MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 25TH JUNE 2024 - DAY 97

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WITNESS PAGE

THE INQUIRY RESUMED ON TUESDAY, 25TH JUNE 2024 AS FOLLOWS:

MS. BERGIN: Good morning, Chair and Panel. The next two Organisational Module 6 witnesses are Bria Mongan and Ian Sutherland, and they can be brought in. 09:55

CHAIRPERSON: Good morning.

MS. BRIA MONGAN AND MR. IAN SUTHERLAND, HAVING BEEN SWORN, WERE EXAMINED BY MS. BERGIN AS FOLLOWS: 09:56

CHAIRPERSON: Good morning to both of you and welcome to the Inquiry.

MR. SUTHERLAND: Good morning.

CHAIRPERSON: This is apparently known as hot-tubbing when we have two witnesses giving evidence at the same time, and the reasons for this are obvious in your case because you co-authored the report which -- sorry, I'll wait until that's finished. You co-authored the report that you're going to speak to. 09:56

The only important thing is to remember that this is all being transcribed, and people who may not be watching will need to understand who is speaking when. So could I ask you, please, to be careful not to over speak and -- well, I think that should actually work, because we've got one male and one female and it will be obvious to the transcriber who is speaking. So we'll see how that works. Okay. 09:57

MS. BERGIN: Thank you, Chair. Good morning, Ms. Mongan and Mr. Sutherland. As you know my name is Rachel Bergin. I am one of the counsel Inquiry team and I have explained to you briefly this morning how we will be moving through your evidence. 09:57

You have both been asked to provide a statement to the Inquiry in relation to Organisational Module 6, Resettlement, and as the Chair has indicated, that's because you are the co-authors of a report titled "An independent review of the Learning Disability Resettlement Programme in Northern Ireland". 09:57

Now, Ms. Mongan, before you, you should have a copy of your statement, and the internal reference is STM-233, and your statement is dated 14th March 2024, and at the back you have signed the Declaration of Truth. And you have also exhibited a copy of the report to your statement. Are you content to adopt that statement as your evidence to the Inquiry? 09:58

MS. MONGAN: I am content, yes.

1 Q. And Mr. Sutherland, you also should have a copy of your statement in front of you, internal reference STM-274, and that is dated 7th June 2024, and you've also signed the Declaration of Truth, and are you content to adopt your statement as your evidence to the Inquiry? 09:58

MR. SUTHERLAND: I am. 09:58

2 Q. Now both of your statements have been published on the Inquiry website, and the Panel and the Core Participants have all had an opportunity to consider your statement and also the report exhibited to it.

During your evidence I will be taking you to specific parts of the report, and those should appear on the screen in front of you also. And in addition to the Chair's comments about how we will deal with your evidence together, if I could also remind you to please speak clearly and as loudly as you can into the microphone, and slowly, for ease of the stenographer. Now, if we could pull up a copy of the report, please? So your report was published in July 2022?

09:59

MR. SUTHERLAND: Correct.

09:59

MS. MONGAN: Yes.

3 Q. And each of you outline in your statement, and we won't go to those, but you outline in your statements that you are both qualified social workers?

MR. SUTHERLAND: Yes.

09:59

4 Q. And you set out your extensive professional experience, including executive and leadership positions in health and social care?

MR. SUTHERLAND: That's correct.

MS. MONGAN: That's correct.

10:00

5 Q. And Ms. Mongan, at paragraph three of your statement in fact you set those out in some detail, and Mr. Sutherland, you set those out at paragraph 2 of your statement and, in fact, these are also set out in some detail at Appendix 2 of your report?

10:00

MR. SUTHERLAND: Yes.

MS. MONGAN: That's correct.

6 Q. And you're both Associate Consultants for the Health and Social Care Leadership Centre?

MR. SUTHERLAND: Yes.

MS. MONGAN: Correct.

7 Q. And it was in this capacity in 2021 that you were both approached by the Health and Social Care Leadership Centre to undertake this review. 10:00

MR. SUTHERLAND: Yes.

8 Q. And the review was an independent review of Learning Disability Resettlement Programme in Northern Ireland, with a particular focus being the resettlement from Muckamore Abbey Hospital? 10:00

MS. MONGAN: That's correct.

9 Q. Now your Review Report that we have in front of us runs to some 116 pages, and you explore a range of issues and draw some conclusions and then make some recommendations for the Department of Health, for the 10:01 Trusts, and for the Strategic Planning and Performance Group?

MR. SUTHERLAND: Yes.

10 Q. I don't, as I've said, intend to take you through every paragraph of the report, but I'm going to pick out some 10:01 sections that we'll be exploring in your evidence. Now, if we could see paragraph 1.1, please? And we'll see there that the review was commissioned by, as I've said, the Health and Social Care Board, and that is now the Strategic Planning and Performance Group for the 10:01 Department of Health?

MR. SUTHERLAND: Yes. That's correct.

MS. MONGAN: That's correct.

11 Q. And paragraphs 1.2 and 2.2, if we could go to section

2, please, outline the Terms of Reference for the Report. And at paragraph 2.2, you state that:

"The purpose of the review built on a stated intention from Department of Health and the Health and Social Care Board to strengthen the existing oversight arrangements for the resettlement of patients from Muckamore and other learning disability hospitals whose discharge plans have been delayed."

10:02

MR. SUTHERLAND: That's correct.

12 Q. Yes. Do you know why the Department of Health and the HSCB commissioned the review at that time?

MS. MONGAN: It is my understanding that the Muckamore Assurance Group that had been established on foot of the recommendations from the two previous reports, that was the "A Way to Go", and indeed the Leadership and Governance Report, were concerned about the lack of progress in regards to the resettlement of individuals, and the SPPG commissioned the report largely to get a better understanding about what were the delays and barriers in order to expedite the resettlement. That was the main understanding, as I believe it.

10:02

10:03

13 Q. And we've referred there to Muckamore and other learning disability hospitals. Were any other learning disability hospitals included in your review?

10:03

MS. MONGAN: Not in the first instance. However, following commencement around the December period, just about two months after we commenced, the Terms of

Reference were extended to include both Dorsey and Lakeview, and that would have been the Western Trust and the Southern Trust facilities. That would be the three learning disability hospitals across Northern Ireland were all then included. But the focus was primarily on the Muckamore Hospital, largely because that was where the majority of the individuals were resident.

14 Q. And was delayed discharge an issue for those other two hospitals you've referred to? 10:04

MS. MONGAN: Yes, those two hospitals had eight patients each, and the delayed discharge issue was a recurring issue there, as it was in Muckamore, but at a different scale.

MR. SUTHERLAND: And we should maybe add that those were single wards, so they were smaller facilities, and some of it was providing assessment and treatment, so relatively short-term admission and discharge arrangements, but there were a small number of patients in those settings who also had had more lengthy admissions. 10:04

DR. MAXWELL: What is the length of stay which moves you from simply being discharged to being resettled?

MR. SUTHERLAND: I'm not sure that there's a specified length of stay. I think in reality it's at what point does the clinical team deem that you're deemed medically fit for discharge or multidisciplinary fit for discharge, is the point at which - if that becomes prolonged, I think it's deemed that you are then 10:04

thought to be considered as potentially awaiting resettlement. But we've never been given a definitive criteria in terms of that.

DR. MAXWELL: Yeah, because we've heard different terms. We've talked about the PTL list, we've heard about delayed discharges, and there is of course a discharge procedure, and I'm wondering how resettlement is different from discharge? 10:05

MS. MONGAN: I don't believe that it is. I believe that Ian has just, or my colleague has just referenced the fact that once the determination has been made that you are medically ready for discharge, then the clock starts to tick, you know, you are then -- should be the focus of discharge. And that's the delay then. And I think from recall it's that seven day period in which any hospital discharge should be affected, and I think that's the period that I would have regarded anyone to have moved from actually being identified for resettlement and actually the delay commencing. It's reasonably quickly, that's my understanding. 10:05 10:06 10:06

DR. MAXWELL: Thank you.

15 Q. MS. BERGIN: And at paragraphs 2.2 and 2.3, you outline that you were to work collaboratively in this review with stakeholders to engage with staff, agencies, families and service users. And there are a range of aims of the review, including identifying good practice and barriers to that, developing an action plan to ensure patient needs were considered and met, and to consider the effectiveness of planning and delivery for 10:06

the proposed supported living and alternative accommodation schemes which were in development to support resettlement plans for these patients.

At 2.5 you state that you were to give particular consideration, as you've indicated, to the current care 10:07
plans for all service users in Muckamore, and to critically analyse the actions taken to identify and commission suitable community placements.

At 2.6 and 2.7, you state that you:

"...were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process."

And a critical factor you were asked to consider was whether and to what extent families were engaged in decision making around resettlement.

At Section 3 of the report you outline that the review 10:07
was conducted by a range of methods, including direct observation, interviewing stakeholders, gathering and analysing data about resettlement, and also conducting focus groups. Is that correct?

MS. MONGAN: That's correct. 10:08

MR. SUTHERLAND: Yes.

16 Q. So having set your review in context then, if we could now look at Section 1 Executive Summary, and 1.3 states that policy and strategy relating to services for

people with learning disabilities is in urgent need of updating and was under review at the time of your review in fact.

And at paragraph 4.10, we don't necessarily need to bring that up, but we're staying with this paragraph, it's related. At paragraph 4.10 you refer to a Department of Health, Social Services and Public Safety Service Framework For Learning Disability, which was launched in 2013 and then revised in 2015. Do you know if the 2015 Framework was the one that was in place when you were carrying out the review?" 10:08 10:09

MS. MONGAN: My understanding is the framework was looking at particular standards that was -- also what we give reference to was the actual Bamford Review which pre-dated that for learning disability -- but the frameworks were standards that Trusts should be working to as opposed to a strategy, an overarching strategy for learning disability. Our understanding at the time that we did the review is the "We Matter" report, which was drafted I think by the SPPG, submitted to the Department was the report that was being worked on, and we were mindful that there had been no policy review for learning disability at a policy level since the Bamford Review. So that was our understanding of the policy context. 10:09 10:09 10:10

DR. MAXWELL: We have heard from various people that there were service frameworks.

MS. MONGAN: Yes.

DR. MAXWELL: And that there was one for learning disability that was suspended because there was going to be this service model and there was sort of interregnum between the two. Did you look at that?
MS. MONGAN: We did look at the draft "We Matter" Report. The standards really, we did look at those as well. I think the issue is the commissioning of the types of services that are going to be required to support people effectively in community. So those were not referenced specifically or robustly in the standards as such, and we were expecting in a sense the overarching review of the strategy through the "We Matter" Report, or overarching strategy, to give further consideration that would enable then commissioning to fall out that of policy framework. The standards in themselves were not driving the commissioning of the types of services that we believe were needed to effectively support people in --
DR. MAXWELL: So with the Service Level Framework, what wasn't in that that is in the "We Matter" document?
MS. MONGAN: I would have to go back to kind of look at both of them in detail, if I'm honest.
DR. MAXWELL: Okay. What I'm wondering is whether there's been a change in philosophy or just a change in motivation to drive it through?
MS. MONGAN: I think one would hope it would be a change in motivation to drive the delivery of the type and range of services that are going to be needed. Not just to effect resettlement, but actually the focus had

to be on developing the type of community service that were going to be needed to sustain those individuals in community, and it is that piece that I guess we were particularly focused on, because the two, both resettlement and the breadth of service that was going to be needed to effectively prevent admission, but also sustain those placements in community, that would be the piece that we were hoping would have been given more granularity and commissioning intent as a result of the policy. 10:12

17 Q. MS. BERGIN: At paragraph 1.4, you say that:

"Leadership and governance for resettlement programme in Northern Ireland has been less than adequate. Progress to deliver homes outside of hospital has been slow."

And that whilst some Trusts have achieved consistent stepped change, other Trusts have made negligible progress. Who was responsible ultimately for ensuring adequate leadership and governance of resettlement? 10:12

MR. SUTHERLAND: I'll take this one. So the Health and Social Care Board who commissioned us, who subsequently became SPPG, had an overall responsibility for coordinating resettlement across all of the Trusts. 10:13 Obviously then individual Trusts had a responsibility for the individuals who they were responsible for within the hospital settings, and in order to fulfil that responsibility they needed to either commission

care independently from a provider or develop a scheme which would allow them to do that. The reason we commented that we felt it was less than adequate was, we didn't believe that there was a well coordinated programme for the whole resettlement programme. So what we found was quite a lot of disintegration between Trusts working together. Although they had a very clearly stated aspiration to be collaborative, we heard a lot about that, but when we started to dig into it, what we found was the communication between Trusts wasn't such that it allowed them to really deliver that effectively. 10:13 10:14

And I think the other thing that we found was that the Board in its role tended to monitor the performance of Trusts without taking that further to a performance management approach. So they would seek information about what was being done, without challenging that in a way to push that forward. 10:14

CHAIRPERSON: Is that a criticism of each of the Boards? 10:14

MR. SUTHERLAND: We found quite a differential in terms of that, but I think in the body of the report certainly we felt that of the three Trusts that had the majority of patients in Muckamore, the Northern Trust and South Eastern Trust had certainly made more progress over a longer period of time. 10:14

CHAIRPERSON: Yeah, and I'm sure we're going to come on to that.

MR. SUTHERLAND: But the Belfast Trust had not made that sort of progress.
DR. MAXWELL: But you say the responsibility for leadership and governance ultimately sits with HSCB, which should be performance managing the Trusts. So are you saying the HSCB was receiving information but not performance managing the Trusts? 10:15
MR. SUTHERLAND: Yes. Well, what we found was absolutely that they were receiving regular reporting. Again what we've said later in the report is that the consistency of that reporting and the validation of that reporting was sometimes weak, and we felt that the board had a tendency to take it as read that the -- 10:15
DR. MAXWELL: You mean the HSCB when you say the Board?
MR. SUTHERLAND: Yes. Yes, sorry, apology. 10:15
MS. MONGAN: If I could add actually?
DR. MAXWELL: Yes. Yes.
MS. MONGAN: It is my view that in terms of leadership and governance, the accountability for driving resettlement rests with each of the Trusts. The role of the Board would really be to provide the assurance and that the actions of the Trust were driving that. So I mean I think, yes, there are a number of accountabilities, and leadership and governance that we looked at, both at system level and at Board level, but also at each of the individual Trusts as well. 10:15 10:16
DR. MAXWELL: Yeah. I mean you can have dual accountability, but if you're commissioning a service surely you have a duty to make sure that what you've

commissioned is being delivered.
MS. MONGAN: Yes.
DR. MAXWELL: And it sounds though you're saying they were receiving information, so they were aware that resettlement wasn't happening according to plan, but they don't seem to have intervened, they just seemed to have noted that it wasn't happening. 10:16
MR. SUTHERLAND: I think they were certainly making efforts to ensure that there was a coordinated group that would consider that data collectively, but we didn't see a very robust process to either challenge slow performance or really push things on in the way that we would like to have seen. 10:16
DR. MAXWELL: And the other thing you said was that there wasn't the collaborative working between Trusts that people espoused. Would the HSCB not be the forum for resolving differences between Trusts? 10:17
MR. SUTHERLAND: Yes, and I think that's true, and we saw some evidence of that. Particularly senior leaders within HSCB would have brought together roundtable discussions, particularly to express concerns about I suppose the relationship between what was happening with resettlement, and then the pressure for new inpatient admissions to Muckamore Abbey, which was one of the situations that was particularly difficult at the time we undertook the review. 10:17
DR. MAXWELL: So do you think the continued admissions at Muckamore was actually impeding resettlement of patients? 10:17

MR. SUTHERLAND: Yes. Yes, I do.
DR. MAXWELL: Can you say a little bit more about why?
MR. SUTHERLAND: I think what we tended to see was that this brought a considerable pressure trying to find beds to allow admission of patients who sometimes were 10:18
detained, or on the edge of detention, and I suppose what that tended to do was diverted attention away from what you could call "business as usual" around resettlement, to the day-to-day crisis management of creating capacity within the hospital to allow some 10:18
flow in. When you have flow in without flow out, obviously you get a bit of a pressure in the, middle and I think that's what we felt we were seeing.
DR. MAXWELL: And we heard yesterday that there was no crisis intervention team in the community for LD 10:18
services, even though they're very common in Mental Health Services. Did you look at that sort of capacity to reduce admissions, or was that outside your Terms of Reference?
MR. SUTHERLAND: We did look at it. I think it would 10:19
be fair to say that certainly some of the Trusts were starting to develop embryonic crisis services and had elements of a 24/7 provision. Some of the working that we saw in the community side, which was most robust, was where you saw a stronger partnership between an 10:19
independent provider and statutory services, so that between them, if an individual came into crisis, they could come up with a response plan which could often divert somebody from requiring admission to hospital.

But that wasn't available everywhere.

DR. MAXWELL: Okay. Thank you.

18 Q. MS. BERGIN: We will come on to explore some of those in more detail in just a moment as we move through the report, but remaining with paragraph 1.4, just overleaf. Thank you. Here you describe an extended period of organisational change, specifically that the regional commissioning functions which were previously undertaken by the HSCB, were transitioned back within the Department of Health under the SPPG from April '22, and you say that this impacted on resettlement. How did that impact on resettlement? 10:19 10:20

MR. SUTHERLAND: So I suppose what we should describe was, operationally it was the same people doing the process, whether they were employed by the HSCB or SPPG. It wasn't that there was significant change in the team that were under-doing that, undertaking that role. I think what we saw was, as the title would imply, a change in tone. So during that period we did see more of an emphasis on performance management emerging, and certainly that became much clearer within the narrative between staff within the SPPG and the interaction with Trusts. I mean, at the risk of sounding immodest, I think we would also say we have been encouraging the SPPG, HSCB, and then SPPG, to adopt some tools that might give them a better grip and a better view on what was happening, particularly helping them to devise a tracker tool. So -- but I suppose we saw a change in tone, but there wasn't a 10:20 10:20 10:21

significant change in the personnel leading that.

19 Q. And so you're really describing then a positive change at that stage?

MR. SUTHERLAND: Yes, I think it was actually. Yes. I think that would be fair to say. Certainly there was a greater clarity about what the expectations were from the SPPG in terms of how the Trusts were delivering, and I suppose that included that the more senior person within the SPPG had written to the Chief Executives of all the Trusts explaining about the piece of work we were undertaking and encouraging them to actively support and participate in it. 10:21 10:22

20 Q. At paragraph 1.5 then, and in response to Dr. Maxwell's question you've already touched on the role of the Trust Board in terms of scrutiny, and here you say that the Belfast Trust had this dual challenge that you've referred to, of balancing improving quality and safety at Muckamore, whilst also trying to progress resettlement, and you say that this balance was not achieved and that the Trust Board were reassured by Executives that there were plans in place to support resettlement, but that better scrutiny of these assurances would have shown this not to be the case. Did you find any evidence of scrutiny? 10:22 10:22

MS. MONGAN: I looked at all of the Trust Board minutes at a particular point in time, it was over a year period, and actually looking at the information that was provided, there was no evidence of questioning or challenging in regards to the time frame. The 10:23

information that was provided was reassurance that we have 15 or 16 plans in place. The detail that we were looking at would have quickly, if someone had scrutinised those, clarified that those plans were not complete, that they were aspirational, and it was that lack of challenge in regards to what is the time frame, and the dual function, because our view was that reducing the resettlement population in Muckamore would have been one of the most important measures in improving quality and safety at the hospital, so the two should have been progressing in tandem. So we didn't see evidence that that level of scrutiny was there. 10:23 10:24

DR. MAXWELL: Did you look at the Audit Committee?

MS. MONGAN: No. No. 10:24

DR. MAXWELL: Because the Audit Committee, which is the only non-executive only led committee, is supposed to look for the assurance and also search the internal audit programme. Did you see any evidence that there had been any internal audit on resettlement? 10:24

MS. MONGAN: We were not asked to review governance within the context of the Terms of Reference. Our review of the Board minutes was really to see what evidence there was in regards to --

DR. MAXWELL: At the Board meeting. 10:24

MS. MONGAN: At Board meeting, in regards to resettlement per se.

DR. MAXWELL: Okay.

MS. MONGAN: And we needed to be very clear what our

Terms of Reference were.

DR. MAXWELL: Okay.

MS. MONGAN: However, just looking at that high level Board meeting, there was a monthly report, the Director of Mental Health and Learning Disability Service gave a monthly, very robust and full report, including numbers, but there was only at one stage reference to a business case that was proposed or in development for the onsite, that resulted in one question in regards to give us a time frame. So both the delegated statutory function report that was reported through the Trust Board, and indeed the other minutes, there wasn't that level of scrutiny around 'Well, it was 15 last time and it's 15 this time', you know, 'What is the time frame?'. 10:25

DR. MAXWELL: And you didn't see any reference to an internal audit review of the assurances of resettlement?

MS. MONGAN: We didn't seek that level of detail.

DR. MAXWELL: No. No, you didn't see it in the notes I mean? 10:25

MS. MONGAN: No. No, we didn't.

21 Q. MS. BERGIN: We've dealt specifically with the Belfast Trust Board oversight. Elsewhere in the report, and we don't necessarily need to come to it, but at 7.1.34, for reference, you say here that Health Trusts' narratives and reporting in relation to resettlement provided reassurance rather than assurance based on evidence, and you refer to all Health Trusts reporting 10:26

that discharge plans were in place for patients, but your review identified that most plans were in fact still at scoping stages and, therefore, lacked robustness. And you say then generally there was insufficient challenge by Trust Boards. Aside from the Belfast Trust, did you find any evidence of challenge by the other Trust Boards that you were looking at.

MS. MONGAN: We didn't specifically look at any of the minutes from the other Trust Boards, simply because the Belfast Trust is responsible for Muckamore and accountable. So we can't answer that at Board level.

The point here is that, and again one of the steps that we did take as a Review Team, was to create a definition of a plan. It might seem a very simple thing, but Trusts were actually putting forward plans that where aspirational. In other words, 'we hope that this will work'. The definition of the plan that we have identified within the report certainly made that a very concrete approach in terms of it's not a plan unless it's going to be completed. In other words, you have commissioned, you have an address, you have an identified provider, et cetera, and the plans that we saw largely were 'I have an idea that we're going to pursue this route and the expectation hopefully may be', but that's not a plan. I mean that couldn't be seen to have been concrete.

22 Q. You say that the Northern Trust and the South Eastern Trust had well progressed response plans, although

there were some delays, but the Belfast Trust plans failed to progress beyond preliminary stages. Is this difference between Trusts explicable by poor management and, therefore, poor planning, or were there other factors that hindered the Belfast Trust in this? 10:28

MR. SUTHERLAND: I mean I suppose we've already referred to this dual responsibility of trying to keep the hospital safe and of high quality care whilst supporting the resettlement process. And, of course, Belfast Trust and the hospital had a dedicated 10:28 resettlement team that was due to work with all Trusts, not just their own, and we saw particular weaknesses in terms of that. I suppose, and we may came on to this, but the difference that we saw was that with the Northern and South Eastern Trusts, the weaknesses that 10:28 we saw in their plans tended to be they had a solid plan but there might be delay or drift in terms of delivery over time. And quite often that related to identifiable factors that they were clear about, such as staffing was commonly the biggest problem that all 10:29 providers referred to and all Trusts referred to. But we could see actions being taken to try and address that.

When we looked at the Belfast Trust plans, they 10:29 literally were at the very early stage. So it was, 'We're planning to develop something in this area', but when you started to dig, the site hadn't been acquired, there wasn't an agreed capital funding plan agreed

between the Housing Executive and the Trust. So really they were much further back in terms of their development of those schemes.

MS. MONGAN: And one of the additional issues that we identified is the turnover of senior leadership in Belfast Trust, certainly we believe resulted in a lack of traction and less continuity than we were seeing in other Trusts. Certainly within the period of our review, which is just a year, there were turnover in regards to the director, co-director, social work lead. So there was quite significant senior change at that stage. In addition, those senior leaders did not necessarily come with the background of learning disability and, therefore, that system knowledge probably would require some time to, in a sense, get a grip of. So there were a number of factors that also we believe, but it's just our view as to what might have contributed to that. But realistically the other Trusts had taken the steps probably three, four years previously, and I think it's the long lead-in time of any new build, really the steps need to be taken with new to completion the best part between three and five years prior to that. So the South Eastern and the Northern had taken those steps years previously.

CHAIRPERSON: I wanted to ask you about timing, because you published your report, or made it available in July '22. So these comments that you're making about the Belfast Trust effectively are still at the aspirational stage of plans, as compared to other Trusts which had

much more solid plans, which were having their own difficulties for obvious reasons. What was the period, and I'm sure this is in your report so forgive me, but what was the period that you were looking at in terms that conclusion that the Belfast Trust was still aspirational, was that right up until the point of publication?

MS. MONGAN: Yes. At the point of publication, from recall, and it's in the report, Belfast Trust had 15 patients, and we considered 13 of those plans incomplete. So that was the bulk of the population at that stage, at that stage did not have complete plans. And it was really as a result of the three schemes that the Belfast Trust intended to take forward were capital new build schemes that realistically would never have been ready before the 2025/26 period. And they then required to go back and consider all alternatives. They had begun at that stage to put provisional plans in place, but they wouldn't have met the test of a defined plan at the point we concluded our report.

CHAIRPERSON: Did you find that quite surprising?

MR. SUTHERLAND: Yes, we did. I mean -- and disappointing, because as we say within the report, many of these individuals had been in hospital for decades, and the lack of progress and the inertia, it just reflected a lack of a sense of urgency about what it meant in terms of these individuals lives. I suppose to balance that a bit, towards the end of our review there was -- our review period -- there had been

10:31 10:31 10:32 10:32 10:32

some change in senior operational leadership within Learning Disability Services in Belfast, and actually we saw quite rapid improvement over the last couple of months, because they were willing to consider other options other than 'we'll keep going with these unrealistic capital development plans over a five year period', and they started to look at things like repurposing existing provision where they could actually turn that around with providers more quickly potentially, although we would have to say we didn't see the delivery of that by the end of our review period. 10:33 10:33

MS. MONGAN: But in answer to your question, it was no surprise to us that that was the position at the end, simply because the planning hadn't been taken at an early enough stage. So we would have anticipated that even though we saw a recognition and a real drive to think of alternatives, there was insufficient time left to do that within the time frame of the review completing. 10:33 10:34

DR. MAXWELL: Can I ask two questions in relation to what you said there. So you said at the time Belfast Trust had 15 patients and you thought 13 of those plans were incomplete. There were more than 15 patients in Muckamore at that time. Did you look at -- are you saying that the other patients hadn't been deemed ready for resettlement or just that they didn't have a plan? 10:34

MS. MONGAN: No, those 15 I referenced were the 15 patients that were Belfast Trust's own, their patients.

DR. MAXWELL: Oh, I see. The other patients belonged to other Trusts.
MS. MONGAN: Yes. We looked at all of those in regards to the same.
DR. MAXWELL: Okay. I see. So these were 15 that were the responsibility, commissioning responsibility of Belfast Trust. 10:34

You also said there towards the end you saw more flexibility, and as I think we'll come on to, you've got your projected discharge graph, which as we have learnt didn't come to fruition, they were unable to close, are unable to close at the end. So given that you had thought the problem was managers not thinking alternatively, and last June they were, why didn't those plans come to fruition, because there's still quite a significant number of patients in Muckamore? 10:34 10:35
MR. SUTHERLAND: I think it's difficult for us to comment on that because we really haven't had a role in terms of -- 10:35
DR. MAXWELL: Okay.
MR. SUTHERLAND: -- reviewing post the completion of our report.
DR. MAXWELL: But it might suggest that your assertion that it was the leadership who weren't thinking flexibly, wasn't the root cause. 10:35
MR. SUTHERLAND: Yes. I mean we know that -- I mean we've already referenced there was a lot of shift and shuffle in the leadership within the Learning

Disability Belfast Trust Services, and actually we know subsequently there were further changes in that leadership.

DR. MAXWELL: Yeah.

MR. SUTHERLAND: So that could have been a contributory factor. But I couldn't definitively say that. 10:36

DR. MAXWELL: Okay. Okay.

23 Q. MS. BERGIN: At paragraph 1.7 then, looking at the approach to individualised care planning, you say that:

"There was a lack of consistency in the documentation used to support care planning for transition from hospital to community..."

And you also say: 10:36

"..there was no agreed regional pathway for resettlement, to map out roles and responsibilities within that process."

Was that lack of consistency in planning something that was a feature for all of the Trusts or was that just the Belfast Trust?

MS. MONGAN: Lack of consistency meant that there wasn't consistency across all five Trusts. Some Trusts 10:36 had a much broader range of tools that they used than other Trusts, and when we saw those particular Trusts and the level of detail, and more particularly the Essential Lifestyle Plans and the range of tools that

might actually bring the needs of the individual to life in a much more effective way than some of the more generic assessment tools that other Trusts would have relied on. So certainly it was our view that that needs to be standardised, and the focus on the range of tools that will effectively create a good understanding of that individual's needs and the transition arrangements into community.

24 Q. Continuing in this paragraph you also say that: 10:37

"Of the remaining patients awaiting discharge almost a quarter had been in Muckamore for more than 20 years..."

And one person had been there for more than 40 years. And of this group a third of them had had one or two previous trials in community placements, and you've referred already to some improvement, and you say here that from June 21 to '22, those in Muckamore awaiting resettlement had reduced by 20%. 10:37 10:38

Now, at paragraph 1.10 you say that the Northern and South Eastern Trust had reached a stage where two substantial new care settings and smaller scale provision would provide new homes to approximately 80% of their remaining Muckamore residents, but the Belfast Trust, as you've already referred to, were still scoping schemes that hadn't got past infancy really. The significant improvement that you refer to here, 10:38

that 20% reduction of those awaiting resettlement, did that not apply to Belfast Trust patients awaiting resettlement?

MR. SUTHERLAND: Certainly it was a very small number from Belfast Trust relative to the other two, and the detail is later in the report, but I'd have to look it up for you. 10:38

25 Q. Okay. If we go to paragraph 1.8 then you say that Trusts -- thank you. You say that Trusts reviewed their approach to resettlement to consider alternative options for discharge, and this improved the resettlement trajectory. And if we look at the graph further down the page, we can see that it anticipates that the population will reduce to between 15 to 19 patients awaiting resettlement by the end of March '23, and as you've already indicated in your evidence in response to Dr. Maxwell, that doesn't appear to have been achieved. Your report was published in July 2022, so how did you calculate the points beyond that date? 10:39 10:39

MS. MONGAN: Those were calculated based on the test: Do you have a provider? Is there a defined scheme with an address? And, actually, what is the prospective date that you are anticipating? So a trajectory is developed on the basis of anticipation, and it is really largely to be used then for performance management so that you can actually then review why delays might be occurring. So we actually took the information and the test of whether or not. So, for instance, the Northern Trust had two new build schemes, 10:40 10:40

they were built, they were in commissioning stage. There were a number of factors that might have created delay. As I say, in the first instance there were supply chain issues in regards to impacting the new build, and then subsequently the recruitment of staff. 10:40
So those may be issues that cause delay, but notwithstanding that, they had a discrete number of places available and names of individuals that would eventually be going into those places. The commissioning of that would have been over a period of 10:41
time, and those times were the times that the Trusts were reflecting the anticipated admission. So it's in order to get into a much more concrete way of anticipating the dates of discharge. The delays then would be down to the SPPG in terms of their performance 10:41
management of this system to actually challenge what's creating that delay.

DR. MAXWELL: So is it fair to say your trajectory is based on your confidence of the plan in place?

MS. MONGAN: Yes. 10:41

DR. MAXWELL: So there was a robust plan and you assumed that it would be delivered because it was robust, and had it been delivered this would have been the trajectory.

MS. MONGAN: At that stage there was a fair degree of 10:41
confidence, unless something untoward happened, or the individual became unwell, or they had major recruitment difficulties. There should have been an expectation that those individuals should have been then

accommodated, and that was on the basis of fairly discrete plans and commissioning of those services.

DR. MAXWELL: And did you factor in a confidence interval for failed resettlements, because at a later point you say that 37.5% of patients had at least one failed resettlement, and we've heard quite a lot of evidence about that, sometimes you can plan but sometimes you just don't know what's going to happen. Did you add a margin of error for failed resettlements? 10:42

MS. MONGAN: This was really to drive the first stage, which was actually -- 10:42

DR. MAXWELL: Okay.

MS. MONGAN: -- getting people into accommodation. We did give consideration to what needs to be in place to effectively sustain those placements, and we did reference in the report the importance of getting this right first time, but in order to do that there would need to be a range of services available in the community. 10:42

DR. MAXWELL: Okay. And it didn't account for the continuing admission rate either? 10:43

MR. SUTHERLAND: No.

MS. MONGAN: No, this was purely to try and get a trajectory around the discrete plans that the Trusts had in place and whether or not those would deliver against numbers. 10:43

DR. MAXWELL: So potentially these did work, but some of them were failed and there were readmissions, and there were more admissions of patients who had never

been in Muckamore that gives us the current population.
MS. MONGAN: My suspicion is that it wasn't a question of failed placements, but delay in affecting the discharge that may have resulted in the expected numbers not being realised, but we weren't involved in the implementation. 10:43
DR. MAXWELL: Okay.
MS. MONGAN: One of our recommendations was that an Oversight Board should be established. The Chair of that Oversight Board probably be best placed to give evidence to the reasons why this trajectory wasn't realised. 10:44
DR. MAXWELL: And was this trajectory taken up, you know you've have talked about SPPG being more performance management orientated than HSCB, did they look at this and think this is the performance we have to manage, or did they not give you any feedback? 10:44
MR. SUTHERLAND: I think they did, and I think it would be fair to say we were reasonably optimistic about this trajectory, because we had been quite tight about 'We want to be clear there is an actual new home for this person and there is an agreed realistically planned date for that person to move into that new home', and actually we were seeing some evidence that that was beginning to happen. So perhaps naively we were relatively optimistic about the trajectory. 10:44
DR. MAXWELL: I'm just wondering whether to your knowledge SPPG used this as a KPI to performance manage the Trust? 10:44

MR. SUTHERLAND: We couldn't say that definitively, but certainly in the discussions that we had when we closed the project, and in the feedback sessions that we did with the SPPG and the Trusts, that was the certainly the positions of SPPG at the time. 10:45

DR. MAXWELL: That's a question we can ask the SPPG.

MR. SUTHERLAND: Yes.

MS. MONGAN: And what we did hear is that all of our recommendations were accepted, and that included the maintenance. But we also said this could be further 10:45 enhanced. So we made a recommendation that this tracker tool should be further strengthened. So we would have hoped and expected that they would have used this, and in fact then further enhanced it to performance manage. 10:45

26 Q. MS. BERGIN: At paragraph 1.9 then, please? We've referred to resettlement options which include new build and the issues that they can present. Now here you say that in terms of delivery for resettlement operationally there is an impressive range of provision 10:46 across registered care and supported living settings providing approximately 2,500 places with learning disability in the community. And you say although this has changed at the time of writing your report, there had however been a tendency of commissioners and 10:46 resettlement teams to not engage with providers to consider potential existing opportunities. In terms of those 2,500 places you refer to, did you in any way categorise those into levels of care that they could

provide as opposed to just being places, whether they were suitable for particular needs.

MR. SUTHERLAND: No, we didn't look at that in terms of the level of need that those places represented. What we did understand from our engagement with providers, and we met extensively with providers through their network organisations, what we knew about that is there's a diverse range of need being met within that 2,500. Certainly some people will need very minimal support and will live relatively independently. But I think what's important to say was, what we had seen was certainly there was a percentage of those places where people with very complex needs comparable to some of the people we were hearing about in Muckamore Abbey Hospital. So we had a confidence and a belief that the sector, if commissioned appropriately, had the potential to meet the needs of some of the Muckamore patients. 10:46 10:47 10:47

27 Q. And staying on the theme of needs, and I suppose the resources required to meet those needs, you also say here that the biggest single issue and risk facing the range and quality of provision was workforce, and you say that at that stage the Department of Health were sponsoring work regionally to try to address this. Do you know if the Department's work was looking at skill force mix? 10:47 10:48

MS. MONGAN: My understanding is that the Department commissioned a piece of work specifically relating to learning disability to look at the skill mix, but I

can't answer in any more detail, and that was reporting within the overarching workforce strategy.

DR. MAXWELL: So we heard yesterday from Fiona Boyle, who had done some evaluations, and one of her findings was that actually these people have complex needs, including physical needs and mental health needs, and that actually the commissioning was for social care, around a social care model rather than a blended model, and she actually felt there was a deficit of LD nursing. Did the Department of Health or you actually consider that or was it just about the workforce in terms of social care workers? 10:48 10:49

MS. MONGAN: No, it wouldn't have been workforce in regards to one particular professional grouping. It was our view that a full multidisciplinary team is required, not just nursing, social work, but also psychology, occupational therapy, all of those skills are required. So our view was that actually it needed to look much more broadly at multidisciplinary working. These are complex individuals, presenting, as you've said, with a whole range of needs, and where we saw the placements working most effectively, there was the responsiveness and fluidity across from the Health and Social Care Trust working in a fairly responsive way with the provider, bringing the additional skills in when those were needed, not just to support the individual but to actually support the staff team who were under pressure as well, but the main driver was to prevent the breakdown. 10:49 10:49 10:49

DR. MAXWELL: What we've heard a lot of is for a long time, certainly since 2012, there were staffing crisis in Muckamore. Currently some of the wards don't have anybody who is trained in LD working on them. So, there was no capacity to provide that support in the community. Do you know if the regional work of the Department of Health has actually looked at the availability of health staff with LD backgrounds?

MR. SUTHERLAND: It's fair to say we didn't look at that specifically. If I may though say, later in the report what we provided -- we weren't provided with a supply map in terms of 'What's the nature of provision in Northern Ireland?', so we did a fairly rudimentary one ourselves, if we're honest, but we felt it was a useful tool. Within that we were able to define specialist learning disability nursing homes as part of that sector, and we certainly met with proprietors or managers of those homes, who were themselves learning disability nurses, actually quite a significant number of whom were former nurses in Muckamore Abbey Hospital, but some time ago. And what was interesting to us in terms of that was actually several of those providers said 'We've worked in Muckamore, we know the system well, we actually have vacancies in our provision, but no-one is initially approaching us to consider our ability to provide a potential resettlement placement.' In fact in one of the situations, one provider said to us, 'I wasn't approached initially, but I was approached to take somebody where they had had a failed

placement previously and then they were successfully placed with us.' I'm sorry, that may not go specifically to your question about LD nurses.

DR. MAXWELL: No, no, no. That's a really important point, and we have heard that a lot of former Muckamore staff have set up homes, but a lot of people are being resettled not to a home, and the point you made about the flexibility between the Trusts, I'm wondering if one of the differences between Belfast Trust and other Trusts is, we've heard that for complex reasons there was an exodus of LD nurses from Belfast Trust to the other Trusts. We've had people give evidence here saying 'I took a job in one of the other Trusts'. Is the ability of Northern and South Eastern Trust to support people in part because they have more access to LD staff than Belfast Trust? 10:52 10:52 10:52

MR. SUTHERLAND: I think what we certainly saw was both those Trusts, and indeed the Southern Trust, were perhaps further forward in developing their range of community services, and I suspect that some of those nurses who had previously worked in hospital had taken up post within Community Learning Disability Services. So you might have seen that shift. 10:52

DR. MAXWELL: But we've also heard from nurses that because of the ramifications of the 2017 CCTV, it became not a place they wanted to work. 10:53

MR. SUTHERLAND: Yes.

DR. MAXWELL: So actually that affected Belfast Trust's ability to provide outreach service.

MR. SUTHERLAND: Yes. I think that would be fair, yes.
DR. MAXWELL: Yes.
28 Q. MS. BERGIN: Just to pick back up then. We were looking at the alternatives to new builds, and one of those being then existing provision in the community, 10:53
and you said in your evidence that there were examples given to you of very complex needs being met, as well as less severe needs.

Now at paragraph 4.2, and I appreciate we're jumping 10:53
around, but it relates to the same topic. Here you say that you visited community resettlement schemes which were successfully supporting individuals with very complex needs, equivalent to the needs of those awaiting with delayed discharge and, you say that these 10:54
examples of good practice highlight that models of care and support required to build sustainable community placements for people with complex needs are already operational in Northern Ireland, and you say that really the success factors for these need to be scaled 10:54
up in commissioning and procurement. In terms of the examples of good practice for complex cases, did you find any evidence that the Trusts were sharing information and meeting and liaising with each other to share these good examples? 10:54
MR. SUTHERLAND: No, not significantly. It's one of the reasons why we made a recommendation around commissioning collaborative, that we felt there could be more partnership between the sector and those

commissioning services, because we certainly weren't getting a sense that that shared learning was being well distributed across the whole of the sector.

MS. MONGAN: And it would be fair to say that it just wasn't the sharing across Trusts, but our view was that that sharing should have also been with providers of learning disability services in the independent and voluntary sector, that there were missed opportunities in many respects to share that best practice and work as a whole system. 10:55

29 Q. The Inquiry has heard evidence that the East London Foundation Trust visited the Belfast Trust in 2019 to share best practice. I'm not sure if you're aware that of?

MR. SUTHERLAND: Yes, we were made aware of it at the time. 10:55

30 Q. Did you find any evidence during your review that the Trust had consulted or sought advice from any Trusts in England or elsewhere to inform resettlement planning?

MR. SUTHERLAND: Not particularly. I mean we had -- certainly staff in the Belfast Trust had advised us that East London had been in. They didn't give us a lot of detail as to what that had been. I suppose one thing we should comment on was, there were some staff within Belfast Trust who we had met who certainly had experience of working in other places and other approaches. Although, while they were able to make that observation, they weren't always in the sorts of roles that could have applied that experience or 10:56

learning to have a bigger impact perhaps.
MS. MONGAN: And our understanding was that the work that East London were assisting Belfast was very much around the quality and safety in the wards in Muckamore as opposed to actually then the focus on transitioning and successfully resettling people into community.
31 Q. If we could look at paragraph 1.11, please? And while we're bringing it up, here you say that: 10:56

"...adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place..."

Now, that was in July 2022. Which adult safeguarding arrangements are you referring to there? 10:57
MS. MONGAN: We were referring to the work to develop an Adult Protection Board in the first instance, and we were mindful that it was at interim. So it was really to do with the work -- to progress the legislation in regards to that. 10:57
32 Q. And why was that an Interim Board? Was that pending legislation, or what was the reason?
MS. MONGAN: My understanding is the arrangements on an interim basis were as a consequence of the recommendations arising from the review in -- it's gone now -- older people services. The... 10:57
MR. SUTHERLAND: Can't remember.
MS. MONGAN: It was a report in regards to a

particular, say Dunmurry Manor, and there was a review commissioned, I think, well a report completed by -- that made recommendations in regards to the strengthening of that. So my understanding was that was the catalyst for the interim arrangements being put in place.

33 Q. Can you tell us anything about how the role of the Interim Adult Protection Board differed from another group that the Inquiry has heard about, the Regional Adult Safeguarding Partnership? Is that anything you know about? 10:58

MS. MONGAN: I wouldn't be able to make comment, and I think that's something that the SPPG would be better placed to make a comment on. The safeguarding issue was not part of our Terms of Reference. It became a chapter in our report largely as a result of our engagement with families, and the import they gave to safeguarding on the back of the identification of abuse in Muckamore Abbey, and particularly in regards to the issues around planning for resettlement for their loved ones in community around the use of CCTV. So there was a real issue that required to be resolved in regards to the families expectations, and what the Trusts were planning to operationalise for individuals living in the community. So it felt as though we needed to make reference to the safeguarding issues in that regard, but really the lens was on what the families were telling us and their experiences as a consequence of safeguarding in Muckamore Abbey. 10:58 10:58 10:59 10:59

34 Q. I appreciate we're jumping around somewhat, but I think it makes sense to stay on the safeguarding topic, so if we could go to Section 9, please? And in this section, while it's being brought up, you consider the safeguarding policies, the findings of previous independent investigations of failures in care, and as you've referred to, the experiences of families of safeguarding in relation to their relatives. At paragraph 9.13, please?

CHAIRPERSON: Do you give a page reference as well? Sorry. 11:00

MS. BERGIN: I don't have the page reference in front of me, Chair. Apologies.

MR. SUTHERLAND: It's 91, Chair.

CHAIRPERSON: Thank you very much. 11:00

MS. BERGIN: And here you state:

"The RQIA commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings in January 2020 and this was in response to concerns about the quality of care and potential for abuse in care home settings." 11:00

And you say that:

"The review concluded there was insufficient research evidence to support the proposed use of CCTV in care home settings." 11:01

Following that review, do you know what decisions have been taken about CCTV in resettlement facilities?

MS. MONGAN: Each Trust were progressing that in the context of the services they were commissioning in discussion with each individual family, but I do recall that the Belfast Trust had a working group or people looking at the use of CCTV in that regard. My intent in drafting this aspect of the report was to really give weight to the importance families were putting to this. It is a complex issue and, ideally, one would wish that you wouldn't aspire to looking to CCTV as a measure only to provide safeguarding, but the confidence and trust of the families had been so broken that it was nearly as though the system was hoisting a batard of CCTV, so my view was actually there needed to be much more robust engagement and ongoing discussions with families in order to get to a position which would have assured them. But there were a number of measures, it just wasn't CCTV, it was also the ability to visit their family member without having to pre-book appointments, be able to have access to living arrangements, all of those things that on reflection they felt were missing during their experience in Muckamore.

11:01 11:01 11:02 11:02

35 Q. We're jumping around somewhat but if we move through the report in order, we're now at Section 4, please. I think, Chair, I'm mindful of the time, but I think if we could just deal with this section before the break, that would be helpful?

11:02

CHAIRPERSON: Yes, sure. Yes.

36 Q. MS. BERGIN: Now, at paragraph 4.2, and we've already referred to this paragraph in fact in relation to delayed discharge. You state here that 10 of the delayed discharge population are from the original priority target lists, which relates to patients living in long-stay learning disability hospital for more than a year at 1st April 2007, and have been discharged delayed between 16 and 45 years. Did you explore in your review why certain patients had been on the priority targets lists since 2017? 11:03 11:03

MS. MONGAN: We reviewed the numbers of trial placements, and there was evidence that some of those individuals who were now in later years, some of those individuals who were now in their 70s, maybe even older than that, had known no other home than Muckamore, and the impact of the institutionalisation and prospect of another resettlement certainly was one of the genuine barriers in regards to progressing. As a result of that, there were four individuals identified from the Muckamore population who were deemed as requiring an alternate provision, and that's why the Belfast Trust looked to an onsite solution at that stage. But, whilst that was in the planning stage, it didn't progress, and it is my understanding, and this was towards the end of our review, that the other Trusts were then looking at making alternative arrangements. But these are individuals whose needs would have been very different by -- as a consequence of the length of 11:03 11:04 11:04

time they had actually lived in Muckamore and had known no other home.

DR. MAXWELL: But in what sense is it a priority list if people have been on it since 2007? I mean, is it just an administrative list of delayed discharges? 11:05

MS. MONGAN: It was -- the PTL was at a point in time. It drew the line that from here on, you know, people aren't long stay in hospital they are actually delayed. But it's -- by definition it was never, in my view, treated as a priority list. 11:05

MR. SUTHERLAND: I think also the patient target list was language that was sometimes used in acute discharge planning, in acute hospital settings, and it had become used across all of the system. So it was designed to ensure the targeting of patients delayed for discharge 11:05 in acute hospital settings, so I think its application --

DR. MAXWELL: It simply meant not having active treatment.

MS. MONGAN: Yes. 11:06

MR. SUTHERLAND: Yes.

DR. MAXWELL: And didn't tell you anything about this person needs more effort because they're a priority.

MR. SUTHERLAND: Yes.

CHAIRPERSON: So it specifically doesn't do what it 11:06 says on the tin, as it were?

MR. SUTHERLAND: Yes.

MS. BERGIN: At paragraphs 4.8 onwards, and we're not going to go to each of them, but at 4.8, 4.9, and 4.16

you set out various resettlement targets and deadlines that were set in 2005, 2007 and 2018. For example, the Bamford Review Equal Lives target to resettle all patients into the community by 2011. The Transforming Your Care Minister of Health 2011 target to close long-stay institutions and complete resettlement by 2015. And there's also then a commitment by the Department of Health Permanent Secretary in 2018 to resettle delayed discharge patients by the end of 2019. Do you think these types of targets help to catalyse action for resettlement, or are they a hindrance to good resettlement planning because the focus is on the target rather than the individual patient?

MR. SUTHERLAND: I think one thing that we could say is that this process, it felt a bit like a roller coaster ride in terms of resettlement. So there were periods when there was a clear focus and I think there was probably more activity. One of the things we should say is that at one point there were three large learning disability hospitals in Northern Ireland, and two of those had closed completely, certainly by, I would say, the end of the 2010s. But in relation to your second point, I think you're absolutely right. I think there came a point where it felt like that, that roller coaster plateaued, and at that point you were left with a population of patients in Muckamore who probably had very complex needs. I think while we may not have stated it within the report, our concern was that ironically you had left the people with most

complex needs to the end of that process, and perhaps what would have been better would have been to have made them more of a priority earlier on in the process.

DR. MAXWELL: You say that, and we've heard from a lot of people, that as the resettlement progress the people with most complex needs were left. Was there any recognition at a political level that they might need a different strategy, or was it just do more of the same, you've done it for this number of people, do the same and it will work for these people? Because it sounds like they have very different needs and, therefore, different requirements? 11:08 11:08

MS. MONGAN: I think there was a recognition that those individuals would need a broader range of services in the community, but we didn't see evidence that those services were being commissioned at a pace or with a degree of breadth to genuinely support that level of needs in the community. 11:09

DR. MAXWELL: So people were saying it, but actually they were just doing more of the same. 11:09

MR. SUTHERLAND: Yes.

MS. MONGAN: Yes.

MR. SUTHERLAND: I think -- I'm not sure if your question was in relation to political oversight?

DR. MAXWELL: Well, originally it is because, you know, these big announcements, and then of course we had one last summer that it would close by the end of this month, and... 11:09

MR. SUTHERLAND: I mean in fairness we didn't look at

the Health Committee, for instance, which would have been an oversight body in terms of what they were saying in relation to that.

DR. MAXWELL: But presumably more complex patients require a higher level of funding? 11:10

MR. SUTHERLAND: Yes.

DR. MAXWELL: Which has to involve politics, you know.

MR. SUTHERLAND: Yes.

MS. MONGAN: Yes.

DR. MAXWELL: If you've been able to settle the first 600 people at X pounds, and you need triple that for the last 50, you need political imperative to increase the funding. 11:10

MR. SUTHERLAND: Yes.

MS. MONGAN: So if I go back to the success of previous resettlement, and we've talked about that in the report in the early '20s, late '90s, that, I believe, was the consequence of the Department ring-fencing funding, not just for health and social care, but also for housing. And looking back, that actually created the impetus for two departments to actually work collaboratively to create the accommodation in community. That was not the case during the period of this review where there was an onus on the Trusts largely do both. 11:10

DR. MAXWELL: So the political impetus and understanding wasn't -- hasn't been there more recently than it was previously? 11:10

MR. SUTHERLAND: I think your comment that it felt like we got to a point where it was more of the same was a

fair one. Yes.

CHAIRPERSON: But so far as you're concerned -- well I think we'll look at budget later, because you do deal with the funds available.

MR. SUTHERLAND: Yes. 11:11

CHAIRPERSON: But you were only looking at it, as it were, at SPPG level, or as 'this is the envelope we've got'.

MR. SUTHERLAND: Yes.

CHAIRPERSON: As opposed to outside that. 11:11

MR. SUTHERLAND: Yes, that's correct.

MS. MONGAN: Yes.

37 Q. MS. BERGIN: Staying on paragraph 4.8, you say at the start of the paragraph that:

11:11

"The Bamford Review "Equal Lives" published in 2005 included a target that all people with a learning disability in a hospital should be resettled in the community by June 2007."

11:11

And then the final sentence of that paragraph then says:

"In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011." 11:12

So were there two different targets then for resettlement in 2005? One to resettle all patients and one to specifically --

MR. SUTHERLAND: Oh, yes. Yes.
MS. MONGAN: The first Equal Lives were saying no-one should call a hospital their home, everyone should be out. What I understand by the priority target list, they were actually saying what can we achieve within whatever time frame? So they, again, were looking to set that target for that period of time. That certainly doesn't suggest that it was an intention or an expectation that we could get all resettlements completed, it may have been a reflection of what they were anticipating they could do. 11:12 11:12

38 Q. And in terms of what evidence you reviewed during the review, was that closer aligned then to the ladder there in terms of the specific resettlement of 87 patients? Could you see work that was working towards that target, or was it more general than that in line with the priority lists? 11:13

MS. MONGAN: At the time we commenced our review, the total number of patients in Muckamore were 46, and then an additional 8 in the other two units. So the population had already reduced beyond that 87 by the time we commenced our review. Our focus was on that particular cohort, and particularly those 46 in Muckamore. 11:13

PROFESSOR MURPHY: There was a time, I think, when there were plans to rebuild the hospital, and it was around this time, I imagine, that they were being set. So we frequently heard about the core hospital, as it later became known, and it sounded to me as though 11:13

there might be one group, i.e. the Bamford group, saying 'we're going to resettle everybody', but another group saying 'no, we need 87 beds and they're going to be in this new hospital we're building', was that what you thought had been going on? 11:14

MR. SUTHERLAND: We didn't see it articulated as clearly as that. Certainly the Bamford ambition was in Equal Lives that no-one should live in hospital. But I have to say I don't think we saw it articulated in that way. 11:14

DR. MAXWELL: But Bamford did not negate the idea that there would be short-term admissions for assessment and treatment.

MS. MONGAN: Oh, yes.

MR. SUTHERLAND: Absolutely. 11:14

DR. MAXWELL: So is there a distinction here that everybody should be resettled, but we think there might be a need for 87 short-term assessment and treatment beds?

MR. SUTHERLAND: If you look at what happened in the other Trust areas, the units we referred to earlier, Lakeview and Dorsey, were exactly that. They were a development to create short-term assessment and treatment provision, usually aligned to larger mental health units, quite often on a general hospital site. 11:14 11:15 So that was very much the overarching vision, I suppose, for Bamford, was that if you had a learning disability you got treated where everybody else got treated. I'm not sure that we saw that the 87 -- I

think it could have been a mix. Because there was this issue about where will the assessment and treatment beds be for the Belfast population, which also served the South Eastern Trust population and the Northern Trust population I think.

MS. MONGAN: And during the period of the review we already saw evidence of the Northern Trust beginning to develop their own in-patient short-stay unit. So you could begin to see the beginnings of alternative provisions to any provision on the Muckamore site. The intention in this chapter was continuously just to do a little bit of tabletop exercise to look at the number of times this recurring issue of targets was set. We then looked at judicial reviews that were ongoing at the time of the review, and I mean we viewed this as both an ethical and a legal requirement, so we wanted to iterate out on this chapter just the frequency that these targets kept getting repeated. The reality is that no person should call a hospital their home, but at the same time they should have an expectation if they require to be admitted for assessment and treated, that should be done in a timely way and, therefore, the full system needs to be operating. But in order to do that, really, apart from getting these people out, we wanted really to focus on the fact that the community services need to be strengthened as well.

MS. BERGIN: Chair, I'm just conscious of the time. I have two more questions left in this session, but we have been going for quite some time.

CHAIRPERSON: We have. We've been going about an hour and 25 minutes, and that's a long time. Were you going to say something? Sorry.
MS. MONGAN: No, just to say that we're okay.
CHAIRPERSON: I mean how -- two more questions. How long do you think they're going to take you? 11:17
MS. BERGIN: Yes. I think perhaps we'll take a break. It's difficult to say, Chair.
CHAIRPERSON: All right. No. We're intervening quite a lot. All right. Thank you very much. 15 minutes. 11:17

A SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:32

MS. BERGIN: So picking up at paragraph 4.12, please. Here you say that a review of Adult Learning Disability Community Services carried out by RQIA in 2016 found no agreed uniformed model for behaviour support services 11:33 across the five Trusts, and that was also the case at the time of your review some years later in 2022. Is the lack of a model of this type, is that an issue before the Department of Health or for individual Trusts? 11:33
MS. MONGAN: I would regard that as an issue for both in regards to what is commissioned and then the response would be for the Trusts. In a small place like Northern Ireland, you need transferability of

staff, and actually those individuals who need to be placed in a number of services, or receive service from a number of services, it needs to be uniform in approach to ensure continuity for the individual user themselves. 11:34

MR. SUTHERLAND: And I think it links to our earlier comment about there not being an agreed single pathway for resettlement. I suppose what we know is that clinical and care variation tends to lead to poorer outcomes for individuals in a whole range of settings, 11:34 and particularly given our size in Northern Ireland, a population of 1.8 million, but particularly for this very identifiable population it just would seem more sensible to have more standardisation in terms of pathways and approaches. 11:34

39 Q. If we look at paragraph 4.19, please. And in this paragraph and the following paragraph you outline that the Leadership and Governance Review findings highlight that discharge of statutory function reports, or DSF Reports: 11:35

"...provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance..." 11:35

And that there was insufficient challenge from Trust Board and HSC Board, and we've touched on these issues already.

Do those DSF reports provide adult safeguarding and resettlement reporting within them?

MS. MONGAN: They would do, and should do, but it is our understanding that they were not robust enough. We also, in discussion with the SPPG during the period of our review, understood that they were reviewing their approach to what was the delegated statutory functions process, to strengthen that. If I look back to the comment I made previously, which is the review of Trust Board minutes, and with particular reference to the Executive Director of social work's in Belfast report to the Trust Board on the discharge of statutory functions, that actually did include the issue of resettlement. But, again, it inferred that there were -- there was an expectation of 15 resettlement plans and, again, it was the lack of robustness in those reports that we were concerned about. 11:35 11:36 11:36

40 Q. And do you know if --

DR. MAXWELL: Sorry, can I just ask? So we've heard about DSF reports before, and it appears as a pro forma that's produced regionally that gets populated. So I suppose one question is; did the other Trusts manage to populate it in a way that wasn't largely repetitive and that did provide assurances? So is this a problem with the pro forma or is it a problem with the way Belfast Trust completed it? 11:36 11:37

MS. MONGAN: We looked specifically at the DSF through the lens of what was presented to the Belfast Trust Board. So that was the one that we could actually make

comment on in terms of the robustness of that. It is our view that the approach from the Belfast Trust is not significantly different from all of the other Trusts and, therefore, the SPPG were intending to revise and review the delegated statutory function -- 11:37

DR. MAXWELL: So the vehicle is wrong?

MS. MONGAN: Yes, I think right through all of the Trusts. And the Delegated Statutory Functions Reports cover such a breadth of services, we're talking about all services delivered by the Trusts, apart from acute 11:37 hospital care and, therefore, the level of detail in providing the assurance was the issue. But in regards to resettlement, if the report was indicating the intention to resettle a number of individuals and due diligence hadn't been done to ensure that that number 11:38 would actually be resettled or had been resettled.

DR. MAXWELL: So coming back to the DSF report. It's a pro forma that gets populated. Does it have a section on resettlement?

MR. SUTHERLAND: No, but it would have a section on 11:38 learning disability and it would be an expectation that that would include an update on resettlement progress for your Trust's population.

DR. MAXWELL: Okay. So there was a space where you might reasonably expect a particular -- particularly at 11:38 the point that you were looking when Muckamore was so high profile.

MR. SUTHERLAND: Yes.

DR. MAXWELL: And yet did it not contain any reference

to resettlement?
MS. MONGAN: Looking at what was highlighted, all of the Trusts were highlighting the lack of community infrastructure and the lack of accommodations that were currently available, and I think that was the lens or 11:39
the focus on their reporting.
DR. MAXWELL: So the Belfast Trust DSF were saying 'here are the barriers to resettlement', not 'these are the numbers that we have resettled, or these are the delayed'? 11:39
MS. MONGAN: Well, looking at the minute of the Trust Board, it looked as if they were really focusing on the numbers rather than --
DR. MAXWELL: Oh, so you didn't look at the report? You looked at the minutes? 11:39
MS. MONGAN: We looked at the minutes. We didn't actually look in detail at the reports. Because again we were just trying to get an understanding of what the Belfast Trust was relying on at Board level and what the scrutiny might be. We both would have experience 11:39
of the delegated statutory function process.
DR. MAXWELL: I was thinking that.
MS. MONGAN: In our previous roles, and there is genuinely a breadth of services that have to be covered, but issues in regards to safeguarding, 11:40
resettlement -- it is also an opportunity for Trusts to highlight gaps to the Health and Social Care Board, as much as being accounted for or being accountable for the delivery of statutory functions.

MR. SUTHERLAND: And we should maybe add that it's also used as a vehicle for holding to account by the Director of Children's and Social Care at the Board, as was, with the executive directors of social work within the Trusts, and there are -- there is a review meeting upon submission of the report, and then there's a mid year review about progress against that. But that covers everything, all aspects, children's services, everything. 11:40

DR. MAXWELL: So the fact that they were repetitive and not really helpful, this goes again to the HSCB not performance managing, just receiving -- 11:40

MR. SUTHERLAND: Yes, it's part of the overarching performance management structure really.

DR. MAXWELL: Or lack off. 11:41

MR. SUTHERLAND: Or lack off, yes.

41 Q. MS. BERGIN: If we could look at Section 5 of the report, please? This section deals with leadership and governance, and here you consider how leaders in Northern Ireland engaged with the issue of resettlement. And at 5.2.5, we're looking at the heading "Strategic Leadership & Governance". Now, after the 2017 allegations of abuse at Muckamore, in 2018 there was then an Independent Serious Adverse Incident (SAI) Review of safeguarding practices at Muckamore between 2012 and 2017. And at 5.2.5, you say that: 11:41 11:41

"In the context of the significant concerns about

Muckamore, the Department of Health established a Muckamore Departmental Assurance Group (MDAG) to monitor the effectiveness of the health and social care system's actions in response to that SAI review..."

11:42

- and the Permanent Secretary's subsequent commitment on resettlement that we've already referred to in December 2018. And you say that there was a comprehensive action plan for the group and a robust mechanism for holding the system to account, but ultimately after three years of MDAG, all of the actions relating to resettlement continued to be rated as red. And you say there was an inertia of slow or negligible progress. So despite a well articulated call to action, there was an absolute lack of urgency and focus in the delivery of resettlement. So does that not indicate that despite being well-intended, MDAG was ineffective in providing governance?

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11:42

MR. SUTHERLAND: Yes, I mean I think MDAG was looking at everything relating to Muckamore Abbey Hospital, and I think it's similar to points we've made in other places. I think the focus very much was on concern about the risk to patients, safety, staffing, that was absolutely what we observed the majority of the focus and attention of the meetings we met and our review of the action plans seemed to be, and it was almost as if resettlement had become less focused on, and that was why we felt we needed to highlight that. Despite them being red ragged as actions, we weren't seeing those

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11:43

being progressed, or even mitigations being put in place to suggest 'We're concerned about this because it's red. We really now need to take more escalated action in relation to this.'

DR. MAXWELL: But the fact that resettlement was on the action plan, and was rated red, suggests they thought it came in their remit. 11:43

MR. SUTHERLAND: Yes.

DR. MAXWELL: And it was Chaired by the chief social worker and the chief nursing officer. 11:44

MR. SUTHERLAND: Yes. The Chief Social Services Officer was also I think the Deputy Permanent Secretary at the time. But it was co-chaired by the chief social worker and the chief nurse, yes.

DR. MAXWELL: So is it not a bit surprising that the chief social worker had taken his eye off the ball? 11:44

MR. SUTHERLAND: Certainly it's disappointing that there hadn't been a sort of level of scrutiny that had driven forward progress in that area, yes.

MS. MONGAN: It's my understanding that the MDAG also relied on the work of the Regional Learning Disability Operational Group, (RLDOG) to look in detail and then report to the MDAG. So there were a number of groups within the SPPG, including that Regional Learning Regional Disability Operational Group, and then a supporting group called the Community Integration Programme that were frequently meeting with the Trusts to review the progress in place. Ian and I, at the time that we were appointed, were appointed in 11:44 11:45

recognition by the Department of Health, and also the SPPG, that the process was not progressing at a pace that they would have expected, and it was with a view to better understanding what might expedite that in a more effective way. What we did find is those two groups, there was a degree of overlap between the two groups that were within the SPPG, one looking at broader remit than just resettlement, but the other one looking specifically at resettlement, and that's what we gave our attention to in regards to strengthening some of the approaches in those two processes. 11:45 11:45

42 Q. At paragraph 5.2.6 then, you say the HSCB held responsibility for ensuring that individual Trusts were held to account in relation to the delivery of those DSFs, and in relation to the resettlement programme: 11:46

"The actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management."

11:46

Did you see any evidence of the HSCB holding Trusts to account in relation to resettlement targets?

MR. SUTHERLAND: Yes. So I mean we've already referenced the relationship in terms of DSF review meetings, although we didn't attend any of those as part of this process. The main way we saw it was through the Regional Learning Disability Operational Group, which was a senior officer from the Board, meeting with those senior operational leaders in 11:46

Trusts.

I mean what we meant by the performance monitoring rather than performance management piece was, there was a sense that they received data but didn't really do the analytical piece to look at what's the data telling us in terms of performance? So there was a broad acceptance of what the data was received, but there wasn't that sort of scrutiny and challenge, or even helping the Trusts to find solutions to get over whatever barriers were being presented really. 11:47 11:47

43 Q. In addition to this lack of challenge, if I can put it in those terms, by the HSCB, you've referred elsewhere, and we've previously mentioned it, the lack of scrutiny or challenge by the Trust Board. Taking both of those, I suppose lacks of challenge in two respects, what effect do you think overall those had on the resettlement progress? 11:47

MR. SUTHERLAND: I think it certainly contributed to the drift in delay. I mean we felt there was an absence of both managerial grip, particularly around Belfast Trust in terms of having a robust plan that they were driving forward, and I suppose our criticism in terms of the Trust Board was that they should have had the inquisitiveness to delve beyond the assurance that they were being offered, to seek some level of evidence that gave them a confidence that what they were being offered by way of assurance, we've said more reassurance, that there was a robust evidence base to 11:48 11:48

support that.
DR. MAXWELL: In relation to the Belfast Trust are you talking about non-execs primarily?
MR. SUTHERLAND: Yes. Yes.
CHAIRPERSON: Just if you could help us between reassurance and assurance, it's a phrase I've come across often, but the general public may not know it very well? 11:49
MR. SUTHERLAND: Yes. I suppose what we mean by that is that reassurance is for -- we're telling you this is all going to be fine, it's going to -- we believe that we have something happening. Assurance would be that you're giving concrete evidence to support that. So "I know that Ian is going to be resettled to a home in Armagh", I know that because we've seen the plan, we know the address, we've been given a date. And I suppose that's the differentiation that we're trying to draw. 11:49 11:49
CHAIRPERSON: Thank you.
44 Q. MS. BERGIN: At paragraph 5.2.11, then you say here that there had been real vigour within the Belfast Trust to address the issues that emerged following the institutional abuse becoming clear at Muckamore, but the importance of getting the hospital back to a safe position diverted attention from consistent progress in relation to resettlement, and we've touched on that already in your evidence. So is it right that the very fact that the Trust were dealing with this abuse scandal led to patients remaining in Muckamore for 11:49 11:50

longer?
MR. SUTHERLAND: That's our view, yes.
45 Q. And those patients were generally then, and we've heard about staff shortages, being cared for by non-learning disability staff? 11:50
MR. SUTHERLAND: Yes. We visited the wards in Muckamore on one occasion, and we certainly met the Ward Managers who were responsible for some of the wards. Those were learning disability qualified nurses, but certainly they were explaining that they 11:50 were concerned about the skill mix, particularly with the high reliance on agency staffing, not -- I may it may have been not any of whom had learning disability qualifications, I think they may have had mental health nursing qualifications, so we certainly did see that. 11:51 But certainly some of the Muckamore Abbey staff, if you like the main core, were learning disability nurses, many of whom had trained in Northern Ireland.
DR. MAXWELL: That's not quite the evidence we've heard about this time period from others. 11:51
MR. SUTHERLAND: Okay.
DR. MAXWELL: And they say that actually they were down to one LD nurse per shift.
MR. SUTHERLAND: Well, we visited -- all I can say is we visited the ward in the middle of the day. We met 11:51 two Ward Managers, both of whom were I think learning disability qualified nurses, and had been longstanding members of staff within Muckamore.
MS. MONGAN: We didn't, as it was viewed, actually

analysing, you know, the staffing per se. One additional issue that I think is significant is the inattention given to the level of skills development that would be required for patients to make the transition after a long time in Muckamore to living effectively in the community. So we did hear that Covid, the pandemic, did reduce the opportunities that we understand were previously there, but we didn't see -- so there were three aspects; running a safe ward, trying to get the resettlement home, but the bit in the middle would be what are you actually doing to support the individual patient themselves to develop the type of skills and orientation to make that a successful transition -- 11:52 11:52

DR. MAXWELL: So this is patient skills. Activities of daily living -- 11:52

MS. MONGAN: Patient skills. All of that. The opportunities to leave the hospital, to sample all of those were not as robust as required.

DR. MAXWELL: Because we've certainly heard that the staffing crisis meant they couldn't provide the day services where a lot of those vocational skills and activities of daily living were happening. 11:52

MS. MONGAN: Correct.

MR. SUTHERLAND: And we felt that probably contributed to this mismatch between assessment of an individual while living in the hospital and assessment of their potential to live in the next home, because the patients were rarely given the opportunity to engage in 11:53

the sorts of activities that were going to be available to them in the new setting.

CHAIRPERSON: And that will be affected by whether you've got LD trained staff?

MR. SUTHERLAND: Yes. 11:53

CHAIRPERSON: Looking after them.

MR. SUTHERLAND: Yes.

MS. MONGAN: Yes.

46 Q. MS. BERGIN: At paragraph 5.2.12, you say that given the high profile concerns about the safety of 11:53 Muckamore, and the linked urgency to find alternative homes for remaining patients as soon as possible, you were concerned that not all Trusts had included resettlement of people with learning disabilities on their Corporate Risk Registers, although in some cases 11:54 they were on the Directorate Risk Registers. Can you recall from your review which Trusts didn't have them on the Risk Register?

MS. MONGAN: Belfast and Northern did have it on the Corporate Risk Register, the other three didn't. But 11:54 that might have been a reflection of the mitigations those Trusts were taking to reduce their populations. So the two Trusts with the largest number of patients still to resettle, did have this on the Corporate Risk Register. The other three Trusts had placed it on the 11:54 Directorate Risk Register. Our view on that was, as long as there was one patient who actually was calling a hospital a home, that was an urgency that probably did require oversight on the Corporate Risk Register.

47 Q. At paragraph 5.4.1, and we're looking at the heading 5.4, which is "Leadership Engagement with People who Use Services and their Carers", and you describe the engagement that you had with the Chief Executive, and the Patient Client Council, and one of the outcomes of that was that the PCC advised that families talked about the invisibility of learning disability and expressed anger and a lack of Trust in health and social care systems. 11:55

And at 5.4.3 you say that the families that you engaged with in the three Trusts we've referred to, reported feeling that learning disability was invisible at government and policy level, and those families -- and you've referenced this already -- reported fatigue and emotional toll in terms of caring for their loved ones and battling for resources over the years. 11:55

Did you feel that the expressions of anger and fatigue that you were made aware of, and the sense that learning disability was invisible to government, was justified? 11:56

MS. MONGAN: I guess largely, yes. And one of the points that the families were making is that Bamford brought forward both mental health and learning disability, obviously with a view to different or even similar services, but the families were reflecting that a mental health strategy had been developed, a mental health champion, and that gave them a sense that 11:56

learning disability had not had the same degree of focus that it would have had previously from a government policy perspective.

48 Q. If we can go to Section 6, please? And in this section Strategic Commissioning, Planning and Inter-Agency Working. You consider the models and approaches to commissioning of facilities and resources for patients being resettled into the community. 11:56

Now under paragraph 6.1.2, which deals with the prevalence of learning disability, you say that: 11:57

"The University of Ulster and others undertook data analysis of existing data relating to learning disability in Northern Ireland between 2007 and 2011." 11:57

And one of the key findings was that within the overall census population, the overall prevalence of learning disability ranged from 1.9% in the Northern Trust, to 2.5% in the Belfast Trust. Does that mean that the Belfast Trust has a larger proportion of people with learning disabilities in its catchment area? 11:57

MR. SUTHERLAND: I think it may do, but I'm not sure that it would be so significantly larger to mean that there was such an increased pressure in terms of demand that it would be significantly different from the other Trusts. 11:58

49 Q. And do you know at all if that was broken down by, I suppose need, in terms of severe needs versus less

complex needs?

MR. SUTHERLAND: No, sorry, I don't know that.

50 Q. If we look at 6.4.4, please, and this section of your report deals with the commissioning of health and social care services, and you say that: 11:58

"Until April 2022, the responsibility for commissioning health and social care services sat with the HSCB and the Public Health Agency who set key priorities within a commissioning plan." 11:58

And that commissioning plan was in response to a Commissioning Plan Direction from the Department of Health. And you looked in your review at the 2019/2020 Commissioning Plan, which identified some actions 11:59 arising out of the allegations of abuse at Muckamore.

Now in this paragraph you state that:

"In terms of financial resources made available to 11:59 Trusts and other providers to meet the needs of those with learning disabilities and their families, this amounted to 6.58% of the total allocation for health and social care in Northern Ireland."

11:59

And that's approximately 342 million. And Ms. Mongan, you've previously, in your evidence, said that some of the resettlement progress that you were aware of as being positive had -- previously had largely been due

to funding being ring-fenced. Now in terms of this 342 million, do you know if there was any calculation of the spending per head for the various groups between mental health versus learning disability?

DR. MAXWELL: I think you're saying this is for learning disability, aren't you? 12:00

MS. MONGAN: It is, yeah.

MR. SUTHERLAND: Yeah. Yeah.

MS. MONGAN: This relates to the funding allocated to learning disability only, rather than learning disability and mental health. 12:00

MS. BERGIN: Okay. Thank you. And in terms of breakdown of that budget, is that something that you had more detail on, or was it just those global figures? 12:00

MR. SUTHERLAND: No, it was the global figure that we looked at.

MS. BERGIN: Okay.

DR. MAXWELL: Can I ask how it's allocated? So there's the Framework Agreement between the Executive and HSCB, is it -- or the Department of Health and HSCB? 12:00

MR. SUTHERLAND: Yes.

DR. MAXWELL: Is it entirely discretionary how they interpret the funding to meet the framework?

MR. SUTHERLAND: I'm not sure I understand the question. 12:01

DR. MAXWELL: So there's an allocation.

MR. SUTHERLAND: Yes.

DR. MAXWELL: That comes from the Executive to the

Department of Health.
MR. SUTHERLAND: Yes.
DR. MAXWELL: And then the Department of Health has a Framework Agreement about what this money has to be spent on, which is at broad principle level. When the Department of Health, and through the HSCB at the time there was an HSCB, when they decide how much money they're going to allocate, is that entirely at their discretion? 12:01
MR. SUTHERLAND: Thank you for clarifying. Sorry, I understand what you mean now. No, there would be notional allocations in terms of 'This is the proportion we would expect you to spend on hospital services. This is the proportion we would expect you to spend on community services', and then there might be further delineation. So 'This is what you're spending on statutory community learning disability services. This is what you're spending on care packages within the community.' So there would be a delineation in that way. 12:01
DR. MAXWELL: And do you know if there was a notional sum for resettlement or was that somewhere between hospital and community services?
MR. SUTHERLAND: We found it difficult to get detail on financial data in relation to that, but no-one gave us a dedicated budget for the region that could be identified solely for resettlement. 12:02
DR. MAXWELL: Yes. So from your endeavours you couldn't see a ring-fenced notional budget to support

resettlement?
MR. SUTHERLAND: No, no. And part of the reason -- and I mean we did this cautiously. So we referred to policy and commissioning frameworks in other parts of the UK. Having worked in both places, I'm always 12:02
cautious about saying 'This is how England do it', I promise you.
DR. MAXWELL: Well go and say it anyhow.
MR. SUTHERLAND: But what we were trying to say was there are other models, you could consider them. There 12:02
seemed to be common elements of those models that work, and one of those elements is a dedicated funding source to support resettlement activity. Now, that said, that hasn't always been the silver bullet that has meant resettlement has completely been successful in those 12:03
other areas, but it does seem to have driven more progress, along with clarity around commissioning and pathway agreement across the national frameworks.
DR. MAXWELL: So you wouldn't be able to say what the deficit in the money spent on resettlement is with best 12:03
practice?
MR. SUTHERLAND: No.
DR. MAXWELL: Because you don't know what was spent?
MR. SUTHERLAND: No, we don't.
CHAIRPERSON: Can I just understand what is meant by 12:03
the "budget for resettlement", because it seems to be there may be lots of aspects to it. One is the move itself and all the planning for that, and potentially bridging so that you retain a place at the hospital and

then you have your resettlement. And then of course you have your resettlement going forward, which may last years. So when we talk about the budget for resettlement, are we looking at the annual envelope for all of that? 12:04

MR. SUTHERLAND: Yes, and we comment in the report that the mechanism -- so there were resources that would be available, if you like, to create the infrastructure for resettlement. So that would include, for instance, funding from the Housing Executive for capital 12:04 development of properties, but it also included the dedicated resettlement team within Muckamore Abbey Hospital, which we've commented on within the report. But in addition to that, certainly at the point where we were looking at the resettlement, Trusts were 12:04 required to submit an individualised business case for each individual undergoing the resettlement process, and that would have to have demonstrated that there was both the capital and a revenue care stream to fund that individual's care for what would seem to be a 12:05 reasonable future forecasting around that care.

CHAIRPERSON: Right. Thank you.

DR. MAXWELL: And who was the business case submitted to?

MR. SUTHERLAND: The Health and Social Care Board. 12:05

DR. MAXWELL: So the costs -- so when you would come up with a robust plan, finally, was that being funded direct from HSCB and not out of the general revenue budget of the Trust?

MR. SUTHERLAND: Yes. Yes, that's right.
DR. MAXWELL: Sort of separate --
MR. SUTHERLAND: It was dedicated funding from the Board for that individual. Although an element of that might have been Supporting People funds from the Housing Executive for capital development.
DR. MAXWELL: Yes, and the ongoing support of the current community infrastructure.
A. Yes.
DR. MAXWELL: But there was a dedicated funding stream through HSCB that was quite separate from Belfast Trust's existing budget?
MS. MONGAN: Yes.
MR. SUTHERLAND: Yes. I mean, sorry if I may just add? I mean what we've commented on was our previous experience of resettlement in other areas was that often there would have then been a decommissioning plan.
DR. MAXWELL: Yes.
MR. SUTHERLAND: To decommission the hospital service that was no longer required because you had resettled somebody, and we didn't see -- at this time, we didn't see a decommissioning plan in relation to Muckamore, and I think that then allowed further admissions to Muckamore, because you weren't closing a ward or closing beds.
DR. MAXWELL: I think we're coming to this later.
MR. SUTHERLAND: Oh, sorry.
CHAIRPERSON: Yes.

DR. MAXWELL: But we have heard a lot about the problems about the fact they were trying to decommission it, which was creating pressures certainly on the ward staffing, but I think we're coming to that later. 12:06

MR. SUTHERLAND: Sorry. Okay.

51 Q. MS. BERGIN: At paragraph 6.4.6, just a very net point here. You refer to an independent review of MAH. So:

"Effective arrangements should be in place to address deficits in assessment and treatment in learning disability inpatient units as highlighted by the Independent Review of MAH." 12:07

Which Independent Review is that referring to, that paragraph? 12:07

MR. SUTHERLAND: That's a good question and I'm not sure we can recall.

52 Q. It's perhaps something we can follow up on, if necessary. 12:07

MR. SUTHERLAND: Yes. We'll go back.

53 Q. If we look at paragraph 6.6.12, please? And we've touched on the issue of existing provision in the community versus new builds, and here you say that: 12:07

"...all of the Trusts had engaged with some of the well known-providers in the not-for-profit sector..."

- which had resulted in a small number of

resettlements. But generally you found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for provision within existing or re-designed provision. If this had been possible, then options for resettlement could have been developed in a much more speedy way. So are you saying really there that there were missed opportunities to speed up resettlement for Muckamore? 12:08

MS. MONGAN: Our view is that previously all options would have been considered, including new build, along with reconfiguration of current services. And also looking at any vacancies to see how they could be redesigned to meet the needs of the remaining population. We feel that there has been, for whatever reason, a tendency over the more recent past to focus on new build. What we heard was that was a reflection of designing into the system the specification that could be required for more complex individuals, but notwithstanding that, we were able to see existing service in the community that gave evidence to the fact that people with complex needs were already being accommodated. So we felt that Trusts were putting all of their eggs into one basket in regards to the new build process, but actually that inbuilt a very significant delay factor, given the time frame to realise a new build. 12:08 12:08 12:09 12:09

So our criticism was that insufficient consideration had been given to considering other options, including

actually sitting down with other providers to see, many of whom were running their own business, to see whether they had an appetite in many respects to further develop their service in order to meet. So it was -- actually, if you want to put it in a very simple way, you need to put your imagination hat on, you need to really be considering all options, but we just saw, for whatever reason, a tendency for the system to be putting their focus on just one methodology to create accommodation. 12:09 12:10

PROFESSOR MURPHY: Did you think that was partly because they were trying to avoid overusing the nursing homes, which, you know, are a more old-fashioned kind of community provision, and you said earlier on there were vacancies in those? Was it that they thought 'Oh, well we shouldn't go there, we should be doing something a bit more like what Bamford had proposed', i.e. small homes of five and less? 12:10

MR. SUTHERLAND: Yes, I think that's a fair point. And I think the other thing we should say is, there needs to be a bit of realism around this. I think we had identified there was 5% vacancy rate within the totality of the Supporting People Specialist Supported House Provision. It would have been extremely unlikely that anyone in Muckamore could have moved immediately into one of those vacancies. Similarly, we knew that there were, particularly in the Northern Trust areas, learning disability nursing, registered nursing homes, that had vacancies. Again, we didn't think there was 12:10 12:10

anybody from Muckamore who was likely to be able to move directly. Our point was, however, there wasn't engagement with those providers to say what could we do with you to create that opportunity or potential?

12:11

I think the other thing we should say is of course family expectations sometimes meant that families may be indicating, as part of a resettlement planning process, 'We don't want to use existing provision. We thought the aspiration was brand new', if you like platinum standard. And I think that's fair, that's a fair aspiration. So there were a range of factors. But what we were disappointed by, there wasn't really that sort of partnership and engagement with the sector to say, if we want these people to have new homes quickly, how could we make that happen? And we were seeing that in terms of -- because obviously we were focusing on the resettlement population, but there's a population of people being identified within the community, particularly younger adults who are needing very specialist provision, and we were seeing the sector responding to that need actually quickly, and planning ahead for that, but it almost felt like the Muckamore population had got left behind in all of that.

12:11 12:11 12:12 12:12

PROFESSOR MURPHY: Thank you.

54 Q. MS. BERGIN: Just to pick up on, Ms. Mongan, what you said in relation to, I suppose, the imagination and working towards different solutions for resettlement.

There are examples within your report I think of patients who had successfully been brought home by relatives, I think one example was a Belfast Trust patient during Covid, and they had remained with their family with support. Do you know if that model of 12:12
patients being, I suppose returning to their families at home, is something that featured in these considerations on a broader scale?

MS. MONGAN: Our concern was that the families had elected to make that step, and the Trust de facto, had 12:13
to create a wraparound support for that individual to be supported at home. Our concern was there was no evaluation. There was no attempt to actually say 'well, actually, what made that work?', and some of those placements had sustained right through the Covid 12:13
period and right through the period of time throughout the review. So it was more a missed opportunity to do the evaluation on which you could build further models of support in that way, and I think there were three cases from recall in that, and one in the South Eastern 12:13
as well as one in the Belfast Trust.

55 Q. If we could just pick up on the Panel questions in relation to the resources available in the community, one of those being nursing homes, and if we could look at 6.7.8, please? And this section of your report 12:14
looks at that market for resettlement provision, and there's a table at the bottom of the page. Yes, thank you. The first column of this table appears to show nursing home provision and it shows 606 places at that

time, compared to much smaller numbers in terms of other provision in the community, supported living or residential care. Is that figure of 606 nursing home places, is that disproportionate compared to other parts of the UK in terms of the balance between different types of provision available in the community, do you know? 12:14

MR. SUTHERLAND: We didn't analyse that thoroughly, but I think in terms of my experience elsewhere, I think it would probably be. I think we saw more -- we thought there was probably more nursing home provision here in the mixed economy than probably in other parts. I think, particularly my experience of working in England was, I think there was more of a predominance within the social care provision generally. I think the other thing we should maybe say about this was, it felt like nobody had planned that proportion of nursing home provision, residential care provision, and supported living provision. It had very much grown historically through a whole range of factors. But also what we didn't really see was an analysis of the population of people with learning disability in Northern Ireland, and a thought of 'well, actually, we have too much of this, and too little of this, and we should be now trying to shift our commissioning in a way that shapes the market more towards the population need.' 12:15 12:15 12:15

DR. MAXWELL: Although from this table the vast majority of people are in supported living, 1,420.

MR. SUTHERLAND: Yes. Yes. Absolutely. And I think

the other thing that maybe the table doesn't fully explain was, there's a bit of a tendency to assume that the people with most complex need would always be in nursing home provision, but that actually wasn't the case. Some of the people with very complex needs were in supported living accommodation. Of course there'll be some people with a learning disability who have complex physical needs, and often those people were within nursing home provision. 12:16

DR. MAXWELL: Yeah, I was going to say, so these nursing homes will not all be exclusively learning disability? 12:16

MR. SUTHERLAND: I think these were.

DR. MAXWELL: These are exclusively?

MR. SUTHERLAND: Yes, they are. I mean one thing we didn't -- we weren't really able to look at was, there will also be a proportion of people with learning disability in non-learning disability residential care and nursing homes. It was too difficult for us in the time frame, and with the resources we had, to be able to quantify that. But, again, from our experience, we would know that -- and especially where a factor for a family is, 'what's most important to me is local. I want my relative to be near me', rather than 'I feel I need very specialist provision.' 12:16 12:17

MS. MONGAN: But I think the point here is just the actual robustness of population needs assessment certainly was an area that we thought needed to be strengthened. We were reassured by the level of detail

the Housing Executive were able to give us in regards to the schemes that they were budgeting for. We asked all of the Health and Social Care Trust to provide detail with regard to the number of individuals in the variety. It was not a robust response. So, again, just actually being able to at any given stage say how many people we have in whatever facility, and for what reason, we would feel should be something that Trusts should be able to do. But that was -- so assessment needed both individual case level, but more particularly at population level is something that certainly we thought should be strengthened. 12:17 12:18

DR. MAXWELL: Did you consider direct payments? We heard some powerful testimony from families, right at the beginning of our hearings, who were able to bring people home from Muckamore once they discovered direct payments. But then we haven't heard very much about it since? 12:18

MR. SUTHERLAND: No, we didn't. We didn't. And, equally, no-one was saying too us we see that as a strong vehicle for supporting resettlement for this group of individuals. That said, I think what we were seeing was use of -- again, back to that younger population in the community. Certainly when we went out to talk to some providers, you were hearing people trying to be more innovative in terms of how they would put together support packages. 12:18 12:18

DR. MAXWELL: So that's potentially a missed opportunity for resettlement for people from Muckamore?

MR. SUTHERLAND: Yes, I think it could potentially be. Yes.
MS. MONGAN: Yes. And an area that perhaps needs to be given further consideration of whether it is actually direct payment, but that's self-direction, that's self-directed support, and giving the user, and more particularly their loved ones and family, an enhanced voice in the determination of the suitable accommodation, I think that is the area that should and could be strengthened. 12:19
DR. MAXWELL: I think we heard evidence that family had used it to pay a sibling to assist with care.
MR. SUTHERLAND: Yes. Yes.
MS. MONGAN: Yes.
CHAIRPERSON: But does that get harder, the core element, as it were, of people who were remaining in Muckamore, because they haven't been resettled, may, I suppose, have more difficulties and behavioural difficulties, does that therefore mean that a home settlement is going to become harder, or is your experience that you can still do it? 12:20
MR. SUTHERLAND: I mean I think it would be, undoubtedly. I think the other thing about direct payment is, you need someone who is willing to manage that process. Receive the payment, employ staff, or pay a family member. And there's a degree of administration required around all of that. Certainly from the families we met, we didn't get a sense that they would have an appetite for that. 12:20

But if I may comment on the other point? I mean the other thing that surprised was obviously some of these individuals in Muckamore had lived there a very long time and were now elderly, so the reasons why they were admitted to the hospital, and the need that presented at that point, was probably not the profile of need that they now had, because like all of us as we get older, other things become more prominent in terms of what we need in terms of care and support. So actually one of the things we felt was sometimes for some of those older patients, there wasn't really that acknowledgment that actually perhaps now your needs could be met within a care setting where other older people who don't have a learning disability are living, and we didn't really -- again, we didn't really see much creativity around that. 12:20 12:20 12:21

CHAIRPERSON: Thank you.

56 Q. MS. BERGIN: If we could go to Section 7 then, please? In this section of your report you look at individualised care planning, and you review and assess the effectiveness of this in terms of the arrangements at each of the five Trusts. Now, paragraph 7.1.30. 7.1.30. Thank you. And in respect of the five Trusts discharge planning, what you say is that: 12:21 12:22

"The focus has moved to new build..."

- and we've discussed this "bespoke schemes", and you

outline some of the difficulties with those, and you refer to the Belfast Trust having three capital schemes in the pipeline. Minnowburn, which was a Belfast Trust only scheme for five patients, and you refer to on-site and forensic schemes to accommodate patients from all three Health Trusts.

And then at 7.3.1, you stayed that you were concerned that robust needs assessments had not been completed for patients identified for the on-site and forensic schemes, resulting in a lack of clarity about the appropriate service model and whether registration of the on-site scheme should be for a nursing home or residential facility. Can you tell us a bit more about the on-site and forensic services that you're referring to here?

MS. MONGAN: Yes. There are smaller numbers of individuals who have been identified with forensic histories. Those may be individuals with adjudicated histories or those that have been admitted but not processed through the criminal justice system, whose behaviours are thought to have been such. The on-site really reflected those individuals who may have aged into, you know, they may have been at Muckamore for some considerable period of time, the determination would be made that to try them again in the community could cause further harm and, therefore, a solution was to be considered for a social care model on-site. In the period of the year that we were completing this

review, I think the original numbers of proposed on-site was for 10 individuals. That seemed to have been as a result of three Trusts re-looking at their population, reduced to four. But we didn't see any real granularity in terms of, well, what is this on-site model going to look like? What are the registration regulations that are going to govern all of this? So, it was always there was a lack of clarity in regards to what that was to deliver. 12:24

Similarly for the forensic scheme. It was our view that individuals had labels, and that might be appropriate to raise a flag or to give some consideration, but it should not have prevented those individuals from having individualised assessments of needs with an appropriate risk assessment that may have determined those individuals having a range of options, and not necessarily just all of them requiring to rely on just one commissioned scheme. 12:24

So, again, it goes back to the point we made previously that it was, in a sense, one type of care that was being considered rather than actually concurrently looking at a range that might be considered in order to get the best one to meet the needs of those individuals. But underpinning that, I think there just was a lack of robust needs assessment to actually then feed up into the overarching plan to deliver a scheme. That was the point that... 12:25

57 Q. In terms of any detail that you might have been aware of the on-site and forensic planning. You've said "on-site", Muckamore I presume you're referring to? Do you know if any of that contemplated anywhere other than Muckamore, or was that all focused on the Muckamore site?

MS. MONGAN: No, the on-site clearly was within the Muckamore site. The forensic schemes, from recall the Belfast Trust was looking at a range of considerations, and they had identified sites in other areas in Northern Ireland, including in other Trust areas. But, again, those were just again in the scoping stages. We didn't see evidence of anything being identified that that would have resulted in the beginnings of an actual process that would have resulted in commissioning. And we just didn't see demonstrated the urgency or the push towards -- we did see drift in regards to both proposals. There was a Muckamore group that was established to monitor the on-site. One of our proposals was they should have been considering both rather than just the one, if that answers your question?

PROFESSOR MURPHY: What sort of numbers were they considering for forensic schemes?

MS. MONGAN: It probably is in the report somewhere, but they were reasonably small numbers for each of the Trusts, probably about two per Trusts, that's the type of numbers from recall. So you're talking about a reasonably small proportion, but nonetheless a

significant number of individuals. And those particular individuals seemed to -- there were significant issues and barriers in regards to progressing plans for those particular individuals.

MR. SUTHERLAND: And I think -- 12:27

PROFESSOR MURPHY: They were thinking of them as long-term settings, were they? They weren't thinking of them as short-term assessment and treatment type services?

MR. SUTHERLAND: Yes. No. They were looking at them as either sort of low secure long-term provision. And I think the other thing that we felt was a bit of a confusion around the discussions around the forensic, proposed forensic unit was, it was unclear whether it was solely for the population they had identified within Muckamore who could be considered to have a forensic history, or whether that included some future planning for community demand in terms of forensic beds. And that, that was a point of confusion in terms of that. And we did press them on 'But surely you need to have absolute clarity about who are you trying to, whose needs are you trying to meet within this?' But it certainly felt like their thinking was 'We want it to be for more than just those people within Muckamore Abbey.' 12:27 12:27 12:28 12:28

CHAIRPERSON: I think you look at this in more detail at paragraph 7.1.38. If you could just? That should come up on the screen for you.

MR. SUTHERLAND: Oh, yes.

CHAIRPERSON: So when you refer -- sorry -- to:

"Discharge plans in development for 4 patients appear to be realistic..."

12:28

Are those forensic patients you're referring to there?

MR. SUTHERLAND: No. I don't think they were specifically the forensic patients. I think they were not within the forensic cohort within the total population.

12:29

CHAIRPERSON: Oh, I see. Okay. Thank you.

58 Q. MS. BERGIN: If we could look at Section 8 then, please? This section of your report looks at operational delivery of care and support, and you also look at the experience of people who have been resettled and their families.

12:29

Paragraph 8.4.2 of your report states that one area of concern that you had was that region didn't appear to have developed a regionally agreed resettlement transition pathway for people who were transitioning from hospital, and you asked the Belfast Trust as the lead Trust in terms of resettlement, to provide you with a resettlement pathway. There was a gap of several weeks and they then issued you with a draft resettlement pathway, which you believe was produced in consultation with other Trusts, families or providers. And you say that whilst it was good to see a willingness to develop an agreed pathway, you would

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12:30

have expected it to have previously been in place and to have gone through a co-production process.

So did you understand that this draft resettlement pathway document that you were provided with had essentially been created to meet your request to see it?

MR. SUTHERLAND: Yes.

59 Q. If we look at 8.6.1 under the subheading "Lessons Learnt and Evaluation" of resettlement. 8.6.1. Thank you. Here you say that you were disappointed that there didn't appear to have been any systemic evaluation of the experience of individuals who had been resettled both successfully and unsuccessfully. Now, the Inquiry has heard evidence and understands from Joe Marley, who is from Bryson Care, an advocacy service, that data on the evaluation of betterment was collected. Did you see any data from other organisations even in the course of your review?

MR. SUTHERLAND: No, we didn't, that I recall. But I suppose what would be surprising to us was nobody from the Board of the Trust offered us that as information. We certainly were asking questions about, you know, as we've said within the report, a significant proportion of the patients in Muckamore had had unsuccessful placements, and what we were saying was; what have learnt from these experiences? What didn't work for an individual that you could change and make different? Not just for that individual, but what do you learn

from that for others? And we weren't seeing that. So, sorry, we weren't aware of that piece.

DR. MAXWELL: Were you not aware of Fiona Rowan's work where she looked at all the serious event audits? Because every failed placement was an SAI Level 1, and she talked to us earlier this week about a review of them. Did they not share that with you? 12:32

MR. SUTHERLAND: No. Certainly I don't recall being offered that.

MS. MONGAN: And, again, it's of interest, because the Level 1s would have been progressed within each individual Trust. 12:32

DR. MAXWELL: Yes, and they done an audit.

MS. MONGAN: So the question for us actually was what is escalated up to the region to actually share the learning from those Level 1 reviews, if that had taken place, to inform others as well? 12:32

DR. MAXWELL: She told us it was shared with MDAG.

MS. MONGAN: Right.

MR. SUTHERLAND: Yes, and it may well have been. I mean we only interacted with MDAG over a relatively short time frame. 12:32

DR. MAXWELL: You didn't see it. But you weren't given a copy?

MR. SUTHERLAND: No. 12:33

MS. MONGAN: But again on reflection, I think Joe Marley and Bryson House's work was point in time, if I understand? This needs to be ongoing, you know, you need a constant reiteration of that rather than at a

point in time. So, again, it's something that we felt strongly about just needs to be...

DR. MAXWELL: Can I ask you about that? I was going to ask you. On page 44 of the report at 6.6.2 you're talking about the various structures that were set up, and I was going to say was there any consideration about the interface with other agencies, such as RQIA? In a rounded system you might have thought 'While we're setting this up we'll talk to the RQIA about how they might monitor it.' 12:33

MR. SUTHERLAND: Within the Trust leadership Group, RQIA and departmental representation joined. I'm not sure they were there all the time, but they certainly joined on occasion, and we saw that. But I'm not sure that that was, if you like, a fully strategic system-led approach to how you might plan for resettlement. 12:34

DR. MAXWELL: But potentially for something quite that important, a conversation with RQIA about 'how are you going to monitor this?', might well have been appropriate. 12:34

MR. SUTHERLAND: Oh, yes. Absolutely. Yes.

MS. BERGIN: If we look at the final section then, 12. And here, following your conclusion, which is the section above, you then set out your recommendations to the Department of Health, or for, rather, the Department of Health, the SPPG, and the Trusts. And as you've already referred to in your evidence earlier, Mr. Sutherland, in fact you've said that your 12:34

recommendations include collaboration for the Trusts, and if we scroll down we can see that under the Trusts section, for example, one of the recommendations is that:

"Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care."

Consistently throughout your report you highlight, and indeed it's been a feature of your evidence today, that there's been a failure of different Trusts to work together in planning globally for resettlement together. Did you not consider inviting the Department of Health to take action in terms of making sure this was implemented, or is that what you intended? If you look at the second SPPG recommendation, please, which says that there should be a regional oversight board established by SPPG. 12:35 12:35

MR. SUTHERLAND: Yes, it was really. I mean I don't think we felt the Department -- I think what we were trying to get at here was, there needed to be some standardisation of practice, and that that was why we wanted to see a commonly agreed pathway. 12:35

In our experience that wouldn't be something that the Department would directly deliver themselves, but they would expect the Board to be working with the Trust to ensure that that happened. And I think that was our recommendation. 12:36

In terms of the Oversight Board that we recommended, what we hoped that would do, when you asked us about the trajectory, what we wanted to see was the point of confidence that we had about the continued resettlement. We felt there should be some level of 12:36
independent oversight to ensure a continued scrutiny and challenge and support function to ensure that that trajectory was met. Sorry. And that could have included recommendations around practice measures like pathways, but also some performance management and 12:37
oversight of the system.

60 Q. MS. BERGIN: Looking then to the Trusts section of your recommendation, and here you provide various recommendations for the Trusts. Throughout your report, however, you have described the Belfast Trust 12:37
on a number of occasions as an outlier. For example, at 11.15, and we don't need to go to it, but there you're describing it as an outlier in relation to progress with resettlement options compared to the other South Eastern and Northern Trusts. 12:37

You've also strongly criticised, I think it's fair to say, the Belfast Trust throughout your report in relation to resettlement. Why then, when you have looked at the Belfast Trust in isolation throughout 12:37
your report, have you not made specific recommendations relating to the Belfast Trust as opposed to global Trust recommendations?

MR. SUTHERLAND: Yeah, that's a fair point. I think

part of our -- I think there's two things in relation to that. Part of our recommendation around the Oversight Board with to ensure that there was a continued rigour around that and, frankly, within that I think the Belfast Trust would have come under greater scrutiny than some of the others by virtue of where they were. 12:38

I think the other thing, just more generally on the point of collaboration was, what we didn't really see was as a system the Trust collaborating in a way that might have offered mutual support to the Belfast Trust. That other Trusts could have been saying, and indeed your earlier reference to the use of the East London Foundation Trust. Where was the mutual support that said 'Look, we can see Belfast Trust are, for want of a better word struggling here, so why don't we lean in to offer additional support?', and I think in an effectively managed system where there is strong collaboration and partnership, you would have seen that happening. I mean you could argue that there could have been other measures taken around enforcement action or whatever, but I think as we were arguing for a collaborative model, we weren't yet seeing that level of mutual support being offered. 12:38 12:39 12:39

MS. MONGAN: It would be fair to say though that towards the latter stages of our involvement in the review process, or in conducting the review, we did see the three Directors from Belfast, Northern and South

Eastern begin to meet in a much more collaborative way, and there were a number of workshops held around their mutual combined challenges. So there was the beginnings of them moving beyond aspiration to actually doing something about it. But we didn't see evidence that that in itself resulted in any concrete outcomes for the patients who were awaiting resettlement. 12:40

61 Q. Earlier in your evidence, I think at the very beginning, you had indicated, Ms. Mongan, that the recommendations from your report, you believe were accepted, and you've also referred in your evidence to feedback sessions. So, when you published your report, did you present it to anyone? 12:40

MS. MONGAN: Yes. We presented it to the families who had loved ones in Muckamore, that was one feedback session. And then directly after that we invited the directors of all of the Trusts with their senior teams, and they collectively received the feedback at the same time. So we made a point actually of trying to give feedback to the variety of stakeholders, including the provider organisations that we met with and were generous with their time, and we did that through a number of ways, the Association For Real Change convened meetings to include. So we were quite mindful of actually providing feedback to those that had supported and contributed to the review. 12:40 12:41

62 Q. And I think I'm correct in summarising your evidence earlier that you said that you understood your recommendations were accepted, but can you tell us why

you're of that view?
MS. MONGAN: My understanding is the Minister announced that to the Assembly. That was the first. And that was in the context of commencing the consultation on the proposed closure of Muckamore. But that was a clear evidence that at Department level those recommendations had been accepted in full. 12:41

It would be fair to say that the feedback sessions with the Trusts Directors, there was no challenge. They accepted -- they appeared to accept the recommendations, it would be fair to say. But I think the main issue is that actually this was commissioned by the Department through the SPPG and, therefore, we took the evidence from the Minister himself as commitment to accepting and, therefore, moving forward to implement the recommendations. 12:41 12:42

63 Q. Do you know at all if any steps have been taken to implement the recommendations?

MS. MONGAN: The only two steps that I can speak to was the first to establish the Oversight Board and to appoint an independent Chair, and we know that happened fairly speedily after the report was concluded. And, indeed, we met with the incoming independent Chair, Patricia Donnelly. And the second was the commitment to hold a summit across the entire sector, to include parent representation, user representation, along with provider organisations, Trusts, and the Housing Executive, and that event was held on the 4th July, and 12:42 12:42

again we were invited to present at that. So those are the only two that remained that we were engaged with. So we've had no further involvement, and I can't comment further on whether or not any action has been taken to implement. Those are the only two I can say that I know action was taken.

CHAIRPERSON: Can I just ask, did you have any method of follow-up? I think you made a total of about 25 recommendations to various bodies, and you've mentioned two that you think were actually affected. Have you done any analysis about the other 23 and whether anything has actually happened? Because there is always a temptation by bodies to say "yes, we accept all of these recommendations", I have to say I've experienced that myself.

MR. SUTHERLAND: We would like to have, but we were commissioned very specifically. I think our expectation was that the SPPG who commissioned the report had the responsibility to ensure --

CHAIRPERSON: To take them forward.

MR. SUTHERLAND: -- that the recommendations were delivered. And I mean we were pleased that, you know, in terms of the engagement both with families, but also with leadership groups, you know, there seemed to be a broad acceptance that the recommendations were sensible and were the sorts of things that they would want to progress, but we couldn't -- we honestly couldn't say that we've had an opportunity to see how that happened. But I believe the SPPG would have.

CHAIRPERSON: Yes.
MR. SUTHERLAND: And obviously MDAG, you would hope that MDAG, with this overarching assurance responsibility, would be taking interest in that, given that the Minister -- our understanding from the press releases at the time was the Minister accepted all the recommendations.
CHAIRPERSON: Indeed. Thank you.
64 Q. MS. BERGIN: I don't have any further questions, except before I hand you over to the Panel who might, except to ask you finally is there anything in relation to your review that you would want to highlight or clarify for the Panel?
MR. SUTHERLAND: No, I think we've had a good opportunity to explore many of the important areas with you.
CHAIRPERSON: You'll have a bit more now, because Dr. Maxwell is --
DR. MAXWELL: I haven't finished.

MS. MONGAN AND MR. SUTHERLAND WERE THEN QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

65 Q. DR. MAXWELL: No, I haven't got that many, I've just have got two. On section 6.7.16, which is on page 51 of your report, you talk about the Social Care Procurement Board.
MR. SUTHERLAND: Yep.

66 Q. DR. MAXWELL: Which was organising the statutory sector. So can you just tell me a little bit more about what they did and when the Board was established?
MR. SUTHERLAND: Yes. So we'll try to help in relation to that. What we were advised at the point -- so we wanted to see was there a mechanism at a high strategic level that was overseeing procurement and commissioning of services. When we asked that question, we were advised that there was a Social Care Procurement Board, but equally we were told that it had fallen into abeyance, that it hadn't been operating effectively for a while. With Brendan Whittle assuming the DCSC role, he had given us an assurance that he was reestablishing that, if you like, and that there was a new appointment of an individual who would take responsibility for that. 12:46 12:46 12:46
67 Q. DR. MAXWELL: So that was commissioning the statutory social care services, so care homes that were run by the statutory sector, care support workers going into people's own homes, or supported living, is that right? 12:47
MR. SUTHERLAND: No, our understanding was it went beyond that, that it was looking at the contracting process with services within the independent sector as well.
68 Q. DR. MAXWELL: But it was overseeing the procurement of out of hospital services, the sort of places that people who are being resettled were going to. 12:47
MS. MONGAN: The reason we were particularly interested in this is, what are the contracting mechanisms that

Trusts and the region rely on? And the regional contract is used by all Trusts, it's a standardised pro forma, but it hadn't been updated in so long that it didn't actually reflect the level of complexity of some of the individuals. So you had a standard nursing home 12:47
contract, a standard care home contract, a standard domiciliary contract, and actually, that urgently needed to be -- what we did see is that the contracts within Trusts on occasion then needed a variational contract to give weight to the additional costs 12:48
associated beyond the standard rate. So it was an area that the providers were concerned about. They didn't feel that it provided the clarity in regards to: What do you require to purchase? How many are you going to pay? So the contract in itself. And what Brendan 12:48
Whittle was saying, we recognise that and we are reinvigorating it through the SPPG social care procurement. I know that they had an independent person who assisted them who had come from Scotland in regards to giving evidence and guidance around more 12:48
robust commissioning. So it was really from that perspective.

69 Q. DR. MAXWELL: So the Board was actually setting the model contract, it was doing the negotiation with all the stakeholders to say this is the standard contract? 12:48

MS. MONGAN: No, they would have historically established a model contract, then each of the Trusts would have used that model contract to go out and commission in that context.

70 Q. DR. MAXWELL: Yeah. Yeah. Yeah. So they said 'Here's a standard contract. You can go and have an independent conversation with somebody'?
MS. MONGAN: Yes. Yes.
71 Q. DR. MAXWELL: And you've raised a bit earlier in that page that there were issues about the statutory and the independent sector having different terms of conditions and this was affecting recruitment. Is that the sort of thing that the Board might have worked on and said 'Here's a standard contract. Whether you're independent or statutory, this is the pay. This is the conditions'? 12:49 12:49
MR. SUTHERLAND: No, that wasn't, that wasn't where we were going with that point I don't think.
72 Q. DR. MAXWELL: Okay. 12:49
MR. SUTHERLAND: The point that we were making was for statutory it was residential care or supported living provision. There was no statutory nursing provision. Those staff were employed on agenda for change terms and conditions, which generally I think almost always was more favourable than the pay rates being offered by the independents, both the voluntary and the independent sector. And I suppose our point partly around that was; why is the statutory sector continuing to provide this and is it limiting growth in the market for the not-for-profit or profit sectors who might want to come in and do that? But in fact it was almost creating a disincentive for people to look at that area. 12:50 12:50

73 Q. DR. MAXWELL: But this was left unresolved. Because we heard from a lot of people one of the rate limiting factors on resettlement was actually staffing.
MR. SUTHERLAND: Yes. Yes.
74 Q. DR. MAXWELL: So if you thought you were doing the same job as somebody else and getting paid less, and you'd get paid more to work in Tesco than either of them, why would you? 12:50
MR. SUTHERLAND: Yes. Absolutely. But obviously also its a problem for the independent sector, because as vacancies come up in the statutory sector, their staff are often applying because its more favourable terms and conditions. 12:50
75 Q. DR. MAXWELL: Okay. So we don't quite know what's happened to that Board. It went into abeyance. 12:51
MR. SUTHERLAND: No.
76 Q. DR. MAXWELL: Brendan Whittle said it was going to be resuscitated, but we're not sure where it is now.
MR. SUTHERLAND: Yes. No. We did meet -- we did have a conversation with the person from Scotland who had been providing some support, and we do know that they were in the process of appointing an officer within the SPPG who would overtake responsibility for the Board. 12:51
77 Q. DR. MAXWELL: Okay. One other question, I said I'd come back to this whole thing about cash releasing from the hospital. 12:51
MR. SUTHERLAND: Oh, yes.
78 Q. DR. MAXWELL: And you talk about that on page 53 at 6.8.6 I think, according to my notes. We have heard

quite a lot about how money was taken out of Muckamore. So we've heard a lot of evidence that particularly from 2012 onwards they were very keen to take money out to fund resettlement, and there were a lot of concerns raised about staffing. There were periods of time when 12:52
Belfast Trust was not recruiting any substantive staff, they were all on three month rolling contracts, which affected their ability to recruit. So it was quite interesting to see you say that you hadn't seen a plan for the disinvestment. 12:52

We also heard that actually there hadn't been any recognition that as you cohorted the more complex patients together you needed a richer skill mix. So I suppose my question is, is there any understanding that 12:52
the cash release savings are not linear, that in fact in order to have effective resettlement and safe care until you close the hospital, you cannot release money from the hospital?

MR. SUTHERLAND: Thank you. There's quite a lot in 12:53
your question. I think one thing we should say is we didn't look historically back on decommissioning plans. So the point that you make may be true, if you've heard that from others. There may have been significant withdrawal of funding from the hospital and Belfast 12:53
Trust with earlier periods of resettlement, but we didn't actually look at that.

79 Q. DR. MAXWELL: Okay.

MR. SUTHERLAND: I think in relation to what we did

hear from finance officers within the Board was that this was a constant issue of debate with the Belfast Trust, and what they indicated to us was there were substantial amounts of non-recurrent funding provided to support the staffing pressures that were emerging, and particularly the costs associated with having to bring in a workforce with significant additional costs because they were agency and there was travel and accommodation responsibilities. But other than that, we didn't really investigate that further. 12:53 12:54

I think I would support the point that you make, and it's partly about what we were trying to say and looking at other models about where it has been done elsewhere is that sort of bridging fund that gets you from where you are now to the resettlement world. You undoubtedly need a bridge of additional funding to support that transition period. But what you would want to see was that was well managed in the context of a regional programme, rather than it was constantly slipping and getting longer and longer and longer. 12:54 12:54

80 Q. DR. MAXWELL: So you'd rather have seen a plan for it than these little pots of non-recurrent money that weren't strategically being managed.

MR. SUTHERLAND: Yes. 12:54

MS. MONGAN: Again, if we go back to our previous experience and what we referred to as the success of the previous resettlement push when it was - when a significant proportion of the population had been

effectively resettled, there was much more evidence of finance being addressed alongside the individualised care planning. So, you know, it wasn't a linear thing about just look at the individual and then present the costs at some stage for the Board, the Board were strategically and operationally involved, along with the Trusts, in really driving that to keep the two.

So while there was closures of wards in Muckamore to, in a sense, partly fund the resettlement, it is my view that it was looked at holistically in regards to the focus on finance. So it's just not a linear thing, you know, you just need to kind of ensure that someone is looking to what will it take to maintain safe service as well as the transition fund, and that's where the diary system or an allocated amount, it was quite helpful just to allow you to at least have some sort of benchmark to working against.

DR. MAXWELL: Thank you.

CHAIRPERSON: I think we're all done. We've asked quite a lot of questions as we've gone along. But can I thank you both very much, it has been a genuinely instructive session. And can I thank you also because you wrote this report some two years ago, so I suspect you've both done a bit of re-reading in the quiet hours, as it were. And so can I thank you for that quiet work you've done to prepare yourselves for this morning. So thank you both very much indeed.

MR. SUTHERLAND: Thank you.

MS. MONGAN: Thank you.
CHAIRPERSON: Okay. We'll try and sit again at 2:10. I think we've got reading this afternoon.
MS. BERGIN: Yes.
CHAIRPERSON: Okay. Lovely. 2:10. Thank you. 12:56

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS: 14:02

CHAIRPERSON: Right. We're moving back now into staff evidence, having finished that last module, although Resettlement, of course, is going to arise again when we get to M7 and beyond. So the link is obviously off. 14:02
And we've got some reading do. Who are we going to first.
MS. TANG: Good afternoon, Chair. Good afternoon, Panel. This afternoon the first statement to be read into evidence is that of H282, and I should say that 14:02
there is a Restriction Order in place, and it is Restriction Order No. 77.
CHAIRPERSON: Sorry, the Restriction Order in relation to the cipher?
MS. TANG: Yes, in relation to the cipher. That's 14:03
correct.
CHAIRPERSON: Yes. Sorry. But there's no additional...
MS. TANG: No, there's no additional.

The internal page reference number for the statement is STM-270-1.

CHAIRPERSON: Will you just give me a second? I am sorry. Hold on.

MS. TANG: Yes, of course. 14:03

CHAIRPERSON: Right.

MS. TANG: Okay.

STATEMENT OF H282 - REFERENCE STM-270-1 READ BY MS. TANG AS FOLLOWS:

MS. TANG:

"I, H282, make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement." 14:03

Sorry, I should say the statement is dated 31st May 2024.

14:03

"My connection with MAH is that I am a full-time nurse at the hospital. I am currently the Community Integration Manager for the Belfast Health and Social Care Trust, which is a Band 8A post. The relevant time period that I can speak about is between 2010 to the present date. 14:03

I began my nursing degree at Queen's University Belfast in 2010 and qualified in or around May or June 2013.

During this time I completed three placements at MAH in Finglass F/3, Rathmullan and Oldstone Wards".

The witness then goes on to describe a number of posts that she held over her time in Muckamore, including posts in Greenan Ward, in Iveagh in Belfast, in Cranfield, in PICU, and was later promoted to a Ward Sister post, and that covers paragraphs 4 up until paragraph 10, where the witness then goes on to detail that she was Assistant Service Manager and was promoted in January 2022 to Community Integration Manager, which is at paragraph 11. 14:04 14:04

Paragraphs 12, 13, and 14, deal with the training processes that the witness underwent, and she sets out that she was trained in MAPA and also in adult safeguarding, amongst other things, and also the supervision arrangements that she was subject to, which would have been in paragraph 13. 14:05

At paragraph 14 she goes on to speak about the mandatory training that she was required to undertake. 14:05

Paragraph 15 refers to some training that was - certification that was provided, and 16 some postgraduate training that the witness undertook.

At paragraph 17 the witness sets out some ward training systems, and if I can pick up the reading of the

statement from paragraph 18, please?

"I learned a lot during my time in Greenan Ward about acute nursing care. This involved training in PEG feeding, palliative end of life care training, and catheter training. I completed MAPA training. This is a mandatory training course on Greenan Ward, but I did not need to use physical holding or disengagement skills while working in this ward. 14:06

In relation to my first impressions of MAH, I was apprehensive, but this was due to me being a student nurse rather than the hospital or because of the people or patients there. I have fond memories of the Rathmullan and Greenan Wards. I had a good relationship with the patient group and they were really lovely people. It was a privilege to work with them and there were some very nice families. 14:06

As previously mentioned, I was working in Greenan Ward on a temporary contract and chose to apply for a permanent post in the Iveagh Centre. This post was working with children add adolescents. Iveagh was a steep learning curve and required a different skill set. This was very different role to Greenan Ward as the children posed a degree of risk to themselves and others. There was more need for the use of MAPA or safety intervention, ranging from the use of de-escalation skills to the use of disengagement or 14:06

physical holding skills at times to maintain safety. While in Iveagh I completed training specific to the needs of children. Iveagh had a school, occupational therapist, behavioural nurse, psychiatrist and doctors all in the one building so it was quite self-contained. 14:07
In Greenan ward there was a low degree of risk. Families spent a lot of time on the ward. In Iveagh there was not the same level of visiting on the ward as this was disruptive for some of the patients and there was a higher degree of risk to visitors. Visiting was 14:07
at designated times and in designated visitor rooms. Cranfield Female Ward was a female admissions ward for patients who were acutely unwell. Due to the nature of these patients illnesses and some of the associated risks, visiting was in designated visitors room off the 14:07
ward.

Iveagh had very robust processes around the review of incidents. There was a local review or Significant Event Audit (SEA) at any time that there was an 14:08
incident involving a patient where they might have required the use of as required medications, physical intervention skills, or restrictive interventions. The staff team would review the information to see if there was any potential trigger for the patient or any 14:08
learning that can be implemented with the staff team in how they support the patient. This was recorded on a board for other staff for the next day. This was a very good process and was proactive.

I would describe the culture in Iveagh as reflective. The information captured on these forms was then transferred on to a handover communication board, as mentioned, and this information was then discussed with all staff at the handovers. This gave staff an opportunity to share learning. It was normal for staff to be worried or nervous about working in this environment and the reflective nature of the handovers gave staff a space to reflect, voice any concerns, and try to look for ways to manage the situation differently. This helped staff to feel empowered. The staff wanted to resolve issues and felt that changes could be made for the better but there were very hard days. For example, there was a lot of self-harm and there were days when I was very upset by what I had seen. At handovers staff looked at the day ahead and there was a united front. Staff tried to support each other as best they could. There was a high degree of risk for staff at the Iveagh, but I always felt supported. Everyone was involved in this culture. For example, if a patient wanted to go shopping, a risk assessment was carried out and staff would take them. If the staff felt unsafe another staff member would have been there. If the level of risk being displayed by a patient was high, and the staff felt at risk of harm or felt that there was potential for an incident to occur, then they would have contacted another member of staff and requested their support. There were

14:08 14:09 14:09 14:09 14:09

robust processes. Significant event audits were in place discussing the strategies used and what could have been done differently. Staff were always working on improving things for the patients and the team. Staff acted quickly to put learning back into practice to resolve any issues and ensure they do not remain.

I moved back to MAH in 2015/2016. This was mainly due to the locality and wanting to work closer to my home. However, I felt I had learned a lot in Iveagh. There is a connection between Iveagh and MAH, and this is mainly around staffing and resourcing. There was a morning call to discuss staffing, and if staff were needed at Iveagh, MAH would send staff across to assist. I believe that this was because Iveagh was under the umbrella of Learning Disability Services. The on-call Senior Nurse Manager who covers the MAH site during evening and weekends would also be the same Senior Nurse Manager that covers Iveagh on evenings and weekends. This was the only joint arrangement that I was aware of.

In relation to the question I've been asked about visitors to MAH, in a general sense visitors were welcome to visit patients in the visitor rooms. However, depending on the ward and the particular patient, you may have needed to have staff present during visiting and, therefore, it does require planning and organisation. There were three or four

families who asked for supported visits. Sometimes, two staff are required to support the patient and this does take resources to allow this to happen.

Killead Ward was a bigger building with a designated visitors area. Cranfield 2 Ward was an open ward with free access. Families could spend time on the ward and may have spent two or three hours during visits. They could spend as long as they wanted. Six Mile Ward is the low secure forensic unit, so it was not an open ward. 14:11 14:12

A number of patients have a diagnosis of autism and have certain schedules and routines. I would have asked families to let me know when they were coming so that the patient was not having a rest, having a bath, or having their meals. However, if someone just turned up for a visit then would I try to facilitate it, but it was not always possible, and I could not bring the patient out straight away for these reasons. Families would often ask "Why do we have to tell you when we're coming?", but this was simply due to planning. I had to explain that staff were not always available if it was meal times or perhaps we were short staffed that day. Sometimes, I would bring the families to the visitor room and ring across to another ward to see if anyone else was able to come over and support the visit. We had to look at it from a holistic point of view, to consider all of the patients living on the 14:12 14:12 14:12

ward and their needs. This was sometimes a challenge to balance."

And the witness then goes on to speak about during Covid slightly different arrangements with guidance from the Trust. Sorry, there was no leeway in terms of guidance from the Trust. 14:13

Picking up at paragraph 29:

14:13

"In terms of the question I have been asked about culture, the wards I worked on were very different. In Greenan, the patients could have been very ill and may have been palliative care patients at the end of life care. It would be extremely sad when they passed away. However, when a patient's condition improved it would really improve the atmosphere. The staff attitude was generally based on how patients were. The Greenan Ward was very task orientated and everybody helped each other out. There was a good standard of care provided to patients. 14:13 14:13

Cranfield Womens' Ward, the female admissions ward, had a well-established nursing and managerial team that had been in place for a long time. I felt very well supported on this ward. There was a team of experienced Band 6 and 7 nurses who were very hands-on and engaged well with the patients and their families. I felt this was a culture where everyone was involved. 14:14

At Christmas, there would have been a dinner and a disco on the ward for patients and families. Despite the potential for patient incidents or a challenging situation, we made it happen regardless, as these were good opportunities for the patients. There was a culture of positive risk taking within the ward and I learnt a lot from that period of leadership. H285, the Ward Sister, was in charge, and H298, Deputy Ward Sister. H298 was fantastic in engaging, always asking questions and leading from the front. Ward management were out on the floor working with the patients supporting the care staff to meet the patients's needs. H298 was always on the ward working evenings, weekends and banked holidays, she worked every Christmas Day. She always committed do that and I thought she showed very good leadership. I learned a lot from H298. 14:14 14:14 14:15

Cranfield Womens' Ward had a culture which promoted quality improvement and was an open culture across all staff. Band 3 nurses would have come forward with issues as they were on the ground supporting the patients on a daily basis. The nurses, like myself and other managers, would try to resolve this. These may have been issues such as the food or snack options provided being unhealthy and this contributing to weight gain. We would work alongside the kitchen, the dietician, physiotherapist, and medical teams, to try and promote better physical health. 14:15 14:15

In the PICU Ward I was the Deputy Ward Sister between 2017 and 2018. I was in charge of the ward but I was new to the Deputy Ward Sister role at that stage as a Band 6, due to the unavailability of the other Band 6 and Band 7 staff. For the first three to four months 14:15
the team was very inconsistent and despite my best efforts I struggled to provide stability to patients and families during this time. I was told that some staff were unable to work and should be removed from the staff roster. It was destabilising and I was 14:16
struggling to get support to help on the ward. It was difficult to tell patients why the staff were unable to work. We advised the patients that the staff were off on a period of leave. Sometimes, I was informed by senior management about staff who were on their shift 14:16
and who would have to leave work immediately. I was advised of this by senior management who would have been Band 8A or above. The Service Manager was cipher H77 at the time, but there was a lot of change in senior management following this. I have referred to 14:16
my time in PICU Ward more fully below. After a period of time I was advised that CCTV footage had been reviewed, and based on what had been viewed staff had received a precautionary suspension. I was advised by senior management that these staff were subject to an 14:17
investigation and, therefore, would not be returning to work, but I did not have any more information than that. I was told that nothing had been proven at that stage so I was not in a position to tell the patients

anything. There was a script given to all staff by senior management to reassure and support the patients. I did not witness any examples of abuse or poor care during my time working in PICU Ward.

14:17

There is a patient-centred approach to care. Treatment plans are based on the person's care needs and takes into consideration potential risks. I follow the care plans and what works best for each patient. I respond to the patient's needs. If one patient engages better with a certain member of staff, then that member of staff will be prioritised, where possible, to support them. Some patients have severe learning disabilities, some have mild learning disabilities, some have experienced complex trauma, and others not. I engage with patients differently depending on the level of support they require. This is not necessarily dependent on the ward I am working on but the patients I am working with.

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Staff were very well trained, so when they came to work they knew their role and what was expected of them. I have had a lot of positive experiences and I know we provided a good standard of care for patients. For example, on Greenan Ward, we provided acute nursing care and the patient's needs were clearly met. The staff supported their nutrition and all activities of daily living. There was active management of pressure sores and we achieved the best possible outcome for the

14:18

patients.

During my time on Cranfield Female Admission Ward and Killead Ward, everyone knew what they were doing and there were really positive outcomes. For example, there was a patient who had an organic psychosis, not induced by anything such as drugs. She was supported through a treatment plan and made a full recovery. She was eventually discharged back home and was able to return to her job in a cafe, which she travelled to independently. 14:18 14:19

There were families whose loved ones required admission into the service due to behavioural changes which could not be managed at home and may require medical input, for example, medication changes. For some patients there may have been cyclical patterns of behaviour which may have required a number of admissions throughout the year. 14:19

Greenan Ward contained patients from 18-years-old to over 60-years-old, with varying physical and mental health conditions. However, the staff supported each other to care for the patients in the best way possible. If we found ourselves one member of staff down, for example, due to illness, we got through it as it was good support for each other. 14:19

On occasions I was tasked with informing staff that

they had to go off duty because of what had been seen on CCTV, and this made me feel uncomfortable. At the start I had no involvement with this, but on Cranfield 2, I had to deliver the message to staff which had been reported to hospital senior management via Human Resources. I had to tell staff to hand in their pass and keys as they were being suspended pending investigation. The message was that Human Resources had advised that there had been concerns about the staff's actions. After this stage in the process, I had no further involvement in the investigation and disciplinary process. However, I may have had some further engagement with those who were suspended by providing pastoral support. For example, if I saw them out shopping they may have approached me and said hello. In addition, some of those staff who were suspended would have phoned the work phone and I would have provided pastoral support and sign-posted them to support services, such as the counsellor and the Be Well App. Any staff who were on pre-cautionary suspension were advised that they were not permitted on-site while the investigation was ongoing. 14:20 14:20 14:20

The patients with a diagnosis of autism liked routine and liked to know who was caring for them. They saw staff as their family and they suffered a loss when staff were no longer there. It was also difficult for staff who had built relationships with the staff who were suspended or who had decided to leave. It was 14:21

very difficult to predict what was going to happen next. For example, there were days when I expected to have six staff members on the ward, but I perhaps only had three available for work. This directly impacted staff and patient morale and was very unsettling. It had an effect on the families who were unsure why certain staff were not available. These staff may have been the patient's named nurse, for example, and then were no longer available. It also had an impact on what the patients could do as planned outings or appointments had to be cancelled. The ward was safe but staff were limited to providing basic care needs at times. 14:21 14:21

I had to try and be patient with inconsistent support. I would have contacted the nursing office to see if there was anyone on the MAH site who could assist and come over to help us. Support was always found to help and staff really mucked in. The nursing office knew that if I was asking for help that I was asking for a reason and I really needed it. The nursing officer was also aware of the staffing situation on-site and the safe staffing numbers for the ward. 14:22 14:22

I questioned why the senior management had not told me about the issues prior to moving to PICU. In some ways I felt like I was the fall guy. I moved from Killead Female Admissions Ward, where I enjoyed working, to somewhere where there was no stable staff team, 14:22

changing circumstances daily, and a patient group who required high levels of support from people who knew how to meet their needs. However, I recognised that a service had to be provided to patients, regardless of what was happening to the staff, and I wanted to make sure that there was minimal impact for the patients in PICU. 14:23

There are processes in place around staffing and resourcing. Staffing figures are collected and compiled into documents and sent to all nurses in charge and senior managers. There is a safety huddle, call every morning at 8:00 o'clock, where each Ward Manager confirms the numbers they have in their ward. For example, they report who has called in sick. The report is then updated and there is a discussion about staff being redeployed from one ward to another to help if they're short staffed. The MAH rosters run six weeks in advance to foresee any annual leave and in order to plan or backfill deficits. Over the last few years there has been a significant increase in the number of agency staff required to backfill deficits. The main on contract agency supplying nursing staff are direct health care who provide at least 40 agency nurses to MAH. Agency staff do not have the same contractual arrangements as they are employed through a third party rather than directly by the Belfast Trust. Some staff can take holidays of four weeks at a time, so attempting to manage that can be difficult when 14:23 14:23 14:23 14:24

planning a roster.

When I started in PICU I was new to the Band 6 role and had never worked in the ward before. The staffing situation made things extremely difficult and there were days when it was very hard. I saw a lot of change on the ward and I needed additional support. Around this time H462, another Deputy Ward Sister, came back from maternity leave and provided me with a lot of support. She was very calm under pressure and was very experienced. We started by making lists of tasks that needed to be completed on the ward." 14:24 14:24

"The witness then goes on to describe some of the practical steps they took. 14:24

At paragraph 43:

"As mentioned previously, it was tough trying to support the management of PICU Ward with the ongoing investigations and further staff suspensions. I was uncertain about the future of the service because the investigation and the unavailability of staff. In December 2018, a decision came abruptly to close PICU with immediate effect. I was not aware of where this decision had come from and I was not consulted prior to the notification of the closure. I heard about the sudden closure from another member of staff who was a Staff Nurse and had only been in her post for six 14:25 14:25

months. She had received a phone call from hospital senior management and had then called me for advice and support. I was not aware if this decision came from the senior management at the time or if it had been from executive level. 14:25

When the PICU Ward closed, the staff on duty that day were advised that the patients had to be moved in four hours and by the end of the shift. The communication was very poor regarding the closure of the ward. There 14:26 was no prior discussion with the ward management team and staff were not informed prior to the day it was closed. I had been working on a shift that morning and left duty at 3:00pm after an early shift and this had not been discussed with me prior to leaving. I felt 14:26 that giving prior warning would have given some opportunity to prepare the staff and patients to ensure the moves went well, were well prepared and well thought out. I'm still unsure why the ward had to close on that specific day in such a rush. When I 14:26 returned for my next shift there was a sheet on the PICU office door saying "Can you now report to this ward today" and a ward was named. All staff who were due on duty were reallocated to another ward which was detailed beside their name on an A4 sheet. I did not 14:26 feel that I was in senior enough position to ask questions as to why the PICU Ward was closed. I was simply advised that it was not fit to remain open.

It was a difficult task to get everyone moved in four hours. The staff in both Cranfield 1 and Cranfield 2 helped. They helped to move two patients to the Female Admission Ward, now called Killead Ward, and one to Six Mile Ward. One patient had been in Cranfield previously and did not enjoy it. It was not suitable to move them back there, so the team held off their transfer along with two other patients. The PICU Ward remained open for two more days until more care planning was put into place for these patients. One of the three remaining patients went to Six Mile Ward and another two patients went to Cranfield 2 Ward, which was a male long-stay ward. This was not an ideal ward for these two patients as they needed a smaller environment with a familiar staff team.

Cranfield 2 Ward was a delayed discharge ward and at that time was an open ward. This meant that the front door was always open and patients could leave of their own accord. This proved difficult in supporting some of the patients who did not have an awareness of common dangers within their environment and may have exited the door, requiring staff to support them to maintain their safety.

I had regular supervision meetings with the nursing assistants. This could have been weekly or monthly. Some staff were on specific supervision plans in light of the ongoing investigation and required regular

supervision at stipulated timeframes. There is a requirement for registered nurses to have supervision meetings with their manager twice a year. If there were any concerns raised which were a management issue, for example, the use of mobile phones whilst on duty, then the manager would discuss this at supervision and ensure that the staff member is aware of the policies and procedures. Although the manager did not need to wait until a supervision meeting to address a concern. Staff also complete a key skills framework to ensure that they're meeting targets in relation to their allied job role. Staff can use this opportunity to discuss areas for development and courses they may wish to complete. If this will benefit their job role then the manager can signpost the staff to this training, where possible. 14:28 14:28 14:29

In 2021 I commenced my post as Assistant Service Manager at Cranfield Ward. In this time I reviewed audits and oversaw the nursing care records. I carried out quality assurance visits to wards at random times. There was no pattern to my visits. I ensured safety briefs were completed, emergency rooms checked, clinical room audit sheets were correct, and levels of observations were correct. If any issues arose during these audits these were discussed with the nurse in charge. This would allow for immediate action to ensure the issues would be addressed that day. 14:29 14:29

I feel that there has been significant quality improvement over the last number of years that I have been working in MAH. There has been a Safety Quality Belfast Programme where teams attend and are supported to decide on a quality improvement initiative to roll 14:29
out in their service and they are supported in the process of rolling this out. There is a patient experience team within the Belfast Trust who attend the hospital site and complete random audits of the medication Kardex, chat with patients about their 14:30
experience as to provide real-time feedback. This process is supported by the speech and language therapist to support the staff in using alternative communication techniques to ensure information is accessible. This information was fed back to the wards 14:30
and forms part of the key performance indicators for the ward. It also gives you an opportunity to see if there are any issues which need to be addressed. I feel that these things have led to an overall improvement in the quality of care at MAH. 14:30

Following the closure of PICU Ward, I worked in Cranfield 1 Ward for three weeks. There were too many nurses and we were sent out on relief on a rotational basis to cover Cranfield 2 Ward. This did not provide 14:30
any consistency to the patient group or staff team at the time. On New Years Day 2019, the team was split between Cranfield 1 and 2 Wards so that the patients could have some familiarity with the staff supporting

them. The PICU Ward reopened in 2020 as a Covid escalation unit. It is currently used as a single occupancy pod ward for a young man with autism following the closure of Erne Ward on-site in 2021.

14:31

There were further changes on Cranfield 2 around early 2019. It was a very turbulent time for around 8 to 12 weeks. H844, the Deputy Ward Sister, retired. H462 went off on leave. H491 was the Ward Sister at the time.

14:31

Cranfield 2 Ward supported patients who were ready to move out into the community. Staff in Cranfield 2 may have been deployed there because of their own physical health considerations and most of the patients they were working with were treatment complete and ready to transition out to community homes. There were two patients who had transferred from PICU Ward when it had closed. These patients struggled to live in a much larger environment and I believe may have communicated their needs an anxieties through their behaviour. Some staff were not confident in dealing with this level of behavioural challenge. The patients may have grabbed the neck of your uniform or grabbed on to your hair as a means of communicating a need. As a CPI approved safety intervention trainer I was able to support and upskill some of the staff on the ward.

14:31

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14:32

H491 retired in May 2019 and I applied for the role of

Ward Sister. I was successful and took up post in May 2019. Things did begin to settle down a while after that.

In relation to the atmosphere on the wards I worked on, 14:32
I would say that the atmosphere on the wards was very different based on the patient group and the needs on each ward. In Greenan it was a tight team with a consistent routine. The patient group had complex
physical health needs and required all staff to work 14:33
cohesively to meet their care needs on a daily basis. In Iveagh the atmosphere may have changed due to who was on duty because the patients often had preferred staff that they wished to work with. When these staff
were not available the risk levels of their behaviour 14:33
may have increased. The atmosphere was largely based on the confidence of staff and how that impacted on perceived risk that day. In Cranfield Female Admissions this was a good environment and the staff
there loved their work. There was a consistent staff 14:33
team and there was a general routine in the ward, so it was relatively easy for staff to follow and feel part of the team. In PICU the atmosphere may have changed if the team that were expected to be on duty that day
were no longer available or, for example, if someone 14:33
was sent off duty during their shift due to the ongoing investigation.

If a colleague or friend of a member of staff got

suspended, the remaining staff member might have expressed their upset at this to me or management. Staff suspensions were happening regularly for over a year and it was hard to provide stability because of this. I found the process difficult to navigate because there was no advance warning that staff would be going off duty or not available for duty. This caused issues with staffing for the remainder of that day. In the end nearly everyone on the roster had been suspended. I found it hard to comprehend the scale of it. 14:34 14:34

There was a lot of change in or around 2017/2018. H77, the Service Manager, retired. After that, various people seemed to take over in various senior management roles for a period of around six months to a year at a time. I cannot remember in which order they were in post, but the various people were Jan McGall, Gillian Traub, H294, H786, H315, H300..." 14:34

14:34

- and the witness lists a number of staff.

"Jan McGall had an occupational therapy background. She was great, as she wanted to facilitate things and work with people to make things better. Gillian Traub was brilliant too. She was really kind and listened to what you were saying. H294 then came from Mental Health Services. There is often a misconception that mental health and learning disability are much the 14:35

same. Mental Health Services and Learning Disability Services are very different and cannot be compared. Sometimes I felt that the solutions being suggested were not in line with what would best support someone with a learning disability. I felt that this time frame was more difficult when management did not have a background in learning disability."

And the witness then goes on in paragraph 56 to give account of some very positive experiences with H315. 14:35
Again in paragraph 57, picking up there:

"During the time when H315 came to support the service I felt that senior management were much more present on the wards and were available for staff or patients to 14:36
speak to. Before this I felt that senior management were more inclined to stay in their offices and direct people via e-mail or phone rather than in person."

At paragraph 58 the witness sets out the arrangements 14:36
during the Covid Pandemic, and also paragraph 59 makes positive remarks about H627 as Co-Director.

Picking up at paragraph 60:

14:36

"On taking over as the Ward Manager of Cranfield Ward, in terms of communication with my direct line management there was always a Band 8A Assistant Service Manager on site, and I felt comfortable that there was

a steady flow of communication. I was able to have full and frank conversations with them and I felt supported.

Since the Public Inquiry started, there has been more oversight from senior management and non-executive director level. They have been completing safety quality visits to the wards. Prior to the visit, I would complete a report and indicate, for example, things that we were struggling with or someone who I thought had been excelling within the ward. This report would then be discussed with the non-executive directors touring their visit. During the Covid-19 pandemic some of these visits happened virtually. I was not aware of these meetings happening prior to this, although I was not in management prior to 2017. 14:36 14:37 14:37

MAH has experienced greater periods of stabilisation over the last few years. When H315 and H300 came in, I began to see more stabilisation and greater co-operation between staff. Before that, staff tended to stick to their own wards, but now there's more consistent cover when someone is off. Staff work worked collaboratively across all areas to meet the needs of the patients and maintain safety." 14:37 14:37

The witness then goes on in paragraph 62 to set out the arrangements around when a patient is admitted under the Mental Health Order. I'll pick up at paragraph 63:

"I would have had regular discussions regarding the case mix of patients with the multidisciplinary team (MDT) and senior hospital management. In admissions the age range of patients will vary and their needs may be very different. That is not necessarily ideal for those patients to live together in the same environment but this is the nature of an admissions ward.

When ward closures began on site in 2020/21 there were MDT meetings and meetings with the Assistant Service Manager and Service Manager of the hospital to discuss in detail the needs of these patients and where across the site their needs could best be met. 14:38

Decisions were made based on risk and compatibility. For example, when Erne Ward closed, we discussed who was best placed to support the patients who were delayed discharge patients. Some patients moved to Cranfield 2 and others moved to Killead Ward. There were regular MDT meetings to discuss the patient's needs and current presentation and decisions made about their care were regularly reviewed. Some transfers worked and some did not. I recall on one occasion that a patient had to be moved back within the first 24-hours of the transfer as they were presenting as distressed and dysregulated. We felt it was in their best interests to return to the ward that they had been on previously. This was also difficult around Covid as

there were periods of lockdown where there was less opportunity for family contact and more isolation for patients.

There was a varying range of input from families with some families visiting on a daily or weekly basis and others visiting more infrequently. Some families wanted to be involved in meetings, others just wanted to be updated after the meetings. With visiting families members there's a need to try and manage potential distress to other individuals. For example, some patients have been in MAH for a long time and some do not have any known family members. For a number of these patients, MAH is their home, and it can be unsettling to have a new patient's family suddenly in their home. 14:39 14:39 14:40

At the height of the Covid Pandemic there was a patient with severe autism who was very upset without seeing his family. This was causing acute distress and high levels of self-injury. In consultation with the infection control team and the multidisciplinary team, we made a decision to let the family come and meet the patient in the garden outside. Throughout the pandemic it was difficult for patients to understand why they could not have their family on site to visit. 14:40 14:40

There is guidance in place surrounding protected times on the ward around medication administration and meal

times. This is to improve patient safety. I feel that at meal times there needs to be a focus on adhering to any speech and language therapy assessments and the administration of medication should be distraction free to ensure safety and reduce the risk of errors. 14:41

I would have been aware of each patient's functional ability, for example, activities of daily living that they could for their themselves, what support they needed, and how they communicated. This information 14:41 was shared on admission and was added to the assessment phase of their admission. This information would have been contained in the patient's care plan and would have stated the specific help that patient needed. 14:41

Specifically related to meal times, those patients who required specific support with eating and drink would have a personal placement alongside their speech and language therapy assessment. There were copies of this in the patient's apartment area or room, in the ward 14:41 office, and in the servery and kitchen. This would direct all staff on how the patient's food should be prepared and how they needed to be supported at meal times. 14:41

There is a Positive Behaviour Support led approach and patients who require support around behaviours of concern will have a PBS plan. The patients may have a plan in place prior to admission into hospital and this

will be reviewed and updated on admission to reflect the patient's current needs while in hospital. If coming from a family home, then I would have spoken with the family to get an overview of the patient's presentation and feed this information back to the multidisciplinary team to enable the team to discuss support strategies for the patient. 14:42

After admission, observations and assessments were recorded in patient notes and in ward rounds. The behaviour team would carry out their own assessments. If they wanted to track specific behaviour they could do this to try to find out what may have contributed to an escalation in behaviour and review any support strategies that may have helped. They would capture this information on an ABC chart (Antecedent Behaviour Consequence). This would track what happened prior to the behaviour starting, what the actual behaviour was, and what happened after that behaviour. This was then used to try and track trends and patterns of behaviour and to feed back into the support strategies of what had worked for the patient before. 14:42

Under Promoting Quality Care, a document was completed to capture risks to and from the patient. There was a risk screen tool completed and if there was seen to be any enhanced risks associated with the patient then a comprehensive risk assessment would be completed. This included a chronological timeline of all behaviours and 14:43

incidents that the patient had been involved in, and also noted all the risks associated with the individual, as well as any risks from others to that individual. There is a continuous care record which remains with the patient for life. It would outline if there they were vulnerable to risk from others or if they have previously presented risk to others. Therefore, I would have been aware of the risks each patient might potentially pose. For example, the risk of violence, self-harming, or if there was any risk of sexual violence. I would have been aware of this at the point of admission. Sometimes the risk behaviour may have been the reason for the admission. For example, a patient may have committed an assault and was transferred via the criminal justice system. I would also have been aware if a placement had broken down and the reasons for this." 14:43 14:43 14:44 14:44

The witness then goes on at paragraph 71 to set out the detail that would have been in the care plan.

Picking up at paragraph 72:

"There are policies regarding patient property. There are regular checks of cash and patient property drawers. All transactions in or out should be signed by two members of staff. Financial checks happen at ward level by the Ward Sister and Deputy Ward Sister and they carry out weekly audits of cash ledgers. They 14:44

check against the last receipts and check to say that the weekly audits have been completed. There are also drawer checks where you can check the cash register against what is supposed to be in the drawer. There are also monthly finance audits by the Assistant Service Manager, which was me at the time, where two patients are selected at random to have cash and property drawers audited. I would have checked for receipts, two signatures, and that daily checks were being carried out. There are also financial liaison officers. This was H710 and then Patricia McErlean. They conduct random checks, the nurse in charge is notified if the checks are not compliant and this information is fed back to the staff team to ensure learning. Further audits are then completed to ensure compliance. 14:44 14:45 14:45

I do not recall any incidents were money was missing, but there have been times when things have been added up incorrectly and I have had to go through it again. I cannot think of a time when high value property has gone missing, but there were occasions when items were damaged or destroyed by other patients and, if applicable, these could have been replaced or reimbursed by the Belfast Trust. 14:45 14:45

In my role as Assistant Service Manager, I would have escalated disciplinary issues to senior management and liaised with Human Resources for advice."

And the witness then goes on to describe the kinds of issues that might have been escalated, and the support from HR that she had.

14:46

Picking up at paragraph 75:

"During the merger of the wards throughout 2021, team building between substantive and agency staff took place." 14:46

The witness then goes on to detail an away day that they took part in and the experiences that they had as a team building group.

14:46

Paragraph 76:

"I regard any restriction of liberty to be a restrictive intervention. On admission there is a pro forma which details what led to the admission. You 14:46 would look at the specific risks of the patient, for example, risk of self-harm such as ligatures or medication overdose. There are immediate strategies put in place to try and mitigate the risks for each patient. For example, any patient who is an active 14:46 risk of self-harm or suicide will often require constant staff supervision to maintain their safety.

Each patient has a named nurse, the main nurse aligned

to the patient's care and a point of contact for families, who will document the restrictive practices used on the ward. These restrictive practices would be recorded onto the PARIS recording system. The restrictive practices in place are reviewed weekly at MDT meetings, which are attended by all member of MDT, including nursing, medical, social work, and any other allied health professionals involved in the patient's care. The staff review what restrictive practices are in place, are they necessary, can they be discontinued and, if not, a plan on how to reduce them. This would be based on the patient's presentation and review of their care notes. 14:47 14:47

Restrictive practices can also be a collaborative process and risk assessments can be co-produced with the patients themselves. For example, on Cranfield 2 Ward, a patient collaborated with the MDT regarding use of PRN or pro re nata medication. He had a crisis management plan which was used to direct staff in how best to support the patient when he was in crisis. The patient suggested that he thought it would be in his best interests in relation to when his medication should be administered. We followed the plan as this was what worked best for him. If a patient does not have capacity to be involved in these decisions surrounding their care, the MDT would liaise with families for advice on how best to support the patients. In some circumstances where there is no 14:47 14:48 14:48

family input and the patient is deemed not to have capacity to make certain decisions surrounding their care, then a best interests meeting may need to be held. There is a specific checklist which the MDT will work through to decide whether the decisions being made are in the best interests of the patient. For example, this may be in relation to decision making surrounding vaccinations. 14:48

At times staff may have utilised restrictive practices to help keep patients or others around them safe, especially those at risk of self-harm. There are policies around restrictive practices and these are documented in the patient's care plan. There are also certain legalities regarding restrictive interventions. 14:48 14:49

If the patient is detained under the Mental Health Order, there are certain interventions that can be used. For example, if the behaviour escalates, nurses can use physical intervention techniques to keep the patient and others safe, or if a patient tries to leave hospital, nurses can support them to remain in the ward for their safety. For voluntary patients, who are deemed to have capacity to make decisions surrounding their care, this would not be the case. 14:49 14:49

If physical intervention is used, it's recorded in the Datix recording form. This is an electronic recording system. There was a MAPA and safety intervention

section within this form to record any interventions used. This recorded what intervention was used, who used it, and what the time frame was. In my role as Ward Manager and Assistant Service Manager I would have reviewed these forms to see if there were any aspects which I would need to discuss with staff or to bring back for discussion at the multidisciplinary team meetings. There was also oversight of the physical intervention section of the Datix forms completed by the safety intervention corporate team at Knockbracken Health Care Park." 14:50 14:50

The witness then goes on to describe weekly hospital level governance meetings and what happened at those.

14:50

Picking up at paragraph 82:

"Patients who were experiencing behavioural distress would be supported in many different ways. I would look at what the crisis management plan stated and look at the patient's PBS plan. PBS plans are modelled on the traffic light system with green, amber and red sections. The green section refers to strategies that should be used to support the patient to remain at baseline presentation each day. The amber section refers to strategies that should be considered when the patient's presentation is moving off baseline and could include verbal de-escalation and moving others away. This might remove the trigger from the patient and 14:50 14:50

support the patient to de-escalate. If the patient communicates non-verbally it can be difficult to understand the trigger for the behaviour. This highlights the importance of having a PBS plan in place to support staff in supporting the patient effectively. It may advise on the use of symbols to try and support the patient to communicate their needs effectively. The red section refers to crisis management. For example, if the patient is exhibiting risky behaviours and all other support strategies have failed, then staff might be advised to use PRN medication or the use of physical intervention skills to maintain safety. The intervention used should be the least restrictive intervention proportionate to the risk and for the least amount of time necessary." 14:51 14:51 14:51

And the witness then goes on to set out the National Institute of Clinical Excellence Guidance.

Picking up at paragraph 84: 14:52

"There has been a change in seclusion policy in the last number of years. The policy was previously that patients were to be checked every 15 minutes while in seclusion and observations were documented each time. It is now continuous monitoring by a registered nurse. A Senior Nurse Manager has to be contacted at the point of seclusion as well as a medical staff to inform them that seclusion is commencing. When I was on the wards, 14:52

I would have been involved in incidents to support with decision making. When I was the Assistant Service Manager, Band 8A, I would have attended the seclusion room to review periods of seclusion and support staff looking at less restrictive ways to manage the risk and to try and improve practices. 14:52

With the new seclusion policy a doctor now has to attend within one hour of the seclusion commencing and has to set eyes on the patient. They determine whether or not he or she agrees with the seclusion or whether to try other strategies. Within the policy it specifically states that if the patient falls asleep, then the seclusion is immediately terminated. There has been an overall reduction in the use of seclusion in the time I have worked in MAH. It is not something that is frequently used now in MAH and I have not seen it used in over a year. This reduction maybe due to the reduction of acute admissions and overall fewer patients. Some individuals require the use of seclusion once, perhaps twice a year, during periods of acute agitation. The policy is more robust and promotes better practice which leads to better outcomes for patients. The policy was reviewed by a Policy Working Group who were noted on the policy. 14:53 14:53 14:53

Prior to 2017 some years had up to 400 periods of seclusion. These were statistics from the seclusion audits completed by the resource nurse. In 2023,

seclusion had decreased drastically to only one period of authorised seclusion in that year. In my opinion this was a very positive outcome for patients. Staff were working collaboratively to promote a reduction in the restrictive interventions being used. 14:54

In terms of the use of seclusion across the wards, there was no seclusion room in Killead and Donegore Ward. There was a designated seclusion room in PICU Ward, which was used by patients in Cranfield Ward, but 14:54 which would also be used on occasions by other patients across site who may have required its use. Six Mile Ward had a low stimulus room which had locked facilities to enable it to be used for seclusion. This room was out of use for works to be completed. Once 14:54 the works were completed, RQIA advised that the room could no longer be used for seclusion. Following this, the room was only used as a low stimulus room for supporting de-escalation. The use of physical restraint and seclusion was always recorded in the 14:55 areas I worked in.

CCTV was installed in Cranfield Ward in early 2017. I recall that H392 was involved in this process at the time. Staff were informed that CCTV was being 14:55 installed into the hospital. A draft CCTV Policy was shared with staff. A Frequently Asked Questions or FAQs sheet or leaflet was shared with staff and families at the time by senior management admin team.

I assume that there was e-mail communication regarding this, but I cannot recall.

The CCTV was not supposed to be operational until 14th September that year. I am now aware that the cameras were operational before this date, although I am not aware of the specific date the cameras were recording from. I believe that a pocket of CCTV footage had been found from in or around March to September 2017, and because of what was seen, many staff were suspended. 14:55 14:56

Following the introduction of CCTV in Cranfield Ward, CCTV was rolled across the site to Six Mile, Killead and Donegore Wards, and it is installed everywhere now. I do not think that the introduction of CCTV on the wards affected the behaviour or conduct of staff, although I cannot say for sure. I was working in Cranfield Female Admissions at the time where there were no CCTV cameras, so I do not have a comparison on that ward before and after installation. I then moved to the PICU Ward where there were the new cameras installed already. So, again, I do not have any comparison of before and after. I did witness a change in behaviour around the time of the announcement of the Public Inquiry. This caused a lot of fear and anxiety. I feel that the installation of the CCTV and the Public Inquiry had the effect of disempowering pouring staff who were previously doing positive things. For example, I began to get a lot more questions from staff 14:56 14:56 14:56

for approvals, such as taking a patient a short distance to the shop. These were things that staff were previously very able to do without feeling the need for specific authority.

14:57

For Department of Health assurance purposes there is contemporaneous viewing of CCTV footage, which remains ongoing to date. CCTV footage was randomly selected. The viewing of the footage would have highlighted areas where restrictive practices were used and areas of good practice. The footage was viewed by retired social workers who review the footage and produce reports. These reports are then given to the Assistant Service Manager and the Designated Adult Protection Officer (DAPOs) who reviewed the reports on a weekly basis. This involved all of the Assistant Service Managers..."

14:57

14:57

- and the witness then goes on to list those for Cranfield, Killead, and Donegore, and Six Mile Wards at the time.

14:58

"They would ascertain if there was an adult safeguarding concern. If the concern met threshold, the Adult Safeguarding Team would liaise with the Assistant Service Manager for that area. For example, if it involved the Six Mile Ward it was dealt with by H230, who put an interim protection plan in place. If it was a managerial or disciplinary issue, for example, staff using their phone whilst on duty, a written

14:58

direction would be made about what I should do, such as review the policy with staff and feedback to the DAPO. I would have acted on the direction and written on the form that I had done so."

14:58

And then the witness goes on to give some examples.

"I believe that the review of the CCTV has been very good for learning and that there has been positive learning outcomes from it. It is a robust process. 14:58

When I began work on the PICU Ward in September/October 2017, there were two or three staff suspended at that point following the review of CCTV and subsequent adult safeguarding referrals. I believe that there are 24 staff in total who were suspended or unavailable for duty prior to the closure of the ward. H54, a Nursing Assistant, and another man, I cannot recall his name, had already been suspended. I would have heard what had happened by word of mouth. It is common for there 14:59 to be members of the same family working at MAH. H54's father worked in the nursing office at the time and would have organised resourcing during the day by moving staff to different wards. MAH is based on the periphery of a small town, and a number of local people 14:59 from the town would have taken up employment at MAH following school or university in various different roles.

Discharge can be back to a patient's home, or to the family member's care, or back to supported or residential housing."

And the witness then goes on to detail some of the arrangements that would take place around a patient being discharged. 14:59

Picking up at paragraph 94:

"On admission onto the ward there is an inventory of the patient's belongs. The patients's clothing and finances are then returned upon discharge. The PARIS care recording system is updated to reflect the patient's discharge." 15:00

The witness then goes on to set out some of the arrangements that would happen in terms of facilitating the transition out of MAH for those patients. 15:00

Paragraph 95, picking up halfway through that paragraph, please:

"There were a lot of delayed discharge patients. There is a co-production with other health and social care Trusts. The Trusts need to be involved in finding a suitable placement for the patient and will be involved in planning and supporting the placement. 15:00

The Bamford Review recommended that all patients who remained in long-stay hospitals should be resettled into the community. This resulted in a lot of focus to resettle MAH patients into the community and reduce the number of delayed discharge patients on the wards. For example, all patients on the Greenan Ward were ready to leave. They were no longer receiving treatment and were categorised as a delayed discharge. They had been there a long time and were the primary target list patients." 15:01

At paragraph 97 the witness then goes on to list the various stages in the resettlement process around assessment phase, planning, review and trial, and you'll see in the statement that there are a significant list of those which go across the following page and on to page 33. 15:01

I'm going to pick up at paragraph 98: 15:01

"There are weekly MDT resettlement team meetings with the ward consultant, a member of the nursing team, an occupational therapist, behaviour nurse, a psychologist, physiotherapist and dietician, to discuss patient care, including resettlement. The meetings document how the patient has been and any significant changes." 15:02

Then she's picking up halfway through the paragraph:

"The families would be invited to review placements and to see if they felt it would meet their loved ones needs. This was measured against the patient's assessed need and what would be in the patient's best 15:02
interest. Some families had huge involvement in the resettlement planning for their loved one and would have worked in partnership with the multidisciplinary and resettlement team in relation to care planning, training the new staff, decor, day provisions, and 15:02
other aspects of the process. The families views were taken into account throughout this process.

Families are routinely invited to meetings during the discharge planning process, but there is no obligation 15:02
on them to attend. Families views are considered and their wishes taken into account, again measured against the patient's best interests. On occasions during the process of making decisions there may be a need for a separate best interest meeting. These meetings may be 15:02
required in the instance that a patient does not have capacity to make those decisions surrounding their care and there's no family input. In this case the MDT are required to make a decision.
15:03

Also on occasions the families wishes may not align with the patient's assessed need and there may be a need for a best interests meeting to determine what is in the patient's best interests. For example, the

family may prefer the patient to be placed closer to the family home, but there are no facilities to meet the patient's assessed need in that area, but there are in other areas. The patient's discharge may be further delayed as a result of this. Families views are 15:03
respected and taken into consideration in the meeting, but it is important to determine what is in the best interests of the patient holistically, not solely the family. If the patient has capacity to make decisions surrounding their care then they can advocate for 15:03
themselves and make these decisions.

As previously mentioned, there are various reasons why placements may have broken down. These could include the service not being able to meet the complex needs of 15:04
the patient, including their own mental health and nursing needs. There are occasions when the provider might not be able to manage the risks that the patient presented. There are other circumstances where incompatibility with other patients in the scheme may 15:04
lead to a placement breakdown. For example, there was a patient who, when dysregulated and distressed, would barricade herself at the main door stopping others getting in and out. When others tried to have access or to leave the area, the patient would shout verbal 15:04
abuse and present with physical aggression towards staff and peers. This was destabilising for others and the scheme were finding it increasingly difficult to manage all patient's safety. This resulted in the

placement breaking down and the patient returning to the hospital as an in-patient. Often the placement area requested assessment for detention and the person was assessed by a doctor and an approved social worker. The patient could then be detained based on the risks being presented. Once detained, they would request admission to a hospital bed. Following this, the need for single occupancy accommodation was noted as needing to be considered for future placements." 15:04

15:05

And the witness then goes on to set out some positive experiences of resettlements into the community, and some details around resettlement of Patient P245, where the placement didn't work out and had to come back.

15:05

I'm going to pick up at paragraph 103:

"A review was carried out into the resettlement process in 2019/2020. The review centred on why placements had broken down and any learning that had been achieved from the process around these placements. This information was used to create a more robust resettlement process. There are various different phases within the new process and the various actions which must be completed at each point before moving to the next phase." 15:05 15:05

And the witness then goes on to describe the different tasks that she undertook on that.

And at paragraph 104, again the witness sets out some details of the new process.

Picking up at paragraph 105, the witness refers to changes in the legislation recently through the Mental Capacity Act, and sets out some details of that and how it applies. 15:06

I'm going to pick up at 106: 15:06

"Any complaints or concerns that may have been raised were escalated to the Ward Manager and myself. We would look at the nature of the complaint to see if it was something that could be resolved locally, for example." 15:06

And the witness then goes on to set out what they did with any that could be resolved locally or those that were sent on to McKinney House within the Trust. 15:06

In paragraph 107 the witness sets out details of various frameworks to support staff involved in incidents if they had been assaulted by patients, with flow charts created to guide people on how to conduct -- how to seek help. 15:06

The witness describes at paragraph 108 the Zero Tolerance Policy in terms of abuse towards staff and

the various supports that are in place. The witness also sets out details of completing incident report forms on Datix or RIDDOR.

Over the page. Picking up at the top of the page: 15:07

"I may have also considered suggesting changes to the crisis management plan for the patient or positive behaviour plan strategies and shared this with the MDT and staff team for agreement. I would have 15:07
communicated these changes to staff to see if or how we could support the staff member back to work, if and when appropriate. Staff often found it helpful to know something is being done to try and support them and the patient. I tried to help staff depersonalise the 15:07
crisis situation and understand what the source of the behaviour might be. For example, it may have been the patient communicating something that they could not verbalise. It is often the case that the staff who are most supportive and know the patient well, working with 15:08
them regularly, are the subject of assault, as the patient often knows that staff member can meet their needs or usually understands what they are communicating."

15:08

The witness then goes on in paragraph 109 to set out the processes that they undertook whilst Assistant Manager in Cranfield in reviewing incidents and frequency where individual staff were involved, and

gives an example of a particular case where a staff member was assaulted by a patient.

I'm going to move on to paragraph 110 and just briefly summarise. The witness speaks of how proud she is of her role as a learning disability nurse and how thankful that she is for the opportunity to work with her patients and their families over the years. 15:08

And in paragraph 111, the witness then makes some comments on the challenges around providing her statement, and completes her statement at 112 with remarks that she... 15:08

CHAIRPERSON: Right. Okay. Thank you very much. I think we'll take a break now. 15:09

MS. TANG: Yes.

CHAIRPERSON: So I think the last -- the next two statements are significantly shorter in fact.

MS. TANG: Yes. Yes. The next one is very short.

CHAIRPERSON: And you're not dealing with those? 15:09

MS. TANG: I am dealing with the shorter of the two, and then Ms. Bergin is going to step in.

CHAIRPERSON: Right. Okay. All right. Well we'll take a break and we'll try and make it 10 minutes and then we'll be back. Thank you very much. 15:09

A SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Right. 15:23
MS. TANG: Thank you.
CHAIRPERSON: Where do we go now?
MS. TANG: Yes, ready to go. Thank you. The next statement to be read in is that of H51, and I should advise that there is a Restriction Order in place over 15:23 certain paragraphs of that statement. So what I would propose do is read in the unrestricted elements and then come back to the restricted elements and read them separately once I've --
CHAIRPERSON: Can you just remind me which paragraphs? 15:23
MS. TANG: Yes, I can of course.
CHAIRPERSON: Even though I did the Order, but I can't remember which paragraphs.
MS. TANG: Yes. The Restriction Order applies to paragraph 8 after the word... 15:23
CHAIRPERSON: Oh, yes.
MS. TANG: Yes. And paragraphs 9 to 11, and then the last sentence of paragraph 17.
CHAIRPERSON: Yes. This is going back some time in fact ago when this was dealt with. Hold on. Yeah. 15:24 Okay.
MS. TANG: Thank you.

STATEMENT OF H51 - REFERENCE STM-032-1 READ BY MS. TANG AS FOLLOWS:

MS. TANG: This is the statement of H51, and it's dated 30th June 2022, and the internal page reference number is STM-032-1.

"I, H51, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

There are no documents produced with my statement.

My connection to MAH is that I was a healthcare worker at MAH. The relevant time periods that I can speak about are between 1970 to '79, and thereafter from 1984 to 2004, and again from 2006 to 2015.

My initial period of employment at MAH was from 1970 to around 1978. I worked in MAH as a Nursing Assistant for nine months, before commencing my training to become an enrolled nurse in 1972. I remained working in MAH until 1978, when I left and worked in retail for approximately 15 months. I returned to nursing in and around 1979 to 1980.

Following my return to nursing I took a job in the caring profession at a hostel. This was a settling community which catered for the needs of 18 residents with mild disabilities. I worked in the hostel. I

left this environment in or around 1983 and returned to work at MAH on a full-time basis. I started my family in 1985. In and around 2004, there was an opportunity to work in a day centre. I worked there for approximately nine months before returning to MAH. I remained at MAH until I retired in 2015. 15:26

I wanted to do something different within the learning disability setting. I loved the ethos whilst working in the day centre. I then returned to MAH from 2005/2006 until around 2015 when I retired. 15:26

During the majority of my career as a nurse I have worked with patients with learning disabilities. I have no doubt that this part of the health service has been what I would call the "Cinderella" of the health system. It is often under-resourced and understaffed. I recall in the early part of my career dealing with 40 patients in wards that only had six staff and nothing was individualised. For example, there was no individual clothing and the food provided to patients was not tailored to meet their specific needs. There was a store where clothes were kept and nurses would just go into the store and pick clothes that looked as if they would fit certain patients. 15:26 15:26

I've seen many positive changes over the years during my career. Things have progressed and things have become better over a long period of time. From the

1990s onwards, these positive changes include patients being allowed to go on holidays, shopping trips, and home visits. Patients were also able to participate in regular events such as discos, pantomimes and even gardening. New departments were set up such as pharmacy departments and recreation departments that helped provide a more tailored approach to patients with learning disabilities. MAH tried to create a home-like environment. 15:27

Unfortunately some of these positive changes were removed. The recreation hall was taken away in MAH and there were no more social events for patients. I recall the recreation hall was removed to make way for the new hospital wards; Six Mile, Donegore 1 & 2, and ICU. I cannot recall the exact date this happened. The regular events patients used to be able to attend all stopped. I presumed this was just down to a lack of funds, but I think management wanted to make MAH more of a hospital rather than a home environment. The garden facilities were closed too. This is where patients would go on a daily basis. They were able to make window boxes and baskets, which in turn were sold to staff and members of the public. I believe this provided a therapeutic environment and the patients really enjoyed going there. The patients who were previously engaged and involved in shows and selling plants in the gardens had very little do and became bored. They had previously been allowed to go on 15:27 15:28 15:28

holidays with staff to places like Portrush and Fermanagh. MAH used to provide eight Oldstone houses for patients who could have some degree of independence, supervised by staff. Patients were accommodated in these houses before returning to the community. Unfortunately the management decided to close the houses, and I recall that would have happened just before I retired, although I believe it has since reopened. When the houses were closed, patients who had gained community placements would have just left MAH straight into the community. There was no adjustment period for them. There would have been one staff member per house, with around four or five patients in each house. In my view the Trust wanted to close MAH. 15:28 15:29 15:29

The patients I dealt with often did not need any particular treatment. They just needed a kind word and to be treated respectfully as people and to have their needs met by health care staff. I retired in 2014 but went back to MAH for two days a week as a banking nurse. I worked in the Oldstone houses and then went to the ICU ward for approximately one year, working two days a week. It wasn't my cup of tea and I did not like the environment, so I left and have not worked since." 15:29 15:29

I'm going to move on then to paragraph 12:

"I would say that MAH definitely had a male orientated culture. On occasions there were opportunities for promotions for the post of Ward Manager. I applied for these promotions, but I was generally up against male employees and was unsuccessful. It was clear to me 15:30
that they had all been briefed on the questions. It was a place where there were jobs for the boys.

I am aware of the court case involving another MAH employee, H52. He was promoted even after he had been 15:30
investigated two years prior for apparently breaking a patient's jaw. I went for promotion on two occasions, even though I never felt encouraged to do so. It was always men that were successful in the promotions. I remember getting feedback following one promotion round 15:30
when H52 was successful. I cannot remember exactly what the feedback was, but I believe it was probably positive enough and just really pointed out my shortfalls. I remember telling a colleague in an off the record discussion, that I couldn't believe he had 15:30
been promoted given his track record and that he should actually be in jail. I said this to a Nurse Manager, H53, and she simply said I had sour grapes.

Generally people who made complaints were not listened 15:31
to, whether they were patients or staff nurses like me. Nobody really cared and you felt that you would only get yourself talked about if you did raise any concerns or complaints. I could not put my hand on my heart and

say that I ever witnessed anything directly, but it was definitely that type of culture.

Back in the 1970s and 1980s we did the best we could with the resources available. I was a bit more innocent then and my eyes weren't fully open to what was going on. There were certainly accepted practices not just in MAH but in other hospitals that we can look back on nowadays with some shock. For example, patients would receive injections and would be subjected to the seclusion procedure. It all went on back then, but that was the norm. That sort of thing wasn't unique to MAH. It was common to have 40 patients in one ward with a nurse in charge of five staff. There were many patients who were put in MAH and unfortunately their family or friends would never have darkened the door. 15:31 15:31 15:32

In 2014/15 when I was a banking nurse, I felt that the place had changed for the worst. I felt that I could not do anything with the patients as all the resources had been taken away. The Trust never bothered with MAH and I remained a banking nurse for around a year. 15:32

For me, employees whose family members also worked at MAH was a big downfall and was part of the reason why MAH has ended up in this position facing an Inquiry. It would be quite common to have two or three family members working on the one ward. Family members would 15:32

not report other family members if they had seen anything untoward or improper. Those who had worked with the family members, such as young staff nurses, would maybe not have the courage to speak up. I recall during my banking career in 2014/2015 a female member of staff telling the charge nurse that she had concerns around H54 practices." 15:32

Paragraph 18:

"I loved working at MAH the first 40 years I was there. My time went so fast. When I went back to MAH during my banking year I felt horrendous going back into the wards. I felt that everything was just a tick box exercise." 15:33

Chair, I would now propose to read the restricted elements of the statement.

CHAIRPERSON: Yes. So those need to form a different part of the transcript. Yes. 15:33

RESTRICTED SESSION

OPEN SESSION RESUMED

15:33

CHAIRPERSON: Thank you very much. So that completes that statement, and I think there is one more to come.

MS. TANG: Yes, and Ms. Bergin is going to read the next statement.

CHAIRPERSON: Ms. Tang, thank you very much.
MS. BERGIN: Good afternoon Chair and Panel. The next statement to be read is that of the witness A-10. You will be aware, Chair, that you granted an Anonymity Order, which is RO No. 47, on the 12th February 2024, granting this witness anonymity. And for reference A-10's statement is STM-202. 15:35

Statement of A-10 dated 9th February 2024 --
CHAIRPERSON: Sorry to pause you. Apart from the anonymity, there's no other restriction order over this? 15:36
MS. BERGIN: No.
CHAIRPERSON: Right. So we can have Room B back. Sorry to... 15:36
MS. BERGIN: No, not at all.
CHAIRPERSON: Okay. Yes.
MS. BERGIN: Thank you, Chair.

STATEMENT OF A-10 - REFERENCE STM-202 READ BY MS. BERGIN AS FOLLOWS:

MS. BERGIN:

"I, A10, make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry. 15:36

There are no documents to be produced with my statement.

My connection with MAH is that I was on a student placement at Muckamore and upon qualification I worked there as a learning disability nurse.

15:36

The relevant time periods that I can speak about are my student placements from 2011 to 2014, and 2015 until 2019, when I was a qualified nurse.

I studied Learning Disability Nursing at Queen's University, Belfast. As part of this course I did approximately three placements at MAH." 15:37

And the witness then between paragraphs 4 to 7 goes on to describe enjoying working at Muckamore as a student nurse, describing this as a supportive, positive experience. They say that after they qualified as a learning disability nurse and worked elsewhere, they applied for a job in Muckamore because it meant less travelling for them, and when they started there were approximately 10 other nurses from their year on other wards. 15:37 15:37

Paragraph 8:

15:37

"In around 2015, I began working at Muckamore on Cranfield Womens' Ward in the admissions and treatment section. My induction consisted of my preceptorship. This lasted for the usual six months. During this

time, a Senior Staff Nurse Band 5, mentored me. I was shown around Muckamore, around the Cranfield Ward, given written records, shown the clinical room and met with the patients. I met with my mentor around once per week." 15:38

And the witness goes on to describe in some detail how supportive this mentor was.

Paragraph 9: 15:38

"I knew the wards and became familiar with some of the staff so I settled well. I remember some of the staff that were there when I was a student nurse in Cranfield Women. I felt that the staff were all very welcoming. 15:38 I did not know the particular ward staff or patients. I was nervous and a little scared. I saw challenging behaviour but I felt supported by the other staff in Cranfield Ward. I would call it a tight knit team. 15:38

The nurse in charge was H285. I felt that she led a great team. There were a lot of Band 5 nurses and a lot of very experienced nurses. H285 was a Band 6. I felt this team was very good in that it could support new nurses like me. H285 did my appraisals and they 15:39 went well."

And the witness describes Cranfield as a well staffed ward and staff moral when they began at Cranfield as

being high. The witness also describes becoming MAPA trained and being a MAPA trainer for three years.

Picking up at paragraph 11:

15:39

"The atmosphere for patients seemed to me to be quite safe. Some of the higher ability patients would have said to me that they wanted to stay there. There was a familial relationship between the staff and the parents, however it was positive and professional. 15:39
There were really tough days and certain admissions which may have been harder to manage. The staff always had to keep in mind the patients who were already on the ward. That was always at the forefront of my mind. I asked myself were the patients safe?" 15:39

The witness then describes all of their experience at Muckamore being with female patients and only rarely being on other wards and seeing male patients when responding to alarms for short periods of time. 15:40

Paragraph 13, the witness describes staff usually being assigned three patients each by ward management and this being reviewed regularly, and they describe keeping patient records updated and being supported by 15:40
Band 3 nurses, and their tasks including linking in with patient's next of kin and speaking with patient's next of kin when updating care plans or if patients required more toiletries or items.

At paragraph 14, the witness describes taking patients out all the time and having to notify other staff and obtain permission following MDT risk assessments. And the witness gives some examples of shopping, restaurant and cinema trips, and an example of patient P176 who was diagnosed with cancer after discharge and who had requested that this witness and H820 visit them in the cancer centre before they passed away, and would have commented on how much they enjoyed their time at Muckamore. 15:41 15:41

Paragraph 15:

"Our discharge planning meetings displayed good care as they were opportunities for us to demonstrate support for patients and their individual needs in resettling them to the best possible option. Some of the patients did not have supportive families and I would have had to fill that gap. I did this by sitting with the patient and gaining their consent for me to help them in their discharge. As far as I was aware, there were very few complaints about Cranfield. However, any complaints received were dealt in accordance with the Belfast Trust's complaints procedure. 15:41 15:41

At Christmas time, other staff and I were given gifts from families. Upon discharge I received a lot of good feedback but staff were not good at recording the

positive feedback. One patient, P159, always made me a card for my birthday and it really gave me a morale boost. She was very good. I think that she is still in MAH.

15:42

I did not see any incidents of poor care or abuse of patients. Often staff were subject to assault from patients. This was at times quite difficult emotionally and physically. For example, a patient, P109, was admitted to Muckamore due to a crisis at home. It was quite difficult for all patients coming into a ward with 15 women. However, P109 was quite mentally unwell. It was the first time I had directly experienced a physical attack. I had only been working on the ward for around five months. P109 pulled my hair and pulled me to the ground and I burst out crying. I lost quite a bit of hair and still have a bald patch due to this incident. P109 was discharged and then readmitted sometime later. She and I had developed quite a good relationship whilst she was in MAH. However, she had another crisis. On this occasion she came behind me and punched me on the nose. I had concussion. For four to six hours afterwards I felt lightheaded and weak. The next day she came to apologise to me. I accepted her apology. I quickly learned how to deal with this type of behaviour and incident. I dealt with this type of incident by using the MAPA skills I learnt and using verbal de-escalation by talking to the patient in a calm manner.

15:42

15:42

15:43

15:43

We had good de-briefing skills. As a MAPA trainer I debriefed the patient and the staff. In or around 2018, a patient, P167, was coming back from day care and she knew what car I drove. She took a stone from day care, threw it at my car and cracked the windscreen. I asked a member of management if they would cover the cost of this? I never heard back from anyone. Nothing further was done when I complained about it. P167 targeted younger members of staff by running at them to hit out and pulling hair and that was quite difficult to manage. 15:43 15:44

I saw positive times where MAPA was used safely and effectively. An example of this would be with P177 who required a lot of physical intervention, but as I learned her ways, I was able to work with her. I would have asked her what she wanted to do, meaning she would walk to her room on her own, and so I was using de-escalation techniques and MAPA intervention less. 15:44 15:44

From memory, I did not see any bad practices of MAPA. One particular assault on staff stands out in my memory. A high ability patient..."

15:44

- who the witness names:

"...was admitted for drug and alcohol misuse. She attacked a Band 6 nurse, H298. I do not recall the

precise date. The incident took place in Cranfield Womens' Ward. She strangled her to the extent that H298's lips turned blue. A staff member, I cannot recall who, using their personal alarm summoned for assistance and the police attended. I was working the next morning and the patient was in crisis again in high emotion and her behaviour became challenging to the extent that she broke all the windows on the washed. My priority was to move all of the other patients on the ward to a safe place. The patient was very upset and displayed self-injurious behaviours in the form of cutting her arms using the glass from the broken windows. A staff member telephoned the police. H77, MAH manager, ran out to her in the grounds. I was worried that she could have turned on him but she dropped the glass. He supported her by talking to her and asking her to drop the glass. She responded well to senior members of staff. 15:45 15:45 15:45

Another assault which stands out in my memory is from when I moved to Killead Ward. P52 assaulted a staff member who was on special observations for her, meaning she was nursing her very closely. The member of staff, H821, a bank nurse, was one-to-one nursing her. P52 was tall and had severe autism. I was her named nurse. On this particular day P52 was upset and agitated. H821 was approximately 50 or 60-years-old. P52 pushed her against the wall resulting in H821 breaking her hip." 15:46 15:46

And the witness says that they don't think that H821 then returned to nursing after this assault.

"I do not recall particular incidents that I was uncomfortable with. At times I was frightened, especially when a patient..." 15:46

- who the patient names:

"...was breaking windows, for example. That really frightened me. The intensity of some patient's behaviours did sometimes concern me. However, I always felt safe because I had a good team around me. This changed over time when the staffing crisis developed and as staffing levels decreased and the level of experienced staff decreased I felt less safe. 15:47

In around 2016, the patients and staff moved from Cranfield Ward to Killead Ward. That was a massive move for the staff and the patients. I was on annual leave at the time. The patients and staff were then moved to Ardmore Ward. I cannot recall when this took place. These were the same staff and same patients. Ardmore was a treatment and admissions unit and patients would come there following mental crisis in the community following outward physical aggression against family or staff in the community. This was the same as when we were in Cranfield Ward, we just changed 15:47 15:47

environments. Sometimes the patients came in as detained patients on the basis of a Mental Health Order, other patients admitted themselves on a voluntary basis. If patients were presenting as high risk, we, Band 3 support workers or Staff Nurses, would have went through the MHO to assess detention. This process involved discussing how long they would be here for and the different forms of the MHO that they may have been detained under. The ward had a lot of different patients. Some were really high ability but with a borderline learning disability and some had a very low ability in terms of learning disability and required much more support with meeting their daily living tasks. 15:48 15:48

I do not think that the atmosphere changed with different staff on duty. There was quite a strong staff team with a good mixture of very experienced and some new staff. In 2018 or 2019, the staffing crisis became serious and MAH lost a lot of staff from what I recall all wards. The loss of staff resulted in the increased use of agency staff and periods where wards were understaffed. This meant that patient care was impacted given at times we could not provide outing trips or cookery sessions as we just had the right amount of staff to ensure safety. It was harder for me to stay motivated and confident about the care I was providing when each day I was coming into work with a less experienced team. The patients would have felt a 15:48 15:49

bit uneasy and unsettled because of staffing changes and receiving care from members of staff with whom they were less familiar. Some patients would have been used to their staff and then agency staff came in and some had broken English. For example, P176 and P177 found this difficult." 15:49

The witness then describes work on the ward being allocated by use of an allocation sheet by the nurse in charge for the next day, and this changing depending on different patients being admitted, and the witness describes again feeling supported by H298 and their mentor. 15:49

"Towards the end I would not have felt as supported by management. In 2019, for example, we may have needed 13 staff, but then I vividly remember only six staff on shift. I called the nursing office and I do not recall who I spoke to. They told me that they had no staff but they ended up sending over some staff from the nursing office to me for the morning. I did not feel that management was as aware of the staffing levels on the ward as they should have been. When I was assaulted I felt supported by my colleagues, and in particular my Band 3 colleagues. Following my assault I received a one-to-one with H298. The de-briefing was informal. The Datix forms would have been filled out. These were completed for patient-on-staff attacks and patient-on-patient attacks. These were completed 15:50 15:50 15:50

on-line and they would have went to our management.

At times the culture of management was stand-off'ish. They would not have been on the ward environment often. This was especially the case with very senior management. They only appeared in the case of a very serious incident. I do not think they were as involved and as supportive as they could or should have been. H298 was always on the floor. She did work in her office sometimes but she was supportive." 15:51

And the witness then describes ward staff meetings every five to six months where staffing, resources and other matters were discussed, and the witness describes these meetings as an open space where they could suggest improvements or raise concerns. 15:51

Paragraph 29:

"I do not recall making any complaints or raising concerns, save for one incident involving a patient's medication. P178 had been prescribed diazepam, I think, but it had been given at too high a dose. I gave her the diazepam and spotted the error. The patient was informed as well as her next of kin. As a result of this we had to go on medication training. I felt that this issue was adequately addressed." 15:51 15:52

The witness then describes gathering information from

family, social workers, and general practitioners for admissions. If they weren't on shift, handovers were provided, which were detailed, and they also checked care plans and risk assessments, and towards the end of their time at Killead Ward, PIPS were introduced every morning, which included an extra session section on restrictive practices and risk assessments. 15:52

Paragraph 31: 15:52

"I think that family involvement with patients on the ward was something which was supported. I feel we were very open with family coming to visit. If, for example, a family needed support to facilitate a visit, we would have provided that. On some occasions some of the family wanted to come onto the ward. This was risk assessed in detail as we were aware of the need to protect them in case of incident or crisis. This never really happened. There were some families who never visited. 15:52 15:53

"I recall a patient..."

- who the witness names: 15:53

"...who had been granted home visits at a MDT meeting chaired by Dr. H40. Following these visits the patient and her mum were quite intoxicated with alcohol. It was quite difficult to manage when the mum was not

complying with the guidance of staff. The patient caused a massive crisis. She had been eating her supper and she got a fork and ran after a member of staff to stab her with it. The patient has now passed away. Overall mostly family visits were positive." 15:53

The witness then goes on to outline that nurses completed robust nursing assessments upon admission, where they asked patients about daily skills and patients interests in order to monitor their baselines, 15:53 and they monitored skills through cooking, baking and other activities. During admission, detailed information was compiled about challenging behaviour and mental health to establish and monitor patient baselines, and any new behaviour that patients had 15:54 learned was also recorded in handover notes.

At paragraph 35 the witness describes that after admission in the first few weeks, assessing patients via a daily written report, which eventually became the 15:54 PARIS system, that Band 3 nurses were important because they were on the ward all the time observing patients, and that the witness and more senior nurses did their own assessments, covering physical health, and although these assessments were sometimes difficult for patients 15:54 in terms of taking observations, they would have fully considered this and discussed this with the patients and families and documented these assessments.

"After admission the care plan for each patient was determined from the nursing assessments. Initially this was recorded in writing and then on PARIS. These were reviewed every three months automatically but there could have been changes. We collaborated when reviewing these. For example, a patient P176 read through her care plans with me. Some patients read through their own care plan. On other occasions the care plans would have been read and considered by the patient's next of kin. 15:55

Patients had a range of treatment plans. The treatment plans were based on our assessments and observations. Some of our patients had Positive Behaviour Support Plans which provided effective treatment. There were two patients, P179 and P180, who had electroconvulsive therapy in Holywell Hospital, Antrim. I cannot recall their surnames. P179 had 12 sessions and we observed an amazing change in her presentation. 15:55

Medication reviews were considered as part of the multidisciplinary team meetings. These were attended by a range of professionals and for patients on our ward, H84 the social worker, and the most senior Staff Nurse, my mentor, or H298. When the more senior people left I began attending these meetings." 15:56

The witness then outlines that patient risk assessments were completed on admission and staff were made aware

of any known risks. Changes in behaviour were recorded. Information from relatives was used to establish a baseline. And the witness gives an example of Patient P181 getting into crisis at home and their behaviour at Muckamore escalating to attacking patients through learned behaviour from other patients, but this behaviour being managed and risk decreasing with new medication and ongoing assessment, and the patient making considerable progress to the point that they were discharged in 2019. 15:56

The witness goes on to say that patients were referred to speech and language therapy or occupational therapy, vulnerability was assessed on admission, and then also daily, and the witness also gives an example of Patient P176 whose self-injurious behaviour spiked around their parents' anniversaries, and staff addressed these increased risks periods with one-to-one care. 15:57

Picking up at paragraph 40, the witness describes meal times being supervised by two to three staff and being very well supervised. 15:57

41: 15:57

"The use of restrictive practices was recorded and reviewed on a monthly basis or as and when required. When I first started I was not aware of the full range of restrictive practices. As I became more experienced

I became more familiar with the paperwork and process and sign off.

Distressed patients were provided with verbal reassurance. Their anxiety levels would have been increasing and I assessed whether they would be outwardly aggressive to others or to themselves and I would consider MAPA. That was the most restrictive and you did not want to go to do that, but if the patient was a risk to themselves or others, MAPA was necessary and used to keep them safe. Sometimes patients were prescribed PRN and we had to consider whether they met the threshold for the use of PRN. 15:57 15:58

By 2018/2019, restrictive practices were well recorded. It would normally have been the nurse in charge who made the decision to use seclusion. A Band 3 nurse would have been on the ward and may have used MAPA. You could say it was whoever was involved in the crisis were involved in the decision making. If you were the nurse in charge it was up to you to make the decision about PRN, physical intervention, and PSNI intervention." 15:58 15:58

And the witness then recalls restrictive practices including door locks, lap belts on wheel chairs, and one-to-one nursing, which would have been discussed with patients and families. There was a seclusion room in Cranfield 1 in 2015, which the witness was involved 15:58

in supervising and documenting patients in the room, and states that a staff member was outside that room at all times recording in patient notes every 15 minutes.

Paragraph 47: 15:59

"I do not really recall any particular use of seclusion. The night that the patient..."

- who the witness names: 15:59

"...tried to strangle H298, I know that she went to seclusion. I was more supporting H298, so I did not witness seclusion as such. I do not really recall seclusion being used very often. 15:59

When CCTV was installed we were in Killead. There were 32 or 33 cameras installed as it was a large ward. I think we were told by e-mail. I remember the cameras were put in by men and we had some patients who were 15:59 sexually different or had experienced sexual abuse or trauma in their past. I recall some patients changed into inappropriate clothing due to the presence of men on the ward. That sometimes turned into verbal abuse between staff and patient when we had to get the 16:00 patient to change into more appropriate clothing.

In addition we had some patients who were paranoid and felt that people were watching them on the camera. I

do not think that this was well thought through by management. The patients should have been consulted and informed more, although I do think this may have been discussed at some of the patient meetings.
We were sent emails about CCTV, but I do not recall whether we were told or, if we were told, when they were being switched on or whether there was audio. I remember some patients asking me whether they could hear us and I did not know. Our patients got used to the CCTV and we just got on with it. 16:00

I think that the presence of CCTV had an impact on staff and patients. For some staff when the abuse allegations started circling in around 2018, staff became more self-conscious that they thought people were watching and judging. 16:00

We were part of the discharge planning meetings. We met with the staff in the private facility who would be caring for the patient and we provided a handover. For example, for P176, I had numerous discharge planning meetings. She attended them along with the staff from where she was going. I would say we were quite heavily involved in discharge planning." 16:01

16:01

The witness then describes being involved in discharge planning during preceptorship with her mentor and having experience through shadowing senior staff.
The witness then describes delegating to Band 3 staff

based on assessing patient needs. For example, delegating aspects of P167's care to older Band 3 staff because they did not respond well to younger staff, and the opposite being the case with P176.

16:02

The witness recalls there being three skilled and experienced unregistered staff in 2016/17, who they did not manage or delegate to, but recalls those staff being allocated tasks such as taking P159 to a hospital appointment. They don't recall any issues with these staff and the witness says that they would have reassessed patients daily living activities in addition to regular three monthly formal reassessment.

16:02

The witness describes assessment and management of patients' physical needs, including tests and observations upon admission, and assessing patients' behaviour patterns, and that there was also always a doctor on-call for night shift, and patients who required more physical intensive physical treatment were taken to Antrim Area Hospital.

16:02

The witness describes being involved in administering PRN, and gives examples of two patients, P177 and P176, who would request PRN. When a patient was in crisis there was a previously agreed second line stronger PRN, and PRN was prescribed by a consultant psychiatrist and also administered by intramuscular injection for a real crisis, and they recall one such occasion of a

16:03

consultant psychiatrist administering this by injection to a patient's hip.

Picking up at paragraph 60:

16:03

"MAPA was discussed and decided at MDT meetings. In the way that PRN was managed, MAPA use varied from patient to patient and was managed according to a particular patient's care requirements. I feel that all decisions about restraint and seclusion were 16:03
appropriately recorded.

Consent, incidents, changes to treatment, and the outcomes of MDT meetings were discussed or explained to the patient, their family, or next of kin would be 16:03
updated, and the patient was able to ring their family or next of kin if they wanted."

The witness then describes a range of staff interventions for therapeutic purposes, including 16:04
taking patients on walks, a beauty room, shopping trips, and states that Band 3 staff were very forthcoming with ideas for trips and events, which had a great impact on patient well-being.

16:04

The witness received clinical supervision from H285, H298, and a more senior nurse, H214, for a period of time.

The witness doesn't think that they had protected time for CPD training, and occasionally requested night duty to use this quieter time if the ward was well staffed to do CPD and catch up, but not during 2018/2019.

16:04

The witness then indicates that they would like the Inquiry to consider staff views on Muckamore as much as those of patients and families.

Picking up at paragraph 66: 16:05

"To summarise my statement, overall my time at Muckamore was quite positive. However, towards the end of my time there I did get extremely stressed with the lack of staff and trying to manage a very busy ward." 16:05

The witness then gives some details about a medical condition which they were told was due to stress, which they say cleared up after they left Muckamore in 2019, and the witness concludes at paragraph 67: 16:05

"Some of the staff I worked with in MAH were fantastic in communicating with patients and were caring, kind individuals. I learned so much at MAH and my work there helped me grow in confidence." 16:05

There is then, Panel, a signed Declaration of Truth.

That concludes the staff evidence for today, and we

have two further witnesses tomorrow.

CHAIRPERSON: Excellent. Thank you very much indeed. All right. So we've got two witnesses tomorrow. It may be quite a long day tomorrow as well. We'll see how we do. Okay. Thank you everybody very much. 16:06 10:00 o'clock tomorrow.

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 26TH JUNE 2024, AT 10:00 A.M.