MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Patricia Cullen

Date: 24 April 2024

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

This is my first statement to the Inquiry.

There are no documents produced with my statement.

Qualifications and positions

1. I am a qualified mental health nurse. I hold a degree in Professional Development in Nursing from Ulster University, 1992. I hold a Masters degree in Human Resource Management from Ulster University, 1994.

2. I have held the following positions. From approximately September 2009 to December 2012, I was the Deputy Director of Nursing, Safety, Quality and Patient Experience in the Northern Ireland Public Health Agency (PHA). From December 2012 to May 2015, I was the Executive Director of Nursing and Allied Health Professions in the PHA. From May 2015 to 2016, I was the Co-chair of the Unscheduled Care Regional Team of the Health and Social Care Board (HSCB).

3. I commenced employment with the Royal College of Nursing (RCN) in November 2016 as the temporary Operations Manager for Northern Ireland. In May 2019, I was appointed to the RCN post of Director for Northern Ireland. In April 2021, I

became Interim General Secretary and Chief Executive of the RCN and I continue in that role.

Module

4. I have been asked to provide a statement for the purposes of M8: Professional Organisation and Oversight.

5. My evidence relates to paragraphs 9, 10-13, 17 and 18-19 of the Inquiry's Terms of Reference.

6. I have been asked to address several questions for the purpose of my statement. I will address those questions in turn.

7. I would like to preface the evidence provided, by stating that I have not had the benefit of accessing or reviewing any relevant documentation from my roles in the PHA. I left the PHA in May 2016. The questions that have been asked date as far back as sixteen years ago and are answered to the best of my knowledge and recollection. I contacted Aidan Dawson, Chief Executive of the PHA, to inform him that I received this request for evidence and due to my inability to access any information, my response to the Inquiry would be limited. This email was sent on 11 March 2024, and I have not received a response.

8. The two organisations, the Public Health Agency (PHA) and the Health and Social Care Board (HSCB) were conjoined. The PHA held all the public health functions, and as a result they employed professional staff, mainly doctors and nurses. The professional staff provided expert professional advice to commissioning, and this was actioned by the HSCB. They were responsible for commissioning health and social care services throughout Northern Ireland.

9. Responsibility for Mental Health and Learning Disability Services sat with the Director of Social Care and Children; between 2009 and 2018 this was the late Ms Fionnuala McAndrew. Ms McAndrew was employed by Health and Social Care

Board, and she held full professional responsibility for the commissioning of learning disability services. Ms Molly Kane, one of the nurse consultants within the PHA, held the professional portfolio for Mental Health and Learning Disability Services and was responsible for providing professional advice to Ms McAndrew and her team.

10. I had line management responsibility for a team of nurse consultants in the PHA, including Ms Kane, but reporting by Ms Kane in relation to the commissioning of Mental Health and Learning Disability services was through to Ms McAndrew in the HSCB.

Serious adverse incidents and concerns regarding MAH

Q1. What was the role of PHA Nurse Consultants in the investigation of level 3 serious adverse incidents?

11. There was a designated nurse consultant responsible for providing professional advice for Mental Health and Learning Disability services. During my tenure with the PHA Ms Kane held that position.

12. Level 3 is the highest level of investigation. The designated nurse consultant, to my recollection, would have received the level 3 Serious Adverse Incident (SAI) investigation reports. This nurse consultant would also have acted as the Designated Review Officer (DRO) for those level 3 SAI reports that required nursing advice and expertise.

13. As part of the commissioning team for those services, Ms Kane would have considered the recommendations and their implementation. As I understand, Ms Kane also would have provided professional nursing advice in relation to their implementation from a commissioning perspective.

14. Any member of the Learning Disability commissioning team may have been allocated the DRO role, depending on the professional expertise required for the SAI.

Q2. Did the PHA Nurse Consultants have any role in post-investigation actions regarding serious adverse incidents? If they did, please describe their role.

15. The responsibility for the implementation of the actions belonged to the Trust as it owned the report of any Level 3 SAI. The PHA Nurse Consultant's responsibility was to receive an assurance at performance management review meetings with the Trust (commissioning meetings) that the recommendations were being implemented.

Q3. Were you informed about the number and type of incidents? If so, how were you informed?

16. Within the PHA, a SAI review group was established; this group was co-chaired by the Director of Public Health and the Director of Nursing. The relevant DROs attended this group, on an ad hoc basis, to report on progress implementing key recommendations within level 3 SAI reports. However, the Mental Health and Learning Disability Commissioning Team would have ensured the relevant trust was held to account for the implementation of the recommendations.

Q4. If the answer to question 3 is yes, was this reported to the PHA Board? If so, how and by whom was this reported?

17. From recollection, but I cannot be certain without access to relevant papers, the SAI review group, through the Director of Public Health, provided a quarterly report to the HSCB Board Meeting.

Q5. Did you have concerns about safeguarding at MAH before September 2017 and, if so, what were the nature of your concerns? What action, if any, was taken in relation to those concerns?

18. To the best of my recollection, I was not aware of any safeguarding issues having been raised at MAH and I did not have any concerns. I have not had the benefit of considering any internal documents from that time and cannot recollect if any safeguarding issues were reported to me.

Q6. Did you or your team make any recommendations about education and training of staff at MAH? If so, please provide details of your recommendations and describe whether those recommendations were implemented.

19. Ms Kane may have made recommendations about education and/or training of staff at MAH. Any recommendations made would have arisen from and been aligned with the findings and recommendations from SAI reports.

20. Those recommendations would have been actioned or discussed at the HSCB Mental Health and Learning Disability Commissioning Team meetings, that Ms Kane attended to provide professional advice.

Q7. Were you or your team aware of serious adverse incidents relating to safeguarding for any person resettled out of MAH from 2008 onwards? If so, please provide details, including the number of serious adverse incidents and the PHA response.

21. I do not have that detail. I assume the PHA will be able to provide information in relation to this. I left in 2016 and do not have any access to documents or emails and therefore cannot comment.

Q8. As an attendee at the HSCB, were you present at any Board discussion regarding concerns about MAH? If yes, please provide details, including details of the professional advice given, if any.

22. Ms McAndrew, in her role as Director of Social Care and Social Services, was the responsible Director on the HSCB for Mental Health and Learning Disability Services. Ms McAndrew may have taken reports to the Senior Management Team meeting for discussion or to the Mental Health and Learning Disability Commissioning Team, and those reports may have been discussed at the HSCB Board meetings I attended as a director.

23. I do not remember concerns coming to the Board, but in the absence of documentation, I cannot be sure. In any case, I did not have direct involvement in those matters.

Commissioning

Q9. What advice did PHA provide about the commissioning of learning disability services?

24. Any advice relating to the commissioning of Learning Disability services would have been provided to the Mental Health and Learning Disability Commissioning Team in the HSCB by the designated Nurse Consultant, Ms Kane. I was not directly involved in this work and cannot comment further on this without any contemporaneous documents or information.

Q10. Was that advice always incorporated into the commissioning plan?

25. I was not directly involved in this work and cannot comment further on this without any contemporaneous documents or information.

PHA and Ennis investigation

Q11. Was PHA provided with the Ennis report? If it was:

i. Who received it?

ii. When was it received?

iii. How did it come to be received?

26. If the Ennis Report was received by the PHA, and I am assuming it was, it would have been provided to the Designated Nurse Consultant. I have no access to documentation from that time and cannot assist with the sub questions.

27. In 2012 I was the Deputy Director of Nursing; I do not believe I would have received the Ennis Report as I was not a part of the commissioning team responsible.

Q12. If PHA was provided with the report, what action, if any, did PHA take upon receipt?

28. I cannot provide any information in relation to this. If there was action taken by the PHA I was not directly involved.

Q13. Was the report shared with the PHA Board or any of its sub-committees? If so, please provide full details.

29. I wasn't a member of the PHA Board of any of its sub-committees at that time, so I cannot comment on this.

Q14. In correspondence from RQIA to the Hospital Services Manager dated 03 December 2012 (concerning Ennis Ward), it is stated that a review of staffing levels at MAH had been requested by Molly Kane, Regional Lead Nurse Consultant at the PHA. Was this review carried out? If so, please provide details of and evidence relating to this exercise.

30. Without access to any PHA documentation from 2012 I am unable to provide any information on this.

PHA and the Leadership and Governance report

Q15. At pages 163-165 of "A Review of Leadership and Governance at Muckamore Abbey Hospital", dated 31 July 2020, the Review Team made a series of recommendations concerning PHA and other bodies (the Department of Health, the Belfast Trust and the HSC Board). The Inquiry would invite any comments that you wish to make regarding those recommendations.

31. I was no longer employed by the PHA at the time of this report therefore I was not involved with it and have no comments to make.

Q16. What action, if any, did PHA take in relation to those recommendations? Please provide dates and details of any action taken.

32. As above.

General

Q17. 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 paragraphs 9, 10-13, 17 and 18-19 of the Terms of Reference?

33. Nothing further that I wish to add.

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: P Cullen.

Date: 24/04/2024