, later on, and I think 2020 or 2021, but certainly it's difficult to read that knowing what we now know, I think would be the best thing I can say.

12:37 12:38 12:38

DR. MAXWELL: But can I ask, in your statement you queried the statement that there was potential to identify any other institutional malpractice or institutional abuse and you're not sure what the evidence for assuming there was institutional abuse was. Did the Trust raise that with the authors?

12:39

A. We didn't have the opportunity to make any representations to the authors.

DR. MAXWELL: So did you see -- did the Trust see the report before it was published or --

12:39

A. We saw the report, but we didn't have the opportunity to make any comment on the report, and I suppose, for me, it's -- in the context of this, we were -- we were

a team who were keen to learn and improve at that time, but we didn't have a right of reply to the report.

DR. MAXWELL: But the comments in 8.35 assume an -- make an assumption that there was some institutional abuse -- 12:39

A. Yes.

DR. MAXWELL: -- and it was a missed opportunity to look for wider. If you aren't sure that what happened in Ennis was institutional abuse, then this paragraph -- it has implications for this paragraph 12:40 whether you believe there was institutional abuse or a culture of abuse?

A. But I think I have already said, for me, institutional abuse would be site-wide, Muckamore-Abbey-wide. Until we knew what we did in 2017, we didn't have anything to 12:40 indicate that. How the Leadership and Governance Review arrived at this conclusion, I couldn't answer for them, but certainly we didn't have the opportunity to question this.

DR. MAXWELL: So you're saying, based on what you knew 12:40 in -- well, 2015, when the safeguarding report was published, even on the investigating officer's or the designated officer's evidence, which was slightly disputed with others, there was no evidence of institutional problems and, on that basis, there was no 12:40 reason for escalating the report?

A. No. I mean, there was evidence of safeguarding issues across the site --

DR. MAXWELL: Yes.

A. -- absolutely, but there was no evidence escalated in relation to widespread abuse.

DR. MAXWELL: Thank you.

202 Q. MR. DORAN: Just following on from Dr. Maxwell's point, the matter is perhaps put in more stark terms at another point in the Review Report. Can we go to page 717, please, and scroll down, please. So the second bullet point down on screen: 12:41

"The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards." 12:41

Now, I think you point out in your statement that you can't find any consideration in the Leadership and Governance Report of the definition of 'institutional abuse'? 12:42

A. Yes.

203 Q. And you deal with this in paragraph 184, but -- and again, following from Dr. Maxwell's question, is the Trust view now that Mr. Bingham was wrong to reach that conclusion? 12:42

A. It's very difficult for me to say he was wrong because that was the conclusion he reached, but, certainly, and we have considered this and we have considered this, as I said, through a learning event, it was shocking to read this and certainly I do think it's important to consider this report at the time it was produced, but 12:42

certainly, his conclusion is something we need to -- we need to consider and learn from. I don't think I could say he was wrong because that's his opinion, but certainly it was shocking for us to read that.

PROFESSOR MURPHY: Could I just ask, is it necessarily the case, if you're talking about institutional abuse, that it would apply to every single ward in a setting or could it not be institutional abuse in just one ward or maybe a couple of wards? 12:43

A. No, it absolutely could be one ward or a couple of wards, but, you know, if I take you back to the other considerations, you know, external staff had told us they had not come across any concerns elsewhere. We also have a series of reports from RQIA, other -- other pieces of work where, you know, Muckamore was credited for the standard of care, behavioural support it provided, so I'm looking at it in the context of all of those different reports. I wouldn't say, you know, that it has to be totally widespread, but there was no indication that there were any other issues, apart from those which were brought to our attention by the Bohill staff. Notwithstanding that, however, there were safeguarding issues being raised and managed across the Muckamore site and it's important to look at it and we know that from the figures we have. 12:43 12:44 12:44 12:44

PROFESSOR MURPHY: Thank you.

204 Q. MR. DORAN: Ms. Creaney, the final matter that you address in your statement relates to the issues raised by Aine Morrison about her experience as the designated

officer during the safeguarding process and you deal with this at paragraphs 190 to 203 of your statement, and that matter was referred to Mr. Bingham, isn't that right?

A. Yes, that's correct. 12:45

205 Q. And again, without going into the granular detail, there was some, what could be described as to-ing and fro-ing between David Bingham and the Trust and, ultimately, David Bingham said that he would deal with these matters separately from Leadership and 12:45 Governance?

A. That's my understanding, although I wasn't personally involved in those conversations.

206 Q. I think you say at paragraph 198 that you hadn't yet been able to speak to the Chief Executive about this 12:45 matter. Have you been able to have that conversation yet?

A. Dr. Bingham -- Dr. Jack is, just as we've said, is just back. I haven't had a conversation with her about this as yet, no. 12:46

207 Q. But you say you "anticipate the reason for asking David Bingham to deal with the matter was that he was independent of the Trust and was already looking at matters relating to those raised by Aine Morrison."

A. Yes, yes, and they occurred around the same time. 12:46

208 Q. Yes. But do you have any further insight at this stage into why the matter was referred to David Bingham?

A. I'm sorry, I don't. Apart from the correspondence I have, it wasn't discussed with me.

209 Q. It's just, on one view, it might be seen as somewhat unusual that a person who was conducting a review commissioned by the Department of Health, independently of the Trust, should be asked to consider what was essentially akin to a grievance against the Trust? 12:46

A. Yeah, I'm really sorry, I wasn't involved in the discussions around that. I was aware of it and I was aware of discussions between the Chief Executive and the Department of Health, but I wasn't involved in any of the decision-making around it. 12:47

210 Q. I am not going to ask you anything further about the matter in that case. Now, we have covered quite a lot of ground. You will be contributing at a later stage, as we've said, Ms. Creaney, and we may wish to pick up on some of these Ennis issues later on. 12:47

I just wanted to go back to paragraph 13 in your statement, and that is at page 4, it's the bottom of page 4 and the top of page 5, and you say: 12:47

"The key issue that the Belfast Trust would want to emphasise and, as demonstrated by the content of the available documentation when considered in detail, that the allegations about what was said to have occurred on the Ennis Ward in 2012 were taken very seriously. This 12:48 is not to say that the Belfast Trust will have got everything right in its response to those matters, nor that everyone involved would have agreed with each other about every matter that was considered, but the

Belfast Trust would not want the MAH Inquiry, or anyone following its work, to think that the matter was addressed other than seriously. It is an unfortunate fact, as discussed later in this statement, that there will be occasions right across the health and social care sector where staff do not behave as they should. It will also be the case that how those situations are addressed will prompt legitimate disagreement amongst those dealing with the situation."

12:48

12:48

And you make the point the Trust took these matters seriously, but you also say that this is not to say that the Belfast Trust will have got everything right in its response. If you are asked to reflect now and say what, in your view, the Trust may not have got right, how would you answer that question?

12:49

A. I do think how we communicate from our divisions and directorates, up to and including the Executive Team and the Trust Board, has changed hugely. We have put in place new systems around how we seek those assurances. Certainly, there could have been other opportunities to look at this with more rigour and more detail and that's the way our organisation behaves today. We - I referred to it earlier - we did have a specific extraordinary Trust Board about where are we now and what have we learnt, and we used the learning from the Leadership and Governance Review, and indeed all of the safety reports we have been receiving from Muckamore, to ask ourselves is care safe today and what

12:49

12:50

would we do going forward. So, certainly, how we do our business has changed hugely, and I do think this was a real pivotal movement for us as an organisation to change how we communicate, and certainly at Trust Board and Executive Team, much more detailed information in respect of risk is now discussed at those meetings.

211 Q. And finally from me, following on from those observations is there anything else that you would like to bring to the attention of the Panel at this stage? 12:50

A. No, just to say thank you for giving me the opportunity to present my statement to you today. It's of huge regret to the Belfast Trust that these events occurred, both in earlier years in relation to Ennis and subsequently, and we're doing all we can to ensure the safety of our patients in Muckamore Abbey and, indeed, across the entire Trust. 12:51

MR. DORAN: Thank you, Ms. Creaney, those are my questions. It may be that the Panel will have some matters to pick up on at this stage. 12:51

CHAIRPERSON: Dr. Maxwell first.

MS. CREANEY WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

12:51

212 Q. DR. MAXWELL: Can I take you back to paragraph 55 of your statement, where you're reporting that:

"Ms. Morrison reported back to the Learning Disability

and Children's Disability Service Governance Meeting in May 2012 that all Trusts were having difficulty interpreting the guidance and there were different approaches by the PSNI in different areas, and this meant that --"

Well, the implication here is that the Trust has the highest number of vulnerable adult incidents due to different interpretation about what should be referred. This is the theme that actually comes up in some of the evidence we've heard after 2017, that people had different ideas of the policy, there was a lowering of the threshold, inconsistent approaches. Certainly in the review the Department of Health have done on 60 safeguarding files, one of their conclusions were there were inconsistencies. Do you feel, as far as you know, that this matter was ever resolved or is it still a bit ambiguous?

A. I do think we -- firstly, at the time - I think I referred to this earlier in my statement - we had raised these concerns about inconsistent practice. I do believe we have a much lower threshold for escalating adult safeguarding issues, and certainly there is a much wider awareness, not only within Learning Disability but across the entire Trust, in relation to what constitutes an adult safeguarding concern. Certainly I believe we tend to escalate and then screen down, rather than wait for further -- wait for further incidents to occur, and I think that's a

good thing.

213 Q. DR. MAXWELL: So do you -- to the best of your knowledge, do these different interpretations exist to this day?

A. There are always different interpretations, and I think that's why it's really important that any adult safeguarding process is multidisciplinary, open and people bring their perspectives, but I do think it's really important to be heard but also to be able to reach a conclusion which is in the safety interests of patients and their families, and sometimes that's very challenging for individuals. But I do believe, if I were a family member, I would want people to err on the side of caution and thoroughly investigate if there was an issue with my relative. 12:53 12:54 12:54

DR. MAXWELL: Thank you.

214 Q. CHAIRPERSON: On the same topic, possibly even repeating the question: If you don't have a standard across the Trust, how can you ever tell, because there is no benchmark, how can you ever tell whether one Trust is actually doing far worse than another? 12:54

A. I do believe there is a benchmark and there is criteria, but professional opinion, impact on the patient and consideration of circumstance, are also important factors, and I do think we need to look at all of those factors, particularly in areas where the evidence is not clear, but, you know, for me, the most important factor around the management of a 12:54

safeguarding issue, whether it's a child or an adult, is the impact on the person's well-being, and that isn't always specific, you know, so we must consider the concern first, would be my view.

CHAIRPERSON: Yes. 12:55

A. It's very difficult to say this is it, this is absolutely a safeguarding or, in some cases, an abuse issue. There are some barn-door examples, but it isn't always specific, so we need to look at the whole person and the whole evidence. 12:55

215 Q. CHAIRPERSON: I do appreciate that there's a subjective element to this, and I get that. One way of dealing with that, I suppose, is to have roundtable discussions between the Trusts and those who are responsible for this aspect of patient safety, to ensure that they are 12:56 all applying a similar standard?

A. And there is a regional group which looks at that for Northern Ireland, which is referred to, I think, in my statement.

216 Q. CHAIRPERSON: So that is -- that does happen now? 12:56

A. There is a regional group, which would be led by the executive directors of Social Work.

217 Q. CHAIRPERSON: So the standards should flatten out?

A. They should, but I do think there always is room for debate and discussion, you know, and learning. 12:56

218 Q. CHAIRPERSON: Yes. One other topic, you touched upon this very early in your evidence, about the disciplinary process having effectively to play second fiddle - perhaps that's a bad expression - to the

police investigation. Doesn't that lead to the potential for staff to be under investigation and potentially suspended for a very long time while a police investigation takes its course?

A. It absolutely does, and we are in that situation at the moment, but within Joint Protocol, on occasions where the police are designated the lead agency, I mean we work closely with the police and we try to minimise that as much as possible, but, unfortunately, that is the case; it leads to very long suspensions and, indeed, regulatory sanctions. 12:57

219 Q. CHAIRPERSON: The effect of which may, of course, be effectively debilitating on other staff?

A. Yes - well, debilitating on the individual, but also our impact -- the impact on our ability to safely staff, absolutely. 12:57

CHAIRPERSON: Yes. That's all that I have, Ms. Creaney. Can I thank you very much for coming along to assist the Inquiry. Thank you.

A. Thank you very much. 12:57

CHAIRPERSON: Okay, perfect timing, Mr. Doran. We'll stop then, and I think it's Ms. Kiley taking over this afternoon.

MR. DORAN: That's correct, Chair.

CHAIRPERSON: All right, thank you very much. We'll sit again at 2:10. Thank you. 12:58

THE WITNESS THEN WITHDREW.

LUNCH ADJOURNMENT.

THE INQUIRY RESUMED AFTER THE LUNCH ADJOURNMENT AS FOLLOWS:

14:00

CHAIRPERSON: Thank you.

MS. KILEY: Good afternoon, Chair, Panel. This afternoon's witness, as you know, is Aine Morrison, so if the Panel are ready, she's ready to be called.

CHAIRPERSON: Okay, thank you. 14:06

MS. AINE MORRISON, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Ms. Morrison, can I just welcome you to the Inquiry, and thank you very much for your statement and for coming along to assist us this afternoon. If you need a break at any stage, would you just give me a nod and we'll stop straight away, okay? 14:06

A. Thank you. 14:07

220 Q. MS. KILEY: Good afternoon, Ms. Morrison. We met just briefly a few moments ago. As you know, I am Denise Kiley, I am one of the Inquiry counsel team, and I am going to take you through your evidence this afternoon. I can see you have the folder of documents in front of you, is that right, that the folder contains the two statements that you have made to the Inquiry? 14:07

A. I'm not sure that I have the first statement. I don't have the full first statement.

221 Q. You don't have the full first statement, but you have a second statement?

A. I do.

222 Q. Let me just take some time to explain the position. So, you made a first statement on 1st May 2023, isn't that right? 14:07

A. Yeah.

223 Q. And for the Inquiry's reference, the number is MAHI STM-113. And is it right, Ms. Morrison, that statement was made without the benefit of some documents relating to the Ennis investigation? 14:08

A. The only document I had at that time was the -- was the copy of the report that I produced at the investigation, but none of my other records.

224 Q. Yes. And the Inquiry then, at a later stage, asked you to make a replacement statement, and at that time the Inquiry provided you with a series of documents and what we now refer to as the Ennis Bundle, and you made that replacement statement then on 2nd of February 2024, is that right? 14:08 14:08

A. Yes, that's right.

225 Q. And that is the statement that bears the reference MAHI STM-198. And I just want to explain the interaction between those two statements. Now, on 22nd of May 2024, your solicitor wrote to the Inquiry highlighting 14:08 an erroneous sentence in the first statement, so I want to just bring that up so we can clarify it. Can we have the letter from DSO, please, on the screen. So this is the letter that was sent by your

instructing -- your solicitor, Ms. Morrison, about the first statement. It is dated there 22nd May 2023, but that, I think, is a typing error; it was May 2024. And if we can just go to the bottom of the third page, please, and just pause there, and that final paragraph that starts "The issue..." 14:09

You can see there that it refers in the final sentence to an erroneous sentence in paragraph 3.81, and that is of your first statement. And the erroneous statement reads: 14:09

"I felt I could not give an open and honest briefing families." [As read]

And then if you just turn over to the next page, please, we can see the explanation of the error. It says: 14:10

"The first two sentences of paragraph 3.81 were intended to be a direct lift from the final paragraph of Exhibit AM6 and the sentence in question was intended to read: 'I felt that I could not give an open and honest briefing without mentioning some of the difficulties I experienced and, therefore, wished to share this information with the Trust in advance of briefing families'." 14:10 14:10

And the additional words that were meant to be included are underlined there. And after that first statement,

of course, as we've heard, you went on to make a replacement statement, and is it right, Ms. Morrison, that the replacement statement does reflect your sentiments and does include that full extract as you had intended? 14:10

A. It does, yes.

226 Q. So, subject, then, to that clarification, can I ask, are you content to adopt both your first and your second statement as your evidence to the Inquiry today?

A. I am. 14:11

227 Q. And as your replacement statement, I am going to focus mostly on your second statement. We have already referred to what I'm describing as the Ennis Bundle and that's the bundle of documents that you were provided with for the purpose of making your second statement, 14:11 so I might bring up some of those documents, too. When I refer to particular documents or parts of your statement, you will see them come up on the screen in front of you, okay?

14:11

So your role, Ms. Morrison, is, you're now Chief Social Worker for Northern Ireland, isn't that right?

A. Yes.

228 Q. But you're actually here today to give evidence about your role as the author of a report on the Adult 14:11 Safeguarding Investigation which took place in Ennis Ward in - the report is dated 2013, isn't that right?

A. The report is, yes. The allegations first came to light in November 2012.

229 Q. Yes.
CHAIRPERSON: Could you bring the microphone a bit closer to you and speak up a little bit, sorry. Thank you.
230 Q. MS. KILEY: You were the lead author of the report into those allegations, isn't that right? 14:12
A. Yes.
231 Q. And the report is dated 23rd of October 2013 and, as you say, it related to allegations which came to light on 8th of November 2012, I think, isn't that right? 14:12
A. Yes.
232 Q. And thinking back then to that time, November 2012, your role was as Operations Manager for the Community Adult Learning Disability Teams, isn't that right?
A. The Community Multidisciplinary Adult Teams in north and east Belfast. 14:12
233 Q. North and east Belfast, okay. But was that a role that was a Belfast Trust role at the time then?
A. Yes, it was a role within the line management structure for Learning Disability Services in the Belfast Trust. 14:12
234 Q. So the Belfast Trust was your employer at that time?
A. Yes, they were.
235 Q. But your role wasn't based in Muckamore Abbey Hospital, is that right?
A. No - well, I had no operational management responsibility for any aspect of the hospital services, although I did, at various levels and more particularly in my subsequent post, I had an ad hoc role in providing professional social work advice and I also 14:13

provided professional social work supervision for the senior social worker in the Muckamore Abbey Hospital social work team.

236 Q. Did that role cause you to have to visit Muckamore Abbey Hospital on any occasion? 14:13

A. Not routinely. I -- usually, if I was having a professional social work supervision with the senior social worker, that usually would have taken place on site. Occasionally, I would have attended governance or management meetings. I think probably most of my 14:14 sort of visits to the site at that point in my Operation Manager role were largely in and around individual patients, perhaps post-admission meetings or discharge meetings.

237 Q. Okay. And in terms of the Adult Safeguarding 14:14 Investigation, you were brought in then to carry out the role of designated officer, isn't that right?

A. Yes, yeah, that's right.

238 Q. And can you explain a little bit about what that role is? 14:14

A. The role is -- was described in the 2006 policy at the time, it was -- the designated officer was responsible for a range of issues within the safeguarding investigation, including the decision -- decision-making about protection planning that was 14:15 necessary, about the decision whether or not to proceed with an adult protection investigation following initial screening, also about whether or not to consult with the PSNI. And then I suppose, subsequently, where

an investigation was agreed as necessary about directing that investigation, supporting the drawing of conclusions and making recommendations. And again, along that process, the review of the protection plan would be an important part of the function of the designated officer as well.

239 Q. Yes. And is it right to say then that the designated officer essentially leads the Adult Safeguarding Investigation, is that fair to say?

A. Yes. 14:15

240 Q. And you were assisted in the Ennis investigation by two others, Carmel Drysdale and Colette Ireland, and at paragraph 21 of your second statement you describe them as investigating officers. Can you explain the difference between your role as designated officer and their role as investigation officer? 14:16

A. In this particular investigation, we actually worked very much as a team; you know, it was a large-scale, complex investigation. However, Carmel and Colette would have done the majority of the interviewing of staff, both from the private-sector care home that had reported the concerns and of the ward staff, and then they would have fed back the outcome of those interviews or assessment of the issues to myself. 14:16

241 Q. Okay. And I'll come on to ask you a little bit about that in due course. I just want to bring up the report itself because the report is contained in the -- this is in the Ennis Bundle, if we can have page 221, please. Can you see that document on screen, 14:16

Ms. Morrison? So that's the first page of the report. I'm not going to ask you to take us through every detail of it. The report, as you know, is in the Ennis Bundle and the Panel has seen that, as have Core Participants, and will have an opportunity to consider it in its entirety, but I do have some specific questions relating about it. The first thing that I want to establish is, the nature of your report. The Belfast Trust have described your report as an Adult Safeguarding Report. Is that an appropriate description of what it was, or was it something more than that, would you say? 14:17 14:17

A. No, I think that's an adequate description. It was a report of a safeguarding investigation, what occurred during the investigation and leading then to conclusions and recommendations. 14:17

242 Q. And is it fair to say that it wasn't typical for all adult safeguarding incidents to result in an investigation of this kind and a report of the kind that we can see here? 14:18

A. Well, all adult safeguarding referrals would be screened, in the first instance, to make decisions about how to proceed with the concerns that had been raised, so some referrals would not have proceeded beyond that point. However, on this occasion, they did. It wouldn't have been uncommon for there to be a written report of an investigation, although there would have been cases where -- I suppose that weren't as large scale or as complex as this one, where, you 14:18

know, the minutes of the meeting or a risk assessment or some significant interviews would have been viewed as the sort of main body of the reporting of the investigation. In this investigation, because it was, you know, so large scale and complex, I felt it would be useful to pull all that together into -- into one overall report. I would say, though, that the various conclusions and the feedback from various stages of the investigation were reported at regular intervals to the strategy meeting and the case conference. So the report, when it was first drafted and then finalised, was very much, I suppose, a bringing together of information that had already been shared with various parties throughout the process. 14:19 14:19

243 Q. Yes. 14:19

DR. MAXWELL: Can I just clarify, so there are referrals that come in, a DAPO screener and then, some are screened out, and we heard this morning there was a culture of reporting a lot on the understanding that that was better because the DAPO would screen things out. For those that were screened in, there would always have been a strategy meeting and a case conference? 14:20

A. There would have been a strategy discussion.

DR. MAXWELL: Right. 14:20

A. Not necessarily always a meeting. And would there have been a case conference? In the majority of cases, I think there would have been some form of meeting, case conference. I think there would also have been a

number of cases where, yes, it was screened in and there was some further investigation, but the further investigation then indicated, you know, that there weren't particular concerns or that they were better dealt with via another route, so, for those cases, the process may have stopped before a case conference.

DR. MAXWELL: So is that at the discretion of the DAPO or are there clear guidelines?

A. In the 2006 policy, there was less discretion. In the current -- the 2015 policy, there is more room for discretion at -- of -- in terms of various routes that could be taken and I suppose exit points from an adult safeguarding process, be that perhaps best dealt with under contracting arrangements in relation to a quality concern, possibly by advice, guidance and training of staff. So the 2015 policy, deliberately that was the policy intent, I suppose, was less -- did give more discretion about the best way to handle a particular concern.

DR. MAXWELL: So, for this particular report, the Ennis, you were following regional guidelines. This wasn't -- this was what you would have expected following the regional guidelines on investigating a safeguarding concern?

A. Yes, absolutely.

DR. MAXWELL: Thank you.

244 Q. MS. KILEY: And, Ms. Morrison, whilst it might have been what you expected following the regional guidelines, was there something unusual about the Ennis

investigation? Because we can see the date of your report is 2013 and I think we will come on to see that it was delivered in October 2013 and the allegations were made in November 2012; was that unusual?

A. Not particularly unusual for an investigation of this scale and complexity. Adult Safeguarding Investigations, particularly large-scale ones and also where there are -- where the Joint Protocol is being followed, where it is a joint investigation with the PSNI, they do tend to take some considerable time. There were -- so there were issues about the police investigation and their pace that contributed to the overall time scales. There was also -- there were a large number of staff, both staff from the private care home and from the ward, to be interviewed. So, the report was largely complete by July and, you know, there were no significant changes between that and October, and I suppose I would stress that there weren't any surprises in the report when it came. So the fact that the final report wasn't -- you know, wasn't completed until October, that's not to suggest that a lot of the issues had not already been addressed by that point. 14:22 14:22 14:23 14:23

245 Q. Yes, and we'll come on to look at all that. So are you saying then in terms of your appointment as designated officer, whenever you first were appointed and first started the investigation, there was nothing unusual about the Ennis investigation; this was a typical safeguarding investigation, is that what you're saying? 14:23

A. There was nothing unusual in terms of, you know, following the process, the relevant procedures and going through the various steps. Those are the steps that you would take in any safeguarding investigation. The nature of the referral, which was suggesting that ward staff were behaving in an abusive fashion very openly, while -- you know, while that wasn't unheard of, it was more unusual. The fact that these were allegations from visiting staff and I suppose the seriousness of the concerns, they would have -- yeah, they wouldn't have been -- those sort of concerns would not have been the sort of -- typical of the majority of referrals you would receive, but equally, not unheard of, either. 14:24 14:24

246 Q. Yes. And I think we can -- if we can move down, please, to page 222, the report itself summarises the allegations. And you can see there, the allegations first came to light, as you've already said, on 8th November 2012: 14:25

"A care assistant from the Priory Group, Bohill Care Home, had been working on the ward as part of an introduction programme for patients who were moving to Bohill. She alleged that whilst working on the ward on 7th of November 2012, she witnessed named staff being verbally and physically abusive to four named patients. Only one patient's surname was provided, but the Christian names provided for the other three allowed the hospital to identify these individuals." 14:25

So there were four patients who were the subject of these allegations, and am I right in saying the allegations were made against three members of staff? Can you recall that, Ms. Morrison? 14:26

A. Yes, I believe so.

247 Q. And you say you were first notified of the allegations on 8th November 2012, so that was just, as you describe in your report, when they first came to light, is that right? 14:26

A. Yes.

248 Q. And so that's what you were first -- the allegations first involved, but is it also right to say that, as your investigation developed, the investigation came on to encompass a wider range of issues over and above those that we have just seen in that first paragraph? 14:26

A. Yes, that's right, and I suppose that arose from sort of two different mechanisms. So the first was, that by interviewing all the Bohill staff who had worked on Ennis Ward, there were other allegations made, and then, in the course of our own investigation or the safeguarding investigation, because of the nature of the concerns, that we were certainly open to exploring whether or not there were other issues of concern above and beyond what the Bohill staff had described. 14:27

249 Q. Yeah. You've referred to the matters raised by Bohill staff at interview, and we can see those summarised, if we can move on to page 255, please. If you scroll down, please. If we zoom out there, please. I think

I'll find the reference for it, but can we try 225, please, I think.

PROFESSOR MURPHY: I think they are listed on about page 3 or 4 of Ennis.

250 Q. MS. KILEY: Yes, they are on page 225. This is what I was looking for, I beg your pardon. Thank you. So you can see there the heading: "Interviews with Bohill staff by PSNI or Belfast Trust staff". And you say: 14:28

"A summary list of all the concerns emerging from both PSNI and Social Services interviews is given at Appendix A." 14:28

So there is, we know, an appendix to your report. It has, as you know, been subject to redaction for the purposes of this Inquiry, but we can establish then that that appendix is the summary of all the interviews, the issues that emerged in the interviews, is that right? 14:28

A. The interviews with Bohill staff -- 14:29

251 Q. The Bohill.

A. Not other -- from other staff interviews, from Muckamore staff interviews.

252 Q. Yes. And we can see there in the second paragraph, it says that a total of nine Bohill staff were interviewed. And if we keep scrolling down then, please, to just stop there, the paragraph that starts "A number of themes", you say that "A number of themes emerged", and then this part of the report goes on to 14:29

list those, so we can see those in the sub-headings. So the first one we can see in bold print there is concerns raised about the physical treatment of patients. And if we just scroll down slightly, you can see it is noted there, there were a total of 22 incidents identified there, is that right?

A. Yes. I should clarify that the list of, you know, what we called allegations, was very broad; it ranged from things that were -- you know, that would certainly have constituted a criminal offence, to concerns about atmosphere on the ward or the environmental situation, so -- but, there were 22 incidents, yes, that were about physical treatment.

253 Q. Yes. And from that, then, you identified these broad themes?

A. Yes.

254 Q. And if we scroll down then to the next sub-heading, please, at page 226:

"Concerns were raised about the verbal treatment of patients..."

And the number noted there is that there were 10 reported incidents of concern about how patients were spoken to, and the report goes on to explain that. The next sub-heading is "Concerns raised about the management of behaviour of patients", and we can see there, there were 16 concerns raised about the management of patient behaviour. If we scroll down

again then to the next sub-heading, please, "Concerns raised about the lack of supervision of patients". And then scroll down again, please, and then "Concerns regarding the lack of induction" and then other issues of concern.

So, in terms of how the investigation developed, is it right to say that it started with those allegations that we saw in the first paragraph that we looked at, but then, as a result of the interviews of Bohill staff, it developed to consider this much more wide-ranging issues, is that right? 14:31

A. Yes, that's right. I should just clarify perhaps that, as far as I recall, when we talked about the number of incidents, some of those incidents were different staff reporting largely the same thing. 14:31

255 Q. Okay. And in terms of the topics there that we have seen, was it usual for an Adult Safeguarding Investigation to consider wider issues such as those that we've seen noted there, the management of the behaviour of patients and concerns regarding lack of supervision and induction, were those things usually the type of thing that were considered by an Adult Safeguarding Investigation? 14:32

A. I think it would be very difficult to generalise. It would very much depend on the nature of the referral and the concerns that had arisen in the first place. It would be the nature of the concern that would then guide your investigation in terms of where -- where to 14:32

look.

256 Q. Did you feel that your investigation team had the necessary expertise to look at all those wider issues?

A. Yes, in terms of the safeguarding investigation. They both, as did I, you know, had lots of experience in Learning Disability Services, so we knew learning disability well. All three of us were also Joint-Protocol-trained and Achieving-Best-Evidence-trained, so, as a group, we had considerable safeguarding experience. I would say that it wouldn't be unusual within a safeguarding investigation that you would, if it was an issue that you were less sure on, you might have taken advice from elsewhere, so, as an example, in many safeguarding investigations that I was involved in, we may have sought advice from nursing colleagues about the management of pressure source, for instance, or an indication of, you know, recording practices for nursing in relation to a particular issue. We might also seek advice about the use of physical interventions and whether or not the physical intervention that was used was an approved technique, so -- so, yes, we had considerable experience, but, as with many other safeguarding investigations, if there was a particular issue, we would have sought expert advice on it. 14:32 14:33 14:33 14:33 14:34

257 Q. And just continuing with this issue about the scope of your investigation, I want to pick up on something you say in your statement. If we can go back to the second

statement, please, and bring up paragraph 13. You can see there, you refer to the screening decision, and you say that:

"The allegations made were clearly very serious and potentially criminal. The fact that it was alleged that the abused had happened openly in front of external staff made me immediately concerned about potential widespread abuse on Ennis Ward. The vulnerability of the patients concerned and the ongoing nature of the risk were all factors in the decision that further investigation was required." 14:34 14:35

You seem to say there that, at an early stage, you were "immediately concerned about potential widespread abuse on Ennis Ward". What led you to be concerned about that at that early stage? 14:35

A. There were a couple of factors. I think the first one was that the concerns from the Bohill staff were not just about a single incident, they referred to a number of different incidents and to a number of different patients, and then primarily the thing that rang, you know, the most alarm bells, was very much about the allegations were that this abused had happened openly in front of Bohill staff, and I felt that was unusual and perhaps indicated a scenario where staff felt that they could behave abusively and would not be challenged or, indeed, that they -- that they did not recognise their behaviour as abusive. 14:35 14:36

258 Q. When you refer there to the phrase "potential widespread abuse", what do you mean when you use the term "widespread"? Do you mean widespread in Ennis Ward or widespread in different wards throughout the hospital? 14:36

A. No, I mean widespread on Ennis Ward. It was one of the first things that we checked with the Bohill staff, about whether or not they had concerns about behaviour on other wards. Many of them had also been spending time on other wards and they contrasted their 14:37 experience on other wards very clearly with what they witnessed on Ennis Ward and were very positive about staff practice on other wards.

259 Q. Yes. And I think, in fairness, you describe that at paragraph 40 of your statement, 198, page 11, please. 14:37 You can see paragraph 40 there, you say:

"The Bohill staff who made allegations were very clear that they had no concerns about staff conduct on other wards that they had also spent time in and, indeed, had 14:37 observed very compassionate care on other wards, so we did not have any reason to suspect abuse elsewhere on the MAH site."

Is that what you were referring to? 14:38

A. Yes.

260 Q. And so it's right to say then that your investigation, even though you had those concerns about potential widespread abuse, as you described it, the

investigation focused on Ennis Ward?

A. Yeah, there were no allegations that would have prompted an Adult Safeguarding Investigation elsewhere on the site at that point.

261 Q. I'll come back to that issue, but, for now, I just want to, sticking with the early stages of the investigation, think about the process. If we can go back to paragraph 14 of the statement, please, page 198-4. You recall there that your memory is that, whenever the referral was made to you, the hospital had already taken steps to ensure that staff named were not on duty at that point and they were in the process of suspending them. You say: 14:38 14:38

"I think suspension was arranged that same day. I was content that this was an adequate immediate protection plan." 14:39

Can you recall the number of staff that were suspended in the investigation, Ms. Morrison? 14:39

A. Over the course of the investigation or at that point?

262 Q. Well, give me this point first, and then if it changed throughout the course of the investigation, tell me that.

A. I would need to check this to be sure, but, at that point, arrangements were made to suspend three staff, is my memory. 14:39

263 Q. And then you refer to a different stage in the investigation, so were there more suspensions

throughout the investigation?

A. There was -- there was a subsequent suspension of a nurse in charge of a particular shift where the Bohill staff had alleged abuse.

264 Q. And that subsequent suspension, who took that decision? 14:40

A. I believe that was discussed at one of the strategy meetings case conference and that I asked the hospital then to action a suspension.

265 Q. Okay. So it was the hospital that actioned the suspension, but it was on foot of something that had 14:40 been raised as part of your investigation, is that right?

A. That subsequent investigation -- or that subsequent suspension, the previous had been instigated by the hospital, although, you know, I was in agreement that 14:40 that was necessary action.

266 Q. At the outset of your evidence, you did say that one of the roles of the designated officer was to consider the protection plan, but you're saying here that, at the early stage, you were content with the immediate 14:41 protection plan that the hospital had put in place, is that right?

A. Yes. It very much was for the immediate stage, I had arranged this strategy meeting for the next day, but for the day that the allegations came to light, yes. 14:41

267 Q. Yes. I'll come to look at that strategy meeting in due course. I just want to ask you about your visit to the ward. You deal with this at paragraph 29 of your statement, if we could turn to that, please, and you

say that you visited Ennis Ward for the first time on 13th November 2012. If we could just bring up that paragraph, please. And you describe that visit as the first time you had been on that ward in MAH. You describe being shown around the ward, and then you say: "I came away from the visit with an uneasy feeling." And I wonder can you explain a little bit more about what you mean about that feeling that you came away with? 14:42

A. Yeah, I mean, it's difficult to describe exactly because it was an unease rather than anything very definite, and I would also say that it was the first time I had been on that ward and, indeed, it had probably been quite some time since I had been on any of the older-style wards, of which Ennis was one. So, I certainly was entering into a ward environment that was quite old-fashioned and where the environment, you know, was not what you would have wanted, so that probably contributed to my unease. But I think, in particular, I had some concerns about how the ward manager was, I suppose, interacting with the patients; as I was being shown round, a lot of patients were coming up to us and attempting to engage, and I felt that the ward manager, I suppose, was not particularly responsive to the efforts to engage. I've mentioned in the paragraph a particular incident where, you know, somebody was ushered out of the way and the door locked, and again, it seemed to me that it was done without particular care for that patient's sort of 14:42 14:42 14:43 14:43

feelings and, you know, what that person was trying to express. I should say, in fairness, though, also, you know, do you know, this was a very difficult period within the ward, ward staff felt very criticised and under scrutiny. I have no doubt that the ward manager was concerned about showing me round and probably focused on my questions and explaining things to me rather than the patients, but -- but, yeah, I did come out uneasy. 14:44

268 Q. You, later, as part of your investigation, interviewed some patients on Ennis Ward, isn't that right? 14:44

A. I don't -- I did not do any of the interviews myself, but the investigating officers conducted a number of interviews.

269 Q. Yes, and that's -- they are recorded at part 2B of the report. I need not turn to that. In terms of the outcome of those interviews, what were -- were patients able to communicate to the investigation whether they had any concerns? 14:44

A. Is it possible to get the -- where I have described the -- 14:45

270 Q. Yes, if we bring up page 229, please, of the Ennis Bundle. This is part 2B of your report. If you just scroll out so we can see that whole page, please. Can you see that, Ms. Morrison? 14:45

A. Is it possible to make it a little bigger, please?

271 Q. So you can see there that there's a record of interviews with four patients on this page and the next page, there is a record of an interview with Patient

P42, P40 and P44. Those interviews were held in January '13. And then an interview with P47 held in August '13.

A. I think it's fair to say that we certainly attempted to interview any patients that we could. However, their capacity was quite significantly limited in terms of being able to participate in any sort of interview process. Even where we, you know, had prepared carefully and were certainly very cognisant of the communication issues, I think, as it turned out, none of the interviews were particularly successful in adding to the information that we had about what may or may not have happened. There were two sets of interviews with patients. The first were conducted, I think, largely in the month of January, after quite a bit of preparation about capacity and working with speech and language therapist, and then, at a later point in the investigation, we considered whether or not we would interview any of the other patients on the ward, not those directly involved in terms of the allegations that had been made, and those would have been -- the intention there was to seek a view from patients about their general experience on the ward. In the event, we only proceeded with one of those interviews. We had hoped to do at least two others initially, but the relatives of both of the other patients were opposed to us interviewing them, and that was accepted.

14:46 14:46 14:47 14:47 14:47

272 Q. And reflecting on that role of patient interviews in

the investigation, do you think now that there's anything that could have been done differently to obtain effective evidence from patients?

A. No, I don't.

273 Q. Were the issues that you encountered relating mostly to capacity of the patients to engage in an investigation? 14:48

A. Yeah, they were wholly related, except in the case of the two patients where the relatives hadn't wanted us to interview them.

274 Q. And moving on then to other interviews that took place as part of the investigation, there were also interviews by both your investigation team and the PSNI of the staff on Ennis Ward, isn't that right? 14:48

A. Yes. The police interviewed, I suppose, a smaller group of ward staff and the Trust team interviewed all the other staff. 14:48

275 Q. Yes, and if we can return, please, to Ms. Morrison's statement, STM-198, you deal with this at paragraph 56, so page 14, please. And at paragraph 56 there, you describe the interviews that took place and you go on to describe that process at paragraph 57 and 58. In summary, and you can tell me if I have got any of this wrong, Ms. Morrison, but is it right to say that the PSNI conducted the interviews of the two staff who were specifically named in allegations and they were the two staff who were then referred for prosecution, is that right? 14:49 14:49

A. Yes, that's right. I am trying to remember if the police also interviewed some other staff in addition to

our interviews of them and I'm afraid I would need to check that.

276 Q. But you do say there at paragraph 56, you identify that there were four other staff that were interviewed by your investigation team. They were interviewed, but, in short summary, the investigation team didn't feel that there was enough evidence to prove those particular allegations, isn't that right? 14:50

A. Yes, so the interview of those four staff was, they were in relation to specific incidents that we had got information about during the course of the interviews with Bohill staff and we had agreed with the police that, you know, we would carry out those interviews but then report back to the police on what occurred. Those interviews are slightly different to the second set of Muckamore staff interviews, which were -- which involved all staff, whether or not they had been named -- 14:50 14:51

277 Q. Yes.

A. -- in any of the allegations. 14:51

278 Q. Yes. And if we scroll down, we can see you describe that at paragraph 60. So, this was you describing, at a later point in the investigation, there were interviews of all staff who worked in any capacity on the Ennis Ward, and I think you say that, at the end of this paragraph, a total of 34 staff were interviewed. And at paragraph 61, if we could scroll down, please, we can see you say: 14:51

"Apart from one previous adult safeguarding incident, all staff denied any knowledge of or involvement in any abusive behaviour. The investigation team did note that the Ennis staff appeared to be genuinely caring about the patients in their care and spoke very warmly about them."

And if we scroll down to paragraph 62 then, we can see that you highlight that:

14:51

14:52

"Most staff reported significant staff shortage on Ennis Ward at various points and were concerned about the impact of short-staffing on patient care and on staff well-being."

14:52

Just pausing there to look at that issue about staff shortage, the Inquiry has heard from the ward sister of Ennis and she has described how she was making reports about staff shortages in the months that preceded the incidents in November, so from around June 2012 she was making reports about staff shortages and, in fact, that led to Queen's University students not being placed on the ward. Were you aware of that at the time of your investigation?

14:52

A. I was aware that -- yeah, I was made aware that there had been staff shortages at various points. I think I was made aware that, on two particular incidents -- that, you know, this shortage was so significant it had been reported as an adverse incident or as a sort of

14:53

risk concern. I think I was also broadly aware that the hospital was experiencing staffing difficulties at that point.

279 Q. And was that something that then was considered as part of your investigation? 14:53

A. It was considered as part of the investigation, now not at the level of, you know, how short it was on particular shifts or at particular times, but we certainly thought it was potentially a -- provided some significant context for our examination of, I suppose, 14:54 the overall care that was being provided in the ward.

280 Q. And was that all it was, Ms. Morrison, for your investigation context? Was a review of staffing levels, the adequacy of staffing skill-mix, was that something that was outside the remit of your 14:54 investigation?

A. It was largely context, although I think we thought that it was significant in looking at a couple of the allegations about the likelihood of whether or not there would have been staff available, you know, to 14:54 supervise or to see what was going on. Certainly, the sort of response to staffing and considerations, about how many staff were needed and what the skill-mix was, I was certainly aware that, you know, those debates were happening and the issues were being -- they were 14:55 being flagged at various meetings, so while I was not leading them, I was aware of various discussions. Where we had some direct input was in relation to staffing, was in relation to staffing, the protection

plan of 24-hour monitoring, and certainly I was aware that that, you know, was causing some staffing difficulties, but I was also aware that, certainly in the early stages of the investigation, both myself and RQIA, you know, did not feel that we had all the information we needed about the staffing on the ward and there were some contradictory reports about whether the monitors were there and whether they were supernumerary, you know, above and beyond the sort of calculation of what was needed to provide the care. 14:55 14:56

281 Q. Well, I am going to come on shortly and ask you just about the monitoring.

A. Okay.

DR. MAXWELL: Can I just ask a question. So did you consider -- so we've heard quite a lot of evidence about a shortage of staff before the event; the ward manager gave us lots of information about how she had escalated it, the service manager had raised it with the CQC, I think the CQC had raised it all before -- just before November. When you were considering the incidents that the Bohill staff had raised, did you consider that the lack of staff, and particularly the lack of registered nurses, had meant that they didn't have the capacity to supervise the Bohill staff appropriately? Again, that was one of the things the ward manager told us, that she felt they weren't able to supervise them. And when you were thinking about the culture of the ward, did you actually think about the lack of registered nurses meant that it wasn't 14:56 14:56 14:56

possible to supervisor all care at all times, before we got on to the monitoring?

A. Yeah, I think we did consider those, although probably, probably not in huge detail, because I would have left the staffing of the ward and the balance of registrants or non-registrants, I wouldn't have considered that that was an area that, you know, I could contribute to significantly. However, I do think we -- we raised the issue particularly in the context of nursing-assistant staff who were certainly reporting feeling unsupported in the management of challenging behaviours on the ward and that we could see that it was largely those unregistered staff that were doing most of the hands-on care, and that was something that we, I suppose, made a recommendation on in terms of the sort of support that they needed. 14:57 14:57 14:58

DR. MAXWELL: So would it be fair to say then that the lack of the registered nurses was a contributory factor to the abuse that the Bohill staff observed?

A. I don't -- 14:58

DR. MAXWELL: Did you not explore that?

A. I don't know that I would have drawn that very firm conclusion with a sort of direct link. It was part of, I suppose, a concern about the ward functioning as a whole, but I wouldn't necessarily have seen it directly linked to nursing. The other thing I would say is, running alongside the safeguarding investigation, there were a lot of recommendations about the staffing and the nursing and the skill-mix, and so I was certainly 14:58

aware that there was a sort of, a concurrent programme of addressing issues.

DR. MAXWELL: So would it be fair to say you didn't explore the extent to which the absence of registered nurses contributed to the incidents? 14:59

A. Yeah, I think that would be fair in terms of a direct link, but, as part of the general context, I think it was explored.

DR. MAXWELL: Thank you.

282 Q. MS. KILEY: And you referred, Ms. Morrison, in answers to some of my earlier questions, to some strategy meetings that were taking place and other concurrent processes, and I want to come on to ask you about those. You describe the purpose of a strategy meeting at paragraph 21 of your statement, if we could go back to that, please, page 6. You say there: 14:59 14:59

"The core purpose of a strategy planning meeting is to decide on a protection plan for vulnerable adults concerned and to plan an investigation. In a Joint Protocol investigation, the PSNI has the investigation lead and the Belfast Trust has the protection lead. However, both agencies collaborated on the investigation." 15:00

You refer to appointing two investigating officers and how you chose them, and then you say: 15:00

"It was agreed with the PSNI with the Belfast Trust

investigating officers should carry out interviews with some of the Bohill staff and also that the investigating officers and I would interview some of the Ennis staff. Information from these interviews was then shared with the PSNI." 15:00

In terms of the PSNI's investigation then, that was something that was running alongside your investigation, but the PSNI were also involved in the strategy meetings, isn't that right? 15:01

A. Yes, you know, they were all part of the, sort of, holistic response from different agencies and different services within the Trust as well.

283 Q. And we have a number of the strategy minutes in the Ennis Bundle, I'll come to look at some of them, but 15:01 just in terms of who was involved in those, PSNI were involved, but we can also see that RQIA was involved in those strategy meetings, is that right?

A. Yes.

284 Q. And was that usual, for RQIA to be involved in meetings 15:01 of that kind?

A. At that point, it was. At a later point, RQIA tended to -- not to have quite such operational involvement, but on this occasion -- or for this investigation, they did. They were also carrying out their own 15:02 inspections, which they would have reported back into the case conference strategy discussions as well.

285 Q. And the purpose of that was to allow the meeting to decide on a protection plan, is that right?

A. I suppose all of the information was relevant to the overall response to the concerns, so we had, you know, the information from the PSNI, we had the information from RQIA. So I suppose in having all those people, you know, present in the room, we were, I suppose, working collaboratively on how we should best respond to what had been alleged.

286 Q. And in terms of those persons that were in the room, you do say later in your statement - we need not turn to it, but, for reference, it's at paragraph 90 - that a particular dispute arose about the inclusion of the consultant psychiatrist doctor in those meetings; do you recall that, Ms. Morrison? 15:02

A. I do.

287 Q. And can you explain why you did not want the consultant psychiatrist to attend the strategy meetings? 15:03

A. Yeah, the consultant psychiatrist in question was the psychiatrist for Ennis Ward, and particularly at that early stage, you know, the purpose of the strategy was about protection planning and planning an investigation and, you know, at that point, we were very, very much considering, you know, the possibility that this abuse was widespread and happening openly and, therefore, I didn't feel -- I didn't feel it was appropriate that somebody who worked on the ward would be part of those discussions. 15:03 15:03

DR. MAXWELL: Can I ask, going back to the context, because we also heard evidence earlier this week - in fact, maybe it was only yesterday - from Clinton

Stewart, who said that he was excluded from this, whereas his usual experience of safeguarding investigations was, it was a partnership, and people who worked at the hospital would be involved in setting the context. If there was widespread abuse, where were you getting the context about practice from if you were excluding everybody who worked at Muckamore? 15:04

A. So the normal process would indeed be that a sort of a management level within a sort of facility or service under investigation would be part of the process, largely in terms of, as you say, explaining particular issues, but also providing information and feeding back on actions and recommendations. For this particular investigation, I had wanted Esther Rafferty to play that role. My objection was only to the consultant psychiatrist in question. That became a dispute between myself and Esther Rafferty, and Catherine McNicholl, who was the Director of Adult Social Care Services, I suppose directed that there should be no Muckamore staff involved in these meetings. I thought that was a very unsatisfactory arrangement and not what I would have wanted, and at a later point Esther Rafferty then did return to those meetings. So, no, it wouldn't have been unusual to exclude everyone. 15:04 15:04 15:05

DR. MAXWELL: So if the initial decision to have nobody who worked at Muckamore was there, how would the context have been explained? 15:05

A. I suppose that would have happened in communication outside the meetings, so, you know, if there were

issues that I needed to ask people about, then I would have followed up, or likewise with the investigating officer as well. Also, RQIA were, you know, were doing their own inspections and their own communications around their issues of concern with staff, and again, that would have been fed back into the meeting.

DR. MAXWELL: But you are stating it is very unusual to do a safeguarding investigation in this way, without anybody from the hospital site present in their strategy meetings? 15:06

A. Yes.

CHAIRPERSON: And can I just ask on the same topic, you were pretty adamant, I think, that the consultant psychiatrist shouldn't attend; can I ask why not?

A. Sorry? 15:06

CHAIRPERSON: Why not?

A. Because I suppose I -- I felt I needed to be open to the possibility that the staff in that ward were involved in or were tolerant of abuse, given the allegations that had been received, and so I thought it 15:07 was -- potentially, that it may have compromised an investigation if one of the staff members that we may -- you know, staff members that we would have wanted to speak to about it, either ourselves or the police, knew of the investigation strategy and the 15:07 detail of the allegations in advance.

CHAIRPERSON: So the effect of that, though, is, if somebody like a consultant psychiatrist is being excluded, is that effectively everybody from the ward

is going to be excluded as well?

A. Yes, and I think that was the case, yeah.

288 Q. MS. KILEY: And do you think, looking back, that those early strategy meetings before Esther Rafferty returned, which I think was January 2013, were those early strategy meetings missing that input then? 15:08

A. I think Esther was at a December meeting. Yes, there was an element of that being missing, although there was considerable correspondence and communication with Esther and through RQIA outside the meetings, which I suppose sort of mitigated the sort of adverse impact of that. As I say, it wasn't a position that I was comfortable with, but it was something that was directed by Catherine McNicholl. 15:08

289 Q. Returning then to that first strategy meeting which took place on 9th of November 2012, you refer to that at paragraph 22 of your statement, and this was the meeting where you recommended that 24-hour monitoring be started on Ennis Ward by staff external to the ward as a necessary protection plan, and you say that you "believed this to be necessary because the allegations involved significant numbers of staff acting openly in front of visiting staff and I feared that this meant that abusive practice was widespread and accepted as normal practice." 15:08 15:09

You refer there to "significant numbers of staff", but as we've already seen, those initial referrals only related to three staff, isn't that right?

A. I'm sorry, I can't remember whether it was -- oh, no, it was four patients but three staff, yes.

290 Q. Four patients and three staff.

A. Yes.

291 Q. So I'm just wondering what you mean there about "significant numbers" whenever you refer to that in that paragraph? Are you saying that three was a significant number? 15:10

A. Yeah, three would be a significant number. I think, on looking at the sentence now, it was probably the "acting openly in front of visiting staff" that was the primary concern. 15:10

292 Q. Okay. And in terms of the 24-hour monitoring itself, is that something which is a typical protection measure in an Adult Safeguarding Investigation? 15:10

A. No, it would be unusual, but the scale -- the nature and extent of the allegations, I suppose, were also unusual.

293 Q. With it being an unusual measure then, did you discuss the potential impacts that it might have on the ward, on both patients and staff, with anyone, before implementing it? 15:10

A. We certainly -- we were certainly very conscious that it was unusual, very conscious that it would be uncomfortable for staff, and I suppose we were also conscious of the -- I suppose of the practical difficulties, putting the protection plan into place, given the sort of staffing that would be required. There are -- certainly, at a, maybe, later point on the 15:11

9th, yes, it was fed back that it was believed that having monitoring staff was also disruptive to patients as well.

294 Q. Yes, and I'll come to ask you about that. But just at that early stage, you say that you were conscious of it, but I just wonder did you actually specifically consult with anyone in the hospital about the potential impact so that you could understand that before imposing the monitoring? 15:11

A. I believe I would have discussed it with Esther and that it would have been part of that conversation. It was also part of my conversation, I think, with Catherine McNicholl and, potentially, John Woolcott (?) at the time as well, but it was probably at a slightly later point that the sort of more detailed -- this was detailed, I suppose, evaluation and consideration of the impact was considered, this was very much an immediate measure, you know, the day after the allegations came to light, when my, you know, predominant concern was about ensuring the immediate protection of patients. 15:12 15:12

DR. MAXWELL: Can I ask about the people who were at this strategy planning meeting that made this decision. We have heard a lot of evidence about the hospital was reducing in size and the patients who were left had complex needs, a lot of them had autism and reacted badly to being in the presence of people they didn't know. Was there anybody on the strategy planning meeting who was an expert in autism or challenging 15:13

behaviours who could have anticipated this, because you had excluded the consultant psychiatrist who might have commented on that?

A. Yes, I mean -- well, I would certainly think that myself and the two investigating officers, we had long experience of learning disability and autism in people with learning disability as well. 15:13

DR. MAXWELL: So, you had that expertise. Did you actively consider what impact is it going to have on this group of patients if there are, 24/7, people they've never seen, observing staff, interact with them? 15:13

A. At that point, you know, I don't know that we considered it beyond the -- this is quite a -- you know, it's quite a significant measure to put in place. I think, to be honest, at that point our concerns were more about the immediate protection rather than the other impact. 15:14

DR. MAXWELL: So there is a balance between, you've got a feeling there might be widespread abuse, although you haven't got evidence of this at the moment, and you've got the knowledge that this is likely to have a distressing effect on patients; how did you balance those two risks? 15:14

A. I suppose by -- by weighing them up, and I suppose I have sort of indicated, certainly in some of the discussions after that meeting where the point was being made very clearly to me that it was disruptive, I suppose I did feel at the time that, you know, there 15:14

were a lot of people in and out of Ennis at this point who were unfamiliar, and my view at that point was that one additional member of staff on the ward was unlikely to be so significant that it outweighed the benefit of ensuring that the care being provided there and then was appropriate.

PROFESSOR MURPHY: Can I ask why they were supernumerary, at least to start with?

A. As far as I recall, that was very much about ensuring that, you know, they had the flexibility to observe, so that had they been included in the complement of staff, that they would have -- you know, they may have been tied up with supporting somebody's personal care or giving a patient a meal and that, therefore, they might have been tied up for a long periods of time that would not have allowed them to have that kind of overview of what was happening on the ward.

PROFESSOR MURPHY: Did you think that that was something that kind of fed into staff's anxiety about being watched and being scrutinised?

A. Yes, I think, undoubtedly, you know, staff did feel scrutinised and watched.

CHAIRPERSON: And can I just ask, you may have dealt with this elsewhere, but who actually chose the monitors?

A. I believe that was led by Moira Mannion and Esther Rafferty.

CHAIRPERSON: Right. And do you know if the sorts of issues that Dr. Maxwell has raised with you, that the

factor of introducing a new person into the ward, as it were, might disturb a patient who is autistic, do you know if the monitors themselves received any particular advice or training?

A. The monitors were all nurses, so, you know, they brought their professional skill and expertise. My memory is that most of them had a background in learning disability, though I would need to check records to be completely sure about what that proportion was, and they certainly would have had the expertise, you know, to be aware of impact on patients who might have autism. 15:17 15:17

CHAIRPERSON: Okay.

A. They also -- we -- there was guidance provided for every staff member that was coming onto the ward as a monitor, as well as about what the role was, and the monitors were supported by Esther and by Moira in terms of feeding back what they were observing. 15:18

CHAIRPERSON: And certainly you only anticipated one monitor at any time? 15:18

A. Yes.

PROFESSOR MURPHY: But was it a large pool of monitors; in other words, would it be a different person every day for weeks or --

A. I don't have the details of -- it wasn't a very large pool, so, you know, a lot of then monitors were certainly then, you know, building up their knowledge and experience of the patients, so there would have been, I suppose, some changeover, but it wasn't that 15:18

there was a pool of 20 people doing this either.

PROFESSOR MURPHY: And how long did it go on for?

A. I think, and I'm sorry, I'd need to go through the minutes to be absolutely sure, there were changes made at certain points. One was that we agreed that the monitoring could be provided by a lower band and, also, that it no longer needed to be supernumerary. Also, where new staff came onto, you know, came onto the ward who had not previously worked in Ennis, that they could fulfil this monitoring role. I think -- I think the monitoring was stood down in and around July 2013, but there had been changes prior to that. 15:19 15:19

PROFESSOR MURPHY: So it started very soon in November and went on until about July?

A. Yes, with changes to the arrangements, yes. 15:20

CHAIRPERSON: I'm sorry, we have intervened quite a lot, but I do think probably a break would be --

MS. KILEY: Yes, there is just one more point that I want to address about monitoring and then I think it would be an appropriate time, if I may, Chair. 15:20

CHAIRPERSON: Yes, of course.

295 Q. MS. KILEY: So, just, you said there, Ms. Morrison, that the point was made to you at a later stage that the monitoring was disruptive. Can you recall what stage that was? 15:20

A. My recall is that the objections to the monitoring began very shortly after it was put in place, and that was one of the arguments that was being made.

296 Q. And what were the other arguments that were objecting

to the monitoring?

A. I suppose there was a -- the arguments were, disruption to patients, distress caused to staff, and I have to say, this was not argued very much, but there was a concern about the practicalities of enduring monitoring as well.

297 Q. And who was making those objections to you?

A. Esther Rafferty and Moira Mannion.

298 Q. And did that cause you to reconsider the practice of the 24-hour monitoring? 15:21

A. Yes, reconsider it, but, having weighed it up, as I said, I felt that the -- you know, that the protection was the more significant factor and justified, you know, the acknowledged difficulties with the protection plan and felt that, you know, that the need to ensure protection was the more significant factor. 15:22

299 Q. And so, looking back now with hindsight and reflecting on the issue, do you think that the 24-monitoring is something that you would impose had you been conducting the investigation again? 15:22

A. Yeah, given the same set of circumstances, yes, I think I was very significantly concerned about the allegations, that they indicated a sort of -- you know, an abusive culture, and particularly the point I have already made about behaviour happening openly, and I suppose I would have considered, as DO, that my primary responsibility, as it would be in any safeguarding investigation, was to ensure the protection of the vulnerable adult or adults, as there was in this case. 15:22

So I do believe I would make the same decision again.

MS. KILEY: Okay, I think that's maybe an appropriate time, Chair.

CHAIRPERSON: We will take a break. We may have to sit a little bit later, I suspect, this evening. 15:23

MS. KILEY: Yes, I am confident that we will get finished, Chair, but just because of the time of the afternoon, it may be useful to sit a little bit later than usual.

CHAIRPERSON: Okay, thank you. 15:29

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you.

300 Q. MS. KILEY: Thank you, Ms. Morrison. Can we bring up 15:38
paragraph 31 of Ms. Morrison's second statement, please, STM-198-8. Ms. Morrison, just before the break we were talking about strategy meetings, and in paragraph 31 of your statement you refer to a particular strategy meeting which you single out as 15:38
being particularly difficult, and it's on that page 9 that you can see in front of you. If you just scroll down a little bit. That third line down, "I recall", and you say there:

15:38

"I recall a particularly difficult strategy meeting on 9th January 2013 where I faced considerable challenge from John Veitch and Moira Mannion. Barney McNearney, my line manager, had returned from sick leave and he

was in attendance. After the meeting, Barney spoke to me and said that John Veitch suggested that perhaps Barney should take over as the Chair of the strategy meetings. Given the extent of the opposition I was facing, I felt that I may have some difficulty carrying out my Designated Officer role if I was not also chairing the meeting. I told Barney that I would prefer to continue to Chair, and Barney accepted this."

Now, we have the minute of that strategy meeting at page 52 of the Ennis Bundle, and we can turn to that if we need to, but, in general terms, can you explain what was particularly difficult about that meeting? 15:39

A. It was the level of challenge from John Veitch and Moira Mannion, it was their repeated challenges about what I considered to be evidence and also, I suppose a -- yeah, a challenge to my consideration of whether or not, you know, there were wider concerns about abuse; in particular, a lot of stress was placed on what the monitoring staff had said about the lack of any sort of concern about an abusive culture, and I felt that that challenge did not take into account the fact that it was unlikely that staff would behave abusively in the presence of monitoring staff, and I suppose when I raised my concern about that, I don't feel that that -- that that was accepted. 15:39 15:40 15:40

DR. MAXWELL: Did you take into consideration, though, the fact that there's quite a lot of evidence that, yes, people will change their behaviour when they are

initially observed, but when they are being observed 24/7 for months, they can't sustain that, if that's not their true intent. Given the fact that it was 24/7 over seven months, did that not give some weight to their finding? 15:41

A. There was certainly weight that I gave to the monitoring reports, and I was conscious that they were, you know, they were expressing that, you know, staff were behaving, you know, warmly and in a caring fashion and were also skilled, and there's no doubt that there were reassurances in that, but I suppose I -- certainly, in January, I felt we were still at a very early stage with that. 15:41

DR. MAXWELL: And wasn't there also some difference of opinion between the Bohill staff? I mean, we heard in -- I think it was in Brenda Creaney's statement, that there was at least one member of staff from Bohill, the only one to have any LD experience, who said she hadn't experienced an abusive culture? 15:42

A. Absolutely, not -- not all the Bohill staff reported concerns and, of those who did, some of them were more minor concerns. 15:42

DR. MAXWELL: So wasn't it appropriate really that there was a multiprofessional discussion about this, you know, what could be concluded from apparently conflicting information? 15:42

A. It was certainly appropriate that there would be a discussion about it. What I believe was inappropriate was the -- I suppose, the tone and the manner in which

it was conducted, and I suppose for what appeared to me to be an overemphasis on a factor in terms of, you know, whether or not any abusive practice was being seen now.

DR. MAXWELL: So, given that there was an impasse, there were different opinions, what would the normal route to resolving differences of opinion be? 15:43

A. The normal route would be that you would, you know, that you would discuss within the context of the case conference. 15:43

DR. MAXWELL: But would you escalate to somebody outside? Because sometimes it can be difficult when you believe something very strongly and somebody else -- and you get into entrenched positions. Was there any consideration given to actually getting somebody who hadn't been so closely involved, to assess all of the evidence and -- 15:44

A. So, there was certainly a route to, you know, to line management, discussion where there would have been concerns about, as you describe, an impasse or different views. This was an unusual situation, I suppose, because my line management were also in attendance at the meeting. I think -- I have to say it was unusual -- it would have been unusual for there not to be a degree of consensus. I would also say that some of the people involved in the meeting, you know, were people that were expressing a range of views, so RQIA were there with what I believe, you know, was a, you know, an independent viewpoint and that external 15:44 15:44

viewpoint as well. I was also speaking regularly to the Trust adult safeguarding specialist, Yvonne McKnight, who was present at the meeting, and indeed had been asked to be there to support me in the issues, and equally, you know, nursing were there as well. So, 15:45
I suppose I believe that the challenge - and this was why it was particularly difficult - was confrontational and antagonistic, so it was the nature and the way in which things were expressed and discussed, and I suppose what I experienced to be, I suppose, a -- yeah, 15:45
a hostile questioning rather than -- rather than an exploratory questioning.

301 Q. MS. KILEY: Just while you have raised that point, Ms. Morrison, you've described the questioning as hostile and you will have seen that Ms. Mannion has 15:46
made a statement to the Inquiry, and have you seen in that statement that Ms. Mannion says that she does not accept that she was hostile? Have you seen that?

A. Yes, I have.

302 Q. And how do you account then for the different 15:46
perceptions that you both have of that meeting and, indeed, other interactions that you had?

A. Well, I mean, I think the first point I would say is, you know, people -- you know, I accept that people perceive things in different ways and, you know, that 15:46
that is always a factor. I can also see that -- you know, I understand why Moira would say that no, her -- she didn't believe her behaviour had been hostile. I suppose I would point to the experience of other people

who were there also who certainly would have spoken to me about the hostile nature of some of the challenge I faced in the meetings as a whole.

303 Q. Are you saying there were other people at the meeting who shared your view? 15:47

A. Yes, there were other people who were certainly aware that -- or were conscious that those meetings were particularly difficult and, in submitting my grievance to the Trust before I did that, I consulted with five people who would have witnessed some of the behaviour 15:48 that I experienced, and those five people were willing to corroborate, you know, the extent of the challenge and the tone and manner of those meetings.

304 Q. Are you able to tell us the role of those people?

A. RQIA Inspectors and Trust adult safeguarding specialist 15:48 and investigating officers.

305 Q. You referred there to submitting a grievance, and it may be an appropriate time to turn to one of the exhibits that you have provided. Could we have up page 41 to 49, please. Now, this isn't yet the grievance, 15:48 but what I'm turning up is a written account of your experience acting as the Designated Officer. We see that on the screen. And is it right, Ms. Morrison, that you prepared that in or around January 2020?

A. Yes. 15:49

306 Q. And this sets out some of your experience and indeed some of the challenges which you faced in the investigation, isn't that right?

A. Yes, that's right.

307 Q. Can you explain how you came to put that experience in writing at that time?

A. Yes. So the Ennis Ward Investigation Report, Safeguarding Investigation Reported, been leaked to The Irish News, and that publicity and the existence of the report was then subsequently raised at MDAG, the Muckamore Departmental Assurance Group, and particularly by the family representatives on MDAG. There was, firstly, a discussion, I suppose about what had occurred, and it was agreed that a synopsis of what had occurred would be provided, and then, subsequently, that the Belfast Trust and myself would give a briefing to families about what happened. So, at that point, in consultation, with departmental colleagues, I felt that I couldn't -- I couldn't update or I couldn't detail what had happened during Ennis without mentioning some of the difficulties that I experienced, and I felt, before I would do that, that it was the right thing for me do, to make the Belfast Trust aware of those difficulties. The second factor was the Leadership and Governance Review which was about to commence. One of the issues in the Terms of Reference for the Leadership and Governance Review was about the informal culture within the hospital, and I felt that my experiences in Ennis were relevant to a consideration of informal culture, and again, assuming that the Leadership and Governance Review would want to speak to me -- team would want to speak to me, again I felt that I wanted to share the concerns with the Belfast Trust before

15:49 15:50 15:50 15:51 15:51

sharing them with the Leadership and Governance Review team.

308 Q. And why had you not felt that you wanted do that before that time, before 2020?

A. So I suppose there's probably a number of factors there, so I think the first thing that I would say is that I believe that I did challenge the behaviours at the time or the statements that were made; that I -- you know, if somebody presented a particular view to me or was particularly hostile about a particular issue, I was challenging that there and then. I think the second thing I would say is that some of the behaviours that I experienced were -- you know, this wasn't hidden behaviour, it was happening openly, by and large in meetings, so there were a lot of people and a lot of very senior people aware of some of the challenges that I faced in the investigation. I think probably one of the most important things that I would say in relation to my actions at the time is that I believed that I had countered the challenges and that I had completed the investigation and drawn the conclusions and made the recommendations that I wanted to do, so I would describe my experience as my job being made really difficult, but that, ultimately, I believe I completed my work to my satisfaction. 15:51 15:52 15:52 15:53 15:53

I suppose the other thing I would say is, do you know, the issues that I have, you know, that I have described, you know, they were about attitudes, they

were about tone, you know, manner. You know, they would have been difficult things to raise in that they could be relatively easily dismissed, and ultimately, you know, the Trust did not believe my account of what occurred. I should say that it was only much more recently that I became aware of later discussions about a serious adverse incident and statements that were made.

309 Q. Yes, I am going to come on to that. If you don't mind, I will ask you to park that because I do specifically want to ask you about some of the discussions about a serious adverse incident, and you deal with that in your statement, but just to focus in on this written experience. Are you saying -- and the Panel have that and Core Participants have it, I'm not going to ask you to go through it all, but in terms of the import of this, are you saying that whilst the challenges existed and you wanted to make the Belfast Trust aware of them and the Inquiry is now aware of them, are you saying that the challenges didn't have any substantive impact on the outcomes of your investigations and the recommendations that you were able to reach?

A. Largely, yes. I believe that I carried out the investigation that I would have wanted to carry out and I wasn't hindered in any way in the investigation. I believe the protection planning again, although it was made very difficult for me, I believe that I was able to ensure the protection plan that I felt was appropriate, and the conclusions and recommendations

are the conclusions and recommendations that I think were justified.

I would say -- I would say, on reflecting on this, and obviously I have reflected a lot, given what we are now aware of, I do think some of my language in my report is perhaps a little bit more cautious than perhaps I might otherwise have used.

310 Q. That's in the Ennis report itself?

A. It's in the Ennis report itself, but not to the extent that I think it detracts from what I was able to say. I think the lack of certainty that is reflected in my report in being able to say whether something had been proved or not, is really a reflection of on -- you know, on the difficulty of making those judgments, as opposed to any pressure. I feel that I withstood the pressure and said what I wanted to say in the report. 15:56

311 Q. And just on that, if we can go back to your statement at paragraph 100, please, 198-26. You touch on this issue about the impact, or otherwise, of these issues on your report, and you say: 15:57

"At the time I believed that the reasons for the behaviour I experienced were attitudinal, I did not believe there was any attempt to cover up or hide anything. I attributed the difficulties I experienced to a range of possible factors, including professional defensiveness on the part of Nursing and a reflection of some community hospital and social work nursing tensions. Whilst some defensiveness is not unusual 15:57

from services which are under investigation, this was beyond the normal. I also believed there was a reluctance, perhaps subconsciously, to accept the possibility of widespread abuse on Ennis Ward."

15:58

So, again, are you saying there, Ms. Morrison, that, in respect of the challenges, whilst you have told us that your report essentially came to the conclusions that you want it to come to, you were also making it clear that this was attitudinal. Are you saying that there were personality issues between you and some of the other staff involved that you had these challenges with?

15:58

A. No, not particularly. I think the challenges were about the issues of protection planning and judgments that were made about what was likely to be happening or not, or the judgments that we had made on things. So, no, I think the challenge was very much about aspects of the investigation and protection planning. I mean, I should say that, you know, I have considerable experience in leading safeguarding investigations and, as I've said in that paragraph, you know, they are often difficult environments to work in. This was -- this was beyond anything I had experienced in any other investigation, the level of what I experienced as a hostility and antagonism.

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312 Q. And you say that you have reflected on this matter. In those reflections, do you have any view about how this, what you've described as antagonistic and

confrontational behaviour, could be avoided in future, in future investigations?

A. I find that difficult to answer because this was not the norm or not the routine of any other safeguarding investigations. To me, it pertained to this particular investigation and that particular set of circumstances. I suppose I would say, you know, for example, in terms of the protection planning and, you know, the unusual nature of a 24-hour monitoring as part of the protection plan, you know, those -- the necessity of that, you know, was agreed by all other parties at the meeting bar Esther Rafferty, Moira Mannion and John Veitch, so -- and that would be my experience normally, that, you know, that it is possible to reach a reasonable consensus about what is necessary. 16:00

313 Q. One of the things you referred to earlier, in answer I think to Dr. Maxwell, was about the unusual nature of the particular meeting that I took you to in the 9th January and you had described how it was unusual because your line manager was actually in that meeting. 16:01 And are you saying that there was any difficulty with the fact that your line manager was at the meeting, did that pose any difficulty in your ability to escalate any issues or challenges that you encountered during the investigation? 16:01

A. It absolutely did. I mean, John Veitch was, you know, not just the level above me but the level above that again, for most of the investigation when I was Operations Manager, and, you know, so that pressure, I

suppose, had a -- you know, had a particular significance, in that it was my only line manager who I felt was placing the pressure on me. In terms of escalation, you know, John Veitch, in other safeguarding investigations, might have been the person I would have escalated things to. An escalation about John Veitch would have been to, you know, Catherine McNicholl, which was the director, which, you know, was a very senior level compared to my position within the Trust. But equally, I suppose I would say is, there was a consciousness that there were difficulties in this investigation as well, but, yes, undoubtedly John Veitch's position as Co-director within Learning Disability Services was a very particular factor for me in terms of how I experienced, you know, the interventions in the process. 16:02 16:02 16:03

314 Q. And that came about effectively because you were employed by the Trust and Mr. Veitch and others were employed by the Trust. Is it right then that the only potential alternative to avoid that happening is to have someone outside the Trust carrying out the role that you did? 16:03

A. Again, I have reflected on that question quite a bit and reflected on it at the time of carrying out the Ennis investigation. I do believe that there are advantages sometimes when carrying out an investigation, even within a Trust service, to knowing the service, knowing how things work, perhaps knowing, you know, the service user involved, and that sometimes 16:03

that is protective and supports an investigation. I think in -- I think I would feel now that where an investigation is -- where an investigation involves a number of members of staff and I suppose, you know, is potentially large scale, that, at the very least, it would be -- it would be a good idea that the investigation was carried out by staff from a different programme of care and potentially, in some cases, by a different Trust.

315 Q. And just finally before we move on from the particular complaints that you raised, your document that sets out your experience refers to issues particularly in respect of monitoring, and we've already covered those, but there is one other issue I just want to ask you about before we leave this and if we could bring up page 44, please. If we could zoom in on the second paragraph. There is one particular issue that you refer to, and you use initials here, but when you use the initial "MM", you are referring to Moira Mannion, isn't that right? 16:04 16:04 16:05 16:05

A. Yes, that's right.

316 Q. And you refer to a particular occasion and you say:

"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." 16:05

And I just want to ask you to clarify, you appear to be saying there that Ms. Mannion was suggesting that nurses couldn't be involved in abuse because they were nurses, is that what you were suggesting there?

A. Yes, that's what I'm suggesting. 16:06

317 Q. And you know -- I think you said you have seen Ms. Mannion's statement, isn't that right, and you will then have seen that she says that she completely refutes that. Have you seen that in her statement, Ms. Morrison? 16:06

A. I have.

318 Q. And having seen that, did that give you cause to reflect on what you have said here?

A. Absolutely, but my reflection was that I remember it clearly. I was very shocked by it. I was quite shaken 16:06 by the extent of the hostility and what felt like, you know, a very inappropriate challenge, and it is my clear memory that that incident occurred.

DR. MAXWELL: So that's a very serious accusation to make. Did you raise it with her line manager, Brenda 16:07 Creaney?

A. No, I didn't.

DR. MAXWELL: Why not? Because it's a very, very serious thing to have said, it negates the whole safeguarding process, and I would have thought that was 16:07 a huge safeguarding concern and something that should have been raised with her professional line manager?

A. I think there is a couple of factors in my response to that, I suppose. You know, this was part of a meeting

where -- a part of a series of meetings and discussions where a lot of the behaviour was, you know, I would describe as hostile and antagonistic. This one did stand out as being particularly shocking to me, certainly. Again, I suppose I would point to what I've said about my actions at the time. I did believe that -- you know, I believe I tackled all of these issues there and then at the time and that I did not allow that pressure to influence my own practice, what I did in the investigation, the discussion, the discussions that I had. I would point to, again, the seniority of the people involved. I believe it would have been very difficult for me to go to Brenda Creaney; to be honest, at that point I'm not even sure that I was terribly aware who Moira reported to, and I suppose I would point back to -- I would point back to the -- I suppose what I have said about the behaviours that I experienced, you know, were about attitude and they were about tone and manner, I belive they would have been easily argued against and dismissed. I didn't feel that I would necessarily have been able to, sort of, to prove intent, and, I mean, I think ultimately, you know, the fact that I have not been believed, from a personal point of view, that, I suppose, to me, I suppose justifies some of the concerns that I would have had, that people would have said no, no, I was simply asking reasonable questions and exploring issues.

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DR. MAXWELL: So I can understand that going straight

to Brenda Creaney was a big ask from your position.
A. Yes.
DR. MAXWELL: But as a social worker, you have a professional supervisor?
A. Yes. 16:10
DR. MAXWELL: Am I right ---
A. Well, I didn't have a separate professional supervisor.
DR. MAXWELL: Do you not have social work supervision?
A. My line manager was a social worker, so I didn't have additional professional supervision. Professional 16:10
supervision is only -- is only provided where your direct line manager isn't a social worker. I would have access to professional --
DR. MAXWELL: So you had -- your line manager was a social worker? 16:10
A. Both Barney McNeaney and John Veitch were social workers.
DR. MAXWELL: So Barney was a social worker. I mean, Moira Mannion was one of the deputy directors of nursing of the Trust and you've talked a lot about 16:10
issues of culture, and if she said that, that is quite serious for the culture of nursing within the Trust. I can understand it might have been difficult to go to Brenda Creaney, but did you raise it with Barney?
A. I didn't raise it with Barney in the meeting in which 16:11
it occurred and I am -- yeah, I am now a little less sure about which meeting it occurred in, having thought it through. I'm not actually sure Barney was around. But I accept the point that I did not -- you know, I

did not go to anybody and say I am particularly concerned about this comment. What I did do was, I suppose, you know, I would have raised and would have discussed the difficulties I had in carrying out this investigation and the extent of the challenge that I was faced with.

PROFESSOR MURPHY: Could I ask one more question before we move on. Do you feel that the policies were in some ways pitting social work against nursing, in that social work was doing the investigations of nursing, and I'm just sitting here wondering, well, what if one involved more nurses in the investigating and allowed more social workers onto the ward, would that help? Because I think at one point you say that you weren't welcomed on the ward. So it was as though the policies were kind of pushing you apart into very different roles and making the antagonism more likely, I would have thought?

A. Yeah, I don't believe that that was influenced by the policy. I think the policy clearly envisaged collaboration and co-operation with people, you know, across the system who were involved in the issues. I would also say that, actually, that -- the 2006 policy - that was the policy in place at the time - allowed for both social workers, nurses, a range of Allied Health Professionals, to be investigating officers or designated officers. That subsequently changed in the 2015 policy. I think -- I think at that particular time and in that particular place, there were some

tensions between nursing and social work, and while I wouldn't want to overplay those, because I do think they were probably very time, place and people-specific, I think there is -- there can occasionally be tensions, which are, you know, about people coming, I think, probably from -- you know from different professional backgrounds or experience or expertise. Again, I would say my experience is that, while there are tensions, they are normally overcome. In this situation, yeah, the tensions seemed to me to be much more of a factor than I think they would normally be. And I suppose, you know, I would say that in terms of, you know, the statements that were made to me, particularly the statement about Moira Mannion, I agree that it was a very surprising statement for me and one that I was very concerned about. I do feel that, I suppose part of my reasoning for not raising it, other than raising it in terms of the general difficulties I had, was very much, I suppose, that I felt in my investigation and my conclusions and recommendations that -- that, you know, that I had an open mind to who might be involved in abuse and who mightn't.

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PROFESSOR MURPHY: Thank you.

319 Q. MS. KILEY: Okay, Ms. Morrison, I want to turn now to look at your conclusions and recommendations and your delivery of those. If we could turn to the Ennis Bundle, please, and page 285. You set out the conclusions, and there are recommendations in part 3 of

16:15

your report, and again, I am not going to ask you to take us through all of those. But if you could just scroll down to the next pages, please. We can see that they commence there and, in fact, there are, in total, 14 conclusions in this section of the report. Not all are accompanied by recommendations, but some of them are. And in terms of the delivery, then, of these and the timescale, I just want to get it clear on how that worked out. 16:16

So I think we can see from the minutes of the strategy meeting on 5th of July, which we need not turn to but just for everyone's note is at page 67, that you presented a draft report to that meeting. Do you recall that, Ms. Morrison, the July 2013? 16:16

A. I don't recall it specifically, but I see that that's what's recorded in the minutes, yes.

320 Q. Okay. And -- well, if we -- let's turn to that minute, then. If we could go to page 70 of this same bundle, please, and just scroll down to the numbered points, please. It is said there -- above this, there is reference to the draft report, there is a review of the care and protection plan, and then there are a number of numbered steps. And at number 5, it says: 16:17

"This is the conclusion of the investigation. The investigation team will finalise the recommendations, including improvements which are already in place and which need to happen."

And then you say:

"A final report will be circulated with a final action plan. This will be reviewed under adult safeguarding procedures when closure of the investigation will be considered."

And I just want to ask you about that reference to "a final action plan". Who was responsible for drafting that? 16:17 16:18

A. I think -- I think it was -- the conclusions and recommendations were, you know, that they needed to be finalised because it was a draft report and that they formed the action plan. 16:18

321 Q. Okay.

A. I don't think it was about a specific additional action plan, other than that, you know, there was an agreement that the protection plan of suspension of two members of staff would remain in place post the closure of the investigation. 16:18

322 Q. So it's not envisaged there that there is some separate document then that forms an action plan; that is, for all intents and purposes, your recommendations, is that right? 16:18

A. Yes, that's right.

323 Q. And then the amended report was presented to the case conference on 28th of October 2013 and the minute there starts at page 71. And in terms of the timing of that

then from July to October, why was there that three-month delay in the draft reporting being presented as final, can you recall?

A. Sorry, between July and October?

324 Q. Yes. 16:19

A. I don't recall. I imagine it was probably just about work pressures and concluding issues, but I don't recall specifically.

325 Q. And do you recall if there were significant amendments to the report between that draft phase and the final 16:19 phase?

A. I don't believe there were. I would also say, you know, the gap between July and October wasn't unusual in terms of, you know, it wasn't just about finalising your report; it was also about allowing time for 16:19 actions to be complete to review the situation some months on as well. So I don't think the October timescale would simply have been about the report; I think it was probably useful to have the few months to sort of -- to see what progress had been made with the 16:20 various recommendations and actions.

326 Q. And you delivered the report to that conference on 28th October '13. If we just scroll out, we can see the list of those present, and you can see that there is someone present from the Northern Trust, the East 16:20 Belfast Community Learning Disability Team, Mr. Veitch is there, Ms. Mannion is there, someone from the RQIA, Ms. Rafferty, representatives from the PSNI, representatives from the South Eastern Trust and your

co-authors. Can you describe how your report was received by that meeting?

A. I mean, there were not -- there weren't any challenges to -- you know, detailed challenges to the -- you know, to a large part of the content of the report. There was -- you know, having reviewed the minute, there was some continued challenge, from John Veitch primarily, in and around the question of whether or not there had been institutional abuse, and Moira Mannion does also comment on those aspects as well. 16:21

327 Q. I want to ask you about that. If we could just scroll down later to this. Keep going down to the next page, please, keep scrolling down, keep going just to the bottom, and if we just pause there. Under 14, you can see there: 16:22

"Mr. Veitch acknowledged the very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse..." 16:22

And we can see there's a comment from Ms. Mannion there. If you just scroll down so we can see the later text on that, is that the conversation to which you are referring? 16:22

A. Yes, it is.

328 Q. Whenever the meeting there is discussing institutional abuse, and we can see that Mr. Veitch appears to have used the reference, and Ms. Mannion, what did you

understand "institutional abuse" to relate to? Was it relating to the Ennis Ward in this context or to the wider hospital site?

A. In this context, it's referring -- it's referring to Ennis Ward. I should say that I always had some reluctance about the term "institutional abuse". It wasn't defined within the 2006 policy; it was mentioned as a category of abuse, but not defined. And my understanding of the term at that point would have been that it referred to, I suppose, you know, systems, practices, routines within an institution, that either, I suppose, created, you know, a context in which abuse could happen or actually were abusive themselves in those routines or practices. I think other people used it more broadly to say it was abuse which happened in an institution, so I personally at that point was not particularly keen on using the term, because I do -- I was aware that there were different understandings. 16:23 16:23 16:24

329 Q. And there wasn't an agreed understanding then within the meeting about what that term meant, is that right? 16:24

A. No, not within the policy, and just I would have been aware of that in practice, so -- however, if we understand "institutional abuse" to mean abuse that happens in an institution or, you know, perhaps that is widespread or endemic, I'm very clear that I was considering that from the outset, and also that when John Veitch referred to "institutional abuse", he was referring to that sort of widespread part of the culture, possibility of endemic abuse, so -- but 16:24

specifically that reference is solely referring to Ennis Ward.

330 Q. Okay.

DR. MAXWELL: And what you say is that whilst you couldn't definitively say there was institutional abuse, nor could you definitively say that there was; it was inconclusive? 16:25

A. Yeah, I suppose the outcome of the investigation had been that we believed we could really only be confident that there was a weight of evidence about two particular staff members, and I suppose I felt that -- I should say that's not particularly unusual in Adult Safeguarding Investigations, about, perhaps, having wider concerns or suspicions but not having been able to necessarily, I suppose, prove a particular allegation, and that was unfortunately the case where we were in Ennis. I felt that I didn't have enough information or evidence to conclusively prove that the abuse had been more widespread. However, I felt there was enough evidence to justify a suspicion about that and certainly not a sort of an outcome that said no, we had not found institutional abuse. 16:25 16:26 16:26

CHAIRPERSON: Could I just understand, I understand what you meant by "institutional abuse" because you were focusing on Ennis Ward and you didn't find institutional abuse, but you were not prepared to totally exclude it? 16:26

A. Yes.

CHAIRPERSON: But Mr. Veitch, you think, was looking at

institutional abuse in a wider context, a hospital-wide context?

A. No, no, I think he was referring to Ennis Ward as well.

CHAIRPERSON: Right, okay. Did you confirm that with him? Did you actually have that conversation? 16:27

A. I can't recall, but -- but I'm -- yeah, I don't -- I don't believe there was a discussion about the judgment on institutional abuse referring to the wider hospital. All of this discussion was focused on Ennis Ward and what the investigation had found or hadn't found. 16:27

CHAIRPERSON: Thank you.

331 Q. MS. KILEY: In your statement at paragraph 97, you say that:

"John Veitch put considerable pressure on me to state that I had found no evidence of institutional abuse." 16:28

When do you say that that pressure was put on you?

A. It was -- it was put on me in meetings and I also recall a couple of individual discussions, possibly in one-to-one meetings, where, again, John said that he believed there had been no evidence found of institutional abuse, and I continued to make it clear that I felt that that was -- you know, that absence of institutional abuse was not a judgment that I felt able 16:28 to make and that I felt suspicion remained, and I appreciate that's an unsatisfactory position, but it was all that I felt that I -- you know, I didn't feel I could go beyond that, but I did very strongly feel that

to say that the investigation had not found institutional abuse and there was no evidence of it, was equally -- I would have been very concerned about that because I think that would have given an indication that the investigation had conclusively not found institutional abuse, and I didn't feel able to say that.

332 Q. And, in fact, while we see this mentioned in the strategy meeting minutes, your report itself doesn't actually reference institutional abuse, isn't that right? 16:29

A. It doesn't, but I suppose what I would say is, the report -- I wouldn't have intended that the report was the only record of the discussions and decisions that were made throughout the course of the investigation, and it was discussed, it was discussed in the various meetings. Also, my report does say that, it does make reference to, had there been wider concerns about abuse, it also refers to not being able to prove some of the allegations and makes recommendations that are about -- about, very much, putting in place protective factors against the possibility of wider-spread abuse. So, while the term wasn't used, I believe there are aspects of the report that refer to the fact that the possibility was considered and that the -- you know, that the investigation was making recommendations that were designed to be protective about it as well. 16:29 16:30 16:30 16:30

333 Q. Even where the possibility was considered, just to be clear, it was considered only in respect of Ennis Ward,

isn't that right, it wasn't considered in respect of potential issues in the wider Muckamore site?

A. Largely, yes. There was, you know, certainly from my point of view in terms of safeguarding investigation, that there was nothing leading me to other wards. There were one or two of the recommendations where we had, I suppose, considered the wider position in the hospital and, you know, some of the recommendations, I think, about safeguarding, training and environmental concerns, were certainly -- we recommended that they were considered for all of the hospital, not just Ennis Ward. 16:31 16:31

CHAIRPERSON: Can I just ask this to try and bring this to some sort of conclusion. If you had been set a legal test - a legal test don't always help - but if you had been set a legal test, then, on the balance of probabilities - in other words, if one thing is more likely than another - you wouldn't have found institutional abuse, is that fair? 16:32

A. I find that question difficult to answer because it does involve a certainty that I'm not sure that we -- I think I would say, on the balance of probabilities, I was suspicious of more widespread abuse. 16:32

CHAIRPERSON: All right. That's not quite the test, but, okay, I won't press you. 16:32

A. No, I appreciate that.

DR. MAXWELL: Can I ask, so your suspicions were based on the Bohill staff reporting it and you felt that they were reporting they had seen things quite openly and

that's what had raised your concerns. Were the -- did the Bohill staff make statements and sign them? Because I've only seen summaries of what they said. Were they interviewed by the investigating officers who made notes of the interviews? 16:33

A. Yes, there was a -- now, I haven't seen these, you know, since the time of the investigation, but there was an individual interview record for every single member of staff that was interviewed.

DR. MAXWELL: And did that member of staff see that record and sign it to say "yes, I agree that's what I said"? 16:33

A. I'm afraid I can't recall whether they did or didn't. It would be -- you know the interview record should be there, but I can't remember. 16:33

DR. MAXWELL: So, coming back to this point about the legal thing, you would expect a level of evidence and you would expect the reporter to have confirmed that that's what they were conveying, and you're not sure whether they did that? 16:34

A. Well, I don't know if they signed the record, but, you know, the interview, I suppose -- you know, I think the conclusions that were being drawn or the information that had they had given was carefully considered and checked: "Are you saying this? Can you describe that a little bit further?" So there would have been a lot of process in the interview that was about clarifying what the person was saying. There were also repeat interviews with quite a number of the Bohill staff as 16:34

well, and, while they focused on staff identification, I would have also have seen them as a sort of -- that there would have been a confirmatory process as part of those repeat interviews as well.

DR. MAXWELL: I'm just thinking about this whole issue that they didn't come back, they didn't engage with the investigation, the disciplinary investigation. I mean, surely if you take a statement that somebody has confirmed is accurate, that could have been used by the disciplinary investigation, if somebody had signed it to say "yes, that is my statement, that is my record"? 16:34 16:35

A. I would agree, I think it should have been accepted as evidence in the disciplinary investigation --

DR. MAXWELL: Well, that was a different question. The question was, did they sign that it was accurate and then it could have been used in the disciplinary? 16:35

A. I don't know that I would have seen the lack of a signature as meaning that it couldn't have been used in the disciplinary. I mean, I would have felt that the recording of the interview, you know, as carried out by the investigating officers, you know, was the evidence that that was what had been said. 16:35

DR. MAXWELL: Except the disciplinary is covered by law, employment law, and so they would have had legal standards about which evidence they could use. 16:36

A. And, you know, I think that's what ultimately occurred, in that the disciplinary investigation didn't feel that they could rely on the -- but I don't know whether that was about the lack of a signature or otherwise. And as

I say, I can't recall whether or not people were asked to sign the interview record.

CHAIRPERSON: Thank you.

334 Q. MS. KILEY: You have, in your statement, referred to the disciplinary and finding out that there was a disciplinary process being undertaken, and you've touched on some of that in answer to Dr. Maxwell, but you were concerned about that, I think it's fair to say, how that process was being undertaken, is that right? 16:36

A. Yes.

335 Q. And you were concerned about the weight in which that process was attaching to the conclusions and findings of your report, isn't that right?

A. Yes. 16:37

336 Q. And we touched a little bit on the interview process, but aside from whether or not staff got to sign records of their interviews, I think there is another issue, and Brenda Creaney raised this in her statement, she gives an example of one staff member who was interviewed for the disciplinary investigation but not for the safeguarding investigation. Were you aware that the disciplinary investigation and the safeguarding investigation were interviewing different members of staff? 16:37

A. No, I only became aware of the content of the disciplinary investigation when the bundle for witnesses was made available for me. I hadn't seen it up until that point.

337 Q. Okay. Do you have a view on whether it would have been possible to have a single set of interviews of staff, both Bohill staff and Trust staff, that could be used for both the purpose of the Adult Safeguarding Investigation and the disciplinary investigation? 16:38

A. At the time, you know, the policy, I supported two separate processes, though, again, I would have expected, you know, the disciplinary process to be informed by the safeguarding process, but I can understand why the disciplinary investigation team 16:38 wanted to, I suppose, seek their own evidence and to take those statements again. I think it was certainly one of the aspects of this when I became aware that the case hadn't proceeded to any disciplinary action that, you know, I did raise my concern about this. Since 16:38 then, I think there had been a number of attempts to, I suppose, to join up, you know, disciplinary and safeguarding investigation processes in a more satisfactory manner. My understanding is, it still does present some difficulties. I'm also conscious 16:39 that we did, you know -- certainly, you know, we did have HR present at a number of the strategy meetings, particularly earlier on, so, you know, we were conscious of that interplay and interface from the beginning. And I have to say, I suppose I'm -- I 16:39 certainly, at that point, was not sufficiently well-informed about disciplinary processes to know exactly what was permitted and not permitted. My own expectation, and possibly wrongly, was that the

evidence gathered during the safeguarding investigation would have -- you know, would have been able to have been used and relied upon in a disciplinary investigation.

338 Q. Okay. I want to just, finally then, move on to the Leadership and Governance Review and, as you know, that was a review that was commissioned by the Department of Health to review the leadership and governance arrangements in the Belfast Trust between 2012 and 2017 and -- 16:40

CHAIRPERSON: Sorry, are you okay to keep going, or do you want a short break?

MS. KILEY: I don't have very much more, if it does help factor that in.

CHAIRPERSON: I am just watching the witness. 16:40

A. No, I'm okay.

CHAIRPERSON: Okay.

339 Q. MS. KILEY: And are you aware then, Ms. Morrison, that the Leadership and Governance Review did look back at the Ennis investigation as part of that review? 16:40

A. Yes.

340 Q. And one of the things that you referred to earlier was this issue about whether Ennis should have been dealt with as an SAI, and I said I would come back to that, and are you aware that the Leadership and Governance Review concluded that there was merit in Ennis being dealt with as an SAI also? 16:41

A. Yes.

341 Q. And in terms of your involvement and role at the time,

did you have any involvement in the decision not to submit an SAI in respect of the Ennis safeguarding issues at the time?

A. I don't -- I don't recall being involved at all, certainly in any discussions at the initial part of, you know, the investigation and the allegations having come to light, I don't remember any -- any involvement of myself, nor would I have particularly expected to have been involved in those decisions. Decisions about incident reporting and what level, you know, certainly would have sat really with the management of the facility rather than sort of through the designated officer line, and certainly the sort of post-investigation allegation -- or consideration of an SAI, I am very confident that I wasn't involved in that, because, on seeing some of the records now, you know, I feel that the outcome of the investigation appeared to me to be misrepresented and, had I been aware of that, I feel confident that I would have challenged it at the time. 16:41 16:42 16:42 16:42

342 Q. But you weren't aware at the time, is that what you're saying?

A. I wasn't aware about -- I wasn't aware of the position that was being reported, largely, I think, to the Health and Social Care Board, that the investigation had not found institutional abuse and, indeed, had found evidence of good practice, or similar comments, I wasn't aware of those, or, indeed, the consideration of whether or not there should have been an SAI at all. 16:42

343 Q. Okay. And in terms then of the Leadership and Governance Review, have you seen the findings that it makes in respect of the Ennis investigation?

A. Yes.

344 Q. And I won't take you through all of them, but one of the things that I think it's fair to say is that it was critical of the investigation and suggested that the investigation might have had too wide a remit. Do you have any response to that? 16:43

A. I suppose I was surprised by that comment, in that, you know, it seemed to me the Leadership and Governance Review was critical, that -- you know, as it perceived that institutional abuse was not considered, but then equally to say that the investigation is too wide a remit - to me, that appeared contradictory. And I feel that I was justified in having a fairly wide remit because I needed to consider, you know, the practice on the Ennis Ward as a whole. I note that the Leadership and Governance Review were particularly critical of my involvement with -- about the staffing in Ennis Ward. I feel that my involvement was about the protection, planning, which it did involve additional monitoring staff. I would also say, you know, that I was very much reliant on the reports of the monitoring staff about, you know, what they were saying was the practice, what skills, what expertise there were -- there was on Ennis Ward and, in many senses, the monitoring staff were there at my instigation. There were also some -- there were also some concerns raised, 16:43 16:44 16:44 16:44

certainly in the early part, that the agreed protection plan was not in place and, you know, that was a concern certainly RQIA had raised as well at the time. So, I felt that my involvement was justified and necessary because it was about the protection plan and also what the monitoring -- you know, how the monitoring reports were informing the consideration of what had happened. So, yeah, I think -- you know, I suppose as I said at the beginning, I was surprised to see -- to see that criticism of the sort of, the wider consideration that I carried out during the course of the investigation. 16:45 16:45

345 Q. And you referred there, in answer to the Leadership and Governance Review's finding, that Ennis was an example of institutional abuse and that a wider investigation ought to have occurred at that time. Do you accept that now, on reflection? 16:46

A. I feel that that was what was carried out, that, you know, that -- you know, effectively the investigation it carried out and the considerations we had, were, in effect, an investigation into institutional abuse. In terms of the conclusions, I suppose, as I have explained earlier, I felt that the -- you know, I felt that being able to prove allegations about just two members of staff, probably was not sufficient to say there was definitely institutional abuse. I felt that the only conclusion that I could make is how I have described it earlier. 16:46 16:47

346 Q. Yes. And just finally then, in fairness to you, at paragraph 116 onward of your second statement, you do

refer to one of the authors of the Leadership and Governance Review, David Bingham, and how he conducted a separate investigation and produced separate reports on the concerns that you raised about the challenges that you encountered, particularly with other staff during the Ennis investigation, and the Panel and Core Participants have all that information and you have explained your concerns about that. You go on to say that you feel that you felt very unfairly treated in that process. And again, the reasons that you say that you were unfairly treated are set out in this part of your statement and also in Exhibits 3 and 4 to your statement, which set out your views on the Leadership and Governance Review and also which contain the grievance which you submitted to the Belfast Trust on this issue, so all of that is in evidence and I don't want to ask you to go over it, Ms. Morrison, but I just want to ask you, you say that you felt that you were treated unfairly, but do you say that that unfair treatment by the author of the Leadership and Governance Review and by the Belfast Trust, had an impact on the overall findings of the Leadership and Governance Review about Ennis?

16:47 16:48 16:48 16:48

A. It's not a point I have considered before, but, I think -- I think the Leadership and Governance Review, in many senses what they recorded on Ennis I would have had, you know, no argument with. However, I don't believe that the Leadership and Governance Review, or David Bingham separately, sought any corroboration of

16:49

what I had said in relation to the behaviours I experienced during the investigation and I'm also puzzled by a reading of the minutes where David Bingham, you know, subsequently said there was no evidence in any of the records about the points that I made. So while those things come out more clearly in the separate accounts that David Bingham made to the Belfast Trust, I think there is an element of that also in the Leadership and Governance Review, where corroboration and evidence that would, I feel, support my account of what occurred, do not seem to have been given particular weight or possibly explored at all, although I don't know exactly what was explored and, indeed, what other witnesses or staff may have said. 16:49 16:50

MS. KILEY: Ms. Morrison, thank you, those are all the questions that I have for you. The Panel may have additional questions. 16:50

CHAIRPERSON: No. Can I thank you. We've asked all the questions as we have gone along. You have had a long and quite testing afternoon, so can I thank you very much indeed for coming along to give your evidence and to help the Inquiry, so thank you, and you can go with the Secretary to the Inquiry. 16:51

THE WITNESS THEN WITHDREW 16:51

CHAIRPERSON: We will next sit on Monday, the 17th, at 10 a.m.

Can I just mention, I am aware that it is the funeral of Geraldine O'Hagan that morning, and if anybody from this Inquiry wishes to go and attend that, it won't be considered in anyway discourteous to this Inquiry not to be here rather than there, but otherwise I wish you a good weekend, when it eventually comes, and we will see you on Monday next. Thank you. 16:51

THE INQUIRY ADJOURNED UNTIL MONDAY, 17TH JUNE 2024, AT 10 A.M. 16:52