MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 18TH JUNE 2024 - DAY 93

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THE INQUIRY RESUMED ON TUESDAY, 18TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you very much. Yes, Ms. Kiley. 09:51

MS. KILEY: Good morning, Chair, Panel. This morning's witness is Mr. John Veitch and he's ready to be called when the Panel is ready.

CHAIRPERSON: Yes. Shall we bring him in?

MS. KILEY: Thank you, 09:52

MR. JOHN VEITCH, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Mr. Veitch, good morning. Thank you very much for coming along to help the Inquiry, thank you for your statement, and I'll hand you over to Ms. Kiley who is going to deal with your evidence this morning. Thank you. 09:52

1 Q. MS. KILEY: Mr. Veitch, good morning. 09:52

A. Good morning.

2 Q. You and I met just a short time ago. As you know my name is Denise Kiley. I'm one of the Inquiry counsel team and I'm going to take you through your evidence this morning. I can see you have a folder in front of you and I think that contains the statement which you have made to the Inquiry in respect of the Ennis Investigation, is that right? 09:53

A. That's correct.

3 Q. And for everyone's reference, that has the Inquiry reference number STM-205. Do you, Mr. Veitch, wish to adopt that statement as your evidence to the Inquiry today?

A. Yes, I do. 09:53

4 Q. And I should say that the Inquiry has asked you to make a further statement in respect of the organisational modules which it will be looking at after the summer, and indeed has asked you to make a statement in respect of Organisational Module 7, which relates to the 09:53 operational management of the hospital. Isn't that right?

A. That's correct, and I understand that that has been already submitted to the Inquiry.

5 Q. Yes. Thank you for that, Mr. Veitch. And it may be 09:53 then that you may be returning after the summer period to talk about wider issues, but as you know, today the focus is on your role and experience in the Ennis Safeguarding Investigation. So, just to go straight into that then. In your statement you explain that at 09:54 the time of the Ennis Safeguarding Investigation, which was November 2012, your role was as Co-Director for Children and Adult Learning Disability Services in the Belfast Trust, isn't that right?

A. That's correct. 09:54

6 Q. And that, I think, is a large role, and has a wide remit. Is that right? If you were to have to summarise your remit in respect of Muckamore Abbey Hospital, how would you describe that?

A. I would describe it as being responsible for all the services provided within Muckamore Abbey Hospital and being accountable for the quality of the services provided at that location.

7 Q. Yes. And I think at paragraph 11 of your statement you explain that you had responsibility for safe and effective care across all services, and so is that a fair summary also of your role in relation to Muckamore Abbey Hospital? 09:54

A. That's correct. 09:55

8 Q. Your background, Mr. Veitch, is as a social worker, is that right?

A. That's correct, yes, I'm a qualified social worker by background.

9 Q. And in your experience as a social worker prior to the Ennis Investigation, did you have professional experience of other Adult Safeguarding Investigations? 09:55

A. I don't recall experience in Adult Safeguarding Investigations. My earlier career was largely within family and child care services, so I would have had significant specialist experience in terms of child protection. 09:55

10 Q. Okay. And what about -- you took up the post as co-director in 2011, isn't that right?

A. That's correct. 09:56

11 Q. And after you took up that post then did you have experience of Adult Safeguarding Investigations in respect of your co-director role?

A. Yes, I would have had experience in terms of

safeguarding.

12 Q. In respect of your role as co-director, so thinking particularly about that period of time in and around 2012, how often would you have visited Muckamore Abbey Hospital? 09:56

A. I would have been in Muckamore Abbey Hospital probably at least once per week.

13 Q. And what was your purpose generally of those weekly visits?

A. The weekly visits would have ranged -- well fortnightly I would have been chairing the core management team meeting, and on the other occasions it would have related to operational issues, whether it would have related to particular priorities, including resettlement type issues as well. 09:56 09:57

14 Q. And in respect of those visits then would you have been meeting with management staff only or ward staff also?

A. It would have been largely with management staff.

15 Q. The reason I ask, Mr. Veitch, is that the Inquiry has heard some evidence from other witnesses that describes staff explaining at the time of the Ennis Investigation that they felt that management were remote from Muckamore Abbey Hospital. Have you seen that in the other statements? 09:57

A. I've seen one or two references to it. 09:57

16 Q. Would you accept it as a fair characterisation?

A. I would accept that as a fair criticism and, you know, I would want to acknowledge that in preparing for, for the Inquiry, that I did not have a sufficiently visible

presence around practitioner staff.

17 Q. And were you aware of staff feeling that way, so feeling that management were remote, at the time of the Ennis Investigation, or is that something you've only become aware of recently? 09:58

A. It's something that has emerged in my preparation for this Inquiry.

18 Q. If I can ask you to turn to paragraph 7 of your statement, please, you explain just your initial involvement in the Ennis Safeguarding Investigation, 09:58 and you explain that you became aware of the concerns which were reported on the 8th November 2012 in relation to Ennis Ward on your return from annual leave on the 28th November 2012, and I just want to set that in context, Mr. Veitch. So by that time two members of 09:59 staff were already on precautionary suspension, an Early Alert had been issued, and Aine Morrison had been appointed as the designated officer for the safeguarding investigation, isn't that right?

A. That's correct. 09:59

19 Q. And, indeed, two strategy meetings had already taken place by that time, isn't that right?

A. That's correct, yes.

20 Q. Had 24-hour monitoring already commenced on the Ennis Ward by the time you heard about the allegation? 09:59

A. Yes, the Band 6 and the Band 7 arrangements had commenced, and preparations, I believe, were in place for the more extensive monitoring arrangements which were coordinated by Moira Mannion.

21 Q. And, so, is the Inquiry to understand then that you didn't have a role in that initial decision to implement 24-hour monitoring?

A. No, I was absent when that, absent on leave when that decision was taken, but I was very reassured by the fact that it had been put in place by the time of my return. 10:00

22 Q. Did you have experience of 24-hour monitoring being used as a protection measure in Adult Safeguarding Investigations before the Ennis? 10:00

A. I was not aware of any precedent in relation to that, but I did fully understand and appreciate the value and the benefits of such an approach, and certainly if I had been around I would have agreed with the immediate implementation of such a measure. 10:00

23 Q. So you felt that it was appropriate in the early stages?

A. Oh, absolutely.

DR. MAXWELL: Can I ask if you had come across this as a safeguarding intervention at any other point in your career? 10:00

A. No, I hadn't.

DR. MAXWELL: So, what was it that made it appropriate in this case and not in previous safeguarding circumstances? 10:01

A. Sorry, could you just repeat that for me?

DR. MAXWELL: So you said that you hadn't come across this type of monitoring in other safeguarding situations, so what was unique about this situation?

A. The gravity of the initial reports and the pervasive nature of the allegations being made in relation to this particular ward.

DR. MAXWELL: Thank you.

24 Q. MS. KILEY: Mr. Veitch, can I ask you to turn to paragraph 17 of your statement? You can use your hard copy or it will come up on the screen in front of you, if that's easier. 10:01

A. Yeah, I'm happy enough from my own copy.

25 Q. Thank you. So just there you refer, as you can see, to being aware of Moira Mannion's briefing report dated the 19th December 2012. I'll just read what you say about that. You say: 10:01

"I was aware of Moira Mannion's briefing reported dated 19th December 2012 which summarised the actions completed in accordance with her monitoring brief and the issues identified. It specifically highlighted that 85 monitoring forms had been submitted over a five week period by 20 independent senior nursing staff reflecting 840 hours of observed practice over a 24-hour cycle." 10:02 10:02

You go on at paragraph 18 to say:

"This report of 19th December 2012 also specifically noted continuing concern regarding staffing levels and environmental issues, but monitoring also had demonstrated best practice and positive interaction by 10:02

staff with the patients. It concluded that there was no indication of any possibility of a culture that may be accepting of behaviour or communication that could be referred to as abusive."

10:02

And you give the reference to that report in the Ennis Bundle.

The Inquiry has heard from Ms. Mannion herself yesterday, and has heard from Ms. Mannion and indeed 10:03
other witnesses about the monitoring, and one of the things that the Inquiry has heard is that there was a strategy meeting the day after that initial briefing report, so on the 20th of December, and the Inquiry has heard that on that date Ms. Mannion put forward a 10:03
proposal that 24-hour monitoring should be ceased. Do you recall that happening?

A. I recall being aware of that at the time. I understood that at that stage Moira Mannion's suggestion was based on her concern about the impact on the staff and the 10:03
residents in relation to disruption to routine, and my recollection is that her suggestion was to consider alternative monitoring arrangements as opposed to the continuation of those that existed at that time. I understand that that was discussed at the meeting, and 10:04
it was agreed that the existing extensive 24-hour monitoring arrangements should continue.

26 Q. And did you, Mr. Veitch, have a view at that time about how appropriate it was to continue the monitoring?

A. Well, as previously stated, I was assured and reassured by the 24-hour monitoring that had been put in place. I think it was legitimate and understandable that Moira Mannion should raise the issue within the context of the broad interagency strategy discussion, to consider or reconsider that, given the issues of concern which she had about the disruption to the ward routine. And I also thought at the conclusion of that meeting that the decision had been taken to continue the 24-hour monitoring, and that was accepted by all the participants, including Moira Mannion. 10:05 10:05

DR. MAXWELL: Can I just ask about that? So you have said you had not come across this 24/7 monitoring before, and in fact Aine Morrison told us that before. So it's an unproven technique for safeguarding. In the time up to the 19th December, this unproven method had not identified any concerns, and yet it had had a negative effect on the patients and the staff. Why then was there not a discussion about 'Is this the most effective way of uncovering poor practice or poor cultures?', why continue with something for which there was no evidence base, which has as yet not produced any benefit and had actually produced some harm? Why was there not a discussion of the balance of risks and the consideration of other methods of investigating culture? 10:05 10:06 10:06

A. Well, I think that Moira Mannion had wished to open that debate. Now I wasn't present, I don't recall, at that particular meeting. I think it was legitimate and

understandable that Moira Mannion was raising that issue within that context. I accept exactly what you have put to me, that there was some suggestion that it was an unproven method, but it was providing assurance in the sense of reporting back on the quality of interaction between the patients and the staff. And... 10:07

DR. MAXWELL: But was it, because in later discussions Aine Morrison repeatedly said she still had suspicion, she clearly wasn't reassured by this as a method?

A. Well, I personally, as I stated, was reassured as co-director. 10:07

DR. MAXWELL: Okay.

A. By the reports back from that, and I thought it was, given the nature of the initial referrals from the staff at Bohill, an immediate measure, which I think was measured and appropriate for a period of time to provide assurance to the Trust. 10:08

DR. MAXWELL: Okay.

CHAIRPERSON: Mr. Veitch, could I just ask a question? Obviously Aine Morrison is conducting an independent investigation and she makes, effectively she makes recommendations, one of which was to continue monitoring. But whose decision at the Trust would it have been if such a decision had been made to say 'no, this has got to stop', in whose hands would that be? Would those be your hands? 10:08 10:08

A. Well, I would have -- I, at one point -- at such a point if that had been my firm view, I would have discussed that in the first instance with -- sorry, I

can use -- Esther Rafferty and Moira Mannion. We would have agreed as a senior team, and we would have then have taken that to my Director, Catherine McNicholl, and to Brenda Creaney as the Nursing Director, saying we were totally unhappy with such approach continuing, and as an agency our view is that you, as directors, should support us drawing that line.

CHAIRPERSON: Right. But of course that conversation never took place?

A. No, it didn't. 10:09

CHAIRPERSON: No. Thank you.

DR. MAXWELL: So you seem to be suggesting that the DAPO has operational responsibility for the ward, and that if you were unhappy you would have to go to Executive Directors to override that. Is that your understanding, that the DAPO can, operationally, direct --

A. Basically the DAPO does not have operational responsibility, and if it had got to the point that I, in consultation with Moira Mannion and Esther, thought that it was no longer a measured, appropriate response, it would have been our duty to have, to have asserted that position.

DR. MAXWELL: So in terms of the lines of responsibility and accountability, that lay with you as the co-director?

A. That's correct, yes.

27 Q. MS. KILEY: Mr. Veitch, we have focused on the period in December, and that was whenever Ms. Mannion's first

briefing report was dated the 19th December, but are you also aware that there was a second briefing report prepared by Ms. Mannion on the 9th January 2013, and Ms. Mannion again told the Inquiry about that yesterday, and in summary she described how, again, on the 9th January, she went to the strategy meeting and proposed that it was an appropriate time to cease 24-hour monitoring. She also told the Inquiry that Aine Morrison disagreed with that at the time and monitoring continued. I asked her then whether she did anything to try and resolve the disagreement between her and Ms. Morrison about that at the time, and she said that she had a discussion with you and Catherine McNicholl about that to try and seek to resolve the difference between her and Ms. Mannion about it. Do you recall that? 10:11 10:11 10:11

A. I don't recall that, although I'm not saying that that meeting did not occur.

28 Q. Yes.

A. But I certainly do not recall that meeting. 10:12

29 Q. Do you recall there being a level of disagreement between Ms. Mannion and Ms. Morrison on this issue?

A. I recall Moira Mannion's view that she would want that monitoring to be stood down soon. I recall that within the strategy meeting that was not agreed to. I don't recall it being such a contentious issue, as has just been presented to me now. 10:12

30 Q. Okay. So at the time you're saying you didn't understand it to be a contentious issue?

A. Not such a contentious issue as being presented.
31 Q. Okay. But ultimately the monitoring did continue. And looking back and reflecting on that now, do you consider that the continued 24-hour monitoring for the entire period that it was in place was a proportionate measure? 10:13
A. Can I just have a moment or two to think about that?
32 Q. Yes.
A. I think it was a proportionate measure in terms of providing the assurance which is reflected in the two Moira Mannion reports to which you referred. I think possibly retrospectively that into January that we could have been more proactive in looking at alternative measures of monitoring which proved less disruptive to the patients, and that is -- I'm saying that with the benefit of hindsight. 10:13 10:14
33 Q. Yes. And one of the other things that you refer to in your statement is the cost of monitoring, it ultimately cost around £500,000. Did the resources that were required to cover the roles of monitors for that period that it was in place have a negative impact on staffing of other wards at Muckamore? 10:14
A. No, it didn't. The extra £500,000, you know, in terms of the nature of the concern, my view is that that finance in such circumstances should not be an impediment to providing assurance about the safety of patients. The Trust has an overriding duty to the safety and welfare of its patients. It has a statutory responsibility to do so, regardless of finance, and in 10:15

view of the additional £500,000, that was a discrete amount of money which, which did not impact on the overall budgeting for Muckamore. It was a decision which had been taken and underpinned by the two directors, the operational and the nursing director, and should not impact beyond that.

DR. MAXWELL: So was additional funding made available from corporate funds?

A. I don't think I ever had discussion with anyone about that, but that was my assumption, that as a result of those measures being put in place, if it proved to be an additional half a million pound overspend for Muckamore, that the Trust would have to absorb that expenditure.

10:15

10:16

DR. MAXWELL: Were you not responsible for the budget?

10:16

A. Yes.

DR. MAXWELL: So I'm struggling now. There was an overspend. Was it written off, was it funded, or did you carry it forward to the next year's budget?

A. It was absorbed within the Trust's overall budget.

10:16

DR. MAXWELL: So you had zero-base budgeting?

A. I had a significant overspend, but the Trust was aware of the reasons for that.

DR. MAXWELL: And it wasn't carried forward as a cost saving in the following year?

10:17

A. It was absorbed, as I understood it, within that year's Trust's overall budget.

34 Q. MS. KILEY: Okay. I want to move on from monitoring, Mr. Veitch. We have referred to the meeting of the 9th

January, and there were some other issues that were discussed at that meeting that I want to raise with you. Could we bring up the Ennis Bundle, please, page 53? You were in attendance at the strategy meeting on the 9th January 2013, isn't that right? 10:17

A. That's correct, yes.

35 Q. And in fact in your statement you say that you attended all strategy meetings after the 9th January, is that right?

A. I believe I did, yes. 10:17

36 Q. Why did you make the decision to start attending the strategy meetings on that date, when you hadn't attended them previously?

A. I had been on leave until the 28th November, as already outlined. I don't -- I assume that I was unavailable 10:18 for the two December meetings. I was obviously getting feedback both from Aine Morrison, and Esther Rafferty, and also from Moira Mannion in relation to those. Given the nature of the investigation, given the development of the investigation through the, through 10:18 those meetings, I believed that I had to prioritise my attendance at those meetings.

37 Q. Okay. You can see in front of you the minute of the 9th January. If we just -- can we scroll up to page 52, please, just so we can see the first page? Do you 10:18 recognise these minutes, Mr. Veitch? You have seen them in the bundle of the documents provided by the Inquiry?

A. Yes, I do.

38 Q. And if we just go up, please, so we can see that whole page, and you can see you're listed as being present at the meeting. So if we go down then to page 53 again and to the -- scroll down so we can see the whole list of allegations, please. Just pause there, please. Go back so we can just see "List of Allegations", that's it, thank you. So the Inquiry has heard, Mr. Veitch, that the investigation team prepared a list of allegations made by the Bohill staff, and that that later became Appendix 1 to the Ennis Report. Are you familiar with that? 10:19 10:19

A. Yes.

39 Q. And it appears that the list of allegations was being discussed at this meeting. Is that right? And you draw attention to the list of the allegations, I'll just read what is said there: 10:19

"John Veitch drew attention to the list of allegations presented by Aine Morrison at the last meeting and updated today. He noted that whilst some of the allegations were quite specific, others appeared to be negative comments (i.e. not specific allegations). He emphasised the need to obtain evidence and facts when allegations are being made and noted a potential difficulty in doing so with regard to negative comments." 10:19 10:20

And then the paragraph goes on. But just pausing there. In raising that issue about the list of

allegations, and highlighting that some appear to be negative comments, not specific allegations, and emphasising the need to obtain evidence, was that because you were concerned about what you saw in the list of allegations at the time? 10:20

A. I was concerned about the initial reported concern on the 8th November. Obviously additional work had been undertaken by the investigation team. The list which was presented at that meeting, to me was not specifically a list of allegations, it was a list of 10:21 concerns, and I thought that there was a need to disseminate those which constituted very measurable allegations to those concerns which required further clarifications before they were regarded as allegations, and that negative comments were clarified 10:21 in terms of, on what basis were such negative comments being made and what was the reference? How could you reference those to particular facts and information?

40 Q. How did Aine Morrison respond to you raising those issues? 10:21

A. Well, it's reflected within the minutes that they were an aide-memoire and, you know, an aid to the investigation team to ensure that it comprehensively addressed issues which came to its attention.

41 Q. But were you concerned, Mr. Veitch, that the 10:22 investigation team was operating two widely in dealing with matters that were concerns rather than allegations?

A. I was trying to tease out precisely that issue, with a

view to trying to establish what would remain core components of this particular Vulnerable Adults Investigation, what were issues which perhaps were core issues for RQIA in its regulatory role, and perhaps issues which required clarification by Muckamore management and staff before it was being regarded as "allegation".

42 Q. Did you feel that the remit of the safeguarding investigation then was unclear at this time in January '13? 10:22 10:23

A. My view was that we needed to have -- to operate cautiously to ensure that any matter of concern was being addressed through the most appropriate channels.

43 Q. But Aine Morrison, we can see in the minute, confirmed to you that the purpose of the list was to ensure that all allegations were collated to scope the investigation, and to ensure all matters of concern were covered by the investigation. So did you understand that everything that was contained within the list of allegations was therefore something that was subject to consideration by the investigation team? 10:23 10:23

A. When it was presented, as I've already stated, under the frame, the phraseology, of a "list of allegations", I didn't regard it as a list of allegations, I regarded it as a list of issues which had to be addressed in order to achieve safe care for the patients. I wanted to try and draw out within the discussion what was legitimately part of the VA investigation and what should perhaps be addressed through other channels in 10:24

the first instance, while not at any point stating that there shouldn't be awareness across the totality of the Vulnerable Adults Core Group, which included the police, RQIA.

44 Q. Yes. And do you recall this discussion? I know we're looking at the minute, but can you recall this meeting and the discussions you had with Ms. Morrison on that date? 10:25

A. I can, yes.

45 Q. Ms. Morrison has told the Inquiry that she particularly recollects this meeting on the 9th January 2013, because she describes it as a difficult meeting. Do you -- did you experience that it was a difficult meeting? 10:25

A. No, I didn't experience it as a difficult meeting. You know, I thought it was a very legitimate, thought through discussion. I didn't regard it as difficult at all, and I thought that it was accepted on the basis of what I was trying to discriminate in terms of what was being presented as a list of allegations. 10:25 10:26

46 Q. Ms. Mannion describes the discussion -- sorry, not Ms. Mannion, Ms. Morrison in describing the discussion said that you and Ms. Mannion repeatedly challenged her on what constituted evidence. Is that a fair characterisation of the conversation that you had about this? 10:26

A. It was not challenge her on the basis of evidence, it was challenging her on the basis -- in terms of this discussion about a list, and I've repeated it on

numerous times over the last 5/10 minutes, it was discriminating between allegations and issues of concern. It was ensuring that there was clarification in terms of the evidence base for some of the items that were on that list, and what was behind negative comments, what was behind each of the issues, and then determining how an issue best be addressed.

PROFESSOR MURPHY: Sorry, can I ask you, would it be fair to characterise it then in this way; that you felt the ones that were allegations were legitimately part of a safeguarding investigation. The ones you felt were negative comments or concerns, you felt might reflect culture on the ward, but were more properly dealt with by something like RQIA?

A. I thought that the allegation ones were core components of the Vulnerable Adult Investigation. Negative comments, I thought we needed to delve deeper into those to understand where -- the origins of the negative comments and the basis of the negative comments, and then determine how, by what channel such issues should be further investigated. Whether clarified through management arrangements at Muckamore Abbey Hospital, whether the issue of concern was fundamentally a core component of the regulatory role, and deciding how best each issue should be taken forward. It was just trying to be very clear about individual agency's roles and responsibilities, and the role and responsibilities of the VA Adult Protection Investigation.

PROFESSOR MURPHY: Thank you.

47 Q. MS. KILEY: Continuing to think about the meeting. Ms. Morrison has told the Inquiry that after the meeting she was approached by Barney McNeaney, who I think was her line manager, isn't that right, at the time?

A. That's correct.

48 Q. And Barney McNeaney reported to you, isn't that right?

A. That's correct, yes.

49 Q. Yes. And what Ms. Morrison says is that after this meeting, Barney McNeaney approached her and told her that you had suggested that perhaps Barney should Chair the meetings after this. You're nodding. Do you recall that conversation?

A. Yes, I do recall that conversation.

50 Q. So you had suggested that to Barney?

A. That's right. And the basis -- sorry.

51 Q. I was just going to ask you why, and I think you were going on to tell me?

A. Yes. Barney McNeaney had been off, as I recall, most of December 2012, with minor surgery - for minor surgery. So I don't recall him being present on my return from leave at the end of November. Aine Morrison was there for, during December, chairing -- or during -- well, I can't recall November, I'm not sure about November, but during December Aine Morrison was operating in the absence of Barney McNeaney. I was aware of the difficulty and complexity of her role in relation to both chairing the vulnerable adult

safeguarding meetings and also having a role within that process as an investigator. So she was investigating and also chairing. And I was also aware, and I -- some tensions between Aine, and Esther, and Moira in respect of their specific roles and responsibilities. In January I spoke to Barney and I briefed him on what had occurred during his absence, and I said to him perhaps it would be easier and it would be a support to Aine Morrison if you were to step in and Chair the meetings, and it would perhaps make life easier for Aine in that. Now, I know that there was no procedural basis for anyone other than Aine to be chairing the meetings, but I thought that that might have been an additional support to her. I didn't think it would in any way compromise the investigation, and I know he spoke to her about it, and that's the basis of why I did it. 10:31 10:31 10:32 10:32

52 Q. And after he spoke to her about it, ultimately Ms. Mannion did continue chairing the --

A. Ms. Morrison. 10:32

53 Q. Ms. Morrison, I beg your pardon, did continue chairing the strategy meetings?

A. She did.

54 Q. Isn't that right? And were you satisfied with that?

A. I accepted that. 10:32

55 Q. And did you consider the optics of that? Because you at that time were two management positions above Ms. Morrison, isn't that right? So Ms. Morrison reports to Mr. McNeaney and Mr. McNeaney reported to

you. Did you consider what that looked like from a perspective of independence of Ms. Morrison's investigation?

A. I saw that suggestion as being one to support Ms. Morrison in her role, and nothing beyond that. 10:33

56 Q. Yes. The reason I ask that is that Ms. Morrison, in her evidence to the Inquiry, has suggested that because of the line management arrangements that were in place at the time of the investigation, that she felt that the investigation wasn't wholly independent, as she 10:33 described that. Do you think that that's a fair characterisation?

A. No, I don't. I have an overriding responsibility for the safety and services to the learning disability population, and clearly in this context it was the 10:33 patients on Ennis Ward, but I have a supplementary responsibility to staff, and I would expect staff to be treated in a manner which is fair and supportive, but the overriding responsibility, and the overwhelming responsibility, is good quality safe care for the 10:34 relatives -- for the patients, sorry.

57 Q. Yes.

A. And I didn't see any conflict of interest within that.

58 Q. And are you saying that your involvement in the strategy meetings, and therefore the investigation, 10:34 brought benefits to it? And, if so, what were those?

A. My personal involvement was to seek assurance that everything was happening to safeguard the care of the patients and to ensure that all aspects of the

investigation were, were contributing to that overall goal. I also saw my role as being supportive to both Esther Rafferty and to Aine Morrison.

59 Q. Yes. And you explained in answer to one of my earlier questions, you did refer to being aware of some tensions between Aine Morrison, Esther Rafferty and Moira Mannion, and I wanted to ask you, were there tensions between you and Aine Morrison? 10:35

A. There -- I had been in senior management positions, you know, previous to the ones which are included in my statement. I had been Director of Children's Services, multidisciplinary services in a legacy Trust. I had also been principal social worker, programme manager, and an assistant principal of social worker specifically for child protection. When you're in a senior management position there are tensions, which are part of the job, and they've got to be managed in a constructive manner. So I had, on occasions, tensions within my senior management team, but those are parts, part and parcel of the day-to-day job, they're not unusual, and they're an expectation of people to be able to deal with in a mature, professional manner, referenced to the overall outcomes for patients and clients. 10:36 10:36 10:36

60 Q. Yes. I want to -- I wonder can we bring up Ms. Morrison's statement, please, STM-198, at paragraph 100? And I just want to show you this while we're discussing this topic, Mr. Veitch, because in fairness to you Ms. Morrison has come to the Inquiry and has 10:37

given evidence about what she says your behaviour was during the investigation, so I want to give you an opportunity to see that and to comment on it. STM-198, please, at paragraph 100. If we just scroll down, please? At 100 it says: 10:37

"At the time I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced 10:38 to a range of possible factors, including professional defensiveness on the part of nursing and a reflection of some community hospital and social work/nursing tensions. Whilst some defensiveness is not unusual from services which are under investigation, this was 10:38 beyond the normal. I also believed there was a reluctance, perhaps subconsciously, to accept the possibility of widespread abuse on Ennis Ward. The pressure from John Veitch was one of the most difficult parts of the investigation for me as it was repeated 10:38 and coming from within my own line management hierarchy."

And then at 101:

10:38

"John Veitch's position as Co-Director for Learning Disability Services, and subsequently as my line manager, Moira Mannion's position also as co-director, and Esther Rafferty at service level, were all more

senior to me up until July 2013 when I took up a Service Manager post. This made the challenges I faced from them particularly difficult to handle. I believe that the behaviour of John Veitch, Moira Mannion, and to a lesser extent Esther Rafferty, was bullying in nature, and it took a significant personal toll on me to have to maintain my own position and not to give into the pressure and to carry out my professional responsibilities in the face of such opposition." 10:39

10:39

So I think you will have seen that before, Mr. Veitch, because I know that you will have seen Ms. Mannion's statement. Having seen that, and having heard me read it out today, do you accept that as a fair characterisation of your behaviour during the investigation? 10:39

A. I most certainly do not. I do not understand the basis of that. I was quite upfront in any discussions that I had in relation to this. I thought that I was being supportive to Ms. Morrison. I note the reference specifically to not accepting that there may be a culture within Ennis Ward. One of the things that struck me was that in the very first strategy discussion during my absence, the issue of a culture within Ennis Ward was mentioned I think by Ms. McKnight. I, certainly within -- when I started to attend the strategy meetings I specifically raised the issue of "institutional abuse", which was based on the concept of a culture within the ward. So I was openly 10:39 10:40

acknowledging that that was an issue which needed to be borne in mind, even though it was specifically referenced in both Moira Mannion's reports.
I'm particularly concerned about the reference to bullying, because -- well, I've explained my position in relation to that. Ms. Morrison had access to her line manager Barney McNeaney, who was a very strong principled line manager. She had also demonstrated her direct line of accountability for the vulnerable adult aspect of the investigation through to the Director of Social Work. She, I was aware, was keeping John Grocott, the Co-Director for Professional Social Work appraised, and I have absolutely no doubt that if there were contemporaneous concerns which Ms. Morrison was unable to resolve through discussions within her own line management, that she would have escalated those concerns through the direct line of social work accountability.

10:41
10:41
10:42

She had also been involved in direct discussions and consultations with my line manager, Catherine McNicholl, during my absence, about the particular investigation, and I have no doubt that that would have been a second acceptable line of concern. And if she had such concerns as are appearing in this statement, I would have expected her to have escalated that beyond me, and I would totally accept that I would have to account for my actions and behaviours. There is also Trust Policies in relation to whistle-blowing and, yes,

10:42
10:43

when I read that I was not impressed.

61 Q. When did you first become aware of Ms. Morrison's allegations about your behaviour?

A. In preparing for the Inquiry.

62 Q. Okay. In answer to my question about that, you did refer briefly to your consideration of institutional abuse throughout the investigation, so I want to come on to look at that now, Mr. Veitch, and the Draft Ennis Report was presented to a meeting of this strategy group on the 5th July 2013? 10:43 10:44

A. That's correct.

63 Q. And then a final draft report was presented to the strategy meeting on 28th October 2013. So we can turn up the meeting of the October meeting, it's at page 71 of the Ennis Bundle, please. So this is the meeting of the safeguarding case conference on 28th October 2013, and you're noted as an attendee. If we could scroll down to page 76, please, and just move up so we can see the end of 75, please? Up a little bit more. That's it. Thank you. So you can see there that the minute records discussion about this issue of institutional abuse and it's recorded that you: 10:44 10:44

"Mr. Veitch acknowledged the very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse. Ms. Mannion noted that the monitoring process had been stepped down as there was no concern about institutional abuse. 10:45

Ms. Morrison stated that while the monitoring reports confirmed no evidence of institutional abuse post the allegations being made, she did not feel that this could be necessarily generalised to the period before the allegations were made. Ms. Morrison reiterated the conclusions in Point 2 of the Recommendations and Conclusions section of the report and felt that this summed up the best judgment that the investigation team could form. Ms. Morrison did not feel that the investigation was conclusive enough to be able to state categorically that there had not been institutional abuse. Ms. Kelly concurred with Ms. Morrison's views that it had not been possible to reach a conclusion on whether or not there had been institutional abuse. She also stated that RQIA felt there was enough evidence to justify at least some concern about wider practice on the ward. Mr. Veitch said he felt that it was important that we did not speculate but only draw conclusions on evidence. Ms. Morrison said she felt the conclusions of the report were based on evidence and on the professional judgments made by the investigating team based on that evidence. Mr. Veitch asked to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue." 10:45 10:45 10:46 10:46 10:46

So just to clarify, Mr. Veitch, during that conversation, whenever the participants of the meeting were discussing institutional abuse, what was your

understanding about the term "institutional abuse"? Were you thinking about it in terms of just the Ennis Ward or the wider hospital?

A. Basically this discussion was specifically and exclusively in relation to Ennis Ward. Okay. What I meant by "institutional abuse", and it was not defined within the procedures, what to me I was trying to establish was to clarify the reference to a culture on the ward. Now, to me the term "culture" means what is learned and shared, i.e., was there a norm on this ward that unacceptable practice or abuse had become endemic and was accepted by all staff on the ward and was pervasive. That, in general terms, was what I was thinking about in terms of culture of abuse, or institutional abuse on the ward, sorry. 10:47 10:47 10:48

64 Q. And having seen the draft report then at this meeting, had you come to a firm conclusion about whether there was institutional abuse on the ward?

A. The point I was making in terms of the minute there was, there had been extremely extensive monitoring arrangements put in place in response to the reported concern. There were very clear statements made by Moira Mannion, who was an extremely experienced senior nurse, in terms of her findings in relation to any culture of abuse. Not only that, and there were disadvantages as were dealt with earlier in my evidence about the impact of monitoring arrangements, but these monitoring arrangements had gone on for quite a number of months, probably six, seven months in total in 10:48 10:49

different forms. Monitoring arrangements are more than watching to see if anybody is committing abusive acts. Monitoring arrangements are about the quality of interaction, about how staff perform their duties, about how patients respond to individual members of staff. The conclusion drawn from all those monitoring arrangements, I thought were in keeping with Moira Mannion's statements. 10:49

Having said that, the statements made by the staff at, from Bohill, remained active in my mind. Why would staff from a partner organisation maliciously make allegations? So the two issues had to be weighed up. What I was trying to draw out in that was drawing the conclusions. Now in terms of Ms. Morrison's investigation, as far as I could establish it did not reveal any substantiating or corroborative concerns beyond the initial statements about the culture of abuse. The conclusion was that she, on the balance of probabilities, which was the measure, was not confirming that any, any culture of abuse existed, but saying that she couldn't 100% rule it out prior to the actions being taken on immediate receipt of the referral. 10:50 10:51

CHAIRPERSON: Mr. Veitch, can I just ask this, do you accept that it's quite possible that the Bohill allegations, the allegations made by Bohill staff, were genuine and true, but nevertheless they didn't indicate institutional abuse? 10:51

A. Well, if, if they were all relevant and true, I think that there would have to be a debate about it, but to me that would present to me a prima facie case of a culture of abuse.

CHAIRPERSON: So for you, one followed from the other? 10:52

A. Sorry.

CHAIRPERSON: So for you, one would follow from the other, potentially.

A. Potentially. Potentially. Subject to rigorous investigation. And within -- sorry. 10:52

CHAIRPERSON: No, go on.

A. Just within the investigation there were some comments and/or "allegations" made by Bohill staff, which were established as having been made perhaps in good faith, but having no basis, because on clarification of the 10:53 incidents -- there's one that sticks in my mind and it's where it was, it was confirmed that it was a normal jokey remark as opposed to an abusive incident, and there were some interactions that had been misinterpreted by Bohill staff, which, on 10:53 investigation, concluded were not issues of concern at all.

CHAIRPERSON: Yes, I understand that.

A. Yeah.

CHAIRPERSON: So some allegations might be proved, 10:53 other allegations might not be proved. But where would you draw the dividing line between allegations against three members of staff and institutional abuse?

A. If there were acts by any member of staff, which were

on the balance of probability abusive, there are consequences to that. Where you draw the distinction between an isolated incident, or a small number of incidents, and a regime where it is accepted, accepted, not reported by other members of staff who may have witnessed it, where it was pervasive, that is a much broader, wider issue.

The other thing I should have added perhaps to some of my earlier responses, is that there was Moira Mannion's conclusions, which were significant to me, but there was also the transcripts of the interviews with individual staff, which Ms. Morrison herself remarked as being genuine, and I don't want to -- along the lines, perhaps not precisely, showed genuineness and compassion.

65 Q. MS. KILEY: Yes, and I think there is reference to that within both this minute and the report. We've looked at the extract of the minute and the view that you had, the view that Ms. Mannion had, and the view that Ms. Morrison had. Ms. Morrison has told the Inquiry that she felt that you put considerable pressure on her to state that she had found no evidence of institutional abuse. Do you accept that that's accurate?

A. No, I don't -- I didn't put particular pressure. I didn't put pressure on Ms. Morrison to draw that conclusion. I put pressure on Ms. Morrison -- no, I didn't put pressure on Ms. Morrison. I sought

clarification from Ms. Morrison on the basis of the facts and the evidence which would draw her to such a conclusion.

66 Q. Yes. And so far as seeking that clarity, and so far as we can see that it was left at this meeting in October, 10:57
we can see the final sentence that I read out said that you asked to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on the issue. So is it right to say that the issue wasn't fully resolved at this 10:57
meeting?

A. Yeah, basically that sentence is saying that if there is going to be a specific conclusion drawn on that, that the participants need to review the earlier, the earlier minutes, the totality of the investigation, and 10:57
to seek to draw a clear conclusion in relation to the evidence, and the substance of the investigation, and the original referral.

67 Q. Is that something which you then did?

A. No, let me be straight on that, I don't think that was 10:58
ever done. I anticipated that that would be done at a future meeting of the VA, and as far as I can see that was not the subject of conclusive discussion.

68 Q. Who did you anticipate would carry out that check or the review of previous discussions? 10:58

A. The Core Group. Sorry, the VA.

69 Q. Ms. Morrison?

A. The VA Review Group.

70 Q. The Vulnerable Adults Review Group?

A. Yes. Yes. Chaired by Aine Morrison.

71 Q. Okay. But are you including yourself in that?

A. Yes. Yes.

72 Q. But it wasn't ultimately done. So is the Inquiry --

DR. MAXWELL: Can I just clarify? When you say the VA Review Group, is that different from the case conference and the strategy group. 10:59

A. No, all the same thing.

DR. MAXWELL: So the meeting at which you were at.

A. Yes, these meetings. 10:59

DR. MAXWELL: You thought was going to, at some future date, review its own minutes and comment on this?

A. Yes, yes, yes. Sorry for the lack of clarity on that.

DR. MAXWELL: That's okay.

73 Q. MS. KILEY: But, Mr. Veitch, this issue of institutional abuse is an important issue. 10:59

A. Of course.

74 Q. Or was an important issue in the investigation. Would you accept that? And it appears from the minute that we've just looked at that it was unresolved at this meeting on 28th October, but an action was agreed to try and bring it to a resolution, but that didn't happen. So can you help the Inquiry understand why that important issue was never brought to a conclusion? 10:59

A. I believe that Ms. Morrison's final VA report, in terms of its conclusions did not -- on the balance of probabilities was not saying that there was evidence of institutional abuse. I think her final conclusions were saying, to summarise, that there was no evidence 11:00

on the balance of probabilities to suggest institutional abuse. She then said that 'but it couldn't be ruled out in the past'. Now, that was being presented to that review meeting. I was -- well, I raised the issue that it perhaps, perhaps needed further clarification at a future meeting of the group, which was planned. That didn't happen, by omission, and perhaps in terms of what I know now with the Inquiry's work, that's something that I should have gone back on and pushed on, but it... 11:01 11:02

DR. MAXWELL: And who is responsible for making sure that the actions of the group are carried out? You know, most committees the Chair is responsible, and you have a standing item of actions from previous meetings. Did you -- 11:02

A. I'm not ducking my responsibility in terms of that, you know, I'm a --

DR. MAXWELL: But you weren't the Chair?

A. No, I wasn't the Chair. But having said that, and what I know now, I should have insisted on that. 11:02

DR. MAXWELL: But would it have been Ms. Morrison's job as Chair?

A. I regarded it as Ms. Morrison's job as Chair, and certainly it was an issue which I was highlighting to her in terms of the conclusions. I regarded it as Ms. Morrison's responsibility to ensure that that issue that I was raising was actioned. 11:03

DR. MAXWELL: So can I then ask --

A. But --

DR. MAXWELL: -- the report has three names on it.
A. Yes.
DR. MAXWELL: But it was guided by a strategy group, also known as a case conference, also known as a VA review, and many other names. 11:03
A. I'm sorry.
DR. MAXWELL: Is it the case then that this meeting was purely advisory and Ms. Morrison can put whatever she wanted in the report, or was this meeting directing Ms. Morrison, because she did issue a report without this action having happened? I'm really confused as to where the authority sat. 11:03
A. Ms. Morrison's -- in terms of the vulnerable adult procedures, Ms. Morrison was the designated officer and the lead investigator. She had a responsibility to draw conclusions at the completion of her investigation. Obviously those conclusions should be informed by the process of the investigation, including the discussions at each of the meetings. She has independence as the lead investigator and designated officer to draw the conclusions of the investigation. When that is presented, it is the responsibility of the direct line of professionals, nursing, social work, and primarily the executive management, which is myself and Catherine McNicholl, to review the summary and recommendations and to take appropriate action. Now I don't know if that answers your query? 11:04 11:04 11:05
DR. MAXWELL: So it is an investigation and they've put forward their evidence.

A. Yeah.

DR. MAXWELL: And then other people decide whether this is satisfactory and has considered all the evidence?

A. Yes, it would be unusual, it would be unusual for anybody to be taking issue with the outcome of the summary and recommendations of a VA investigation. But if there were issues which senior management thought at the end of the process required action, clarification, or whatever, that would follow. 11:06

DR. MAXWELL: So is there no quality assurance or governance process around safeguarding investigations? 11:06

A. Yeah, I think the governance arrangements are through, are through professional and operational line management.

DR. MAXWELL: So is there no committee that receives all safeguarding reports and forms a view about whether they're consistent, whether the policy has been accurately applied? I mean if we think about disciplinary, you know, there's a whole load in the HR process about assuring investigations, they don't just say 'well, here's an investigation, it must be right'? 11:07 11:07

A. Yes, there is through the adult safeguarding, the local Adult Safeguarding Committee and the area local, meaning the regional, which reported to the Regional Safeguarding Committee, and I understood -- I understand that adult safeguarding reports were processed through the Local Adult Safeguarding Committee, which was chaired, when I left, by the Director of Social Work. 11:07

DR. MAXWELL: And how did this report get to the Local Adult Safeguarding Partnership meeting?

A. Through the designated officer, Aine Morrison.

DR. MAXWELL: So Aine Morrison would have sent it to this... 11:08

A. It would have been her responsibility.

DR. MAXWELL: I see.

A. And it would have also been her responsibility to report any operational or significant concerns she may have had through the process. 11:08

DR. MAXWELL: So she has told the Inquiry that she had a suspicion that there were cultural issues, even though she couldn't find the evidence to support it. Would you expect her to have told the local area safeguarding partnership that she remained concerned? 11:09

A. Yes. And also I would have expected her to have raised that personally in the first instance with the Director, the Executive Director of Social Work.

DR. MAXWELL: And would you have expected her to have raised the fact that there was, in her opinion, a 11:09 difference between yourself, Ms. Mannion, and herself, about the risk of a culture of institutional abuse?

A. If she thought that that was her conclusion.

DR. MAXWELL: That would have been her professional duty? 11:09

A. I would have expected, I would have expected her to have done that, and that would have been a healthy way to resolve any concerns that she may have had.

DR. MAXWELL: So we would find in the local area

safeguarding partnership minutes this being raised, had she raised the concern?

A. Well, I would have expected her to have robustly raised it with John Grocott and Cecil Worthington, who were the Co-Director and Director of Social Work. 11:10

DR. MAXWELL: So these were the corporate level, they were at Trust Headquarters level?

A. John Grocott was a couple of doors down from me at a local office. Cecil was at...

DR. MAXWELL: The Executive Director of Social Worker? 11:10

A. He was at Trust Headquarters. And I would have expected Aine, if it was unresolved in her mind, to have robustly raised her concerns with them.

DR. MAXWELL: Thank you.

CHAIRPERSON: Could I just ask, we're probably coming up to a break, I just want to understand about the execution of any recommendations made in a Safeguarding Report. I understand, first of all, Aine Morrison has a duty to draw clear and independent conclusions, there may be a question about whether they were clear, but it's not her responsibility to execute those recommendations, is it? 11:11

A. No, it's not, and my conclusion, and I didn't make an issue of it, was the majority of her recommendations were regulatory issues for the Trust and RQIA. 11:11

CHAIRPERSON: Yes. It's effectively for the Executive Group at the hospital, or I suppose at the Trust, to decide which of the recommendations it's going to follow and then execute them.

A. Yes.

CHAIRPERSON: Is that a fair way of putting it?

A. Yes, that's right, and be accountable for that to the Trust and to RQIA. As it was, we accepted them all, and that was reflected by the final meetings attended by RQIA, ourselves, the executive management, and the investigation team had accepted the final report and, therefore, by accepting the final report you were accepting the recommendations. 11:12

CHAIRPERSON: And therefore your duty to put them into effect. 11:12

A. Absolutely.

CHAIRPERSON: Thank you.

75 Q. MS. KILEY: Mr. Veitch, I'm going to come on to ask you about recommendations at a later stage, but just to bring this topic of institutional abuse to a close, I have one final issue I want to ask you about. Are you aware now of the review of leadership and governance that took place, and you're nodding, in and around 2020? You are aware of that. And are you aware that the Review Team looked at this issue of whether the Ennis allegations were an example of institutional abuse? You are. And you know then that the report found that Ennis, the allegations were an example of institutional abuse. And do you accept that? 11:12 11:13 11:13

A. My position I think has been set out in the last half hour of evidence. The Leadership and Governance Report, I did not have an opportunity to contribute to. I stated very immediately that I was very willing to

assist with that report, or in any way possible support the Trust in responding to what I saw as emerging in the press. The only thing I asked for was to have access to the relevant documentation on the topics that they wanted me to comment on when I was interviewed by them, because I was not content to go to a meeting in terms of such an important review, without having some preparation. There was ongoing correspondence between myself, the review, and the Trust, and at the point when the review decided that they weren't going to wait to interview me, I still had not received access to the documentation that I thought I needed before being interviewed. So I'm not sure the basis on which they drew that conclusion, so I'm not able to comment on the validity or not without nothing that. 11:14 11:15 11:15

76 Q. So in drawing that conclusion, they didn't have the benefit of the thoughts that you have given to the Inquiry today?

A. Nor do I know the basis on which they drew such a conclusion. 11:15

77 Q. And I think in fairness to you, and you refer to the exchange about requiring notes, you were retired by the time the Leadership and Governance Review was taking place, isn't that right?

A. That's right. I retired 2016. The first I heard was from the Trust in March 2020. I wrote, I e-mailed back to the Trust on the day I received the letter saying 'Yes, I am more than happy to assist'. Now immediately within a few days I sent the Trust -- because I didn't 11:15

know the breadth of the review -- a wish list of documentation that I would want to review. I recognise in hindsight that it was so extensive that it wasn't reasonable, and it also coincided with the worst of the Trust's position in terms of Covid. But then the review itself narrowed it down to about four or five points, which I shared with the Trust. Now, I am not criticising the Trust at all in terms of this because it still was heavy Covid, but I hadn't received a positive response to see the documentation, and I couldn't remember very many details at all about Ennis, without having the chance to refresh my view on it, and I wasn't prepared to go in and say "I don't remember" and be a fool. 11:16 11:16

78 Q. Okay. Thank you, Mr. Veitch. 11:17

CHAIRPERSON: We've been going a good hour and 25 minutes, which is a long time for any witness and for the stenographer, so we'll take a break there, Mr. Veitch. You'll be offered a cup of tea or coffee or whatever you need, and we'll come back in about 15 minutes. Thank you very much. 11:17

SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A THE SHORT ADJOURNMENT AS FOLLOWS: 11:17

79 Q. MS. KILEY: Mr. Veitch, I want to move on to a different topic now, and take you back in time to the

period just before the Ennis allegations emerged, so to around August/September 2012. And the reason I want to do that is because Esther Rafferty has given evidence to the Inquiry, and she has referred to what she described as a staffing crisis at Muckamore Abbey Hospital in that period. You're nodding. Are you familiar with the staffing crisis at that time? I'll bring up what Ms. Rafferty says just so you can see that. STM-2296, please. This is paragraph 15 of Ms. Rafferty's statement. It should come up on the screen in front of you. You can see there at the start of paragraph 15, Ms. Rafferty is referring to the 24-hour monitoring of staff and the challenges of that for the management of the hospital. Then the second sentence starts: 11:32 11:32 11:32

"MAH already had a staffing crisis in August and September 2012. Staffing was on the Risk Register. The staff were being depleted and there had been a moratorium on recruitment prior to me taking up my post in January 2012, as the hospital was supposed to be retracting due to resettlement. I had already started recruitment processes earlier in the year and staffing was on the Risk Register from March 2012, but staffing remained a serious concern. In September 2012 I had further escalated my concerns around staffing in MAH to John Veitch, Catherine McNicholl, Brenda Creaney and Nicki Patterson, Co-Director of Central Nursing, to come up with a plan to address this serious issues 11:33 11:33

following incident reports."

Just pausing there. Do you recall this staffing issue being on the Risk Register at that time?

A. Yes, I do. 11:33

80 Q. Did you have a role in the decision to place it on the Risk Register?

A. Yes, the Risk Register would be reviewed at the -- well, issues in terms of Muckamore, which were considered eligible for the Risk Register, would be 11:34 discussed at Core Group meetings, which were held fortnightly, which I chaired. They would also have been discussed at the service group governance meetings, which I also chaired, and clearly if a crisis or a particular concern was emerging, that would be 11:34 addressed by putting it on to the Register immediately. I wouldn't have to be consulted prior to a senior manager putting it on the Register, but I would expect to be advised.

81 Q. Do you recall then -- 11:34

A. I certainly do recall the concerns about staffing around that time.

82 Q. And do you agree that it's accurate to describe what was occurring as a crisis?

A. Well, it certainly it was of -- yes, it was a grave 11:34 concern whenever, you know, crisis, whatever.

83 Q. But it related to the whole site, not just Ennis, isn't that right?

A. It related -- yeah, it related primarily to the

availability of registered nurses locally, in terms of filling vacancies and the response to it. Now the crisis in around September/October, my understanding was that recruitment processes were already in process in terms of that, which resulted in I think 17 nursing assistants being appointed in January and -- maybe it was 20 nursing assistants -- and we were also trying to fill, and I think candidates were identified for registered nursing posts, and I think that was the 17. But there were delays, inevitably, with the process of recruitment and when appointments were offered the vetting arrangements prior to taking up post, yes. 11:35 11:36

84 Q. Yes, and Ms. Rafferty described that yesterday in her evidence. She I think said that these things don't move quickly and there can be delay between interviewing someone, then working a notice period, and then them getting there, but are you saying that in response to the staffing crisis in March, and in September, those were the actions that were taken recruitment? 11:36 11:36

A. Certainly there were a number of actions taken by the Trust. Now I can't pin it down to today to particular dates, but one of them was -- and can I just, before I develop that, the issue of -- the word "moratorium" I don't think is accurate. 11:37

85 Q. Okay.

A. Because it seems to suggest that recruitment at Muckamore is not going to be processed. Basically the issue there was that we needed to be planning for the

future in terms of the closure of wards, and planning to ensure that that is a smooth process, but that consideration is given to the protection of employment for our existing staff. It wasn't a moratorium because if there was a need developing to recruit, that would have been approved. 11:37

In terms of the events in the early Autumn of 2012, the Trust did respond to that in terms of trying to accelerate the recruitment processes. As I've just stated there were some in process. We then developed an arrangement, and it was an extraordinary arrangement within the Trust, that Muckamore could have beneficial terms within the Trust in being able to have rolling recruitment processes for nursing and nursing assistant staff, without having to go through the formal Trust, dare I say bureaucratic process, for approval. So we did respond as best we could to that. But as Esther, from your statement acknowledged, the recruitment process does take some time in terms of it's not instant in terms of being able to produce people, it was further exacerbated by what I've described as a shortage of available nursing staff within Northern Ireland. 11:38 11:38 11:39 11:39

We did, and I think I suggested that, we did try to target local -- in fact we did, around that time, target local universities in terms of their final year learning disability specialist nursing courses. I

believe that we also targeted some universities in Scotland as well. I'm not 100% sure, but I did suggest that one of our senior nurses should actually go across to a couple of Scottish Universities, but I can't 100% state that that occurred. But we did try to respond as proactively as we could while -- sorry.

86 Q. And did you respond using other measures? You've referred specifically to recruitment, but you've also referred to the challenges of the recruitment and how that can take some time. But you as co-director were aware that staffing was on the Risk Register from March 2012, and then Esther Rafferty specifically escalated the issue to you in September. So with the knowledge that recruitment processes may have been ongoing but could take some time, were there any other measures that you took? 11:40 11:40 11:40

A. We were -- yeah, it wasn't just through the executive line with myself, you know, it was -- the same processes were occurring and Esther was pursuing through the nursing directorate line. I'm not sure whether it was with Moira or, but certainly through to Brenda Creaney. I know there were discussions being elevated to the Chief Nursing Officer at the department, and also trying to look at how we could perhaps, and it didn't prove effective, but look Trust-wide whether there were resources within the, you know, Trust-wide, in terms of other directorates that could be redeployed. 11:40 11:41

DR. MAXWELL: Can I just ask about the governance

arrangements, which I want to ask about? It was on the hospital Risk Register and it was RAG-rated as red. We heard yesterday that it was on the service, the Learning Disability Services Risk Register, again rated as red. It presumably then went to be discussed, as all red risks are, at the Directorate Governance meeting. Did you present it at the Directorate Governance meeting.

A. The Directorate Governance -- I can't answer that "yes" or "no". The Directorate Governance meetings did review the Risk Register.

DR. MAXWELL: Yes.

A. I would have to review the records in relation to that, but my assumption is that it would have been part of the review. But it also, I believe as a red risk, would have been escalated to the corporate.

DR. MAXWELL: Well that was going to be my question, because the whole reason for having governance structures is that if you rely on individuals having individual conversations, lots of things drop between stools and, so, relying on somebody having a conversation with Moira and the CMO is not good governance?

A. Can I just also add to that, that it's not just the bureaucratic completion of a Risk Register, I was acutely aware of the concern, Catherine, my boss, was equally acutely aware of the concern, and I know through the nursing line that Brenda was as well. So, you know, in addition to the completion of the Risk

Register, it had a high profile within the Directorate.

DR. MAXWELL: But in order to be actioned, it would have to get up to either the Assurance Committee or the full Board, and the route to do that is through escalation. So are you saying you don't know whether the directorate had it as a red risk? 11:43

A. I wouldn't necessarily know beyond my directorate.

DR. MAXWELL: But do you know if it was rated as red in the directorate?

A. I know it was rated red. 11:44

DR. MAXWELL: So it was rated as red in the directorate?

A. Yes. Yes.

DR. MAXWELL: Which means it should have been discussed at a Corporate Governance Committee. Can I just ask you a little bit -- you were saying that you perceived the shortages to be around inability to recruit or slow recruitment. We've heard from a lot of witnesses that as the hospital was contracting, the number of registered nurse posts was contracting, for ostensibly good reasons about releasing the resource, but we've also heard that as resettlement progressed, the acuity, the case mix of the patients who were left was more intense and required a higher ratio of registered nurses. We've also heard that after the Ennis incident, actually the skill mix on Ennis Ward was increased. So, was there not a discussion in March about 'well, actually, this issue isn't just about supply, it's about have we got, have we thought about 11:44 11:44 11:45

the skill mix we need'?

A. Yes, there is two aspects to that I can comment on. As wards closed, that should not have -- that did not imply a diminution of the skill mix for the remaining wards, you know, which should be informed by the acuity of the patient needs, you know. So through ward closures you shouldn't have residually a less skilled, skill mix on any ward. 11:45

DR. MAXWELL: But might you need an enhanced skill mix because you are cohorting more complex patients? 11:46

A. Yes, yes. I'm not sure if it's in this statement or in the one I have prepared for after the summer, but certainly I had concerns, and Esther had concerns about the skill mix overall within the hospital, which we inherited, and we did make very strong representations on numerous occasions on numerous fronts to enhance that. Now, our primary focus in seeking assistance to do that was the Commissioner, i.e. the Health and Social Care Board, and I did raise on a frequent basis our concerns about that. 11:46 11:47

Now, again, I'm not at all critical of the response I received from the Board, but I was relating to the Deputy Director of Social Services and his finance people, with whom I met frequently and often, about, particularly about pressures at Muckamore, and they did assist us with quite significant subventions of short-term finance on occasions, but they were also very clear to me that any enhancement of skill mix, and 11:47

they did provide some, which was not -- was helpful, but not that significant, but they had to be provided on a short-term basis through slippage available to them from resettlement funding. So we did pursue those issues.

DR. MAXWELL: So staffing was based on the finance available rather than patient need?

A. Sorry?

DR. MAXWELL: So staffing was based on the finance available and not the patient need? 11:48

A. Well, that's what we inherited and tried to resolve.

DR. MAXWELL: Yes.

87 Q. MS. KILEY: Mr. Veitch, you referred to your second statement there, so it may be that those wider issues about staffing pressures are something that we can 11:48 return to after the summer. But continuing in relation to the Ennis Investigation, and you have already touched on the implementation of the recommendations. You set this out at paragraph 52 onwards of your statement, and you say there that Esther Rafferty was 11:48 responsible for the implementation of recommendations. Just for IT, this is moving back now to Mr. Veitch's statement at page 205. And there at paragraph 52, you set out the nine recommendations made by the Ennis Safeguarding Report. I'm not going to ask you to go 11:49 through all of them, but I want to ask you in particular about the recommendation in relation to the disciplinary investigation. So your point No. 1 there:

"The investigation team recommended disciplinary investigations into two members of staff."

And we can see there that you say that the Terms of Reference were set by Esther Rafferty and that the disciplinary investigation was then commissioned. 11:49

Later on in your statement you explain some actions that you took in respect of the disciplinary investigation, and in fact it's at paragraph 42, so backwards, if you're flicking back, paragraph 42, and you received draft reports, it seems, in respect of the disciplinary investigation. Is that right, Mr. Veitch? 11:50

A. Well, I think what I was presented with was deemed to be not a draft but the final report, but I did not accept it as a final report, and instructed the investigating team to -- I asked them had they consulted Aine Morrison as part of their investigation, discovered they hadn't, and said that I wanted them to take the report away, discuss as part of their investigation, have a discussion with Aine Morrison, and re-present a final report. 11:50

88 Q. And you describe that rejection at paragraph 42 as an extraordinary measure. Was that the first time that you had done that? 11:51

A. I believe so, because strictly speaking in terms of employment law, as particularly as I may have been ultimately the disciplinary authority, I should not be discriminating in terms of a report once it is

presented to me as final.

89 Q. What concerns then prompted you to take that extraordinary measure?

A. Basically I was acutely aware that there were two particular staff members against whom the allegations, I think, were characterised by more staff at Bohill expressing their concerns. The second, and probably most relevant factor, was that the police and the Prosecution Service had decided to prosecute based on the standard of beyond reasonable doubt, whereas our standard in terms of disciplinary is balance of probabilities. I couldn't understand the inconsistency of that, and I wanted to ensure that the disciplinary investigation report had addressed and taken into account the factors in relation to the allegations, the police and the Prosecution Service response, and the content of the Vulnerable Adult Investigation. 11:52 11:52 11:53

90 Q. And you say there that you instructed the disciplinary investigation team to have a full discussion with Aine Morrison, and as far as you were aware that took place, is that right? 11:53

A. Yes.

91 Q. But in the end, the recommendations of the investigation team didn't change, isn't that right?

A. Yes, that's right. 11:53

92 Q. And the disciplinary investigation team still chose not to take disciplinary action against those two members of staff, isn't that right? And the final reports appear in the Ennis Bundle that you have, and that the

Inquiry and Core Participants have, and for the record they're at pages 293 to 376.

Can you recall whether there were any changes in the reports at all between that first time that you saw them and then after the discussion by the team with Aine Morrison? 11:54

A. I can't, because that would require, you know, a detailed analysis of the two, which I, you know, which I can't recall. 11:54

93 Q. Okay. But you found yourself then in the position where you were faced with the final disciplinary reports, which didn't recommend taking disciplinary action on the one hand, but then on the other hand the outcome of the Ennis Safeguarding Report, which did come to the conclusion that disciplinary action ought to be taken. So... 11:54

A. Well the Ennis Report -- sorry. The Vulnerable Adults Report can't recommend disciplinary panels, it can recommend a disciplinary investigation, which in certain circumstances can lead to a panel. 11:55

94 Q. Yes, but you were faced with two reports that suggested two different things, isn't that right?

A. Yes.

95 Q. Because the disciplinary investigation said that action was not going to be taken, but the clear, the clear findings of the Adult Safeguarding Investigation was that there was sufficient evidence against these two people, isn't that right? So what I'm getting at, 11:55

Mr. Veitch, is, when faced with those two competing --

A. Yes

96 Q. -- views, in two different reports, what did you do about that?

A. We consulted HR. I was acutely aware that the two processes, while ideally complimentary, are independent and standalone processes. There was a meeting convened with HR which reinforced, or confirmed from the HR perspective, the disciplinary perspective, that that was the resolved position, which left -- and clearly through the employment law disciplinary route, the employees who are the subject of a disciplinary have a right to access to the disciplinary investigation report and conclusions, so therein lay the issue. 11:55 11:56

97 Q. Are you saying -- did you feel that you had -- there was nothing more that you could do at that stage? 11:57

A. Well I did say to Esther that before these two people returned to work that they should be brought in and told that even though the disciplinary investigation had established on the balance of probabilities that they hadn't a case to answer, the Trust and the service remained concerned about the nature of the allegations that had been made against them, and that if a return to work was to occur, they would be subject to significant supervision and surveillance. 11:57 11:58

98 Q. And, so, is it fair to say then, Mr. Veitch, that the two different conclusions put you in a difficult position as co-director?

A. Well, I would have much preferred if the two

conclusions had synchronised.

99 Q. And just can you help the Inquiry, reflecting on this episode, is there anything that you think can be learned from that process and from your experience of having those two different conclusions? 11:58

A. I think that there is a lesson and possibly an issue for the Inquiry in relation to this, as you've -- and I think it needs to be highlighted in terms of synchronising the two processes, and I think that that was the subject of discussion -- beginning to be the 11:59 subject of discussion through the review of adult safeguarding, because there was a duplication which not only ended up in conflict, or not supplementary, but it also led to unnecessary delays, and if the outcome of one process could be accepted as part of the 12:00 disciplinary, without the need to duplicate, that would be helpful I think.

CHAIRPERSON: Could I just ask this, sorry, just in terms of timing. The disciplinary investigation didn't start until the safeguarding investigation had 12:00 finished? Is that right?

A. That's right.

CHAIRPERSON: So witnesses who may have been available to the safeguarding may not have been available to the disciplinary investigation? 12:00

A. And I would have expected -- because the final report I received on the disciplinary, and I think it maybe relates back to your question 'Was there a difference?', the second final report that I received

in the disciplinary made specific reference that it had considered, had had access to and had considered the Vulnerable Adults Investigation. The Vulnerable Adult Investigation had signed statements from Bohill members of staff who were not available for interview, and receipt of that report should have ensured that that was taken account of.

CHAIRPERSON: Yes, but I expect the personnel department -- do you know if they consulted lawyers? I don't want to know what they were told by the lawyers, but... 12:01

A. I don't know, because the disciplinary Terms of Reference and arrangements were commissioned by Esther Rafferty in consultation with HR, and as in all disciplinary investigations I would have expected staff to have been consulting HR. 12:01

CHAIRPERSON: Yes. Quite.

A. As dilemmas arose.

DR. MAXWELL: But isn't it the case that under employment law and disciplinary procedures, the member of staff who was under investigation has the right to hear the evidence put to them at the hearing by the accuser. And, so, you're operating in slightly different legal fields? 12:02

A. Yeah, but the investigation possibly could have led me into the disciplinary hearing, you know. The investigation could have led to a Disciplinary Panel, which possibly could have then... 12:02

DR. MAXWELL: But without specific --

A. Yes, I know. I know.

DR. MAXWELL: -- specific evidence from the accused, wouldn't the unions just say "this isn't right"?

A. I know. I know. Yeah.

CHAIRPERSON: Can I just interrupt because I think there's quite a lot of law actually around what one tribunal can use from another tribunal, and you were relying on the advice that was received from Human Resources. 12:02

A. Ultimately. 12:03

100 Q. MS. KILEY: And in the end you've explained you weren't involved with the Terms of Reference, but you were dealing with the consequences.

A. Well, you know, maybe I shouldn't say this, and others can advise me, but sometimes if you make life difficult for people returning from such circumstances, based on concerns you may personally hold, they sometimes don't return. 12:03

101 Q. Well in fact in this respect --

A. One didn't. 12:03

102 Q. One didn't.

A. And one did very briefly. But I don't --

103 Q. Well, I think, Mr. Veitch, you've explained your views about the process and about the consequences that it had for you. I think we can leave that topic there. 12:03 There is one final thing that I want to ask you about, and that is the SAI in respect of Ennis, and you have addressed this at paragraph 66 of your statement. I'm not going to read all that out, but the Panel has it

and the Core Participants have it, but it's the case, isn't it, that an SAI was not submitted in respect of Ennis? That's your understanding, isn't it?

A. Yes.

104 Q. And you refer to not being in post at the time, or being on leave at the time that the initial decision was made not to submit an SAI, isn't that right? But you do later go on to say, just at the bottom of the paragraph, that you recognise that there was a Health and Social Care Board request for the SAI, and you say that you acknowledge that: 12:04 12:04

"...by not complying with the Health and Social Care Board's request at an early stage was a mistake and that there were potential additional benefits to the level of scrutiny which would have been facilitated through the serious adverse procedure. I accept my responsibility in relation to this." 12:05

I just wonder can you explain a little more to the Panel about what the potential additional benefits might have been that you're referring to there, had there been that additional level of scrutiny? 12:05

A. Can I say first of all when this came in, when the allegations were made and the Early Alert was completed, that it was, you know, I know it was considered, I know that Mairead Mitchell would have been prominent in the consideration of that, and I'm also aware and I did look at the SAI criteria as it 12:05

existed at that time, and I did understand why the initial decision against that criteria was taken to initially process the issue initially, subject to review through adult safeguarding.

12:06

When the Board came back to the Trust querying that decision, I think it was probably late '13/early '14, and I think that the SAI criteria had been superceded at that point, and the Board was applying the measure of the subsequent SAI procedure. 12:06

Now, having said that, and perhaps for me one of the most significant part of the Ennis Investigation was the police decision to prosecute and the subsequent court, criminal court hearings. When Mairead consulted 12:06 me about the Board's request to re-categorise it under the new revised procedure, I accepted that -- I accepted that it was assessed and evaluated against the procedure which occurred, which was in place in November 2012. Having said that, with retrospect it 12:07 wouldn't have been a big issue to say, and a pragmatic response as well, and sometimes you need to be pragmatic, and looking back on it I think that I should have just said re-categorise it as an SAI, particularly in relation to the two developments which could attract 12:08 very major adverse publicity to the Trust through the prosecutions of the two members of staff. The additional benefits would have been additional scrutiny through the Trust's assurance arrangements and also by

the Board Public Health Agency.

105 Q. And you have, as we've seen, accepted your own responsibility in relation to that, but was it solely your responsibility to make the decision?

A. No. 12:08

106 Q. And who else had input into that decision about whether to?

A. Well, you know, Mairead Mitchell was the governance, Senior Governance and Service Improvement Manager, and in my experience always, always provided very balanced 12:08 and good advice. Mairead didn't have the executive responsibility, okay, that was down the service line. So the issue for me is I had -- I am responsible and accountable, Catherine and possibly Brenda from the corporate nursing, given the nature of the concerns 12:09 being investigated.

107 Q. Okay. Mr. Veitch, I said that was my final issue. I have no additional questions for you on the Ennis statement. It may be that the Panel have some.

12:09

MR. JOHN VEITCH WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

108 Q. PROFESSOR MURPHY: I just have one. You said at one point in your statement that you felt the Ennis 12:09 Investigation took too long and that you would have preferred a disaggregated and more focused approach. Can you just say a bit more about what you mean by that?

A. I think I touched on that maybe earlier this morning in terms of trying to disaggregate what was the primary focus of the investigation in terms of the allegations which were made on the 8th November by Bohill staff. Then when you got into analysing the early part of it, identifying what aspects of it were regulatory matters which could be taken off the agenda of the VA Investigation and pursued by RQIA and passing back some of the issues to the Trust for clarification, but all three processes being taken forward contemporaneously by the three agencies, as opposed to sequentially, but all reporting back into the VA planning meetings.

PROFESSOR MURPHY: Lovely. Thank you.

109 Q. DR. MAXWELL: Yeah, I've just got one. So had you concluded at the end that you had concerns about institutional abuse, or a culture of abuse, what would you have done differently in response? Because there was a lot of action happening, a lot of practice development, you were sorting out the staffing, what would the difference have been if that had been the conclusion?

A. Well, going back to 2014 when this concluded, I can't stop anybody from saying, but we don't know what happened in the past, but what I can do is to weigh up the evidence from the processes of investigation. Now I didn't -- Aine Morrison's conclusion was, in my interpretation, 'We have undertaken a very extensive investigation on the balance of probabilities. Nothing has emerged to signify institutional abuse', and I took

it at that.

110 Q. DR. MAXWELL: I'm not questioning the question, I'm just saying hypothetically. So potentially one could say there was a lot of tension on the ward, Moira Mannion and her team had been there, and she talked yesterday about the practice development stuff, she done the 15 Steps, which was Kim Manley's work. 12:12

A. Yeah.

111 Q. DR. MAXWELL: Could it be said that regardless of whether it was found to be institutional abuse or not, you had put so much effort into the ward that you wouldn't have done anything differently even if you had concluded there had been institutional abuse, because you had already made a number of changes on the ward? 12:13

A. Well, sitting here today with hindsight I probably, were it to occur today and myself be in post, would be taking the two reports and all my dilemmas to a meeting at directorate level; nursing, social work, operational, and HR, to try and conclude at that level. 12:13

112 Q. DR. MAXWELL: No, I understand that. But if the conclusion was there had been, what material difference would it have made on the ward, had you already done enough to change the ward, or would you have done something different? 12:14

A. I know the question that was asked of me was when I referred to institutional abuse was I looking at this ward or was I looking at all the wards? At the time I was looking only at this ward. 12:14

113 Q. DR. MAXWELL: Yes.

A. And there was very positive remarks about the other two wards. If there had been a conclusion about institutional abuse on this ward, I believe it would possibly have sparked broader look, initially across the other resettlement wards, but possibly into the core hospital. 12:14

114 Q. DR. MAXWELL: Sorry, just one final question that you may not be able to answer, how would you do that broader look?

A. Sorry? 12:15

DR. MAXWELL: How would you conduct that broader look?

A. How would I?

115 Q. DR. MAXWELL: How would that broader look at the hospital, at the culture, have been done? What would have been done? But that may not be fair to ask you at the moment. 12:15

A. Can I avoid that one?

DR. MAXWELL: Yeah.

116 Q. CHAIRPERSON: I mean it's speculative to some extent, isn't it? 12:15

A. Yes, it is very speculative.

117 Q. CHAIRPERSON: Because you weren't in that position. But if institutional abused had been found, would that have been escalated to the Board?

A. The bottom line is, if things are wrong, get them out on the table and put them right, and grasp the nettle as opposed to be where I'm sitting today. 12:15

118 Q. CHAIRPERSON: What would grasping the nettle look like?

A. A fundamental review of all aspects of the service.

There be dangers in speculating, you know, but -- and it's maybe something for after the summer. One of the issues that I was very concerned about in my time in that post was Iveagh, which was the unit, the children's unit. I did convince the Board to assist me by funding an independent review undertaken by independent core professionals who reinforced my concerns about the concerns, ultimately led to RQIA escalation, but also led to funding for a much better skill mix and produced a much better service. 12:17

119 Q. CHAIRPERSON: I should know, when was that.

A. I think it was late '13/early '14.

120 Q. CHAIRPERSON: Okay.

A. But it wasn't a pretty -- it wasn't a pleasant process.

121 Q. CHAIRPERSON: And the only other thing I suppose is, we know that CCTV was introduced in 2015, and we've yet to hear about the thinking behind that and why it was necessary, but if a finding of institutional abuse had been found back in 2012 or '13, might that have accelerated the introduction of CCTV? 12:17 12:18

A. In order to accurately respond to you, but I do know, and I think it was back in about 2012/2013, the issue of CCTV was raised by the senior social worker at one of the Core Group meetings. I think there's a cipher, which is why I'm referring to it. 12:18

122 Q. CHAIRPERSON: Right. Thank you.

A. And that initiated the process back in 2012/'13. But I think that that actually is in the minutes of one of the Core Group meetings.

123 Q. CHAIRPERSON: But that was obviously independent of this investigation that we've been examining.

A. Yes. Yes.

CHAIRPERSON: Okay. Mr. Veitch, can I thank you very much for coming to assist us on this occasion. We may be seeing you again of course, but thank you for giving up your time this morning and for making a detailed statement. Thank you. 12:19

Okay. We'll sit again at 2:00 o'clock. 12:19

MS. KILEY: Chair, if we sit at 2:00. David Bingham is our live witness.

CHAIRPERSON: Back at 2:00, please. Thank you.

LUNCHEON ADJOURNMENT 12:19

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Yes, Ms. Tang.

MS. TANG: Thank you. Thank you, Chair. Good afternoon, Chair. Good afternoon, Panel. This afternoon the Inquiry will hear the evidence of Mr. David Bingham, and that's as part of Module 6D, which considers the Review of Leadership and Governance at Muckamore Abbey, and the report of that was published in August 2020. Can I check everyone can hear me okay or would you like me to pull this closer? 13:57 13:57

DR. MAXWELL: A little bit closer.

MS. TANG: A bit closer. Okay. Thank you.

Mr. Bingham has provided two statements to the Inquiry. The first one is dated 24th April 2023, and it exhibits a copy of the Review Report. Mr. Bingham's second statement is dated 23rd April 2024, and that statement has one exhibit. I'll take Mr. Bingham to some sections of both statements and both exhibits in the course of his evidence. If there are no issues, the witness could be called. 13:57

CHAIRPERSON: Yes. Thank you.

MR. DAVID BINGHAM, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS: 13:58

CHAIRPERSON: Good afternoon, Mr. Bingham. Welcome to

the Inquiry. Thank you for coming to assist us and for making your statements, and I'm going to hand you over to Ms. Tang.

124 Q. MS. TANG: Thank you, Chair. Good afternoon again Mr. Bingham. You and I met a short time ago. Just to remind you, I'm Shirley Tang. I'm one of the counsel to the Inquiry. 13:59

You have provided two statements to the Inquiry. Can I confirm that you have copies of those two statements, the first of which is dated 24th April 2023, and the then the next is 23rd April 2024, in front of you? Do you have those to hand? I should say they will come up on screen in sections as well. 13:59

A. Yes, I can confirm. Yes.

125 Q. You do. Thank you. And can I ask you to confirm if you are content to adopt those statements as your evidence to the Inquiry? 13:59

A. I am.

126 Q. Thank you. I'm going to take you to various points in both of your statements and the exhibits in the course of your giving evidence to the Inquiry today, and as I may have said to you, when I'm referring to a particular part of your statement it should come up on the screen in front of you for ease of reference. 13:59

You'll see the microphone in front of you there. Please try and keep your voice up, and for the benefit of our stenographer I'm going to try not to speak too quickly, and if you could as well, please, that would help her. 14:00

Can I turn to your first statement, which is at internal page number 115, beginning at page 1, and that's your statement dated 24th April 2023. You tell us at the opening page of your statement there that prior to your retirement in 2016 you had been in senior management in the health and social care sector, was that throughout your career?

A. Through most of my career. I started off my career as a general management trainee in the health service, left for a short period into DeLorean Motors, and then via university back into a career in health service management.

127 Q. And your post before you retired you tell us was as Chief Executive of the Business Services Organisation?

A. That's correct. 14:01

128 Q. And you retired from that in 2016?

A. Yes.

129 Q. And between 2016 and 2022, you undertook some consultancy work. Was that through the leadership centre or... 14:01

A. Yes, almost all of it was through the leadership centre where I was registered as an associate.

130 Q. Thank you. So your statement exhibits a copy of the Review of Leadership and Governance that you helped to carry out, that was published in 2020, and at paragraph 1 of your report you detail that the Leadership and Governance Report came after a previous report, the "Way to Go Report", which was published in November 2018, and following that initial report the Department 14:01

of Health had wanted some more in-depth exploration of leadership and governance arrangements at Muckamore Abbey Hospital, and that the review you were party to began in January 2020. Can you tell us how your involvement in the Leadership and Governance Review Group came about? 14:02

A. I was contacted -- so the Department of Health asked the PHA and the Health and Social Care Board to conduct this review, or to arrange to have it conducted. I was -- I think it was the Health and Care Board/PHA, they operated as one unit in fact for this review, asked me to -- I can't remember if I was asked to Chair it initially or whether be part of the review, but I think I was asked to Chair it, yeah. 14:02

131 Q. And prior to being part of that review group, had you met either of your fellow group members, Marian Reynolds or Moira Devlin before? 14:02

A. I would have known Moira Devlin very well. She headed up the Nurse Development Unit, which was part of my organisation. So I would have known Moira and her career in nursing. I don't think I knew or I had met the other member before. 14:03

132 Q. Okay. And how familiar with Muckamore Abbey Hospital itself would you have been before you undertook the review? 14:03

A. Not very. So back in the 1990s I was Director of Human Resources for the Belfast, what was then Eastern Health and Social Services Board. I would have had some familiarity with industrial relations issues on the

site. In the noughties I was Director of HR at the Department of Health, and I commissioned from the Open University several degree programmes, part-time programmes through the Open University for learning disability nursing. That's probably the extent of my familiarity.

133 Q. I want to go down to paragraph 6 of the report, which is at page 115-8, and in that you set out that the review was to consider three -- the review considered three events at Muckamore, the first of which was the Ennis Investigation, which had commenced in November 2012. Then the installation of CCTV in some areas of Muckamore, and finally reports of an assault on a patient in the PICU on 12th August 2017, and how this had been handled. 14:04

The Terms of Reference for that report you provide -- for your review, sorry, you provide in the appendix of the report. Can I ask you in relation to the report itself, you've told us that the Department of Health had been a driver in that, why do you feel that they wanted more investigation of the leadership and governance arrangements than had been in the "Way to Go" Report? 14:04

A. We were told that the "Way to Go" Report did not -- I can't remember whether it was adequate or comprehensive, but it did not cover leadership and management issues to the degree that they wished to have it covered. 14:05

134 Q. Okay. And would it be fair to say that the Terms of

Reference for the Leadership and Governance Review set out broad objectives, but it was for the Review Team itself to decide how it went about the investigation and the review?

A. Yes. So, for instance, I don't think Ennis was mentioned in our Terms of Reference, but we structured our report by trying to define what we meant by leadership and governance, then giving an overview of leadership and governance as we saw it from our investigations in the Belfast Trust, the Department of Health, and the Health Board, and then we took -- we decided to take these three, three events really, to illustrate leadership and development issues, there may have been others we could have taken, but those were the three. We felt Ennis was significant. Clearly CCTV was very significant, and the complaint arising from that we felt was worth examining in some detail. 14:05 14:05 14:05

135 Q. Okay. Looking down to paragraph 5 on page 115-7. Looking at the Executive Summary of the Leadership and Governance Report, you used the phrase that: 14:06

"There was dysfunctional leadership team at MAH."

Can you tell us what you mean by the term "dysfunctional leadership"? 14:06

A. So it was clear there was tensions. You could characterise those or generalise those tensions as nursing v Social Services, that would be a bit of a generalisation, there may have been personality

elements as well, but it was clear that there were tensions throughout Ennis, and certainly when we came to look at CCTV, those tensions were still there.

DR. MAXWELL: Can I just ask you, you said you characterised it as nursing and Social Services, and yet we've heard quite a lot that there were dysfunctional relationships within Social Services. So we've heard just this morning that Aine Morrison and John Veitch had differences of opinion. So is it actually fair to say it was between nursing and Social Services, or is it more complex than that? 14:07 14:07

A. No, I did say it was a generalisation, and I did say it was personality, there was an element of personality as well.

DR. MAXWELL: So it was personality and it was not just between the two groups. 14:07

A. Well -- yeah. There was probably a different philosophy. So for nurses it was, and really I am generalising now, but for nurses it was a hospital. For Social Services I remember someone saying it's a home. Someone explained the two differences. 14:07

136 Q. MS. TANG: Can you give us an example of what made you think it was dysfunctional? Was this an observation of some of the people involved and how they interacted or what kind of things? 14:08

A. Well if you go to the Ennis Report, the fact that it took I think 11 months to complete the report, that there were tensions throughout that, that would have been an example where, you know, it just took far too

long, and part of that was because of the nature. But when you come to CCTV, another illustration would be CCTV was thought of as a good idea in 2012, I think, and yet it was 2015 before it actually got installed, and unknown to them it was 2017 before they actually discovered that it had been working. So that to me illustrates all was not well with management on that site.

DR. MAXWELL: But the approval of the policy.

A. Sorry, I missed that? 14:08 14:09

DR. MAXWELL: So after the CCTV was installed.

A. Yes.

DR. MAXWELL: The approval of the policy went through lots of committees that weren't in MAH.

A. Our report contains a timeline. So let's say it was -- I think it was over two years from installation to policy. My recollection is that at actual Trust level they dealt with that policy in a month. There was an 18 month delay while it bounced round inside Muckamore. Somewhere in our report we actually have a timeline of how long it took to get a policy to -- and even then it wasn't implementable. 14:09 14:09

137 Q. MS. TANG: So in your mind you're very much connecting the amount of time certain things took, whether it be the Ennis process or CCTV installation. 14:09

A. Yes.

138 Q. That that indicates a dysfunctionality in the Muckamore team?

A. Yeah, I'm also influenced in that by the issues brought

up by -- can I name the recent witnesses?

139 Q. Yes.

A. So Aine Morrison, John Veitch, Esther Rafferty, and -- yeah.

140 Q. You also mention in paragraph 5 that you observed there was a lack of continuity and stability at directorate level, and a lack of interest or curiosity at Trust level about MAH. Can I check, whenever you talk -- when you talk about Trust level, do you mean the Trust Board or who do you mean? 14:10

A. No, when I mean "Board", I would say Trust Board level. So there were a number of Directors. My recollection is there were a number of Directors held responsibility for learning disability during the course of our -- our investigation covered the period 2012 to '17, and I mean I've been involved in management most of my life, but I found the structures quite complex. Sorry, I missed the second part of your question? 14:10

141 Q. It was the lack of interest and lack of curiosity that you observed at Trust level? 14:11

A. Yeah. So one of the things we looked at was Trust Board minutes, and we couldn't find any reference to Muckamore Abbey in the minutes. The only issue that seemed to draw attention at a very senior level was the movement of patients into the community, the dispersal from the hospital to the community. That was clearly the strategic priority. We couldn't find any evidence of, for instance, the Trust Board having carried out one of their meetings in Muckamore. And, in fact, in 14:11

our report we mention that although Muckamore was designated as a hospital, it didn't appear on the Trust website until we drew it to their attention in 2020.

142 Q. And when you talk about the movement of patients, you mean the resettlement agenda? 14:11

A. Yes.

143 Q. That would have featured. Yes, I understand. So the lack of curiosity, as you referred to it, why do you think that issues pertaining to Muckamore would have rarely appeared on the Trust Board or Executive Team discussions? 14:12

A. Belfast is a huge Trust, one of the largest in the United Kingdom. It has got one of the most complex services, you know, carrying -- being responsible for acute hospitals in Belfast, workforce of 20 plus thousand, very complex agenda. There was a debate back at restructuring in 2007/'08 as to whether Muckamore should have gone to the Northern Trust, in whose geographical catchment I think it was. So Muckamore was kind of bolted on physically to the edge of the Trust. But I think if you ask how are Trust Board members meant to be alerted to issues, you'll see on a number of occasions we refer to the lack of the use of serious adverse incidents, SAIs. SAIs tended to find their way to the top of the organisation, or at least they were monitored at the top of the organisation. Less so the adult protection route for reporting. So you would also expect directors, executive directors, to bring issues to the Board. So non-executive members 14:12 14:12 14:13

rely on that. Now there should also be a natural curiosity, and one of the things the Trust did post 2017 was to -- one of their non-executives having a special interest in learning disability, and I mean that's now I think quite common in Trusts now. 14:13

DR. MAXWELL: Did you look at the feeder committees? So you're right, Belfast Trust is big, and you couldn't take every safeguarding or SAI report to the Board, because you'd never have time to discuss anything else. So they have a number of feeder organisations, feeder committees, and two in particular: one, the Assurance Committee, and the second the Audit Committee. Did you look at the minutes of either of those? 14:14

A. We certainly were aware of both of those committees and I can't -- I would think we did, but I cannot be sure. 14:14

DR. MAXWELL: Because in a well-functioning governance committee, they would have been the filters of all the information that the Board needs to look at, and if they felt that something was being well managed and mitigated, they wouldn't necessarily escalate it to the full Board, would they? 14:14

A. No. But equally if there's not a flow of information, then...

DR. MAXWELL: Well there's a question about whether it got as far as the Assurance Committee and the Audit Committee, I agree. 14:14

A. Yes.

DR. MAXWELL: But if it got there and they considered it and thought 'Everything that can be done has been

done. We'll keep an eye on it, but we don't need to raise it at the Board'.

A. Right. But I'm not sure that the, for instance, the Ennis Report, which was the outcome of that Adult Safeguarding Investigation, ever got that far.

DR. MAXWELL: But do you know if it got that far? Did you look?

A. We did, and I think -- I would say it didn't get that far. It remained with the directors.

DR. MAXWELL: Can I just pick up your other point about the non-execs. So clearly the non-execs are really important, because apart from anything they're overseeing what the executives are doing and, you know, if we look all the way back to the Cadbury Report on Corporate Governance, the Audit Committee is supposed to have independent scrutiny of what's going on, so NEDs should assure themselves and not rely on the execs telling them. So did you look at whether the Audit Committee had examined these issues?

A. No, I can't recollect that. But, again, the general comment there was a lack of curiosity about Muckamore, and it was viewed as place apart I think.

DR. MAXWELL: So your view that there was a lack of curiosity was because it wasn't often discussed in the full Board meeting?

A. Well that would have been one of the reasons, yes.

DR. MAXWELL: And what other evidence?

A. Well, in a very very complex organisation where constantly other issues and problems were being brought

to Board level, and back to your point about time, you know.

DR. MAXWELL: Okay.

144 Q. MS. TANG: Thinking about the complexity of the organisation, do you think is it possible that issues like, places like Muckamore were to some extent overshadowed by a lot of the issues that will come to the fore in a big acute Trust, so issues around medicine, surgery, waiting times, et cetera. 14:16

A. Yeah, that's certainly my opinion, and I think we tried to convey that in the report. 14:16

145 Q. Can I ask if you feel that the Muckamore senior leadership team played any part in the lack of curiosity that was, that you observed above them at Trust level? Were they escalating concerns often enough to the Trust, or do you think that there was a tendency to try and manage most things on site? 14:17

A. I think there was a tendency to try and manage things on site. One illustration of that, again it comes back to not using Serious Adverse Incident Reports. Even after the CCTV was discovered and footage viewed, the Service Manager tried to raise it as an SAI, and that was turned down by others in that management team. 14:17

146 Q. And was it clear why they turned it down and thought it wasn't an SAI? Did you look at that in your -- 14:17

A. One of the persons who would have had a key role in that would not meet us, so we never got to explore that, as to what the motive was.

147 Q. Okay. Can I ask you, did you get the sense in your

interactions with the Muckamore senior team that you did meet, that they might have ever felt as a site that they were "out of sight out of mind" as far as the rest of the Trust is concerned?

A. I'm trying to think. So there were three people very much involved in the management of Muckamore who did not meet us, for various reasons. The Service Manager did meet us. She didn't convey that. I think she felt she was adequately supported down the nursing line. 14:18

DR. MAXWELL: Can I ask, you talk about this not reporting up, and of course there are a number of levels between Muckamore Abbey and the Trust Board, and did you explore what was being done in terms of leadership and governance at the Directorate level? Because as I understand it, Muckamore had its own arrangements, they reported into the Learning Disability Services Unit, which was a subsection of the Directorate, and things would be escalated through those, not go direct to the Board. Did you look at how those systems worked? 14:18 14:19 14:19

A. Yes, there was one example where the services manager was, I think it's 2012, was very concerned about nurse staffing levels.

DR. MAXWELL: Yes.

A. And she put it on the Risk Register as red. Now our understanding was that that should automatically have escalated up to Directorate level, and then if it was considered still red, or not dealt with, it would then get to the senior team level and ultimately Board. It 14:19

didn't ever get beyond the site was my understanding, and we --

DR. MAXWELL: That's not the evidence we've heard. We've heard it was on, definitely on the Learning Disability Services Risk Register, and then we heard this morning it was definitely rated red on the Directorate Risk Register. 14:20

A. Okay. Well, I may have not been aware of that, or overlooked that, but the reality was what happened to it? 14:20

DR. MAXWELL: So did you look at what mitigation action was taken?

A. I can't recall.

148 Q. MS. TANG: We've come on to Trust Governance and Leadership Arrangements in particular, and looking at page 115-11, down at paragraph 14, please. It states there that: 14:20

"The Review Team had concluded the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation." 14:21

Can you explain what you meant by that, please?

A. So, when we came to look at the Trust Governance arrangements, on paper they were, they seemed to be strong, they seemed to meet by and large the criteria that you would expect from a well run organisation, but you can have as many policies as you want, but unless 14:21

they're actually implemented and there are safeguards to ensure they're implemented, then it may not make a big lot of difference.

DR. MAXWELL: Can I just ask, did you look at the safeguarding governance arrangements? 14:21

A. Yes, one of my colleagues on the Review Team would have looked at those, yes.

DR. MAXWELL: So, what was the team's expectation about how a Safeguarding Report would go through the governance process? 14:22

A. It would have gone from the, the DO, to the Learning Disability Directorate, particularly there were a couple of levels between her and the Director, but our understanding it had got to Director level, but we never found out what actually happened to it. 14:22

DR. MAXWELL: Well, we found this confusing as well, but we've been told by at least two different people that the governance arrangement that was -- would be that the report would go to the Local Adult Safeguarding Partnership, which of course is a 14:22 multi-agency governance structure outside the Belfast Trust, and nobody seems entirely clear what should have happened within the Belfast Trust for Safeguarding Reports, because they would definitely go to the Local Adult Safeguarding Partnership and then up to HSCB, and 14:23 we were told that somebody at HSCB would have a copy of all safeguarding reports, but we were unable -- well I have been unable to understand what was supposed to happen within Belfast Trust for Safeguarding Report,

and nobody seems to be able to point me to a policy that says where it was supposed to go.

A. And I'm afraid I can't shed much light on that.

DR. MAXWELL: So on paper there is some confusion about that governance arrangement? 14:23

A. Well, I may get the terminology wrong, but the Trust would have to give an assurance each year -- I've forgotten the name of the formal report.

DR. MAXWELL: DSF Report. Delegated Statutory Functions. 14:23

A. That's it. And we -- you would have expected something as significant as the Ennis Report to be mentioned in that. My understanding was that it didn't, it wasn't mentioned.

DR. MAXWELL: So why do you think the Ennis Report was more significant than other safeguarding reports? Because they're not all mentioned? 14:23

A. Well, because Ennis was very significant. It required expenditure of nearly half a million pounds to deal with a temporary measure. Police and the courts were involved. 14:24

149 Q. MS. TANG: We had touched -- you touched briefly on the Delegated Statutory Function Reports, and I noted at, in your statement, page 115-44, at paragraph 6.89, sorry 6.88 first of all, please. I think it's at page 44. 14:24

CHAIRPERSON: Sorry, 6 point?

150 Q. MS. TANG: 6.88. It'll be coming up on the screen shortly. It refers to Delegated Statutory Function

Reports, and one of the observations which was that:

"These were largely repetitive and gave little sense of the extent of compliance with statutory functions."

Can I take it that that's an observation about the Trust's Delegated Statutory Function Reports in general, or is that specific to MAH?

A. Sorry, what was the...

151 Q. At 6.88. 14:25

CHAIRPERSON: It should now be in front of you.

152 Q. MS. TANG: Yes. My apologies. I may have given the wrong page number to our technical team.

A. So it's 6.88.

153 Q. This one in front of you now on the screen, 6.88. 14:25

A. Yes.

154 Q. And you'll see the sentence there, the third sentence of that paragraph:

"The reports were largely repetitive and gave little 14:25 sense of the extent of compliance with statutory functions."

A. Well, as I say, one of our Review Team members had great experience in social care and that would have 14:26 been her view in considering the Statutory Function Reports.

155 Q. And do you recall whether or not she felt that for Muckamore particularly more detail should have been

given or...

A. I don't recall, but I think the way it's written it was a generalisation, because one of our recommendations was to the Department of Health that they should review the current arrangements. 14:26

156 Q. I noted also that there was mention that there was no discussion of complaints or incidents that was observed. Did you find that surprising?

A. I don't have a recollection of that.

157 Q. Okay. The Inquiry has heard from the Associate Medical Director for Adult, Social and Primary Care Directorate, that the Associate Medical Directors didn't have a collective responsibility for the Directorate and were not part of the clinical governance structures. Did the Review Team consider that whenever they were assessing the leadership and governance structures? 14:26 14:27

A. Yeah, we certainly sought to look at medical leadership on site, and I think we interviewed one of the most senior clinicians, and medical leadership was largely absent from the site. 14:27

DR. MAXWELL: So how could you then say that there are appropriate governance structures to alert the Board to risks pertaining to safe and effective care, if you had already recognised that medical leadership wasn't involved in clinical governance? 14:27

A. Well, how much medical leadership was required on the Muckamore site, is the issue behind an answer to that question? We would have expected more.

DR. MAXWELL: If I think about the governance on -- clinical governance came in after the Bristol paediatric cardiac scandal, and the definitive framework was written by two people from Northern Ireland, Scally and Donaldson, which was very clear about the need for medical staff to be involved in looking at all clinical risks, not just medical practice. And, yet, we were told by the Associate Medical Director, so the most senior doctor in the Directorate, that until 2018 medical staff weren't involved in anything other than medical staff practice. That seems to negate the definition of clinical governance. 14:28 14:28

A. Yeah, I would accept that.

DR. MAXWELL: And so probably not fair then to say that it had appropriate governance in place? 14:28

A. Yes.

CHAIRPERSON: Well, can you explain what you meant by that?

A. So meant by we felt they had appropriate clinical governance arrangements in place? 14:29

CHAIRPERSON: Yes.

A. Because on paper they had the various committees, they had implemented regional guidelines on complaints, on other means of reporting. But I accept that if, if governance guidelines in Northern Ireland said there must be medical involvement in learning disability, then we were wrong. 14:29

CHAIRPERSON: Thank you.

PROFESSOR MURPHY: Are you saying really that the structure for governance existed, it just wasn't functioning well?

A. I think that's what we were saying in the report, yes.

158 Q. MS. TANG: What do you think, looking back now with the benefit of hindsight, what should the Trust Board or the Executive Team have done differently, or what could they have done differently? 14:29

A. They should have, over the period of five years we looked at, there should have been visits to the site. There were occasional visits by directors, but we got the impression they were not regular visits. I'm not sure if non-execs, we could find no evidence of non-executive visits to the site, there must have been some, but generally speaking there was -- and Board minutes did not reflect that the site was discussed. The focus of the organisation was on resettlement, not the institution. And on one occasion when we pursued this with a retired Chief Executive, he said "We don't manage institutions, we manage services." 14:30 14:30 14:30

159 Q. So the lack of Director presence on site and regular attending is one thing. Is there anything else that you think would have made a difference?

A. Well, back to that curiosity, you know, "how are things going in Muckamore?". 14:31

CHAIRPERSON: Sorry, could I just ask? Your answer that the focus of the organisation was on resettlement, not the institution, was in answer to a question from Ms. Tang. What do you think, looking back now with the

benefit of hindsight, should the Trust Board or the Executive Team have done differently? So which are you referring to, or is it both?

A. It's both. But also I think directors have an important role to ensure that the service that they manage is kept in strategic view in the organisation.

CHAIRPERSON: By both the Board and the Executive Team?

A. Yeah.

DR. MAXWELL: We certainly heard a lot of evidence that Brenda Creaney, the Executive Director of Nursing, and Catherine McNicholl, the Director of the Directorate, I think, had a lot of visits to Muckamore, both around the Ennis Investigation, so both overseeing that quite closely and at later times. So are you saying that you think other directors should have been visible on site? 14:32

A. No, those two would have had most responsibility for the site, and there may -- I'm referring to the overall period. I mean certainly in 2017 the Trust gave the site their full attention in every possible way, but we couldn't find the evidence that between 2012 and '17 there was much attention given. 14:32

160 Q. MS. TANG: I want to move on to look at the element of your report that deals with the Ennis Investigation Review, and if we could go to page 115-20, please? And at the top of that page there you'll see there's reference to the fact that: 14:31 14:33

"There were some former senior MAH staff who did not engage with the review process for different reasons."

And you've confirmed there the titles of those individuals who didn't participate, and you've made some reference to that already. Can I just ask, are you content to provide the names of those individuals separately to the Inquiry? 14:33

A. Yes.

161 Q. Thank you. In relation to the individuals who didn't participate, do you know if a copy of the report, the final report, was sent to them for comment or... 14:34

A. I don't. Of our report? No, I don't know.

162 Q. Yes. Okay.

CHAIRPERSON: Sorry, just to deal with that, because there is some public interest in that. What I think is proposed is that the witness gives us the names and then we follow that up, and of course disclose it in due course to Core Participants and anybody else who needs to know. 14:34

163 Q. MS. TANG: Thank you, Chair. At Appendix 3 of your report, which is on page 115-187, you detail helpfully a number of different items of material that came in to allow you to consider the investigation, and at point 12 on page 187 it notes there that you got some material just titled "Ennis Investigation". Can you recollect what kind of material that actually was? 14:34

A. I think it was -- we actually got a copy of the Ennis Report, which I presume was -- which was written by AM.

DR. MAXWELL: So you mean the Safeguarding Report?

A. Yes. We initially got the redacted copy, which we

couldn't make sense of, and they gave us an unredacted copy. We don't think it was the complete report because I don't think -- some of the appendices were missing. But, yes. So I think that's what that is referring to.

164 Q. MS. TANG: And how did you go about reviewing what had been done there? Did you go and meet with individuals? What was your process?

A. We met with the author of the report, the lead author. We met with the Service Manager, with the Co-Director of Nursing. So we met with some of the key players.

165 Q. Mhm-mhm.

DR. MAXWELL: Did you get the opportunity to look at the disciplinary investigation that followed on?

A. One of my colleagues would have had access to the notes, yes.

DR. MAXWELL: Because there were -- there was the Safeguarding Report, there were the reports that Moira Mannion had done, and there was the disciplinary investigation, and they all reached slightly different conclusions.

A. Yes.

DR. MAXWELL: Did you take that into account?

A. I'm not sure we dwelt on the disciplinary account, because it in effect did not proceed with disciplinary action, as I recall. The Inquiry did make -- the Adult Safeguarding Report did make recommendations about disciplinary action.

DR. MAXWELL: Well, it made recommendations that there

should be a disciplinary investigation, which there was.

A. Yes. Yes. Yes. Sorry, what was the third?

DR. MAXWELL: Well, Moira Mannion did two briefing reports, based on the 24-hour monitoring of the wards, and it reached slightly different conclusions from Aine Morrison. 14:36

A. Yes.

DR. MAXWELL: About the extent to which there was a culture of abuse. Did you look at both of them, or did you only look at the Safeguarding Report? 14:37

A. We certainly interviewed Moira Mannion, and so she would have had the opportunity -- I'm sure we did discuss the outcome, some of the developmental work that came out of Ennis. 14:37

DR. MAXWELL: But your team didn't see the briefing reports about the monitoring?

A. I don't have any recollection of seeing that.

DR. MAXWELL: Okay.

166 Q. **MS.TANG:** You've indicated at paragraph 6 on page 115-8 that the Ennis Investigation, you felt, and the Review Team felt: 14:37

"...was a missed opportunity to raise MAH issues at Board level..." 14:38

- and that it should have been an SAI, and some other witnesses have told us that it didn't fit the definition of an SAI at the time. Do you feel that was

a reasonable position?

A. I don't. Now with the benefit of hindsight, because clearly there was abuse at an institutional level gon on, whether -- you could argue was it going on in 2012? But there were indicators of that. Sorry, the second part of your question? 14:38

167 Q. It was really just to see if you felt that it was a reasonable position that it hadn't met the definition of an SAI at the time?

A. No. 14:38

DR. MAXWELL: Because the definition changed in 2016.

A. Yes.

DR. MAXWELL: Do you think it met the 2012 definition?

A. Well, anything that required half a million pounds to be spent as a temporary measure to deal with an issue... 14:38

DR. MAXWELL: But there are specific criteria in the policy about what is an SAI.

A. Yes.

DR. MAXWELL: And we've been told by some witnesses that whilst it might have met the 2016 criteria, it didn't meet the 2012 criteria? 14:38

A. We would have looked at that, and it was still our view that it should have been raised as an SAI. And if in doubt, you know, the Health Board and PHA pursued this issue for two years and said 'Why haven't you raised an SAI?' Now they would have been arbiters of, you know, what was or wasn't an SAI. So it was quite extraordinary the amount of correspondence between the 14:39

Trust, and the HSCB and PSA on 'Why aren't you raising this as an SAI?'

168 Q. MS. TANG: You made reference just now to institutional abuse, and in the paragraph we've just looked at, paragraph 6, you mention that you considered the situation at Ennis to be an example of institutional abuse. Can you tell us what your definition of institutional abuse is? 14:39

A. Well, I suppose we all have Stephen Lawrence Inquiry at the back of our minds, where you have an organisation where abuse seeps into the culture, whether its corruption, physical abuse, other times, it seeps into the culture of an organisation, but it doesn't necessarily take it over. But on reflection, I mean the signs that we saw, and clearly Aine Morrison saw, was patients being abused in front of external, the people from another organisation. So the fact that, you know, a qualified nurse and student nurse and one other were involved, the fact that the police -- was this a one-off isolated incident? With the benefit of hindsight, knowing what had gone on subsequent to that, we're clearly saying -- our view was that it was institutional abuse, and institutional as it related to the whole hospital. I think when we used that term we weren't just thinking of Ennis, we were saying this was a flag or a warning to look at what possibly was going on elsewhere in the hospital. 14:40 14:40 14:40 14:41

PROFESSOR MURPHY: Even though Bohill staff, for example, were not reporting that kind of behaviour on

other wards? I mean previous witnesses have said to us they think it was really about whether institutional abuse was happening on Ennis Ward. I don't think anyone else has said to us it referred to the whole hospital? 14:41

A. Well, I suppose how would they know? Because staff weren't -- local staff didn't report the abuse, it was external staff reported.

DR. MAXWELL: And the external staff said they were very happy with other wards and they had no concerns about them, in their interviews with the safeguarding team. 14:41

A. Well, we still -- we felt there was a warning sign there, as did the author of the Safeguarding Report.

DR. MAXWELL: Well I think what she said is that she hadn't got evidence of it, but she had a suspicion. That's slightly different from you saying that this was an example of it. I mean you've said it's a red flag, but actually I think you've put it as an example of institutional abuse rather than a red flag for it. 14:42

A. Yeah. Well, I suppose that was our opinion.

DR. MAXWELL: Even though the Safeguarding Report and the disciplinary investigation didn't conclude that?

A. Well, we had the author of the report saying she couldn't exclude it. 14:42

DR. MAXWELL: But she couldn't prove it either.

A. Yeah.

CHAIRPERSON: But can I just ask, apart from this report, did you have any other material that you were

relying on to come to that conclusion?
A. At this -- in 2012, no.
CHAIRPERSON: Right. So we can be satisfied that this opinion is based entirely on what we're calling the Safeguarding Report, or the Ennis Report, and speaking to the author. 14:43
A. Yes.
CHAIRPERSON: Yes. Okay. Thank you.
DR. MAXWELL: Can I ask, if it had been considered by the Safeguarding Report to be an example, evidence, rather than not being able to disprove it, what actions did your team think might have been taken? Because I think you called it a missed opportunity. 14:43
A. Yes.
DR. MAXWELL: So if it was a missed opportunity, what opportunity would it have created? 14:43
A. It could have created, if it had gone through the SAI route, in a Stage 3, or whatever the equivalent was, an external investigation. So when "A Way to Go" was written, that was I think an SAI Level 3 external investigation. 14:44
DR. MAXWELL: So that's what you think the missed opportunity was, to have an external investigation?
A. I think it would have had to have been external, because... 14:44
DR. MAXWELL: Yes, I'm just asking you, that's the missed opportunity?
A. Yes.
DR. MAXWELL: There was a missed opportunity to have an

external investigation in 2013?

A. Well, to have a further -- I'm not sure as a team we ever debated whether it should be external or internal, but it was a missed opportunity to look at the matter in more detail across the site. 14:44

DR. MAXWELL: Across the site.

A. Yeah.

DR. MAXWELL: So it was a missed opportunity to look at the whole site and not to examine Ennis in more detail?

A. Well, Ennis was put under a regime of 24-hour monitoring. So -- it's the old Hawthorne principle, you know, when you watch people, their behaviour changes. 14:44

DR. MAXWELL: Do you think it changes 24/7 for 12 weeks? Can people sustain that change in behaviour for that long if it's really not their intrinsic motivation? 14:45

A. I don't know. That's outside my field of expertise.

169 Q. MS. TANG: We're touching on now the approach that was taken in the original Ennis Investigation, and you've made reference to the potential for an external investigation had it been dealt with as an SAI. How do you feel about the amount of time that the Ennis Review, as it was, actually took? 14:45

A. I think one of our findings, we were critical of the 11 months that it took, and that because witnesses weren't interviewed at an appropriate time, things got stale. So we were quite critical. 14:45

170 Q. And had you been doing that review, what would you have

done differently?

A. Interviewed much more quickly. Greater alacrity. I don't know. The delays were not all the fault of the author. Towards the end there was a dispute over whether institutional abuse was involved. So, generally a lack of momentum in the investigation. 14:46

171 Q. The investigation was ran as part of the Joint Protocol you've made reference to. Do you feel that that was effective?

A. Well I can't comment. We never had access to police statements or police timetables and all of this, so I don't know. 14:46

172 Q. Had you been undertaking the investigation at the time, would you have felt it justified to look at other areas within the hospital, based on the information about Ennis? 14:46

A. If someone had been saying to me there's, and arguing that this is institutional abuse, I think I would have wanted to know go a bit further and ask that.

173 Q. Although as we've spoken a short time ago, there weren't complaints from elsewhere at that point in time? 14:47

A. Mhm-mhm.

174 Q. So would it be --

A. But there weren't complaints. If you go to 2017, and all of that abuse that was captured, there weren't complaints about that. There was, I mean, when the patient's father in 2017 brought the presence of CCTV on wards and queried is it, you know, is there CCTV? I 14:47

mean there weren't red flags necessarily before that, that I am aware of.

175 Q. It's trying to get to the reasonableness of the approach that the Ennis Investigation took. Did they miss red flags at the time on the basis of what we've -- 14:47

A. No, the Ennis Investigation looks as though it was very thorough. It took too long. There is the issue as to whether it -- one of the reasons it may have taken too long, its sort of Terms of Reference started to spread out. So whether they were dealing with the abuse allegations or ending up dealing with nurse practice or other practice on the wards. So I think somewhere in our report we comment on the fact that there was sort of mission creep for those who wrote the Ennis Report. 14:48

CHAIRPERSON: But you're saying there should have been more mission creep?

A. No, less.

CHAIRPERSON: Well, aren't you saying they should have potentially looked at other wards as well? 14:48

A. No, that would have happened at the -- at the end of all of that, when that report was received, if there was a view that there was institutional abuse, that's the point at which it would have taken a wider -- you know, the adult safeguarding, and I'm talking about 14:48 what took place in Ennis, there was mission creep -- I mean we didn't use those words in the report, but they started taking on board, we think, areas of practice, rather than dealing purely with the allegations.

CHAIRPERSON: Right.

176 Q. MS. TANG: You set out a number of recommendations in your report, and those are listed starting at page 174 of the report. It'll be up on screen shortly. Do you know if your recommendations were carried out? Did you get any feedback on that? 14:49

A. No, we got no feedback.

177 Q. You don't know. Were you aware if there was an action plan created even in response to those?

A. No. No. 14:49

178 Q. You didn't hear that?

DR. MAXWELL: Who was sponsoring your work?

A. The Department of Health ultimately.

DR. MAXWELL: Was there a named person?

A. Well, when our report, when we had the finalised at the end of July, we made a presentation to the Permanent Secretary and his top team. 14:49

DR. MAXWELL: So it was the Permanent Secretary who was responsible for actioning your report?

A. Ultimately. 14:50

CHAIRPERSON: And you never got any feedback or discovered what was happening with it?

A. No.

CHAIRPERSON: So it went out into the ether?

A. We made a presentation to parents and carers, and in fact that was done within a day or two of our presentation to the Permanent Secretary, he didn't wish any delay, and so we convened in a hotel near Muckamore and we made a several hour presentation and took 14:50

questions and answers to parents and carers.

CHAIRPERSON: And did you get any indication whether your recommendations had been accepted and were going to be taken forward? I think that's what counsel is getting at. 14:50

A. Yes. No, not formally, but I know that the Belfast Trust took our report seriously. They felt it was a hard report, a difficult report, very critical of them, but I think my impression was that they were acting on it. So, for instance, they put a very significant -- 14:51 well, no, sorry, I'll stop there. Yeah.

179 Q. MS. TANG: I want to ask you about the CCTV element of your report, and if we could turn to page 115-8, please, and we'll be looking at paragraphs 7 to 10. Can I ask you, in relation to paragraph 7, which is 14:51 towards the bottom of the page, do you know why the CCTV policy took so long to produce?

A. Well, somewhere in our report we give a timeline, and you'll see that the main delays took place on the Muckamore site. So we traced through minutes of the 14:51 site manager's meetings that CCTV would be useful, it will help counter allegations, it would help -- my recollection is it would help counter allegations against staff. And it just bounced around. There was a lack of direction and a lack of leadership perhaps in 14:52 implementing it. But I'm not sure in our report where we list the...

DR. MAXWELL: On the front of the policy itself, which we have previously looked at, there are a list of the

different committees that it went through, and they certainly weren't all at MAH?

A. No. No, they weren't.

DR. MAXWELL: So over a two year period it was going around a whole circle of corporate committees? 14:52

A. My recollection was -- yes, but when you get to the -- it needed formal approval by the senior team in the Trust.

DR. MAXWELL: But it needed to go through a number of committees actually, didn't it? 14:52

A. Yes. Oh, yes, it did, yeah. I think there were four or five steps, but most of the time taken -- I'm sorry, I'm not sure where it is in the report.

180 Q. MS. TANG: I think at one of the appendices. Appendix 3. Look at page 14 -- well, internal page 145, and 14:53 that lists the amount of time taken. And the appendices I should have here. Your timescale, it begins at -- your timeline, sorry, it begins at internal page 193, Appendix 5. In your report itself the page is 182, I believe. That may help you find it. 14:53 The bottom corner page. Is that the one you mean?

A. Yep. No, I thought we had listed somewhere ---

DR. MAXWELL: You have listed it, I had it a minute ago and I can't find it now.

A. Yes. 14:54

DR. MAXWELL: But I seem to recall from looking at the 2017 policy that was approved, there were more committees listed on that --

A. Yes. Yes.

DR. MAXWELL: -- than in your timeline.
CHAIRPERSON: What you do say in your summary is that:

"It took 22 months, an inexplicably long time to produce a policy. Most of the delay was at local level." 14:54

A. Yes.
CHAIRPERSON: What do you mean by "local level"?
A. Within the Muckamore Abbey Hospital. 14:54
181 Q. MS. TANG: Do you see it as within your gift, or within their gift that they could have made that much faster, that they introduced delay?
A. I don't think it was deliberate. The key person who could have given us some answers to this was the 14:54 Business Services Manager on the site who did not respond to our invitation. He was retired by then. Our invitation to staff, like that went through the Trust, but he never responded. He could have told us, given us more information on the process of why it took 14:55 so long, and critically why the CCTV seemed to be running from 2015 to 2017, and nobody either knew about it or did anything about it.
DR. MAXWELL: Do you think it was odd that it was running without a policy? Because, of course, the Data 14:55 Protection Act covers this. So to have it running without any policy at all seems very strange?
A. Well, I think --
DR. MAXWELL: And there had been concerns raised about

using CCTV.

A. Oh, absolutely.

DR. MAXWELL: Because this is intimate and the patients couldn't give consent.

A. Yeah. So we went back -- so no-one was able to tell us when the CC -- so bear in mind we wrote this looking back to 2017, when the CCTV footage was discovered. 14:55

DR. MAXWELL: Yes.

A. No-one could tell us at that point when it was switched on. So we went back to the company that installed the CCTV, we asked them when it was commissioned, and there's a date, again I think June/July 2015, and in response -- it's in the report somewhere -- in response to when was it operational, it was operational from that date. It was recording from that date. The system appeared to record on to a hard drive and then after a certain amount of time it would drop off. So it's -- I don't know how -- 14:56 14:56

DR. MAXWELL: But that wouldn't be compliant with the Data Protection Act, to just start doing that without a policy, would it? 14:56

A. Right. I believe most of the senior managers in the site new nothing about that. We would have liked to talk to the Business Services Manager, who would have known which rooms the hard drives were kept in. They were paying -- the Trust -- from December 2015, the Trust was paying a maintenance fee for the system. So somebody somewhere should have known that it was operational, and either switched it off, or whatever, 14:56

but actually not switch it off, but say 'Right, we need to start using this and get the policies in place immediately.'

182 Q. MS. TANG: Would you say that it was a failing on the part of the Trust then to not have those policies in place and not have a process of making use of the CCTV system? 14:57

A. Well, it was an overall failure. Where that failure and responsibility for that failure lay, I think my own view, backed up by what we knew, was that the responsibility would have lain at the -- within the hospital. The managers in the hospital. I'm not sure, until the CCTV policy came to the Trust Board, or Trust senior team and its governance committees in 2017, did they know that CCTV was on the agenda? It was quite a small capital. I think the total cost was £80,000 or something. So that wouldn't necessarily have got to the top team or the Board. 14:57 14:57

183 Q. Do you think CCTV should have been installed in other areas of MAH? 14:58

A. Well it was rolled out very quickly, and I mean there were certain areas it wasn't installed in. It wasn't installed in the swimming pools and a couple of other areas. But by and large it had rolled out. I mean we were told there was something like 400 cameras. The police told us there was some 300,000 hours of video. Now, I find that -- I don't know whether that was actually -- these were motion activated cameras, so whether that was, that was just motion or whether that 14:58

was the whole thing, I don't know.

184 Q. In terms of how it was initially installed, did they start in the right place in your view?

A. I don't know where they started, but I mean it was -- they installed it in the key areas. 14:58

185 Q. I want to move on to your second statement, which is dated 23rd April --

CHAIRPERSON: Well, I just wonder if that would be a good point to break? How much longer do you think you've got to go with the second statement? 14:59

MS. TANG: I have I would say probably about another 20 minutes.

CHAIRPERSON: How are you feeling? Are you content to go on?

A. Yes. Fine. 14:59

CHAIRPERSON: Okay. Everybody is happy. We'll keep going. If do you want a break at any stage, please just say so.

186 Q. MS. TANG: Thank you. Thank you, Chair. Okay. So if we cn move on to your second statement, it's dated 23rd April 2024, and the page reference for that statement begins at 238. You exhibit a report that you prepared in respect of allegations made against Esther Rafferty in this with your statement, and you refer to two reports that you prepared in total, the other related to allegations made against Moira Mannion. Can you tell us how you came to be involved, how you came to produce those reports? 14:59 15:00

A. So, if I deal with Esther. I can't remember the

sequence, but if I deal with Esther Rafferty first. I think in -- our report was coming to a conclusion at the end of June, beginning of July. We had a deadline to submit the report towards the end of July. We -- I should say that originally it was May, but because of the Covid outbreak we had a six week, negotiated a six week period. So we had interviewed Esther as a team. The request I think came through from the Trust. RO67 [redacted], and they asked us, the Review Team, to comment on that. We felt that was outside our Terms of Reference. I mean we were commissioned by the Health and Care Board/PHA, not the Trust, so it wasn't our role. We were aware of the conflict that would have gone on, because Aine Morrison gave us her statement, her nine page statement, when we interviewed her. But -- so we came back to the Trust and said 'Sorry, it's outside our Terms of Reference.' However, I expressed willingness to write my personal views. We had collected lots of information. So we didn't interview either Esther or Moira Mannion. I didn't interview them. There may have been some confusion in their minds as to whether I did, but I'm fairly sure I didn't. I used the evidence that we had gathered as a Review Team to come to my own conclusions. 15:00 15:00 15:01 15:01 15:01

For Moira Mannion, again I was asked by the Trust to give my views, particularly in regard to the allegations made by Aine.

187 Q. So in terms of the process, you've told us that you

didn't interview either Ms. Mannion or Ms. Rafferty. Did you speak to Aine Morrison, or did you interview her in the course of it?

A. We had previously interviewed her at least once, and I think she had raised the issue. She presented us with the statement that you would have, the nine page statement, so I was -- we were aware of her views, yes. 15:02

188 Q. Had you had to conduct investigations of that nature before, where individuals were having a dispute?

A. I'm sure in my career I had. But this was -- mine was not an investigation, I should say. It was a summary of my views on the evidence that we had collected. So it wasn't -- it was not a formal investigation in that sense. But, yes, I would have in the past had to. 15:02

189 Q. Do you know what the intention was that -- the Trust asked you to do this review exercise, what did they intend to do with it? 15:02

A. That's what I'm not sure, and I'm not sure what they did with it.

190 Q. I see. 15:03

DR. MAXWELL: Sorry, but I notice you are a member of CIPD, or you have been?

A. I'm qualified in CIPD, yes. Was. Yes.

DR. MAXWELL: And you took on this remit without being clear what it was the Trust wanted? And your previous membership with CIPD would mean you would be quite sensitive to HR disputes? 15:03

A. Sorry, I'm not clear what they did with it.

DR. MAXWELL: Oh, you are clear what they wanted you to

do?

A. Well, yes. RO67 [redacted].

DR. MAXWELL: And what were you tasked with doing?

A. Well, I set down in writing my views as to how Esther had conducted herself and her role in Muckamore. 15:03

DR. MAXWELL: And based on?

A. Based on the evidence as a team we had gathered.

DR. MAXWELL: Based on your review of the Ennis Investigation, the Ennis Safeguarding 15:04

-- A. No, the whole report.

DR. MAXWELL: Yeah, the Safeguarding Report?

A. No, right through to --

DR. MAXWELL: Oh, your report of all three incidents?

A. Yes, our review. Yes. Yes. 15:04

RO67 [redacted]

15:04

15:04

RO67 [redacted] [redacted]

DR. MAXWELL: So I was just asking what you had been asked to do by the Trust and what information you had based your reflections on?

A. So I based my reflections on the evidence that we, as a team, had collected in our dealings with Esther and Muckamore Abbey, right through to 2017, not just the Ennis Report, but 2017, her handling of the CCTV issue, where she tried to raise it as a serious adverse incident and the internal team said 'no, it's not.' 15:05 15:06

DR. MAXWELL: Okay.

191 Q. **MS. TANG:** Can I go down to page 238-6, and it's the second paragraph? And this is in relation to the Review Team's initial conversation with Aine Rafferty, or, sorry, with Aine Morrison, and it says there that: 15:06

"She was asked about the amount of time that it had taken for her to make her allegations, but failed in the view of the Review Team to give an adequate explanation." 15:06

And further down that page you state:

"The time gap and the apparent need of the author of the allegations to get her side of the story on the record, some seven years later, does not lend credibility to the allegations." 15:06

And you considered those allegations in the course of

reviewing the findings that you made for Esther Rafferty. Are you effectively saying there that you didn't believe the allegations?

A. Well, we're saying the time delay, I mean why would someone wait seven years to make very serious allegations? And we couldn't find -- we asked her. There was no explanation. There were circumstances -- I mean she became aware of our investigation and that Ennis was going to be part of it, so it seemed to us she was trying to get her side of the story in, but in doing so, laying responsibility on others. 15:07 15:07

CHAIRPERSON: When you say "us", I thought the Review Team --

A. The Review Team. Yeah, the full Review Team.

CHAIRPERSON: But I thought they thought this was outside their brief? 15:08

A. This is my report and I'm giving that view. So we didn't look into -- as a team we didn't try to adjudicate between both views.

DR. MAXWELL: But you think the fact that the team was doing the review might have been the trigger for the allegations? 15:08

A. Well, it would have been a coincidence if it wasn't. I think from memory there was also an issue, some story had appeared in one of the local newspapers as well, so she was maybe anxious to -- but again... 15:08

192 Q. MS. TANG: Whenever you were considering these as part of your own findings, did you consider speaking to Ms. Morrison at that point in time?

A. No, because I didn't -- I wasn't there to conduct a further investigation. That was the basis on which I was giving my views on the evidence that we had collected earlier.

CHAIRPERSON: Can you just help me, I'm sorry, it's just for clarification? If we go to MAHI-STM-238-4, just so that we know where this starts. This is the introduction to allegations made against Esther Rafferty and concerns raised by her, yes? So this is your -- this is not part of the Leadership and Governance Review, this is your personal report? 15:09

A. Yes.

CHAIRPERSON: Right. And if we then go to page 6 of this, it starts at the top:

15:09

"The Review Team in its report stated that AM in her role as DO appeared to have an oversight function in respect of the operation of Ennis Ward during the period of the investigation. It was their opinion that it was not appropriate and served to weaken the focus on completing the investigation." 15:10

So that goes back actually to part of your review. But then you go on, if we go on to:

15:10

"Conclusion regarding the Ennis Investigation

Although the Review Team did not comment on its report on the veracity of the claims made by AM against ER, it

did gather information which I have used."

But this is all your personal opinion, yes?

A. Yes.

CHAIRPERSON: If we go three paragraphs, four paragraphs on, do you see this: 15:10

"The Review Team could find no evidence to collaborate..."

15:11

- I think you mean "corroborate":

"...AM's accusations."

But AM's accusations is the thing that the Review Team had said they didn't want to deal with because it was outside their Terms of Reference, wasn't it? 15:11

A. When the Belfast Trust asked us to comment on those allegations, a response to them from the team would have been outside our Terms of Reference. 15:11

CHAIRPERSON: Yeah.

A. But we received Aine's allegations during our investigation as a team.

CHAIRPERSON: Right. But is this your finding or the team's finding? 15:11

A. Yes, it should have said...

CHAIRPERSON: It's quite important.

A. This is my finding. Yes. I accept that.

CHAIRPERSON: Right. So it should be "I could find no

evidence"?

A. Yes.

CHAIRPERSON: Right. And in fact that appears elsewhere?

A. Yes. 15:11

CHAIRPERSON: So for the "team", we should always read "I"?

A. Yes.

CHAIRPERSON: Thank you.

A. Other than, Chair, when I'm referring to evidence considered by the team, because -- 15:11

CHAIRPERSON: Yes, I understand that. No, I understand that. But the opinion, the results of that is all you and not your team's.

A. Yes. I accept that, yes. 15:12

CHAIRPERSON: Okay.

193 Q. MS. TANG: Okay. I have covered all of the questions that I want to cover with you, but I did promise that I would give you the chance to add anything that you wanted to at the end. Is there anything else that you 15:12 would like to tell the Panel?

A. No, I think that's...

CHAIRPERSON: Do you want a few minutes to think about it or are you happy? Dr. Maxwell.

15:12

MR. DAVID BINGHAM WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

194 Q. DR. MAXWELL: Yes. So there are a number of themes

that came out in the Ennis Investigation and subsequent actions that I think come out again in 2017, and if I can group them into three? Firstly, issues of staffing, particularly the number of registered nurses supervising health care assistants that we have heard 15:13
extensive evidence, and you've referred to it as well, about staffing being on the Risk Register, and things got worse, and we've heard from the ward manager and the RQIA that this had been raised in the weeks coming up to the incident that resulted in the incident. We 15:13
discussed governance, or lack of functioning of governance, we could debate whether the structure was there, but I think we agree the structure doesn't appear to have been used as designed. And there's also this difference of opinion. And it seems that those 15:13
three things weren't resolved after the Ennis Safeguarding Investigation. Staffing continued to be a problem, governance didn't seem to have got resolved, and nobody had resolved this difference of opinion between Aine Morrison on the one hand, John Veitch, 15:14
Esther Rafferty and Moira Mannion on the other hand. And so I'm struggling to see how you could have, as a headline in your report, have said that actually there was adequate governance, because three red flags had been identified that don't appear to have been resolved 15:14
in the intervening years?

A. Yeah, I see your point, but governance has two essential components. One is the process -- the procedures, the documented structures in the

organisation. But the second is, are people using them?

DR. MAXWELL: And actually if they had had effective governance, then the Board might well have known that a very significant contextual factor to the abuse on Ennis was actually the staffing issue, and that there was an unresolved opinion about the extent to which this reflected a culture? 15:14

A. Well, that's a dilemma every organisation has. You can put in place the best procedures and assurance mechanisms, but if people aren't using them. Now could you say, well, it's because they haven't been trained or there's not enough scrutiny, and I accept if that's part of governance then that governance was lacking. But again I come back to the example of 2017, where the Service Manager, once CCTV is discovered, she wants to raise an SAI, something really really big, and it's resisted inside the organisation, and it's only when -- yeah. 15:15 15:15

195 Q. DR. MAXWELL: I accept that. But, you know, we shouldn't wait for a crisis... 15:15

A. No.

196 Q. DR. MAXWELL: -- to deal with something. And, you know, I come back to my point about the Audit Committee. So the point of an Audit Committee is that it is made up only of non-executives, so it's not influenced by the executive, and their job is not to passively wait for information to come to them, it's to actively go out and seek assurance about things. 15:16

Actually we have seen some evidence that the Board was aware. There has been a report of the arrests to the Board at the Ennis. Did the non-executives fulfil their obligation having -- and it was widely reported in the press -- should the non-executives not have gone out and said 'Well, actually, we need some indicators. It's a high risk organisation. Even without the Ennis Report, this is a group of very vulnerable people. We know from the Winterbourne Review and a whole host of other investigations that there's a high risk of abuse', should the Board have, and particularly the non-execs, have been proactively asking for assurance information rather than waiting for serious incidents to be reported through SAIs? 15:16 15:16

A. Yes. But in mitigation, and I'm not here to mitigate for the Trust, but I mean they were dealing with huge additional issues. So I think the real emphasis should have been on Directors bringing matters to the attention of non-execs. 15:17

197 Q. DR. MAXWELL: But the whole point of having non-execs is because you shouldn't rely on execs, otherwise why have them? 15:17

A. Yeah, I'm not disagreeing with you. I mean we do say there was a lack of inquiry, there was a lack of interest on what was going on in Muckamore. 15:17

198 Q. DR. MAXWELL: And so that was in the non-execs as well.

A. Yes, yes, yes.

DR. MAXWELL: Okay. Thank you.

199 Q. CHAIRPERSON: Could I just ask you about this so that

when we read your report again, which eventually we will, we understand what you actually mean. If we could go to MAHI-STM-115-11, because this is the same topic I'm afraid that Dr. Maxwell has just been asking you about:

"The Review Team concluded that the trust had adequate governance and leadership arrangements in place..."

- and one has got to read the whole sentence, hasn't one: 15:18

"...but that these were not appropriately implemented at various levels within the organisation." 15:18

Now, I suppose one could argue that that really means there isn't good governance in place, because things aren't filtering through to where they should?

A. Yeah, I accept that.

200 Q. CHAIRPERSON: You then say: 15:18

"This failure resulted in harm to patients."

Well, what failure resulted in the harm to patients? If you're talking about Ennis Ward, what are you saying 15:19 didn't filter through at the time that things were going wrong that should have done, and therefore resulted in harm to patients?

A. Well, I don't think that statement relates purely to

Ennis.

201 Q. CHAIRPERSON: Right.

A. It's -- the fact is that there was a great deal of harm to patients over the years.

202 Q. CHAIRPERSON: Right. So it's the red flags that were not heeded? 15:19

A. Were they even raised as red flags? They were raised as -- they were raised as debates, as topics, after Ennis, you know, 'Is this institutional abuse or not?'. But the resistance to use reporting mechanisms, such as a complaints procedure or serious adverse incident processes, which would -- the serious adverse incident process takes you ultimately to the top of the organisation, it's a mechanism designed -- and to the Department of Health. And I come back to the fact that the Board/PHA argued for two years that Ennis was a serious adverse incident, and the Trust said 'No, it's not.' Then eventually said 'Well, actually, yes it is, but there's nothing to investigate.' 15:19 15:20

203 Q. DR. MAXWELL: But we've heard evidence that actually that correspondence wasn't managed at the hospital level. So the first Early Alert was reported by the AED in Brenda Creaney's corporate team. 15:20

A. Yes. Yes.

204 Q. DR. MAXWELL: And actually if you look at the correspondence on the Early Alerts, it's not happening at hospital level, it's happening at corporate level, the governance function at the corporate level? 15:20

A. Yes, but something was happening at Muckamore.

205 Q. DR. MAXWELL: Well the decision not to make Ennis an SAI was not a decision that senior managers at MAH were taking. The correspondence was at Trust Headquarters?

A. Within a Directorate or...

206 Q. DR. MAXWELL: No, in the corporate team that managed governance. So there's a whole team at corporate headquarters that manage governance. 15:21

A. Yeah.

207 Q. DR. MAXWELL: And they were the ones who were saying 'Well, we've done everything we're going to do. What difference would it make to have an SAI now?'. 15:21

A. Yeah. Well, where are they getting their information and advice from?

208 Q. DR. MAXWELL: I agree. I'm not saying it's satisfactory. But you're putting all the blame on the senior managers at MAH. 15:21

A. Not necessarily for that SAI. I put -- I question, and we needed to interview someone who wouldn't talk to us, why did you resist an SAI in 2017 after CCTV was discovered? 15:21

209 Q. DR. MAXWELL: So this was about resisting reporting it to corporate governance, who were the people who would then do the Early Alert?

A. I'm not sure it was active resistance, but it seems to have been a mindset. And in 2017/18 there was a report went to the Belfast Trust Board which described Muckamore really as a place apart with its own culture, and I think that kind of summed up for me the attitude towards -- 15:22

210 Q. DR. MAXWELL: The two might be true, that might be true, and also the corporate governance wasn't functioning well.

A. Yes.

CHAIRPERSON: I think -- do you have anything else? 15:22

MS. TANG: I had a couple of little things that I just wanted to clarify, if that's all right, please?

CHAIRPERSON: Yes, of course.

MR. DAVID BINGHAM WAS THEN FURTHER EXAMINED BY MS. TANG AS FOLLOWS:

211 Q. MS. TANG: Two details that I just want to make sure I've got right with you. We have touched on them earlier on. The first one -- probably the simplest 15:22 thing is, if I could do is, the Inquiry has heard some evidence from Martin Dillon in the past regarding some reports that were prepared, and in his statement, which I will give you the page reference for, 107-39.

CHAIRPERSON: Do you want that brought up? 15:23

MS. TANG: Yes, please. If you could bring up Martin Dillon's statement, page 107?

CHAIRPERSON: Can you give the full reference? What's the statement number?

MS. TANG: Statement number is 107. 15:23

CHAIRPERSON: So it's MAHI-STM-107. We can't do that.

212 Q. MS. TANG: That's fine. What I will do instead then is to let you know that he had said that three reports were produced regarding Ennis Ward allegations. I

think that these were what you were referring to earlier on when we spoke about disciplinary reports and details, and it was his contention that he didn't think the Review of Leadership and Governance were provided with those reports. Can I clarify with you if you think you were? 15:24

A. So we got the Ennis Report. I've no recollection of getting Moira Mannion's report, and the third report we would have had access to the disciplinary, the process. So I'm not sure we ever saw a disciplinary report as such. I'm not sure there was one. 15:24

213 Q. So on the individuals that were taken through disciplinary proceedings as a result of the Ennis allegations, are you saying that you don't think you've seen reports in relation to those people? 15:24

A. We would have been aware that the disciplinary action was not -- was discontinued, or did not proceed, but I'm not sure we ever saw a report or if there was a report.

DR. MAXWELL: The investigation report. There was an investigation report. 15:24

A. I have no recollection. I don't think we refer to it in our report.

214 Q. MS. TANG: So you don't think you saw that. And the other thing I just wanted to clarify with you, and again we touched on it, whenever you prepared your reports in considering the allegations made against Esther Rafferty and Moira Mannion, were those given to the Trust only, or would the Department of Health have 15:24

seen those as well?

A. I think just the Trust.

MS. TANG: Just the Trust. Okay. Thank you. I have no further questions.

CHAIRPERSON: Okay. Can I thank you very much, you've been quite well tested I think this afternoon, but can I thank you very much for coming along and helping the Inquiry. 15:25

A. Thank you.

CHAIRPERSON: Okay. If you'd like to go with the Secretary to the Inquiry. Okay. We'll sit again tomorrow at 10:00 o'clock. Thank you very much. 15:25

THE HEARING THEN ADJOURNED UNTIL WEDNESDAY, 19TH JUNE 2024 AT 10.00 A.M. 15:25