ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Oscar Donnelly

Date: 28/06/2024

I, Oscar Donnelly, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of myself in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

There are no documents produced with my statement.

Qualifications and positions

1. I do not hold a health and social care professional qualification. I hold a Masters degree in Business Administration, June 1991.

2. I held the following positions. From 1991 to circa 2001, I was Business Manager Learning Disability Services, North and West Belfast Health and Social Care Trust (NWBHSCT). From circa 2001 to 2004, I was Assistant Director Learning Disability Services NWBHSCT. I left NWBHSCT in 2004 having been appointed Director of Mental Health Services, Homefirst H&SC Trust.

Module

3. I have been asked to provide a statement for the purpose of M7: MAH Operational Management.

4. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn. In doing so I would reflect to the Inquiry that my response to the questions/issues are in respect of the arrangements extant some 20 to 33 years ago and I am challenged in regards to clarity of recollection, including differentiating between what I believe did happen and what I suppose must have happened. In making my responses where I have referred to others, I have used job titles rather than individual names as there may have been more than one post holder in any role over my time of employment at NWBHSCT. I can provide the names of individuals if that would be helpful to the Inquiry.

Q1. Please explain what your role was in the operational management of MAH and when you held that role? In doing so please explain:

i. The cohort of staff or area for which you had leadership and/or management responsibility.

ii. The day to day responsibilities of your role.

5. I was employed by the North and West Belfast Health and Social Care Unit of Management (UoM), which subsequently became the North and West Belfast Health and Social Care Trust (NWBHSCT), in June 1991 as a Business Manager in the Learning Disability Directorate. Prior to this I had worked for the Northern Ireland Housing Executive as a Regional Grounds Manager. This I recall was one of three Business Manager posts created by North and West Belfast at that time in response to new organisational arrangements involving the separation of service commissioning from service delivery in Health and Social Care in Northern Ireland. The new arrangements included the creation of contracts, or service level agreements as they were known, between commissioning health and social care boards and the new provider organisations, of which NWBHSCT was one.

6. I reported in my role as business manager to the Director of Learning Disability Services. I was responsible for the administrative & clerical staff in the Learning Disability Directorate of the Trust. This included administrative & clerical staff across community learning disability facilities and administrative & clerical staff at

Muckamore Abbey Hospital. The latter comprised medical records, medical secretaries, typing pool, switchboard and hospital library staff. My base was in Trust headquarters in Belfast though I split my time between Trust headquarters and Muckamore Abbey, initially using whatever office was free in Muckamore and eventually also having an office dedicated to my use there, along with the office in Belfast.

7. My main duties were;
   - Supervision and management of the learning disability directorate administrative and clerical staff. This included responsibility for the medical records section at Muckamore Abbey Hospital who had responsibility for supporting administration arrangements for the mental health order including ensuring that required forms were checked and submitted to the mental health commission. Medical Records would also have been responsible for ensuring that the required Korner statistical returns were completed and submitted to Trust head quarters for submission to the Department of Health (DoH). This to my recollection was largely around hospital bed occupancy including number and types of admissions by legal status.
   - Completion of service level agreement responses to the four Health and Social Care (H&SC) Boards commissioner requirements. Beds at Muckamore Abbey were contracted for by all four H&SC Boards in N Ireland. Predominantly these were for the Eastern Health and Social Care Board (EHSCB) which was the biggest commissioner with just under 2/3 of the patients, followed by the Northern Health and Social Care Board (NHSCB) with just under 1/3 of the patients. The other two H&SC Boards had local Learning Disability inpatient units and only used a small number of beds at Muckamore Abbey for the care of patients who had more complex needs. I would believe that the four H&SC Boards funded NWHHSCT for services at Muckamore Abbey Hospital on a basis broadly proportionate to their bed useage. The service level agreements were block contracts meaning that the Boards contracted for access to an agreed bed capacity rather than for actual bed usage. Whilst processes developed across the years broadly each year the DoH would issue a Priorities for Action and H&SC Boards would issue commissioning statements based

upon this and further reflecting their population needs and priorities and Trusts would then respond to those statements. I had a responsibility for collating that portion of the Trust's response relevant to Learning Disability Services both Hospital and Community. This process would lead to service level agreements between each of the Boards and the Trusts. I do not recall with clarity the content of these agreements and I would believe that these evolved over the years. I would believe that always they would have included information on funding and activity. I would believe that at various times they included a requirement of the Trust to respond on issues of service development (e.g. to reduce the use of respite care at the hospital, to resettle x number of patients, to reprofile wards) and quality improvement initiatives though I cannot recollect specific examples of these – but would believe that these mostly originated with the Trust. The Trust would also have used this process to highlight pressures or issues in service delivery including accommodation and estate infrastructure.

- Preparing for and attendance at contracting meetings with all four Health and Social Care Boards throughout the year. My recollection is that these meetings were quarterly for EHSCB and NHSCB and annually for SEHSCB and WHSCB. For EHSCB they would be for the range of Trust services including Muckamore Abbey and Community LD services, for the other three boards they would solely be for Muckamore Abbey Hospital. I would occasionally attend the EHSCB contracting meetings and would generally always attend the contract meeting with the other three boards where the focus was entirely on Muckamore Abbey.
- Preparing reports on activity to inform contracting meeting and liaising with finance colleagues on the completion of financial reports.
- Co-ordinating the completion of the Learning Disability annual business plan and co-ordination of updates on progress. The NWBHSCT would each year develop a corporate business plan setting out its priorities for the year ahead reflecting its plans and responses to issues such as commissioner intentions, financial targets, service pressures, issues of patient safety or governance, workforce, capital and estate requirements etc. Learning Disability services would contribute to this, and at least for some of the years that I was there developed a directorate business plan which would, along with business plans from other parts of the organisation, then be incorporated into an overall

corporate business plan for the Trust. This involved me seeking and collating information from a range of sections heads etc. and drafting up the business plan for approval by the Director of Learning Disability prior to it being submitted to the Director of Planning for drawing together into the overall Trust document. My recollection is that throughout the year we would periodically, perhaps quarterly, be required to provide updates on progress against plans, to be submitted to planning directorate in order to provide updates to the Trust Senior Management Team (SMT). I believe that I would also have brought drafts of the business plan and the quarterly updates to the Core Hospital Team for discussion. I would also have coordinated and drafted information on behalf of the learning disability directorate to inform the content of the Trust's annual report.

- Leading projects on and preparing business case bids for, additional funding either against cost pressures or new developments or new requirements. This could either be for relatively small projects such as procurement of medical records storage & accommodation, establishment of the multi-disciplinary library or for larger projects such as for the new core hospital and the reprovision of Children's Services.
- Attendance at weekly Hospital Core Management Team meetings and monthly Learning Disability Directorate meetings. These meetings were chaired by the Director of Learning Disability Services and are referred to further below.
- Specifically, for Muckamore Abbey I was the link person from the directorate leadership team with support services senior management across estates, laundry, catering and transport. These managers were based at Trust Headquarters. Mostly day to day issues were dealt with on site between nursing management and local support services leads however if there were issues which couldn't be resolved locally or of particular concern then I could raise these at that level. I was also the link person with the Supplies Distribution Centre which was the regional body which procured and distributed supplies on behalf of H&SC. An example is an initiative to establish arrangements whereby nursing staff could use requisitioning arrangements to procure clothing for patients from local clothing outlets such as Marks and Spencer and Dunnes Stores

- Leadership of specific ad-hoc projects e.g. for the introduction of an electronic patient administration system at Muckamore Abbey, the development of a Trust Administrative Operational Policy Manual, the provision of new accommodation/equipment etc.
- Co-ordination of arrangements, papers etc. for the annual inspection of the hospital by the Mental Health Commission (MHC). These were announced inspections and in advance of these the MHC set out a letter to the Trust advising of their requirements. This included providing information on the patient profile in each ward and their legal status, advising patients and relatives of the visit and giving them the opportunity to meet in private with visiting commissioners and the provision of an overall programme. There would be a number of commissioners on the inspection who would split into teams for the ward visits. It is my recollection that this would take place in a single day though it may have been two. It would commence with a briefing meeting by the commissioners with the hospital management team and finish with a feedback meeting which would also be attended by members of the Trust SMT including the Chief Executive and Medical Director depending upon availability. I would also have led on collating the Trust response to MHC reports of their visits including on any recommendations. I would also have been involved with the co-ordination of arrangements for other ad-hoc visits/events e.g. by the Hospital Advisory Service Inspection, Antrim Council visits, local faith leaders, etc.
- Complaints manager responsible for the administration of complaints at Muckamore Abbey. This involved ensuring that, working to designated timeframes, complaints were acknowledged, sent to an appropriate individual to arrange to investigate and a draft complaint's response sent for review and approval by the director of learning disability. Responses approved by the director were sent by her to the Trust complaint's manager at the chief executive's office for final approval and chief executive signature and issue to the complainant. My role did not involve complaints investigation though it would have involved drafting a single response based on reports from more than one investigator.
- Income Generation – in the 1990s Muckamore Abbey had a number of "extra-contractual referral" patients admitted from the Republic of Ireland. I would have

led on developing and agreeing the service levels agreements and contracting for these with the various commissioners in the Republic of Ireland.

- Directorate nomination on a number of Trust and working groups or committees some standing, some ad-hoc e.g. Trust Endowment and Gifts Committee, Trust Capital Group, Cash Releasing Groups, Person Centred Information System (PCIS) IT project, Y2K readiness preparation, communications group etc.

8. Circa 2000 the NWBHSCT were tasked in the Department of Health's (DoH's) Priorities for Action document to develop a capital outline business case (OBC) for the development of a core hospital service on the Muckamore Abbey site. This followed regional work led by a DoH convened senior working group describing a future model of care across three strands comprising, 1) the development of community treatment capacity to reduce the need for admissions and support people in the community who had ongoing treatment needs, 2) the resettlement from hospital of people no longer requiring hospital care and 3) the future need for inpatient treatment and care. Aligned to this the EHSCB and the NHSCB indicated their future commissioning requirements for inpatient beds from the core hospital service. This was for a total of 105 beds with the other two Boards estimated to require 5 beds each giving a total of 115 beds. The work of this regional group included completing a specification for the core hospital which set out the types of needs to be met by the future hospital service such as mental health assessment and treatment, forensic assessment and treatment etc. The group which completed the specification for the core hospital was chaired by the EHSCB Director of Public Health Medicine and included senior representation from the EHSCB, NHSCB and the NWBHSCT.

9. The OBC was completed in line with treasury "Green Book" technical guidance and set out the strategic context, including the commissioner bed needs as set out by the H&SCB's, the profile of needs as specified in the specification of the core hospital, and appraisals of the current estate & accommodation. It identified, developed and appraised a range of options for delivery of the service. This included both capital costings for buildings and site infrastructure replacement and/or upgrading, and revenue costings for staffing and other running costs.

10. I was given responsibility by the NWBHSCT for leading on the development of this OBC for the Trust and at this time my post was subject to job evaluation with an outcome that my position was upgraded to Assistant Director. I believe that this occurred in 2001. In this position I was also given the role of link person from the core management team with the “core professions” at the hospital who were a relatively small group of professional staff whose line and professional management was based outside the hospital in the community. These were speech and language therapy, dietetics, dental, orthotics, pharmacy and psychology. This link role had previously been done by the Site Director who retired about this time and whose role was redesignated as Nursing Services Manager.

11. Following the completion, submission and approval by the DoH of the OBC for the core hospital I was then involved in the initial stages of the project for the design of the new hospital. I was the learning disability directorate link person with the Trust head of estates and the project leadership at DoH Health Estates. The Project Board was chaired by the Trust Chief Executive and the Project Team was chaired by the Director of Learning Disability. Following the commencement of this I got allocated another member of staff from a nursing background to liaise across nursing and other professional staff with the appointed architectural design team, to help ensure that the specific nursing and care requirements of patients were reflected in the building design.

12. The core hospital specification did not include for inpatient assessment and treatment services for children and young people reflecting that it had since the early 1990s been DoH policy that children and young people should not be cared for in facilities alongside adults. Following approval of the OBC for adult services the Trust was asked by the DoH to submit a further OBC for the reprovision of children’s treatment services in a community setting separate from services for adults. I led on the development of this OBC which was submitted to DoH in 2004. Children’s services were eventually re-provided away from Muckamore Abbey in the Iveagh site in Belfast.

13. In the latter years of my employment at NWBHSCT work associated with the development of these two OBCs and the subsequent project for the design of the core hospital formed a major focus of my work.

14. I resigned my position in North and West Belfast Trust in 2004 to take up the position as Director of Mental Health Services in the then Homefirst Health and Social Care Trust.

Q2. Please explain your understanding of the structures that were in place for the operational management of MAH?

15. **Wards;** Each ward had a ward sister/charge nurse responsible for care on the ward. Above these there were four senior nurse managers each of whom had responsibility for oversight of a number of wards. The senior nurse managers each also had some functional responsibilities across all wards e.g. for training, workforce etc. The senior nurse managers were based in the nursing office. There was also a duty nurse in the nursing office each day which I believe functioned in-hours and out of hours. The nursing office provided routine support to wards- e.g. if there were staffing issues on a particular ward for a shift or shifts, then the ward sister/charge nurse, or in their absence the nurse in charge for that shift, would contact the nursing office to request additional staffing. The senior nurse managers reported to the Site Director/Nursing Services Manager. I believe that during my period at NWBHSCT the responsibilities of the senior nurse managers changed to a functional arrangement however I cannot remember the details of this and to my recollection these encompassed the same responsibilities overall being undertaken by the four senior nurse managers.

16. **Daycare.** There were a number of daycare sections each of which had its own lead. These leads reported to the Head of Daycare who reported to the Site Director/Nursing Services Manager. In addition to daycare there was also a Behavior Nurse Therapy department which had a lead nurse. This lead nurse worked closely with psychology. I'm not sure from memory whether the lead nurse for Behaviour Nurse Therapy reported to the Head of Day Care or to the Site Director/Nursing Services Manager directly.

17. **Medical Staff.** Each ward had a designated Consultant Psychiatrist. The Consultant Psychiatrists in addition to having inpatient responsibilities, for a number of wards, also had community patches across the Northern Health and Social Care Board and the Eastern Health and Social Care Board Areas, in which they provided outpatient clinics. One of the consultant psychiatrists was also designated as a Clinical Director for Learning Disability Services. One of the consultant psychiatrists was also designated as Medical Director for the N&WBHSCT. In addition to consultant psychiatrists there were two associate specialist doctors based full time in the hospital and who worked as part of the medical team under the supervision of the consultant psychiatrists. Out of hours there was a consultant on-call arrangement for psychiatric out of hours cover and an arrangement with a local GP surgery for out of hours cover for urgent medical needs.

18. **Social Work Staff.** There was a social work team based on the hospital site, led by a senior social worker who reported to the Head of Community Learning Disability Services who was a social worker by profession. This post was based in the community.

19. **Other Health Professionals;** There were a range of other health professionals who provided dedicated input to Muckamore Abbey Hospital patients. These included Psychology, Speech and Language therapy, Orthotics, Physiotherapy, Dental services and Pharmacy. These staff had line and professional management from community leads e.g. the lead for physiotherapy at the hospital reported to the Trust lead for physiotherapy who was based in the community etc. The community leads for these services would have lines of reporting through to Trust directors though I cannot recollect which leads reported to which directors. There were other ad-hoc arrangements e.g. part-time dietetics support was contracted in from the Royal Hospital as NWBHSCT did not directly employ dieticians. The orthotist at the hospital reported to the Medical Director for professional support. There was a quarterly liaison meeting at the hospital of the local leads for these professions as referred to at paragraph 7 above.

20. **Hotel Services;** These principally comprised Catering, Domestics, Laundry and Portering. These staff reported to a Hotel Services manager for Muckamore Abbey Hospital who was based at Muckamore Abbey and who reported to the Assistant Director for Hotel Services based at Trust HQ. The Assistant Director was responsible for the provision of these services across the Trust as a whole reporting to the Trust Director of Corporate Services.

21. **Estates Services;** There was an Estates Services manager based on the Hospital Site responsible for a number of tradespersons and grounds staff. This individual reported to the Assistant Director for Estates based at Trust HQ who was responsible for the provision of these services across the Trust as a whole reporting to the Trust Director of Corporate Services.

22. **General Administrative Staff.** These staff, as referred to at paragraph 6 above though their supervisors/managers reported to myself as Business Manager/Assistant Director.

23. **Other Administrative Staff.** There were based at Muckamore Abbey Hospital finance staff, whose duties included a cash office function, and human resources staff who dealt with local HR issues. The leads for these staff reported into the respective finance and human resources management structures for the Trust.

24. **The Site Director/Nursing Services Manager.** This postholder's primary responsibility was for Ward and Daycare services at Muckamore Abbey Hospital. When I joined the UoM/NWBHSCT the post was called Site Director which I believe may have been a title which predated the forming of the UoM though I am unsure of this. When the Site Director retired, circa 2001, then the post was redesignated Nursing Services Manager with essentially similar duties. The Site Director and then the Nursing Services Manager had day to day operational responsibility for ward and daycare services at the hospital. These postholders also had lead professional nurse responsibility for Muckamore Abbey and being a registered nurse learning disability was an essential criterion for the position. Operationally the postholders reported to the Director of Learning Disability and professionally to the Trust Director of Nursing. My recollection was that the Site

Director/Nursing Services Manager chaired a monthly meeting attended by the Senior Nurse Managers, Ward Sisters/Charge Nurses and Daycare management. I also believe that the Site Director/Nursing Services Manager had weekly meetings with the Senior Nurse Managers. It is my belief that the Site Director/Nursing Services Manager also attended professional nurse lead meetings with the Trust Director of Nursing though I am not aware of the frequency of those or who else would have attended.

25. **Director of Learning Disability.** The NWBHSCT had a Director of Learning Disability who had a base in Trust Headquarters and at Muckamore Abbey Hospital. The Site Director/Nursing Services Manager, Head of Community Learning Disability Services and myself reported to the Director of Learning Disability. The Director of Learning Disability Services reported to the Trust Chief Executive.

26. **Hospital Core Management Team**. This group met weekly and comprised the Director of Learning Disability, the Clinical Director, the Site Director/Nursing Services Manager, and myself. It was chaired by the Director of Learning Disability. Towards the end of my employment at NWBH&SCT funding was received from the EHSCB, by the Trust for clinical governance and a Clinical Governance Lead was consequently appointed for the Learning Disability Directorate. I believe that this individual also then attended these meetings. This appointment may have been circa 2003/04.

27. **Medical Staff Committee.** This group met at Muckamore Abbey Hospital. It was chaired by the Medical Director and attended by the Clinical Director and the other medical staff at Muckamore. This would have been attended by the Director of Learning Disability though I am unsure from memory if her attendance was purely in respect of specific matters or routine.

28. **Trust Senior Management Team (SMT).** This group met weekly and was chaired by the Trust Chief Executive. Its membership included the Director of Learning Disability, the Medical Director, the Director of Nursing, the Director of Operations/Executive Director of Social Work, the Director of Corporate Services

(including HR/Estates/Hotel Services), the Director of Planning and the Director of Finance.

29. **Trust Board.** The Trust Board met monthly generally in Trust headquarters but also from time to time at Muckamore Abbey Hospital. Included in its attendance was the Medical Director and the Director of Learning Disability.

Q3. Please explain the lines of accountability from MAH ward staff through to the Trust Board? Who decided that matters ought to be escalated? Was there guidance to identify when that ought to happen and what action ought to be taken?

30. Managerially the lines of accountability were from Ward Staff to - Senior Nurse Manager/Site Director/Nursing Services Manager to - Director of Learning Disability services to - Chief Executive/SMT and though to Trust Board. The Director of Learning Disability was a member of the SMT who attended Trust Board meetings.

31. Professionally the lines of accountability were from Ward Nurse to – Ward Staff to - Senior Nurse Manager/Site Director/Nursing Services Manager to – Trust Director of Nursing to - Chief Executive/SMT and through to Trust Board. The Director of Nursing was a member of the SMT and Trust Board.

32. Both the Director of Learning Disability and the Director of Nursing attended Trust Board and either of these could escalate an issue at Trust Board. In practice, I believe it would have been likely that issues would have been discussed first at SMT, which met weekly, prior to being taken to Trust Board. Issues relevant to ward accommodation would I believe also be brought to Trust Board, via SMT by the Director of Corporate Services and/or Director of Planning.

33. I cannot recollect what, if any, specific guidelines for escalating issues to Trust Board were in place at the time that I was employed in N&WBHSCT. I know that there were nursing policies in place however in my role I would not have had sufficient exposure to these for me now to remember them.

Q4. What training was provided for new line managers at MAH on staff management processes?

34. I believe that there was a staff induction programme for new staff appointed to the Trust. I have no recollection of any specific training routinely provided to new line managers internally promoted. I have no recollection of any training available for new admin management staff though there was no turnover of these staff in my time of employment there. I had no role or involvement in induction provided for management staff outside of my lines of reporting.

Q5. What regular meetings took place at Directorate level in relation to MAH? In answering this question, please provide an explanation of:

i. **How often meetings occurred.**
ii. **Who attended meetings.**
iii. **Who decided the agenda for meetings.**
iv. **What regular reports were provided to meetings.**
v. **How reports were prepared, and by whom.**
vi. **Who reports were sent to.**
vii. **How concerns were escalated.**

35. **Core Hospital Team;** This group met weekly and was attended by the Director of Learning Disability, who chaired it, the Clinical Director, the Site Director/Nursing Services Manager and myself. The Director's secretary would also have been in attendance to make a note of the meeting. Depending upon what was on the agenda others may have attended e.g. Finance officer, Head of Communications, Hotel Services/Estates etc. The agenda was compiled by the Director of Hospital Services. I have no clear recollection of what papers may have come routinely to these meetings and given the high frequency of these meetings I do not believe that there was a standard weekly report. I can remember a range of reports coming to the Core Team Meeting though the frequency of these reports and whether this was consistent across the period of my employment I am unable to reliably recall. These would relate to; Finance Reports, activity reports relating to bed occupancy and patient movement, use of respite beds, reports on accidents/incidents and on the use of seclusion, staff

sickness, contract compliance, complaints and compliments. The finance reports would have come from the Finance department, complaints and compliments reports would have come from the Trust complaints officer at Trust Headquarters, staff sickness came from a system called NIMs which held nursing information located in the nursing office. In terms of the others reports I have no clear memory of where they would have come from. I can recall that reports on incident trends were considered at this meeting. I would be clear that there was discussion on specific incidents or issues of concern, generally brought to the meeting particularly by the clinical director and also by the site director/nursing services manager. I can't recall specific examples of these. I can recall consideration at this meeting of reports on the use of seclusion. I also recall incident reporting which specifically looked not just at numbers but at vulnerability i.e identifying patients who were subjected to multiple assaults or incidents of self-harm over a timeframe and patients who were the perpetrators of multiple assaults and staff who were subjected to multiple assaults over a timeframe. I am unclear from memory of the system whereby these reports would have come to the core management team or of where the information would have come from as I do not believe that there were electronic accidents/incidents reporting systems at that time and my recollection was that individual incidents/accidents were reported on carbonized paper forms sent from wards through to the nursing office with copies to the site director and clinical director and to the director of learning disability services. I have no recollection of how accidents/incidents were notified to the Trust headquarter though I would believe that would have happened, perhaps from the Site Director's or Director of Learning Disability's Office.

36. There were also a range of documents and reports relevant to particular subjects at particular times, which would have been discussed at this meeting e.g. directorate plan, business cases, reports on the state of site infrastructure, adequacy of nursing staffing, reports from mental health commission inspections, hospital reprofiling, arrangements around capital works, ward closures, new proposals for service/quality improvements etc. These reports would have been sent to the Director of Hospital Services to be placed on the agenda.

37. Much of the discussion at these meetings concerned issues arising from the day to day management of the hospital and also the future development of services. Issues could be requested to be placed on the agenda or raised on an ad-hoc basis at the meeting by any of the attendees. Issues arising at ward or daycare level requiring discussion at the core management team would have been raised either by the Site Director or the Clinical Director. Issues were also raised through correspondence either internal or external most of which came through the director's office. Items for discussion would also have come down from Trust HQ including from SMT or Trust Board meetings and issues would also have been escalated by the Director of Learning Disability to the SMT and Trust Board.

38. Issues were also further escalated from SMT/Trust Board level to counterparts at the two main commissioner Boards. My recollection is of the UoM/NWBHSCT consistently over the years I was employed there pressing and making representations to the two main service commissioners on a number of key patient safety issues relating to the need for investment in site infrastructure, ward accommodation, improved staff:patient ratios, improved nursing skill mix and to address ward overcrowding.

39. Issues were also escalated by core hospital team attendees directly to commissioners and in particular by the Site Director/Nursing Services manager to the Mental Health and Learning Disability Professional Nurse Leads at the Eastern and the Northern H&SC Boards who were common visitors to the hospital and onto wards. Issues relating to patient safety were, I believe, also escalated directly by the Head of Estates to his counterparts in DoH Health Estates.

40. **Site Director's Nursing Meeting**. This was a meeting attended by the Senior Nurse Managers, Ward Sisters/Charge Nurses and Daycare management, chaired by the Site Director/Nursing Services Manager. I was not a member of this meeting, so I am not able to be sure about the detail as sought by the Inquiry. My understanding is that the agenda was determined by the chair. Issues could be raised by staff and at this meeting with management. I do not know what if any reports routinely went to this meeting. My understanding is that it was used for communications purposes and I do remember attending it to discuss the future of

the hospital following the decision taken by the then EHSCB and the request from the DoH to the NWBHSCT to bring forward a business case for a Core Hospital. I can also remember occasionally attending this meeting at my request to discuss issues I was working on such as patient mobility transport and patient clothing procurement.

41. **Medical Staff committee**. The chair of the medical staff committee was also the Trust Medical Director. This meeting was attended by all the hospital medical staff and also, I believe by a representative from the GP out of hours practice. I only very rarely attended this committee over the years I was there. My understanding is that it met monthly, and its agenda was set by the chair. I am not aware of what if any reports it routinely considered. The Clinical Director who was a member of this committee would have been a direct conduit between this meeting and the Core Hospital Team. I also remember that the Director of Learning Disability did, at least on occasion, attend this meeting. Issues of concern to medical staff could also be escalated directly from this meeting to SMT/Trust Board by the Trust Medical Director. I recall that in addition to professional issues relating to medicine that issues such as mental health commission reports, ward closures, service changes/developments etc would also have been discussed at this meeting.

42. **Core Professions Meetings.** This was chaired by Site Director until approximately 2000/01 after which time I chaired it. It met generally quarterly and was attended by on-site AHPs, head of social work team and other professions based on the site such as dental. The agenda was set by the chair though other attendees were asked in advance for any items they wished to be added. There were no routine reports considered. The main purpose of this was to provide a forum where information about what was happening at/to the hospital could be shared and discussed and to provide these staff a point of contact with the Core Hospital Team if there were issues they wanted to raise. I believe that when I chaired it, it was also attended by the Nursing Services Manager. If concerns were raised at this forum then I and/or the Nursing Services Manager could either deal with these directly or escalate to the core hospital team as required.

43. **Directorate Management Team.** This team did not to my memory meet on a regular basis. I seem to recall it meeting during my earlier time at the UoM/ NWBHSCT and then not meeting for several years, and then being reconvened again later in my time at NWBHSCT. When it did meet it was monthly and it was chaired by the Director of Mental Health. From recollection it comprised those on the core hospital team, the head of community learning disability services, the head of community LD nursing, the head of physiotherapy and senior representatives from planning and finance. I believe that it was also attended at times by the Consultant Psychiatrist in Learning Disability who had outpatient responsibility for the NWBHSCT community. I don't recall what routine reports were considered at this meeting. There was also a core learning disability community team meeting that I believe met on a monthly meeting. I was represented at this by a member of my community administration staff.

44. In addition to the above there were quarterly meetings at the hospital with the local RCN and Unison representatives on the site. At that time these representatives were both employed as ward charge nurses. These meetings were chaired by the Director of Learning Disability and attended by the Site Director/Nursing Services Manager and myself. The agenda was set by the Director which included times for each of the union representatives to raise issues which had been raised by members with them. Most of the issues raised by the union representatives would have been dealt with by the management staff attending. It also provided management with an opportunity to communicate to staff side on issues of change at the hospital.

Q6. What arrangements were in place at Directorate level to monitor the following:

i. **Staff implementation of and adherence to BHSCT policies.**
ii. **Nursing staff adherence to professional nursing standards.**
iii. **Clinical staff adherence to professional clinical standards.**

45. My response refers to NWBHSCT policies as I had moved employment prior to the formation of the BHSCT. I have limited recollection of the monitoring arrangements for NWBHSCT policies. I recall that Senior Nurse Managers

routinely undertook monitoring visits of ward settings though I do not recall the frequency of these. These would, I believe, have included checking on adherence to operational policy arrangements around the management of patient's property and funds held on the ward. To my recollection these would also have included monitoring arrangements on patient's clothing procured by named nurses for patients. I would believe that these monitoring visits would have focused on nursing and care practice much more widely than those two issues, however I am not aware of the detail. I understand that reports from these monitoring visits would have been considered by the Site Director/Nursing Services Manager.

46. I believe that estates staff undertook routine monitoring and inspections of wards particularly in respect of fire safety and other health and safety issues relating to estates and accommodation. I would, working with estates staff, have led on "Trial Major Incidents" exercises on an annual basis to test local adherence and responsiveness to the Trust major incident and fire safety policies.

47. I also believe that finance/internal audit would have undertaken routine audits of the management of patients' funds and the use of petty cash.

48. Legal requirements under the Mental Health Order were monitored by the Head of Medical Records with reports sent to the Mental Health Commission. If there were issues with detention and other processes the Mental Health Commission would have raised these with the Head of Medical Records and back to the responsible consultant psychiatrist. If there were systemic or recurrent issues of performance the Mental Health Commission would have raised this with the Trust. I have no recollection of such issues having to be raised by the Mental Health Commission with the Trust.

49. In terms of professional nursing and clinical standards I had little exposure or knowledge of these, which would have been dealt with through relevant professional arrangements through the Site Director/Nursing Services Manager with the Director of Nursing and the Clinical Director with the Medical Director.

50. I can recall issues relevant to clinical standards being discussed on occasion at the Core Hospital Team. For example, where a new standard for anesthetics indicated that general anesthetic should not be administered in a setting where there is not an intensive care unit on the site, NWBHSCT had to stop providing dental treatment at Muckamore Abbey to patients, both inpatient and outpatient, who required this to be performed under general anesthetic. Many dental outpatients attended Muckamore Abbey dental services, and I was then involved in negotiating the transfer of this activity with commissioners, with their making alternative arrangements in general hospitals' dental departments.

51. I can recall the development and use of a multi-disciplinary tool or instrument led by nursing staff to audit care on wards at the hospital. This was I believe called EQUATE. I was not involved in this and I have no specific recollection of seeing audit reports from this though I would expect that these would have come to the Core Hospital Team.

52. To my recollection the first time I heard the term "clinical governance" was circa 2002 or 2003 when the Director of Learning Disability advised that funding was being made available by the EHSCB to its Trusts to support clinical governance and that accordingly the Trust had allocated to the directorate a share of this funding to recruit a clinical governance lead. This post was recruited to around that time. I believe that following this a directorate clinical governance team meeting was established in circa 2003/04 though I have no recollection of the meeting. Prior to that time I do not recall that the learning disability directorate had a clinical governance team meeting or forum though there may have been other arrangements established through professional lines that I did not attend and do not recall.

Q7. If concerns about the particular matters addressed in question 6 were identified, how were they escalated?

53. I have no recollection of examples of concerns about particular matters being raised. I don't recall that I had any concerns to address in any formal manner with the staff reporting to me over my years in NWBHSCT. Generally I would believe

that concerns on staff adherence to standards and policy would have been dealt with through the relevant managerial and professional lines as I have identified above with reference to the appropriate Trust policies and procedures. I have some recollection of two instances where allegations of staff abuse on patients in both daycare and ward settings had been made and these were escalated under the Trust's disciplinary procedures with referrals to the police service. I recall these in that they were discussed at the core hospital team.

Q8. What performance management processes were in place to monitor and improve the performance of all staff, including those in leadership positions, at MAH?

54. In terms of "unit senior managers" there was in place a performance appraisal system whereby individuals agreed a set of performance and personal objectives with their line managers at the outset of the year. The manager would then meet with their line manager on a regular basis throughout the year and part of the agenda for this "supervision" would be to discuss progress and performance for the year to date. At the end of the year there would be a specific meeting focusing on last year's performance and discussion of the aims and objectives for the following year. This resulted in an appraisal report from the line manager which was used in determining what, if any, pay progression increment the individual would be awarded for the year. This applied to Directors and individuals who reported to them where they were on the unit senior manager terms and conditions. This may have included some next line reports as well. Some senior staff who reported to Directors may not have been on this system, where they retained professional terms and conditions. This system was I understand brought in across Northern Ireland with the formation of Units of Management/Trusts.

55. In terms of the next level down I have no direct experience and recollection of what systems were in place to monitor and improve the performance of all staff. Reflecting on my line management of the admin staff I would be certain that there was no overall organisational appraisal system. Based on my experience over the years since working in NWBHSCT I would expect that professional staff would

have received supervision in line with the extant requirements of their regulatory bodies, though I am also aware that this has been a developing position over the years.

Q9. Were line managers required to seek HR advice and/or inform HR if they undertook performance management meetings?

56. The appraisal process that I had experience of, which I referenced at paragraphs 54 - 55, would not to my knowledge, have involved my line manager seeking HR advice. If the Inquiry's question is in reference to addressing poor performance, then on the one occasion that I can recall, where I was involved with managing poor performance with one of my staff, due to high levels of absences, I did seek HR advice. As I indicated above there was an onsite HR presence readily available to give advice. It is also my impression that the Site Director met on a fairly regular basis with the Assistant Director for HR.

Q10. What arrangements were in place at Directorate level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also explain how any concerns about such matters were escalated.

57. I have no recollection of directorate wide arrangements for workforce monitoring, planning and implementation. In terms of my administrative staff I would have done this myself in regular communication with line management. There was no system for determining the appropriate number of admin staff. Over the period I was there, a small number of new positions were identified and recruited to with individual funding cases being made for these posts. Examples are with the establishment of a 5th Consultant Psychiatrist position at Muckamore Abbey a new secretarial position was established, with the setting up of the project to develop the core hospital a learning disability nurse project liaison post was established etc.

58. In terms of care staff I was not directly involved in this but I remember that there was a Nursing Information Management System (NIMS) located in the nursing

office which was used by nursing management in the oversight and management of nursing resources. I do believe that reports were brought to the core hospital team by the Site Director/Nursing Services Manager where there were concerns regarding staffing levels, sickness etc. I recollect that one of the Senior Nurse Managers had a designated workforce responsibility which as I would understand it included for recruitment, training and management of the bank nursing system. My recollection is that where any ward was below its establishment for a shift, due for example to sickness or patient observation needs, then the nurse in charge could call the nursing office to have the shortfall addressed.

59. I recollect that the overall adequacy of nursing establishments was an ongoing subject of UoM/NWBHSCT focus, negotiation and engagement with commissioners. This was in relation to both the baseline numbers and skill mix following the UoM/NWBHSCT taking responsibility for Muckamore Abbey Hospital, and then in relation to the nursing establishments as the hospital retracted. I remember in the early -mid 90s a Professor David Sines, who then worked at the University of Ulster was engaged to provide advice and assistance to the Trust in the development of nursing services – though I was not involved in this myself and do not recall the nature or extent of his remit. I remember that in the early/mid 1990s the Trust completed a report on the adequacy of the nursing establishment which was sent to the EHSCCB and NHSCB as I helped with the drafting and presentation of charts based on data provided from the nursing office. I remember throughout my years with UoM/NWBHSCT Directors and more particularly Assistant Directors of Nursing visiting the hospital from each of the two main commissioner organisations to meet with senior trust staff, to visit wards and to get a sense of the position directly for themselves. I was not involved with these visits.

60. My recollection is of a nursing establishment instrument being used to help inform discussions on adequate nursing levels though again I was not involved in this directly. I think it may have been called Monitor, though I am not sure of this, and that this was in later years I believe replaced by another instrument for assessing nursing levels called Telford. The latter was also used, as I recollect, to help

inform negotiations on projected nursing establishments and therefore costs in the outline business case for the new core hospital.

61. As the hospital retracted through net patient discharge associated with resettlement, the Trust on an ongoing basis negotiated and brought evidence to support its case, that there should not be a proportionate reduction in nursing staffing levels. This case was based on two main points, firstly the increasing profile of need in the remaining patient population as proportionately more able patients were initially resettled and secondly the need to improve quality/reduce patient numbers in the remaining wards.

62. Whilst I have no statistics or evidence to support this, it is my belief that the NWBHSCT had a degree of success in improving nurse to patient staffing ratios over the time of its management of the hospital, though this was undoubtedly from a low and neglected baseline.

Q11. What processes were in place to provide career development opportunities to staff at MAH to ensure that staff had the required specialist skills to deliver care in a learning disability facility?

63. I had no responsibilities in regards to the career development of professional staff at Muckamore Abbey Hospital and consequently have little detailed recollection in this regard. I can recall discussions at Core Hospital Team on the development of an adapted sex offenders programme for relevant staff to deliver in the forensic service. I also recall trainers from North America delivering training programs at Muckamore Abbey Hospital to staff on TEACCH for supporting people with Autism. I can remember the hospital arranging for staff to undertake accredited train the trainers programme in Care and Responsibility training in the management of behaviors that challenge. This was delivered by an NHS Trust in England to build in-house training capacity. I recall that there were discussions at the core hospital team on the delivery of this training to staff and ensuring that all staff received both foundation and refresher training. In terms of admin staff I recall designing and commissioning, with the help of the HSC Beeches Centre, a bespoke development programme for my staff. I also recall that the Trust would

circulate details of courses, e.g. on IT skills, provided at the H&SC Beeches Centre which staff could apply to go on.

Q12. Were data analysis and trend identification reports prepared at Directorate level in relation to MAH? If so, how regularly and how was the data used to inform improvements to patient care and staff training?

64. During the 1990s IT systems were limited. The first patient IT system was introduced in circa mid 1990s and was I believe called Protechnic at that time. This was largely a patient administration system holding only some basic clinical information, relating mostly to the oversight of the Mental Health Order. From recollection there was no electronic system for reporting accidents/ incidents etc. My recollection is that this was the position when I left NWBHSCT in 2004.

65. As I indicated at paragraph 35 I can recall that a range of reports came to the core hospital team meetings though how routinely these reports came and whether this was consistent across the period of my employment I am unable to recall. These would relate to; Finance Reports, activity reports relating to bed occupancy and patient movement, reports on accidents/incidents and on the use of seclusion, staff sickness, contract compliance, complaints and compliments. The finance reports would have come from the Finance department, complaints and compliments would have come from the Trust complaints officer at Trust Headquarters, staff sickness came from a system called NIMs which held nursing information and was in the nursing office. In terms of the others reports I have no good memory of where they would have come from.

66. My belief is that where any of these reports indicated a need for action to improve patient safety or care then action was taken. I have referenced earlier in this statement engagements with commissioners regarding the adequacy of nurse staffing and skills mix and the need to improve quality through reducing patient numbers on wards. The case for these quality improvements was informed by data on skill mix, nurse to patient ratios and proxy indicators of complexity on wards such as, numbers of detained patients, levels of constant supervision and levels of accident and incidents.

67. I recall information on levels of incidents and levels of use of seclusion in respect of individual patients being discussed at core hospital team, with the Site Director indicating actions that were or had been taken by his staff in response to these. I do not believe that this type of reporting was in place when I first started work at NWBHSCT so this reporting was developed probably from the mid-1990s. My recollection is that I helped to establish this however I do not recall the frequency of this reporting or how it was maintained throughout my period of employment at NWBHSCT.

68. My understanding is that data on training for nursing care staff was maintained on the NIMS system. I don't recall seeing routine reports tabled from this though I do recall that we would have discussed training where, for example, there was particular issues such as the ability to free up staff to undertake mandatory training in areas such as Care and Responsibility.

Q13. Was support provided by the Directorate to MAH in respect of data analysis and trend identification? If yes, please provide details of this support.

69. When NWBHSCT managed Muckamore Abbey Hospital then the hospital was the biggest part of the learning disability directorate. The remainder of the directorate comprised community learning disability services in North and West Belfast which in terms of staffing and budget was much smaller than the MAH portion of the overall directorate staffing and budget. So, MAH was not, as perhaps is implied by the question, a part of a much larger directorate rather it was the largest part of the directorate. The learning disability directorate for most of the period of my employment had no Governance nor IT departments/sections with only as previously indicated at paragraph 52 a Governance Lead appointed in circa 2002 or 2003. The only capacity to do any data analysis and trend identification in the directorate was in the hospital structures as referred to in my statement above, where the core hospital team did look at accident incident trends, use of seclusion and use of beds though there was not capacity to do this in any statistically sophisticated way. In addition, reporting and recording systems were to my recollection paper based which did not support more sophisticated data analysis and trend identification. Whilst I have no clear recollection, I would

suppose that the trend identification for accident and incidents considered by the core hospital team, and the information on seclusion, was facilitated by summary information from the respective report forms being placed on a locally devised electronic spreadsheet probably in the nursing office or Site Director/Nursing Services Manager's office or possibly in medical records. I do not recollect that the Trust as a whole had a governance department for most of the time of my employment though this may reflect that it was not an area with which I was particularly involved.

70. The Trust had an IT department within its Planning Directorate but to my recollection this was largely concerned with developing and maintaining the IT infrastructure and in providing data on activity for contract compliance etc required by commissioners. I would expect that the Trust was required to submit an annual report to the H&SCBs on delegated statutory functions as part of its establishment. I was familiar with these reports in my posts after leaving NWBHSCT however I have no recollection of seeing them or being involved with compiling them when I worked in NWBHSCT. Reporting requirements for delegated statutory functions were set by the H&SC Boards.

Q14. Please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Directorate level to address such concerns.

71. As referenced at paragraph 53, I can recall two occasions where I became aware of the abuse of patients by staff at MAH. I became aware as these were discussed at the core hospital team. One was I think in Moylena ward where I believe more than one staff member was suspended and action taken under the Trust's disciplinary policy. I also believe that this was reported to the police. I cannot recall the nature of the abuse or the outcome of either the disciplinary process or the police investigation. The second occasion related to a care worker in daycare who was suspended following allegations of sexual assault on a female patient. My recollection of this was that this individual was dismissed and that he further was subject to criminal proceedings leading to his conviction in court.

72. I believe that I was aware of these as they related to relatively serious instances of abuse of patients and were in consequence discussed at core hospital team meetings. I have no recollection as to whether or not further actions in terms of the staff group as a whole was undertaken or how these were discussed in the Trust or further reported to Commissioner/DoH. My understanding is that these incidents pre-dated Vulnerable Adult and Serious Adverse Incident Procedures being put in place in H&SC in Northern Ireland and pre-dated the Early Alert system being established.

73. In my complaint's officer role, I would have been aware of relatives raising concerns about bruising or injuries to patients. Generally, these would have been following a bruising or injury being reported by staff to the relative particularly where the staff indicated that no incident had been observed that would have explained the bruising or injury, or on other occasions they would have been where a bruise or injury was first noticed by the relative. These complaints would have been sent to the Site Director/Nursing Services Manager to arrange to have investigated. Sometimes the Trust response to the complaint would indicate a cause or probable cause of the bruise or injury and other times it would state that no cause could be established. The response would, as appropriate also include any actions to prevent a re-occurrence e.g. where one patient was assaulted by another in a dormitory then the patient assaulted might be moved closer to the night station. Relatives would in such circumstances generally be offered an opportunity to meet with the ward consultant and/or the ward manager and a senior nurse manager to discuss any concerns. Such complaints were not to my recollection particularly common. All complaints and responses were scrutinized by a sub-committee of the Trust Board.

Q15. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

74. I would reflect that prior to UoM/NWBHSCT being created and taking on responsibility for Muckamore Abbey Hospital, that Muckamore Abbey Hospital had been for many years a small part of a much larger H&SC organisation. My

recollection is that when UoM/NWBHSCT took responsibility for Muckamore Abbey it had been very much neglected and that this was apparent in its crumbling estates infrastructure which was on the verge of collapse and in its poor ward accommodation much of which was in poor condition and not fit for purpose. The lack of priority previously given to Muckamore Abbey Hospital was also apparent in the inadequacy of nursing staffing levels reflected in nursing skill mix, staff to patient ratios and in ward patient numbers.

75. When Muckamore Abbey Hospital subsequently formed part of the UoM/NWBHSCT it was the single biggest and most important service provided by the Trust. It was the Trust's only hospital. This was recognized in the NWBHSCT structures in that it, uniquely in H&SC Trusts in Northern Ireland, had a dedicated Director of Learning Disability and further that the Trust Director of Medicine was a Consultant Psychiatrist from Learning Disability based in Muckamore Abbey. Both these individuals had offices in Muckamore Abbey and spent a considerable portion of their working week at Muckamore Abbey. The Trust Chief Executive also had an office at Muckamore Abbey and it was not unusual for Trust Board meetings to be held at Muckamore Abbey Hospital. It would be my understanding that Muckamore Abbey was regularly discussed at Trust board though I cannot vouch for degree of regularity as I was not a member of Trust Board. Non-Executive Directors and in particular the Trust Board Chairs were regular visitors to Muckamore Abbey both for Trust Board and committee meetings and further to attend and participate in various visits and events. I believe that one of the biggest, if not the biggest, nursing specialty in the Trust was RNLDs and the Trust Director of Nursing was also a regular visitor to the hospital, as were the relevant Professional Lead Nurses from the two main commissioner boards.

76. For that period of its existence Muckamore Abbey Hospital was therefore a priority for the organisation that managed it, and accordingly received significant corporate profile and attention. That this was so, is reflected in the considerable improvements through revenue staff investments and capital site investments over that period, up to and including the major capital investment in new buildings secured to provide safe, fit for purpose patient accommodation.

77. I would further reflect that each of the Directors of Learning Disability whom I worked to were individuals with significant relevant prior experience in leading and managing learning disability services. It was evident to me that they each were hugely knowledgeable about services for people with a learning disability, cared passionately about the people those services supported and would have viewed that advocating on behalf of those individuals and their carers was an important part of their role.

78. The Site Director and then the Nursing Services Manager, the two individuals who had day to day responsibility for patient care on the hospital site over the years that I worked in UoM/NWBHSCT, were each highly experienced and respected RNLDs. My impression was that they were each individually committed to the highest standards of nursing care at the hospital which included an active awareness of the vulnerability of its patients and the consequent need for a high level of vigilance towards any indications of ill-treatment of patients or cultures of poor care. My recollection of each of these individuals was that they spent a significant portion of their working week walking the site, visiting the wards and daycare and engaging with patients and staff in those settings. I have a clear recollection that the Site Director would also have made unannounced visits to wards outside of 9-5 including at night and that on occasions he was accompanied by the Director of Learning Disability.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: Oscar Donnelly

Date: 28th June 2024