Muckamore Abbey Hospital Inquiry

Organisational Module 7 – MAH Operational Management

WITNESS STATEMENT OF PETRA CORR

I, Petra Corr, Director of Mental Health, Learning Disability and Community Wellbeing within the Northern Health and Social Care Trust, make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry ("the MAH Inquiry"):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 7 March 2024. The statement addresses a set of questions posed to me relating to MAH Operational Management. My evidence relates to paragraphs 10 to 13 of the MAH Inquiry's Terms of Reference.

2. This is my third statement to the MAH Inquiry. My previous two statements were completed on behalf of the Northern Health and Social Care Trust.

3. I have not exhibited any documents to my statement.

Qualification, Experience and Position of the Statement Maker

4. I am a Consultant Clinical Psychologist. I am registered as a Practitioner Psychologist with Health and Care Professions Council (HCPC). I hold the following qualifications:
   - BSSc. Single Hons. Psychology (QUB);
   - MSc in Clinical Psychology (QUB);
   - Certificate in Health Services Management (UUJ);
   - Doctorate in Clinical Psychology (QUB).

5. Over my career, I have held the following positions:
   - 1994 – 2003: Clinical Psychologist, Homefirst Community Trust

- 2003 – 2008: Consultant Clinical Psychologist, Head of Specialty for Learning Disability Services in North and West Belfast HSS Trust.
- 2008 – 2012: Service Manager, Learning Disability Community Treatment Services, Belfast Health and Social Care Trust.
- 2012 – 2020: Clinical Director Psychological Services, Northern Health and Social Care Trust.
- 2020 – 2022: Interim Director of Mental Health, Learning Disability and Community Wellbeing within the Northern Health and Social Care Trust.
- 2022 - Present: Director of Mental Health, Learning Disability and Community Wellbeing within the Northern Health and Social Care Trust.

6. From the above chronology of the positions I have held throughout my career it can be seen that it has been 12 years since I have worked for the Belfast Trust. It has been 16 years since I held a role that involved some form of operational management in Muckamore Abbey Hospital (MAH). Even then, my operational management was limited to a very small team, as I outline in detail below at paragraph 10.

7. I have answered the questions asked of me to the best of my knowledge and recollection. However, with the passage of time, my recollection has faded and I have found it difficult to recall specifics of titles, processes or examples which I would, had I been answering these questions while I was in post. I also cannot be sure that I have remembered all information which might assist in answering the questions asked. I would therefore be grateful if the following answers might be read with this caveat in mind.

8. I note that the MAH Inquiry has asked for a focus on the adequacy and effectiveness of the systems and processes that I discuss in the answers to my questions. Given the time that has passed, I do not feel I could evaluate the detail of the systems from memory with sufficient accuracy to feel comfortable to do so. However, what I can say is that Learning Disability was a developing area during my time in post in an operational management position in MAH. The systems that were in place aimed to meet best practice and knowledge as it existed at the time, and where failings or gaps were identified, changes were made.

Questions for witnesses with responsibility for operational management of MAH at Directorate Level

9. In keeping with the correspondence which I received in which the MAH Inquiry requested a witness statement, I have answered questions 1 to 16 in relation to my role described in paragraph 1 of question 1, being Consultant Clinical Psychologist, Head of Speciality for Learning Disability Services within the North and West Belfast Health and Social Services Trust ("North and West Belfast Trust"). I have answered question 17 in relation to my role as described in paragraph 11 within question 1 below, being Service Manager for Community Treatment Services in Belfast Health and Social Care Trust ("the Belfast Trust"). I would therefore be grateful if the following answers might be read in this frame.

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.

My role in the operational management of MAH

10. From 2003 to 2008, I held the role of Consultant Clinical Psychologist, Head of Speciality for Learning Disability Services in the North and West Belfast Trust. I was Clinical Lead and Manager of the North and West Belfast Trust Learning Disability Psychological Services. In this position I held overall responsibility for Psychological Services for people with a learning disability across both hospital and community services.

11. In 2008, I became the Service Manager for Community Treatment Services in the Belfast Trust, a post I held until 2012. I had responsibility to manage and lead multi-disciplinary community teams for people with a learning disability across the newly formed Belfast Trust. I also had responsibility for delivery and development of community based treatment services for people with a learning disability. In this role I had no operational management responsibility for staff working in MAH. However, the services I delivered and managed interfaced with MAH.

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

12. In my role as Consultant Clinical Psychologist, Head of Speciality for Learning Disability Services in North and West Belfast Trust over the period of 2003 to 2008, I had managerial and professional responsibility for the small team of clinical psychology staff who delivered services across both hospital and community Learning Disability Services. I describe the members of that team further below.

13. I was managed by the Head of Psychology Services. As far as I recall, our posts sat under the Director of Mental Health, albeit that I worked operationally within the Learning Disability Directorate.

14. When I came into post, as far as I can recall, there was 1 locum psychologist in post in MAH and there were no clinical psychology staff in substantive posts in either hospital or community LD services. One of my core roles was the development of a Clinical Psychology Service. I felt the strategy of separation of hospital and community was not assisting the North and West Belfast Trust in attempts to recruit to posts. As such, I developed a number of posts that operated across hospital and into the community. By the end of this period, there were approximately 3 consultant psychologists in post (including myself); approximately 3 clinical psychologists and approximately 3 assistant psychologists. I provided professional and clinical supervision and line management to these clinical psychology staff.

15. Toward the latter years of my time in the role as Head of Speciality for Learning Disability Psychological Services (approx. 2005 to 2008), I provided clinical supervision to the Behaviour Nurses working within MAH. I did not provide professional supervision (this was provided through a nursing line) and did not provide line management responsibility. The Behaviour Nurses worked across wards to support ward based treating teams to understand the person's behaviour and to develop plans and strategies to deal with these behaviours.

The day to day responsibilities of your role

16. As this is many years ago, my memory of the detail is limited. I no longer have access to any records from this period (such as diaries or notebooks) as these have all been destroyed.

17. However, from recollection, as Consultant Clinical Psychologist, Head of Specialty for Learning Disability Services, I was Clinical Lead and Manager of the North and West Belfast Trust Learning Disability Psychological Services. As such my responsibilities were mainly strategic and focused on service development as the service was in its infancy, although I did also provide a limited clinical role. My role included:
    a. A clinical role within both MAH and community learning disability services.
    b. Provision of Psychological Training and support to staff teams across hospital and community.
    c. Design and Development of the new Hospital.
    d. Research and auditing.
    e. Development of new service initiatives within the community.
    f. Honorary Lecturer in Clinical Psychology at Queen's University, Belfast.
    g. Development of the Bamford Review.

    These roles are described further below.

18. As I have said, my role was mainly strategic, but I did also provide some limited sessional input in the form of psychometric assessment, psychological assessment, and intervention to adults and children with a learning disability in MAH as well as in North and West Belfast community learning disability services. In my early years in post, I had a small caseload and provided input into a small number of wards as part of my clinical role within MAH. During this period, I attended ward rounds, completed assessments of patients, delivered therapeutic sessions with patients on the ward and liaised with their ward based treating staff team. In many cases, I may not have been directly involved with the patient, rather I supported staff through consultation and development of formulations.

19. I provided psychological training and support to staff teams across hospital and community. This was a substantial part of the role of Clinical Psychology Services – with

a focus on training in approaches such as Positive Behaviour Support, psychological therapies for people with learning disabilities, and training in formulation.

20. I contributed to the design and development of the new hospital on Muckamore Abbey site, replacing old ward accommodation. There were many meetings regarding design of this service model and the buildings.

21. I contributed to research and audit at the hospital involving university partners.

22. During this time, I had overall responsibility for the development of a number of new service initiatives within the community, including:
    - *Positive Behaviour Support Service for people with challenging behaviour*. Following engagement with the Commissioners regarding the need for this service, I worked with colleagues to develop an effective multi-disciplinary positive behaviour support service model which worked to prevent admissions to hospital and to support timely discharge.
    - *Hear to Help Service for people with learning disabilities and mental health needs*. I worked in partnership with Trust colleagues and Eastern Health and Social Services Board to develop a business case to address unmet need in this area through the development of an innovative, evidence-based service. I developed an effective multi-disciplinary psychological therapy service for people with a Learning Disability who experienced psychological distress, trauma and mental health issues.
    - *Forensic Services for people with learning disability.* Alongside colleagues within the Trust, I developed a psychology led community based assessment and treatment service for people with a Learning Disability who have challenging needs and engage in forensic behaviours. This service ensured that individuals with complex needs and forensic behaviours could be assessed and treated in the community when it was safe to do so.

23. I also contributed as an Honorary Lecturer at Queens University, Belfast to the training of Clinical Psychologists. I provided supervised placements, delivered teaching and supervised both large and small scale research projects.

24. I was involved in the development of the Bamford Review for people with Learning Disabilities in particular the chapters on the legislation, capacity and approaches to people who display challenging behaviours.

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

The structures and processes that were in place for the operational management of MAH

25. As this is many years ago, my memory for the detail is limited. I would direct the Inquiry to the assurance framework for the North and West Belfast Trust which I would presume would provide a detailed account of this.

26. As mentioned in paragraph 10 above, my operational management responsibilities connected to MAH were limited to the clinical psychology staff. All clinical psychology staff including myself were managed through a Clinical Psychology line within the Mental Health Directorate.

27. While I was not therefore working within the conventional managerial lines in MAH, which sat within the Hospital Services and Community Learning Disability Services Directorate, I can recall the operational management of MAH more generally, having worked operationally in MAH. My understanding and memory of the operational management of Muckamore between 2003 and the end of the operation of the North and West Belfast trust is outlined below.

28. The Director of Hospital and Community Learning Disability Services reported directly to the Chief Executive and had responsibility for Learning Disability services across both hospital and community.

29. The Director for Medical Services (Hospital) reported to the Chief Executive. This role did not report to Director of Hospital and Community Learning Disability Services, rather was a peer. Both attended Trust Board and SMT.

30. When I started in post, the Directorate of Hospital and Community Learning Disability Services had two Assistant Directors (an Assistant Director for Learning Disability Hospital Services and an Assistant Director for Learning Disability Community Services) and a Business Manager, who all reported to the Director. Assistant Director for Learning Disability Hospital Services was traditionally a nurse, and therefore reported professionally to the Director of Nursing on professional nursing matters.

31. A third Assistant Director was appointed at a point in time, although I do not recall the year. This was the Assistant Director for Service Improvement and Governance.

32. MAH had a Senior Management Team at that time, known as Core Group. I was not a member of the Core Group. Core Group included the Director of Hospital and Community Learning Disability Services, Director of Medical Services (Hospital), Assistant Director for Learning Disability Hospital Services, Business Manager, and Senior Social Worker for MAH. The Assistant Director for Service Improvement and Governance was also included when they were appointed.

33. The Core Group had oversight of all that happened in the Hospital. Core Group was extended to include Finance and Human Resources representatives on a routine basis. Staff were invited to attend for specific items on occasion. Patient Advocacy Groups such as TILLI supported by ARC also attended on occasions. I did not attend Core Group or Extended Core Group but it was a very clear presence in the functioning of the Hospital during my time there from 2003 to 2008; it was referred to regularly in terms of approvals and escalations and was very visible as meetings were held in the main Admin Building.

34. The Hospital was operationally managed on a day to day basis by the Assistant Director of Learning Disability Hospital Services and the team of senior nurses, in collaboration with the Director of Medical Services (Hospital); all this occurred under the oversight of the Director of Hospital and Community LD Services.

35. All of the staff noted in paragraph 34 were based in MAH and were routinely visible across all wards and services. Visits to wards occurred in hours and out of office hours (such as evening and night visits)

My view of how effective those structures and processes were in ensuring adequate oversight of operational management at MAH

36. I felt the management structure and the associated visible leadership was effective in the operational oversight of MAH during the time that I was there.

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?

The lines of accountability from MAH Ward staff through to Trust Board

37. All Learning Disability Clinical Psychology staff who worked in the hospital reported to me either directly or through another staff member within the service. I reported to the Clinical Psychology Services Manager. As far as I recall, she, in turn, reported to the Director of Mental Health who reported to the Chief Executive. I was not therefore an active participant in the operational management structure of the hospital. I will, however, describe my recall of the operational management on the hospital site in order to assist the MAH Inquiry.

38. Each ward was managed by a ward manager. Ward Managers reported to Senior Nurse Managers, who in turn reported to the Assistant Director of Learning Disability Hospital Services.

39. The Assistant Director for Learning Disability Hospital Services reported to the Director of Hospital and Community Learning Disability Services who reported to the Chief Executive.

40. It is my memory that all operational matters relating to the hospital were discussed each week at Core Group and decisions to escalate matters to Trust SMT / Trust Board were made there.

Guidance in relation to escalation

41. I am not aware of the details of any guidance documents because I did not have operational responsibility for ward staff.

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

42. Within Clinical Psychology Services, we had an induction programme for new staff joining the department involving sharing of policies, induction materials, meetings with relevant staff, and visits to services. We also developed a Departmental Handbook within Clinical Psychology Learning Disability Services which described all the processes within the service and this was shared with all staff.

43. More generally, training for line managers was offered through the Beeches (a leadership centre that provided staff development programmes for HSC).

44. The Trust Human Resources Department also provided training and support on managerial processes.

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.**

45. I can only speak to the particulars asked in relation to meetings that I routinely attended. I have been able to remember how often meetings occurred, who attended these meetings and who decided the agenda. However, I cannot remember the particulars for each group as to what reports were provided to meetings, how these reports were prepared and by whom. I can recall receiving reports at some of these meetings but cannot accurately recall which reports were received at which meetings.

46. During the period where I was involved with specific wards in the hospital, I attended the following meetings:

Ward rounds took place each week in each of the wards across the hospital. Ward rounds involved the full multi-disciplinary team typically including psychiatry, psychology, ward manager, named nurse, speech and language therapist and social worker; community staff attended from time to time. Within the ward round, the team considered the assessment and treatment of each patient on the ward.

Individual Planning Meetings. These were longer more detailed discussions regarding a specific patient. They were planned in advance and invites were often sent to the named worked from the Community Team and family members. These meetings were an opportunity to share progress with assessment and treatment in detail and to plan for discharge from hospital.

47. I also attended a number of organisational / managerial meetings. These included:

Clinical Psychology Department Meetings involved all qualified and prequalified psychology staff and trainee clinical psychologists across all services in the Trust. This was chaired by the Head of Department.

Clinical Psychology Learning Disability Section Team Meetings involved all qualified psychology staff, prequalified psychology staff and trainee clinical psychologists on placement across the learning disability service in the Trust; these meetings occurred monthly. Typically, I or another Consultant Clinical Psychologist chaired these meetings. This was an opportunity to share updates and to discuss operational matters across the team. Issues of concern could be raised here or alternatively in individual supervision sessions. (As per British Psychological Society

guidance, all qualified clinical psychology staff had monthly supervision; all assistant psychologists had weekly supervision.)

Core Professions was a group chaired by Assistant Director for Learning Disability Hospital Services. This was attended by all the professional groups who provided services on the hospital site – such as pharmacy, social work, dentistry, AHPs, and Clinical Psychology. Within this forum, information was shared on a broad range of operational and strategic matters. This ensured that all professions were aware of changes and updates in relation to the hospital. This also enabled discussion on interface matters across professional groups. Any matters of concern from this group were escalated to Core Group and / or up professional lines. As far as I recall, this meeting occurred approximately quarterly.

Clinical and Social Care Governance Meetings were held during this time period. These meetings were attended by a broad group and were at Directorate level. The attendees that I can recall include the Director of Learning Disability Hospital and Community Services, the Director for Medical Services (Hospital), the Assistant Director for Community Learning Disability Services, the Assistant Director of Learning Disability Hospital Services, the Governance Manager, myself as the Head of Specialty for Learning Disability Psychology Services and professional leads. There may well have been others that attended this meeting. As far as I recall, it was held monthly. There were discussions on all matters relating to governance – including presentations from teams / services, best practice guidance, review of risk registers, discussions about incidents, consideration of complaints and complements etc.

Supervision Groups: Clinical Psychology staff and Behaviour nursing staff had a **supervision group**. This group provided opportunity for detailed peer group discussions regarding cases that were current for practitioners. Reflective practice was encouraged in this forum. This group provided an opportunity to share good practice and consider new approaches within the evolving evidence base. Clinical Supervision was also offered on an individual basis to nursing staff who undertook specialist psychologically informed training such positive behaviour support, cognitive behaviour therapy and forensic interventions such as adapted sex offender treatment programme.

48. There were many more meetings which took place in or included MAH issues which I did not attend. To assist the MAH Inquiry, I have attempted to provide detail on those which I recall and consider to be of significance in the life of the Hospital were as follows:

Core Group was held weekly and was chaired by Director for Hospital and Community Learning Disability and was attended by Director for Medical Services (Hospital), Assistant Director of Learning Disability Hospital Services and Senior Social Worker for Muckamore Abbey Hospital. I did not attend this meeting but I recall it reviewed all incidents, physical interventions / use of restraint, seclusion, and complaints. At a point in time, the Assistant Director for Governance also joined Core Group. The Core Group had oversight of all that happened in the Hospital. Core Group was extended to include Finance and Human Resources Business Partners on a routine basis. Staff were invited to attend for specific items on occasion. Patient Advocacy Groups such as TILLI supported by ARC also attended on occasions – I do not recall the frequency.

Resettlement meetings and delayed discharge meetings occurred involving Eastern and Northern Health and Social Services Board staff, senior staff from community trusts, MAH staff including Assistant Director Muckamore Abbey Hospital, Medical Director, and Social Work staff. As far as I recall, the Lead for Supporting People from NIHE attended these meetings also. I think this occurred monthly or quarterly.

Ward managers meetings were attended by senior nurse managers and the Assistant Director for Learning Disability Hospital Services. I did not attend these.

Muckamore Abbey Hospital TILLI (Self and Peer advocacy) group was set up during this period to provide a service user voice on matters of concern to people with a learning disability. ARC supported the TILLI Group during this period. TILLI met together to consider matters and then met with Learning Disability senior managers regularly to discuss matters of mutual interest regarding changes at the hospital and in the community.

Muckamore Abbey Hospital Parents and Friends was an active group during this period. I recall that MAH Management Team met this group regularly.

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.

49. I have been asked this question in relation to a time at which I held a position with operationality responsibility within the North and West Belfast Trust. I have therefore treated this question as if it were asking about policies within the North and West Belfast Trust, a predecessor to the Belfast Trust, as opposed to Belfast Trust policies.

Arrangements that were in place at Directorate level to monitor staff implementation of and adherence to North and West Belfast Trust NWBT policies

50. Within the Clinical Psychology Service, all policies were shared via managerial cascade. When a policy was received by the Department, the admin staff placed a circulation sheet at the front of the policy to enable all clinical psychology staff (qualified and assistant psychologists) to sign off that they had read and were aware of each policy circulated.

51. The EQC Audit Tool was used routinely (annually as far as I recall) to monitor compliance with all standards across the hospital (including policy review / sign off / implementation). The audit was carried out by a member of the EQC team and a peer from another service. Scores from each Ward / Team / Service on EQC Audits were shared with the relevant team / service, posted on notice boards, and were discussed and reviewed at core group.

Arrangements that were in place at Directorate level to monitor nursing staff adherence to professional nursing standards

52. I am not able to answer this question as it is not applicable to my role.

Arrangements that were in place at Directorate level to monitor Clinical staff adherence to professional clinical standards

53. Within the Clinical Psychology Department, all members of staff were actively encouraged to be members of the British Psychological Society (the professional body). This is not a

requirement within the profession but is accepted as good practice. This provided access to training, journal publications, conferences and peer group networks such as the NI Learning Disability Faculty of the British Psychological Society. NI Learning Disability Faculty of the British Psychological Society was very active at this time and we routinely hosted events for colleagues across the region. This supported dissemination of the evolving evidence base for service models and therapeutic approaches in the area of learning disability.

54. Within the Clinical Psychology Department, we shared all best practice standards via our routine team meetings within the learning disability team, and more broadly in the Clinical Psychology Department Meeting. (This meeting is described in paragraph 47 above and was a Trust wide group chaired by the Head of Psychology Services).

55. In addition, within the learning disability section of the clinical psychology department, file audit and supervision audits were carried out annually and a feedback loop was implemented to ensure learning occurred.

56. In keeping with British Psychological Society guidance, each qualified member of clinical psychology staff had monthly supervision and line management; all assistant psychologists had a weekly meeting which covered professional and clinical supervision and line management. Within this forum, there is space for discussion of clinical cases, operational and performance management, and governance oversight.

57. Matters of concern would have been highlighted by myself as Head of Specialty to the Director of Learning Disability, if relevant to service delivery and to the professional Head of Psychology Services, if professionally relevant.

58. As I have mentioned above, I also attended the Clinical and Social Care Governance Meetings. At these meetings we were provided with reports on matters such as complaints, incidents and seclusion. These reports were analysed and if they identified any issues with staff adherence to clinical standards this would have been addressed appropriately.

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

59. The answer to this question depends on where and how the particular matter was identified.

60. Any matter could be raised by a member of staff via professional or operational managerial lines at any stage. Matters could then be escalated further up the relevant professional or operational managerial lines as appropriate.

61. If the issue was identified or raised at a meeting but could not be resolved at that meeting, it could then be escalated upwards by the appropriate person at that meeting. For example, if an issue was raised at a meeting which I attended which related to Psychology but which I did not feel I could resolve or which I felt required escalation, then I could take that to the departmental meeting or professional/line manager.

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

62. Individual staff performance in Clinical Psychology was managed via monthly or weekly supervision and line management processes as appropriate. I have set out the details of this more fully in answer to question 5.

63. Staff members also had Individual Development Reviews annually which considered the staff member's personal development plan. Relevant outcomes of file audits and supervision audits would have been considered within the supervision and line management process. Any issues that were identified during these processes were then addressed in supervision and learning was identified, implemented and reviewed in subsequent supervision sessions. An agreed record of each supervision session was held by the supervisor and supervisee.

64. Human Resource advice could be sought from the team at any time.

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

65. I do not recall ever having to manage any significant level of underperformance within the clinical psychology learning disability team. I do not recall if managers were required to seek HR advice or inform HR if they were managing a staff member's poor / under performance. In general, I do recall that Human Resources were routinely available to support clinicians if required. There was a Human Resources base in MAH, and in the community in Glendinning House, which was then the headquarters of the North and West Belfast Trust.

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.

66. I can only answer this in relation to clinical psychology staff and psychological services.

67. Initially when I came into post, there was a very limited psychology resource in MAH (as far as I recall, there was 1 locum and 1 vacant post) and no posts in Learning Disability Services in the community. I carried out an exercise to benchmark Trust services against British Psychological Society Guidance Documents and gaps were highlighted to the Director for Hospital and Community Learning Disability Services and to Commissioners.

68. This was a time of great growth in the knowledge base in learning disability. As such, additional service needs and evidence for new service models (such as positive behaviour support services, psychological therapy such as CBT adapted for people with learning disabilities, and forensic treatment services) were scoped and presented to the Eastern Health and Social Services Board as service pressures which required new funding. As a result of this work, funding was identified for Consultant Forensic Psychologist for the delivery of the Adapted Sex Offender Treatment Programme in MAH; for community assessment and treatment services such as the Positive Behaviour Support Service and

Hear to Help (the psychological therapy service for people with a learning disability) and community forensic service for people with a learning disability.

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?

69. As I have explained earlier in this statement, one of my core roles was the development of a Clinical Psychology Service in learning disability. In this role, I ensured that the evolving evidence base and philosophical framework for the provision of learning disability services was at the forefront of Clinical Psychology Services and Learning Disability Services more broadly. This was achieved through review of the literature, attendance at conferences (such as British Institute of Learning Disability and the National Learning Disability Faculty of the British Psychological Society) and review of best practice and service models elsewhere.

70. Information regarding training opportunities, conferences, and courses was shared with staff through team meetings, via managerial cascade and on an ad hoc basis when received into the department. Clinical Psychology Staff members routinely identified training opportunities which would support their practice and career development. They would then raise these in supervision with their line manager and consider the appropriateness and availability of funding to support this training / development. Similarly, the line manager may have identified a training programme or development opportunity that they felt would be relevant to a member of staff and would then share that with the member of the team. In general, training opportunities were reviewed in line with the service priorities. Training in relation to the delivery of specific evidence-based approaches was supported (e.g. ASOTP, DBT, Adapted CBT).

71. Outside of the Clinical Psychology Learning Disability Service which I directly managed, I had a role, in consultation with nurse line managers, in identifying opportunities for development of those nurses who were undertaking roles that were underpinned by psychological interventions (e.g. ‘behaviour nurses’ and CBT nurses). Many of the Behaviour Nurses undertook training at the Tizard Centre through the University of Kent,

in relation to managing challenging behaviours. This was also subsequently offered and made available to other behaviour nurses via University of Ulster. Other training courses on mental health interventions and forensic interventions, were also available to nurses via CEC commissioning arrangements.

72. In keeping with the recognition of the importance of the communicative function of many challenging behaviours, I also identified and supported opportunities for staff more broadly across the hospital to have access to training in TEACCH and PECs. These approaches are beneficial in enabling staff to better support individuals with autism and severe learning disabilities. Makaton training was widely available to staff in MAH delivered by Speech and Language Therapy Service.

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?

73. The only meeting I attended at Directorate level in relation to MAH was the Clinical and Social Care Governance Group. At this meeting issues were discussed and learning was identified with actions agreed to address these matters. Complaints were also tabled at this meeting.

74. I understand that the Core Group received reports which included data on incidents, use of restraint, seclusion and complaints. I did not attend Core Group so am unable to comment on how this data was used in this forum.

75. There was a significant focus on communication training, positive behaviour support, working with people with autism, training on risk assessment and risk management in forensic services and supporting the mental health needs of people with learning disabilities.

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.

76. There were several nurses from the EQC team, who were based in the Business Team, who provided data analysis at MAH. They supported the production of trend data and reports. I cannot recall precisely what reports were produced and at what frequency. These reports were shared at Clinical and Social Care Governance meetings.

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.

77. I recall being advised by the Director of Hospital and Community Learning Disability Services in approximately 2007 that I may be required to identify psychology support for an individual or individuals who were potentially impacted by allegations of historical abuse. My sense was that this was historical and was perhaps from many years before. There was an investigation which I was not involved in and I was not party to the findings at that stage.

78. I was advised at the time (in approximately 2007) that those interviewed as part of the investigation were offered access to psychological support but no patients came forward or were identified as requiring psychological support on this matter.

79. I subsequently became aware in 2011, through my operational management of the ABE interviewer from that investigation that this related to incidents of patient-on-patient abuse.

80. I recall hearing discussion regarding adult safeguarding issues from time to time within the hospital. I do not have any specific recall of any specific situations. The discussion regarding these matters generally involved seeking advice from Social Work colleagues and considering in line with Vulnerable Adults and Safeguarding Policies / Guidance in place at that time.

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?

81. In addition to the 14 questions above which I was asked to address above, the correspondence I received from the MAH Inquiry also stated,
"In addition, given your role in community assessment and treatment services, the Panel would be assisted if you would also address the following questions in your statement:

i. How were patients referred for admission?
ii. Who was involved in the referral process?
iii. What factors impacted whether someone was able to stay at home or in the community or whether they were referred to MAH?
iv. Specifically, did lack of resources or delay in availability of support in the community impact on whether a patient was referred to MAH? If so, please explain.
v. Were other options to enable someone to remain at home or in the community always explored prior to the decision to admit them to MAH?"

The referral process and the people involved in that process

82. From 2008 to 2012, as Service Manager for Community Treatment Services in Belfast Trust, I had responsibility to manage and lead multi-disciplinary community teams for people with a learning disability across the newly formed Belfast Trust. I also had responsibility for delivery and development of community-based treatment services for people with LD. In this role I had no operational management responsibility for MAH. However, the services I delivered and managed interfaced into MAH.

83. The Multi-Disciplinary Community Learning Disability Teams which I managed, routinely were involved with people with learning disabilities and their carers. In situations where people with a learning disability experienced mental ill health or challenging behaviours, community assessment and treatment services often were involved in development of community based interventions. In these situations, the multi-disciplinary team involving staff from the Community Learning Disability Team and staff from community treatment

services typically had regular meetings and case conferences to discuss the community responses to the person, their family or carers and their placement. In addition, named workers and community treatment staff would have been attending the home or placement, offering support services, completing assessments or implementing interventions. I did not fulfil these roles myself, however I managed the services and the staff therein who did carry out these roles and functions.

84. When or if these situations deteriorated beyond the capability of the family or the placement provider to safely care for the person with a learning disability, an admission for further assessment and / or treatment in hospital was sought. In these planned situations, a discussion focussed on how best to meet the person's needs occurred involving the named worker, the team leader, the consultant psychiatrist from the community and the admitting consultant in the hospital. Hospital and community based options were again considered to determine how best to meet the person's needs in the least restrictive environment. Families and carers were routinely involved in these discussions. It should be noted that community supports and treatment options were somewhat limited at this time.

85. In emergency situations, the Mental Health (NI) Order 1986 was often required to support admission. This involved GP, ASW and consultation with family / carers as well as discussions with the person with a learning disability. If a recommendation for admission was agreed, the admitting consultant from the hospital was also contacted.

86. The majority of Community Learning Disability Services operated from Monday to Friday from 9am to 5pm. On occasions, outside of these hours, such as evenings and weekends, admissions to hospital under the Mental Health (NI) Order 1986 were sought.

87. Small numbers of people with Learning Disability were transferred to MAH from court or from prison under specific directions under the Mental Health (NI) Order 1986.

The factors that impacted whether someone was able to stay at home, or in the community or whether they were referred to MAH

88. My time in this role was a time of an evolving theoretical and evidence base in the area of

learning disability. As a result, there were changes occurring on an ongoing basis in relation to the delivery of services, the appropriate service model and the underpinning values. Over my time in this role, community assessment, treatment and support services continued to evolve with more focus on supporting people to remain at home and receive assessment and treatment at home without the need for an admission to hospital. However, as I explain further below, for some people, admission to hospital was required to facilitate a better understanding of the person's illness or challenging behaviour within a safe environment.

89. Admission to MAH was typically sought if the person's behaviour or presentation was so challenging or dangerous that the physical safety of the person or others was at risk. The general approach is that a person should be treated in the least restrictive environment possible. However, hospital admission is on occasions the best and most appropriate response to meet a person's need for assessment and treatment of specific mental illnesses – for example – a person in a manic phase of a bipolar disorder may be best assessed and treated in hospital.

90. On many occasions, significant efforts were made to support the person in their home or their placement; however on other occasions it was challenging to bring sufficient staff and services into family homes or care home settings to safely manage the situation in the community.

91. Over this period, community services developed options to support families and individuals in the community. These included Positive Behaviour Support Services, Adapted / Specialist Mental Health Services for people with LD, community forensic services, respite services, day services and day opportunities and community learning disability teams.

The impact of resources or delay in availability of support in the community on whether a patient was referred to MAH

92. Between 2008 and 2012 across Northern Ireland, Learning Disability Services available within the community were under developed and typically were limited to traditional

working hours – Monday to Friday 9am to 5pm. There was little to no access to the following services:

- Bed based community assessment and treatment services
- Community Learning Disability Crisis Services 24-7
- Highly skilled and capable community placements

93. Had there been better access to these services and responsive support for carers to reduce their burden (such as preventative and emergency respite), it is likely more people could perhaps have received all their assessment and treatment within the community.

94. Growth in access to these interventions and supports over the intervening years have led to higher levels of community assessment and treatment and with individuals who display greater levels of complexity being managed effectively and safely in the community.

95. However, it remains the position that in some cases, admission to hospital for assessment and treatment was and remains the most appropriate option.

The exploration of options to enable someone to remain at home or in the community prior to the decision to admit them to MAH

96. Options to support the person at home were always considered prior to the decision to admit a person to MAH. As I have explained above, hospital admission was only pursued when it was necessary or the most appropriate option. When one had reached that stage, community options had been considered and ruled out. The options available in the community at that time were limited by the service model in place.

Section 5: Declaration of Truth

The content 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:  Dr Petra Corr

Date: 14 June 2024