ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Dr Colin Milliken
Date: 13 May 2024

I, Dr Colin Milliken, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

This statement is made in response to a request for evidence by the Inquiry Panel dated 28 March 2024.

This is my first statement to the Inquiry.

There are no documents produced with my statement.

As will be apparent from the below, I am no longer employed by the Belfast Health and Social Care Trust ("the Belfast Trust"). I no longer have access to Belfast Trust documents such as policies, procedures, emails, correspondence, memoranda and minutes of various meetings. I expect that any such relevant documents will by now have been provided to the Inquiry by the Belfast Trust. I have not had access to any such documents in the preparation of this statement. I wish to stress that this statement has been prepared on the basis only of my present recollection which I have no doubt will, due to the passage of time, be imperfect in some respects. I have nevertheless done my best to assist the important work of the Inquiry by providing the best answers I can. If it should transpire that documentary evidence exists that contradicts my recollection of events, I would be very happy to amend or reconsider my statement at the request of the Inquiry. If any of this statement is found to be inaccurate any such inaccuracies are due to the imperfect nature of my recollection of events and not due to any intention to mislead the Inquiry.

Qualifications and positions

1. I am a registered medical practitioner. I qualified from Queen's University Belfast in 1991 with the qualification MB BCh BAO. I hold the following postgraduate qualifications:

    - MRCPsych 1998

2. I am presently employed by the Southern Health and Social Care Trust as a Consultant Psychiatrist in the Psychiatry of Intellectual Disability. I have held this post since 2023. I was previously employed by the Belfast Trust as a Consultant Psychiatrist in the Psychiatry of Intellectual Disability between 2001 and 2022. In addition to my post as a Consultant Psychiatrist, I also held the post of Clinical Director for Muckamore Abbey Hospital between 2005 and 2018.

Module

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

4. My evidence spans across the Inquiry's Terms of Reference.

5. 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.

Questions for witnesses working in a management position at MAH

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

i. the cohort of staff for which you had leadership and/or management responsibility;
ii. the day to day responsibilities of your role.

6. As Clinical Director I had management/leadership responsibility for the doctors at MAH. I did not have any management or leadership responsibility for other staff, in particular nurses or healthcare assistants (who reported to the Director of Nursing).

7. My main duties in Muckamore Abbey Hospital were those of a Consultant Psychiatrist in the Psychiatry of Intellectual Disability. Doctor's job plans are allocated on the basis of a number of programmed activities ("PA") each week. Each PA is equivalent to approximately 4 hours or half a day. My job plan was updated on several occasions throughout my time at MAH but in broad terms I was allocated 10 PAs in relation to my post as a Consultant Psychiatrist and 2 PAs in relation to the additional work as Clinical Director.

8. My main inpatient responsibility was for the forensic ward which is where patients received assessment and treatment in the context of alleged criminal behavior, though I was Consultant Psychiatrist for various other wards during my time working at the hospital. I also provided Community Psychiatry services for an allocated region. My region was the North Down and Ards sector of the South Eastern Health and Social Care Trust. If Community services in my region required advice in relation to a patient in that area, I would be consulted and could advise about treatment options. I also did outpatient clinics in North Down and Ards and worked with the Multi-Disciplinary Teams ("MDT") there. The Belfast Trust will have job descriptions, job plans and contracts of employment which will expand on the above and could provide additional information to the Inquiry if necessary.

9. As Clinical Director I had responsibility for things like:

    - Reviewing and assigning roles for doctors in MAH and outpatient clinics
    - Line management and leadership for the doctors at MAH
    - Providing input at Core Hospital Management Team meetings into matters relating to doctors
    - Providing clinical advice regarding the development and delivery of treatment services at the hospital

Q2. If you had a role in the admission [to] and discharge of patients [from] MAH, please explain:

i. How patients were referred for admission.

10. Patients came to MAH through various routes. Most admissions were unplanned admissions in a crisis. There were a much smaller number of planned admissions for assessment and treatment. In the forensic unit where I mostly worked, most patients were admitted for assessment or treatment in the context of alleged criminal behaviour. In other wards, patients may have been admitted to MAH after being detained under the Mental Health Order or as a voluntary admission. The process for detained patients was as set out in the Mental Health Order.

ii. Who was involved in the referral process.

11. Depending on the circumstances, some or all of the following may have been involved:

- Patient
- Family
- Community providers for Intellectual Disability services
- GP
- Approved Social Worker
- Courts
- Bed Manager
- Consultant Psychiatrist

iii. What factors impacted whether someone was able to stay at home or in the community or whether they were referred to MAH.

12. The main trigger for admission was if the patient was deemed to be a risk to themselves or others. Other patients needed to be admitted for further

assessment and/or specialist treatment due to mental illness or behaviour that challenges.

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.**

13. I believe so. Patients with complex needs required input from specialist staff who were often not available in the community. I do not have statistics (although I imagine the Belfast Trust does) but my impression was that a lot of patients were admitted to MAH out of hours. There was no one available out of hours to help with behavioural support services, nor was there any crisis response team for intellectual disability. Sometimes patients needed to be admitted due to complex behavioural needs that community providers were unequipped to provide in the community.

14. Families provided excellent care to patients but would sometimes reach a point where they were unable to manage a patient's complex behavioural needs in the community and they may have experienced a lack of hands-on support in the community, especially in an out of hours setting.

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?**

15. Where I was involved, I would always have explored any option to avoid patients being admitted to MAH where better alternative treatment options were available. In the context of out of hours admissions where it had been determined that a patient required admission, it was much more difficult for the on-call Psychiatrist to explore alternative options to admission.

vi. How was it decided when a patient was ready for discharge from MAH?

16. A clinical decision was made by the Multi-Disciplinary Team ("MDT"). The key decision was whether the patient was medically fit for discharge. The problem that led to delayed discharge was that there was often nowhere suitable for the patient to go upon discharge, so patients ended up staying in MAH much longer than they needed to, with resulting detriment to the patient's mental state and behaviour.

vii. Were there patients at MAH for whom discharge was never considered? If so, why?

17. No.

Q3. How regularly did management meetings take place at MAH? Who set the agenda for any such meetings? Were minutes always kept of such meetings?

18. The Core Hospital Management Team usually met weekly or fortnightly. The Learning Disability Senior Management Team in the Belfast Trust met monthly. The agenda for both meetings was set by the Assistant Director for Learning Disability Services. Minutes were kept of all such meetings.

Q4. Did MAH managers receive regular reports on:

i. The use of seclusion.

19. Yes.

ii. The use of PRN medication.

20. No. I think we received occasional ad hoc audits, but we did not receive regular reports.

iii. The use of physical intervention including MAPA.

21. Yes.

iv. Safeguarding.

22. I do not recall receiving regular reports on safeguarding prior to 2011. From around 2011 onwards there was a safeguarding social worker who provided reports (perhaps quarterly) to the Core Hospital Management Team.

v. Complaints.

23. I do not recall the Core Hospital Management Team receiving regular reports on complaints. The Learning Disability Senior Management Team in the Belfast Trust did receive reports about numbers of complaints on a regular basis although I do not recall when that started.

If yes, please explain who prepared any such reports and how any concerns identified from the reports were escalated.

24. Reports in relation to seclusion and physical intervention were provided on a regular basis to the Core Hospital Management Team and to the Learning Disability Senior Management Team. Reports were prepared by the audit coordinator. We had limited ability to analyse the data from a statistical perspective. In or around 2017 I recall we received training in quality improvement and statistical significance, and we were better equipped from that point onwards to identify trends from the data. We also benchmarked our data against similar hospitals across the UK. My recollection is that when we did that type of benchmarking exercise, MAH didn't stand out as being very different from other hospitals. I expect that the Belfast Trust will have the data from those benchmarking exercises should the Panel wish to see it.

Q5. What procedures or processes were in place to ensure co-production between MAH staff and relatives of patients at MAH?

25. Families were invited to review meetings throughout patients' admissions. There was a resettlement project from around 2010 to 2013 and families were on the steering group for that project. At one stage MAH employed a carers consultant to provide a liaison between MAH and families and to advocate for patients and their families in the development of services in the hospital. MAH had an independent advocacy service for patients and families where required. MAH representatives met the Society of parents and friends of MAH occasionally.

Q6. What procedures or processes were in place to ensure co-production between MAH staff and community teams?

26. Each community team had input from one of the MAH psychiatrists. When a patient was admitted a representative from the community team was invited to post admission meetings, review meetings and discharge planning meetings. There was a regional Assistant Director's group that met regularly to discuss issues relating to MAH and its role as a regional hospital.

Q7. What were the arrangements for multi-disciplinary team working with patients at MAH?

27. There were regular multi-disciplinary meetings. Those meetings were weekly initially but have become more frequent in recent years. In the sixmile forensic unit patients were invited to join multi-disciplinary meetings when they were capable of joining.

Q8. What arrangements were in place at hospital level to monitor the implementation of and adherence to BHSCT policies by staff at MAH?

28. Staff received training in relation to BHSCT policies in their induction and during their training. There was an opportunity for discussions about adherence to

policies in supervision and appraisals. I am aware that BHSCT retained training records for staff so there may be records of the training staff received in various policies. Adherence to policies was a topic that RQIA assessed in the course of inspections. There were also audits of various policies carried out on an ad hoc basis.

Q9. What were the arrangements for clinical supervision of the practice of staff across all disciplines (including healthcare assistants) at MAH?

29. I was not party to or involved with supervision of healthcare assistants. I was only involved in the clinical supervision of doctors. For doctors, each trainee and non-consultant doctor would have a clinical supervisor. I was an accredited clinical supervisor through NIMDTA, as were the other consultants. I held weekly supervision meetings with my trainees. NIMDTA had oversight of the training programme and received feedback from the trainees about their training which was shared with us. All doctors were subject to annual appraisal.

Q10. What were the performance management arrangements for all staff, including managers, at MAH?

30. I was only involved in performance management in respect of doctors and cannot speak to what the arrangements were for non-medical staff. Junior doctors were subject to supervision, and all doctors including me were subject to annual appraisal, including all aspects of work and job planning. I met my line manager, the Associate Medical Director on a regular basis to discuss relevant issues.

Q11. What opportunities were available for the professional development of all staff at MAH?

31. I can only answer this in relation to the professional development opportunities for doctors. I had no involvement in the professional development arrangements for non-medical staff. All doctors were subject to CPD requirements monitored by the Royal College of Psychiatrists or by NIMDTA.

All consultants were all part of Royal College of Psychiatrists peer groups for CPD. Doctors were part of the Belfast Trust Psychiatry academic weekly programme. Intellectual disability also had a quarterly academic programme. The Belfast Trust also had various mandatory training for doctors.

Q12. Did you have any role in workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? If so, please describe that role. Please also explain how any concerns about such matters were escalated.

32. I only had such a role in relation to doctors although as clinical director I was involved in advocating for additional resources within MAH such as PBS, clinical pharmacy, psychology, social work and allied health professionals. My views in relation to same were relayed to the Assistant Director for Intellectual Disability.

Q13. Did MAH managers carry out regular data analysis and trend identification? If so, please explain how this was done.

33. See paragraph 4 above. Some data was presented at Core Hospital Management Team meetings, and some was presented at the Learning Disability Senior Management Team meetings. Minutes of those meetings should be available from the Belfast Trust. My general view is that there was limited scope to analyse that data or to identify trends. I recall that some time perhaps in 2017 we received training in quality improvement and statistical significance and from then onwards we were better able to analyse the data. Around 2017 we received part time assistance from a data and information specialist which hadn't previously been available, which led to the quality of the data improving. We also occasionally benchmarked data against national trends – again, the Belfast Trust should have details of this.

Q14. What arrangements were in place at hospital level to monitor the use of seclusion at MAH?

34. Seclusion was monitored by the Audit Co-Ordinator and figures were presented to the Core Hospital Management Team. There was a seclusion policy that was reviewed several times and more recently re-written. The Belfast Trust should have minutes from the Core Hospital Management Team and copies of the seclusion policies. Data in relation to the use of seclusion was presented to the Learning Disability Senior Management Team of the Belfast Trust.

Q15. 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 management level to address such concerns.

35. Other than the present Inquiry and the Ennis report (which I think the Inquiry is aware of) I was never aware of any allegation of abuse of patients by staff at MAH. I no longer have access to documentation relating to the Ennis report, but the Belfast Trust will have all relevant documentation. My recollection is that the individuals concerned were nurses/healthcare assistants and there was a police investigation, a referral to the relevant regulator, disciplinary proceedings and a Trust investigation.

36. There were occasional allegations made against staff by patients and when such allegations were raised, they were investigated through the appropriate line management channels. I do not recall ever having to deal with any such allegations against doctors and my belief is that those allegations were dealt with by the nursing line of management. One of the actions taken by management was to install the CCTV to assist with adult safeguarding and to assist in investigations when allegations were made by patients.

Q16. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist the Panel's consideration of the Terms of Reference.

37. No, but I would be very glad to provide clarification on any of the above issues if the Panel think that would be helpful.

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: 

Dr Colin Milliken

Date: 13 May 2024