MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 15TH MAY 2023 - DAY 41

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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1 THE INQUIRY RESUMED at 10:00 A.M. ON MONDAY, 15TH
2 MAY 2023 AS FOLLOWS:
3
4 CHAIRPERSON: Good morning, Mr. McEvoy.
5 MR. MCEVOY: Good morning, Chair, morning Panel. Your 10:00
6 witness today is Miriam Somerville who will be giving
7 evidence in relation to module 6A, which was the
8 Eastern Health and Social Services Board and North and
9 West Belfast Health and Social Services Trust review of
10 policies and procedures to safeguard children and 10:01
11 vulnerable adults in Muckamore Abbey. It will be known
12 as the Review.
13
14 MIRIAM SOMERVILLE, HAVING BEEN AFFIRMED, WAS EXAMINED
15 BY MR. McEVOY AS FOLLOWS: 10:02
16
17 CHAIRPERSON: Good morning and welcome to the Inquiry.
18 We met very briefly outside. I'll hand you over to
19 Mr. McEvoy. Just to say again, if at any stage you
20 want a break, just let me know and we'll stop 10:02
21 straightaway.
22 A. Thank you.
23 MR. MCEVOY: Good morning, Ms. Somerville. We met
24 briefly also earlier this morning.
25 A. We did. 10:02
26 1 Q. My name is Mark McEvoy and I am one of the Inquiry
27 counsel. Ms. Somerville, you should hopefully have
28 before you a very brief statement of a page and a
29 little bit dated the 27th of April '23. Do you have

1 that before you?
2 A. I don't have that in front of me.
3 2 Q. I'll make sure that that's before you.
4 A. Thank you. Yes.
5 3 Q. A very brief statement of a page and a bit. On the 10:03
6 second page overleaf --
7 CHAIRPERSON: Sorry, Mr. McEvoy, just one second. Just
8 give us one second, Caseview isn't working for one of
9 us.
10 4 Q. MR. MCEVOY: At the top of the second page is a 10:03
11 signature?
12 A. Yep.
13 5 Q. Is that your signature?
14 A. That's my signature.
15 6 Q. And then we can see overleaf there's a very short page 10:04
16 which says List of Exhibits, and the exhibit then is
17 titled Eastern Health and Social Services Board and
18 North and West Belfast Health and Social Services Trust
19 Review of Policies and Procedures to Safeguard Children
20 and Vulnerable Adults in Muckamore Abbey Hospital 10:04
21 completed in December 2005. So, a very short statement
22 and then the exhibit, being the Review.
23
24 Ms. Somerville, do you wish then to adopt that
25 statement and the exhibit as your evidence? 10:04
26 A. Yes, I will.
27 7 Q. So as you know, I am going to ask you some questions
28 about the content of the Review and how it was prepared
29 and so on. You have indicated in your statement that

1 you were the chair of this review?
2 A. Yes.
3 8 Q. Can you tell us who else was on the review with you and
4 what their roles were?
5 A. Yes. There's a list towards the end of the report of 10:04
6 the people who were on the review panel. It was a
7 mixture of people from North and West Belfast Trust,
8 some of whom were in the hospital, some of whom
9 weren't, were in the community side of the Trust. And
10 people from the Eastern Board. 10:05
11 9 Q. Okay. And that can be found, just for everyone's
12 reference, at page 112 being the Inquiry reference
13 number, and then it's page 81. That's appendix 10, I
14 think, of the Review?
15 A. Yep. 10:05
16 10 Q. So yourself as chair. That was your role at the time
17 then, Director of Hospital and Community Learning
18 Disability Services?
19 A. That's correct, yes.
20 11 Q. And that was in the North and West Belfast Trust; is 10:05
21 that right?
22 A. Yes, that's correct.
23 12 Q. And then Mrs. Eilish Steele, who was the Assistant
24 Director of Hospital Services?
25 A. Yes. 10:06
26 13 Q. Do you recall where she was based?
27 A. She was based at Muckamore.
28 14 Q. And then Mrs. Mairead Mitchell, Assistant Director of
29 Service Improvement and Governance. Can you recall

1 where she was based?
2 A. She was based partly at Muckamore, probably half-time
3 at Muckamore, and half-time in community services.
4 15 Q. Thank you. Then Mrs. Pauline McDonald, Operations
5 Manager? 10:06
6 A. Community services.
7 16 Q. Okay.
8 A. Community learning disability services, I should say.
9 17 Q. Is that again with the old --
10 A. Within North and West. 10:06
11 18 Q. Mr. Aidan Murray, then Assistant Director Learning
12 Disability; is that the Eastern Health and Social
13 Services Board?
14 A. It is, yes.
15 19 Q. Mrs. Deirdre Webb, Assistant Director of Nursing then 10:06
16 within the same board?
17 A. Yep.
18 20 Q. Ms. Ann McGarry, senior social worker. Do you recall
19 where Ms. McGarry was based?
20 A. At Muckamore. 10:06
21 21 Q. Then Mr. Tommy Boyle, principal social worker
22 community, North and West Belfast Health and Social
23 Services Trust then?
24 A. Yes.
25 22 Q. And then there's an indication of the result. So, a 10:07
26 paediatrician who was co-opted into the group for
27 review of notes that you mentioned?
28 A. Yes.
29 23 Q. Okay. So it's been intimated, I suppose, at the very

1 start of the Review that this was a joint review
2 carried out by both the Trust and the Board. Can you
3 tell the Inquiry what it was that prompted the carrying
4 out of the Review?
5 A. Yep. The Review was carried out because a man who had 10:07
6 been a patient at Muckamore during the time that the
7 Eastern Board was responsible for running the hospital,
8 and that would have been at some point between 1973 and
9 '94 - I think those are the dates - he had come forward
10 to the Eastern Board and told the Eastern Board that he 10:07
11 had been abused by another patient at Muckamore. The
12 Eastern Board, in a desire to do right by him, listened
13 to him and paid some compensation to this patient,
14 ex-patient. So, from that, the Eastern Board wanted to
15 make sure that policies and procedures were working, 10:08
16 were in place and were working at the hospital, and so
17 that was why the Review was commissioned. It was, I
18 suppose if I look at it now and reading it again, I
19 would see it more as an internal audit process to check
20 that policies and procedures are in place and are 10:08
21 working.
22 24 Q. Okay. So you're saying if you were looking at it
23 again, is that with 2023 eyes?
24 A. Absolutely, yes.
25 25 Q. And I suppose one might term it an internal audit 10:08
26 because you were the director?
27 A. Yes.
28 26 Q. And you were looking at the services that ultimately
29 you were responsible for; would that be fair to say?

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1 A. To a point, but because the -- and that is absolutely
2 correct what you're saying. It's important to note the
3 patient who had come forward, it was many years since
4 this had happened.
5 27 Q. But this wasn't an historical review; isn't that right? 10:09
6 A. No, it was a here and now review.
7 28 Q. The terms of reference that you set out then at 1.1 are
8 described as agreed by the group for the Review. Did
9 you design your own terms of reference; is that what
10 that means? 10:09
11 A. We were given terms of reference from what was, to my
12 memory, it was called a strategic board which had been
13 set up between North and West and the Eastern health
14 and Social Services Board to make sure the issue had
15 been dealt with properly, because there were other 10:10
16 actions. This was just one action that emerged from
17 the particular issue.
18 29 Q. When it was commissioned, if I can use that phrase, do
19 you recall there being any discussion among those who
20 asked you to conduct the Review about whether or not 10:10
21 whatever you produced was going to be scrutinised
22 externally?
23 A. It was going to be scrutinised by the Eastern Board. I
24 don't think it was going to be scrutinised anywhere
25 else. I would imagine it would have been shared 10:10
26 probably with the Department of Health but I'm not
27 certain about that.
28 30 Q. Do you know whether it was in the end?
29 A. I don't, I don't. That would have been for the Eastern

1 Board to share, so I don't know the answer to that.
2 31 Q. All right. Then at 1.2 you describe the process of the
3 Review or what might otherwise be called, I suppose, a
4 methodology. Officers involved in the Review, are
5 those the members of the panel or was anybody else 10:11
6 engaged?
7 A. No, those were the members of the panel.
8 32 Q. Examined the systems and the relevant policies and
9 procedures. They also read the case notes of a
10 selection of current patients to ascertain the level to 10:11
11 which child protection and vulnerable adults policies
12 and procedures are being implemented.
13
14 So that the Inquiry understands that a bit better, was
15 this essentially a review of paperwork? 10:11
16 A. It was.
17 33 Q. Essentially you were looking at policies and
18 procedures?
19 A. Yes.
20 34 Q. And therefore there were no interviews with staff or 10:11
21 families?
22 A. No.
23 35 Q. It's a long time ago, I know, but can you offer any
24 explanation as to why it was just done on the papers,
25 as it were, and you didn't speak to staff or families? 10:12
26 A. I think at the time it was considered adequate to look
27 at the paperwork, to note that there were policies in
28 place and also to look at how do you know those
29 policies are actually working and being used. There

1 was just no brief given to this review panel from the
2 strategic group about involving families or patients at
3 this stage.
4 36 Q. Okay. That's may be something we'll come back to as we
5 look further at the review. 10:12
6 A. Yes.
7 37 Q. Then at 1.3 you give a description of a sampling
8 framework?
9 A. Mhm-mhm.
10 38 Q. So, it was agreed that the files of all of the Eastern 10:13
11 Board, if I can just for shorthand call it that,
12 children and young people aged under 19 years who had
13 been treated on an adult ward during 2005 should be
14 reviewed.
15 10:13
16 "There were seven such children and young people, four
17 female aged 14 to 17 years and three male aged 15 years
18 and 16 years. Also, the files of a 40% sample of all
19 children admitted to Conicar Ward were reviewed. There
20 were six children in the sample. All were boys aged 10:13
21 nine to 16 years".
22
23 Then: "The files of all Eastern Board patients who had
24 been involved in the vulnerable adults procedures
25 during 2004 and 2005 were also reviewed. The files of 10:13
26 nine people involved in eight vulnerable adults
27 investigations were reviewed. These involved seven men
28 and two women".
29

1 You then indicate that "appropriate social work and
2 nursing professionals from outside the hospital
3 reviewed these files. A consultant paediatrician with
4 responsibility for child protection within the Trust
5 reviewed five files. Three of these are children in 10:14
6 adult wards and two are children in Conicar".
7
8 I just read that into the record so that it gives you
9 an opportunity just to reflect on it and also to be
10 able to help us with how you arrived at that sampling 10:14
11 framework.
12 A. Okay. The sample really -- this review was expected to
13 be done quite quickly and to be manageable, so we were
14 really deciding, well, how would we look at knowing
15 that the policies and procedures we have in place are 10:14
16 actually working. So, the way to do that is to look at
17 what has happened over the last year and that's -- from
18 memory, I think that's why we took that approach.
19 39 Q. There's then a section entitled "Context", which is
20 Section 2. I won't read this out in detail but there 10:15
21 are a number of themes that one can glean from Section
22 2. First, paragraph 2.1 begins by saying:
23
24 "The Review must be set in the context of a hospital
25 for people with learning disabilities which is in a 10:15
26 state of transition".
27
28 Then just indicating the patient base from across the
29 province. You indicate then in the next paragraph that

1 there has been a history of the hospital as one for
2 dealing with patients requiring assistance because of
3 forensic requirements or offending behaviour. There is
4 an indication at 2.2 that there is a redevelopment
5 programme, and reference to a new unit. 10:16
6
7 As far as the Inquiry understands it, there was a
8 discussion, or certainly a long term plan, from around
9 the late 1990s to resettle patients?
10 A. Yeah. 10:16
11 40 Q. Can you help us understand why there is a discussion
12 about a new unit at this point in time?
13 A. I came to the hospital in 2002, and North and West
14 Belfast had submitted a business plan to the Department
15 for the development of an assessment and treatment 10:16
16 unit. There would be a regional facility for people
17 with learning disabilities, and a treatment unit for
18 people with forensic needs. That business plan was
19 approved I think in early 2003, and the plan was that
20 that was for 58 beds in total and the rest of the 10:17
21 hospital would be closed; the resettlement wards would
22 be closed.
23 41 Q. So it would remain as an assessment and treatment
24 facility --
25 A. It would, yes. 10:17
26 42 Q. -- for forensic patients?
27 A. There would be two elements to the hospital. There
28 were to be, if I remember correctly, 35 beds for
29 assessment and treatment of people who didn't have

1 forensic needs, and 23 beds for people with forensic
2 needs.
3 43 Q. Can you just help me there. When did you say that that
4 business case was produced and put forward?
5 A. When I came in October 2002, that had already been 10:17
6 submitted to the Department, and I think it was
7 approved early 2003.
8 44 Q. All right. Then, the next paragraph 23 deals with the
9 children's ward, Conicar.
10 10:18
11 "A business case was developed by the Trust in 1995 to
12 relocate this to a more appropriate community location.
13 This business case was not approved at the time, and a
14 further business case is in the process of being
15 submitted to the Boards and the Department". 10:18
16
17 You note that 15 children at the time of your review
18 were still in Conicar. Do you know -- going back, I
19 know it's before the Inquiry's terms of reference but
20 it might be helpful just to know why the 1995 business 10:18
21 case was refused?
22 A. I have no knowledge of that, I'm sorry.
23 45 Q. Do you know what happened with the one that was under
24 review at this time?
25 A. Yes. It was successful and the new children's 10:18
26 assessment and treatment unit called Iveagh opened in
27 Belfast, but I think it didn't open until 2010.
28 46 Q. It was a bit after that, I think.
29 A. Was it? Yeah.

1 47 Q. But why do you think it took - I mean even on that
2 analysis - why do you think it took from 2005 and
3 before until at least 2010 before it was --
4 A. I think that's a question for decision-makers on
5 business cases. North and West was pushing this very 10:19
6 hard at the time because North and West believed that
7 it wasn't appropriate for the children's ward to remain
8 on the Muckamore site. But, you know, I don't know the
9 answer to what you're asking.
10 48 Q. What was the view of the review panel about that? 10:19
11 A. The view of the review panel, I think you'll see it
12 several times in the report, that it was difficult to
13 keep children safe on the hospital site. We took that
14 very seriously. You'll see in the report about
15 one-to-one supervision, about children being admitted 10:20
16 to adult wards, which we believed was not appropriate.
17 49 Q. Indeed, you say in the next paragraph that:
18
19 "Both the Trust and the Board remain concerned that
20 young people continue to be admitted to adult wards, 10:20
21 while noting that there is no specific provision in
22 Northern Ireland for young people with learning
23 disabilities".
24
25 Indeed then you note at 2.5, top of the next page: 10:20
26
27 "All patients in the hospital are vulnerable and most
28 exhibit varying degrees of challenging behaviour".
29

1 I suppose it would be almost an accepted understanding
2 broadly now that challenging behaviour starts to
3 manifest and becomes most problematic during
4 adolescence. Would you accept that premise?
5 A. Absolutely, yes. 10:21
6 50 Q. And bearing that in mind, how come specialist
7 adolescent provision wasn't further up the priority
8 list, and why does that not find its way into the
9 review?
10 A. Again, that's not a question that I can answer. What I 10:21
11 can tell you is that North and West presented this
12 argument to the Boards and the Department on many
13 occasions. North and West was doing everything it
14 could to raise the issue of the inappropriateness of
15 children and adolescents continuing to be admitted on 10:21
16 the site.
17 51 Q. I suppose although you say it's not a question you can
18 answer, the point of this review was to qualitatively
19 assess safeguarding?
20 A. Yeah. 10:21
21 52 Q. And presumably having any circumstance where there is a
22 mix of adults and adolescence together and a lack of
23 specialist adolescent provision, is, on its face, a
24 safeguarding issue?
25 A. Yes. 10:22
26 53 Q. You would accept that?
27 A. Oh, yes. Yes.
28 54 Q. Okay. 2.6 then, nonetheless you say that,
29

1 "Muckamore is recognised as a centre of good practice
2 in the field of learning disabilities".
3
4 What allowed you to offer that opinion in the Review?
5 A. I think what contributes to that are some of the things 10:22
6 listed at 2.7. But we were at the time considered to
7 be, as it says there in 2.6, a centre for training
8 learning disability nurses, psychiatry, and there were
9 a number of service improvement projects or quality
10 awards going on in the hospital and that the hospital 10:22
11 had been awarded.
12 55 Q. At 2.7, as you say, there are a number of positives
13 noted under the various bullet points that one sees
14 there. A Charter Mark, the third in succession in the
15 same year that this review was prepared; the hospital's 10:23
16 designated as a Good Practice Site in the same year as
17 part of the Public Service Reform Unit; a service
18 improvement project undertaken at the hospital in the
19 same year leading to a selection as the Northern
20 Ireland entry in the International Quality Healthcare 10:23
21 Forum; a selection by the Home Office as a pilot site
22 for an adapted sex offenders treatment programme; the
23 development of a multidisciplinary quality audit tool
24 specifically for learning disability services, which,
25 as you say, may shortly be copyrighted and shared 10:23
26 across the province.
27
28 How are those evidence of a strong record of reform and
29 modernisation when you have indicated the difficulties

1 in this context section that we are facing at
2 Muckamore?
3 A. I wouldn't ever want to be complacent about it because
4 of course there continued to be challenges and
5 considerable challenges, especially around children and 10:24
6 adolescents, but that doesn't mean that good work
7 wasn't happening elsewhere in the hospital, and these
8 reflect that.
9 56 Q. Just taking that fourth bullet point in relation to the
10 Adapted Sex Offenders Treatment Programme, would the 10:24
11 Home Office have been aware of the challenges facing
12 the provision of forensic services in the hospital when
13 that decision to select the hospital was taken?
14 A. Yes, they would. Yes.
15 57 Q. Okay. The next section then of the Review deals with 10:24
16 monitoring mechanisms, child protection procedures.
17 This is Section 3. You set out then by saying:
18
19 "The hospital operates a procedure which complies with
20 and complements the core policies and procedures set 10:25
21 out in Cooperating to Safeguard Children from May 2003,
22 and the Regional Child Protection Policy and Procedures
23 from May 2005. The regional policy and procedures make
24 particular reference to child protection in hospital
25 settings and to the needs of children with 10:25
26 disabilities. The hospital procedure has been drafted
27 with these in mind".
28
29 Now, is that the suite of sort of policies and

1 procedures you were examining in the course of this
2 review?
3 A. They were part of it, yes.
4 58 Q. This is something maybe I'll come back to in the course
5 of your evidence. I suppose adopting this desktop 10:25
6 review, this panel of highly qualified and senior
7 people which you chaired can examine a policy and say,
8 well, in terms this looks like it ticks all the boxes
9 and meets all the requirements, but without going and
10 speaking to, interviewing, staff and indeed families, 10:26
11 how was it possible to come to a view that these
12 procedures were understood by those who needed to
13 understand them in the hospital?
14 A. I would say to you that that's where the review of the
15 files, the clinical notes of patients in the hospital 10:26
16 came in, because what we were looking for in reviewing
17 the files was evidence that the policies and procedures
18 were actually being used in real situations on wards
19 and other departments.
20 59 Q. What about situations where it might not have been? 10:27
21 How would you have gauged that by conducting a desktop
22 type review?
23 A. If we had -- in the files that were reviewed, if
24 something had been noted that appeared to not have been
25 dealt with properly or according to the policy, and I'm 10:27
26 trying to think of an example of that - I can't think
27 of something off the top of my head - but if we had
28 found that, that would have come back either to this
29 panel to discuss, but also to probably the Assistant

1 Director of Hospital Services to take some action.
2 60 Q. So, you will have expected the papers to have revealed
3 that? The files, I should say, the files to have
4 revealed that?
5 A. We would. Yes, yes. 10:27
6 61 Q. Having examined the files, would it have been prudent
7 just to go a bit further and test the understanding on
8 a ward level of nursing staff, and indeed of families
9 as well?
10 A. When I look at it now, yes of course that would have 10:28
11 been helpful. But I think, as I said earlier, this was
12 intended to be a speedy review to provide some
13 assurance to the Board and the Trust of what was
14 happening in the hospital.
15 62 Q. Just on that particular point, it reported in December 10:28
16 '05. Can you recall when it commenced?
17 A. I honestly can't. No, I'm sorry.
18 63 Q. In terms of assurance to senior people at the Board and
19 the Trust who asked you to conduct it, was there an
20 understanding that assurance also needed to be provided 10:28
21 not only to people at senior levels but also to staff
22 and patients and their loved ones?
23 A. At the time that this review was done, it was the
24 Eastern Board and the Trust who were aware of why this
25 was happening. So, there hadn't been a particular 10:29
26 difficulty that staff, families and patients would have
27 been aware of that we needed to communicate about. But
28 after this, there was certainly communication,
29 certainly with staff and, from memory, and it is going

1 back a long time, I think there was discussion with the
2 Society of Parents and Friends about this review.
3 64 Q. You think there was discussion with them at which
4 point, sorry?
5 A. After this was done. 10:29
6 65 Q. After it?
7 A. Yeah.
8 66 Q. In the next paragraph you make reference to an
9 inspection by SSI in 2003?
10 A. Yep. 10:30
11 67 Q. Can you help us understand just what SSI means and what
12 it was?
13 A. Yes. Social Services Inspectorate. This was a routine
14 inspection. I don't know how often they did this but
15 they would inspect different parts of the Trust from 10:30
16 time to time. That's what this was.
17 68 Q. Okay. How routine were the SSI inspections?
18 A. I can't remember how often they were.
19 69 Q. You came into post in 2002?
20 A. 2002. 10:30
21 70 Q. Do you recall there being any others between 2002 and
22 2005?
23 A. No.
24 71 Q. It makes reference then to the Review Team. That's
25 your Review Team, presumably? 10:31
26 A. Yeah.
27 72 Q. Noting that the hospital undertook to strengthen child
28 protection policies, procedures and training of staff.
29

1 Why were undertakings given in relation to child
2 protection policies, procedures and the training of
3 staff, and to whom were they given?
4 A. The SSI team had produced some recommendations, as you
5 can see in one of the appendices. The Trust was 10:31
6 working through implementing those recommendations.
7 The Review Team, I think what this is saying is that
8 the Review Team noted that the hospital will continue
9 to do that.
10 73 Q. Do you know did the SSI follow up with you on those 10:31
11 issues?
12 A. I don't remember that but I would have expected them
13 to. Certainly the SSI inspection report would have
14 gone to Trust, would have been seen by Trust Board, and
15 so we would have been expected to report on progress 10:32
16 there.
17 74 Q. Okay. Do you recall them coming back to check on
18 progress?
19 A. No, I don't, no.
20 75 Q. Now again then, at 3.3 you tell us that children and 10:32
21 young people's files were specifically reviewed in
22 search of evidence of awareness by staff of child
23 protection issues, policies and procedures and
24 adherence to the looked-after children arrangements. I
25 suppose by now it's a familiar theme to my questions to 10:32
26 you, Ms. Somerville, but looking back, was a mere file
27 review the best way to assess staff awareness of child
28 protection issues, policies and procedures,
29 particularly with regard to the LAC arrangements?

1 A. If I was repeating it now, I would probably do more to
2 involve staff and perhaps patients and families in what
3 their awareness was of the policies and procedures.
4 But at the time, this was the brief that we were given.
5 CHAIRPERSON: Can I just ask, did you have authority to 10:33
6 do that or would you have had to go back and request
7 it?
8 A. I would have had to go back to the Strategic Review
9 Group.
10 CHAIRPERSON: Thank you. 10:33
11 76 Q. Mr. McEVOY: Picking up on the same theme, and we are
12 overleaf now, it's page 10 of the statement. That's
13 paragraph 3.9 for your reference, Ms. Somerville.
14 Evidence from the notes, and presumably those are file
15 notes -- 10:34
16 A. Yeah.
17 77 Q. -- indicates that:
18
19 "LAC reviews are often late and can be unproductive as
20 it is difficult for staff in community Trusts to 10:34
21 prioritise the needs of children and young people in
22 the hospital".
23
24 Can you offer from memory any reason why there was a
25 situation whereby LAC reviews were often late and 10:34
26 unproductive?
27 A. I think from what we learned at the time, it's down to
28 staff being very busy, and when a child or adolescent
29 came to the hospital, staff in the community knew that

1 they were in the hospital, they were receiving
2 treatment, and so they weren't always at the top of the
3 priority list from very busy social workers.
4 78 Q. Would you - I'm putting it strongly, I appreciate - but
5 would you accept that that could give the impression to 10:35
6 families of those patients that community staff were of
7 the view that if their children or child patients were
8 in hospital, they were out of sight out of mind?
9 A. I think that's too strong a view, I don't think it was
10 that but I think there were other difficulties for care 10:35
11 managers in the community. They were having to think
12 about what they needed to develop as a child was being
13 discharged from the hospital, were there specific
14 arrangements needed to be made. Sometimes that could
15 take time and was difficult for them. 10:36
16 79 Q. Turning then to paragraph 3.18, this is on page 12 or
17 internal page 8. The Review discusses admissions to
18 adolescence to adult wards which you note is "an
19 undesirable position but, on occasion, unavoidable".
20 10:36
21 A little bit on down towards the bottom of the page
22 then, the recommendation, your first recommendation is
23 that a specific -- this is in bold type:
24
25 "A specific admission protocol be developed for 10:36
26 adolescents. This will take account of the fact that
27 this should be an unusual occurrence and immediately
28 raises awareness of vulnerability and issues of
29 protection. This will be implemented and will take

1 account of both new referrals and children transferred
2 from Conicar to adult wards".
3
4 Do you know how long after you made that recommendation
5 any thought was given to its implementation? 10:37
6 A. It was implemented very quickly. I can't give you
7 exact time but I would say in a matter of weeks.
8 80 Q. In addition to a specific admission procedure for
9 adolescents on to adult wards, was there any
10 consideration among the review panel for specific 10:37
11 procedures and guidance for the care and management of
12 those adolescents once they were actually on an adult
13 ward setting, and the safeguarding implications of
14 that?
15 A. Yes. Just to say the admission protocol wasn't for 10:37
16 adolescents into adult wards, it was for adolescents
17 being admitted full stop. So, they might have been
18 admitted to the children's ward. We weren't assuming
19 that all adolescents were coming to adult wards.
20 Sorry, I've lost what you asked me there. 10:38
21 81 Q. It was just in terms of the specific procedures and
22 guidance for the care and management of situations
23 where adolescents may, notwithstanding best efforts,
24 have found themselves actually on an adult ward
25 setting? 10:38
26 A. That would be picked up in the multidisciplinary team
27 meetings, and also in supervision of adolescents on
28 adult wards. So, there were other ways in which
29 absolutely the care and treatment provided to

1 adolescents on adult wards was addressed.
2 82 Q. Was there specific input from psychology, from
3 psychologists in this process?
4 A. I can't answer that but I would expect there would have
5 been. 10:39
6 83 Q. In terms of the overall practice, undesirable as you
7 note it was, of admitting children on to adult wards,
8 could it be said that that was a problem that really
9 affected a lack of community services for those
10 children? 10:39
11 A. Yes, yes.
12 84 Q. I appreciate you were in the hospital, you were based
13 in the hospital at this time, but do you know what was
14 being done at that point in time to have a look at
15 enhancing community services for those young people? 10:39
16 A. Each Trust was -- well, actually I shouldn't say that
17 because all I can talk about is North and West Trust.
18 North and West was certainly putting forward, not just
19 the business case for the development of an assessment
20 and treatment service but also social care 10:39
21 arrangements, and looking at what could be developed to
22 support young people, children and young people in the
23 community so that admissions to hospital could be
24 avoided.
25 85 Q. Paragraph 3.21, which is on page 13. It tells us that: 10:40
26
27 "There was evidence from clinical notes that from time
28 to time, young people require seclusion. The team
29 found that consent for the use of seclusion was not

1 always documented. This is in the process of being
2 addressed by the clinical team at the hospital".
3 A. Yes.
4 86 Q. How soon after that practice was identified from the
5 notes was it addressed? 10:40
6 A. Again, I can't give you certainty about how quickly it
7 was addressed but it was already being addressed at the
8 time that this review took place. So, I would expect
9 that would have happened quite quickly.
10 87 Q. In the box entitled "Examples of Good Practice", there 10:41
11 are three bullet points. Can I take you just to the
12 bottom. The third:
13
14 "It was also clear from a number of files that when
15 possible, these children and young people were sleeping 10:41
16 in single rooms as part of efforts to protect them in
17 an overcrowded environment".
18
19 I mean, the implication or the inference that a reader
20 might draw from that sentence at first blush is that 10:41
21 there were circumstances where there was room sharing?
22 A. Mhm-mhm.
23 88 Q. And that would have been presumably a safeguarding
24 issue?
25 A. It absolutely would. What tended to happen is that, 10:41
26 and you'll probably have seen later in this report, in
27 the Mental Health Commission inspection they were
28 talking about sleeping out, which meant that an adult
29 would be moved from the ward they were in during the

day to sleep in a different ward and sometimes that's how the safeguarding issue had to be managed. But that was a rare occurrence. We did everything we could, and the nursing staff did everything they could, to make sure that if there was an adolescent on an adult ward, they were in their own room. 10:42

89 Q. When you say it was a rare occurrence, I know it is a long time ago but can you give us some idea of just how rare?

A. If that had been happening, it would have come to me. There would have been a discussion with me at the time, I would have expected that, and I don't ever remember that discussion happening. 10:42

90 Q. Okay. Then finally on Section 3 then, there is specific reference to the SSI inspection. It says that the children's service on the hospital was inspected in 2003, as we've touched on. 10:43

"Following receipt of the report in 2004, an action plan was drawn up jointly with the Eastern Board. Many of the actions have been completed, some ongoing and some are longer term". 10:43

Then there is reference to an action plan following receipt of the SSI report in 2004. 10:43

"The recent SSI report Care At Its Best made reference to the planned relocation of Conicar into the community".

1
2 Then you indicate that this will not, however, take
3 place for some time and does not address the needs of
4 adolescents. I mean, preparing the review and putting
5 that up to senior officials in the Board and in the 10:43
6 Trust, how did you feel about having to indicate that
7 and convey that message?
8 A. Well, I felt it was very important. It was frustrating
9 because we were saying this regularly, often and at
10 contracting meetings and other meetings that we had. 10:44
11 91 Q. Again, I suppose, the lay person reading that section
12 at first glance might draw the inference that, in
13 effect, meeting the needs of adolescents in any
14 meaningful way was on hold unless and until the
15 relocation took place. Is that a fair inference to 10:44
16 draw?
17 A. I think it is, yes.
18 92 Q. So, did that mean that the needs of adolescents were
19 going to have to go largely meaningfully unmet until
20 that time? 10:44
21 A. Well, they weren't unmet but they were being met at
22 Muckamore, which we believed continued to be not the
23 best place to meet those needs.
24 93 Q. Less than adequate?
25 A. We made the very best that we could do but at times it 10:45
26 would have been less than adequate.
27 94 Q. All right. Then Section 4 deals with monitoring
28 mechanisms as regards vulnerable adults. There are a
29 number of themes. Just without rehearsing them all, we

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1 know that from paragraph 4.2, about half way down the
2 paragraph you tell us that there are:
3
4 "A large number of incidents reported each day as is
5 expected in a learning disability hospital. Not all of 10:45
6 these could or should be considered under vulnerable
7 adults procedures. Consideration is therefore given to
8 such factors as the patient's current mental health,
9 whether or not the incident is atypical and what is
10 known about the circumstances surrounding the 10:46
11 incident".
12
13 Concerning, irrespective of how regular or otherwise,
14 to see an admission and a report like this that there
15 are a large number of incidents every day; would that 10:46
16 be fair to say?
17 A. Ask me that again.
18 95 Q. Sure. Although you say that you know it's expected
19 that there would be a lot of incidents each day at a
20 learning disability hospital, it is concerning to see 10:46
21 that on the face of a report the indication that there
22 are a large number of incidents each day?
23 A. Okay. I think there are two ways of looking at that.
24 It is concerning that patients were living in
25 inadequate facilities and there was overcrowding, which 10:46
26 contributed to the incidents. The other side of it is
27 that I was always given confidence that incidents were
28 being reported, because we did have large numbers of
29 incidents being reported. So, everything from a trip

1 to something more serious, incident forms were
2 completed. On the one hand, it would be wonderful to
3 not have incidents at all --
4 96 Q. Of course.
5 A. -- but it's very important that they are reported. 10:47
6 97 Q. I suppose hinting at that is some form of being able to
7 triage incidents effectively in the course of a day?
8 A. Well, incidents, I suppose they were triaged. We
9 didn't use that word at the time.
10 98 Q. No. 10:47
11 A. But all incidents were looked at and were acted on on a
12 daily basis.
13 99 Q. At the heart of this report, of course, is a concern to
14 examine safeguarding?
15 A. Yeah. 10:48
16 100 Q. When you say there were a large number of incidents,
17 it's not clear from the Review that safeguarding
18 incidents are either exactly what you mean or are just
19 one of a number of types of incident. Can you help us
20 with that? 10:48
21 A. I'll try. I read this paragraph with today's eyes and
22 I had to smile a little because I thought today all
23 those issues would be vulnerable adults. I think it's
24 important to remember that at the time this report was
25 written, vulnerable adults procedures in the Trust had 10:48
26 only come in, I think in July, and this report was
27 written in December. Up until then, vulnerable adults
28 issues would have been dealt with either as incidents
29 or complaints. So people, including me, we were all

1 getting used to what was a vulnerable adults incident
2 and what was something else. Today, they would all be
3 vulnerable adults.
4 101 Q. I suppose to go back to the refrain from my questions,
5 a way to gauge understanding, even though it was 10:49
6 emerging, and perhaps even more so because it was a new
7 policy and procedure, might have been just to speak to
8 the staff on the ground to find out what their
9 understanding was in order to be able to assess it and
10 perhaps even be able to monitor it going forward? 10:49
11 A. I accept that.
12 102 Q. Can you just help us there with responsibilities --
13 just at 4.5. I beg your pardon, just towards the
14 bottom of the page.
15 10:50
16 "Responsibilities of owning Trusts. The lead in
17 setting up a vulnerable adults process rests with the
18 owning community Trust".
19
20 Can you help us understand what you mean by owning 10:50
21 Trust for the uninitiated?
22 A. The owning community Trust is the Trust who has
23 responsibility for that particular patient when they
24 are not in the hospital.
25 103 Q. So, albeit that the owning Trust had responsibility for 10:50
26 that patient as one of their own, safeguarding duties
27 still rest with Muckamore?
28 A. Yeah. Well, safeguarding in Muckamore rested with
29 Muckamore, but to set up a vulnerable adults process

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1 and investigate it properly, the responsibility rested
2 with the owning Trust. So there was -- there had to be
3 a partnership approach in doing that, and that's part
4 of the procedure.
5 104 Q. Again, I suppose it's, as you say, maybe a function of 10:51
6 looking back --
7 A. Yes.
8 105 Q. -- and one has to be mindful of hindsight in these
9 situations. But even bearing that in mind in 2005, it
10 would have been more or less obvious that most people 10:51
11 coming in as learning disability patients into
12 Muckamore were, by definition, vulnerable adults and
13 that ought to have been at the forefront of the minds
14 of both the hospital and owning Trust?
15 A. Absolutely. And that's with today's eyes we look back 10:51
16 at that.
17 106 Q. What I am saying to you is that even back then, it
18 would have been obvious that anybody coming into the
19 hospital with a learning disability need would have
20 qualified as a vulnerable adult and therefore it should 10:51
21 have been at the forefront of the minds of the owning
22 Trust and the hospital?
23 A. And I would say they were, that was at the forefront.
24 But the issues were dealt with under different
25 policies, as had historically been the case. 10:52
26 107 Q. You then say that:
27
28 "As described previously in relation to LAC reviews,
29 similar themes, staff and community Trusts have

1 competing priorities, and work with hospital patients
2 can remain low on their agenda".
3
4 Now, when you were telling us about the LAC reviews and
5 position with regard to children, I suppose what you 10:52
6 said was - if I am summarising you correctly and do
7 correct me if this is unfair - but you were saying that
8 there was an understanding on the part of community
9 staff that if they were in hospital, well then, they
10 were in hospital and therefore they were being looked 10:52
11 after, and they could therefore prioritise their
12 resources elsewhere?
13 A. Yeah.
14 108 Q. So, would it be fair to say that there was a belief or
15 a culture of belief - "culture" is sometimes a loaded 10:53
16 word - but in it's simplest form, was there a belief or
17 a cultural belief among community staff that vulnerable
18 adults in the hospital were less vulnerable than those
19 in the community?
20 A. No, I don't think it was that they were less vulnerable 10:53
21 but there may have been thinking that they were being
22 taken care of, they were being looked after, they were
23 somewhere that was - I don't want to use the word
24 "safe" but that's what comes to mind - whereas they had
25 a number of other young people to look at or adults to 10:53
26 look at in the community. So again, it was a
27 prioritisation issue.
28 109 Q. Was the Review sympathetic to that, to that
29 understanding?

1 A. No, the Review was not sympathetic to that and that's
2 why there is the recommendation to remind community
3 Trusts of their responsibility.
4 110 Q. Do you know how that was actioned or what happened with
5 that recommendation? 10:54
6 A. I know that the whole time I was working at the
7 hospital, this was an issue. We were regularly
8 reminding community Trusts of their responsibility,
9 both for LAC Reviews and for vulnerable adults
10 investigations. 10:54
11 111 Q. Turning then to Section 5 of your report, which is at
12 page 17, internal page 13. The Review looks at other
13 internal monitoring mechanisms. Several other systems
14 in place which provide additional safety for children
15 and vulnerable adults. The first one is the complaints 10:55
16 procedure, which the Review describes as comprehensive.
17 Complaints received in the hospital are responded to as
18 part of this, and letters to complainants are signed by
19 the Chief Executive or the Deputy Chief Executive. It
20 talks about then the recording and summarising and 10:55
21 their presentation to a complaints committee quarterly,
22 that committee being part the Trust's governance
23 arrangements. It is good practice, the Review says,
24 for less formal complaints to be dealt with
25 face-to-face by staff on the wards. 10:55
26
27 Now, the Review doesn't indicate what might qualify as
28 a less formal complaint. I suppose given that this is
29 a review which deals with safeguarding, one might have

1 expected discussion around that to appear in the
2 context of a description by the Review of the
3 complaints procedure; is that fair to say?
4
5 I'll summarise it. This is about complaints; you would 10:56
6 expect in the context of a review about safeguarding to
7 see explicit mention of indicating up the line how
8 safeguarding should fit within the complaints
9 procedure.
10 A. Okay. 10:56
11 112 Q. Would that be fair to say?
12 A. I'm struggling a little bit with that because I think
13 what we are saying here is that all complaints were
14 recorded and dealt with either face-to-face by the
15 staff on the ward at the time or more formally. 10:56
16 113 Q. The Review looked at files, looked at a sample of files
17 and looked at other documentary material?
18 A. Yes.
19 114 Q. Did the Review assess the effectiveness of the
20 complaint procedure with regard to safeguarding? With 10:57
21 the safeguarding approach in mind, I think that's
22 possibly what I am driving at.
23 A. Okay. I think what the Review found, what the panel
24 found, was that issues that today would be dealt with
25 as vulnerable adults issues were dealt with through the 10:57
26 complaints procedure, and they found evidence of that
27 work. Now, you would never want to be complacent about
28 this but I think that's what the panel are saying here.
29 115 Q. So, during the patient experience phase of the Inquiry,

1 there was quite a bit of evidence from patients and
2 their loved ones of the regular making of complaints
3 directly towards staff - missing clothes, missing
4 property, unexplained injuries, issues with money and
5 so on - without receiving any outcome, any meaningful 10:58
6 outcome. These are perhaps complaints which are made
7 face-to-face. Do you accept that the Review, because
8 it didn't speak to or gain the first-hand experience of
9 families or their loved ones, it couldn't make an
10 informed conclusion about how effective the complaints 10:58
11 procedure was from a safeguarding perspective?
12 A. I would say that that wasn't within the brief that we
13 were given by the Eastern Board. I would also say to
14 you I am very sorry to hear that, that families are
15 saying that. Certainly in the time that I was at the 10:59
16 hospital, if that had been brought to me - and I had
17 many, many meetings with Society of Parents and Friends
18 and had an open door policy for them - if that had come
19 to me or to the Assistant Director of Hospital
20 Services, we would have dealt with that immediately. 10:59
21 116 Q. You say that it wasn't within your brief, but would
22 there have been a mechanism for you to speak to those
23 who briefed you to say, look, in order to really
24 understand how the complaints procedure works, we are
25 going to need to take a sample - as you did with the 10:59
26 files - a sample of patients and relatives and gain an
27 understanding of how they think the system works?
28 A. We could have done that, yes. Again, as I say, looking
29 back with today's eyes, I think that's how I would do

1 it today.
2 CHAIRPERSON: We have been going about an hour,
3 Mr. McEvoy. How much longer do you think you have;
4 same again or more than that?
5 MR. MCEVOY: It could be the same again. 11:00
6 CHAIRPERSON: I am just thinking for the witness, I
7 think we might just take a break there. So we'll just
8 take a 15-minute break, if that's all right. Thank you
9 very much indeed.
10 11:00
11 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
12
13 CHAIRPERSON: Yes.
14 117 Q. MR. MCEVOY: Thank you, sir. If we can move on then,
15 Ms. Somerville, and look at Section 7, which deals with 11:20
16 staff training. The section begins by recognising
17 that:
18
19 "The most effective systems can be put in place but are
20 of little value if frontline staff do not understand 11:20
21 them or are not trained to use them. Staff training is
22 a major part of the hospital's work. Training relevant
23 to this report is described below".
24
25 Then the Review identifies induction programs, 11:21
26 principally for nursing staff, and then other training
27 programs described as a variety of training for all
28 staff some of which is mandatory. So, child protection
29 training, vulnerable adults training, training in

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1 personal relationships, incident reporting, and then
2 management of challenging behaviour and physical
3 intervention.
4
5 So, given that this is a review and one of the things - 11:21
6 and we'll move on to look at them very shortly - that
7 you are doing as part of the Review is making
8 recommendations, do you recall the Review discussing,
9 making recommendations around training in the light of
10 this, bearing in mind that this was essentially a 11:21
11 safeguarding review?
12 A. I don't have much memory of us talking about training
13 but I know we did look at training, which is why these
14 elements of training are listed. Again, while we would
15 never want to be complacent, I think we felt training 11:22
16 was comprehensive.
17 118 Q. So it wasn't an area for recommendation?
18 A. No.
19 119 Q. Then in terms of Section 8, which is communication
20 processes, and this is something that you described and 11:22
21 referred to before we had a short break there: "The
22 Review Team noted that the hospital has a culture of
23 openness and accessibility". When the Review team
24 notes that, is that essentially your view of how you
25 ran things, bearing in mind the internal nature of the 11:22
26 Review?
27 A. It is more than my view because we had the Eastern
28 Board there.
29 120 Q. Sorry, I mean the plural "you", but yes?

1 A. As in the Review panel.
2 121 Q. Yes?
3 A. Yes.
4 122 Q. You note then a number of things, a number of
5 mechanisms which assist with that: Provision of 11:23
6 accessible information leaflets, the provision of clear
7 information on how complaints can be made, and this is
8 distributed through the hospital. Families and carers
9 are informed by ward staff about incidents that involve
10 their relative. Wards operating an open door policy 11:23
11 for families, although bearing in mind that it is not
12 always possible because of the needs of an individual
13 patient. Open days and parties which are regular
14 events on the wards. Members of the senior management
15 team make regular visits to the wards, and the 11:23
16 management team operating an open door policy providing
17 staff and patients with an opportunity to talk to them
18 at any time.
19
20 So those are all, I suppose, positive observations. Do 11:23
21 you recall there being discussion about any negative
22 observations or things that could be done better in
23 terms of communication processes?
24 A. I think there are always things that can be done
25 better. I don't remember us coming up with something 11:24
26 that needed to be a recommendation.
27 123 Q. Okay. Would it be fair to say in terms of you
28 personally in your view in this, in your position as
29 the chair, because you had an understanding that you

1 had an open door policy and that you and the management
2 of the hospital would expect anything, let's say
3 untoward, to be brought to your attention, do you think
4 that although that's laudable, that might have
5 inhibited your view of anything that could be done 11:24
6 better in terms of communication processes?
7 A. I would say certainly that's not enough to say that
8 because I would expect things to be brought to my
9 attention. That's not enough. So that's part of the
10 -- the last bullet point here about making regular 11:24
11 visits to the wards, that was something certainly I and
12 other members of the management team in the hospital
13 did regularly. You can gain a very broad view of
14 what's happening on a ward by just appearing and, you
15 know, noting a number of things that are going on. 11:25
16
17 So no, I don't believe it's enough to say because we
18 have an open door policy and we expect things to come
19 to us; we have to go looking as well.
20 124 Q. At around this time when you were in situ for maybe 11:25
21 about two and a half or three years at this stage --
22 A. Yeah.
23 125 Q. -- how often were you and your colleagues making sort
24 of let's say unannounced visits to the wards?
25 A. The Assistant Director of Nursing was making those 11:25
26 visits every week. At least once a week, sometimes
27 more often than that. She would appear unannounced. I
28 was making those visits probably every other month with
29 the Assistant Director of Nursing and we would just

1 appear on a ward.
2 126 Q. Did you feel that those were -- I'm taking you slightly
3 out of your course but did you feel that that process
4 was effective?
5 A. Very. Yes. 11:26
6 127 Q. It's maybe something we will come back to in due course
7 in the Inquiry.
8 A. Okay.
9 128 Q. Ms. Somerville, I wonder could I take you to the
10 recommendations that appear at paragraph 9. It's at 11:26
11 page 22, for your reference. It's internal page 18. I
12 suppose what I would like to do, given you were the
13 report writer and the chair of the Review, I'd like to
14 maybe give you an opportunity just to speak to the
15 recommendations and perhaps develop, if you feel it 11:26
16 necessary, those recommendations that were the
17 important ones, the key ones, because as with every set
18 of recommendations, perhaps are some more significant
19 than others first of all, and then if you can describe
20 whether or not you felt that those recommendations were 11:27
21 implemented.
22 A. Okay. I would start with recommendation 1. I think
23 this was important in relation to children and
24 adolescents coming into the hospital that we had a
25 written admission procedure. The recommendation says 11:27
26 there "existing good practice". The Review Team didn't
27 see, you know, great difficulties with this but it
28 simply wasn't written down and clear for everybody, so
29 that was important. I know that took place quite

1 quickly.
2 129 Q. We discussed that, didn't we?
3 A. We did.
4
5 The risk assessment was important as well. What the 11:27
6 Review Team found was that while there was a risk
7 assessment produced at the multidisciplinary team
8 meetings on the ward, other professionals would have
9 their own risk assessment as well and so risk
10 assessments were in a number of places. Now, that was 11:28
11 fine but it's helpful to have one that captures what
12 everybody, what each of the professionals are thinking.
13 So, this was produced and was expected to be at the
14 front of every clinical file, of every patient's file
15 on the ward. In, I think 2007, this moved to be an 11:28
16 electronic risk assessment with a system called PARIS,
17 which is a single multidisciplinary risk assessment
18 electronically that everybody can see and can share.
19
20 Recommendation 5, if you're asking me to pick the 11:28
21 really important ones?
22 130 Q. Yes.
23 A. Responsibilities of other Trusts. I think we've talked
24 about this at some length. It's extremely important
25 that when somebody comes into the hospital, they don't 11:29
26 get forgotten about and that Trusts, as soon as
27 somebody is admitted, are starting to think about
28 discharging planning and how that's going to work.
29 Taking responsibility for that.

1 131 Q. Just pausing there. We talked about the role of owning
2 Trusts when patients come in, and you've touched on
3 something perhaps significant there which is in
4 relation to discharge planning. Was there a similar
5 level of concern by the engagement of owning Trusts 11:29
6 around discharge?
7 A. Yes, yes, yes. You know, that would be, for children
8 and young people, part of what the LAC Review was
9 looking at what was happening on discharge. But for
10 other vulnerable adults patients coming in, in the 11:30
11 hospital we would have liked discharge planning to
12 start on the day the patient is admitted, but that was
13 not always easy to do. I would say that contributed to
14 the problem of people's discharge being delayed and a
15 significant number of people getting stuck in hospital. 11:30
16 132 Q. We talked about the message that you want transmitted
17 about owning Trusts taking responsibility and not
18 allowing their patients in the hospital to slip down
19 the list of priorities?
20 A. Yeah. 11:30
21 133 Q. What about the implementation of that recommendation?
22 A. All we in North and West could do was keep talking to
23 owning Trusts, keep the communication open, keep
24 chivvying care managers when somebody would come in.
25 So, we did that all the time. But we also, as the 11:31
26 recommendation said, asked the Eastern Board, who was
27 commissioning services from each of the Trusts, to
28 remind Trusts of their responsibilities.
29 134 Q. I suppose in retrospect do you think that a reminder --

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1 it may be that at the time a reminder - without putting
2 words in your mouth - was all you felt you could do,
3 but do you think in retrospect a reminder was enough --
4 A. No.
5 135 Q. -- or might you have done something different given the 11:31
6 opportunity now?
7 A. Well, it's difficult to think what else we could have
8 done in North and West. The best we could do was when
9 somebody came in, make sure we were communicating with
10 the local Trust. Yes, the recommendation was for the 11:31
11 Eastern Board to remind Trusts. Perhaps there were
12 other things the Eastern Board could have done to make
13 that more than just a reminder.
14 136 Q. Okay. That was recommendation 5 then. Of the
15 remaining 6, 7, 8 and 9, are there any you would pick 11:32
16 out as fairly precedent?
17 A. I think the child protection committee is important.
18 This really strengthened how child protection was
19 handled in the hospital because it linked hospital
20 staff into the Child Protection Committee at the 11:32
21 community side of the Trust. We set up our own Child
22 Protection Committee that people from the community
23 side of the Trust attended as well. Now, I think over
24 time what actually happened was staff from the hospital
25 went to the Community Child Protection Committee, and 11:32
26 the Muckamore issues were discussed there, which was
27 really helpful, a lot came out of that. So that's
28 important.
29 DR. MAXWELL: Can I just ask about that? You recommend

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1 that the Trust-wide Child Protection Panel could be
2 strengthened by having a nurse or medical
3 representative; that there were no... So, it was
4 mostly social workers, was it, at that point?
5 A. It wasn't mostly social workers but it was community 11:33
6 staff. So, there were nurses and medical staff from
7 the community side of the house there but not from
8 Muckamore.
9 DR. MAXWELL: So, the Trust-wide Child Protection Panel
10 was focusing on community child protection issues, so 11:33
11 presumably wasn't looking at child protection in other
12 areas of inpatient care either?
13 A. There were no other areas of inpatient care at that
14 time. We were --
15 DR. MAXWELL: No, no, I mean within The Trust, not 11:33
16 within Muckamore.
17 A. I know. There weren't other. It was community Trust,
18 and Muckamore was the only hospital that the Trust was
19 after.
20 DR. MAXWELL: So this was the only inpatient facility 11:33
21 which had people under 18?
22 A. Yes. I'm just making sure I am accurate with that but
23 yes, I am. We were a community Trust.
24 DR. MAXWELL: Thank you.
25 137 Q. MR. MCEVOY: And so the representation on the Trust 11:34
26 Child Protection Panel strengthened by the addition of
27 a nurse or medical representative to have been, to your
28 memory, then implemented as a recommendation?
29 A. Oh, it was, yes, yes, very much so, and worked very

1 well.
2 138 Q. And then are there any others then from 7, 8 or 9?
3 A. I would like to pick up on 9, the advocacy service. It
4 would have been so helpful if advocacy services had
5 been available for children and adolescents and their 11:34
6 families to really... That would have been another way
7 of addressing the responsibilities of owning community
8 Trusts that we have been talking about; to have an
9 advocacy service that's really fighting for those
10 children so that they are not getting stuck in 11:35
11 hospital.
12
13 Advocacy services have been very limited and certainly
14 at this time we are very limited. One of the things we
15 did later, which is not part of this report at all, was 11:35
16 set up a peer advocacy group run by an independent
17 person called - I think the group might still run -
18 Tell It Like It is, where we trained patients in the
19 hospital to be peer advocates. That was extremely
20 effective. I think there are lots of issues around 11:35
21 advocacy services for people with learning
22 disabilities, and it would have been helpful if we'd
23 been able to strengthen that.
24 CHAIRPERSON: Can you remember if the Society of
25 Parents and Friends of Muckamore had any role in 11:36
26 advocacy?
27 A. They were excellent advocates themselves and they would
28 regularly come to both me and the Assistant Director of
29 Hospital Services when they were concerned about

1 anything, including patients' discharge, you know
2 people being stuck in hospital, as well as day-to-day
3 issues on the hospital ward.
4 CHAIRPERSON: So they were fulfilling a part of that
5 role at least, but obviously not within the hospital 11:36
6 structure?
7 A. Yes, exactly. Yes.
8 139 Q. MR. MCEVOY: I think just in fairness to you,
9 Ms. Somerville, if you just go back to page 20. Sorry
10 it's Inquiry page 20 paragraph 6, so it should be your 11:36
11 page 16 perhaps. Internal page 16.
12 A. Okay. Yep.
13 140 Q. Indeed we didn't touch on it in oral evidence but you
14 have dealt with some external monitoring mechanisms, so
15 the Mental Health Commission, visits by the Trust 11:37
16 Board. Then at 6.3 under the heading of "External
17 Monitoring Mechanisms", you have actually mentioned the
18 Society of Parents and Friend?
19 A. Yes.
20 141 Q. Do they find themselves mentioned there because that's 11:37
21 how they were perceived by the Review panel, by an
22 external monitoring mechanism?
23 A. Yes, yes, they were. And they were very effective as
24 an external monitoring mechanism because the society
25 had no fear in coming to me and talking about things 11:37
26 that they were unhappy with. That happened many times.
27 You know, sometimes our meetings were quite difficult
28 and sometimes we'd be talking about the resettlement
29 process where we didn't always agree on what was

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1 happening. So, they took a very active and I suppose
2 very strong advocacy role on behalf of their own family
3 members.
4 142 Q. How often would you have met with them; do you recall?
5 A. We had formal meetings I think quarterly, but I did 11:38
6 have an open door policy and members of the Society and
7 Friends, they could turn up whenever they wanted and
8 they would always be seen by either me or the Assistant
9 Director.
10 143 Q. In terms of what happened with your review, can you 11:38
11 tell us, you made your recommendations and completed
12 the report in December '05; what happened after that?
13 A. Well, the recommendations were implemented apart from
14 the one that talks about using EPEC.
15 144 Q. Number 8? 11:38
16 A. Number 8, yes.
17 145 Q. Page 23, yeah.
18 A. There were some technical issues that prevented that
19 from happening but in 2007, as I said earlier that was
20 an electronic system. The recommendations were 11:39
21 implemented but things like, as I said, the advocacy
22 service, there wasn't a great deal that North and West
23 Trust could do to strengthen that advocacy service
24 other than keep talking about it at contracting
25 meetings, keep talking to the commissioners about the 11:39
26 need for improved advocacy in the hospital. As we've
27 already talked a lot about the other Trusts, the LAC
28 Reviews, and the delayed discharge.
29 CHAIRPERSON: Sorry, on that last point, is that a

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1 problem in terms of funding effectively?
2 A. The advocacy?
3 CHAIRPERSON: Yes.
4 A. Yes. The Boards commissioned a limited amount of
5 advocacy -- at this time a limited amount of advocacy 11:40
6 for community Trusts. Some of that was expected to be
7 for patients in Muckamore but not all of it.
8 CHAIRPERSON: Yes. So you had the society and possibly
9 other charitable influences but nothing really coming
10 from the Department of Health or the Trust? 11:40
11 A. There was some but it was limited. There were two
12 organisations who did provided advocacy services, but
13 they really had very limited time to devote to that.
14 CHAIRPERSON: Okay. Thank you.
15 MR. MCEVOY: Just on that score, about the limited 11:40
16 time --
17 A. Yeah.
18 146 Q. -- what did you envisage, how fully formed a plan,
19 where did you see the gap being in terms of advocacy
20 services? What was the need? 11:40
21 A. Okay. When I came to the hospital, I had come from a
22 service in Birmingham where we had a very strong
23 advocacy service. One of the things I have always said
24 was one of the most difficult meetings I often attended
25 was with the advocacy services, because they were the 11:41
26 people who were going to fight the hardest to support,
27 to get support for people with learning disabilities.
28 So, I was surprised at the lack of advocacy in a very
29 similar setting here when I came to Muckamore. The gap

1 is that an advocate has no ties to the Trust, to the
2 system, to the bureaucracy, and an advocate can fight
3 very hard and with great strength to support somebody
4 maybe getting out of hospital again or, if there are
5 issues within the hospital, to get things sorted. We 11:41
6 lacked that, we lacked that independence.
7 147 Q. I was asking you there a moment or so ago in terms of
8 the destination of your review. Were you called to any
9 meetings with anybody at the Board or Trust level to
10 discuss it? 11:42
11 A. It was looked at by the -- I mentioned the strategic
12 group at the beginning. Certainly the recommendations
13 were looked at by them and, from memory, followed up by
14 them. It was also followed up in our commissioning
15 meetings with the Eastern Board. Beyond that, I have 11:42
16 no memory of anything else, apart from internally in
17 the Trust. It was certainly followed up at our Chief
18 Exec meeting and I was expected to report on progress.
19 148 Q. Ms. Somerville, those are my questions although the
20 Panel may have some more. Thank you very much. 11:43
21
22 THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:
23 CHAIRPERSON: Professor Murphy.
24 PROFESSOR MURPHY: Thank you for that. What you
25 describe sounds to me as though it was quite 11:43
26 frustrating in many ways in that you were wanting major
27 improvements in community services, for example for
28 children and for adolescents, and you were recommending
29 them but nothing was happening. Can you help us

1 understand why it was nothing was happening?
2 A. Yes, I'll try. Obviously I can only talk about my
3 experience and what it was like for me in my role at
4 the hospital. It was difficult to encourage both
5 Trusts and Boards to believe that investment in 11:43
6 community services would actually result in the changes
7 in the hospital that everybody wanted and that had been
8 on the cards since the mid '90s. Because I wasn't part
9 of that commissioning group, I don't know why that was
10 the case, but there just was very limited investment in 11:44
11 community services. Yes, frustrating is absolutely the
12 word.
13 149 Q. Thank you. Can I just follow it up with this one.
14 Obviously the Trusts were also running all kinds of
15 acute medicine services. I wonder whether you feel 11:44
16 that they, to some extent, had learning disabilities as
17 a lower priority compared to all the acute issues?
18 A. At the time that this report was written, I wouldn't
19 say that was the case because North and West took what
20 was happening at Muckamore very seriously. It was one 11:45
21 of the most important areas for North and West Trust.
22 I was expected to report at every board meeting. It's
23 interesting that when the merger of the Trusts happened
24 in 2006/2007, staff at the hospital said they wanted to
25 stay with Belfast Trust because of how they had been 11:45
26 treated and their perception of how North and West had
27 taken Muckamore as a very important part of the Trust,
28 the overall Trust service. Sorry, I have lost track of
29 what you were asking me. That's probably not...

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1 150 Q. Yes, I think you've answered it. It was the extent to
2 which you felt that acute services needs trumped up
3 learning disability needs?
4 A. When we became Belfast Trust, it was much more
5 difficult to get a voice and the voice got lost because 11:46
6 of competing priorities, yes.
7 151 Q. Thank you.
8 CHAIRPERSON: I don't have anything else. Can I thank
9 you very much indeed for coming along to assist the
10 Inquiry. Your evidence has been very clear and very 11:46
11 frank. So, thank you very much for coming to help us.
12 A. Thank you.
13 CHAIRPERSON: All right. We're next sitting I think on
14 Wednesday.
15 MR. McEVOY: Wednesday at 10:00 a.m. 11:46
16 CHAIRPERSON: Which will be a rather longer day.
17 MR. MCEVOY: Should be. Thank you.
18 CHAIRPERSON: Thank you very much everybody. Wednesday,
19 10 o'clock.
20 11:46
21 THE INQUIRY ADJOURNED UNTIL 10:00 A.M. ON WEDNESDAY
22 17TH MAY 2023
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