ORGANISATIONAL MODULES 2024 STATEMENT

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Charlotte McArdle
Date: 28 June 2024

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

The statement is made by me in the capacity of Chief Nursing Officer for Northern Ireland at the Department of Health (DoH) between 4th April 2013 and October 31st 2021 in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "Exhibit 1".

Qualifications and positions

1. I am a registered nurse on part one of the Nursing and Midwifery Council Register and the Nursing and Midwifery Board of Ireland. I hold a degree in Health Science attained in 1996 from Manchester University. I hold a master's degree in nursing from Queens University Belfast in 1999. I am a Visiting Professor at the Ulster University, a Trustee and Vice Chair of the Royal College of Nursing Foundation and am a Board Member and fellow of the Faculty of Nursing and Midwifery in the Royal College of Surgeons in Ireland. I am a fellow of the Queens Nursing Institute. I am an accredited Global nurse consultant with the CGFNS (Commission on Graduates of Foreign Nurses Schools) in USA. I have achieved a Florence Nightingale Leadership Scholarship in 2012, attended the global nurse policy development institute at International Council for Nurses and completed the Institute for Health Care Improvement Advisor's Programme.

2. Following nurse training in Beaumont Hospital Dublin Ireland, I continued my nursing career there until 1992. I then moved to Northern Ireland, taking up a post

in Musgrave Park Hospital in Belfast in Rheumatology, initially as a Staff Nurse and then as a Senior Staff Nurse until 1996 and then Ward Sister until 1998. In 1998 I moved on to take up the role of Ward Sister in the Medical Directorate of the Royal Hospitals, Belfast. In 2000 I became Divisional Nurse and lead nurse for surgery still within the Royal Hospitals group, and then in 2003 I became Deputy Director of Nursing there. In 2007 I was appointed Director of Nursing, Primary Care and Older People in the South-Eastern Health and Social Care Trust, where I remained in post until my appointment as Chief Nursing Officer for Northern Ireland on 5 April 2013 and was in post until 31 October 2021. I am currently employed at NHS England as Deputy Chief Nursing Officer for England.

M10: Department of Health

3. I have been asked to provide a statement for the purpose of M10: Department of Health - the evidence of persons in positions of responsibility for MAH and relevant professional standards, systems and processes, past and present, at Department level.

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 making this statement I have received assistance from former Departmental colleagues who have provided me with information and documentation relevant to the questions posed by the Inquiry. I can indicate their identities to the Inquiry should it require this information. I have tried to indicate in this statement where information is within my own knowledge and recollection and where I have been alerted to it. Where relevant documents have been brought to my attention, I have either exhibited them to this statement or identified where they are found elsewhere in the evidence already provided.

Q1. Please explain the professional reporting lines that existed from MAH to the Chief Nursing Officer.

5. In line with the Department's framework document MAH is managed and governed by the Belfast Health and Social Care Trust (BHSCT). Whilst MAH is under the managerial responsibility of an Operational Director in the BHSCT there are professional reporting lines through to the Executive Director of Nursing. The Executive Director of Nursing is responsible to the Trust Chief Executive Officer and the Trust Board. The Trust Chief Executive as the Accounting Officer is responsible to the Permanent Secretary and the Chair of the Board to the Minister for Health. Each year the Accounting Officer signs an assurance statement to the Department of Health identifying key risks and concerns. These would be subsequently discussed with the Permanent Secretary.

6. There is no statutory or otherwise professional reporting line between Executive Directors of Nursing and the Chief Nursing Officer (CNO). Being cognisant of this position I strengthened existing forums to promote the opportunity for professional discussion between the senior nursing and midwifery communities and provide the opportunity to raise any matters of concern or professional practice. I was very visible as CNO regularly visiting health care facilities and speaking at local and national events. I engaged with the media to provide leadership and strengthen the relationship between nursing and the public. I used social media to engage the profession. I invited nursing students to work shadow me and have placement in my office. I invested heavily in my professional networks and built strong relationships with senior nursing and midwifery leaders across Northern Ireland to gather intelligence and to be attuned to the context in which nursing care was being delivered. Senior nurse and midwifery leaders would often ring me directly to discuss issues and I always prioritised these calls. I would highlight the CNO business meeting and Central Nursing and Midwifery Advisory group as the two forums which I shaped to support the development of a senior nurse network for NI.

7. I understand the Chief Nursing Officer (CNO) Business Meetings commenced in 2006 and therefore has been a long running, regularly scheduled means of convening Nursing and Midwifery leaders from across Northern Ireland's (NI)

Health and Social Care (HSC) sector with the CNO Department of Health (DoH). It was established in recognition of the requirement for such leaders to build and maintain close working relationships, to achieve system wide Nursing and Midwifery engagement and collective decision making on nursing and midwifery policy and professional practice as well as discussions on my strategic priorities as the CNO. It is a forum for sharing and learning and has a strategic focus rather than operational. It is important to note that Directors of Nursing remain accountable to their boards for safety, quality, and effective governance in line with the accountability framework. However, the identification of key issues effecting the profession may have both operational and policy implications such as recruitment and retention, safe staffing, and quality of care delivery. The CNO Business Meeting allowed me to regularly meet with senior nursing leadership from across the Health and Social Care system (HSC). The membership was the Executive Directors of Nursing in each of the HSC Trusts, the Executive Director of Nursing in the Public Health Agency, the Head of Clinical Education Centre, the Chief Executive Officer of Northern Ireland Practice and Education Council, alongside, my Deputy Chief Nursing Officers, the Midwifery Officer, with support as necessary from my Northern Ireland Civil Service team. Prior to taking up the post as CNO I held the position of Executive Director of Nursing, Primary Care and Older People in South Eastern Health and Social Care Trust and a member of the CNO business meeting. I recognised the changing nature of the HSC and the need to build a more collective leadership approach with shared decision making on nursing policy issues. I reshaped the agenda allowing more time for discussion and strategic decision making rather than information giving rather than simply giving and sharing information as had been the case at past meetings. Everyone had the opportunity to contribute to and shape the agenda. The CNO business meetings were generally held monthly.

8. The Department of Health and CNO may ask members of the Business meeting to comment and provide advice on major consultative documents or deliberating on wider professional topics. This advice forms a key component to the continuing development of services to meet the needs of patients and the public throughout

Northern Ireland. CNO Business Meeting members may also initiate matters to be brought under consideration. Overarching nursing issues which affected learning disability nursing were regularly discussed including indicative funding updates for delivering care, undergraduate forecast numbers, updates on reflective supervision policy, recording care programme, Mental Health Capacity Act and the development of a delegation framework to support multi-disciplinary delegation. Specific issues to learning disability were for example the Learning Disability Nursing Review in 2021 and updates on Strengthening the Commitment. Detailed Reference is made in paragraphs 35 to 37 of my statement to a nursing governance review following concerns at MAH and another facility in Northern Ireland. The discussions at CNO business meeting were strategic in nature and were across Learning Disability Nursing as a field of nursing practice rather than specific to MAH.

9. The Central Nursing and Midwifery Advisory Committee (CNMAC) was established under Article 24 of the Health and Personal Social Services (Northern Ireland) Order 1972. It is thus a statutory advisory body whose function is to advise the Minister and the Department through the CNO on matters concerning nursing and midwifery in Northern Ireland, including those matters relating to the regulation and education of the profession and the safety, quality, and experience of patients/service users. CNMAC can also provide advice in relation to wider policy development and the implications for nursing and midwifery practice.

10. The position of Chair of CNMAC was held by me as CNO. The Department and/or CNO may ask CNMAC to undertake specific tasks, whether commenting on major consultative documents or deliberating on wider professional topics. This advice forms a key component to the continuing development of services to meet the needs of patients and the public throughout Northern Ireland. CNMAC may also initiate matters to be brought under consideration including the identification of appropriate areas for research and development and/or policy development to improve practice, patient experience, and outcomes.

11. The Chair and members of CNMAC are formally appointed by the Minister of Health, with most members, including CNO as chair, being appointed due to their position held (ex-officio). The remaining members are appointed following a selection process. Membership is representative of nurses and midwives in practice, education, research, and management roles from a range of care settings. Members are appointed for their knowledge and experience and membership of CNMAC is designed to reflect a spread of expertise. The Royal College of Nursing and the Royal College of Midwives both have representatives on CNMAC, and this strong relationship enabled a strong level of communication and cooperation on all aspects of the nursing and midwifery policy. The meetings were generally held quarterly. Examples of work done by CNMAC are:

    (i) CNMAC commissioned a task and finish group to review recruitment and retention difficulties which was completed in 2016. The report provided eleven recommendations to support the increased recruitment of nurses across the system. Learning disability nursing was referenced as a hard to recruit to area. Appendix four of the report outlines the Belfast Trust Band 5 workforce data including that specific to learning disability. It records the funded staff in post for learning disability nursing band 5 to be 138 whole time equivalent (WTE) and the staff in post to 202.99 WTE suggesting that additional funded posts were required to provide nursing care. In addition, it is noted that there were 27 vacancies and 19 WTE agency/ overtime posts to supplement the nursing workforce at that time. The breakdown for MAH is not provided and, in my view, would have been a substantial component. This report provided evidence to increase the number of nursing students in Northern Ireland from 2016 onward. I include a copy of this report at Exhibit 1.

    (ii) CNMAC reviewed the 'Northern Ireland Action Plan for Learning Disability Nursing Northern Ireland Collaborative Progress Report Sept 2014 - March 2016'. It also discussed a workforce paper which was undertaken by the Regional Collaborative for LD nursing. I include a copy of this at Exhibit 2.

(iii) From 2016 at CNMAC meetings there was a focus on the Nursing and Midwifery Task Group report, finally launched on 10th March 2020, but the implementation of this was subsequently delayed by the focus on the response to the pandemic. Whilst this was not specific to MAH or learning disability the implementation of the finding would have impacted on learning disability nursing. I exhibit this at Exhibit 3.

12. The genesis of the Nursing and Midwifery Task Group report was the Royal College of Nursing made representation to the then Minster Simon Hamilton regarding the challenges that faced the nursing profession, including recruitment, retention and the value of nursing. As a result, Minister Hamilton asked me to bring forward plans for his consideration to address the issues raised. The Minster had not agreed the full proposals prior to the Northern Ireland Assembly Election in May 2016 and Minister Michelle O'Neill was appointed the new Health Minister.

13. The Nursing and Midwifery Task Group Report (NMTG) was the culmination of three years of work commissioned by then-Minister Michelle O'Neill. Following the launch of the Minister's Vision 'Delivering Together Health and Wellbeing 2026' that I include at Exhibit 4, I advised the Minister on the need for a strategic focus on nursing, particularly given the backdrop of workforce shortages in all fields of nursing, as well as an increased reliance on international nurse recruitment and on bank and agency nursing staff. In recognition of these pressures and in line with Minister O'Neill's vision, the Minister agreed to establish a 'Nursing and Midwifery Task Group' (NMTG). I attach a copy of this report at Exhibit 5.

14. The NMTG was independently chaired by Sir Richard Barnett, who, along with key representatives from across the HSC system, oversaw the formulation of a comprehensive nursing and midwifery vision, including the development of key ambitions and recommendations. The recommendations in this report will facilitate the key themes:

(i) Adoption of a population public health approach and put prevention and early intervention at the heart of nursing and midwifery practice;

(ii) Stabilisation of the nursing and midwifery workforce therefore ensuring safe and effective care; and

(iii) Transformation of health and social care service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams (MDTs).

15. The report was also supported by a five-year implementation plan, included as Exhibit 6, which outlines key areas for action.

16. In taking forward the NMTG work, several co-design events involving over 1,000 nurses from all levels and all branches of nursing participated, including bespoke workshops for mental health and learning disability nurses. These engagement events supported the generation of the final recommendations for the report. Following the revelations which emerged about nursing practices in MAH and taking account of the findings of the Rapid Review of Mental Health and Learning Disability Governance conducted by the then Executive Director of Nursing of the Public Health Agency, Mary Hinds, I sought to ensure both the learning and recommendations of the rapid review were incorporated into the NMTG's final recommendations. Specifically, those that related to clinical leadership, clinical governance and the development of nursing and midwifery assurance systems.

17. As detailed in the NMTG plan I developed a costed plan, and as part of the New Decade New Approach, Minister Robin Swan agreed £60 million to be invested in nursing and midwifery over the period 2020–2025. Between 2020-2021 and 2021-2022, I secured £25 million dedicated to addressing the recommendations of the NMTG.

18. I was determined, working with the Executive Directors of Nursing across all HSC bodies, to not only address workforce challenges but also invest in clinical leadership and advanced practice roles. I saw this as a necessity in terms of building the necessary clinical infrastructure and networks to help deliver the ambitions outlined in the NMTG. This resulted in the investment and

commissioning of 43 consultant nurses and 17 advanced nurse practitioners in HSC bodies, which represented over 20% of the investment. It was my vision that once these senior clinicians were appointed, they would be working together both within their clinical areas and as a regional network to drive the delivery of safe, effective, and high-quality care. In this context, I also prioritised investment in learning disability consultant nurses and advanced practice roles in response to the need to strengthen clinical governance and leadership in learning disability nursing. I saw these roles as fundamental to not only creating a career pathway for learning disability nursing but also to the delivery of evidence-based therapeutic interventions and the development of key quality learning disability nursing indicators. As part of my strategy for developing these roles I intended that they would provide additional practice based senior decision making and support for other ward nurses and early career nurses.

19. Through the NMTG investment, I also supported the appointment of Quality Assurance Consultant Nurses. I anticipated that this team of Quality Assurance Consultant Nurses would also partner with all the other consultant nurses, including those within learning disabilities, to lead the development of a new quality assurance framework for nursing and midwifery across all aspects of nursing and midwifery care.

20. The NMTG recommendations and implementation plan provided the necessary strategic blueprint to enable the reform of nursing and midwifery care in Northern Ireland. Having secured the minister's commitment, I had planned to establish work streams around the three key ambitions of NMTG to deliver on the recommendations of the report. These workstreams would have included all fields of practice. During my tenure, despite the impact of the pandemic, I was able to progress some of the NMTG recommendations, and these, as set out below, were starting to influence improvements in learning disability nursing. In summary, I sought to:

    - Stabilise the learning disability nursing workforce by commissioning more undergraduate places until the Department had achieved a position of

oversupply (this applied to all fields of practice. (NMTG recommendation 7.2.1).

- Improve retention, by creating new career opportunities as evidenced by the investment in learning disability consultant nurse, and advanced practitioner roles. (NMTG Recommendation 7.2.3, page 13)

- Strengthen the public health infrastructure by creating dedicated public health nurse consultant roles across all our HSC bodies, including funding a dedicated public health learning disability consultant nurse in PHA. These roles were designed to work across the life course including partnering with subject specific experts, for example, the Learning Disability Nurse Consultants. (NMTG Recommendation 7.1.2, page 13)

- Develop and prepare nurses and midwives for leadership positions as evidenced by NMTG investment in learning disability nurse consultant roles (NMTG recommendations 7.3.1, page 14)

- Build a nursing and midwifery quality improvement infrastructure by investing in quality assurance nurse consultant roles in all HSC bodies. As indicated above, I anticipated this group of consultants leading the development of a new nursing quality assurance framework to underpin the quality, safety, and effectiveness of nursing care. Learning disability consultant nurses, once appointed, would also be involved in co-designing and translating this framework within their field of practice. (NMTG recommendation 7.3.3, page 14)

21. As indicated, this was only a start. I also anticipated that, in time, the adoption of a person-centred framework across all nursing services (NMTG recommendation 7.2.7, page 13) would also help to improve a culture of shared decision-making and partnership with people with learning disabilities and their families.

Q2. How often was MAH discussed within the Office of the Chief Nursing Officer? Please explain what regular information your Office received about MAH. How often was any such information received and who provided it?

22. From I took up post in April 2013 and prior to August 2017 my office neither received regular communication about MAH nor was it discussed in my office.

23. MAH was the remit of the Belfast Health and Social Care Trust, and any conversations or information would have been with my team in a strategic professional policy context for Learning Disability Nursing.

24. I do not recall MAH ever being discussed at the CNO business meeting prior to the revelations in 2017.

25. On 24 November 2014 I received on email from Pat Cullen Acting Executive of Nursing, Midwifery and Allied Health Professionals Public Health Agency raising issues regarding recruitment of learning disability specialist nursing staff for PICU and acute admissions at MAH and requesting me to raise this at CNO business meeting or CNMAC. Ms Cullen provided email correspondences from John Veitch BHSCT to Molly Kane PHA Regional Lead Nurse Consultant for Learning Disability Nursing and Prison Healthcare stating a paper was being prepared and would be shared with PHA in due course. In response I requested further analysis. It was my expectation that the PHA and BHSCT would provide deeper analysis of the problem. In my recollection any further analysis was not shared with me.

26. Whilst no further information is available, I am aware Belfast Health and Social Care Trust developed a recruitment campaign to attract nurses to Psychiatric Intensive Care Unit (PICU) and this included mental health nurses in the absence of being able to recruit RNLDs. From memory this was around 2015.There appeared to be a lack of learning disability nurses wanting to work in MAH possibly due to the retraction of services on the site. At the time there were no other specific recruitment issues identified from this field of practice. I shared

this information and Belfast Trust plans to recruit with my Deputy CNO who was undertaking a workforce review on behalf of the Department and the Nursing Officer for Learning Disability nursing. As part of the development of the nursing and midwifery workforce plan a specific engagement session was held with learning disability nurses across the region and this was then fed into the plan. In addition, I had already asked the Strengthening Commitment Collaborative to undertake in 2014/2015 a workforce review for Learning Disabilities Nursing in NI and this subsequently was represented in the overall nursing workforce plan.

27. In addition, as Northern Ireland's response to the national 'Strengthening the Commitment, the UK Modernising Learning Disabilities Nursing Review,' the Northern Ireland Action Plan for Learning Disability Nurses was launched by me on 20 June 2014. In 2014 I asked NIPEC to establish the Northern Ireland (NI) Collaborative to support and oversee the delivery of the actions of the NI Action Plan that I have exhibited at Exhibit 7. This Collaborative was chaired by the Chief Executive of NIPEC and included representation from a wide range of stakeholders including all five HSCT's; Clinical Education Centre; Universities; the independent sector; the Health and Social Care Board; PHA; RCN; Regulation Quality Improvement Authority (RQIA), individuals with a learning disability and their carers and families. The workplan and the priorities for the Collaborative, were identified and prioritised by members, aligned to the NI Action Plan and agreed with me.

28. I received annual progress reports from the collaborative and I attach an example of this at Exhibit 8. This Regional Collaborative continued throughout my time as CNO as one of the main mechanisms to progress strategic work from a nursing perspective in respect of Learning Disability. Work undertaken by the regional collaborative and with my oversight during that time includes:

    - The promotion, engagement and raising awareness of Strengthening the Commitment and the NI Action Plan and the role of the NI Collaborative regional information seminars organised in each Trust. I include a copy of the Action Plan at Exhibit 9.

- Creation of a microsite on the NIPEC website making information about the activity of the NI Collaborative widely available, and to provide access to a range of relevant resources (Exhibit 10).

- NI Actions Plan Communiques were developed by the NI Collaborative, posted on the microsite, and issued electronically on a regular basis across the HSC system (Exhibit 11).

- 2014/2015, NI Collaborative undertook a workforce review for Learning Disabilities Nursing in NI (Exhibit 12).

29. In 2015 I commissioned a bespoke Senior Nurse Leadership Development Programme for RNLDs, delivered by the RCN (Exhibit 13). This Senior Nurse Leadership Development Programme was cited as example of positive practice in Strengthening the Commitment: the Living the Commitment four country report published in June 2015 (Exhibit 14).

30. I participated in a learning event in October 2015 to explore outcome measures relevant to Learning Disabilities nursing and reach a consensus about the way forward for this specific requirement of the NI Action Plan. A summary report which includes the Programme for the event is included at Exhibit 15.

31. In 2015 established a Regional Learning Disabilities Nurses Network to include HSCTs, the education sector and the independent/voluntary sector. The network, aimed at reaching the RNLD workforce in NI. Membership of this group was further expanded and a joint NIPEC/RCN Professional Development Forum (PDF) for Learning Disabilities Nursing was launched on the 2nd of March 2015 (Exhibit 16).

32. An Outcomes Measurement Resource was launched by me in October 2018 at the RNLD Practice Development Forum (Exhibit 17).

33. In June 2018 I launched the Learning Disabilities Nursing Career Pathway which I had previously commissioned (Exhibit 18).

34. I discuss later in my statement at paragraph 141 an Early Alert which was when the allegations of abuse in 2017 were brought to my attention.

Q3. Did you receive any intelligence about MAH from your professional reporting lines? If so, what information did you receive, and what action(s) did you take, if any, in relation to that information?

35. I understand intelligence in this context to be any information received through my professional network through informal or formal means. I have outlined in my statement how these professional networks work and described the CNO business meeting at paragraph 7 and CNMAC at paragraph 9. MAH was not discussed at these meetings as the purpose was on system level strategic issues. I have identified in paragraph 25 and in paragraph 141 two occasions when intelligence was received. I did not receive any other intelligence of serious concern regarding abuse or quality of care prior to the Executive Director of Nursing in the Public Health Agency advising me of her concern (around mid-November 2017) that four SAIs had been received by the Health and Social Care Board and that all of them were in relation to alleged violence by staff against patients. Two Trusts were involved, one SAI was a mental health setting and the other three were in MAH. Her concern was the potential failure to protect patients and that nursing staff were involved in these allegations. We agreed that while all four incidents were subject to the SAI process, we wished to ensure any regional nursing action which may prevent further incidents could be identified and implemented as soon as possible.

36. I subsequently wrote to the Executive Director of Nursing in the Public Health Agency on 24th November 2017 asking her to undertake a scoping report on the systems, professional structures, policy, and procedures that were in place to provide professional assurances to the Directors of Nursing in Trusts. I specifically asked for her exploration and views on how well learning disability

and mental health nursing have been integrated into the corporate nursing arrangements within the organisations.

37. In addition, I requested information on:

- Supervision, Safeguarding, Practice monitoring arrangements
- The process in place to learn from incident reviews and events; and
- Mechanisms in place for learning disability and mental health nurses to access continued professional development.

38. The report that I include at Exhibit 19**,** concluded in early 2018 and was tabled and discussed at the CNO Business meeting in February and April 2018 and identified 19 areas for consideration. Progress against the action plan was led by Mary Hinds and DCNO Rodney Morton and at the CNO meeting in October 2019 I asked for a comprehensive action plan with timelines for implementation. I have been informed that the department does not hold a copy of the action plan provided by Mary Hinds. I recall that there was one developed with several actions taken mainly in providing robust assurance and investment in leadership development and quality improvement. These themes along with stabilising the workforce and transforming care have been picked up in the recommendations of the Nursing and Midwifery Task group report launched in 2020 referred to in para 12-21 of this statement.

39. At the time all Executive Directors of Nursing provided assurance that there were explicit and effective lines of accountability from the care setting to the Trust Board through the Executive Director of Nursing and that they had sufficient support/processes in place to enable them to provide assurances to their Board about the quality of nursing and midwifery care or that they have an agreed plan in place to support their role.

40. However, the report noted variation and reliance on the skills of a small number of senior nurses and many had joint roles in the organisation therefore I commissioned further work on a new nursing assurance framework in 2019. This was a precursor to the key recommendations (7.3.3) in the Nursing and Midwifery Task Group Report launched in 2020 which stated, “Develop a new statutory assurance framework for nursing and midwifery to underpin quality, safety, and effectiveness”. The work on the statutory assurance framework was hindered by the COVID 19 Pandemic and I understand it remains outstanding.

41. The lack of dedicated investment and the reliance on a small group of staff highlighted the need for bespoke leadership development and I commissioned the Aspiring Nurse Director Programme. I commissioned quality improvement training specifically for nursing led by the South Eastern Trust and provided funding for the Institute of Healthcare Improvement (IHI), improvement advisor programme which a yearlong intensive programme. Trusts identifies which staff should attend. To ensure further capacity and capability for improvement I invested in six quality improvement leads. It was my view they would form a network and drive improvement. In addition to strengthen executive nurse director leadership and visibility to Strengthening the Commitment I appointed the Executive Director of Nursing in the Northern Health and Social Care Trust to co-chair the programme. I secured additional investment for a LD nursing Officer at the Department as part of my team, this post had been vacant for several years due to departmental financial pressures and the need to reduce headcount and I asked the postholder to urgently undertake a review of learning disability nursing.

42. Mary Hinds in her report identified the need for exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system and I provided funding for the Foundation of Nursing studies Creating Caring Cultures Programmes specifically for Learning Disability.

43. The PHA also commissioned positive behavioural support training for staff in LD. Positive Behavioural Support (PBS) is an ethical and effective way of supporting individuals with learning disabilities who present with behaviours of concern. PBS uses the techniques of applied behaviour analysis, guided by a strong values base, delivered in person centred way to meet the needs of individuals who present with behaviours of concern.

Q4. RQIA frequently reported staff shortages at MAH from 2010 onwards, meaning that the prescribed levels of supervision for distressed patients were not achieved. Were you or your professional group aware of these RQIA reports? What action(s), if any, were taken arising from the information provided by those reports?

44. Reports of RQIA inspections at MAH were routinely circulated to the relevant policy lead within the Department, who would in turn share these with relevant Departmental professional officers either for information purposes, or to seek professional advice on issues that may have been identified through inspection reports.

45. Prior to 2017 I and my professional group were not aware of any RQIA reports in relation to MAH. I was aware that RQIA raised concerns about staffing at MAH after 2017. The RQIA Bi-monthly update report provided to Top Management Group (TMG) in January 2018 noted under early alerts that RQIA inspected Cranfield Ward Two at MAH on 20th December 2017 to review staffing following a whistle blowing allegation. It noted that 29% of shifts had not achieved the required staffing level and additional staff had been moved to the ward and the ward manager was monitoring the situation daily. The risk had been placed on the Trust Risk Register and continuous attempts were being made to address the staff shortages.

46. Where inspections find staffing levels in any service to be consistently inadequate, responsibility for addressing these in the first instance rests with the provider organization. If the provider is unable to do so within their existing

resource allocation, then they have a responsibility to raise these with the service commissioner through a bid for the necessary additional funding through the established HSC commissioning arrangements.

47. Where RQIA inspections identify very serious concerns relating to a particular service which is not regulated under Part III of the HPSS (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 they can report these to the Department, and may under Articles 4 and 35(5) of the 2003 Order recommend that the Department takes special measures in relation to the service. I am aware the Department received two such Article 4 letters from RQIA in 2019 in relation to inspections they had carried out at MAH, as set out in Mark McGuicken's statement of 26 May 2023 at paras 1.1-1.5 [MAHI - STM - 118 – 1 to MAHI - STM - 118 – 2]. Copies of these letters have been exhibited to that statement at MMcG/176 [MAHI - STM - 118 – 102] and MMcG/177 [MAHI - STM - 118 – 107].

48. In accordance with the requirement under Article 4 and as set out in Mark McGuicken's statement of 26 May 2023 at paras 1.1-1.5 [MAHI - STM - 118 - 1 to MAHI - STM - 118 – 2], I was made aware of two unannounced inspections at Muckamore by the RQIA in February 2019 and April 2019, the RQIA raised several issues, including staffing levels, at Muckamore with the Department in an Article 4 letter sent to the Department on 6 March 2019. Although I had received the RQIA bi-monthly report in January 2018 this was specific to one ward and the trust were dealing with the issue. I was not aware of the severity of the staffing concerns until this point when the policy lead for learning disability in the Chief Social Services Office brought it to my attention and was very concerned regarding the issues raised on staffing levels in the RQIA unannounced inspection. In response I wrote on behalf of the Department to the Belfast Trust, on 31 May 2019 to seek further information on the current nurse staffing ratio and skill mix Muckamore. A response was received from the Belfast Trust on 20 June 2019. I include a copy of this letter at Exhibit 20 and a copy of the Belfast Trust response at Exhibit 21. Further information is provided in paragraphs 180 and 181 of my statement.

Q5. Are you in a position to express a view on whether the immediate suspension of staff identified following review of CCTV at MAH made patients at MAH safer?

49. The Adult Safeguarding policy provides guidance on action to be taken where alleged intentional harm is suspected. Where an individual is alleged to cause harm to a patient the trust concerned will deal with this matter through the adult safeguarding policy and local investigation and disciplinary policy if required. This is usually jointly led by the Director of Social Services, Director of Human Resources and Director of Nursing. Where evidence gathered suggests harm has been intentionally caused I agree the most appropriate action is suspension of that staff member to primarily protect patients and to ensure a non-bias approach to an investigation.

50. In the case of MAH the suspension of a high number of staff happened over a short period of time. In this unusual circumstance it was right to take the best course of action to protect individual patients. Consideration must also be given to the care environment and the impact of the removal of staff from a continuity of care perspective. This is important given the client group in MAH where meeting their individual needs requires expert knowledge and person-centred approaches to care. I am aware that some activities for patients were restricted or stopped due to the staff situation. This may have had an adverse effect on patients' wellbeing.

51. I am aware that the suspension of staff led to a high usage of agency staff and non-specialist learning disability staff, and this was reported by the BHSCT to Department in their Early Alert updates and later through MDAG. There is no doubt that such dependence on agency and other staff increases the risk to care delivery. This is discussed in response to question 6 of my statement. Other mechanisms to temporarily deploy staff from other Trusts was explored but with minimal effect. The Departmental Permanent Secretary agreed in November 2019 that an enhanced salary uplift of 15% should be offered for a limited period to encourage registered nursing staff from other Trusts to relocate to work in

Muckamore. I attach a copy of the submission to the then Permanent Secretary at Exhibit 22.

52. In the interests of equity this enhancement was also offered to registered nurses and healthcare assistants in Muckamore. Travel cost for those willing to relocate was also agreed for reimbursement in line with existing terms and conditions of employment. I understand this enhancement remained in place until the end of September 2023 when the Belfast Trust made the decision to cease the payments. This had very limited success.

53. In summary for individual cases the use of suspension can be the best course of action. Where there are multiple cases of alleged abuse by several members of staff the totality of the care environment and delivery of safe care increases complexity and risk. Risk mitigation strategies were used to reduce this risk where possible, but the workforce remained fragile and under scrutiny. I cannot confidently answer the question in respect of particular suspensions, as I have not viewed the CCTV footage that grounded them. Clearly where there is an allegation of abuse there is a balance on providing safety and providing care. The criminal investigation prevented information being provided to me to enable me to have a transparent view on the situation.

Q6. Were the consequences of staff suspensions, both intended and unintended, discussed at MDAG? If so, please explain.

54. Muckamore Departmental Assurance Group was established in 2019 and held its first meeting in August 2019. As the CNO I was co-chair of this group. The terms of reference broadly speaking were, and I understand remain, to provide the Permanent Secretary and any incoming Minister with assurance on the effectiveness of the HSC systems response to the Serious Adverse Incident Review and that current services at Muckamore are being delivered in a safe, effective, and human rights compliant manner. In addition, the commitment given by the Permanent Secretary to resettle patients is met, and the issue of delayed discharges is addressed. MDAG monitored and oversaw the delivery against the

HSC Action Plan which sought to address all the recommendations in the level 3 SAI report “A Way to Go”. MDAG received:

- Monthly update reports from action owners on progress to implement the recommendations within the HSC Action Plan.

- Monthly update reports from the Belfast Trust on progress with the identification and review of material in relation to the historical CCTV viewing and ASG referrals.

- Monthly Highlight reports from the Belfast Trust on key aspects of the operational of the hospital such as staffing, current ASG activity, communication/engagement with patients’ families, RQIA inspections.

- Monthly resettlement progress dashboards from the then HSCB (latterly SPPG).

55. The intended consequences of staff suspensions were discussed at MDAG through the standing agenda item for the highlight report. This report provided updates on numbers of staff suspensions and the current position with police investigations and provided an opportunity to share this information with all participants including family representatives at the meetings.

56. As evidenced in the MDAG minutes that I attach at Exhibit 23, regular updates on staff suspension, resignations, vacancies, and the associated staffing pressures were provided to MDAG by Belfast health and Social Care Trust as well as those subsequently identified by regulation and Quality Improvement Agency (RQIA) as part of their inspection activity. This was in recognition of the challenges that related to staff suspension, including wider staffing concerns and the need to maintain safe care to the remaining inpatient population.

57. The discussions at MDAG did consider the implications of staff suspensions in terms of unintended consequences on safety, quality, and availability of care. The increased dependence on agency staff, skill mix, the reliance on staff who have not specialised in learning disability as well as the impact that staff shortages had for safeguarding, admissions, clinical care delivery, and patient /family experience were considered by the group. Whilst responsibility for the delivery of safe, effective, high-quality care remained the responsibility of BHSCT, one of the objectives of MDAG was to ensure that the team on site at Muckamore Abbey Hospital was given the support and resources necessary to achieve their goals. In this regard, discussions at MDAG included possible mitigations and various supportive actions were developed to assist the BHSCT where possible. For example, each Health and Social Care Trust was requested to have a contingency plan in place to support Muckamore Abbey Hospital. This included asking other trusts providing staff to work in MAH. Even with contingency in place more support was required to stabilise the hospital which was an unintended but predicable consequence. As noted earlier a 15% enhancement was agreed by the Permanent Secretary.

Staffing

58. A part of my ongoing consideration of the implications of staff suspensions, in 2019 I worked with the Executive Director of Nursing in BHSCT and the Departmental team to secure external support from a retired former Executive Director of Nursing and Chief Executive, to provide, support for MAH nursing leadership team and to work with them to generate short to medium terms solutions, as well as providing assurance to me around the safety, quality and effectiveness of nursing care. I am unable to locate a copy of this letter. The letter set out a request to Francis Rice to work as professional Nursing advisor alongside clinicians and management in the Belfast Trust to assist with stabilising the nursing workforce, providing expert advice, professional assurances and if appropriate, make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment within Muckamore Abbey Hospital. The external advisor worked with BHSCT nursing teams delivering care and was

a mechanism to ensure the voices of patients, families and staff were heard at MDAG in addition to family representatives. The external nurse advisor attended MDAG on 30 October 2019 and February 2020 and presented his findings, views, and concern on the immediate, medium and long-term sustainability of services at the hospital in view of the continued reliance on bank and agency alongside the current vacancy level. He provided updates on incentives being offered to staff willing to relocate to MAH following agreement through me to the Permanent Secretary and the work he undertook to engage with staff working their notice to understand why they were leaving and if they could be persuaded to stay considering the incentives. Both incentives had limited success. The external advisor completed his assignment in February 2020 and produced a report and action plan for the department. I include a copy of this at Exhibit 24.

Admissions and Resettlement

59. Paras 11.23 – 11.27 of Mark McGuicken's statement of 13 February (MAHI – STM – 089 – 50 to MAHI – STM – 089 - 51) set out the oversight arrangements for monitoring the renewed commitments on resettlement which were made by the Permanent Secretary in December 2018.

60. A standing agenda item was the MAH HSC Action Plan and it was clearly recognised at MDAG that the current model of care at MAH was outdated and not in keeping with policy direction or best practice guidance and that a new learning disability model was required. To achieve this a change in culture and practice underpinned by a clear understanding of the role of specialist in-patient care for people with learning disability was needed and supported by a sustainable multidisciplinary workforce plan. The availability of a range of supporting social care services including residential, occupational, and recreational supports, delivered alongside and in partnership with community-based specialist learning disability health and therapeutic services, delivering evidence-based interventions was fundamental to this future model.

61. At the MDAG meeting on 27 November 2019 (MMcG/211) the Group was advised that the Permanent Secretary commitments on resettlement were unlikely to be met. In response, members agreed (Action point - 27/11/AP10) that proposals to address barriers to resettlement should be tabled by the Belfast Trust for consideration by MDAG. A copy of the minutes from this meeting are attached in Mark McGuicken's statement at MMcG/216 [MAHI - STM - 118 – 1319].

62. The Belfast Trust subsequently presented proposals at the MDAG meeting held on 19 February 2020 (MMcG/213), and members agreed (Action point – 19/2/AP6) that the Department and the Health and Social Care Board should jointly review the effectiveness of the regional resettlement process and structures, with a view to making recommendations for improvement.

63. While progress on this work was delayed by the Covid 19 pandemic, the Department asked the HSCB in October 2021 to commission an independent review of the LD Resettlement Programme.

64. The consequence of this was the continued delay in resettlement and more patients being cared for in the hospital by a fragile nursing workforce. As a result of the multidisciplinary workforce challenges, BHSCT decided that MAH was closed to new admissions since 2018 and therefore making it unavailable for treatment and assessment for acutely unwell people with learning disability who required inpatient assessment and treatment. Given that MAH was sole prover of specialist learning disability inpatient care for Belfast, Northern and South Eastern Health and Social Care Trust areas, and regional provider of specialist learning disability low secure and PICU, this created a significant gap in commissioned specialist learning disability inpatient services across Northern Ireland. I attach a copy of the Early Alert at Exhibit 25, that provides an overview of the reasons for the closure.

65. Although the "Way to go" report recommended a necessary transition to community services and full closure of MAH it was clear to me that this could not

happen immediately or in the short-medium term, and that the important role of specialist inpatient care for people with a learning disability needed to be recognised and planned for. The HSC neither had the full range or capacity of community-based health and social care services required to safely and effectively meet the needs of patients delayed in their discharge from specialist learning disability hospitals in Northern Ireland including MAH nor could the full range of assessment and treatment be provided without a specialist learning disability inpatient service such as MAH. I corresponded by email to the Permanent Secretary on 7th December 2018 noting my concern that in my professional nursing view that there is a group of people with learning disabilities and neuro development challenges who will require acute intervention and simply closing the hospital will not provide for their needs. I reiterated my support for the population being cared for in the community but any changes in policy direction must ensure the safety and protection of vulnerable people and make provision for their health and care needs. I include a copy of this email at Exhibit 26.

66. Effectively no new admissions occurred from August 2018 with other options being explored including the Northern Trust providing a small number of inpatient beds. However, in relation to MDAG it was clear that both delayed discharge and failed resettlement reinforced my expert nursing opinion that Muckamore could not close and further exacerbated the unintended consequences of staff suspension as people remained in hospital.

Safeguarding

67. As CNO I did not have a specific role in decisions in respect of safeguarding under The Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures and Adults at Risk of Harm and Adults in Need of Protection (2016) and whilst recognising the role of employers in determining the most appropriate safeguarding action during an investigation as CNO my ultimate priority was to ensure that the public, and particularly those most vulnerable were protected from harm and were provided with safe and effective care.

68. Safeguarding issues were often discussed at MDAG for example 1st Oct 2019, the initial findings of a report on Adult Safeguarding Processes conducted by HSCB was presented to the meeting. The final report was circulated to members on 27th November 2019 and concluded that adult safeguarding investigations at the hospital had been completed in line with current regional guidelines.

69. In June 2021 the highlight report identified new items of concern in the report given the ward reprofiling exercise carried at MAH and potential decommissioning of Erne Ward. This led to additional information being required on safeguarding arrangements to ensure comprehensive and accurate information was provided recognising the need to maintain safety of patients whilst moving them to another ward and that they are not potentially subjected to abuse or be re traumatised.

70. The BHSCT had reviewed its information and proposed changes to accurately identify staff on patient incidents and patients on patient incidents. However, the families represented said that the information provided at the meeting did not represent their experience of adult safeguarding in the hospital and they expressed a lack of confidence in safeguarding processes in relations to staff inexperience, competence and attitude of some staff involved in safeguarding arrangements.

71. A safeguarding audit was commissioned by the Department due to concerns regarding the number and nature of safeguarding referrals in relations to staff on patient referrals. The Audit findings were presented to MDAG on 25th August 2021 which I was unable to attend. A copy of the minutes from this meeting are exhibited in Mark McGuicken's statement at MMcG/221. The Audit found that there were several system issues which needed to improve. Examples were the poor design of the safeguarding form, lack of follow up recording where PSNI involvement was needed, and no evidence of protection plans being completed. This was acknowledged at the meeting and would be addressed in the reform of adult safeguarding systems.

72. Following completion of the audit, I understand the Department continued to engage with the Trust on its outputs from the audit, including the Trust's development of an action plan to address the recommendations and the work to action the recommendations.

73. Specifically, there was a lack of evidence that wider protection issues had been considered where agency staff were no longer being employed in the hospital such as consideration of regulatory referral or follow up for other employment. Agency staff were disproportionately involved in incidents of concern. Concerns were raised in the audit about the knowledge, skills, and experience of staff. As a result, the BHSCT were asked for an immediate follow up in the areas of:

(i) Review any cases where there had been some actions taken in relation to agency staff to ensure all necessary referrals or action was taken.

(ii) Immediate review of all cases where there had been more than two adult safeguarding referrals involving the same patient.

(iii) Review the referrals to identify what had been the outcome of each investigation adult safeguarding documentation in response to the auditors' comments that the records lacked any conclusion in many cases.

74. Although I did not attend any other MDAG meetings as I left my post in October 2021, I understand that a progress update was provided to MDAG in December 2021.

Clinical Care Delivery

75. Clinical care delivery at MAH was almost exclusively delivered by nursing staff. The unintended consequence of high nursing staff turnover, suspensions and high sickness rates potentially had an impact on care delivery. The use of

restrictive practice was discussed at MDAG and a request made to the BHSCT to provide more specific information on a monthly basis.

76. Further to two unannounced inspections at Muckamore by the RQIA in February 2019 and April 20219, the RQIA raised a number of issues and I wrote to Ms Brenda Creaney regarding clinical care issues. Further detail on this matter is provided in paragraph 181 – 182 of my statement.

77. In February 2020 as part of the regular highlight report an update on restrictive practice was provided by BHSCT showing a reduction in both the rate of seclusion and the physical intervention following staff training, increased use of reflective practice, a reduction of inpatient numbers and better communication and an increase in a multi-disciplinary approach to care. I noted formally the work undertaken by the Trust to reduce the use of restricted practice.

78. However, at the February 2021 meeting it was noted that here had been a rise in the number of seclusion events and a family representative raised concerns about the current level of care provided and ongoing use of agency staff which was disproportionately weighted towards mental health nurses. My office had begun to receive weekly workforce reports at my request given the ongoing concern around the staffing at MAH. Although the reports were mainly retrospective at this point it was useful to review the staff situation regularly. My response to this new data was to request an urgent conversation with the Trust through the director Gillian Traub.

79. The staff situation was so concerning the HSCB had developed a further contingency plan in the event of an emergency for example no staff available for duty. I was conscious that investment was required in Learning Disability Nursing and as part of the Nursing and Midwifery Task Force Report published in March 2020 and I prioritised this investment through Delivering Care. On 21st May 2021 I received a breakdown and investment plan for the I20 new posts for Learning Disability funded through Delivering Care which I had prioritised from Rodney Morton Executive Director of Nursing and Allied Health Professionals at the PHA.

The letter sought my approval for the allocation of funding to specific areas of practice and the oversight and assurance processes and is included at Exhibit 27. This included 5 Nurse Consultant posts one for each trust in Learning Disability, a band 7 and band 8a to improve the continuity of senior leadership and decision making. My response affirming approval is appended at Exhibit 28. In addition, the Nursing and Midwifery Workforce Review had increased the number of undergraduate places from 25 to 35.

80. In April 2021 the Executive DON reported to MDAG that 72 agency staff were employed (50 registrants and 22 non registrants) and noted the families concerns about quality of care. Ms Creaney reported that the situation was stable at present and was under close monitoring noting that 69 staff were on suspension and 58 staff had protection plans in place which had increased due to new information from historical CCTV.

81. I wrote to Ms Brenda Creaney following the meeting on the 10th of May 2021 noting that BHSCT had undertaken a risk summit in relation to staffing which remained a huge collective concern. I include a copy of this correspondence at Exhibit 29. In the weekly departmental returns my team had noticed what appeared to be an increase in staff sickness and I sought the view of the Executive DON regarding trends or anomalies and seeking assurance on additional measures taken in response to the increased sickness level. As the information provided on a weekly basis was retrospective, I offered the assistance of my team to agree a way of providing more current information.

82. Three meetings took place between our joint teams, and I again wrote to Ms Creaney on 22nd October 2021 advising of ways in which I thought from the feedback the assurance could be strengthened and five potential areas were highlighted identifying the need for a weekly Sitrep report to the CNO office. I raised my concern regarding the skill mix of registered nurse learning disability which should be most of the registrant workforce and how they are represented in the new management governance structures designed by the BHSCT. I attach a copy of this correspondence at Exhibit 30.

83. In recognition of Ms Creaney's concerns of the nursing workforce we had a joint wider meeting including the Public Health Agency. Given the concern for the fragility of the workforce at that time the trust agreed to set up regular meetings with the wider group. I had anticipated this would happen before the next MDAG meeting scheduled for the 27th of October but as the wider meeting was not scheduled and I was leaving my post I urged Ms Creaney to set up a meeting to discuss the assurance reports with my successor.

84. As part of the development of the new learning disability care model an acute care review was due to take place under the leadership of Marie Rolston Executive Director of Social Work at the Health and Social Care Board, but this was paused due to COVID 19.

RQIA

85. Following the issue of the Article 4 letter from RQIA to the Department on 5th March 2019 in relation to MAH, RQIA were invited to attend MDAG in observer capacity. Regular updates were received on progress against the MAH improvement plan. I wrote to the Belfast Trust seeking further information on staffing levels.

Patient and Family Experience

86. At the inaugural meeting of MDAG I set out the context of the group and members agreed the need for effective arrangements to ensure the voices of families, carers and patients were represented. This was necessary to build trust and restoring confidence. I suggested seeking advice from the Patient and Client Council. At the November meeting I requested that the Patient and Client Council become a member of MDAG. The PCC brought together an engagement strategy for families. The PCC also undertook an advocacy work programme as part of the engagement process on the Public Inquiry and to support families raising concerns. This included concerns on residential care, interactions with various community teams and failed respite and as a result 21 cases had been escalated

to adult safeguarding. Five of these were from former patients. Both the family representatives and the BHSCT confirmed to me when asked that the involvement of the PCC was both appreciated and helpful.

87. Members considered it important that patients should contribute their views and the BHSCT were asked to undertake a review and critical analysis of current engagement arrangements with MAH patients and present the finding to MDAG. Although this work was delayed due to COVID 19 by September 2020 it was reported by BHSCT that this process had moved to a continuous engagement rather than a one-off event and that several virtual engagements were in planning.

88. The presence of family members was a good sense check on how things were going at MAH. Family members raised concerns about care delivery, agency and mental health nursing usage and safeguarding issues. These issues have been recorded throughout this evidence.

Q7. The Inquiry has received data demonstrating a rise in incident reports from 2011-2018 regarding inappropriate or aggressive behaviour by patients towards staff (see MAHI-STM-101-005490). In relation to this data:

- **i Were you aware of it?**
- **ii What action(s), if any, were taken arising from this data, in the context of changes to and closures of wards at MAH over the same period?**
- **iii What action(s) should have been taken?**
- **iv Was this data significant in relation to the staff shortages reported by RQIA across the same timeframe?**

89. I have reviewed the Inquiry exhibit MAHI-STM-101-005490 and note that this is an exhibit to Chris Hagan's statement of 20 March 2023 and forms part of his statement which describes Belfast Trust policies for management of violence and aggression. I also note that para 63 of Mr Hagans statement indicates that the Trust's Risk and Governance team has collated this data to assist the

Inquiry from information recorded in the Trust's DATIX record system since the system was established. This graph was produced more recently for the MAHI and was not made available to me prior to this statement.

90. I have no recollection of this information being previously made available in this or similar format to the Department and consequently no actions were taken.

91. I would note however that assurance reports provided by the Trust to MDAG since its establishment in 2019 have included information on rates of Adult Safeguarding (ASG) referrals in the hospital. The information, which is provided by the Trust to MDAG to enable it to discharge its assurance function, remains under continuous review and has evolved over the lifetime of MDAG to improve the level of assurance provided through MDAG to the Department.

92. In my opinion, data such as this should be used as a surveillance tool and when trends similar to that in MAHI-STM-101-005490 are identified it should be analysed, quality assured in case of error and then discussed at the Mental Health and Learning Disability Directorate Governance Group meeting within the Trust and then at the appropriate forum within the context of the Trust Governance and Assurance Framework. In my experience at this point consideration would be given to the risk assurance processes and documented on the Directorate risk register and escalated to the Safeguarding committee and/ or corporate risk committee and/or quality and safety subcommittee of the Trust board for decision on further action. It would be appropriate to raise the matter with the Mental Health and Learning Disability Commissioning Group and the Delegated Statutory Functions report in the context of understanding why patients' behaviour had changed. Further advice and consideration could then be given in the context of the region and consideration of an Early Alert to the Department.

93. It is reasonable to assume between 2017 when I became aware of the allegations of abuse at MAH and 2018 that the changing staffing situation, patients with greatest level of need and the impact on staff moral may have

been a variable in rising incidents and impacted on the continuity and delivery of care.

Questions for Department Witnesses

Q1. Please explain what your role was and when you held that role. Please also detail any particular responsibilities you held in relation to MAH and identify any groups relating to MAH which you were a member of.

94. As CNO between April 2013 and October 2021 I was head of the Chief Nursing Officer Group (CNOG) within the Department of Health, which consists of Nursing, Midwifery and Allied Health Professionals, and is supported by a Northern Ireland Civil Service (NICS) policy team. I reported directly to the Permanent Secretary and was a member of the Department's Top Management Group (TMG), and the Departmental Board.

95. I did not have responsibility for operational matters around service delivery, so my primary responsibility and accountability, and that of my Group, was to advise the Minister and the Department on all aspects of policy which impact upon or interface with Nursing, Midwifery and Allied Health Professionals in Northern Ireland, UK, and international level.

96. As head of the Nursing and Midwifery professions (approx. 27,000 nurses across four fields of practice, and 1,200 midwives), I was responsible for the professional leadership, professional standards, and development of these professions in NI and provided strong professional leadership for nurses and midwives across all sectors in Northern Ireland. I worked closely with all nursing and midwifery leaders in the Health & Social Care (HSC) system, university and education providers, independent and voluntary sector nursing care providers, trade unions, regulatory and professional bodies. I worked within the Department's "*Framework Document"* which clearly sets out the roles of Executive Directors of Nursing in the five HSC Trusts and Public Health Agency (PHA) and their professional responsibilities to their own arm's length body independent boards.

97. I was accountable for the strategic leadership and contribution of Allied Health Professions (AHP). I worked closely with the Department's Chief AHP Officer (CAHPO) who reported directly to me and holds a remit which includes responsibility for professional leadership of some 5,000 AHPs across fourteen distinct Allied Health Professions.

98. As the Department's most senior advisor on nursing and midwifery issues, I provided independent expert professional advice and support to the Minister, Permanent Secretary, and senior administrative and professional colleagues within the Department, other Departments and across the HSC, on all aspects of nursing, midwifery and AHP policy. I had a lead role in establishing, promoting, and reinforcing the strategic direction for nursing, midwifery and AHP services, agreeing programmes of action and ensuring that progress is monitored and evaluated.

99. I was a member of the Departmental Board in my role as CNO and through this reporting mechanism, any issues or concerns at Muckamore Abbey Hospital would have been flagged through this process, as well as the Sponsorship and Accountability arrangements, that I will outline later in my statement.

100. Following the allegations of abuse in 2017, the Muckamore Departmental Assurance Group was established in 2019 to provide further oversight and assurance of the hospital. I was Co-Chair of this Group alongside the Chief Social Work Officer, Sean Holland.

Q2. Please explain your understanding of the structures and processes that were in place at Departmental level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Departmental level?

101. As evidenced in Mark McGuicken's first statement of 13 February 2023 at paras 2.10 – 2.33 [MAHI - STM - 089 – 4 to MAHI - STM - 089 – 8] arrangements for oversight of HSC services have evolved considerably over the last 25 years.

This evolution partly reflects the organisational changes in the structures of government of Northern Ireland over this period through the Review of Public Administration.

102. These general oversight arrangements were/are applicable to all HSC services, including those provided at MAH. The statement goes on to describe specific arrangements for oversight of learning disability services at paras 4.1 – 4.6 [MAHI - STM - 089 – 16 to MAHI - STM - 089 – 18].

103. The HSC governance arrangements as structured in Northern Ireland at the time I was in post was in my view broadly reflective of current practice in comparable healthcare administrations. However, risk of abuse of vulnerable individuals in care settings is an increased risk which those who provide care must always be alert to and efforts made to eradicate or minimise the risk. This risk must include additional risk management and governance approaches such as robust safeguarding systems and policies. The effectiveness of the oversight and assurance arrangements is dependent upon effective system implementation, an open and transparent culture and collective leadership and appropriate escalation and action at all levels of the system.

104. Paras 4.4 – 4.6 [MAHI - STM - 089 – 17 to MAHI - STM - 089 – 18] of Mark McGuicken's statement makes reference to the HSC Framework document as the overarching summary of HSC governance and accountability arrangements.

Q3. Did the Department rely on incident reporting in respect of MAH?

105. There are a range of reporting mechanisms which provide the Department with information on front-line service delivery (which includes those services provided at MAH) but the Department does not rely solely on formal incident reporting.

106. These mechanisms range from the formal reporting arrangements outlined in question 9 above through to other specific reporting requirements associated with various statutory requirements as well as safety and quality functions.

107. Examples of specific reporting arrangements relevant to all HSC services (which again included MAH) include information on compliments and complaints (as outlined in Mark's second statement of 26 May 2023 at paras 50.1 - 50.2 [MAHI - STM - 118 – 46 to MAHI - STM - 118 – 47] and 51.1 – 51.4 [MAHI - STM - 118 – 47]), reports on the discharge of Delegated Statutory Functions (outlined in Mark's second statement at paras 66.1 - 66.2 [MAHI - STM - 118 – 54]), adverse incident reporting and the Early Alert system (Mark's first statement, paragraphs 13.1 – 13.21 [MAHI - STM - 089 – 57 to MAHI - STM - 089 - 63).

108. After the emergence of the abuse allegations in 2017, from Jan 2018 the Belfast Trust provided regular update reports to the Department on the actions taken by the Trust to address the allegations. These were initially monthly until May 2018, then bi-monthly after that. These were provided by Marie Heaney from BHSCT to the policy lead in the department.

109. Face to face monthly update meetings between the Department and the Belfast Trust were introduced from April 2019.

110. These monthly meetings were subsequently stood down following the establishment of MDAG in August 2019. The Department commissioned update reports from the Belfast Trust on ASG/patient safety at MAH in advance of each meeting of MDAG which informed the assurance reports prepared for each meeting.

Q4. How would concerns at MAH trigger a notification to the Department? Who decided that a notification ought to be made and what guidance was there to identify when that ought to happen?

111. Depending on the nature of the concern, these may have been triggered through the Department's Early Alert System. This was introduced in June 2010 when responsibility for oversight of Serious Adverse Incident reporting transferred from the Department to the HSCB/PHA.

112. This system was put in place to ensure that the Department and the Minister were made aware in a timely manner of any significant events occurring within the HSC system. The criteria for reporting incidents through the Early Alert system are as follows:

- Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

- The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

- The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

- The event may attract media interest;

- The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that an HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:

(i) there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or

(ii) evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or

(iii) the Coroner's inquest is likely to attract media interest.

- The following should always be notified:

(i) the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;

(ii) the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;

(iii) allegations that a child accommodated in a children's home has committed a serious offence; and

(iv) any serious complaint about a children's home or persons working there.

- There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

113. As CNO I would have on occasions been contacted in relation to an Early Alert from the HSC.

114. The full guidance on the arrangements for the Early Alert reporting system is included at Exhibit 31.

115. Professional networks may also provide early notification, or indication of an issue. This is not a formal process. An example of an early notification which was provided to me through my professional network is outlined in paragraph 25 of my statement. Other routes for identification or notification include concerns from complaints, whistleblowing issues and soft intelligence discussed in more detail at paragraphs 133-138 of my statement.

Q5. Did the Department receive regular data or other reports in respect of MAH? If so, please provide details, including how often they were received and who provided them.

116. The Department receives data and reports in relation to its range of responsibilities on an ongoing and continual basis and these may include information about services provided at MAH. This may include direct information regarding the operation of the hospital which has been commissioned for a specific reason, for example information required for MDAG; or be of a more general nature as part of updates or information being sought on the wider Belfast Trust as part of performance or financial management oversight arrangements. A number of examples of the types of data and reports by way of illustration are set out in the following paragraphs.

Performance Management

117. Before I was in post as CNO but within the HSC as an Executive Director of Nursing I am aware of the operation of the Service Delivery Unit and from around 2006 until 2009, Patient Administration System (PAS) downloads and BSO data warehouse extracts on activity were received from the Business Services Organisation on a weekly basis and used to track progress on the achievement of the Departmental targets, including resettlement from long stay hospitals such as Muckamore. This function was absorbed into the information function of the HSCB when it became established in 2009.

118. As part of the Commissioning Plan monitoring processes which were in place from 2009 the Department received performance reports on progress against targets within the Commissioning Plan from the HSCB, including those with relevance to Muckamore (i.e. learning disability and mental health discharges). The HSCB received updates from Trusts on a regular basis and provided reports based on these to the Department for performance monitoring purposes, including an annual report on outcomes.

119. Also, as part of HSC commissioning processes, the HSCB submitted copies of Trust Delivery Plans (TDPs) to the Department for formal approval. The TDPs set out how each HSC Trust planned to deliver its commissioning commitments, including in relation to resettlement. The Belfast Trust TDP would cover services provided at Muckamore Abbey Hospital. TDPs were submitted to the Department annually as part of the commissioning plan process.

Accountability Processes

120. Between 2013 and 2014 the Department held meetings with RQIA and PCC to assist with system intelligence gathering. I was present at these meetings and found them helpful to receive a system overview from both organisations perspectives. In addition, at that time the Department held mid and end of year accountability meetings with each Trust. Whilst they were time consuming, they were another useful source of evidence gathering. The record shows that MAH was not discussed at the meeting I or my team attended. Over time these processes were undertaken more by the individual organisations sponsor branch with input from professional officers and current arrangements are set out below.

121. The Department's HSC Trust sponsorship branch receives information related to governance from the Belfast Trust including sponsorship checklists, copies of the Trust's Board minute, a mid-year Assurance Statement and an end-year Governance Statement. This process is replicated across all Trusts. These would be shared as appropriate with relevant policy branches within the

Department to consider any specific issues raised that require Departmental intervention. The Trust would complete sponsorship checklists throughout the course of the financial year. Board minutes are shared with the Department following meetings of the Trust Board, which are usually monthly or bi-monthly depending on scheduling by the Trust. Prior to 2017 I do not recall MAH being brought to my attention by sponsor branch or the relevant policy leads.

Delegated Statutory Functions

122. In line with the requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions, there are arrangements in place for ongoing professional oversight to deal with any issues as raised through professional oversight from lines of professional social work. In addition, the Department receives a yearly overview report on the Discharge of Statutory Functions, provided by the HSCB during its existence. I understand SPPG continue to collate and provide the report. I had no specific role or access to these reports. Should there be an issue identified relating to my role as CNO the policy lead would bring this to my attention. This did not occur during my tenure in post.

Information Analysis Directorate

123. The Department's statistical function, the Information Analysis Directorate, requests and receives updates from Trusts on a range of Mental Health and Learning Disability patient activity, which includes Muckamore Abbey, as outlined below on a quarterly or annual basis. Whilst Information Analysis Directorate did prepare reports for the Top Management Group (TMG) of which I was a member I do not recall seeing anything identifying concerns in relation to learning disability in MAH.

124. Information includes detail on:

(i) Admissions under Mental Health (NI) Order 1986: Legal Status (quarterly) (Returns: K15 & KH15b);

(ii) Admissions under Mental Health (NI) Order 1986: Change in Legal Status (quarterly) (Return: KH16);

(iii) Electro-Convulsive Therapy (quarterly) (Return: KH17);

(iv) A summary of available bed days, occupied bed days, discharges and deaths, and day cases (quarterly) (Return: KH03a); and

(v) Mental Illness and Learning Disability (MILD) Census (annually).

125. Detail on the format of these returns I have attached at Exhibit 32, Exhibit 33 and Exhibit 34.

MDAG

126. As co-chair of MDAG and as part of the operation of the Muckamore Departmental Assurance Group (MDAG) over its lifetime, from August 2019 until I left my post, a variety of update material has been, or continues to be, received to help inform reporting to the Group at each meeting. This has included:

(i) Monthly update reports from action owners on progress to implement the recommendations within the HSC Action Plan.

(ii) Monthly update reports from the Belfast Trust on progress with the identification and review of material in relation to the historical CCTV viewing and ASG referrals.

(iii) Monthly Highlight reports from the Belfast Trust on key aspects of the operational of the hospital such as staffing, current ASG activity, communication/engagement with patients' families, RQIA inspections.

(iv) Monthly resettlement progress dashboards from the then HSCB (latterly SPPG); and

(v) Ad-hoc ASG process maps from the Belfast Trust.

System Audit/Accountability Reports

127. Reports in relation to mental health and learning disability would also be received from the RQIA. The department would review any reports to identify any implications for policy development or professional practice and would have brought relevant issues to my attention in my professional capacity. I do not recall these reports being shared with me during the tenure of my post.

Q6. Was soft intelligence triangulated with data? How were different data sources integrated (for example, staff shortages and patient outcomes)?

128. I would understand soft intelligence to refer to information which arises outside the formal HSC reporting metrics and does not lend itself to straightforward classification or quantification. Typically such information may become known to me from a number of potential sources, for example, correspondence to the Minister's Private Office from MPs or MLA's, letters or calls from relatives/carers of patients, members of the public, or staff whistleblowers

129. I would triangulate any such information with advice or data from a range of sources, for example, advice from Departmental professional officers, information from the sponsorship branch for the relevant Trust including sponsorship checklists, minutes from Trust Board meetings and accountability meetings with the Department, and relevant RQIA reports.

130. Where necessary I would seek advice and professional judgement from the PHA, the HSCB and the Trust involved This might include taking sounding from Executive Directors of Nursing, NIPEC or the RCN.

131. Information gathered through these channels would be reviewed by me and my team with the appropriate policy lead to identify any emerging trends or learning and to inform any direct intervention that may be required by the Department.

132. As CNO I often received soft intelligence from my professional networks and from clinical visits. In relation to Muckamore the soft intelligence was in relation to recruitment challenges not dissimilar from other branches of nursing practice and did not identify significant concern regarding care delivery. I visited Muckamore on a number of occasions in 2017 following the revelations to speak to staff and observe the care environment. On a later occasion I again visited PICU to view the seclusion room. I again visited on several occasions to meet with families with other colleagues and the Minster.

133. I do not recall any specific work carried out while I was in post to examine the impact of staff shortages on patient outcomes at MAH. My intention when developing a nursing assurance framework in 2019 was to provide this triangulation using a quadruple aim approach of patient experience (10,000 voices from PHA), staff experiences (1000 voices in developing the nursing and midwifery task group and staff surveys), workforce data and clinical nursing KPI data. However as previously noted this work was suspended due to COVID-19.

Q7. Did the Department have any role in the decision to install and operate CCTV at MAH? If so, please give details.

134. The decision to install and operate CCTV at MAH was an operational one for the Trust as the service provider and therefore the Department would not have been directly involved in this process.

135. I understand that from a search of Departmental records, it appears the Department was informally advised by the Belfast Trust in January 2016 that the Trust was exploring the possibility of piloting the use of CCTV technology in a small number of wards in MAH later that year. I was not aware of this at the time. This was in the context of correspondence from Gordon Lyons, MLA, to the Minister on behalf of a constituent who had made allegations of inappropriate behaviour towards him while he was a patient in MAH. In line with established practice for responding to such correspondence, policy officials contacted the Belfast Trust to inform them of the correspondence and to seek an update from the Trust to inform the Minister's response to Mr Lyons. In their response to the allegations raised the Trust also advised that they was trialling the introduction of CCTV in some of the hospital wards. I exhibit a copy of the Trust response at Exhibit 35.

136. The Department became aware that CCTV was operational at the hospital through an updated Early Alert from the Belfast Trust in relation to the allegations of abuse from August 2017, which I have exhibited at Exhibit 36.

137. The report of the Review of Leadership and Governance at MAH notes that a Belfast Trust business case for the installation of CCTV was developed and approved in 2014 and cameras were first installed in MAH in 2015 (p124 – 131).

Q8. When did the Department first become aware of allegations of the abuse of patients at MAH? What action did it take in response?

138. I understand the Department became aware of allegations of abuse at Muckamore Abbey Hospital on a number of occasions during the period covered by the ToRs of the Inquiry. I am noting the historic timeline for completeness.

Historic abuse allegations

139. The first of these was in the autumn of 2005 when the then Eastern Board alerted the Department to allegations of historic abuse dating back to the 1960's and 1970s which arose from a legal case.

Ennis Ward abuse allegations

140. I am advised the Department was notified on 9 November 2012 by way of an Early Alert about another alleged case of abuse involving four patients at Ennis Ward in Muckamore Abbey Hospital. However, I personally was not aware of Ennis until it was brought to my attention as part of media reports on October 2019 and subsequently reported to the MDAG meeting in November 2019.

2017 abuse allegations

141. Around late August 2017 I received a phone call from the nurse manager at MAH on behalf of the Executive Director of nursing to report that a healthcare support worker was suspended for historical inappropriate behaviour in the swimming pool at MAH in or around 2012. At that time, there was no suggestion that this was other than an isolated incident and I advised that an Early Alert should be submitted to the department that I include at Exhibit 37. The Nurse Manager advised me that appropriate precautions were being taken by the Belfast Trust. The early alert provided in November 2017 detailed that this was one of four historical incidents disclosed by a Band 2 swimming pool attendant in Muckamore.

142. One incident did not involve Muckamore staff or patients but involved other staff and clients who were using the pool. From the early alert I understand that this was the inappropriate sexual behaviour case. The remaining 3 incidents involved Band 2 & Band 3 staff in the swimming pool.

143. Gavin Robinson MP contacted Chris Matthews, then Director of Mental Health, Disability and Older People on 30 August 2017 about an allegation of abuse by staff of a current in-patient in Muckamore. This allegation had been brought to

his attention by the in-patient's father, who was a constituent of Mr Robinson. Chris Mathews made me aware on 30 August.

144. The father had advised that his son had been assaulted by a member of staff in the ward on 22 August 2017, although it subsequently emerged that the assault had actually taken place on 12 August 2017. He was concerned that there was a gap of 10 days in reporting the incident and that Trust staff would not provide him with any details about the incident.

145. Following inquiries from officials about the circumstances of the alleged incident, the BHSCT provided Early Alert notifications on 7 and 26 September 2017 about the incident and the related precautionary suspension of staff involved. Further EAs were subsequently provided by the Trust advising that more safeguarding concerns had emerged following viewing of CCTV footage. The Department immediately followed these up with the Trust and, as result of concerns about the Trust's reporting and handling of the allegations, CSSO and I wrote jointly to the Trust on 20 October to seek assurances that effective arrangements would be put in place to address the issues. I include a copy of this at Exhibit 38. The Department also requested monthly updates to be provided to allow progress to be monitored.

146. I contacted the Executive DON in Belfast Ms Brenda Creaney from memory by telephone on September 1st 2017 seeking her assurance that patients in MAH had adequate surveillance and supervision to ensure no further potential harm was caused. The action from that conversation was to increase the presence of a senior nurse from drop in cover to being in the ward 24/7.

147. On 3rd November, Martin Dillon provided a Trust response to the letter of 20th October, setting out a timeline of the incidents and actions taken by the Trust, as well as the additional structures and actions put in place to address the allegations and provide the necessary assurances about patient safety. Professional colleagues met with senior Trust staff on 17th November to discuss

the detail of the letter of 3rd November, and a subsequent briefing report which was prepared for the Trust's Quality Assurance Committee.

148. Following that meeting, the CSSO and I wrote again to the Trust on 30th November to seek further written assurances on a range of issues which were raised during the 17th November meeting, and also on related matters which had emerged in parallel, including the status of a proposed 'turnaround' team, the state of play regarding the adult safeguarding investigations, allegations made on social media and the Trust's proposal to review only 25% of the available CCTV footage. I attach a copy of this at Exhibit 39. The Trust were also formally requested to provide the Department with a copy of the Terms of Reference for the Level 3 SAI investigation into the incidents as well as fortnightly progress updates.

149. The Trust's response was received on 22nd December providing the written assurances sought, along with further details of the governance structures put in place; and confirmation that the SAI would include a review of all allegations of abuse over the last 5 years and the difficulties the Department faced in securing details and timely information from the Trust in relation to the incidents in August and October. I include a copy of the response at Exhibit 40.

150. An independent Level 3 SAI review was commissioned by the Belfast Trust in January 2018 into the allegations of physical abuse of patients by staff at Muckamore Abbey Hospital. The Department expected the SAI process would be handled without any unnecessary delay, and raised concerns about the length of time it took for the report to be signed off. I include copies of this correspondence at Exhibit 41.

151. The Department received a copy of the SAI report on 6 December 2018, and following this the Belfast Trust shared the report with families of Muckamore patients. The then Permanent Secretary, Richard Pengelly, CSSO and I met with the families on 17 December 2018 and issued statement accepting

recommendations and committing to expediting resettlement of patients' resident in Muckamore. I exhibit a copy of this statement at Exhibit 42.

152. On 30th January 2019, the Permanent Secretary chaired an HSC Summit meeting to plan and expedite a robust and co-ordinated response to delivering on the recommendations in the review. A copy of the note of this meeting can be found at Exhibit 43.

153. The Belfast Trust submitted their monthly report for February 2019, and this raised some concerns about the current protection and safeguarding arrangements for patients in MAH on which the Department required urgent assurance. The Department subsequently wrote to the Belfast Trust and in a response from the Belfast Trust they suggested that the Trust and Department of Health colleagues should meet formally on a monthly basis so that the Trust can provide the assurances sought given the level of operational detail and the evolving nature of this investigation. I attach copies of this correspondence at Exhibit 44.

154. Following two unannounced inspections by RQIA at MAH (26-28 February 2019 and 15-17 April 2019), and recommendation of the establishment of two taskforces to stabilise the hospital and oversee the delayed discharges/relocation planning, the Department subsequently established the Muckamore Departmental Assurance Group (MDAG) which I co-chaired with CSSO, to reinforce and strengthen the existing governance arrangements, as well as giving the Department a direct line of sight on progress with the resettlement programme.

155. MDAG was also intended to provide support to the BHSCT staff team at Muckamore and provide a mechanism for escalating any issues they may encounter. The Group also oversees, through the MAH HSC Action Plan, the actions arising from the SAI 'A Way to Go report' and the Leadership and Governance review report. The first MDAG meeting took place in August 2019

When I left my post as CNO MDAG remained in place meeting on a bi-monthly basis.

156. A letter was sent jointly from CSSO and I in May 2019 in relation to the findings of the RQIA inspection and specifically around staffing concerns. This letter requested that the Belfast Trusts priority should be to stabilise the current position to include contingency planning should the MAH be unable to sustain safe and effective services. The letter also reiterated the aim to resettle patients from the hospital. I include a copy of this letter at Exhibit 45.

157. The Permanent Secretary and CSSO met with the Belfast Trust in a series of Liaison meetings in September 2019 (6th, 13th and 25th) to address concerns about the stability of the services being provided at MAH. Notes of these meetings are attached at Exhibit 46, Exhibit 47 and Exhibit 48.

158. I wrote to the Trust on 24th February 2020 and again on 15th June 2020 as I had not received a response to my request for BHSCT to arrange an urgent meeting with the PSNI, BHSCT, The DOH Director of Workforce Policy and myself to address issues relating to the handling of cases of staff who worked in MAH and the issuing of professional alert letters. I attach copies of these letters at Exhibit 49 and Exhibit 50.

159. I further confirmed on 2nd July 2020 that I wished for these issues to be raised at the next MAH operational meeting with the PSNI, RQIA and BHSCT but that I still required a separate meeting to discuss issues relating to the handling of cases of staff who worked in MAH and the issuing of professional alert letters.

160. During the HSC Summit, the Permanent Secretary outlined that the initial task for the system would be to set out how the system planned to deliver on the commitments and the recommendations in the report. He then set out his expectations in relation to an Action Plan, specifically that this would be a roadmap for change. An initial draft of this Action Plan was submitted by the then HSCB on 20th February 2020.

161. Further to a review of the 'A Way to Go' report, the Department took the view that further analysis of the leadership and governance arrangements in place at the Belfast Trust was required. Sean Holland and Rodney Morton, the Deputy Chief Nursing Officer wrote jointly on 5th July 2019 to formally ask the HSCB, as the commissioning body and overseer of the SAI process, to commission a review to critically examine the effectiveness of the Trust's leadership, management and governance arrangements in relation to the hospital for the five-year period preceding the allegations that came to light in late August 2017. I exhibit a copy of the letter at Exhibit 51. Work by the review team started in January 2020 and a final report was provided to the Department in August 2020.

162. Following the publication of this report, the Review Chair, David Bingham met with families on 5th August 2020 to brief them on the findings and as already outlined, the recommendations from this review were implemented as part of the HSC Action Plan and overseen by MDAG.

163. In September 2020, Minister Swann made the decision to call a Public Inquiry into the abuse at MAH. This was to ensure a full and rigorous investigation into what happened at Muckamore and what lessons need to be learned to ensure there was no repeat of the events.

164. He met with families and carers on 7th December, 9th December and 10th December 2020 alongside me and representatives from the Department of Health and the Patient and Client Council to hear their views on the appointment of a Chair and the Inquiry's Terms of Reference.

Q9. What arrangements were in place at Departmental 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 describe your recollection of any actions taken by the Department to ensure that MAH staff skills matched MAH patient needs.

165. A summary of Departmental arrangements for Workforce planning for disability care services is provided in Mark's first statement (paragraphs 17.1 – 17.14 [MAHI - STM - 089 – 74 to MAHI - STM - 089 - 77). In addition to Marks statement, I would make the following comments.

166. The 2012-15 Bamford Action Plan also included a commitment (Action 53) to develop a UK wide framework for Learning Disability nurses. A Northern Ireland action plan to implement the UK wide framework for learning disability nurses, "Strengthening the Commitment", was launched in July 2014. A copy of this is included in Mark's statement at MMcG/57. Work was initiated in 2015 to undertake a review of the learning disabilities nursing workforce across NI to include all sectors, as I referenced earlier in my statement at paragraph 26.

167. In 2015 the Department published Evolving and Transforming to Deliver Excellence in Care A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025). The report was prepared by my then DCNO for nursing workforce in conjunction with NIPEC. It set out the education and training commissions the department intended to make between 2015-2025. It identified key trend and key challenges for the nursing and midwifery workforce. It utilised the six-step model for integrated workforce planning developed by Skills for Health in 2009. It was updated in 2016 to reflect a quickly changing environment. It proposed an increase in undergraduate learning disability direct entry students from 30 to 35 per annum from 2018-19. In reality the department went further than this increasing the commission to 40 per annum. I attach a copy at Exhibit 52.

168. The Departments policy on Delivering Care and its application to learning disability is an important consideration in workforce planning. It is outlined in detail at paragraphs 194 to 214 of my statement.

Q10. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Department? If so, please describe any actions taken by the Department to address those concerns.

169. Responsibility for day-to-day operational workforce planning at MAH is the responsibility of the Belfast Trust as the employer. This workforce planning addresses issues such as service delivery, safe staffing levels, operational vacancy management and recruitment.

170. The Department has responsibility for longer-term strategic workforce planning and oversees a rolling programme of long-term, regional workforce reviews for this purpose.

171. The Department has been made aware of issues in relation to staffing levels at Muckamore on a number of occasions as part the ongoing systems of assurance that have operated within the HSC system. Examples of these are outlined below.

Early Alerts

172. Issues in relation to staffing shortages on wards within Muckamore have on occasion been raised with the Department through the EA process, for example EA 108/21 that I attach at Exhibit 53.

173. The operation of the Early Alert process is outlined in Mark McGuicken's first statement (paras 13.17, 13.19 – 13.21) [MAHI - STM - 089 – 61, MAHI - STM - 089 – 62 to MAHI - STM - 089 – 63].

2014/14 – 2016/17 Ward Closures/Staff Reductions

174. Mark McGuicken's Addendum statement of 26 May (paragraphs 14.1 – 14.4) [MAHI - STM - 089 - 63 to MAHI - STM - 089 – 64] set out reasons for an underspend on staffing linked to the reduction in staffing levels associated with resettlement. The main issue was the retraction of wards and cohorting of patients in line with resettlement which had an impact on staffing. It appears n response the Belfast Trust had a reduced spend on staffing due to retraction.

There were also issues with staff recruitment as staff became aware that there would eventually be less services at MAH and possible associated employment risks.

RQIA Unannounced Inspections 2019 – Article 4 Letters

175. Further to two unannounced inspections at Muckamore by the RQIA in February 2019 and April 20219, the RQIA raised a number of issues, including staffing levels, at Muckamore with the Department in an Article 4 letter sent to the Department on 6 March 2019. Following correspondence with the Department, and a follow up unannounced inspection at Muckamore, they subsequently wrote to the Department again on 30 April 2019. In response to the issues raised around staffing levels the Department wrote to the Belfast Trust, through the Chief Nursing Officer, on 31 May 2019 to seek further information on the current nurse staffing ratio and skill mix at Muckamore. The Belfast Trust response from Ms Creaney dated 20th June 2019 is appended as Exhibit 20. My team and I remained concerned. Our concerns were that the staffing profile in the letter were almost a month out of date and therefore required further assessment of actual staff and skill mix required and the details of access to senior decision makers was not specified.

176. Further to the assurance gaps identified by the Department in the response received from the Belfast Trust on 20 June 2019, a professional Nursing advisor, Francis Rice, was appointed on 18 September 2019 to work alongside the clinicians and management in the Belfast Trust. This was to provide professional assistance with the stabilisation of the nursing workforce amongst other items. As a result of the work undertaken in conjunction with Francis Rice, the RQIA lifted the Improvement Notices around staffing at Muckamore in full following a further inspection in December 2019. A report on professional nursing assurance was provided by Francis to the Department in February 2020 and included an action plan to address the professional nursing and governance issues identified through the stabilisation work. These included a number of recommendations for the Trust which built on a range of actions included within

the HSC Action Plan being progressed by the MDAG. A copy of this report is included at Exhibit 54.

15% Pay Enhancement

177. Due to the difficulties with staffing shortages at Muckamore as a result of the ongoing investigations into the allegations of abuse the Departmental Permanent Secretary agreed in November 2019 that an enhanced salary uplift of 15% should be offered for a limited period to encourage registered nursing staff from other Trusts to relocate to work in Muckamore. In the interests of equity this enhancement was also offered to registered nurses and healthcare assistants in Muckamore. Travel cost for those willing to relocate was also agreed for reimbursement in line with existing terms and conditions of employment. I understand this enhancement remained in place until the end of September 2023 when the Belfast Trust made the decision to cease the payments.

MDAG – HSC Action Plan Workforce Related Actions

178. Action 37 in the MAH HSC Action Plan required the Department to develop an evidence-based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce for learning disability services, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services.

179. To address this action the Department commenced a Regional Workforce Review across Adult Learning Disability Teams and Services in late 2021. Following initial work to understand the make-up of the workforce a number of baseline reports were issued in June 2023. I understand this work is currently paused pending progress with the work on the Learning Disability Strategic Action Plan.

180. The HSC Action Plan also included an action for the Department at A30 to complete a review of Learning Disability Nursing. I commissioned a review in 2019 led by the nursing officer for learning disability. The project management plan had to be amended due to COVID 19 to create virtual opportunities for engagement. However, involvement of families and careers were key to the engagement process, and this was difficult during COVID 19. The engagement process employed the same methodology as the NMTG report under the *SAFE* framework. At the time of leaving, I am aware that findings were developed into four themes and as follows:

(i) Morale and collective leadership

(ii) Workforce planning

(iii) Education provision

(iv) Public and population health

181. I understand NIPEC have since been asked to undertake a review of the work following the appointment of Maria McIlgorm as Chief Nursing Officer. I understand that work on the draft report 'Equality of Access and Outcome' is now moving to completion (with an update being provided to MDAG on 17 April 2024). The draft report is out for final comments before consideration by the CNO with a view to launching in June 2024 to coincide with Learning Disability week.

182. I have been advised that the Inquiry have requested a copy of this report and understand from Mark's second statement (para 31.1 [MAHI - STM - 118 – 28]) and again in Mark's fourth statement of 12 April 2024 (para 10.1) that a copy will be exhibited when the report is finalised.

MDAG – Assurance Reporting

183. Information on staffing levels at MAH is routinely provided to MDAG as part of its oversight role, along with updates on RQIA inspection activity at the hospital.

General Workforce Developments

LD Nursing Initiatives

184. I provide an overview of a number of LD Nursing initiatives in paragraphs 29 to 33 of my statement.

Bengoa Report

185. Issues in relation to workforce problems and challenges faced by health and social care in Northern Ireland were recognised in the report 'Health and Wellbeing 2026: Delivering Together' from Professor Rafael Bengoa in 2016. In response the Department published the 'Health and Social Care Workforce Strategy 2026: Delivering for our People' in 2018.

186. The Strategy includes detailed analysis of the workforce problems and challenges facing health and social care in Northern Ireland. Amongst other things, the Strategy addressed the need to tackle the serious challenges with supply, recruitment and retention of staff, including on page 56, Learning Disability Nursing. The Strategy aims by 2026 to meet workforce demands and the needs of the health and social care workforce.

Nursing and Midwifery Task Group Report and Recommendations

187. In 2017 the Minister of Health established a Nursing and Midwifery Task Group (NMTG), Chaired by Sir Richard Barnett. Details of this report and recommendations are set out in paragraphs 12-20 of this statement.

Q11. The Inquiry has heard evidence regarding the Chief Nursing Officer's programme "Delivering Care: Nurse Staffing in Northern Ireland" (2014). The Inquiry has heard that Phase 9 of the programme was in relation to Learning Disability nursing. Did the Department consider accelerating this phase when concerns at MAH arose in 2017? If not, why not? If it did, what action, if any, was taken?

188. Delivering Care Policy framework was launched as a policy by the then Minister Poots in 2014. This workforce policy framework for nursing and midwifery in Northern Ireland was designed to standardise and promote a shared understanding of workforce planning principles to govern safe and effective workforce planning in Nursing and Midwifery Services.

189. The primary aim of the Delivering Care Policy Framework was to enable the delivery of high-quality, safe, effective, person centred nursing and midwifery care in hospital and community settings, through the establishment of normative staffing parameters (standards) across nursing and midwifery service and across a range of major specialities.

190. Priorities for implementation under the Framework were agreed through the Chief Nursing Officer (CNO) in discussion with Executive Directors of Nursing in Health and Social Care Trusts and the PHA. These decisions were made using professional judgement, emerging service priorities, and were based on a few factors including local intelligence and regional strategic priorities. The CNO commissioned each phase formally, in writing, to the PHA Executive Director of Nursing, with preparatory work around commissioning of phases usually taking place in the 12-18 months prior to the phase being formally commissioned.

191. The Director of Nursing in the PHA and in partnership with Director of Commissioning in HSCB sought to develop normative standard for nurse staffing levels based on best available evidence or emerging evidence. The PHA Delivery Care Team having formulated an agreed normative workforce model for each phase, costed the normative standards and secured agreement

with Director of Commissioning in HSCB prior to submission to the CNO for approval. It is important to note that funding of each phase was always subject to available resource therefore the implementation of approved phase was often incremental over several years.

192. Delivering care Programme was overseen by the Regional Delivering Care Steering Group, led by the PHA but inclusive of stakeholders across the HSC system. The steering group provided oversight of each commissioned phase. Once finalised the Delivering care Recommendation was submitted to the CNO for endorsement.

193. The responsibility for safe and effective staffing remained the responsibility of each Trust and their respective Board.

194. Initial concerns regarding Muckamore Abbey Hospital (MAH) came to light in August and September 2017. This was an emerging picture which took some time to understand. I took the decision to seek further information to understand the complexity of the problem, the implications and action required for nursing.

195. On 24th November 2017 I commissioned work led by Mary Hinds Executive Director of Nursing in PHA to provide a report on the systems, professional structures, policies, and procedures that were in place to provide professional assurances to Executive Directors of Nursing in Health and Social Care Trusts, specifically related to learning disability nursing and mental health nursing. The report was provided to me in February 2018. A recommendation from this review was to consider the inclusion of learning disability nursing in delivery care.

196. Accepting the recommendation, I considered when best to commission Delivery care phase 9. I believed the completion of the task of phase 9 delivering care should be feasible, practical and in the context of evidence-based policy to get the best result.

197. To contextualise my decision-making regarding phase 9, there were number of factors which influenced the development of a learning disability normative staffing model.

198. At this time there were several delivering care phases under development namely;

(i) Phase 5 (a&b) Mental health

(ii) Phase 6 neonatal nursing

(iii) Phase 7 primary care nursing

(iv) Phase 8 independent sector nursing

199. All these phases had been deemed critical due to safety, quality, and workforce challenges. For example, in 2018 RQIA published a damming report into Dunmurry Manor Care Home which was followed by a report from the Commissioner of Older People Northern Ireland into care in the same facility. This put a lot of attention on independent sector nursing care and safe staffing which was prioritised Phase 8. I also factored the capacity and expertise within the system to undertake another phase into my decision making as I did not believe I could or should stand down the existing programme of work.

200. The health and social care system was under significant pressure as result of a system wide programme of transformation and was financially challenged. This was further compounded by the reality that Northern Ireland did not have a functioning Executive which impacted major investment decisions.

201. In 2018, the Department commissioned the Health and Social Care Board (HSCB) to develop a new service model for adult learning disability services.

The project aimed to provide a strategic response to the significant challenges across the programme of care, including health inequalities; growing complexity of need; transition from children's services, over-reliance on inpatient services and accompanying delayed discharges; accommodation gaps; a lack of meaningful day activity; insufficient short break provision and support for older carers. It was anticipated that this new service model would change how learning disability services would be delivered, particularly acute and high intensity inpatient services, and therefore the outcomes of this model would inevitably change the nursing staffing requirements of Delivery Care phase 9.

202. In addition, I was of the view that there were several foundations that needed to be in place to execute the delivery of Phase 9. At that time there were no senior registered nurses in the field of learning disability either in my policy team or at the Public Health Agency to provide expert regional leadership to the programme of work. This was due to financial challenges with the HSC and within the Civil Service forcing the need to reduce spend within Department of Health across all areas. I was aware of the need to strengthen this position to effect Delivering Care Phase 9 and to that end I secured resources through transformation funding to appoint a Nursing Officer for Learning Disability. This position was filled in Spring 2019.

203. Furthermore, it was my view that there was need for a fundamental review of learning disability nursing services and that the outcome of this review should also inform the development of phase 9. I commissioned a review of learning disability nursing as a priority when the new nursing officer commenced employment in Spring 2019.

204. I was conscious of the sustained issues of nurse recruitment and retention which were emergent from 2015/16. In 2016 the Department published "Evolving and Transforming to Deliver Excellence in Care - A Workforce plan for Nursing and Midwifery in Northern Ireland 2015-2025". In broad terms this plan set out the proposed education and training commissions between 2016 and

2025 taking cognisance of the emerging themes in the HSC at the time alongside the commissioning context and the policy context of Delivering Care.

205. In addition, all Delivering care phases increased the demand for undergraduate training to meet the requirements of each phase. Therefore, in response, the Department increased the number of learning disability undergraduate nursing places by 33% in 2018-19 and by a further 25% in 2019-20. This went further than the projections in the Nursing and Midwifery Workforce Plan.

206. It was anticipated that these early career nurses would increase the availability of RNLD's and support the implementation of delivering care phase 9 when complete. Without the ability to increase RNLD's the exercise of delivering care phase 9 was unlikely to be effective in achieving its aim of provision of high-quality, safe, and effective care in hospital and community settings.

207. In summary considering all the above issues I took the decision to formally commission Delivering Care Phase 9 in collaboration with the senior nursing community of Northern Ireland in 2019 as I felt the necessary preparatory work to inform this phase was well underway, and the system was closer to a state of readiness to deliver the outcome required.

208. In 2020, following a period of industrial action, Minister Swann, through a framework agreement, committed to a safe staffing investment of £60m over a period of 5 years which commenced in the financial year 2020/21. £25m of the additional £60m was allocated, with £35m still expected but has been impacted by the known budgetary constraints

209. There were 20 Registered Nurse Learning Disability posts funded within the 21/22 allocation. These were divided across the 5 geographical HSCTs. Given the pressures across specialist learning disability services at that time. The Executive Director of Nursing of the PHA and I agreed that this funding should be targeted to develop senior clinical decision maker posts within specialist learning disability services to support the delivery of evidenced based nursing

care and provide visible nursing leadership in line with the Nursing and Midwifery Task Group recommendations. Therefore, these posts included the appointment of a Learning Disability Consultant Nurses for each HSCT and in the PHA alongside a range of clinical roles from band 7 to 8b. This was a priority for me to strengthen learning nurse leadership and governance.

Q12. How did the Department assure itself that Trusts had properly checked the current registration of clinical professions with the NMC, HCPC and GMC?

210. The Department has no role in checking the current registration of clinical professions with the relevant professional bodies. This is an issue for the employer, and this would therefore be the responsibility of the Belfast Trust in relation to employees of MAH.

Q13.What systems were in place at Departmental level to ensure adherence to relevant professional standards by MAH staff? What actions were available to the Department if it had any concerns in relation to the adherence to professional standards?

211. The Department operates no such systems, as it was, and remains, the responsibility of the Belfast HSC Trust as the employer of MAH staff, to ensure effective Human Resource policies are in place for recruitment and employment of staff (including agency staff), including ongoing Access NI and continuing professional regulatory checking processes. It is also the role of the Belfast HSC Trust to ensure effective clinical and professional governance processes are in place.

212. If the Department becomes aware of concerns in relation to adherence to professional standards by any individual staff members, it would raise those in the first instance with the employing Trust. The Department also has the option of bringing the concern directly to the relevant professional body. If concerns were more widespread than an individual staff member, the Department could

also commission RQIA to inspect and report on the Trust's compliance with the relevant Quality Standards I identified in para 102 of my statement.

213. The Department is responsible for setting guidance and frameworks on professional standards. The operational day-to-day oversight of individual employees' professional standards is the responsibility of the employer, namely the HSC Trust. HSC Trusts employ professional staff in specific clinical governance roles with an emphasis on quality and safety of care. These include the Medical Director, Director of Nursing, Acute Specialty and Clinical Directors and Leads. The HSC Trust's Board, made up of Executive and Non-Executive Directors, has an overarching responsibility for clinical and corporate governance and must provide assurance to the Department of Health through established channels.

214. During my tenure of the CNO role, HSCTs were accountable to the HSCB for the availability, quality and efficiency of the services they provide against agreed resource allocations. I understand this has now changed following the introduction of the Health and Social Care Act (NI) 2022.

215. Issues of concern can be escalated formally as part of Departmental Arm's Length Body (ALB) Accountability arrangements. The Department may, and often does, also act in response to concerns raised, whistleblowing or other intelligences received as necessary.

216. An important aspect of ensuring adherence to professional standards is through the role of professional regulators. A regulator has a specific role in measuring and ensuring that organisations comply with their own service or quality standards and the regulatory framework within which they operate.

217. Professional regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective

professions. They maintain registers of workers who meet those standards, and this information is publicly available.

218. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

219. There are a variety of standards and best practice guidelines depending on the clinical service area or professional practice and these will be used at regional and organisational level to inform and underpin service delivery, improvement, and transformation. Those with the responsibility of ensuring that effective governance arrangements are in place within their areas of responsibility is set out in the Belfast Trust's Assurance Framework.

220. These are as follows:

(i) **The Executive Director of Nursing and User Experience,** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

(ii) **The Director of Social Work,** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce; and

(iii) **The Medical Director,** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

221. Statutory Professional Regulators, including Nursing & Midwifery Council (NMC), set education and professional performance standards, taking action to improve practice and protect safety and quality where individuals fall short of that standard (this can include for example enhanced training and supervision requirements; put restrictions on practice or ultimately remove individuals from the register and stop them from practising). The Nursing and Midwifery Council is overseen by the Professional Standards Authority (PSA) for Health and Social Care which operates on a UK-wide basis.

222. The Code of conduct for nurses is set out in the NMC Code. The NMC Code sets out a common standard of practice for all those on its register. The Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) also provides guidance to nurses as professionally they continue to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a satisfactory standard. The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

223. Standards for Nursing Assistants employed by HSC Trusts was developed by NIPEC and published by the Department in February 2018 and these apply to all healthcare assistants. This document recognised that nursing assistants ‘are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.

224. In addition, and by way of example I commissioned and launched guidelines on Advanced Nursing Practice Framework- Supporting Advanced Nursing Practice in Health and Social Care Trusts in 2016 and Professional Guidance for Consultant Roles Supporting Consultant Nurses & Consultant Midwives in Health and Social Care in June 2017. Both these documents were part of a career development pathway for nurses in Northern Ireland and the latter document was necessary for the subsequent funding of five nurse consultant posts for registered nurses in learning disabilities and I include this at Exhibit 55.

225. In 2019 I commissioned work on a professional assurance framework (draft version 4). The point of including a draft document to the inquiry is to demonstrate a shift in thinking and moving towards a better and stronger assurance system for professional standards and practice which would use more sophisticated systems to analyse data. The ultimate purpose of developing a regional assurance framework was to support the nursing and midwifery systems leadership assure the public and the profession of the standards of nursing and midwifery practice in services provided by or commissioned by the HSC system and in doing so strengthen the evidence provided by the executive Director of Nursing at trust boards. The draft document divides the assurance system into the following sections:

(i) Entry into employment as a registered nurse

(ii) Maintenance of registration

(iii) Quality of Nursing Practice

(iv) Managing performance

226. From workshops held there were known limitations with the then current information including a lot of data captured but not enough analysis or contextual interpretation. It was primarily acute (hospital focused) and lacked inadequate context and analysis of the factors that contribute to the

results/findings e.g. balancing measures and special cause/common cause variation. Furthermore, there was limited qualitative data to inform decision making.

227. The assurance framework was a recommendation in the nursing and midwifery task group report and remains to the best of my knowledge outstanding. I understand NIPEC are working on an Excellence Framework.

228. The Department did, in my time and I understand until late 2022, operate a Professional Alert scheme which set out arrangements for the issue and revocation of alert notices for health care professionals in Northern Ireland. Under the scheme, an alert could be issued by the Departmental Chief Professional Officer 'only where it is considered that an individual poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC in that capacity, and there is a pressing need to issue an alert notice'. The Chief Professional Officer was formally responsible for assessing whether or not an alert should be issued and remain in place, and for formally revoking an alert when appropriate.

229. As part of the decision-making process for the issuing of a CNO Professional Nursing Alert, all nurses and midwives must have been referred to the NMC. When considering the request for a CNO Professional Nursing Alert, if the NMC had already considered the case and sanctions were in place (i.e. Conditions of Practice, or an Interim Suspension order) an alert would not have been issued.

230. Information on the Nursing Alert system was provided in Mark's first statement (para 6.20), and the reasons for discontinuing this system was provided in Mark's second statement (paras 34.1-34.2 [MAHI - STM - 118 – 32]).

231. Clinical supervision is fundamental to developing safe and effective practice. It provides the opportunity to positively challenge professional practice to improve the quality of care. All nurses including those in Mental health and learning disability benefit by continually developing their knowledge, skills, competence

and confidence to provide the best care for service users in a protected, supportive environment.

232. All staff in Muckamore Abbey Hospital should have the opportunity to share learning and receive support through clinical supervision, either on an individual or group basis. This was the case for nursing as a policy on professional clinical supervision was in place from approximately 2012. Each year I received a report from HSCTs on meeting the policy requirements. The BHSCT 2017-17 report is included at Exhibit 56.

233. At a Central Nursing and Midwifery Advisory Committee (CNMAC) meeting in June 2016, I sought and secured agreement to explore the development of a Nursing and Midwifery Supervision Framework for Northern Ireland positioned under one policy directive.

234. The work was to recognise the separate professions of nursing and midwifery along with recommendations for legislative changes to the Nursing and Midwifery Order 2001, removing statutory supervision of Midwives. As part of this, I intended to review the extant departmental policy for Safeguarding Children Supervision for Nurses and Midwives and the current professional supervision policy and where possible, include the relevant elements of this type of supervision in the new framework. The work was led by the then NIPEC Chief Executive Angela McLernon.

235. The final draft framework for Reflective Supervision for Nursing and Midwifery in Northern Ireland was agreed in October 2019. As a result of industrial action in the autumn of 2019 followed by the required nursing and midwifery response to the SARS-2 Corona (COVID-19) the opportunity to discuss next steps did not present itself until June 2020, when, at a CNO Business meeting[1] proposals for testing were presented and discussed.

[1] Membership of this meeting includes: Executive Directors of Nursing and Midwifery, including PHA, Head of Health and Social Care (HSC) Clinical Education Centre (CEC) and Chief Executive Northern Ireland Practice and Education Council (NIPEC).

236. It was agreed that prior to implementation, a period of testing was needed to consider the utility of the model, requirements for further scoping or review and potential resources required for a future full implementation. This was agreed between September 2020 – May 2021. An update and final report were provided to the September 2021 CNO business meeting. This was my last meeting and I understand the framework has subsequently been launched.

Q14. Equal Lives (Bamford, 2005) recommended improved community services and stated that all people with a learning disability living in a hospital should be relocated to the community by June 2011. Transforming Your Care (2012) recommended the resettlement of all people with a learning disability from hospital to community living options with appropriate support by March 2015. What did the Department do to promote that pledge? What were the barriers to achieving it?

237. Departmental policy on resettlement, along with associated Departmental actions to deliver the policy, is set out in Mark's first statement (section 11) [MAHI - STM - 089 – 46].

238. Whilst I was not directly involved in resettlement policy or implementation of the policy, from both my role as Executive Director of Nursing and commencement of my role as CNO in 2013 during a Comprehensive Spending Review period I am aware that there have been ongoing funding pressures in the CSR period 2011-15, the drive to increase resettlements meant the misalignment of budgets. This meant DHSSPS and the HSC could not commit to such schemes and DSD (and the NIHE) could not invest the capital monies to build them which significantly delayed resettlement schemes.

239. Whilst this not part of my policy brief as a senior healthcare leader and in terms of person centred practice my view is that delays in resettlement were unfortunate and living in the community would be better for individuals health and wellbeing. This does require the skills, expertise and appropriate staff to be available in the community in order to facilitate resettlement. Without

appropriate accommodation and available resources, the most complex patients had difficulties being resettled. Where resettlement failed some families lost confidence in the process and it was traumatic for them and their relative. In some cases families wanted their relative to remain in MAH.

240. Further detail on the reluctance of some remaining patients at Muckamore to be resettled, as a barrier, is provided at para 259 of my statement.

Q15. In seeking to deliver the Bamford Vision, how did the Department consider the impact of bed and budget reductions on the operational running of MAH?

241. The Department and therefore I had no direct role in the operational running of MAH. This was the role of the HSCB as the service commissioner and the Trust as service provider. I had no involvement or policy responsibility for Bamford.

Q16. Did the Department monitor the effectiveness of the resettlement strategy? If so, please provide details.

242. Departmental policy on resettlement, along with associated Departmental actions to deliver and monitor the policy, is set out in Mark's first statement (section 11) [MAHI - STM - 089 – 46].

243. Although I was not directly involved, I understand that progress on resettlement was monitored through the Bamford governance structures. The evaluation of the Bamford Action plan 2012-15 (p12) '*found that there had been many achievements in the development of learning disability services since the Bamford Review, including the resettlement of the majority of people living in long-stay hospitals into the community.'* It went on to note that a total of 347 long stay patients had been resettled into the community and the quality of life for those who had been resettled had much improved.

244. In addition, resettlement targets have also been included in the Executive's Programme for Government, and in Commissioning Plan directions.

245. The Regional Learning Disability Operational Delivery Group was established in 2019 to oversee the effectiveness of resettlement and expedite discharges. The Group was responsible to MDAG, which monitored progress on resettlement for all LD patients.

Q17. Were concerns about the resettlement programme ever raised with the Department, either by the Trust Board or other stakeholders? Please describe any actions taken by the Department to address those concerns.

246. Prior to my post as CNO I would have been aware as Executive Director for Nursing, Primary Care and Older People that resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey to community living facilities has been the overarching policy direction of the Department since the early 1990's. This has been progressed in line with the ethos of betterment, i.e. resettlement would only be where there was betterment for the patient in a community setting and they would not be moved to a placement against their will.

247. The Departmental policy direction of resettlement into community settings is consistent with the rest of the UK in seeking to move away from largescale institutional settings where Learning Disabled patients are cohorted together, often giving rise to perceptions of an 'out of sight, out of mind' approach. The Bamford Review through the Equal Lives report emphasised the need to achieve this aim and for the Department to increase its focus on its implementation without further undue delay.

248. Throughout the lifespan of the resettlement programme, concerns have been raised on occasion with the Department on its operation. These have in the main originated from families of patients in Muckamore who do not agree with the resettlement programme, and from patient representative groups associated

with Muckamore Abbey Hospital. In addition, concerns have also been raised by patients/families on the length of time that their resettlement is taking. These have been raised via a number of avenues, including correspondence received from families or elected representatives to the Minister/Department, Judicial Reviews or Pre-Action Protocol letters and the Departmental ALB Accountability processes. I am only aware of the representations to MDAG, where families were concerned about failed resettlements, insufficient skilled staff, communication with the trust regarding arrangements and the length of time it took to arrange the placement which is discussed further in paragraphs 256 to 259 of this statement.

Correspondence

249. Correspondence received has included representations from interest groups such as the Society of Parents and Friends of Muckamore, citing concerns with the resettlement process being prioritised over the well-being of the patients in Muckamore, with the patients being resettled against their will, and inadequate resettlement planning having been done in advance of resettlements. The Department sought assurances from the Trusts involved on planning and implementation of resettlement for individual patients. CSSO and I met with families with the Permanent Secretary to hear family concerns. In other instances, meetings were offered with the Health Minister that I exhibit at Exhibit 57 was a meeting between the Minister and patients and their families on 21st January 2020 which I attended along with CSSO to hear these concerns firsthand.

Judicial Reviews/Pre-Action Protocol Letters

250. The Department has also been involved in a number of JRs on MAH resettlement cases, on the basis of alleged failure to provide adequate resources to enable resettlement to be progressed in a timely manner. By way of example I understand in 2021 JR152 was in relation to the delay in resettling a patient from MAH. The outcome was that a taskforce was established

between the Dept and Belfast Trust. The purpose of this taskforce was for the Department to seek clarification and details from the Trust in respect of all the avenues it had explored to date to identify a suitable placement for the Applicant in accordance with his assessed needs at each stage of the resettlement process. I was not involved in this taskforce.

MDAG

251. Issues in relation to resettlement have also been raised at MDAG. Examples have included concerns about pressure being put on resettled individuals to move from their current community placements to new supported living developments. At MDAG on November 27th 2019 an updated reporting dashboard was presented to take into account concerns raised by both CSSO and I as well as families at the previous meeting. These concerns were to do with the appropriateness of placements and that the fact that some had failed. Further work was being done to review placements which broke down and to monitor readmissions to MAH.

252. Sean Holland wrote to the Independent Providers and Directors of Adult Services in HSC Trusts on 15th September 2020 to emphasise the need to ensure that community placements were to be treated as forever homes, people should not be being pressured to move and should any moves be required these were on basis of the Betterment principle with appropriately planning and implementation. I include a copy of this letter at Exhibit 58.

253. The reluctance of some remaining patients at Muckamore to be resettled out of Muckamore has also been raised. In response, Sean Holland wrote to the Chief Executive of the Belfast Trust on 15th September 2020 to ask that the Trust to explore the potential for an onsite option for the resettlement of those considered suitable for such provision. I attach a copy of this at Exhibit 59. The relevant Trusts, led by the Belfast Trust, carried out preliminary work to identify those patients who wished to remain onsite (four or five patients), the model of

care that would be required for those patients (bespoke nursing care), the accommodation options (refurb or new build) and associated costs involved.

254. Other issues raised included the slow progress overall of the resettlement programme, concerns over the services provided by the community or private sector, specifically around the availability of suitable accommodation and/or staffing, communication with patients and families around resettlement planning and the need for an understanding of individual patients needs to be central to the planning process. To address concerns, the Department asked the HSCB in October 2021 to commission the independent review of resettlement. The report was compiled by Mr Ian Sutherland and Ms Bria Mongan both with executive director level experience in social work and at which point I left my post as CNO.

255. I understand the final report of the review, including its recommendations, was endorsed by the Health Minister on 29 September 2022 and I exhibit a copy of this at Exhibit 60. The report was published on the Departmental website and I exhibit a copy of the report at Exhibit 61.

Trust Board

256. As part of the Accountability arrangements between the Department and the Belfast Trust, I understand Trust Board members have at various times between 2008/09 and most recently 2022/23, provided high level updates on resettlement progress at meetings as part of the in-year and end-year accountability processes. However this was not discussed at the meetings I or my team attended between 2013 and 2014 and referenced above at para 126.

257. With the exception of 2009/10 and 2013/14, where positive updates where provided on progress against resettlement targets, generally updates have advised in the main of the difficulty in the achievement of resettlement targets at that time.

258. Updates provided since the allegations of abuse in Muckamore came to light in 2017/18 have raised difficulty in resettling patients due to a number of issues including pressures on the hospital, lack of suitable community infrastructure and the need for a regional approach.

259. Before the allegations of abuse at Muckamore came to light, any items raised in these meetings would have been passed to the relevant policy branch for consideration of any actions available to help improve performance.

260. Since the allegations of abuse came to light, the Department has been working with the Trust at senior staff level in order to better understand the issues raised and seek to improve the resettlement landscape to enable well planned and effective resettlements to take place. It has done this through groups such as MDAG and also through the work of the Regional Resettlement Oversight Board which has brought a continuing focus on the planning for resettlement of each patient in Muckamore.

Q18. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Department consider whether similar initiatives should be applied in Northern Ireland, and was any action taken in this regard? If not, why not?

261. I became aware of Winterbourne due to the BBC Panorama programme on Winterbourne View Hospital which aired on the 31 May 2011 highlighted serious and systematic maltreatment of residents with learning difficulties. This was two years before I took up post as CNO and therefore I am unable to comment on actions taken by the Department at that time. I am unable to comment on the steps taken in England to reduce beds. In general I would support the policy direction that people with a learning disability should have the right to live their lives in their community and not in institutional care.

262. Sean Holland issued an e-mail on 22 April 2013 to Departmental policy and professional leads commissioning input to the DHSSPS response to the DH response of 2012. A copy of this is attached at Exhibit 62. Tab 2 to this e-mail provides an assessment of action required in NI to implement locally the recommendations from the DH Transforming Care report.

263. I am aware although not directly involved or with policy responsibility that a number of the actions were taken forward in Northern Ireland. I was not directly involved in these and they were not my policy responsibility.

264. The Department, in conjunction with other agencies, developed measures aimed at safeguarding all vulnerable adults including older people in hospitals and care homes and people with a learning disability. This included 'Adult Safeguarding - Prevention and Protection in Partnership' (2015) and 'Protocol for Joint Investigation of Adult Safeguarding Cases' (2016). Copies of these have been exhibited in Mark McGuicken's first statement at MMcG/72 [MAHI - STM - 089 – 3653] and MMcG/73 [MAHI - STM - 089 – 3716].

265. A change to the disclosure and barring arrangements for preventing unsuitable individuals from working with vulnerable groups was implemented and a service framework for the health and wellbeing of older people was developed. The service framework set standards, specific timeframes and expected outcomes designed to improve the health and wellbeing of older people in Northern Ireland, promote social inclusion, reduce inequalities in health and improve quality of care.

266. The Department developed a policy on Seclusion and Restraint lead by a senior nurse and supported by my team but reporting to the mental health policy lead. This was launched after I left my post as CNO.

267. In my opinion STOMP provides guidance on how to ensure that children or adults with intellectual disability use psychotropic medication appropriately. All healthcare professionals should as part of person-centred care planning review

and plan to reduce psychotropic medication in a safe and closely monitored way if necessary. Whilst I am neither a Mental Health and Learning Disability specialist I understand this approach to medicines management to be good practice even before the publication of STOMP.

268. In certain clinical situations of course, there is a role for medication which can be beneficial and necessary but a clear plan with evidence-based decision making to support this is best practice.

269. Other interventions such as positive behaviour support and an individualised approach to care should also limit the need for psychotropic medications.

270. STOMP and STAMP have been referenced in the Department's new ten-year mental health strategy and the Royal College of Psychiatrists have also published a new position paper on STOMP and STAMP. A copy of this is attached at Exhibit 63.

Q19. 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?

271. I have no further matters to comment on.

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:

Date: 28 June 2024

List of Exhibits

Exhibit 1: CNMAC Task & Finish Group Final Report - Recruitment of Band 5 Nurses - 11 March 2016

Exhibit 2: Notes from CNMAC Meeting - 10 June 2016

Exhibit 3: Notes from CNMAC Meeting - 18 September 2020

Exhibit 4: Department of Health - Health and Wellbeing 2026 - Delivering Together - October 2016

Exhibit 5: Nursing and Midwifery Task Group Report and Recommendations - March 2020

Exhibit 6: Nursing and Midwifery Task Next Steps A Three Phased Approach 2020- 2026

Exhibit 7: Modernising Learning Disabilities Nursing Review Strengthening Commitment Northern Ireland Action Plan - March 2014

Exhibit 8: Northern Ireland Action Plan for Learning Disability Nursing Northern Ireland Collaborative Progress Report - October 2017

Exhibit 9: Northern Ireland Practice and Education Council for Nursing and Midwifery - Modernising Learning Disabilities Nursing Review Strengthening the Commitment Northern Ireland Action Plan - October 2012

Exhibit 10: NI Action Plan: Strengthening the Commitment - Link to NIPEC Website and Screenshot of relevant page - June 2014

Exhibit 11: Strengthening the Commitment Northern Ireland Action Plan - August 2015

Exhibit 12: A Description of the Learning Disabilities Nursing Workforce in Northern Ireland - A Report - September 2015

Exhibit 13: Senior Nurse Leadership Development Programme for Learning Disability Services - Dates for Modules to take place and expected learning outcomes - February to March 2015

Exhibit 14: Strengthening the Commitment: Living the Commitment - UK Strengthening the Commitment Steering Group - June 2015

Exhibit 15: Outcomes Measurement in Learning Disabilities Nursing - Summary Report - 23 October 2015

Exhibit 16: NIPEC Terms of Reference NI Collaborative & Royal College of Nursing Professional Development Forum Learning Disabilities Nursing - March 2017

Exhibit 17: Strengthening the Commitment: Learning Disabilities Nursing Northern Ireland Collaborative Outcomes Based Resource Pack - January 2019

Exhibit 18: NIPEC Event Flyer - Professional Development Forum Registered Nurses - Learning Disabilities - 19 June 2018

Exhibit 19: Professional Nursing Governance Report - Mental Health and Learning Disability Nursing - January 2018

Exhibit 20: Letter from Charlotte McArdle to Brenda Creaney - Concerns around staffing levels - 31 May 2019

Exhibit 21: Letter from Brenda Creaney to Charlotte McArdle - Response to Concerns around staffing levels - 20 June 2019

Exhibit 22: Submission to Richard Pengelly - Stabilisation of Muckamore Abbey Hospital - Pay Enhancement for Registered Nursing Staff - 17 October 2019

Exhibit 23: Minutes for MDAG Meeting - 28 April 2021

Exhibit 24: Report on Professional Nursing Assurance Muckamore Abbey Hospital Finding Recommendations and Action Plan - Francis Rice - February 2020

Exhibit 25: Early Alert - Temporary closure to unplanned admissions to Muckamore Hospital to stabilise workforce - 23 August 2018

Exhibit 26: Email from Charlotte McArdle to Alison McCaffery and Richard Pengelly - Submission to Richard Pengelly to provide update on Muckamore SAI - 07 December 2018

Exhibit 27: Letter to Charlotte McArdle from Rodney Morton - NMTG and Delivering Care 21/22 Investment Plan - for approval - 21 May 2021

Exhibit 28: Letter from Charlotte McArdle to Rodney Morton - NMTG and Delivering Care 21/22 Investment Plan - approval of plan - 10 June 2021

Exhibit 29: Letter from Charlotte McArdle to Brenda Creaney - Nursing Workforce, Muckamore Abbey Hospital - 10 May 2021

Exhibit 30: Letter from Charlotte McArdle to Brenda Creaney - Nursing Workforce, Muckamore Abbey Hospital - 22 October 2021

Exhibit 31: Circular HSC (SQSD) 64/16 - Updated guidance on the operation of the Early Alert System - 28 November 2016

Exhibit 32: Blank KH15/KH15b: Admissions under Mental Health (NI) Order 1986: Legal Status Form

Exhibit 33: Blank Annual Mental Illness/Learning Disabilit Census (MILD) Form

Exhibit 34: Blank KH03a Template - Summary of Available and Occupied Bed Days and Discharges and Deaths and Day Cases

Exhibit 35: Email from Arlene Hanna to Josephine O'Neill and Graeme Crawford - Allegations at Muckamore and CCTV Pilot - 07 January 2016

Exhibit 36: Early Alert - Alleged Assault of a patient in PICU Ward Muckamore Abbey Hospital on 12 August 2017 - 07 September 2017

Exhibit 37: Early Alert - Swimming Pool Attendant in Muckamore disclosed 4 Incidents witness in the Swimming Pool - 24 November 2017

Exhibit 38: Letter to Martin Dillon from Sean Holland & Charlotte McArdle - Issues around Allegations of abuse at Muckamore Abbey Hospital - 20 October 2017

Exhibit 39: Letter to Martin Dillon from Sean Holland & Charlotte McArdle - Following meeting on 17 November 2017 with Marie Heaney and Brenda Creaney - 30 November 2017

Exhibit 40: Letter to Sean Holland and Charlotte McArdle from Martin Dillon - Responding to concerns raised in 17 November 2017 letter - 22 December 2017

Exhibit 41: Letter to Valerie Watts from Sean Holland - Muckamore SAI Report - 4 December 201

Exhibit 42: Permanent Secretary apologises to Muckamore families - 17 December 2018

Exhibit 43: Notes from HSC Summit on Muckamore SAI Report Meeting - 30 January 2019

Exhibit 44: Letter to Jackie McIlroy from Marie Heaney - Public Interest Disclosure - 27 February 2019

Exhibit 45: Letter to Valerie Watts from Sean Holland & Charlotte McArdle - RQIA Unannounced Inspection of Muckamore Abbey Hospital (15-17 April) - 17 May 2019

Exhibit 46: Notes from Muckamore Abbey Hospital Department and Belfast Trust Liaison Meeting - 06 September 2019

Exhibit 47: Notes from Muckamore Abbey Hospital Department and Belfast Trust Liaison Meeting - 13 September 2019

Exhibit 48: Notes from Muckamore Abbey Hospital Department and Belfast Trust Liaison Meeting - 25 September 2019

Exhibit 49: Letter from Charlotte McArdle to Brona Shaw re CNO Review of Alerts update request - Dated 15 Jun 2020

Exhibit 50: Letter from Charlotte McArdle to Brona Shaw re CNO Review of of the continued issuance of Alert letter - Dated 24 Feb 2020

Exhibit 51: Letter from Charlotte McArdle to Valerie Watts re Leadership and Governance Review - Dated 5 Jul 2019

Exhibit 52: Evolving and Transforming to Deliver Excellence in Care - A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025) - May 2016

Exhibit 53: Early Alert - Concern around staffing levels in Muckamore Abbey Hospital - 19 March 2021

Exhibit 54: Report on Professional Nursing Assurance – 9 February 2020

Exhibit 55: Advanced Nursing Practice Framework Supporting Advanced Nursing Practice in Health and Social Care Trusts - February 2016

Exhibit 56: Supervision for Registered Nurses 2016-2017 Annual Report for Executive Director of Nursing and User Experience and the Chief Nursing Officer for Northern Ireland - 27 June 2017

Exhibit 57: INV -1089-2020 - Briefing for Minister Swann ahead of meeting with families re Muckamore 22 January at 6pm - 21 January 2020

Exhibit 58: Letter to Independent Providers & Director of Adult Services HSC Trusts from Sean Holland - Resettlement community placements - 15 September 2020

Exhibit 59: Letter to Cathy Jack from Sean Holland - Resettlement of Long Stay Patients - 15 September 2020

Exhibit 60: Health Minister welcomes findings of resettlement review - 29 September 2022

Exhibit 61: Independent Review of the Learning Disability Resettlement Programme in Northern Ireland - July 2022

Exhibit 62: Email from Sean Holland to Grade 3s Chief Professionals Grade 5s Winterbourne View Reports April 2013 - 02 May 2013

Exhibit 63: Royal College of Psychiatrists Position Statement STOMP & STAMP - August 2021