MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 20TH JUNE 2024 - DAY 95

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1 THE INQUIRY RESUMED ON THURSDAY, 20TH JUNE 2024, AS
2 FOLLOWS:
3
4 CHAIRPERSON: Good morning. Thank you. Mr. McEvoy.
5 MR. McEVOY: Morning, Chair. Morning, Panel. The 09:52
6 first witness today is Wendy McGregor. This is the
7 second of the witnesses in relation to Organisational
8 Module 5.
9
10 Ms. McGregor's statement, for those following 09:52
11 proceedings, is MAHI-STM-214. If the witness could be
12 brought up.
13 CHAIRPERSON: Let's get the witness in.
14
15 MS. WENDY McGREGOR, HAVING BEEN SWORN, WAS EXAMINED BY 09:52
16 MR. McEVOY AS FOLLOWS:
17
18 CHAIRPERSON: Ms. McGregor, good morning, and thank you
19 very much for your statement, and thank you for coming
20 to assist the Inquiry. I'll hand you over to 09:53
21 Mr. McEvoy.
22 1 Q. MR. McEVOY: Morning, Ms. McGregor.
23 A. Morning.
24 2 Q. We met briefly. As you know, my name is Mark McEvoy
25 and I am one of the Inquiry counsel. You have 09:53
26 hopefully before you your statement to the Inquiry,
27 it's a statement of, including exhibits, 114 pages, and
28 it's dated 28th March 2024. Can I ask you just to
29 confirm that you're content to adopt that statement as

1 the basis of your evidence to the Inquiry?
2 A. Yes.
3 3 Q. So, Ms. McGregor, just by way of introduction then.
4 You have, at the outset of your statement at paragraph
5 2, described a bit about your professional background, 09:54
6 being one emersed in learning disability, I think it
7 would be fair to say, and then at paragraph 3 you tell
8 us that you began working for the RQIA as a Mental
9 Health and Learning Disability Inspector in October
10 2012. Is there something you wanted to say to the 09:54
11 Inquiry about that date?
12 A. Yes, that date is incorrect. I started working for the
13 RQIA as a Mental Health and Learning Disability
14 Inspector in October 2013.
15 4 Q. 2013. It may be helpful if you keep your voice up just 09:54
16 a little bit so we can hear you, and you can bring the
17 microphone --
18 CHAIRPERSON: Yes. So, instead of '12 it should be
19 '13.
20 A. It should be '13, yes. 09:55
21 5 Q. MR. McEVOY: Okay. And then we know that you remained
22 in that role until 2019?
23 A. Yes.
24 6 Q. And then in 2019 in you became Senior Inspector, and
25 then after that Assistant Director of Mental Health, 09:55
26 Learning Disability and Prison Healthcare, and that's
27 the role you're in at the present time?
28 A. That's correct.
29 7 Q. And in that role then, are you effectively the number

1 two to Ms. Long, from whom the Inquiry heard yesterday?
2 A. Yes, I am the Assistant Director, yes.
3 8 Q. Now, in terms of your awareness of inspection
4 methodology, which was one of the things that the
5 Inquiry asked you to address, for those purposes you 09:55
6 have helpfully focused on your own experience as
7 someone who has, I suppose, worked your way up. When
8 she gave evidence to the Inquiry last year in her
9 statements, the Chief Executive of the RQIA,
10 Ms. Donaghy, described the process of training and how 09:56
11 it has changed over time. Thinking back to your own
12 training, you describe in paragraph 8 how your
13 experience of inspections came through shadowing of an
14 experienced inspector before completing a primary
15 inspection as a lone inspector. Thinking back, how 09:56
16 long did that shadowing process go on for?
17 A. I suppose it -- the shadowing process really went on
18 for about six months, but you took on the role of a
19 lone inspector when you were deemed competent to take
20 on that role as a lone inspector, both from your own 09:56
21 perspective to say 'I feel confident and competent to
22 do that', but also to ensure the Senior Inspector that
23 I was working to at that time, you know, that she was
24 confident that I took on that role. So it formed very
25 much part of your induction and your probation period, 09:57
26 you know, and that's what the organisation and my
27 manager was satisfied that I was competent enough to
28 take on the role of going out and completing a full
29 inspection on my own.

1 9 Q. Was there a formal signing off process to assure the
2 organisation that you were competent?
3 A. Yeah. So there's a signing off process in terms of
4 your induction period, the induction period would have
5 went on for approximately 12 weeks or so, and part of 09:57
6 that is your training, you know, going out and
7 shadowing inspections as well with another inspector,
8 so that would have been signed off before you went on,
9 and then there's obviously the corporate induction
10 element of employment, I suppose, as well, so there's 09:57
11 part of that. But very much you wouldn't have took on
12 that role until you yourself professionally deemed
13 yourself confident, and your line manager felt you were
14 confident as well. So...
15 10 Q. And once you are a lone inspector, was there a period 09:58
16 of -- there might be a better word, but "probation", so
17 to speak, where there was a Senior Inspector or another
18 monitoring your work as a lone inspector?
19 A. Your work is always monitored by somebody senior doing
20 inspections. So, by way of, if you had some, 09:58
21 identifying some concerns, you would always raise those
22 with your Senior Inspector, either during the
23 inspection, or I always find, you know, just on the
24 drive on the way home or before you left the facility,
25 or depending on the concern, you would be raising that 09:58
26 with your Senior Inspector who would have oversight,
27 and then in terms of when you were coming towards the
28 conclusion of your inspection, you would be contacting
29 your Senior Inspector to advise of your findings, in

1 terms of good practice you've identified, and also
2 areas for improvement or significant concerns that
3 you've identified, to provide that oversight. And then
4 they would have to assure themselves, and assure you,
5 that either you could go ahead and give the feedback to 09:59
6 the Trust at that point, or whether we would both
7 decide, actually, you need to come down, or somebody
8 senior needs to be present at the conclusion of that
9 inspection, or at times during that inspection to
10 provide that support or, you know, maybe if there was 09:59
11 something more escalating, to be there.
12 11 Q. Okay. Okay. So an escalation would have been
13 potentially a factor in the equation?
14 A. Yes.
15 12 Q. All right. A moment or two ago I touched on changes 09:59
16 over time to the training process?
17 A. Yes.
18 13 Q. -- that the Chief Executive of the organisation told us
19 about last year. Are you involved in the training
20 process in your current role? 09:59
21 A. Yes.
22 14 Q. Can you tell us a little bit more about how the
23 training process has evolved in practical terms since
24 you did it yourself?
25 A. I suppose it's evolved with the change in the 10:00
26 methodology, actually. So the training that we provide
27 now reflects very much our current methodology that we
28 use.
29 15 Q. Is this what has been referred to as the 2019

1 methodology?
2 A. Exactly. Yes. So the training covers more of that.
3 It's also our induction and training has been developed
4 on, I suppose, learning that we've identified from
5 recent recruitment, or recruitment over the years, 10:00
6 where inspectors have identified areas where they've
7 needed more support in, so the training has been I
8 suppose enhanced for that.
9 16 Q. Yes.
10 A. But certainly it reflects the methodology. The same 10:00
11 principle is there in terms of your support, your
12 shadowing is still there, and being deemed competent
13 then to what's now known as being the lead inspector
14 rather than the sole inspector of an inspection, so
15 it's been developed in respect of that. 10:01
16 17 Q. And what about your own training? Have you taken steps
17 to -- obviously you're in a senior, I suppose a
18 leadership role now, but have you re-trained to take
19 account of the 2019 methodology yourself?
20 A. Absolutely, yes, and I was very much part of developing 10:01
21 that methodology.
22 18 Q. Yes.
23 A. So there's been a lot of training. Also made some
24 links in with our colleagues in, I call it mainland UK,
25 the likes of CQC and the Scottish inspectorate bodies, 10:01
26 to see what they're doing. So, yes, there's been a lot
27 of -- because I've developed -- been part and parcel of
28 developing that methodology, I've had to train and get
29 myself familiar in terms of the evidence behind that

1 methodology, and the best practice, and all of the
2 guidance around that. In addition to that I've also
3 completed leadership training within the organisation
4 to develop myself as a role in taking up such a senior
5 leadership post within RQIA, and I've been supported to 10:02
6 do that.
7 19 Q. Okay. Again, just before we -- we will move on to look
8 at the post-2019 landscape, but thinking back to how
9 things were in the period between 2013 and 2019, you
10 describe in paragraph 11 how MHLD Inspectors were 10:02
11 aligned to a caseload of wards, meaning that each
12 inspector was allocated responsibility for inspecting
13 wards from across all five health and social care
14 Trusts, and then you describe in A, B and C the factors
15 to which regard would be had; in other words, then, 10:02
16 whether wards were indicated as high, medium, or low
17 risk. Then ensuring that each inspector had a variety
18 of wards in their caseload, and then how long the
19 inspector had been inspecting the service.
20 10:03
21 Looking at the second of those sets of factors, the
22 variety of wards, what was the thinking behind that? I
23 appreciate that things have moved on and things are
24 maybe done in a slightly different way now, but what
25 was the logic for having a variety of wards in your 10:03
26 caseload?
27 A. Well, I suppose there is a variety of wards in Northern
28 Ireland, and we are relatively -- there were four
29 inspectors in the team at that time, so from that point

1 of view, you had to have a mixture of wards on your
2 caseload, but --
3 20 Q. So it was necessity?
4 A. It was a necessity, absolutely. So, it also developed
5 you as an inspector in terms of applying the principles 10:03
6 of a really good inspection across all wards,
7 regardless of the population or the needs of the
8 patients who were admitted to those wards, and for me,
9 you know, you got a lot of benefit from that as well,
10 because if you were identifying, I suppose, good 10:04
11 practice in one area, you could also share it with
12 another area.
13 21 Q. Yes.
14 A. And that was -- that was a good area -- or a good thing
15 to do. So, yes, so really from necessity, but also 10:04
16 just ensuring that everybody was skilled up to inspect
17 any ward really within mental health and learning
18 disability and patient services.
19 22 Q. At paragraph 12 you describe how annually in February
20 of each year inspectors and management of the MHLD team 10:04
21 reviewed caseloads, and then those caseloads were
22 realigned based on the considerations I've just
23 described. What was the reason for changing caseloads?
24 Was there a logic to that?
25 A. Yeah, so there's a number of reasons for changing 10:05
26 caseloads. So, to ensure you had the mixture of case
27 -- or mixture of wards on your actual caseload, to make
28 sure that your caseload, I suppose, didn't have a
29 higher volume of those wards that would have been

1 assessed at being a high risk. So you weren't carrying
2 16 wards that were at, what we would have called a red
3 risk, and that was evenly distributed throughout the
4 team of four inspectors.
5 23 Q. Yes. 10:05
6 A. And also there was a rotation of case, a number of
7 caseloads on -- or number of wards on your caseload,
8 just to have a fresh pair of eyes, really, on different
9 wards and different services. And I suppose again that
10 was a good thing to do, but -- and we were trying to 10:05
11 align with what the rest of the organisation was doing
12 as well in terms of that rotation element, but bearing
13 in mind we were only -- we were inspecting wards, I
14 suppose some wards once a year, more times a year
15 depending on the risk, or more times a year depending 10:06
16 on the intelligence and things like that, but those
17 were really the basic reasons for swapping those around
18 or rotating our review.
19 24 Q. At paragraph 15, then, you describe how -- now we're
20 getting into 2019 and forward -- the alignment, a 10:06
21 change to the alignment of inspectors, and from this
22 point each MHLD Inspector became aligned to a
23 particular Trust, rather than individual wards across
24 the multiple HSC Trusts. You say this change occurred
25 around the same time that there was a significant 10:06
26 change to RQIA's inspection methodology where you moved
27 to a systems-based approach to inspection, and that
28 involved inspecting the entire service as appropriate
29 rather than inspections of individual wards. Has that

1 worked well?
2 A. I think that's been a significant development in our
3 inspection methodology. To look, I suppose, across a
4 whole service, has enabled us to triangulate more
5 information. 10:07
6 25 Q. Yes.
7 A. To have a real focus on governance and leadership
8 across the organisation, across those inpatient
9 services. I mean, there's always more to do, there's
10 always more learning, our methodology continues to 10:07
11 evolve. So I would say that that's been a significant
12 development within our methodology in comparison to
13 what -- the methodology we would have used before in
14 terms of inspecting, that kind of single ward on its
15 own type methodology, to looking across the piece. 10:08
16 CHAIRPERSON: Could I just ask you about your -- the
17 beginning of that answer, so that I understand it. And
18 we may come on to this again a bit later. But you --
19 so it's enabled you to have a real focus on governance
20 and leadership across the organisation. Which 10:08
21 organisation? When you look, for instance, at a unit
22 like Muckamore Abbey Hospital, do you look beyond the
23 Hospital to see -- to look, for instance, at the Trust
24 and the leadership of the Trust, and the governance of
25 the Trust? 10:08
26 A. Yes, we do now from the development of the 2019
27 methodology. So we absolutely look wider into the
28 Belfast Trust, in terms of very senior leadership
29 roles. So not just the leadership within Muckamore

1 Abbey, but also the Directors, the Co-Directors, and
2 sometimes even when, you know, we're escalating or we
3 need to inform, right up to the Chief Executive.
4 CHAIRPERSON: And we see that in your reports, do we?
5 A. You should do, yes. 10:09
6 CHAIRPERSON: Okay.
7 DR. MAXWELL: Do you actually track the way governance
8 systems work, because there are lots of intermediate
9 steps between Muckamore and the Trust Board? Do you
10 actually track the way that information is collected, 10:09
11 managed and assessed?
12 A. Yes.
13 DR. MAXWELL: At all levels of the Trust.
14 A. Yes, very much so. We track information right from
15 ward level. So if I give you an example of perhaps an 10:09
16 incident that's occurred at ward level, we'll look at
17 that. Well, actually, we look at a sample of incidents
18 whenever the inspectors are out on inspection, and
19 we're looking at those for several reasons; to see if
20 they've been reported appropriately and have been 10:09
21 actioned, where we're seeing incidents, I suppose,
22 risks increasing, we'll see what the system is for that
23 in terms of escalation, where it goes to next, what's
24 the system around perhaps middle management in terms of
25 how it's managed there, how are they assuring 10:10
26 themselves that it's being managed appropriately, and
27 then on up to senior management, and right up to senior
28 governance level. So we literally track right up to
29 that level. We look at how they collect the data, how

1 they analyse the data, what they do with the data, what
2 learning has been identified from the data, any action
3 plans that have been developed in respect to the
4 learning, and then we'll track it back down again. So
5 we have to see what assurance mechanisms are in place 10:10
6 to make sure any learning that has been identified is
7 shared at the appropriate level, right to ward level
8 again, and then we'll check on the wards to make sure
9 that the learning is there and that it also has been
10 actioned. 10:10
11 DR. MAXWELL: So can I give you an example? One of the
12 things that's come up a lot is staffing levels at
13 Muckamore.
14 A. Yes.
15 DR. MAXWELL: And we know that at various points in 10:10
16 time this has been put on the Hospital's Risk Register
17 and rated as red. We know that it's got to the service
18 level Risk Register. As yet we're unclear what
19 happened after that, because it certainly didn't make
20 it to the Corporate Risk Register. Would you have 10:11
21 examined that and the decisions at directorate level to
22 change the status of that and downgrade it from red, or
23 at least not put it as red in the directorate?
24 A. I suppose there's always been concerns about staffing
25 levels within Muckamore. At ward level, where concerns 10:11
26 in terms of reduced staffing levels have been
27 identified and expressed to us by the staff, we -- the
28 first thing we would do is to ensure that the staff
29 fill out an incident form, or what they call a Datix

1 form, just to say there's been short staffing here. So
2 that's the staff's first means of escalating that.
3 Where that hasn't been done, we would be concerned that
4 staff are actually not escalating themselves, that
5 there's issues with staff. 10:12
6 DR. MAXWELL: But where it has been escalated and it's
7 been put on the Hospital's Risk Register, but somewhere
8 in the journey it's been downgraded, do you look at
9 that, do you look at the discussion, do you look at the
10 decision-making? The staff have highlighted it, 10:12
11 they've done all the appropriate things but, somehow,
12 outside the Hospital, that decision has been
13 downgraded, do you look at that?
14 A. Well we would look at, I suppose not necessarily the
15 Corporate Risk Register, but we certainly would be 10:12
16 looking at, you know, minutes of meetings where those
17 serious or significant concerns and risks have been
18 addressed up to a senior level within Trust, you know,
19 like the governance level, like senior managers, and
20 certainly I would be seeing that staffing levels would 10:13
21 be discussed at those meetings, and if they weren't we
22 would be concerned and raising that as an issue.
23 DR. MAXWELL: The point I'm trying to get at: What
24 level of governance meeting would you be looking at?
25 Because if it's getting downgraded at either the 10:13
26 directorate governance meeting, or the next step up,
27 that's quite significant, because there have been
28 repeated concerns, and one of the questions for us is;
29 how did it not become a major issue on the Corporate

1 Risk Register? And it may not be your job to do it,
2 I'm not criticising, I'm just asking, you know, to what
3 level inspectors would go to track this through?
4 A. We would go up to directorate level, to senior level
5 within the Trust. 10:14
6 DR. MAXWELL: And would you go up to the Assurance
7 Committee, which is the subcommittee of the Board.
8 A. Not necessarily.
9 DR. MAXWELL: Okay. I'm not saying you should, I'm
10 just trying to track where you get to. 10:14
11 A. Yeah.
12 26 Q. MR. McEVOY: Okay. And then stepping once again just
13 back in time, Ms. McGregor, just to the information
14 that you have provided in terms of what happened
15 historically, and in the next subsection of your 10:14
16 statement you outline the kind of information that
17 inspectors would have been provided with in advance of
18 an inspection, and you then go on to describe how,
19 particularly between 2012 and 2013, you would have been
20 in receipt of self-assessment information from 10:14
21 providers, and you've then -- you then go on to
22 describe what was done with that information and how it
23 informed preparation for your inspection process.
24
25 In terms of that self-assessment process, based on your 10:15
26 experience, did you find it to be -- more or less at
27 the time, was it accurate, inaccurate? Can you give us
28 a flavour of how you found that, how helpful you found
29 that self-assessment information to be?

1 A. On most occasions, the self-assessment did not reflect
2 what we found on the inspection.
3 27 Q. Yeah.
4 A. So we would have found that the Trust would have
5 assessed themselves -- 10:15
6 28 Q. Lift your voice up a tiny bit.
7 A. Sorry. The Trust would have assessed themselves higher
8 than what we would have found on inspection on most
9 occasions.
10 29 Q. Yes. Yes. And were there any particular issues that 10:15
11 were, and I'm thinking about Muckamore in particular,
12 which you inspected.
13 A. Mm-hmm.
14 30 Q. Were there any particular issues that you found to be
15 lacking in -- well, I've used the word "accuracy" -- 10:16
16 were there any particular issues that you found lacking
17 in accuracy across these self-assessment reports?
18 A. Yes. There would have been a number of areas, such as
19 the use of restrictive practices.
20 31 Q. Yes. 10:16
21 A. Care and treatment in terms of the support of
22 individuals who require support with managing their
23 dysregulated behaviours, a lack of understanding on the
24 use of positive behaviour support.
25 Environmentally-wise as well, the Trust may have 10:16
26 assessed themselves as higher in terms of the
27 environment that individuals would have been supported
28 and cared for in, and ward governance would have been
29 another area that would have been assessed, I suppose,

1 substantially lower than what the Trust would have
2 assessed themselves as.
3 32 Q. Yeah.
4 CHAIRPERSON: So to that extent did you find
5 self-assessment quite useful? Because you could see 10:17
6 how the Trust saw itself, perhaps through slightly
7 rosier glasses than you were bringing to bear?
8 A. Absolutely, yes.
9 CHAIRPERSON: And then you stopped doing that. Do you
10 know why? 10:17
11 A. Yeah. I'm not sure. I suppose I can't answer in terms
12 of whether it was more beneficial than seeing that the
13 Trust were assessing themselves better than what we
14 found.
15 CHAIRPERSON: I can wholly understand that there's a 10:17
16 debate about whether self-assessment of itself can be
17 relied on at all.
18 A. Yeah.
19 CHAIRPERSON: But this would give you a little bit of a
20 look at the insight, I suppose, that the Trust, in any 10:18
21 hospital, had. So to that extent, you've said you
22 found that quite useful, but a policy decision was
23 obviously taken not to get that information.
24 A. Yeah. So, I suppose one of the reasons, or one of the
25 I suppose disadvantages, is that you'd be announcing 10:18
26 the inspection. So --
27 CHAIRPERSON: Yes.
28 A. -- to move to the unannounced inspection methodology,
29 it would have become quite difficult then to ask for

1 that.
2 CHAIRPERSON: Yes.
3 A. -- information.
4 CHAIRPERSON: Well, what I understand is there were
5 stages. There was first of all the -- you get the 10:18
6 information and you tell them when the inspection would
7 be; then you move to a policy of asking for
8 self-assessment, but not telling them when the
9 inspection would be, but they'd know it would be within
10 about three months; then you move to totally 10:19
11 unannounced inspections.
12 A. Yeah.
13 CHAIRPERSON: So out of interest, which of those three
14 do you think is most effective?
15 A. I think the unannounced inspection and the 10:19
16 methodologies that we use now are the most effective,
17 because -- because our systems have developed
18 technologically-wise, we almost have an idea of where
19 Trusts are at now in terms of their services, because
20 we can now continue to collect data and intelligence. 10:20
21 CHAIRPERSON: Okay.
22 A. Which we wouldn't have been able to do before.
23 CHAIRPERSON: Okay.
24 A. So it almost gives us an idea of where Trusts, you know
25 how they're performing if there are significant issues 10:20
26 or risks coming through.
27 CHAIRPERSON: I'm sure we're going to come on to
28 iConnect.
29 33 Q. MR. McEVOY: Yeah. Just picking up exactly on that

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1 point. In the -- under the old system, the old, old
2 system, you tell us at paragraph 21 that inspectors
3 would review intelligence about a service prior to the
4 inspection, but the process was not a streamlined as it
5 later became due to the lack of a purpose-built 10:20
6 document management system at the time. What did you
7 have then?
8 A. So, when I started in RQIA, they had more or less just
9 moved away from a very much storage of paper.
10 34 Q. Yeah. 10:21
11 A. To what we would have called an M-drive system, which
12 was lots of folders with facility names in them,
13 patient names in them, because of the Mental Health
14 Order and so forth. It was quite a difficult system, I
15 suppose, to find information that you were looking for 10:21
16 or to pull out data or intelligence.
17 35 Q. Yes.
18 A. Really.
19 36 Q. Yes. It wasn't a bespoke case management system?
20 A. No. 10:21
21 37 Q. Do you think the lack of such a system could have had
22 an effect on how thorough inspections were?
23 A. In comparison to now, we wouldn't have had the level of
24 data and intelligence, you know, collected over a year
25 period, as we would have now, that could easily be 10:22
26 extracted in terms of themes and trends. And I suppose
27 we worked to a system that was available to us at the
28 time. There was an element of relying on
29 recommendations made on previous inspections for

1 follow-up on, you know, the next inspection, as part of
2 that intelligence.
3 38 Q. Was one possible shortcoming, therefore, that you did
4 not have perhaps as good -- perhaps not any, but
5 perhaps not as good a means of tracking from inspection 10:22
6 to inspection across recommendations and so forth?
7 A. Not to what we have now. Now we have, you know --
8 39 Q. I appreciate there's an element of hindsight in what
9 I'm asking you --
10 A. I know but... 10:23
11 40 Q. But the compare and contrast is still valid.
12 A. Yeah.
13 41 Q. If you're able to reflect upon how not having
14 something, you know, which is tailor-made to the job in
15 hand, might have affected how thoroughly you were able 10:23
16 to inspect?
17 A. Yeah. On hindsight, it could have possibly impacted.
18 42 Q. Yes. I suppose, therefore, if you had had such a
19 system in place sooner, and the ability to, as we heard
20 about yesterday, and indeed in the previous evidence of 10:23
21 Ms. Donaghy, the ability to identify themes and trends,
22 do you think that you might have been better placed to
23 flag broader issues with safeguarding within the
24 Hospital?
25 A. Certainly, within the Hospital itself. So if we think 10:24
26 back to the previous methodologies, we were all
27 inspecting single wards.
28 43 Q. Yeah.
29 A. So that's the difference now. I mean, certainly if we

1 had identified adult safeguarding, we would have
2 flagged it and escalated it. And, again, like I said,
3 we were heavily reliant on the tracking through
4 inspection reports, our previous inspections, so any
5 recommendations that would have been made on an 10:24
6 inspection relating to adult safeguarding, would have
7 been followed up on the next inspection.
8 44 Q. Yeah.
9 A. Whenever we brought -- there was a system also brought
10 in in terms of risk, or assessing risk, called the 10:24
11 Inspection Planning Tool, I think that might have come
12 in around '14 or '15, I just can't recall the specific
13 date, but that would have been another way of flagging
14 a risk in a ward. So when you come off the inspection
15 and you identified something in respect to adult 10:25
16 safeguarding, there would have been a section on the
17 risk rating system, the inspection planning, it was
18 called the Inspection Planning Tool, that might have
19 increased the risk. So if I remember the question
20 would have been "Have there been any adult safeguarding 10:25
21 concerns in this ward that have not been addressed in
22 accordance with regional procedure?" or...
23 45 Q. Yes.
24 A. I just can't remember the exact wording. And that
25 would have influenced that. So, as an inspector 10:25
26 aligned to that particular ward, that would have been
27 your way I suppose of tracking that.
28 46 Q. Yeah.
29 A. So to speak. And perhaps if you'd had seen a risk --

1 so say, for example in a ward in Muckamore, that was
2 moving up, because maybe you had received some
3 intelligence in, or a concern, or a complaint from --
4 47 Q. From another part of the Hospital --
5 A. From another part of the Hospital, or perhaps a patient 10:26
6 or another stakeholder, or perhaps a relative.
7 48 Q. Yes.
8 A. You would have been going to that IPT and saying, 'Was
9 there something here that actually we need to follow up
10 on?' 10:26
11 49 Q. Yeah.
12 A. You know, 'Is this increasing the risk?' Where risk
13 increased, there may have been determination or
14 decisions made in terms of going out to do another
15 inspection on that ward, or doing another means of, I 10:26
16 suppose, regulatory response, like contacting the Trust
17 to get some assurances around, 'We've heard of a
18 safeguarding here, are you dealing or addressing with
19 it appropriately?', you know, and getting assurances
20 around that way. So I suppose those were the tools 10:26
21 that were available to us at the time. But bearing in
22 mind it was still single wards, it wasn't across, you
23 know, the whole of the learning disability inpatient
24 service, being Muckamore Abbey.
25 50 Q. Okay. And then we touched on the post-'19 situation a 10:26
26 moment or two ago, and coming back to it. Since 2019,
27 you tell us at paragraph 31, if an inspection is
28 unannounced, as most are, there's no communication with
29 the Hospital specifically relating to the inspection.

1 There are occasions where inspections are announced,
2 for example, target inspections such as finance, and
3 we'll come back to those in a moment, but if no
4 information is sought in advance of inspections, is
5 there any latitude for you to seek information from the 10:27
6 families of patients? Just to say 'I've no information
7 from the Hospital, or indeed the Trust, do you have any
8 information from relatives or families?'
9 A. Only information that relatives and/or patients have
10 made known to us. 10:28
11 51 Q. Yeah.
12 A. -- prior to the inspection. We would use that to form
13 -- or sometimes to determine whether we would go out
14 and do an inspection in the first instance.
15 52 Q. Yes. You said "sometimes" there; how often? 10:28
16 A. I can't answer that now, but I could get you the
17 information in terms of where maybe a family has
18 contacted us, and where we have thought, you know, we
19 need to go out and do an inspection of that service,
20 what the family have raised with us is quite 10:28
21 significant, and the only way we can get assurance is
22 to actually go out to the service itself.
23
24 In terms of contacting a family/families before an
25 inspection, it wouldn't be -- it wouldn't be routine to 10:28
26 do that, to gather information about an inspection, to
27 advise the family we're going to do an inspection by
28 way of it being an unannounced inspection.
29 53 Q. Yes. There might be very good reasons for that, I

1 suppose?
2 A. Absolutely. I mean, an unannounced is kept within the
3 team.
4 54 Q. Yeah.
5 A. In fact, we wouldn't even highlight it in some of our 10:29
6 -- in our own schedules, our own calendars and Outlook.
7 55 Q. Yes.
8 A. It's detailed as a private appointment or something
9 like that.
10 56 Q. Yes, of course. 10:29
11 A. So we would keep that -- because we have been
12 criticised in the past by families actually, and by
13 other stakeholders, you know, that staff have now been
14 aware that we're coming on inspection. So that would
15 be the -- that would be the reason we wouldn't be 10:29
16 informing that. Now, that does have its disadvantages.
17 57 Q. Of course.
18 A. You know, even in terms of, I suppose, advocacy
19 services, you know, because again advocacy have raised
20 the issue that 'We don't know you're going to do this 10:30
21 inspection', so therefore it's been quite difficult for
22 advocates to be available during the inspection.
23 58 Q. Yes.
24 A. So that's, I suppose, one disadvantage.
25 59 Q. I'll give you an opportunity to pick up on that point 10:30
26 actually.
27 A. Okay.
28 60 Q. Because it is something that you mention a little bit
29 later in your statement.

1 A. Yes.
2 61 Q. But I did at this juncture want to ask you a little bit
3 more about the example that you've given of finance
4 inspections. Patient finances have been a theme in the
5 evidence that the Inquiry has heard, and some issues in 10:30
6 relation to the management of them.
7 Finance inspections are cited by you as an example
8 where there might not be an unannounced inspection, you
9 may give some notice, and there's a rationale for that
10 which is around effectively saying to the Trust 'Well, 10:30
11 look, if you can make these records available', it
12 makes your process, it speeds up the advocacy of the
13 process, it means you can look at the material rather
14 than having to wait for it to be pulled down from
15 wherever it might be held within the Trust. But in 10:31
16 terms of the tools that you bring to bear, what kind of
17 specialisms, if any, would those conducting the
18 inspection have in order to be able to conduct a
19 finance inspection?
20 A. For a finance inspection we would be bringing one of 10:31
21 our finance inspectors. So within our care we have
22 different specialisms.
23 62 Q. Yes. Yes.
24 A. So our finance inspectors --
25 63 Q. Is that somebody from an accounting background? 10:31
26 A. By background.
27 64 Q. Yeah.
28 A. It's the same with other specialisms. So pharmacy
29 inspectors, we may bring those.

1 65 Q. Yes.
2 A. Estates inspectors. So we have those inspectors at our
3 disposal, if we so need them. But certainly for
4 something like a finance inspection, in terms of
5 looking at those, that information that would be 10:31
6 sitting at a very corporate level, of course, that's
7 why they're announced.
8 66 Q. Yes.
9 A. And that information has to be, I suppose, available
10 for the finance inspector to review. 10:32
11 67 Q. And while you might have a specialist, an auditor or an
12 accountant conducting that finance inspection, is there
13 collaboration with an inspector from a nursing
14 background or a social work background for that matter?
15 A. Yes, there would be collaboration with -- I mean the 10:32
16 inspection team is a skill mix of nurses and social
17 workers.
18 68 Q. Yes.
19 A. So there would be a skill mix. That would have to
20 happen. 10:32
21 69 Q. Yes.
22 A. Because the nursing -- our care inspector would have to
23 obviously look at the patient's care plan to look at
24 information around that patient's capacity to consent
25 for somebody else to manage their monies, to make sure 10:32
26 all of that is in order or otherwise, and to make sure
27 that, you know, the patient has been given choice in
28 terms of how they want their money managed and spent
29 and so forth.

1 70 Q. Yes.
2 A. So, yes, the two would work very much close together.
3 We have a bespoke finance, we call it a record of
4 inspection, an inspection tool with key lines of
5 inquiry, that has been developed by a care inspector 10:33
6 and by the finance inspector, both jointly, to make
7 sure that both areas are covered.
8 71 Q. Okay. Looking across to paragraph 48, on page 12,
9 we're looking very much at the current state of
10 affairs, which I suppose, in fairness, is after, 10:33
11 strictly speaking after the Inquiry's Terms of
12 Reference, but if we just look at how things are now.
13
14 "Across all MHLD services during inspection in 2023,
15 RQIA began requesting contact details of all relatives 10:33
16 from the service provider to allow RQIA to contact
17 relatives directly with patient's consent, if they had
18 capacity to provide it. There were some patients who
19 did not consent, and where they don't have capacity to
20 consent, perhaps due to severe learning disability, 10:34
21 contact relatives."
22
23 I suppose to an interested observer following the work
24 of the Inquiry, one question that person might have is;
25 why did it take so long to take that step? Could you 10:34
26 address that, do you think?
27 A. I can address it, because I've worked in RQIA for quite
28 a number of years.
29 72 Q. Yeah. Yeah.

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1 A. And I suppose whenever I was an inspector back in
2 '14/'15, each inspector was aligned to a particular
3 area of interest, or a particular activity, and mine
4 just happened to be patient and relative engagement.
5 73 Q. So you've got particular personal experience? 10:35
6 A. So I've particular personal experience in this area for
7 relatives and for patients.
8 74 Q. Yeah.
9 A. In terms of how to better engage with patients for the
10 purpose of inspection, but also for the purpose of PPI, 10:35
11 to make sure what we were doing is the right thing to
12 do. The relatives' piece was always particularly
13 challenging, and we tried to do it in different ways,
14 and I know this because I tried to, I suppose, to
15 improve how we done that. 10:35
16 75 Q. Challenging how?
17 A. Well, early on we would have identified that engaging
18 with relatives, while on inspection, was particularly
19 challenging. So we had a methodology that was used
20 back then, and for a number of years, where we would 10:35
21 have left leaflets on the ward.
22 76 Q. Yes.
23 A. And posters, identifying that the inspection was
24 happening. Because the inspection was announced, the
25 ward was given leaflets before we attended to 10:36
26 distribute out to relatives to have ready for us
27 whenever we attended the ward.
28 77 Q. And presumably that would have carried the obvious risk
29 that without imputing any motive to anybody in

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1 particular, that would carry the risk that maybe those
2 leaflets might not find their way somewhere visible
3 where patients or families could see them?
4 A. Yeah, absolutely, you know, that does carry the risk,
5 you know, that maybe some families didn't get a 10:36
6 leaflet. If they maybe didn't -- if they didn't
7 visit...
8 78 Q. Yes.
9 A. You know, within the period of time that the ward would
10 have received the leaflets, until we arrived, it might 10:36
11 have been just a reason that the families didn't
12 receive those particular questionnaires.
13 79 Q. Yes.
14 A. During the inspection, if I think about Muckamore, we
15 would have asked the ward staff to contact families as 10:37
16 well to ask them, or to tell them that we were there in
17 the ward and, again, that ran the risk, of course, that
18 there might have been some selection. But I suppose
19 from my own experience, I would have had an idea that
20 not all families were contacted by way if there would 10:37
21 have been nil return.
22 80 Q. Mm-hmm.
23 A. And on occasions when families did hear that we were
24 there, some families actually would have come down to
25 meet us, to actually meet with the inspector, you know, 10:37
26 as a matter of course, you know, outside maybe visiting
27 the relative.
28 81 Q. During that time, did you have a metric or a means for
29 testing exactly that point? In other words, what is

1 the ward doing to include patients and families in the
2 fact of the inspection? When you obviously give them
3 the leaflets, you're giving them a certain -- you're
4 giving them a certain responsibility to be candid that
5 the inspection is going to happen, but had you -- once 10:38
6 the inspection is up and going, had you any way of
7 testing and examining the extent to which the ward was
8 cooperating in that process?
9 A. It was by the number of relatives that would have come
10 back, either to request that we contact them and 10:38
11 sometimes -- not sometimes, but we would have contacted
12 them by phone, or they would have come to visit the
13 ward. There was no relatives -- there was nothing
14 written down in policy, but if there was no relatives,
15 or one relative, it would alert an inspector that 10:38
16 there's something wrong here.
17 82 Q. Mm-hmm.
18 A. You know, that the relatives have not been contacted.
19 We still, I suppose, weren't getting the engagement
20 that we would have hoped for. It wasn't unique to 10:39
21 Muckamore, it was right across inpatient mental health
22 services.
23 83 Q. Yes.
24 A. So, our inpatient acute mental health wards, or
25 inpatient dementia wards, you know, it was something 10:39
26 that was a particular issue, and we decided, I think it
27 was around '15, that inspectors would stay later in the
28 evening, just by way of a pilot to try, and I suppose
29 inspectors would have started later in the day, you

1 know, with the inspection, to stay on later in the
2 evening.
3 84 Q. To try and?
4 A. To try and capture visitors.
5 85 Q. Yes. 10:39
6 A. So relatives who would come to visit their family
7 member into the evening time, we were there, so they
8 could come and speak to us. Again, there was nothing
9 really formally written down at the time, but it didn't
10 improve the engagement. 10:40
11 86 Q. Yes.
12 A. It didn't, you know, increase the numbers, as such.
13 87 Q. Tell us a little bit about the practicalities of making
14 yourselves available to families at that time; how
15 would you have identified yourselves and that you were 10:40
16 there?
17 A. So we would have been out on the wards.
18 88 Q. Yeah.
19 A. -- when the families were visiting. And we would have
20 went over and introduced ourselves and said 'We're 10:40
21 here, we're really interested in speaking to you, you
22 know, about your relatives, or your family member's
23 care and treatment on this ward, but also to hear of
24 your experience.' But like I said, that didn't
25 increase the numbers either. 10:40
26 89 Q. Yeah.
27 A. There was a view by us as a team that the relatives
28 were more concerned about spending the time visiting
29 their family member.

1 90 Q. Of course.
2 A. You know, within that hour or two of an evening.
3 91 Q. Do you know was any thought given to commissioning some
4 research to look at that question, the apparent sort of
5 disconnect, if I can put it that way, in terms of 10:41
6 engagement between relatives and patients and
7 yourselves at that time? I appreciate these issues
8 might have been superseded by the change in
9 methodology, but thinking back to how that was an issue
10 at the time. 10:41
11 A. Yeah. I'm not aware of any research on that.
12 92 Q. Okay. Looking forward then to page 15, and the
13 question of restrictive practices, which you've
14 helpfully dealt with at paragraph 61 and following.
15 And just to summarise, here you tell us that in 10:41
16 relation to restrictive practices, inspectors review
17 relevant risk assessments. So this is the current
18 process, isn't that right?
19 A. Yeah.
20 93 Q. So: 10:42
21
22 "Inspectors review relevant risk assessments and care
23 plans, looking for evidence of whether restrictions are
24 used as a last resort, and whether they're
25 proportionate, and whether they're in keeping with both 10:42
26 legislative and policy requirements."
27
28 And then in terms of governance, you consider evidence
29 of oversight in relation to the use of restrictive

1 practices, you want to see that the provider is
2 analysing themes and trends and the use of restrictive
3 practices. Pausing there. Have you been satisfied
4 with what you have seen in the period since 2019 at
5 Muckamore, in terms of its ability to provide you with 10:42
6 themes and trends around restrictive practice usage?
7 A. I'm sure if you read any of our inspection reports,
8 you'll see that we haven't been completely satisfied
9 with how restrictive practices have been managed within
10 Muckamore. It has been a recurring theme within 10:43
11 Muckamore, in terms of the use of restrictive
12 practices, by way of somebody being and remaining in
13 hospital behind a locked door when they shouldn't be
14 there, is a restrictive practice in itself.
15 94 Q. Yes. 10:43
16 A. And that's one where RQIA have continually raised that
17 concern. So that's one restrictive practice we are
18 continually concerned about within Muckamore. But in
19 terms of restrictive practices that occur within the
20 service itself, we're continuously raising concerns 10:43
21 about the use of restrictive practices and how they're
22 managed.
23 95 Q. And in terms of examining the steps in place around
24 their use, I'll finish off that previous paragraph,
25 you're looking at evidence of systems in place to 10:44
26 reduce the use of restrictive practices, and then
27 recording in care plans, and that risk assessments are
28 in place that consider the negative impact on the
29 patient's, liberty, privacy and dignity, and detail how

1 these can be mitigated and minimised, looking also for
2 evidence there's also a proactive approach to reducing
3 their use.
4
5 So we can see -- you've set out very clearly what you 10:44
6 expect to see in terms of records and evidence. Can
7 you help us understand how you test that evidence for
8 its accuracy? So, in other words, you're provided with
9 the hard information; how do you then scrutinise that
10 to assess that what you're being told is, in fact, the 10:45
11 case?
12 A. We would speak to staff who are implementing the
13 restrictive practices, or using the restrictive
14 practices, to establish their knowledge and
15 understanding of the restrictive practice itself. Is 10:45
16 that what you mean?
17 96 Q. Yeah?
18 A. Yeah. So, yes, so we speak to staff. If the patient
19 has capacity to consent.
20 97 Q. Yes. 10:45
21 A. And, you know, has an understanding, we would speak to
22 the patient themselves, particularly if we identify
23 that the patient has experienced themselves a
24 restrictive practice.
25 98 Q. Yes. 10:45
26 A. And, you know, the process and proper support of that
27 patient has been implemented, you know, if there has
28 been a requirement for a restrictive practice, and
29 that's been very clearly documented. So if it's

1 documented, we'll seek out the evidence.
2 99 Q. Yeah. And thinking in terms of the patient example,
3 and where that patient has capacity, you're obviously
4 -- I mean you're obviously a specialised learning
5 disability nurse, but presumably there are measures in 10:46
6 place to ensure that there isn't going to be any
7 suggestibility in terms of what the patient might be
8 telling you; in other words, a risk that the patient
9 might be inclined to tell the audience what he or she
10 thinks they want to hear? Are there measures in place 10:46
11 in terms of your own assessment to ward against that?
12 A. Yes.
13 100 Q. Do you understand what I'm saying?
14 A. Yes. Oh, no, absolutely, you know, and that's where
15 you're depending on the documentation. 10:46
16 101 Q. Yeah.
17 A. In respect to that, and the patient's assessment.
18 102 Q. Yes.
19 A. And if the assessment, you know, is highlighting that,
20 you know, patient's understanding might be not what it 10:46
21 should be, I suppose, or -- so you'll always run the
22 risk of that with any patient that you talk to, but you
23 would be astute enough to understand.
24 103 Q. Yes, of course. Yeah.
25 A. But, I mean, my view, and certainly it's my view that 10:47
26 the inspection team would not take that as a given.
27 104 Q. Yes.
28 A. We would still treat that very seriously, you know,
29 even if the patient was a retelling something

1 different, it really wouldn't matter, we would still
2 take it seriously if a patient expressed that they had
3 experienced a particular incident or a restrictive
4 practice.
5 105 Q. Of course. And we touched on, and I know you mentioned 10:47
6 the issue of patient advocates and access to them.
7 Just use that, and I suppose if we can apply the role
8 of advocates in the specific circumstances of
9 restrictive practices, would you be able to access
10 advocates to, if there was an issue in relation to a 10:47
11 patient who hadn't capacity, to examine any issues
12 around use of restrictive practices there, or has that
13 been an issue?
14 A. It hasn't been an issue, but we would know that an
15 advocate would be there if we required advocacy to be 10:48
16 present, you know, if we were going to speak to a
17 patient and we weren't sure. So, absolutely.
18 106 Q. Thank you. And then just on medicines management,
19 which is the next topic that you describe. At
20 paragraph 67, you describe in terms of the use of PRN, 10:48
21 how inspectors take a sample of medication
22 administration records to consider whether the records
23 indicate an appropriate use of PRN in the circumstances
24 in which it is used. Can you tell us how -- just
25 expand our understanding of what you mean there in 10:48
26 terms of how you assess the appropriateness of the
27 administration of PRN?
28 A. Yeah. So, like it said there, we would take a sample
29 record of medication records, or prescription records,

1 administration records, we would look to see PRN, its
2 prescription, its first line, second line, or third
3 line.
4 107 Q. Yeah.
5 A. If it's clearly documented as to when the PRN 10:49
6 medication should be given. We would also triangulate
7 that with the person's, the individual's care plan as
8 well, to make sure that that is clearly documented.
9 Where we would see that that's not well-documented, we
10 would have concerns in relation to that, so if there's 10:49
11 nothing there to direct the staff when they can
12 actually administer the PRN medication, or if there's
13 very frequent use of PRN medication.
14 108 Q. Yes. That's where I was going. Yeah. Okay.
15 A. Right. So if there was very frequent use of 10:49
16 medication, we would be able to identify that and pick
17 that up. So we would also have pharmacy inspectors.
18 109 Q. Yes.
19 A. So our pharmacy inspection resource is quite limited,
20 but we always have nurses out that can obviously read a 10:50
21 Kardex and would know if there is a lot of PRN being
22 used for a particular patient.
23 110 Q. Yes.
24 A. And we have examples where we have actually identified
25 that for patients within Muckamore, actually, and other 10:50
26 areas.
27 111 Q. Yeah.
28 A. So those are exactly what we would look at.
29 112 Q. So the first flag would be the quality of

1 record-keeping, essentially?
2 A. You would want to see if the Kardex is completed to a
3 good standard and is very clearly written.
4 113 Q. Any other flags? I mean it's not a trick question, but
5 any other flags apart from the quality of 10:50
6 record-keeping, and if there were -- I mean, anything
7 else that might cause you to pick up an issue around
8 the administration of PRN?
9 A. Absolutely. How the patient is, the individual is
10 actually presenting themselves. And, again, we have 10:51
11 significant experience of identifying those issues
12 where we feel that...
13 114 Q. Yes. Tell us a bit more about that.
14 A. ...individuals are, I suppose in layman's terms,
15 heavily medicated, or medicated to an extent where we 10:51
16 would be concerned.
17 115 Q. Yes.
18 A. And on those occasions, we would look to the Kardex to
19 establish if there has been overuse or use of PRN
20 medication. To support us with that, again we would 10:51
21 link in with our pharmacy colleagues and our consultant
22 psychiatrist to have a look at that medication as well.
23 We would also look at the circumstances around the PRN
24 medication being given. So if we think back to the
25 restrictive practices piece, we would be absolutely 10:51
26 looking to see that the PRN medication has been used,
27 again as a last resort, but also possibly as part of
28 the person's behaviours -- behaviour, dysregulated
29 behaviours, to help, I suppose, settle the patient.

1 116 Q. Yes.
2 A. But if we were out on wards and we detected or observed
3 that patients looked to be or presented to be overly
4 medicated, we would absolutely identify, and have done,
5 in different facilities, yeah. 10:52
6 117 Q. Yes. And then turning to patient flow then, which is
7 at the top of -- just the paragraphs on the top of page
8 17, focusing in particular on resettlement and
9 discharge. This is something that you look at. And
10 you look at associated care planning as well as the 10:52
11 service's links with community MHLD staff and services
12 in the preparation for discharge. You say that:
13
14 "From past inspection reports it is evident that
15 inspectors considered in particular the progress with 10:53
16 patients in Muckamore who were delayed in their
17 discharge and requiring resettlement."
18
19 Can you tell us a bit more about how you were able to
20 establish that it was evident that inspectors did so? 10:53
21 In other words, I suppose, how inspectors were able to
22 assess that progress? What did you see in the
23 documentary evidence?
24 A. The reduction, from a very basic level, the reduction
25 of number of individuals from inspection to inspection, 10:53
26 you know, in terms of where there's less patients, is
27 that what you mean or?
28 118 Q. Yes. Yes, I mean
29 A. I'm not sure...

1 119 Q. Well, even on a more granular level, how would you be
2 able to tell that inspectors were taking into account
3 patient progress in relation to delayed discharge and
4 resettlement?
5 A. Progress within the Hospital -- 10:54
6 120 Q. Yes, yes.
7 A. -- towards an individual's resettlement and their
8 delayed discharge?
9 121 Q. And their delayed discharge?
10 A. Yes. So on a ward-based level and an individual level, 10:54
11 as an inspector you would be looking at their
12 resettlement or delayed discharge care plan, you would
13 be looking to see what progress has been made in terms
14 of -- well, first of all, establishing and finding a
15 placement in the community for that individual to go to 10:54
16 that is appropriate to that individual's needs and
17 meets their assessed needs, and then you would be
18 looking to see what the Trust or what the service has
19 done to progress towards the discharge. So, what
20 support has been put in place for the individual in 10:54
21 terms of the in-reach from the service that the person
22 is going to, what does that look like?
23 122 Q. Yes.
24 A. And, you know, how the individual themselves are being
25 prepared, you know, for discharge out to, I suppose, 10:55
26 their home in the community.
27 123 Q. Yes.
28 A. You would to see -- and we'd also be looking for the --
29 so there's a number of patients, a number of

1 individuals who are not Belfast Trust, they also come
2 from a different Trust, so we would be very keen to see
3 what's the link and what's the engagement from the
4 Trust that the individual is from and is moving to on
5 most occasions. So you'd be wanting to see that 10:55
6 engagement.
7 124 Q. Okay. And if there were issues around delayed
8 discharge, how would those have been conveyed to the
9 Hospital, or to the -- I think the phrase we heard last
10 year was the "owning Trust"? 10:56
11 A. Delayed discharges?
12 125 Q. Yes.
13 A. So, I suppose, those are escalated up to previously
14 which we would have known as the Board or the PHA, you
15 know. 10:56
16 126 Q. Yeah.
17 A. I mean, my view, if that's okay to say?
18 127 Q. Absolutely?
19 A. So when I came to RQIA, I moved from the Southern
20 Trust, and we had an inpatient hospital, I did work in 10:56
21 it for a very short period of time, and when I came to
22 RQIA, I worked in the community for about ten years,
23 and that hospital closed, successfully.
24 128 Q. Mm-hmm.
25 A. And when I came to RQIA and started inspecting 10:56
26 Muckamore, I was actually quite shocked to see that
27 there were people still in hospital for very, very -- a
28 very long period of time, it actually was quite
29 alarming to me that this was happening, right across,

1 actually, not just learning disability hospitals, but
2 also people with mental health who have been in
3 hospital for a long period of time. So it was quite
4 shocking for me to see that, because it didn't happen
5 any more in the Southern Trust. 10:57
6 129 Q. Yes.
7 A. So I had a real invested interest in that. So our team
8 were continuously flagging up our concerns about people
9 who were significantly delayed in their discharge and
10 in hospital and how the hospital was their home 10:57
11 address.
12 130 Q. Mm-hmm.
13 A. And it was being escalated, and it was a recurrent
14 theme, and so we were very interested to see that
15 progress was being made, and concerned that progress 10:57
16 was not being made at a pace which we thought it would
17 be. So I suppose we used the powers, and you heard
18 Lynn talking about the powers yesterday in terms of
19 where we can go with information and escalation, to
20 keep flagging it up to a level that we felt needed to 10:58
21 know that there were individuals who were remaining
22 delayed in their discharge.
23 131 Q. Yes.
24 A. And I've maybe spoke out of turn by saying that.
25 132 Q. No. No, no. 10:58
26 A. But we feel it important to say.
27 133 Q. You say that, paragraph 73, turning the question of
28 governance, which is something we touched on a little
29 bit earlier in your evidence, that consideration of the

1 governance of the service has been the most significant
2 change in your time, and consideration of governance
3 began with the introduction of well-led criteria in
4 2017, but then a significant change came in 2019.
5 10:58
6 "There's a clear shift to focus on to governance at
7 Trust level rather than at ward management level."
8
9 Prior to 2019, what was -- was there any function
10 within inspection to look at overall governance within 10:59
11 the Trust in respect of the Hospital?
12 A. No, it was more at ward level.
13 134 Q. And, therefore, prior to 2019, there would have been no
14 overall governance examination of Muckamore?
15 A. Just at ward level. So, actually, it was up until 10:59
16 about 2018 our methodology started to change in respect
17 to other services when we began to look at hospital,
18 but we generally looked at wards, single wards, and the
19 governance at ward level. So we didn't really look
20 beyond that on previous methodology. However, senior 10:59
21 Trust personnel, I would say on most, if not all
22 occasions, would have attended at the conclusion of
23 inspection to hear findings, to hear, you know, what
24 our findings were in terms of any areas for
25 improvement, or any concerns, but it was mostly aimed 11:00
26 at governance at the ward level.
27 135 Q. At the ward. And I mean your personal opinion is
28 entirely, and your personal experience is entirely
29 valid for present purposes, and I suppose as someone

1 who has come through the ranks, so to speak, as an
2 inspector, Senior Inspector, and now in your current
3 role, do you think that not looking at overall
4 governance within the Hospital, or indeed the Trust,
5 was a shortcoming on the part of the organisation, that 11:00
6 is to say the RQIA, prior to 2019?
7 A. I'm not sure -- I suppose we worked to the system and
8 the methodology we had at the time. Certainly, when we
9 began to look at -- across a system, or a system-type
10 inspection where we were looking at governance within 11:01
11 the system, we began to see where the issues and
12 concerns were. Do you want my honest opinion?
13 136 Q. Absolutely.
14 A. Obviously. Sorry. Yes, it -- there could have been
15 issues that we weren't looking at that level, where 11:01
16 issues might have been, or concerns might have been.
17 There was a heavily dependence on ward managers.
18 137 Q. Yes.
19 A. By the way we wrote our reports at that stage as well.
20 138 Q. Yes. 11:01
21 A. Recommendations, areas for improvement, were made to
22 the Ward Manager. So they weren't to the Trust or to
23 -- so there was a significant difference in that.
24 139 Q. All right. Well, look, in the next paragraph then, you
25 describe how governance is considered as a theme in its 11:02
26 own right.
27
28 "An inspector's consideration of the other areas
29 identified above also feeds into the assessment of

1 governance, and specifically relating to governance,
2 RQIA considers accountability structures, the vision of
3 the Trust, models of care, the Trust's internal
4 communication and escalation channels, communication
5 with the Department of Health, other Trusts and other 11:02
6 stakeholders, complaints management, senior managers
7 meetings, and then links with other Trust directorates,
8 for example whether the mental health directorate
9 communicates with the primary care directorate within
10 the Trust." 11:02
11
12 And you would also look at how learning is shared
13 across the Trust.
14
15 So we can see there that when you examine governance 11:02
16 you're looking for evidence of the presence of
17 policies, and committees, and other structures, but I
18 suppose you can agree or disagree with the premise of
19 what I'm going to put, but having those policies, and
20 structures, and committees is the first step, and the 11:03
21 proof of the pudding, if I can put it that way, can
22 only really be obtained in the eating; in other words,
23 how do you assess how those policies, structures, and
24 committees are working? And Dr. Maxwell I think
25 touched on it a little bit earlier in your evidence, 11:03
26 when she wondered whether there had ever been a sort of
27 a test of the following up of a complaint or an
28 incident to see, you know through the structure, to see
29 where it ended up. There's quite a lot in that, but do

1 you understand? The premise of what I'm putting to you
2 is having these things in place is only the first part;
3 how do you test their efficacy?
4 A. Through lots of different ways. So talking with the
5 staff to make sure that they have an understanding, a 11:04
6 knowledge of the policy itself. Again, just giving the
7 example if there was an incident, or an accumulation of
8 incidents, and learning had been identified, we would
9 be looking to see that -- well, first of all, the
10 learning has been identified, because we would be 11:04
11 looking across a number of incidents as well as part of
12 the inspections, we're taking a selection of incidents.
13 140 Q. So you would potentially be following a complaint or an
14 incident through?
15 A. We would follow the journey of an incident or 11:04
16 accumulation of incidents through its path in terms of
17 the governance of it.
18 141 Q. Journey, yes. Yeah.
19 A. If learning has been identified, or there's been policy
20 changes, or changes to a process, we would want to see 11:04
21 how that's been shared with staff.
22 142 Q. Yes.
23 A. Whether it be e-mail, or there's a learning letter, or
24 there's a bulletin put up, whatever it might be, we
25 would want to see. And then we would talk to staff to 11:05
26 find out, well, first of all, did they know?
27 143 Q. Yes.
28 A. Did they have an understanding of it? Were they
29 actioning? Were they taking the actions as they needed

1 to be? We would also take that one step further in
2 that we would want to see what assurance mechanisms the
3 actual Trust or the senior managers had in place to
4 assure themselves that the actions or the learning is
5 being implemented effectively. 11:05
6 144 Q. Yes.
7 A. So at times where we have seen, you know, where there
8 has been an incident, there's been learning identified,
9 and we could see it all very nicely documented, very
10 nicely, the actions are there, there's been some change 11:05
11 to a process. I'm trying to think of an example. This
12 is just an example by way of --
13 DR. MAXWELL: Can I ask you a slightly different
14 question.
15 A. Sorry. Yes. 11:06
16 DR. MAXWELL: So you have focused very much on what is
17 in the control of the people at the hospital. So
18 something has happened, it's been identified there's
19 learning, and it's within the control of the ward staff
20 to change. But we know that when there are quality 11:06
21 failures, a large amount of that is due to structural
22 problems, which is not within the control of either the
23 hospital managers or the ward staff. So the example I
24 gave you earlier about staffing, there is absolutely
25 nothing that the hospital managers or the ward staff 11:06
26 can do if the Trust has a recruitment freeze, or if
27 they haven't funded enough posts, and so it sounds to
28 me as though your focus on governance was about what
29 individuals could do, but that you weren't actually

1 looking at the structural elements, and so the issues
2 about resettlement, those are structural things that
3 the hospital hasn't got any control over. Would it be
4 fair to say that actually that structural element, when
5 you're looking at a hospital, wasn't part of your Terms 11:07
6 of Reference and, therefore, you didn't look at the
7 governance of those structural elements.
8 A. When you mean "structural elements"?
9 DR. MAXWELL: So there are a lot of things that affect
10 the quality of the care of the patients, which are part 11:07
11 of a wider infrastructure and system. So, have we
12 trained enough learning disability nurses? Is there
13 enough funding? Have there been enough thought given
14 to creating appropriate community placements for people
15 to be resettled into? All of those things might be 11:08
16 considered to have an influence on the context and the
17 culture within the hospital, which created
18 overcrowding, patients who weren't in a suitable
19 setting led to more distressed behaviours, all those
20 things are very important to the quality of care, I 11:08
21 would say as important as the actions of individual
22 ward staff. So my question is, when you're looking at
23 governance, was it outside your Terms of Reference to
24 look at that wider governance or did you actually look
25 at those things? 11:08
26 A. We would have looked at wider governance. We would
27 have looked at the directorate, so the directorate for
28 mental health and learning disability within a Trust.
29 So we take it as far as that.

1 DR. MAXWELL: But the directorate couldn't change the
2 budget if the Board hadn't assigned them a budget.
3 A. Yeah. So one of the additional areas that we added
4 into our methodology is the sharing of information with
5 the Trust Board. So we could see that there was -- the 11:09
6 information was shared up to Trust Board as well. Is
7 that --
8 DR. MAXWELL: Yeah, that's part of it. So how did you
9 report on that? Because the reports that I've seen
10 that you've published, and I recognise not everything 11:09
11 can be published in the public domain, it's not clear
12 (a) that you did track that, and (b), how you reported
13 back to the Trust if you thought that was insufficient?
14 A. I suppose it's the level that you escalate to as well,
15 you know, if your findings are outside of -- if -- so, 11:09
16 for example, like staffing levels, you know, we would
17 know that that's not within the Hospital's control,
18 it's wider. In fact it's not just within the Trust
19 control, it's actually a significant regional issue,
20 and we know there's just been a significant piece of 11:10
21 work done there by NIPAC in terms of regional. So we
22 would be very much aware of that and look outside that.
23 So --
24 DR. MAXWELL: So have you got a mechanism of reporting
25 back to the HSCB or the SPPG, or even the professional 11:10
26 leads at the Department of Health, to say 'quality of
27 care is seriously comprised by this, and this has - it
28 cannot be improved until you address this'?
29 A. Yes.

1 DR. MAXWELL: How does that happen?
2 A. Yeah, so that happens through -- we would call that an
3 Article 4 letter.
4 DR. MAXWELL: A what, sorry?
5 A. An Article 4. An Article 4 letter, in terms of the 11:10
6 legislation.
7 DR. MAXWELL: Right.
8 A. So it's within our legislation, our 2003 order, but
9 also within our Mental Health Order, that where there
10 are deficiencies identified, so that could even be 11:11
11 reduced staffing levels, so somebody's care and
12 treatment could be significantly comprised, or a group
13 of individuals. So we would use that mechanism of
14 flagging that up with the, with the SPPG or Department
15 of Health. Quite frequently we would ask to meet. 11:11
16 DR. MAXWELL: And do you know how many times an Article
17 4 letter has been issued about MAH?
18 A. I don't have that information in front of me, but I can
19 certainly --
20 DR. MAXWELL: But that's something that could be 11:11
21 provided?
22 A. We could provide that, absolutely, we could provide.
23 DR. MAXWELL: Thank you.
24 A. Improvement notices are another means of --
25 DR. MAXWELL: But that goes to the Trust? 11:11
26 A. But that goes to the Trust. But a copy of that will
27 also be issued to the SPPG so that they're aware of
28 where there's concerns.
29 DR. MAXWELL: Okay.

1 A. If there's concerns -- if there's serious concerns, and
2 we know Lynn spoke to the different levels of I suppose
3 escalation that we have, serious concerns are also
4 flagged with the SPPG --
5 DR. MAXWELL: So that's the step before an improvement 11:12
6 notice, I think we heard yesterday.
7 A. So that's the step before an improvement notice. All
8 correspondence in relation to escalation, identified
9 concerns, are always sent to the Chief Executive within
10 the Trust. So there's always -- that information 11:12
11 always goes to -- it's written directly to the Chief
12 Executive, so they would be very aware of concerns
13 within the Trust.
14 DR. MAXWELL: When you issue your Inspection Report,
15 who is that sent to? Is that sent to the directorate 11:12
16 or --
17 A. The Trust -- the report goes to the Chief Executive.
18 DR. MAXWELL: So all your correspondence goes via the
19 Chief Executive?
20 A. That's correct. 11:12
21 DR. MAXWELL: Thank you.
22 CHAIRPERSON: Just before you were asked that series of
23 questions by Dr. Maxwell, you were going to give us an
24 example, I think, of a single incident which was
25 followed through the escalation process, and you just 11:13
26 said "I've got one example", and I was just wondering
27 what the example was going to be, if it's still in your
28 mind?
29 A. I was trying to think of an example. So where there's

1 been a change in process. I mean this example is not
2 really, I suppose, particularly related to Muckamore;
3 it's just an example, maybe, of something that we've
4 identified or there's been identified learning.
5 11:13
6 So, say, for example, there's been a significant
7 increase in medication errors, so we've identified that
8 where we could see that through a series of incidents
9 that we've reviewed.
10 CHAIRPERSON: Right. 11:13
11 A. So we'd want to see that the learning had been
12 established in respect to that, and what learning there
13 was. So, say, for example, in an ideal world what
14 you'd want to identify is that the Trust had looked to
15 see why? Is it happening at a particular time? Is it, 11:14
16 you know, particular staff on duty? And so forth. And
17 what do we need to do to improve that? So if the Trust
18 say 'Well, actually, we need to ensure that medications
19 are administered at a time where there's no visitors',
20 that's just an example, you know, so there's no 11:14
21 disruption to a medication round, then you would see
22 that there would be a change in process. Then as an
23 inspector you would be out and you would be observing
24 on an inspection round, you would be seeing where, you
25 know, that process has been implemented, and you would 11:14
26 be talking to staff. So that's just by way of one
27 example. I probably could give a better one, but I
28 just can't think of one now.
29 CHAIRPERSON: All right. Okay. Thank you. I just

1 wanted to give you the opportunity of giving us that if
2 you wanted to.
3 A. That's okay.
4 CHAIRPERSON: Mr. McEvoy, I'm just looking at the time.
5 MR. McEVOY: Not very much longer. I would think we'll 11:14
6 be done by half past.
7 CHAIRPERSON: All right.
8 145 Q. MR. McEVOY: Paragraph 91, Ms. McGregor, you describe
9 how, during your time as an inspector, the RQIA has
10 always sent the inspection report to the relevant 11:15
11 Trust's Chief Executive, and inspection reports
12 historically are also sent to the Ward Manager, which
13 is no longer the case since around 2018. Was the
14 Inspection Report was sent to the Chief Executive of
15 just Muckamore, or was that the practice with all 11:15
16 Trusts?
17 A. That's all Trusts.
18 146 Q. And what was it that prompted an end to the practice of
19 sending it to the Ward Manager, if you can recall?
20 A. Because a lot of the recommendations and areas for 11:15
21 improvement were specifically related to governance, or
22 not a lot, but if there was recommendations that
23 related to governance within the Trust, it was more
24 appropriate that it would go to the Chief Executive
25 rather than to the Ward Manager. 11:16
26 147 Q. Yes. Turning to paragraph 109 on page 24, you were
27 asked about the proportion of time spent interviewing
28 patients, and we've discussed earlier in your evidence
29 interactions that you would have had with patients, and

1 the question of capacity and how that factors into the
2 equation. Those are -- those that cannot communicate
3 verbally are observed by inspectors, you tell us
4 further interaction and engagement with staff, how
5 their needs are being met and how they present in the 11:16
6 presence of staff, and then you describe the family
7 engagement process. We've touched on that as well
8 earlier in your evidence.
9
10 We also talked about, a little bit earlier on, the 11:16
11 question of the role played by advocates. Is there a
12 role, an increased or, somehow or other improved role
13 for advocates in terms of the processes and procedures
14 that RQIA carry out, and in terms of their engagement
15 with patients? 11:17
16 A. So, improved role in terms of how RQIA engage with
17 advocates or how advocates engage with patients?
18 148 Q. You could look at it both ways. Certainly that part of
19 it. But also perhaps you had mentioned earlier in your
20 evidence about accessing, and difficulties accessing 11:17
21 advocates, because self-evidently, I suppose, the
22 mechanics of an unannounced inspection might mean that
23 advocates aren't on site when such an inspection is
24 being carried out.
25 A. Yes. 11:17
26 149 Q. But is there a way in which that circle can be squared,
27 if I can put it that way?
28 A. I think that's an area that RQIA, or the mental health
29 and learning disability team do need to make further

1 development in terms of reaching out to advocacy
2 services to -- I suppose similar to what we've put in
3 place for family engagement.
4 150 Q. Yes.
5 A. So there's been significant improvements in that. So 11:18
6 proactively seeking out advocacy services. There is
7 some reliance on the Trust to inform advocates that we
8 are there.
9 151 Q. Yes.
10 A. But we definitely do need to make some improvements in 11:18
11 terms of ensuring that advocates are contacted as part
12 of the inspection process. We do, if it's necessary,
13 but we'd like to hear more from an advocate in terms of
14 their view on the care and treatment.
15 152 Q. And presumably one of the factors in the equation will 11:18
16 be making sure that in order to preserve the
17 impartiality and independence of what it is that you
18 do, that you access the advocates without relying on
19 the Trust?
20 A. Yes. Yes. In terms of patient engagement with 11:19
21 advocates, it's certainly part of the Inspector's role
22 to ensure that each patient -- each individual has an
23 advocate.
24 153 Q. Yes.
25 A. Where they have requested to have an advocate. There 11:19
26 are some patients, and I'm speaking broadly, do not
27 wish to have an advocate, but on the -- the majority of
28 individuals in Muckamore would have an advocate, and we
29 would want to see that they're clearly involved in key

1 decisions about that individual's life, and we also
2 look to ensure that there's care advocacy arrangements
3 in place for relatives as well, you know, to support
4 relatives. So.
5 154 Q. Looking across to -- it's just into one of your 11:19
6 exhibits, it's at page 53. Now you recognise this
7 document?
8 A. Mm-hmm.
9 155 Q. "Review of information pre-inspection". Is this a
10 document that's currently in use? 11:20
11 A. No.
12 156 Q. All right. This is one under the --
13 A. This was the 14/'15 sort of leading up to the '18/'19
14 change in methodology, so it was used in that period of
15 time. 11:20
16 157 Q. Okay. This document asked how many SAIs on the ward
17 inspected? Did RQIA test during that time to see
18 whether SAIs were being properly declared? Had you a
19 means of being able to assess that and did you do it?
20 A. Well, there would have been a reliance on -- well, we 11:20
21 receive SAIs as part of our role and function.
22 158 Q. Yeah.
23 A. But, yes, if -- when there was a review of incidents on
24 site, or whenever we got the incidents that happened
25 within a period of time, we would have took a sample of 11:21
26 those, obviously sometimes they went into the thousands
27 and we couldn't always look at a thousand or 2,000
28 incidents.
29 159 Q. Of course.

1 A. But certainly if we had of identified that an incident
2 met the criteria for it to be regionally reported as a
3 serious adverse incident, we would have been
4 recommending that the Trust refer it or report it as an
5 SAI. Recently, we've just undertaken a specific 11:21
6 bespoke incident focused inspection, which solely
7 looked at that area, because it had come to light that
8 there weren't, and so the report I think is not
9 published, but we have looked specifically at that one
10 area as part that have inspection. 11:22
11 160 Q. That's a post --
12 A. That's post Terms of Reference.
13 161 Q. Post. Post, yeah. Okay. I'm nearly finished, but I
14 did just want to ask you about the topic of CCTV, and I
15 know there was some discussion about that yesterday. 11:22
16 In terms of the hospitals that you have inspected, do
17 you know whether any of them have introduced CCTV in
18 the way that Muckamore Abbey did?
19 A. Reduced?
20 162 Q. Introduced. 11:22
21 A. Oh introduced.
22 163 Q. Introduced.
23 A. Sorry, I thought you said "reduced". Sorry. Yes, most
24 inpatient mental health services have CCTV.
25 164 Q. Okay. And have you had to use it or had resort to it? 11:22
26 A. As part of an inspection?
27 165 Q. Yes.
28 A. No.
29 166 Q. All right. Once the abuse which is at the, I suppose,

1 the -- at the core of this Inquiry, is publicised and
2 was revealed by CCTV, do you know whether RQIA reviewed
3 processes and considered looking at the CCTV to assist
4 -- to assess what might have been missed in previous
5 inspections? 11:23
6 A. No. We looked at the process for CCTV in terms of how
7 it was being used, and we look at it to make sure that
8 it's being used for several reasons. There's a
9 contemporaneous aspect to CCTV.
10 167 Q. Yes. 11:23
11 A. There's also CCTV is used to -- where there has been an
12 incident on the wards, adult safeguarding or otherwise,
13 we would look to the process of that and how that's
14 been managed. But in terms of watching CCTV, no.
15 168 Q. Yeah. So it was, I guess, an examination of processes 11:23
16 looking prospectively rather than what CCTV might have
17 been able to contribute to previous inspections. Would
18 that be fair to say?
19 A. I can't answer that. I'm not -- I'm not sure. So in
20 terms of us looking at CCTV to see if there was gaps in 11:24
21 our inspection, that perhaps CCTV identified that we
22 may have missed?
23 169 Q. Yes. Yes.
24 A. Well, I wouldn't -- I mean, I wouldn't rule it out. I
25 mean obviously if it would help improve what we do, 11:24
26 RQIA is always an improving organisation in its
27 learning, so I wouldn't rule it out. But I can't say
28 for sure if it would -- well, I don't know, I don't
29 know if it would pick up gaps in terms of those

1 particular incidents, but...
2 170 Q. So, Ms. McGregor, between 2013 and 2020, there were
3 eight inspections of the Psychiatric Intensive Care
4 Unit, there were six at the Cranfield Female, there
5 were eleven of Cranfield Male, six at the Six Mile 11:25
6 Ward, five of a Donegore, and those are publicly
7 available inspections, that's 36 I think if my maths
8 are right, in total, and none appear to have triggered
9 a serious alarm within RQIA. Now, I appreciate you
10 were an inspector, Senior Inspector then in your 11:25
11 leadership role I suppose towards the end of that time,
12 but as a senior manager now in a leadership position,
13 does it surprise you that, whether separately or
14 cumulatively for that matter, any of those led to the
15 triggering of a serious alarm within the organisation? 11:25
16 A. I'll have to ask you to repeat that question?
17 171 Q. Yeah. There were 36 inspections across the various
18 wards, and you were variously an inspector, Senior
19 Inspector, and now in a leadership role. Do you have a
20 concern, would you express surprise when I put it back 11:26
21 to you like that, that separately, or cumulatively,
22 those inspections -- none of those inspections led to
23 the triggering of a serious alarm about what was going
24 on in the hospital?
25 A. Inspections are limited in what they can do. You're 11:26
26 there for a period of time. You get a snapshot of a
27 service during that time. So I suppose there's --
28 there was several elements to the safeguarding in terms
29 of the actual incidents that happened. I actually

1 don't know how to answer that question, but what I
2 would say is, the inspection is limited, and there's an
3 element, I suppose, of hindsight from myself, because
4 I'm very aware of the incidents because I'm part of the
5 Operation Turnstone piece, so I'm aware of the nature 11:27
6 of them.
7 172 Q. Yes. Of course.
8 A. So it's difficult for me to answer that question.
9 173 Q. Yeah.
10 A. Because I'm aware of the nature and when they occurred 11:27
11 and a lot of detail.
12 174 Q. You mean it's difficult for you to answer for fear of
13 saying something that might impact upon the operation?
14 A. There's -- yes.
15 175 Q. Yeah. Yeah? 11:28
16 A. That as well. But also it might impact on my answer
17 because --
18 176 Q. Yeah.
19 A. -- I know that it's happened, say, at a weekend or --
20 and I've seen CCTV. 11:28
21 177 Q. Yeah. Well I don't need you to go into that detail.
22 A. Okay.
23 178 Q. That's for sure. But let's deal with it in this way:
24 Assume, assuming for present purposes, and it is an
25 assumption, that there was abuse of some patients on 11:28
26 some of the wards that I mentioned, and it wasn't
27 identified by RQIA, what could RQIA, do you think,
28 change about its processes and methods to better
29 identify abuse of patients when it occurs?

1 A. I'm not sure. I think our system at the time was as
2 effective as it could be. We're talking about the
3 single ward. I don't know if I can actually answer
4 that. I don't know.
5 179 Q. Well, maybe this might have -- put this question to you 11:29
6 in this way. Thinking about your frontline inspectors,
7 are there tools that those inspectors could benefit
8 from to do their jobs more effectively in and around
9 the prevention of detecting and preventing abuse?
10 A. Well, I suppose one way that we've -- that we have 11:30
11 developed, is inspecting at different times, you know,
12 and that's because we would be aware that abuse would
13 have happened outside of normal working hours.
14 180 Q. Yeah.
15 A. Policies have changed a bit as well in terms of adult 11:30
16 safeguarding. The way we manage adult safeguarding
17 ourselves as an organisation within the mental health
18 team is that we're notified, which we wouldn't have
19 been before.
20 181 Q. Yes. 11:31
21 A. In terms of adult safeguarding, any adult safeguarding
22 which allegedly involves another member of staff is
23 automatically notified to RQIA, so that came in. So we
24 would be following that up and using that as
25 intelligence. 11:31
26 182 Q. Those are things that are in place and have come into
27 --
28 A. Yeah, since.
29 183 Q. Since.

1 A. Yeah.
2 184 Q. Is there anything else, I suppose is the thrust of what
3 I'm asking you, is there anything else you think that
4 inspectors in your role, and those of your team could
5 -- would be assisted by to detect and prevent abuse or 11:31
6 assist in that process?
7 A. I don't think there's any system that's going to 100%
8 prevent abuse, if that -- but --
9 185 Q. That's probably a given and --
10 A. Yeah. 11:31
11 186 Q. -- but I suppose you would accept the premise that we
12 have to strive to do our best.
13 A. Absolutely.
14 187 Q. And if you were given a wish list or an opportunity to
15 write one, perhaps? 11:32
16 A. I can't answer the question.
17 MR. McEVOY: All right. Okay. Thank you. Chair,
18 those are my questions. Thank you very much.
19 A. Thank you.
20 CHAIRPERSON: I've have got a couple of questions. 11:32
21
22 MS. McGREGOR WAS QUESTIONED BY THE INQUIRY PANEL
23 AS FOLLOWS:
24
25 188 Q. CHAIRPERSON: The RQIA is all about improving services, 11:32
26 health services. So since 2017, when the revelations
27 came out about abuse at Muckamore, you tell us you've
28 changed your policies on adult safeguarding and you've
29 changed the times of inspections. Are those the two

1 things that you -- come to your mind, as it were, as
2 the two big changes that you've made?
3 A. So we've changed how we've conducted inspections. So
4 the methodology has changed as well. And we've changed
5 from single word to -- 11:33
6 189 Q. CHAIRPERSON: To whole hospital?
7 A. Whole hospital systems inspections.
8 190 Q. CHAIRPERSON: You mentioned in your statement, and very
9 briefly in your evidence -- it's in your statement at
10 paragraph 25, where you talk about the intelligence 11:33
11 system that has been introduced, and I think that has
12 been introduced in around 2019, and you talk about
13 iConnect, and I just want to understand what that can
14 actually do for you? Because from what you've said
15 about it, it seems to me that it's really simply a data 11:34
16 storage system, and it's still up to inspectors to
17 identify themes and trends. Is that fair?
18 A. Yes. So there is an element of the inspectors having
19 -- need to know what theme that they're actually
20 looking for, you know, so that they can pull, extract 11:34
21 that data from iConnect.
22 191 Q. CHAIRPERSON: Yes. But -- and I'm not saying this
23 would have made a difference, but there are, of course,
24 now, algorithms and the use of AI that can do that for
25 you, and you were just asked if you could change 11:34
26 anything, what would you change? Do you think one of
27 those systems would help you?
28 A. Yes, absolutely. I mean, we are looking at our system
29 to improve what it does. If you wanted to ask me what

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1 my wish-list, I would want a system that would throw
2 out -- that would produce information for me, rather
3 than me having to go look for it. So a system that
4 will automatically identify, we have increasing number
5 of intelligence concerns, or whatever it is, coming in, 11:35
6 relating to adult safeguarding, so that would flag that
7 straight away to me, like an alert. Whereas at the
8 minute, you have to actually know what you're looking
9 for in the current system.
10 192 Q. CHAIRPERSON: Yes. And you're always reliant on the 11:35
11 information that is fed into the system?
12 A. That's correct.
13 193 Q. CHAIRPERSON: But it's then a question of what the
14 system can do for you once it's got that information?
15 A. Yes. 11:35
16 CHAIRPERSON: Yes. I don't have any other questions
17 for you. Can I thank you very much for coming along to
18 assist the Inquiry.
19
20 That was a counsel's five minutes, because it turned 11:35
21 into 15, and I've added to it, but thank you. And
22 we'll will come back again at 12:00 o'clock. Thank
23 you.
24
25 THE WITNESS THEN WITHDREW 11:36
26
27
28
29 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

1
2 CHAIRPERSON: Thank you. Yes.
3 MS. BRIGGS: Good afternoon, Panel. The final Module 5
4 witness is Alan Guthrie. The statement reference is
5 STM-213, and unless there's anything arising, Panel, we 11:53
6 can call the witness in.
7 CHAIRPERSON: No, we'll start Mr. Guthrie. We'll see
8 how far we get. If there's a reasonable likelihood
9 that we'll finish him, you know, not long after 1:00,
10 then we'll sit through. 11:54
11 MS. BRIGGS: Yes.
12 CHAIRPERSON: Unless I have a complaint from the
13 stenographer, but we'll get as far as we can. But
14 obviously we're not going to rush him.
15 MS. BRIGGS: Thank you, Panel. Thank you. 11:54
16 CHAIRPERSON: Okay. Let's get the witness in.
17 MS. BRIGGS: Thank you.
18
19 MR. ALAN GUTHRIE, HAVING AFFIRMED, WAS EXAMINED BY
20 MS. BRIGGS AS FOLLOWS: 11:54
21
22 CHAIRPERSON: Good afternoon, Mr. Guthrie. Thank you
23 very much for your statement and for coming along to
24 assist us. If you need a break at any time tell us,
25 but we're probably going to sit through until we finish 11:54
26 your evidence, unless it gets very late. Okay. Yes.
27 194 Q. MS. BRIGGS: Thank you, Chair. Mr. Guthrie, you've
28 given a statement to the Inquiry, it's at reference
29 213, and you have a copy of it in front of you. It's

1 dated 28th March 2024, and it runs to 36 pages, and it
2 includes three exhibits prepared by you, isn't that
3 right?
4 A. That's correct, yes.
5 195 Q. And I understand that there are two matters that you 11:55
6 wish to correct or add to in your statement, is that
7 right?
8 A. Yes, please.
9 196 Q. And those are issues that you identified when you were
10 reading over your statement before today's evidence, 11:55
11 isn't that right?
12 A. Yes. Yes, further to completing my statement in
13 preparation for today, I've obviously reviewed my
14 statement and noted two factual errors that I'd like to
15 correct. 11:55
16 CHAIRPERSON: Sure. Just tell us what they are.
17 197 Q. MS. BRIGGS: So I understand the first of those is at
18 page 3, is that right, Mr. Guthrie?
19 A. That's correct, yeah, paragraph 7.
20 198 Q. Paragraph 7. 11:55
21 A. Yeah.
22 199 Q. And can you tell the Panel what it is you wish to
23 correct on page 3, paragraph 7?
24 A. Yes. At paragraph 7 I list three wards that I had
25 inspected following information received, the second of 11:55
26 those inspections, Cranfield Male, 17th July 2017,
27 should be the 13th July, and not the 17th.
28 CHAIRPERSON: Right.
29 200 Q. MS. BRIGGS: And then the second of those matters I

1 understand is at page 25, and that's Exhibit 1?
2 A. Yes, that's correct.
3 201 Q. And that's the paragraph marked "5" with the date
4 1st April '15 to 31st March '16, and I understand
5 there's something within that specific paragraph that 11:56
6 you wisher to add to?
7 A. Yes, please. That paragraph should have another
8 inspection added to it of the Killead Ward completed on
9 24th April 2015.
10 202 Q. So after there we can see that there's four different 11:56
11 wards listed --
12 CHAIRPERSON: Sorry, which paragraph number are we on?
13 MS. BRIGGS: Paragraph 5, page 25. Exhibit 1.
14 CHAIRPERSON: Ah! Sorry, apologies. Yeah.
15 203 Q. MS. BRIGGS: The fifth paragraph there is titled "1st 11:56
16 April '15 to 31st March '16 ", and it details four
17 inspection visits of wards you completed at Muckamore,
18 and you've just outlined that there's a fifth that you
19 wish to add to that list?
20 A. Yes, please. I also completed an inspection of the 11:57
21 Killead Ward on 24th April 2015.
22 204 Q. All right. So with those changes, are you content then
23 to adopt the contents of that statement as your
24 evidence to the Inquiry?
25 A. I am. 11:57
26 205 Q. You start off in your statement by giving us your
27 professional background, Mr. Guthrie. You got your
28 degree in 1995 as a social worker, you became a senior
29 social worker?

1 A. Sorry, it was a diploma in social work in 1995.
2 206 Q. A diploma in social work. I'm sorry about that. And
3 you worked as a social worker after that, isn't that
4 right?
5 A. A probation officer, sorry. 11:57
6 207 Q. All right. And then ultimately you worked for RQIA as
7 an inspector in 2013?
8 A. That's correct.
9 208 Q. And you worked as an inspector until 2020?
10 A. Yes. 11:58
11 209 Q. And you no longer work for RQIA, isn't that right? You
12 work within the Belfast Trust?
13 A. That's correct.
14 210 Q. And what's your role within the Belfast Trust?
15 A. I am the social work lead for the West Belfast GP 11:58
16 Federation.
17 211 Q. Okay. And during your time with RQIA as an inspector,
18 you undertook a number of different inspections of a
19 number of different wards in Muckamore, isn't that
20 right? 11:58
21 A. That's correct.
22 212 Q. And you detail the wards in Muckamore that you
23 inspected, and the dates that you inspected them, in
24 your statement, isn't that right?
25 A. To the best of my knowledge on the availability of the 11:58
26 reports, yes.
27 213 Q. Okay. And for the ease of the Panel, the reference for
28 the dates and the wards that were inspected, that's at
29 Exhibit 1, and that's pages 24 through 26. So we've

1 just been there, Mr. Guthrie, haven't we?
2 A. Yes.
3 214 Q. Okay. Now, in terms of the main body of your
4 statement, you, like the other Module 5 witnesses, were
5 asked a series of questions by the Inquiry, and you 11:59
6 answered those in detail, and the statement is
7 available on the Inquiry's website to read, so I don't
8 intend to go through those questions, all right, but I
9 want to pick up on some topics for your evidence today.
10 A. Mm-hmm. 11:59
11 215 Q. One topic is the different types of inspection that
12 were carried out by RQIA. Is it fair to say that there
13 are two main types of inspection, there's a care
14 inspection and a patient experience inspection?
15 A. Yeah, and there's a follow-up inspection as well. 11:59
16 216 Q. Follow-up inspection as well. Okay. Can you describe
17 then the difference between the care inspection and the
18 patient experience inspection?
19 A. Yes. A patient experience inspection is completed for
20 the purpose of gathering patient experience of a ward. 11:59
21 So the inspection is specific to look at patients'
22 situations, their experiences, and how they're being
23 cared and treated on the ward. A care inspection is a
24 much more in-depth ward-based inspection of the ward's
25 processes and the ward's arrangements to provide care 12:00
26 and treatment to patients, and then where the ward sits
27 as well in terms of the context of larger hospital.
28 217 Q. And the follow-up inspection then?
29 A. A follow-up inspection is completed when a care

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1 inspection has been completed and a number of
2 recommendations for areas of improvement may have been
3 made. Those areas for improvement are then reviewed in
4 what's called a follow-up inspection. So an inspector
5 would go out to check the progress the Trust has made, 12:00
6 or not, in relation to meeting those recommendations.
7 218 Q. And those are really the three types of inspections
8 that were in place between 2013 and 2020?
9 A. Yes.
10 219 Q. What about those inspections where information is 12:00
11 received, say, from families or, say, from an anonymous
12 caller or the like, would they be classed as care
13 inspections?
14 A. I'm sorry, they would be a further inspection method.
15 I think in the seven years that I worked in RQIA, I was 12:01
16 involved in three of those types of inspections, all
17 from anonymous callers. So those inspections would be
18 completed when the information is received. Once that
19 information has been assessed and reviewed in the
20 context of all the other information RQIA would have 12:01
21 about that facility, a decision may then be made
22 through the senior management team within the mental
23 health and learning disability structure, that one of
24 the responses could be to go and do an unannounced
25 inspection. 12:01
26 220 Q. I'm going to ask you a little bit about announced and
27 unannounced inspections, and the Panel has heard quite
28 a bit of evidence about this today and yesterday. At
29 paragraph 17 on page 6 of your statement, you describe

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1 how, and the other witnesses have described how, in
2 April 2015, all care inspection visits became
3 unannounced, and comparing those with the patient
4 experience inspections, the patient experience
5 inspections would have remained announced, isn't that 12:02
6 right?
7 A. That's correct.
8 221 Q. Okay. And the Ward Manager for those would have been
9 notified a week before the inspection took place?
10 A. To the best of my knowledge, in terms of timelines, 12:02
11 that's -- yes, that's correct. But they would have
12 been informed before the inspection took place.
13 222 Q. And why did they have to be announced?
14 A. It was to ensure that the patients had the opportunity
15 and were aware that the inspector might be out, and 12:02
16 also to give the ward time maybe to inform relatives or
17 the advocate that patient experience interview will be
18 taking place. So it was just really to make sure that
19 people were aware that an inspector will be out to
20 gather patient experience. 12:03
21 223 Q. At paragraph 48 on page 16, you're describing there,
22 Mr. Guthrie, the different outcomes between an
23 inspection visit that was announced and one that was
24 unannounced, and you say in that paragraph that:
25 12:03
26 "Unannounced visits provided a more objective insight
27 into the quality of care, they gave the view of the
28 Ward on a more typical day, but there would have been
29 less contact with relatives because the timings of

1 inspection visits were outside natural visiting times
2 for the relatives."
3
4 And you describe how the use of the pre-inspection
5 questionnaires were given to relatives, and that helped 12:03
6 to promote their involvement during the inspection
7 process. Thinking about when you were inspecting
8 Muckamore between 2013 and 2020, did you ever see
9 things on unannounced inspections which you hadn't seen
10 before? 12:04
11 A. No, not in terms of findings or evidence, no.
12 224 Q. I want to go to paragraph 18 on the top of page 7,
13 then. You're describing there how, in April 2013
14 through to March 2015, and that's the era of announced
15 care inspections, you say that the Ward Manager would 12:05
16 have been sent the self-assessment report and
17 questionnaires in advance of the visit, and we've heard
18 earlier from Ms. McGregor that the Trust's own
19 self-assessment, it wasn't particularly accurate; does
20 that align with your own experience? 12:05
21 A. Yes, the pre-inspection questionnaires returned by the
22 Ward Manager, when contrasted with outcomes in terms of
23 my findings, there would be variation between what the
24 -- where the Ward Manager felt the ward was and what my
25 evidence detailed in terms of where the ward was. 12:05
26 225 Q. And can you give us an example of that? What might the
27 Ward Manager not have said that you found or vice
28 versa?
29 A. Well, we use the terminology "compliant, substantially

1 compliant, or non-compliant", and the variations would
2 have been between the substantially compliant and
3 compliant, and it's not a case of the Ward Manager I
4 don't think omitting stuff, I suppose I always felt
5 that the Ward Manager, in terms of the pre-inspection 12:06
6 questionnaire, was charged then with assessing the
7 entire ward, including things like the
8 multidisciplinary team, other aspects of care provided
9 to patients on the ward, and they would have written
10 that up in terms of their assessment of that, and I 12:06
11 would have went out, completed the inspection, and on a
12 number of occasions there would have been variation
13 between the Ward Manager, for example, saying that they
14 felt that the ward was compliant, whereas my evidence
15 would have indicated that it was substantially 12:06
16 compliant.
17 226 Q. Okay.
18 DR. MAXWELL: Was the difference just in one grade or
19 was there an occasion when they put fully compliant and
20 you thought it was not compliant at all? 12:06
21 A. To be fair, my -- from my memory, and my memory to be
22 honest is based on my re-reading of all the reports, so
23 I'm cautious just about being accurate.
24 DR. MAXWELL: Okay.
25 A. But to be fair, the variation from the Ward Manager's 12:07
26 perspective, in my experience, wasn't huge. I believe
27 they genuinely felt that their assessment was accurate
28 and appropriate, but there wasn't a massive gulf
29 between what I was finding and what the Ward Manager

1 assessed through the pre-assessment criteria.
2 DR. MAXWELL: And presumably that judgment, the
3 one-word judgment, is a little bit subjective. There
4 aren't precise criteria for it?
5 A. It is. It is. It is. And personally speaking, I need 12:07
6 significant -- in my own head, I need clear evidence to
7 detail why my assessment is that it's substantially
8 compliant, and then obviously they'll progress then to
9 having conversations with the Ward Manager in terms of
10 the difference, so there was an opportunity there to 12:07
11 explore that with the Ward Manager.
12 227 Q. MS. BRIGGS: One topic that you're asked about and that
13 you describe throughout your statement and its exhibits
14 is your time spent interviewing or talking to patients.
15 I'm going to ask paragraph 43 on page 14 to be pulled 12:08
16 up. You say at that paragraph that you felt that there
17 was sufficient time spent on inspections interviewing
18 patients, and you also say that there was sufficient
19 time spent talking to staff as well. Isn't that right?
20 A. Yes. 12:08
21 228 Q. What particular skills did you employ to interview
22 verbal patients with high degrees of autism and other
23 learning disabilities?
24 A. In relation to guidance and tools that we use within
25 RQIA, obviously at pre-inspection level we've a lot of 12:08
26 -- the RQIA, sorry, at that time, had a lot of
27 information about a particular ward. So in terms of my
28 preparation I would have reviewed that information,
29 read the previous reports, and familiarised myself with

1 the types of care, the type of care and treatment
2 provided and the needs of the particular patient
3 population in that ward. So in terms of my previous
4 training and experience in relation to communication,
5 particularly in terms of monitoring non-verbal 12:09
6 communication and being aware of how people interact, I
7 would have utilised those skills, and we also had a
8 QuIS tool, which was used in terms of helping us to
9 structure observation of those patients who maybe
10 weren't verbal, just to get a measurement of exactly 12:09
11 how the interactions were between patients and staff.
12 And normally, and especially in a care inspection, I
13 would have spent two-and-a-half days approximately on a
14 ward, so I would have become very familiar with the
15 needs of patients and how they communicated, and I 12:09
16 would have continually observed that and continually
17 observed how the patients were in the context of the
18 ward. So there was a range of tools and interventions
19 I would have applied to allow me to satisfy myself that
20 I had a good overview of how patients were being 12:10
21 supported in the ward in terms of their communication.
22 229 Q. And picking up there on the QuIS tool.
23 A. Mm-hmm.
24 230 Q. It's a quality -- QuIS stands for?
25 A. I'm not sure. 12:10
26 231 Q. I'll pull it up now for everyone.
27 A. Thank you.
28 232 Q. It's paragraph 11 in the third exhibit. It's a Quality
29 of Interactions Schedule observation tool. Can you

1 tell us a little bit more about what that was and how
2 it worked?
3 A. Yeah. I found it was -- to me, it was a tool used in
4 terms of being able to structure and to remind me of
5 exactly the areas I needed to look at in regards to 12:10
6 communication. So a tool that could be applied over
7 20-minute periods. During my inspections I would have
8 taken my lunch in the main dining area, and obviously
9 in terms of the application of the tool, I was
10 extremely sensitive in relation to the potential impact 12:10
11 that would have on patients and staff. So there was
12 ways to observe where you weren't actually directly
13 engaging, but obviously you made staff and the patient
14 aware that you were using the tool. So there were
15 occasions as well that the tool may not have been used, 12:11
16 but I would have used the structure of the tool and
17 gone back to it and used that throughout the inspection
18 to make sure that I was covering all the areas that I
19 needed to cover in terms of that overview of
20 patient/staff relationships and communication between 12:11
21 patients and staff.
22 PROFESSOR MURPHY: We understand it's not used any
23 longer, isn't that right, and can you say a bit about
24 why?
25 A. I can't answer that question. I think my last 12:11
26 inspections with RQIA were in 2019, the large
27 inspections. I can't remember, to be honest, if the
28 tool was used then, and I don't know if the tool is
29 still being used now.

1 PROFESSOR MURPHY: Okay.
2 233 Q. MS. BRIGGS: You describe there taking your lunch with
3 patients.
4 A. Mm-hmm.
5 234 Q. Can I ask you a little bit about that? When you were 12:12
6 taking your lunch with patients, is that what you were
7 saying you would have done, you might have done?
8 A. I would have taken my lunch in the main dining area.
9 235 Q. In the main dining area.
10 A. Providing it was appropriate in terms of the needs of 12:12
11 the patient group and providing it wasn't interfering
12 with any care or treatment being provided by the staff,
13 which arguably because I was on the ward for
14 two-and-a-half days, I was always sensitive to that
15 point. If it wasn't appropriate to take lunch for 12:12
16 whatever reason, I would have observed in other ways.
17 236 Q. Okay. And what about the staff and patients during
18 lunch times? And I'm talking about perhaps on wards
19 where it might have been possible for staff and
20 patients to take their lunch together. Is that 12:12
21 something you ever saw happening?
22 A. I would have witnessed staff supporting patients to
23 have lunch, and I would have witnessed -- it wasn't
24 always that everybody sat down together to have lunch,
25 but I certainly would have witnessed staff supporting 12:12
26 patients in having lunch. And I think obviously in
27 terms of some patients potentially being unsettled or
28 being unwell, it may not have been appropriate for them
29 to have lunch, so I would have picked up on that and

1 obviously observed what was going on for those
2 patients. So to answer your question, there wasn't --
3 the entire ward didn't stop and everybody had lunch at
4 the same time. The lunches were provided in accordance
5 with the needs of the patients. 12:13
6 237 Q. Yes. And assuming that there was a scenario where it
7 was possible for everyone to take lunch together, or at
8 least some staff to take their lunch with the patients,
9 did you see that happen, that kind of integration
10 between the staff and the patients, or was it a 12:13
11 separate mealtime for each? Say they were eating at
12 the same time, was there staff at one table and
13 patients at another?
14 A. I saw lots of integration between staff and patients,
15 that was generally my experience on the wards. But in 12:13
16 terms of having set meal times, I think that -- I
17 didn't witness that, but I wasn't concerned, because
18 that would have been impacted upon in terms of the
19 duties of the staff, and also staff supporting
20 individuals on a one-to-one basis. 12:14
21 CHAIRPERSON: Sorry, can I ask it in a slightly
22 different way. If you had noticed staff sitting at one
23 table, maybe four or six of them sitting at a table, to
24 the exclusion of the patients, as it were, would you
25 have noted that? 12:14
26 A. I would have addressed that. I would have addressed it
27 with the staff immediately, because that would have
28 been inappropriate.
29 CHAIRPERSON: Right. Thank you.

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1 238 Q. MS. BRIGGS: Another thing that your statement
2 addresses and discusses, is your interactions as an
3 inspector with the Ward Manager, or the Charge Nurse on
4 the ward, and that's largely at page 29, although it's
5 weaved throughout your statement. Did you find overall 12:14
6 that the Ward Managers or Charge Nurses were welcoming
7 of the work that you were doing as an inspector?
8 A. Yes.
9 239 Q. And did you ever question the Ward Manager or the nurse
10 in charge as to the regularity with which they left 12:15
11 their office, or toured the ward, for example?
12 A. I would have noted that during the inspection. I would
13 have noted about access for patients to staff, and
14 particularly the Ward Manager and the leadership within
15 the ward. I wouldn't have directly asked the Ward 12:15
16 Manager how much time they would have spent every day
17 in the office versus how much time they would have
18 spent in and around the ward, but I was certainly
19 confident during my inspections that the Ward Manager
20 and the Charge Nurse were very much involved in the 12:15
21 daily routine of the ward, and very much approachable
22 and visible throughout the ward.
23 240 Q. So there was nothing on your inspections that you can
24 recall that caused you concern in that regard?
25 A. There would have been occasions, obviously, that the 12:15
26 Ward Manager may not have been there, and there would
27 have been a charge, a Deputy Ward Manager or a Charge
28 Nurse there, so -- but, again, I had no concerns about
29 the accessibility or availability of those, the

1 leadership within the ward during inspections.
2 241 Q. Okay. On page 29, and I think we've got it on the
3 screen, towards the bottom at paragraph 5, and further
4 on into page 30, you're describing there the
5 information that inspectors needed to receive from the 12:16
6 Ward Manager or the Charge Nurse, and that includes,
7 and I'm not going to go through the whole list, but it
8 includes patient files, incident reports, safeguarding
9 referrals, use of MAPA, use of other restrictive
10 practice, and you would have reviewed that type of 12:16
11 information when you received it, that's fair to say?
12 A. Yes, that's correct.
13 242 Q. When you were reviewing them, did you have to accept
14 what they said, what those documents said, and take it
15 at face value that it was correct? 12:17
16 A. No. I would have -- I would have looked at a wide
17 range of evidence to be able to give myself -- to
18 satisfy myself about the situation on the ward in
19 relation to a particular area. So, for example, in
20 relation to use of restrictive practices, my 12:17
21 observation of restrictive practices would have started
22 before I got on to the ward in terms of whether or not
23 the main door was open. I would have then looked at
24 the environmental aspects of restrictions; can patients
25 access the entire ward, the garden, other areas within 12:17
26 the ward? I would have looked at the psychological
27 aspects of restrictions in terms of was there any
28 evidence of coercion, was there any evidence of
29 patients not being able to do certain activities or,

1 you know, that being used. I would have then looked in
2 terms of restrictive practices at the type of physical
3 restrictive practices, so was the environment used, was
4 there other mechanical restrictions in terms of straps
5 and chairs, or those deep chairs that patients could 12:18
6 sit in and wouldn't be -- couldn't really get out of
7 without support? And then I would have looked at the
8 use of MAPA and how MAPA was used, when it was used,
9 who, when and why, and looked at the reports relevant
10 to that, including an incident report. And then I 12:18
11 would have also considered the use of observations in
12 terms of how those were being managed by the MDT and by
13 the ward staff. So -- and more importantly, actually,
14 and I should have said this first, I would have asked
15 the patients in relation to their experience, and then 12:18
16 I would have questioned the staff about their knowledge
17 and understanding, and also their experience. So,
18 that's the sort of -- it gives you an example of how I
19 needed to satisfy myself in terms of being factual,
20 objective, and evidence-based in relation to what was 12:18
21 going on in the ward.
22 243 Q. All right. I want to move on to another topic, okay,
23 and that's interviewing or speaking with families.
24 A. Mm-hmm.
25 244 Q. Back in the main body of your statement at page 19, 12:19
26 paragraph 58, you say this, you say that:
27
28 "Between 2013 and late 2014, families were consulted
29 during RQIA MHLD inspections through the distribution

1 of pre-inspection questionnaires, and when relatives
2 were available, through face-to-face interviews with
3 the inspector during an inspection visit. During this
4 period, the Ward Manager distributed the questionnaires
5 to families. From 2015 onwards, families could consult 12:19
6 with an inspector during an inspection visit."
7
8 How did RQIA ensure that relatives were informed about
9 those processes and knew about them?
10 A. From 2015 onwards or -- 12:20
11 245 Q. Well, if we look at each period, if we look at 2013/
12 2014 first, and then on to the 2015 position.
13 A. Okay. Yeah. I suppose from 2013 to 2015
14 approximately, there would have been pre-inspection
15 information sent out to the ward, care of the Ward 12:20
16 Manager, and that would have included information and
17 questionnaires for relatives, and we would have
18 followed that up with the Ward Manager. To be fair,
19 questionnaires -- I can't quite remember if they were
20 returned to us prior to the inspection, or the Ward 12:20
21 Manager gave them to us during inspection? My guess is
22 probably a bit of both. So the -- we were reliant on
23 the Ward Manager then letting relatives and family
24 members know that an inspection was pending, to give
25 relatives and family members the opportunity then to 12:20
26 complete a questionnaire, or to know when we were going
27 to be on the ward, so that they could come in at that
28 point to meet with the Inspector. Following --
29 246 Q. If I stop you there and I ask you about that? We'll

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1 move on to 2015. How did RQIA know that the Ward
2 Manager was letting the families know that these
3 questionnaires were here and that they should avail and
4 use them? Were RQIA taking any steps to engage with
5 families themselves to ensure that they knew about 12:21
6 this, they knew about the questionnaires, and that they
7 could use them?
8 A. That was always quite a challenging area in terms of
9 trying to involve relatives and family members as best
10 we could. We were -- the information that would have 12:21
11 sent to the Ward Manager would have also included
12 questionnaires for patients and questionnaires for
13 staff. So I suppose if I was an inspector going out
14 and received all the pre-inspection information and
15 there was no relatives' questionnaires there, I would 12:21
16 be asking why, when I arrived at the ward to complete
17 the inspection, and I'd be asking why possibly before
18 that, and then I'd be working with the Ward Manager to
19 ensure that they could invite relatives potentially to
20 come to the inspection for me to meet with them. 12:22
21
22 The methodology at that point, to be fair, in my
23 experience, Ward Managers generally returned a number
24 of relatives's questionnaires and were engaged in the
25 process. 12:22
26 247 Q. But it might have been the case that Ward Managers
27 perhaps gave the questionnaires to some families and
28 not others. Would you disagree with me on that?
29 A. I've no evidence to suggest that was the case, though I

1 can't really answer that.
2 248 Q. And, obviously, the methodology changed, in that after
3 2015, families were spoken to by inspectors during the
4 visit?
5 A. When available, yes. And we would have -- upon arrival 12:22
6 at a ward I would have put posters up at the front
7 door, I would have asked the Ward Manager as part of
8 the inspection process -- we would have had leaflets as
9 well and we would have asked the Ward Manager to
10 contact relatives to see if they were available to 12:23
11 meet, and let relatives know that we would be on the
12 ward, or I would be on the ward over the next two to
13 two-and-a-half days.
14 249 Q. One of the major developments that happened in
15 Muckamore during your time as an inspector, is that 12:23
16 CCTV was installed at Muckamore. Did you notice,
17 conducting your inspections, that CCTV had gone up?
18 A. I can recall seeing a camera, or cameras, but it's --
19 trying to remember what wards, but I can't actually
20 remember what wards, but I do recall seeing a camera. 12:23
21 But when I get in to complete my inspection, because
22 that wasn't part of our methodology in relation to how
23 they were used, what was happening with them, I just
24 carried on with the inspection.
25 250 Q. Did you ask any questions when you saw the cameras, can 12:24
26 you recall?
27 A. I can't recall asking any particular questions. I'm
28 sure we had conversations about it, but I can't recall
29 exactly when or who with.

1 251 Q. So they might have been with RQIA, they might have been
2 with the Trust? Is your evidence that you just can't
3 recall?
4 A. I can't recall.
5 252 Q. Okay. The final matter I'd like to ask you about is 12:24
6 how you perceive the effectiveness of RQIA's
7 inspections as an inspector, and you were asked about
8 this first of all on page 12, question 4, and your
9 answers go through to the next few pages, through to
10 page 13 and on. And as a summary, Mr. Guthrie, you say 12:24
11 that you felt that RQIA's inspections were good at
12 analysing key themes over time, and they were good at
13 following up on recommendations. You felt that you
14 were good at responding to patient concerns identified
15 at inspections, and you do, in that section of your 12:25
16 statement, express some concerns about delayed
17 discharges patients, but, overall, is it fair to say
18 that in terms of RQIA systems and its inspections, that
19 you felt that they were effective?
20 A. I would have described them as effective insofar as 12:25
21 that they were continually evolving and continually
22 developing. The methodology changed and was
23 continually reviewed on an annual basis, and that was
24 appropriate because of new information and research
25 that was coming -- becoming available more widely. So 12:25
26 following the Frances report, and other reports that
27 were published, we were continually reviewing our
28 methodology, and CQC, and NICE guidance, and other
29 guidance. So it was good in that it was being

1 continually adapted, but it wasn't perfect, and I hope
2 I've reflected that in my statement, but I suppose I
3 felt it was continually evolving and continually
4 changing, and some examples of that would have included
5 the use of lay assessors. I completed a number of 12:26
6 inspections where lay assessors were with me. And then
7 the introduction of other multidisciplinary colleagues,
8 including psychology, consultant psychiatrists, and
9 nursing colleagues, and then ultimately the
10 introduction of a further new methodology into 12:26
11 Muckamore Abbey in 2019, which involved a very big
12 multidisciplinary team and allowed much broader view of
13 the entire hospital.
14 DR. MAXWELL: Can you say a little bit more about the
15 lay assessors? Who were they and what was their role? 12:27
16 A. Lay assessors were members of the public who had come
17 through a recruitment process with RQIA to become what
18 was called "lay assessors", and their role -- they were
19 voluntary, and their role was to join inspectors on the
20 ward to help assess patient experience. I thought it 12:27
21 was an excellent extension to and development within
22 inspection processes, because the lay assessors brought
23 fresh eyes, and the lay assessors, you know, could
24 focus totally on patients, in terms of their
25 experience, which supported me in terms of trying to 12:27
26 get as much information as I could in terms of reality
27 of life for patients on the ward.
28 DR. MAXWELL: And were any of these lay assessors
29 people with learning disabilities themselves?

1 A. Yes, there was. There was -- I recall working with
2 three lay assessors and one of those individuals had a
3 learning disability.
4 DR. MAXWELL: And did the lay assessors have training
5 about how to participate in the inspection? 12:28
6 A. They did. They were supported -- there was an initial
7 recruitment process, and although I wasn't directly
8 involved, I was confident, having met with the lay
9 assessors prior to inspections, etc., that they were
10 tuned into the role, they were content to be part of 12:28
11 the inspection, and that they'd received good support
12 in terms of their -- their involvement in inspections.
13 DR. MAXWELL: And did they get to see the draft report?
14 Were they providing you with information or were they
15 actually part of the team deciding what the final 12:28
16 report was?
17 A. In terms of my coordination of an inspection, I would
18 have asked lay assessors to complete the interviews
19 with patients using the tools that we had, although I
20 would have overseen the QuIS tool, and I also would 12:29
21 have supported lay assessors if they had asked me to
22 interview particular patients if any issue had arisen
23 or any concerns. Sorry, I've drifted a bit, what was
24 your question?
25 DR. MAXWELL: I'm just wondering whether they were 12:29
26 collecting data and supplying it to you only, or
27 whether they were actually involved in the discussion
28 about your assessment, whether it was compliant --
29 A. No, they were supplying data. But it was broader than

1 that in terms of they were supplying their assessment
2 of what was happening for patients, which I really
3 valued.
4 DR. MAXWELL: Yes. But you made the judgment.
5 A. I made the judgment, yeah. 12:29
6 CHAIRPERSON: Could I just go back to the question that
7 you were originally asked, and that's, Ms. Briggs asked
8 you is it fair to say in terms of RQIA systems and its
9 inspections, you felt they were effective, and you
10 began your answer by saying: "I would have described 12:29
11 them as effective insofar as they were continually
12 evolving." Well, that's not really an answer, with
13 respect, to the question of were they effective?
14 A. Yes. Yes.
15 CHAIRPERSON: And I suppose underlying that is, first 12:30
16 of all, what would you say was the purpose of an
17 inspection?
18 A. The purpose of an inspection was to assess a ward --
19 well, assess the care and treatment provided to
20 patients, assess patients' experience of that, and 12:30
21 assess how the ward was delivering care and treatment,
22 set against best practice and set against the '86
23 Mental Health Order, the 2003 Regulatory Improvement
24 Order, and other best practice guidance from -- so that
25 was the -- the purpose of the inspection is to go in 12:30
26 and assess the ward on those couple of days that the
27 inspection was being completed, and then make a
28 judgment in relation to how the ward was performing.
29 CHAIRPERSON: And identify concerns if you felt that

1 they were --
2 A. Absolutely.
3 CHAIRPERSON: -- not performing to the right standard?
4 A. Yes.
5 PROFESSOR MURPHY: Isn't the real problem that when you 12:31
6 arrive on a particular day, even if it's unannounced,
7 you knock on the door and you have to say who you are,
8 and that staff may behave very differently when they
9 know you've arrived than what they would have, perhaps,
10 done had you not arrived? That's a big issue for RQIA 12:31
11 in terms of its effectiveness, isn't it? And how would
12 you ever solve that?
13 A. Yes. To answer your question, it is a big issue,
14 because obviously if I'm on the ward as an inspector,
15 it's going to change the dynamic of the ward because 12:32
16 I'm on and I'm there to observe, to make judgments, and
17 to measure how effective the ward is or isn't. How
18 RQIA -- to answer the second part of your question, how
19 RQIA challenge that or rectify that? I suppose in my
20 time as inspector some of the methodology introduced 12:32
21 tried to address that in terms of, I recall going into
22 a ward at 3:00 o'clock in the morning in 2019, and
23 whilst the staff knew we were on site, because we were
24 there for the week, they didn't realise we were going
25 to come in at 3:00 o'clock in the morning. But, yes, I 12:32
26 think that's going to be an area that the regulators
27 will continually address, or try to address. I'm never
28 sure they'll get it absolutely perfect, but it is an
29 area absolutely that needs to be looked at on a

1 continuous basis.
2 CHAIRPERSON: Could I just ask you this on the same
3 topic: We know of course that it was the CCTV that
4 revealed abuse in 2017, and I understand there may have
5 been all sorts of policies and GDPR issues about who 12:33
6 could look at that CCTV, but did RQIA ever ask to look
7 at it or dip-sample it?
8 A. I don't know. I know from inspections that I was part
9 of in 2019, we -- the policy was being closely looked
10 at, and how the policy was being implemented, and what 12:33
11 the policy looked like, and how that was going to
12 impact potentially on regulation of the services, but I
13 don't know, is the honest answer, in relation to did
14 RQIA ask to look at --
15 CHAIRPERSON: So at the point of your leaving the RQIA, 12:34
16 which was 2020 --
17 A. Yes.
18 CHAIRPERSON: -- there presumably would have been a
19 relook, and we've heard there was a relook at the
20 systems that were being applied, but you -- you may 12:34
21 have to take this further -- but you can't tell us
22 whether to your knowledge the RQIA were actually
23 interested in that process potentially of dip-sampling
24 CCTV?
25 A. RQIA were interested, in my experience, in all 12:34
26 processes, but I can't specifically give you an answer
27 in term of -- because I wasn't involved in that
28 decision-making.
29 CHAIRPERSON: Fine. Thank you.

1 253 Q. MS. BRIGGS: When one looks at the total sum of RQIA
2 reports during your time with RQIA, 2013 to 2020, there
3 were multiple inspections of many different wards;
4 eight of PICU, six of Cranfield Female, eleven
5 Cranfield Male, six of Six Mile, and five of Donegore, 12:35
6 and of course you weren't yourself the inspector of
7 many of those.
8 A. Mm-hmm.
9 254 Q. But none of those reports, I'll suggest, triggered any
10 serious alarm, it seems, within RQIA, about the abuse 12:35
11 of patients. As a previous inspector would you have
12 any thoughts about how those systems might be changed
13 to improve their effectiveness?
14 A. On completing inspections, it was always the
15 methodology, and my aim as an inspector, was to speak 12:35
16 to patients first and foremost, speak to staff, and
17 review all the information available on the ward to try
18 and get a clear picture of how the ward was delivering
19 care and treatment to patients. I never witnessed any
20 abuse or witnessed staff being abusive. Had I have, I 12:36
21 would have addressed that directly.
22
23 To answer your question in terms of what RQIA or a
24 regulator can do to address that? I suppose there's a
25 number of variables that could be considered, 12:36
26 everything from staff training to how CCTV is used, and
27 how the regulator may be able to become part of that
28 process, and retrospectively potentially, if there is
29 an incident, or an alleged incident, can the regulator

1 be part of the review of that? And I suppose that's
2 something the regulators will have to continue to look
3 at.
4
5 As an inspector, to me that's probably the next natural 12:36
6 step in relation to trying to get assurance that people
7 aren't being abused whilst in the care and treatment of
8 a particular facility.
9 MS. BRIGGS: Mr. Guthrie, that's all the questions I
10 have. The Panel might have some more. 12:37
11 CHAIRPERSON: No, I think we've covered all the
12 questions as we've gone along. So can I thank you very
13 much for coming to assist the Panel, and we've finished
14 in good time. So, thank you.
15 A. Thank you. 12:37
16 CHAIRPERSON: Okay. So we have no -- I don't think
17 we've got any reading for the afternoon, have we?
18 MS. BRIGGS: We don't. We're back on Monday, Chair,
19 for Module 6.
20 CHAIRPERSON: Okay. Excellent. Monday at 10:00 12:37
21 o'clock. Thank you very much.
22
23 THE INQUIRY WAS THEN ADJOURNED TO MONDAY, 24TH JUNE
24 2024 AT 10:00 A.M.
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29