ORGANISATIONAL MODULES 2024 STATEMENT

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Professor Sir Michael McBride
Date: 28 June 2024

I, Professor Sir Michael McBride, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

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 qualified Doctor. In 1986 I graduated from Queen's University Belfast with a MB BCh BAO medical degree, with distinction in Medicine and Surgery, completing my post graduate training in general medicine and my specialist training in HIV and Genitourinary Medicine. I have no general or specialist medical training in mental health or learning disability. In 1991, I attained a Research Fellowship at St Mary's Hospital Medical School and Imperial College London, conducting research into new drug treatments for HIV (Human Immunodeficiency Virus). From 1994 to 2006 I worked as an HIV

Consultant within the Genitourinary Medicine service at the Royal Group Hospitals Trust and was appointed Medical Director of the Royal Group of Hospitals in August 2002. I am a Fellow of the Royal College of Physicians of London, and a Fellow of the Royal College of Physicians of Ireland. I have been awarded an Honorary Senior Fellowship by the Faculty of Medical Leadership and Management (FMLM) for my contribution to healthcare. In July 2021 I was made an honorary Professor of Practice by Queen’s University Belfast (QUB) and awarded an honorary degree of Doctor of Medical Science for Distinction in Medicine. In March 2022 I was elected to Honorary Fellowship of the Faculty of Public Health. I was Knighted in 2021 for services to public health in Northern Ireland.

2. From 1994 to 2006 I worked as an HIV Consultant within the Genitourinary Medicine service at the Royal Group Hospitals Trust and was appointed Medical Director of the Royal Group of Hospitals in August 2002. In September 2006, I was appointed as Northern Ireland's Chief Medical Officer (CMO). I was appointed acting Permanent Secretary of the Department of Health and Chief Executive of Northern Ireland Health and Social Care between March and August 2009 arising from the unpredicted absence of the then Permanent Secretary due to a health related issue. In December 2014, at the request of the then Health Minister and Chair of the Belfast Health and Social Care Trust (BHSCT or Belfast Trust hereafter), I was appointed as acting Chief Executive of the BHSCT (Exhibit 1), serving until February 2017 while continuing in the role of CMO. This was the result of a unique set of circumstances, arising from the resignation of the previous CEO to take up another post. As the largest HSC Trust providing regional services across NI I understand it was believed this would ensure strategic organisational leadership within the Trust at that time. Although it was intended that this would be for a relatively short period and firewalls were put in place to ensure there were no conflicts of interest, the arrangement was not ideal. Combining the roles and responsibilities of both offices was professionally and personally demanding.

Module

3. I have been asked to provide a statement for the purpose of M10: Department of Health and M9: Trust Board.

4. My evidence relates to a number of paragraphs of the Inquiry's Terms of Reference.

5. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

6. To assist the Inquiry, I have referenced documents that have come to my attention in the preparation of this statement and that I have reviewed. A number of these documents I would not have reviewed contemporaneously unless matters were brought to me for my consideration and professional review and advice. Where this is the case, I have indicated the limits of my personal knowledge and understanding at the time and sought to identify from whom further information might be sought. I have also reviewed the Departments Corporate Witness Statement and addendums prepared by Mark McGuicken and have referred to relevant extracts rather than repeat in full in my own statement. Furthermore, in response to some questions where I have no personal or professional knowledge of the subject matter or knowledge of specific action that was taken, in order to assist the Inquiry, I have sought input from relevant policy and professional colleagues, and again indicated those who may be best placed to provided additional information if required. I have sought to clearly indicate were I sought input from others to inform my response. There are also a significant number of areas were in my response I have indicated that I had no professional or personal involvement as Chief Medical Officer. This is not a reflection of my consideration of the importance of these matters, rather a reflection of my other extensive professional and policy responsibilities and in keeping with professional and policy responsibilities of colleagues within the Department. In response to other questions, I have also indicated what I normally have expected to occur

within the extant governance and accountability arrangements across the HSC and the Department. Given the passage of time, I do not now in some instances recall, or fully recall my consideration of some matters, actions that I may have taken or advice I provided. My recollection of some matters has been assisted by reviewing documents available to me and I have indicated were that is the case. I appreciate that others recollection of circumstances and events may differ and, in some circumstances, may be more comprehensive.

M10: Department of Health

Q1. Please explain the professional reporting lines that existed from Muckamore Abbey Hospital (MAH) to the Chief Medical Officer.

7. There are no extant or previous professional reporting lines from Muckamore Abbey Hospital (MAH) to me as Chief Medical Officer. Given the scale, scope and complexity of health and social care policy implementation and service delivery the Department by necessity relies on a delegated system of governance and accountability. I summarise this in more detail and how this has evolved in paragraphs below as I believe this is of relevance to the matters under consideration by the Inquiry. The extant professional and managerial reporting lines of doctors within Muckamore Abbey Hospital (MAH) would be to the respective clinical lead, clinical director, to the Medical Director of the Belfast Trust, and similarly, managerially doctors would be accountable to the service director, co-director, and directors within the Belfast Trust with responsibility for MAH. As Chief Medical Officer, I chair the Medical Leaders Forum, which is comprised of the Trust Medical Directors, the Director of Public Health in the Public Health Agency (PHA), NI Blood Transfusion Medical Director, the Clinical lead at Regulation and Quality Improvement Authority, the Postgraduate Medical Dean from NI Medical Dental Training Agency (NIMDTA) and the respective Deans from the schools of medicine at Queens University and Ulster University. The purpose of the group is largely to provide a forum for exchange of information and discussion

between the Chief Medical Officer of DoH and HSC medical leaders in Northern Ireland, on policy and professional matters, advising on strategic issues and informing policy development and guidance. Agenda items would usually include the following themes: Primary Care; Secondary Care; Public Health; Quality and Safety; Medical Education; and Research & Development within the HSC.

8. These individuals while members of the Medical Leaders Forum are Executive level posts or hold senior academic and administrative positions within the Universities and as such are accountable to their respective Chief Executives (CEO) and allied university management arrangements to the Vice Chancellors of the respective Universities. There is no professional reporting line to me, rather a professional relationship. All medical staff, myself included, as registrants on the medical register who hold a licence to practice, are accountable to the General Medical Council (GMC) for their professional practice in keeping with the standards in Good Medical Practice (GMP), and with respect to those who work for the BHSCT are accountable for their clinical practice within the extant corporate accountability and governance arrangements within the BHSCT.

9. As CMO, under the Medical Profession (Responsible Officers) Regulations (NI) 2010, I have been appointed by the Department as the Designated Body as the Responsible Officer (RO) for doctors working within the Department, and by agreement with Permanent Secretaries of other departments, such as the Department of Finance, for doctors working within the Occupational Health Service. As part of that role, as their Responsible Officer (RO), under the revalidation process for licensed medical practitioners I make recommendations to the General Medical Council (GMC) with respect to the doctors connected to me that they are up to date and fit to practise. All doctors have to revalidate usually every five years. As the Tier 3 RO I am responsible for making recommendations to the GMC with respect to revalidation of the tier two RO, the Director of Public Health within the PHA who in turn is responsible for making revalidation recommendations with

respect to all consultants in the PHA and the tier one ROs within HSC Trusts. I am also responsible for making recommendations with respect to revalidation of the tier two RO, the Medical Director / Lead, in the Regulation and Quality Improvement Authority (RQIA) who is in turn responsible for making recommendations with respect to the tier one ROs in Independent Sector organisations within NI and some medical doctors working in RQIA. Such consideration and recommendations are subject to the governance arrangements of respective organisations and information submitted by individual doctors as assessed by their appraiser during their annual appraisal against the standards set out in *Good Medical Practice*. Annual appraisal is a contractual and professional requirement of all doctors and is both formative and summative. All HSC organisations are required to ensure that there are arrangements in place to support appraisal and to ensure doctors maintain their skills and knowledge through continuous provisional development and the completion of an annual professional development plan. As such this is not a line management reporting arrangement to me as CMO. To ensure that all NI's ROs maintain their professional knowledge and experience with respect to their designated respective organisation roles and responsibilities the Department facilitates and convenes RO Forums with the HSC and the Independent Sector.

10. With respect to professional and managerial accountability, while the Belfast Trust would be best placed to inform the Inquiry of the relevant managerial structures, from my previous experience in the Belfast Trust within these arrangements, medical professionals are managerially and clinically accountable within the Trusts clinical directorate and divisional structures to the respective clinical director and directorate manager and in turn to divisional directors and managers, within a delegated system of accountability. I have covered this in further detail later in my statement. I would expect issues or concerns in relation to Muckamore Abbey Hospital, the clinical performance of the service, the adequacy and quality of the care provided and any concerns with respect to patient safety, safeguarding, or patient experience to be identified and escalated through the extant

governance and accountability arrangement within the BHSCT in the first instance. All Health and Social Care professionals, including doctors, have a professional duty to raise and escalate any such concerns which must be fully and comprehensively addressed by provider organisations/the commissioners of service in line with the extant duty of quality placed on all HSC organisations under the The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (HPSS Order 2003) and in keeping with respective roles and responsibilities set out within the Framework Document [MAHI - STM - 089 – 1145] as described at paragraph 57, with the ultimately responsibility residing with the Department. Consistent with this hierarchy of responsibility and accountability, depending on their significance, it would have been expected that any matters of significant concern that may have been identified would be escalated by the lead provider organisation to the commissioners of Health and Social Care Services, the then HSCB Directorate of Social Care and Children within the Health and Social Care Board (now Strategic Planning and Performance Group (SPPG) within the Department), with escalation to the Department if necessary. While I cannot now recall, I would have normally expected significant matters relating to MAH to have been raised through this reporting mechanism to the Departments senior leadership team, Top Management Group (TMG) and potentially to the Departmental Board, both of which I am a member of. Significant matters of concern may also have been flagged through Sponsorship and Accountability arrangements with the relevant professional and policy leads which I understand during the period in question was the responsibility of the then Social Services Policy Group (SSPG) within the Department and specifically the Director of Mental Health, Learning Disability and Older People Services reporting to the Chief Social Work Officer (CSWO) as the then professional and policy lead. Similarly, Safety and Quality Directorate (SQD) within Chief Medical Officer Group (CMOG) as the sponsor branch for RQIA, would normally have been expected to be notified of any significant concerns identified by RQIA and these would then normally be relayed to the responsible policy and professional lead for consideration of any necessary action. I have no recollection at this time of matters or concerns being brought to my attention for professional medical advice other

than matters referred to later in my statement. While the primary responsibility for the quality and safety of service rests with the service provider organisation (in the instance of MAH this was the BHSCT), there was also a duty of quality on the commissioning body to ensure the quality of services commissioned.

11. During the period being considered there has been significant change in the structure of the health service, the extant governance and accountability arrangements and relevant policy context. As stated in the first witness statement of Mark McGuicken, dated the 13 February 2023 [MAHI - STM – 089] in paragraphs 2.26 to 2.33, the number of Health and Social Services Trusts (HSSTs) was reduced from eighteen to six in 2007 under the Review of Public Administration (RPA). Section 1(3) of the 2009 Act makes provision to rename the HSSTs as Heath and Social Care Trusts (HSC Trusts). The Regional Health and Social Care Board was established in April 2009 under Section 7(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (the 2009 Act), subsequently known as the Health and Social Care Board (HSCB), amalgamating, and replacing the previous four area Health and Social Services Boards (HSSBs) that had been established under the 1972 Order. The HSCB had a range of functions which broadly can be summarised under three headings, first, commissioning the provision of health and social care for the population, second performance management and service improvement, and third resource management.

12. The six HSC Trusts provide commissioned services for the purposes of health and social care and each HSC Trust has a statutory obligation to put and keep in place, arrangements for monitoring and improving the quality of health and social care which it provided. Section 21 of the 2009 Act also placed a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and, reducing the health inequalities between, those for whom it provides, or may provide, health and social care. Prior to the introduction of the Health and Social Care Act (NI) 2022 (the 2022 Act), HSC Trusts were accountable to the HSCB for the

availability, quality, and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the Department and the HSCB for performance against Ministerial targets including compliance with any statutory obligations. The efficiency and effectiveness of these arrangements have been considered in a number of reports, for example in respect of resettlement within the "Independent Review of the Learning Disability Resettlement Programme in Northern Ireland," by Bria Mongan and Ian Sutherland dated July 2022 (see section 5 with respect to Leadership and Governance (Exhibit 2).

13. As referred to in paragraph 10 above, and as stated in the fourth statement of Mark McGuicken, dated the 12 April 2024 at paragraphs 1.9, Article 34 (1) of the HPSS Order 2003 placed a duty on the then Health and Social Services (HSS) Boards (and each HSS Trust) to make arrangements for monitoring and improving the quality of the health and social care it provides to individuals. This provision was made among other commissioned services to reflect the role of HSS Boards in the delivery of Social Care and Children's functions. In the 2009 Act, HSS Boards were abolished and the HSCB was established, and the duty of quality was then extended to the HSCB. As is outlined in paragraphs 1.11 to 1.16, of the same statement, in developing the 2022 Act which dissolved the HSCB, the reference to the HSS Board at Article 34 (1) of the HPSS Order 2003 was removed. The reference to HSS Board was also removed from Article 35 (9) of the HPSS Order 2003, again as a direct consequence of the closure of the HSCB. Consequently, unlike the HSCB with respect to the services it previously commissioned, SPPG is now outside the remit of the Regulation and Quality Improvement Authority (RQIA). The revisions to Article 34 (1) and Article 35 (9) of the HPSS 2003 Order mean that with effect from April 2022 that SPPG does not have a statutory duty of quality for the services it commissions and is not subject to inspection or the regulatory activities of RQIA. As further explained at paragraphs 1.15 to 1.18, of the same statement, the Department no longer has a statutory requirement to issue a Commissioning Plan Direction to the HSCB and the Public Health Agency (PHA) no longer has a direct role in the approval of a

Commissioning Plan or consideration of Trust Deliver Plans (TDP) and Service and Budget Agreements (SBA) with TDPs and SBA also no longer being required. The detail of the previous arrangements and the commissioning processes and oversight of same is described in paragraphs 5.1 to 5.5 of the second witness statement of Mark McGuicken, dated the 26 May 2023.

14. On the dissolution of the HSCB, responsibility for the majority of its functions transferred to the Department of Health with effect from 1 April 2022. The Health and Social Care (NI) Act 2022 (‘the Act’) transferred responsibility for the former functions of the HSCB to the Department of Health, with the exception of those pertaining to the exercise of Social Care and Childrens Functions which were transferred to HSC Trusts. Currently SPPG are establishing new arrangements under a proposed Integrated Care System (ICS) and will be best placed to advise of timeframes for completion.

15. As the Chief Medical Officer, I provide professional leadership and policy guidance to the medical profession in NI on a range of clinical and professional matters. This does not include providing operational clinical guidance on treatment and care. Evidence base clinical guidance is considered and developed by the National Institute for Health and Care Excellence (NICE). The Department of Health established formal links with the National Institute for Health and Care Excellence (NICE) on 1 July 2006 whereby guidance published by the Institute from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in Health and Social Care (HSC). This link has ensured that Northern Ireland has access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions. The Departmental review is not a reassessment of the clinical and cost evidence used by NICE in forming its advice. NICE guidance is proofed by the Department only to check for legal, policy and financial consequences related to its implementation in NI. As a result, the guidance may be endorsed with caveats to advise local HSC organisations of any

equivalent legislation or policy or any specific instructions or requirements. There are arrangements in place which require the SPPG (formerly the HSCB) as the commissioner of services and Trusts to ensure the implementation of NICE guidance. The Department issued guidelines on the arrangements for implementing and monitoring NICE guidance in circular HSC (SQSD) 13/22: NICE Clinical Guidelines – Process for Endorsement, Implementation, Monitoring and Assurance in Northern Ireland. I understand that this circular been previously provided to the Inquiry at MMcG/48 [MAHI - STM - 089 – 2538].

16. While 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 relevant HSC Trust. The Department did, until late 2022, operate a Professional Alert scheme for Nurses, Midwives and Allied Health Professionals 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. I understand this scheme was stood down following an internal review and in future it was confirmed that fitness to practice concerns should be referred directly to the appropriate regulatory body. The Chief Nursing Officer (CNO) would be best placed to provide further details as necessary. The Chief Medical Officer Group (CMOG) still has a process in place for issuing and revoking alert letters for doctors in Northern Ireland (Local Northern Ireland Alerts – NI Alert Letters). CMOG also processes Health Professional Alert Notices (HPAN) received from NHS Resolution Practitioner Performance Advice (formerly NCAS). NI Alerts are issued when the HSC Trusts initiate contact with CMO

office. Trusts will email/write/telephone the Chief Medical Officer / Deputy Chief Medical Officer with concerns and/or details of an issue. All the available information will be considered, and a decision made to issue an alert letter or not. The Alert will issue under cover letters to Health and Social Care Trusts (HSCTs), HSC Business Services Organisation and Regulation and Quality Improvement Authority, Strategic Performance and Planning Group & Public Health Agency. They are also sent to Chief Medical Officer Wales & Scotland, and NHS Resolutions. NHS Resolution Practitioner Performance Advice (formerly NCAS) issue alert notices and alert notice cancellations using a Healthcare Professional Alert Notice (HPAN) letter. NHS Resolution PPA (HPAN Letter) Alerts (Encrypted) are received by email to the CMO Office at the Department. These are then issued under cover letters to HSCTs, HSC Business Services Organisation and Regulation and Quality Improvement Authority, Strategic Performance and Planning Group & Public Health Agency.

17. I lead a team of medical professionals which includes, but is not limited to, two Deputy Chief Medical Officers (DCMO) and a number of Senior Medical Officers (SMO). Until retirement in September 2022, the Senior Medical Officer for Mental Health and Learning Disability was the professional medical adviser within CMOG in relation to Learning Disability Services including MAH. This Senior Medical Officer, worked closely with respective policy and professional colleagues and would have provided professional advice in individual communication as well as through his participating in groups and meetings on any issues relating to MAH directly to policy colleagues and to the Chief Social Work Officer who was the head of Social Services Policy Group which had responsibility for Special Education Needs, Learning Disability, Physical and Sensory Disability, Autism, Adult Safeguarding Legislation, Gender Identity, Care Homes, Domiciliary Care, Carers, Dementia and the Reform of Adult Social Care. I have sought input from this retired SMO to assist my recall of events and this has been of assistance in preparing my statement.

18. I am also the head of the Chief Medical Officer Group (CMOG). During the specified period, my policy responsibilities were wide ranging and included population health, health improvement, health protection, and healthcare quality, safety and improvement and HSC Research and Development. While all aspects of my policy responsibilities for public health and respective strategies are relevant to people living with a Learning Disability, of possibly more immediate relevance to the Inquiry is the CMOG responsibility for policy in relation to quality and safety. The Quality, Safety and Improvement Directorate (QSID), which was within my Group during the specified period, had policy responsibility for a range of areas including the HSC Complaints Process; Serious Adverse Incidents (SAIs) Reporting and Investigation; Adverse Incidents involving Medical Devices; 'Never' Events; and the Regulation and Inspection of HSC services. It is important to note that there is a distinction between being responsible for the SAI policy itself, for example, and being the policy lead for an issue raised under the SAI process, such as a child or adult safeguarding issue. This means that while QSID was responsible for the relevant departmental policy in relation to these areas or processes, any notifications by way of an Early Alert (EA) received through these processes would have been referred to the relevant policy colleagues elsewhere in the Department for review, consideration and identification of necessary and appropriate action. Such notifications were not reviewed within QSID as they had no specialist subject matter or policy knowledge, and they would normally have been escalated to the relevant policy areas rather than such matters being routinely brought to my attention in keeping with extant arrangement for an EA (Exhibit 3).

19. The QSID Directorate is also the sponsor branch for the Regulation and Quality Improvement Authority (RQIA), an ALB of the Department which is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging HSC Trusts, the HSCB as commissioner (until the amendments to the Article 35 (9) of the HPSS 2003 Order, its dissolution and transfer of its function into the Department), and the independent sector in order to ensure

improvements in the quality of those services. A key function of the RQIA is to keep the Department informed about the provision of health and social care services, and, in particular, their availability and their quality. ALBs are sponsored by the Department as a whole. Strong partnerships between the Department and its ALBs are critical to the delivery of high quality public services and those relationships are based on trust, shared outcomes, transparency and clear lines of accountability and responsibility. Sponsor Branches are the primary point of contact within the Department on issues of the ALB's assurance and accountability, but the relationship is a two-way one where Departments and ALBs jointly assess its effectiveness, share ideas and approaches and ALBs are able to raise concerns at an early stage. Policy and Professional leads across the Department are responsible for contributing to the accountability process by providing agenda items and briefing for the Ground Clearing and Accountability meetings and attending as required. The Department will hold ALBs, such as RQIA, to account by assessing their performance and delivery of their prescribed functions and their compliance with other statutory responsibilities. In November 2023 QSID transferred from CMOG to Healthcare Policy Group.

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

20. The SMO for Mental Health and Learning Disability (MHLD) was the professional medical adviser in relation to mental health and learning disability issues as they pertain to MAH reporting to my Deputy CMO and in turn to me. In the context of my professional and policy responsibilities, I did not routinely or normally receive detailed operational information in relation to HSC services which would have been primarily a matter for the relevant policy lead. As I recall, during the period in question a high level summary of HSC Service Performance would have been presented at the then Top Management Group (TMG) of the Department and quarterly at the Departmental Board. I do not

recall that this presented granular level detail in relation to specific Learning Disability Services or specifically MAH, however colleagues within Social Services Policy Group within the Department during the relevant period would be best placed to advise. While issues relating to MAH may have come up during the course of the DCMO's regularly meeting or my less frequent meetings and conversations with the Senior Medical Officer for MHLD, any such matters would have been officially raised by the SMO in MHLD, as necessary and appropriate, directly with the Chief Social Work Officer who was the head of Social Services Policy Group and other relevant directors within SSPG. The SMO in MHLD did not receive regular information or reports on MAH other than those received as a member of groups established by policy colleagues in response to Learning Disability Services or MAH concerns. I understand that the sources of that information reflected the membership of such groups and included HSCTs, the then HSCB, RQIA, policy and professional colleagues.

21. Within the Department, as a member of TMG, I was would have expected, and was, copied into submissions regarding MAH, prepared by the policy team within Social Services Policy Group to the Permanent Secretary when deemed necessary by the policy and professional colleagues for information even if and I had no action to take on these from a professional or policy perspective. Some of these submissions may have had additional professional input from the SMO in MHLD.

22. As part of its sponsorship role, CMOG held regular bi-monthly liaison meetings with RQIA and I attended these, on occasion. These liaison meetings are held in accordance with extant DoH Governance unit guidance at the time. At these meetings RQIA provided updates on its activity across all registered and statutory services. This included an update in relation to Mental Health and Learning Disability hospitals, including Muckamore. Examples of such meetings can be found at Exhibit 4 and Exhibit 5. In addition to direct liaison with the relevant policy and professional leads, a bi-

monthly summary of RQIA activity of all registered and statutory services was prepared and circulated to TMG for its consideration.

23. Assurance and Accountability Meetings were also held twice a year with RQIA as part of sponsorship arrangements and RQIA raised specific issues and concerns in relation to MAH (for example, Exhibit 6 and Exhibit 7). These meetings were usually chaired by the Permanent Secretary, and I as the Executive Board Member (EBM) responsible for sponsor branch of RQIA or the DCMO normally attended in support. Departmental Policy colleagues and other chief professional could also attend, based on the agenda, and could be asked to provide briefing where relevant. As EBM, I also normally chaired (or delegated to a Deputy, whether that be a DCMO or Director) ground clearing meetings with RQIA prior to these Assurance and Accountability meetings. The Ground Clearing meetings are an opportunity for Senior Departmental colleagues to hold ALBs to account and any issues or concerns not resolved at these meetings are then escalated to the Assurance and Accountability meeting with the Permanent Secretary.

24. Separate to these sponsorship arrangements, and in line with Departmental practice, RQIA are required to engage directly with the relevant Departmental Policy Leads about any issues of concerns in the HSC in NI that they become aware of and are required to escalate these to respective Policy Leads who will take the necessary action. Update reports provided by RQIA to sponsor branch on its activity were also shared with relevant professional/policy leads when received (for example, Exhibit 8 and Exhibit 9).

25. Although not sent directly to me, RQIA sponsor branch would have received notifications of unannounced inspections and contacted the appropriate Departmental Policy Leads to advise that the inspection was taking place. The Department would only subsequently be contacted by RQIA if there was an issue or problem identified that RQIA needed to bring to the Department’s attention (for example, Exhibit 10).

26. RQIA sponsor branch also received copies of RQIA Failure to Comply Notices in respect of registered establishments and Improvement Notices in respect of Trust services. Again, these Notices are not routinely shared with me. Three Improvement Notices were sent to the Department on 16 August 2019 (Exhibit 11) in respect of MAH covering a wide range of issues including Staffing, Patients Physical Health Care Needs, Financial Governance, Safeguarding, Restrictive Practices, Hospital Governance & Discharge Planning. These were forwarded by sponsor branch upon receipt to the relevant Departmental Policy Lead for Mental Health and Disability, for any necessary appropriate action as required.

27. Prior to receipt of the three Improvement Notices, on 6 March 2019 RQIA issued an Article 4 Letter (Exhibit 12) to me as head of RQIA sponsor branch, copied to the CSWO and policy colleagues in Social Services Policy Group following their unannounced inspection of MAH on 26 to 28 February 2019. This was an unusual step and I do not previously recall receiving an Article 4 Letter. It is worth noting that the recommendation of special measures by RQIA has only happened a small number of times. The letter indicated that the governance and operational systems across MAH fell below that required in the Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (Exhibit 13) with respect to: Theme 1 - Corporate Leadership and Accountability of Organisations; Theme 2 - Safe and Effective Care; Theme 4 - Promoting, Protecting, and Improving Health and Social Well-being and Theme 5 – Effective Communication and Information. It recommended that the Department agree and implement a special measure for Belfast Trust, specifically in relation to MAH. The special measure that RQIA recommended was the establishment of two taskforces: a taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care; and a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community. The letter stated that the recommendations were made to improve care and treatment for people in MAH, ensuring appropriate governance arrangements to effect appropriate planning for relocation of

those who had completed their assessment and treatment into the community. Furthermore, the letter stressed the importance of ensuring that MAH is recognised as providing inpatient beds for three other Trusts and that “therefore all Trusts and the Commissioner will need to work earnestly together to effect the required improvements.” Further to this, the Chief Executive of the Belfast Trust wrote to the Permanent Secretary, copied to myself, the CSWO and the CNO, on 8 March 2019 (Exhibit 14) to update him on the ongoing improvement work being done in relation to the Muckamore Abbey Hospital Action Plan.

28. RQIA again wrote to the DCMO in my absence on the 14 March 2019 (Exhibit 15), representing sponsor branch, copied to relevant policy and professional leads, providing an update in determinations made following RQIA’s ‘Intention to Serve Improvement Notices’ meeting with the Belfast Trust on the 07 March 2019. The letter advised that following RQIA’s consideration of the Trust’s representation and of additional information received from the Trust at the meeting detailing the work it was progressing in relation to improving care and treatment of patients at MAH, RQIA made determinations again relating to the six areas of serious concern which had been previously identified including: staffing; patients’ physical health care needs; financial governance; Safeguarding practices; Restrictive practices (seclusion); and hospital governance. The letter advised that RQIA had determined that in respect of all six areas that an improvement notice would not be served at that time and that RQIA would continue to monitor the six aspects of care closely and seek evidence of improvement resulting from actions and measures by the Belfast Trust. In their letter of 14 March 2019 RQIA also again advised that their recommendation, that the Department implement a special measure for BHSCT in relation to MAH. The then Permanent Secretary was updated has on these issues by Mental Health, Disability and Older Peoples Directorate (MHDOP) in a submission on 20 March 2019 (Exhibit 16). The submission provided advice on RQIA’s recommendation to implement a special measure, suggesting that there was already a significant amount of joined up “task-force” working already taking place with the focused aim of stabilising MAH

and delivering on the discharge planning work. It also made reference to enhanced governance arrangements which had been put in place following the allegations of abuse in MAH, and the HSCB's recent establishment of a Mental health and Learning Disability Improvement Board to act as a Regional Oversight Group for the work being taken forward on resettlement/ delayed discharge. The submission advised that external expertise had been secured on an independent panel engaged by HSCB/ PHA to lead on the review of Learning Disability acute care and treatment. It also advised that the Department had recently agreed to set up monthly check point meetings between the BHSCT, HSCB, PHA and others to provide the Permanent Secretary with the relevant assurances in relation to the various strand of work in relation to the safe operation of the hospital. As a result, the submission did not recommend that the Department implement the special measures. It did recommend that the Permanent Secretary accept an invitation to meet with RQIA. The Permanent Secretary wrote to the then Chief Executive of RQIA, on the 22 March 2019 (Exhibit 17) in response to RQIA's letters of 6 and 14 March 2019 and subsequently met with the RQIA Chief Executive and Medical Director/Director of Improvement and senior Departmental Officials on 25 March to discuss inspection findings. Officials from CMO group were not in attendance.

29. In a further letter of 30 April 2019 (Exhibit 18), RQIA advised that further to an unannounced inspection on 15-17 April 2019 to assess progress regarding the Trust's action plan/Quality Improvement plan and to follow up on assurances previously provided by the Trust during discussion at the 'Intention to Serve Improvement Notices' meeting 7 March 2019 and in subsequent correspondence from the Trust to the Department, the inspection team evidenced limited progress on the areas of concern previously outlining some of the main findings from their further inspection. RQIA again recommended that the Department implements a special measure for BHSCT with respect to MAH with the establishment of two taskforces referred to in previous correspondence. RQIA had raised the potential significant implications for the safety and quality of the service being provided to patients

in MAH under their statutory responsibilities and highlighted a pressing need to ensure that senior operational nursing leadership is provided in the hospital as soon as possible and that it was essential that frontline nursing staff receive appropriate support as they continue to deliver care in the most complex and challenging environments. RQIA indicated they would be happy to meet to discuss the relevant issues and provide a more detailed update. This series of events, correspondence and Departmental action is summarised in submission from RQIA sponsor branch to me 3 May 2019 (Exhibit 19).

30. In response, on 2 May 2019 in the absence of the Permanent Secretary and the CSWO on a separate commitment, I arranged an urgent meeting with the then Director for Mental Health, Learning Disability and Older People and members of this policy team along with the PHA Director of Nursing and the DCMO to discuss the Departmental response in relation to RQIA's letter of escalation and a summary of concerns of a member of staff who contacted RQIA. On the same day, I emailed (Exhibit 20) the then CSWO and CNO advising them of the meeting and that all present were agreed on the need for greater support and appropriate challenge to the Trust, coordination by HSCB and PHA given the regional nature of the service and that assurances on progress required by the Departments from a policy and professional could be best addressed through the recommendation of RQIA for a regional task group. The email advised that the following had been agreed in principle subject to further discussion with the CSWO as policy lead:

a) Meeting to include BHSCT, RQIA, HSCB and the Department to arrive at a reconciled position and view as a Department in relation to: safety of current service; adequacy of support arrangements to staff; progress or otherwise on matters previous identified; need for additional regional or external expertise to support the Trust.

b) Regional Coordination Group – jointly chaired by HSCB and PHA.

c) Departmental Assurance Group chaired by CSSO and CNO with professional input from CMOG and RQIA.

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?

31. As set out in paras 21 to 23 above, I would have received intelligence about MAH through the Department's then arrangement and CMOG's sponsorship arrangements from RQIA. I did not receive intelligence along professional lines. For example, in an update paper for the liaison group meeting in November 2018 (exhibit 21) RQIA advised that they had received a draft report for a Level 3 SAI review carried out following the suspension of 13 staff from MAH and had requested a meeting with the Designated Review Officer for that SAI in HSCB to discuss the report. However, in line with extant Departmental practice, RQIA would have raised any issues or concerns directly with the relevant policy leads who were responsible for taking appropriate action.

32. In addition, under Article 4 of the HPSS (Quality, Improvement and Regulation (Northern Ireland) Order 2003 RQIA are required to keep the Department informed about the provision of services and in particular about their availability and their quality; encouraging improvement in the quality of services.

33. Prior to the receipt of the improvement notices detailed at paragraph 26, in my capacity as Executive Departmental Board Member for sponsorship of RQIA, I or my DCMO, received the following three Article 4 letters from RQIA, in respect of Muckamore:

- 5 March 2019 (see exhibit 12 above) - this correspondence followed RQIA's unannounced inspection of MAH from 26 to 28 February 2019. RQIA's findings included issues with staffing levels, patients' physical

health care needs, financial governance, safeguarding practices, restrictive practices, hospital governance, and discharge/ relocation planning. RQIA advised that they planned to hold an 'Intention to Serve' meeting with the Trust's Chief Executive and Executive Management Team on 7 March 2019 to discuss RQIA's intention to issue improvement notices to the Trust. They also recommended that the Department implemented a special measure for the Trust in relation to MAH by establishing a taskforce to stabilise the hospital site and a taskforce for the programme to relocate patients.

- 14 March 2019 (see exhibit 15 above) – this correspondence provided an update following the 'Intention to Serve' meeting held on 7 March 2019, the Trust's subsequent response in terms of the work they were progressing. Following an assessment of evidence provided by the Trust, RQIA determined not to serve Improvement Notices at that time but continued to recommend that the Department agreed to implement the special measure outlined above.

- 30 April 2019 (see exhibit 18 above) - This correspondence advised that RQIA had carried out an unannounced inspection on 15 -17 April 2019 to assess progress regarding the Trust's action plan/Quality Improvement plan and to follow up on assurances provided by the Trust during discussion at the 'Intention to Serve Improvement Notices' meeting on the 07 March 2019 and in subsequent correspondence from the Trust to the Department. RQIA reported that their inspection team evidenced limited progress in relation to the areas of concern previously identified and they highlighted a pressing need to ensure that senior operational nursing leadership was provided in the hospital as soon as possible. They continued to recommend the special measure outlined above.

34. The Departmental Policy Lead for Mental Health and Disability were copied into these letters for consideration and appropriate action. The Permanent

Secretary wrote to Olive Macleod, RQIA Chief Executive, on the 22 March 2019 (see Exhibit 17 above) in response to RQIA's letters of 6 and 14 March 2019 (see Exhibits 12 and 15 above). The Permanent Secretary subsequently met with the RQIA Chief Executive and Medical Director/Director of Improvement and senior DoH Officials on 25 March to discuss the inspection findings.

35. On 2 May 2019 I met with Departmental officials to discuss the Departmental response in relation to RQIA's letter of escalation of 30 April 2019 and a summary of concerns of a member of staff who contacted RQIA. As previously indicated in paragraphs 29 - 30, as I recall this was due to the Permanent Secretary and the then CSWO being out of the UK on a work commitment. The same day, I subsequently emailed the CSWO and CNO to advise them of the meeting and to suggest a further meeting with the BHSCT, RQIA and HSCB and the establishment of a regional co-ordination group and a Departmental Assurance Group to be chaired by the CSWO and CNO.

36. In response the Department subsequently established the Muckamore Departmental Assurance Group (MDAG) co-chaired by Sean Holland, the then CSWO and Charlotte McArdle, the then Chief Nursing Officer (CNO) to take forward the necessary actions in respect of Muckamore. The SMO for Mental Health and Learning Disability was the professional adviser for CMOG on this Group. A member of RQIA attended monthly meetings of this group as an observer.

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?

37. The 2003 Order established a statutory duty of quality on HSCTs under which they must have in place arrangements to monitor and improve the quality of

health and social services which it provides and the environment in which it provides them. The duty of quality extends to the services commissioned by Trusts.

38. The regulatory framework in Northern Ireland is built around the principle that providers and commissioners of services take responsibility for the quality of care delivered to individuals.

39. As commissioners, the HSCB remained responsible and accountable for the quality of the provision of service they have commissioned. As commissioners, they must ensure that there are appropriate governance arrangements in place to provide them with assurances and satisfy them in respect of the service delivered to individuals.

40. Prior to the introduction of the 2022 Act, HSC Trusts as described at paragraph 10 above were accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the Department and the HSCB for performance against Ministerial targets including compliance with any statutory obligations. Trusts must also have their own effective system for satisfying themselves and providing assurance on what they are providing/commissioning.

41. QSID within CMOG, through the regular accountability meetings, were aware of RQIA concerns in relation to MAH. As set out in the answer to question 2 above it was for the relevant policy lead rather than QSID within CMOG as RQIA's sponsorship branch to follow up issues or concerns raised as deemed necessary. I would have also normally expected any matters not requiring immediate follow-up by the policy team to be reviewed and considered as a potential agenda item at the Belfast Trust Sponsorship and Accountability Meetings with input from the policy team if additional assurances were required as described at paragraph 54.

42. QSID within CMOG received the following information regarding MAH through the mid-year assurance and accountability meetings and liaison group meetings with RQIA and sponsorship arrangements with RQIA. The purpose of RQIA providing update reports is to inform and update sponsor branch across the broad range of its activities. As previously described, Sponsor Branch will then raise issues with the relevant policy leads to substantively follow-up on issues of concern or policy matters. Sponsor Branch shares RQIA update reports with TMG and policy leads. RQIA are fully aware of the requirement to engage directly with the relevant Departmental Policy Leads on the substance of any issues of concerns in the HSC in NI that they become aware of; and indeed, it is normal RQIA process to do so. The information received by CMOG was:

- **26 November 2012** – At a liaison group meeting, RQIA expressed concerns about current staffing levels and the skills mix at Muckamore and Longstone mental health and learning disability facilities operated by the HSC Trusts. RQIA advised that it was working pro-actively with the Trusts on this to triangulate all issues and concerns and that it had received a note of concern from parents and relatives (Exhibit 22). A more comprehensive response around the Departments assessment of these concerns and any actions taken are best provided by policy officials within the Department (Social Services Policy Group) or the then HSCB (now SPPG within the Department) with whom I would have expected RQIA to inform as necessary if the concerns were regarded as material and significant.

- **February 2013** – Following an unannounced inspection of Ennis Ward, MAH, RQIA wrote to Colm Donaghy, Chief Executive of BHSCT, to outline a number of serious matters, including staffing levels. This letter was copied to myself as head of RQIA sponsor branch and to relevant policy and professional colleagues within the Department including the CSWO. RQIA sponsor branch shared this with the policy lead for appropriate action and follow up (Exhibit 23). Details of the Departments assessment

of these concerns and actions taken are best provided by departmental policy officials within Social Services Policy Group.

- **14 September 2016** – at a liaison group meeting, I understand that RQIA advised that it had received a whistleblowing disclosure on 30 August 2016 in respect of alleged understaffing and cleanliness of Moylena Ward, MAH. An unannounced inspection was undertaken on the 2 September 2016. RQIA found that the allegations made by the whistleblower were not substantiated. (Exhibit 24)

- **March 2017** – in an update report provided for the liaison group meeting, RQIA advised that it undertook an unannounced inspection of Erne Wards 1 and 2, MAH, following allegations from a whistle-blower regarding staff shortages and overcrowding of patients on the wards (Exhibit 25).

- **January 2018** – in an update report (see Exhibit 8 above) provided for the liaison group meeting, RQIA advised that they had carried out an inspection of Cranfield Ward 2, MAH, on 20 December 2017 to review staffing levels as a result of whistleblowing allegations and that staffing levels were now monitored daily by the Ward manager, was on the Trust risk register and continuing attempts were being made to address staff shortages through the use of Agency staff. This report was circulated to TMG, and relevant policy leads at G5 and G6 level (see Exhibit 9 above)

- **March 2018** – at a liaison group meeting, RQIA gave an update on the inspection carried out on 20 December 2017 relating to unsafe staffing levels. Two concerns were substantiated by RQIA regarding reduced staffing levels and non-adherence to trust policy on enhanced observations. RQIA advised that it would follow up the areas for improvement identified in the next 3 months (Exhibit 26).

- **10 April 2019** – at a liaison group meeting, RQIA referred to their update paper (Exhibit 27) and advised that an unannounced inspection had been

carried out in MAH between 26-28 February and that areas of concern relate to staffing levels, management of patients' physical health care needs, financial governance, safeguarding practices, restrictive practices and hospital governance were evidenced as below the required standards. As is covered at paragraphs 27 - 29 in response to Question 2, three article 4 letters had been forwarded to the Department recommending special measures and an Intention to Serve (improvement notices) meeting was held with the Belfast Trust on 7 March 2019 (see Exhibits 12, 15, 18 above). RQIA advised that, following this, The BHSCT provided further information and committed to making immediate improvements which will be kept under review and monitored through follow up inspection and a quality improvement plan. RQIA's Chief Executive and Medical Director/Director of Improvement had met with the Permanent Secretary and senior DoH Officials on 25 March to discuss the inspection findings.

- **January 2020** – in a Quarterly Update Report (Exhibit 28), RQIA advised that the date for compliance with respect to the three MAH Improvement Notices issued in August 2019 was 16 November. RQIA met with the Belfast Trust representatives on 2 October and 22 November to discuss progress towards compliance with the actions outlined in their three Improvement Notices. RQIA undertook a multidisciplinary inspection from 10 to 12 December, including an overnight visit, to assess the progress in respect of each of the notices and other areas of concern identified during inspections undertaken earlier this year. RQIA advised that there was evidence of considerable improvement across all of the areas assessed, including the areas for which the Improvement Notices were served. RQIA had subsequently lifted all aspects of the notice relating to staff and all but one element in each of the other two notices (financial governance and safe guarding arrangements). RQIA advised that it would continue to meet regularly with the PSNI and Belfast Trust under Adult Safeguarding Joint Protocol arrangements in relation to historic adult safeguarding

concerns. This update report was shared with TMG in February 2020 (Exhibit 29).

43. The terms of reference of the Medical Leaders Forum makes provision for members to provide organisational updates at the meeting in order for lead organisations to provide early awareness of emerging issues should they wish to do so. At the meeting on the 14 January 2019, Dr Cathy Jack as the Medical Director in the BHSCT informed members, including myself as Chair, that MAH was currently closed for admissions given staffing issues and this remained under daily review by Divisional SMT. She also advised that investigation continues regarding CCTV. There would not be detailed discussion at the meeting during organisational updates as issues reported would already be subject to appropriate action by the lead organisation and relevant authorities (Exhibit 30).

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?

44. I am not in a position to express a view on the impact of the immediate suspension of staff as I was not directly involved. As stated at paragraph 43 above, Dr Cathy Jack as the Medical Director in the BHSCT informed members of the Medical Leaders Forum on 14 January 2019, including myself, that MAH was currently closed for admissions given staffing issues and this remained under daily review by Divisional SMT. She also advised that investigation continues regarding CCTV. As previously described, there would not be detailed discussion at the meeting during organisational updates as issues reported would already be subject to appropriate action by the lead organisation and relevant authorities (see Exhibit 30 above). More generally it is unquestionably the case that the patient safety and the protection of vulnerable people and patients should be the primary consideration when such concerns are raised, and that those in receipt of such care and their families should expect that care to be provided with appropriate professional

commitment and dedication in keeping with relevant professional standards. Those who have demonstrably failed to do so have no place in providing clinical care and support and the suspension of staff in such circumstances when necessary is a proportionate and approach action to protect patients. I cannot objectively comment on whether the extent of the suspensions was in all circumstance proportionate and whether the mitigations subsequently put in place to address the associated staffing shortfalls were adequate to maintain the quality and safety of patient services. Professional and policy colleagues in Social Services Policy Group and officials in SPPG (formerly the HSCB) will be better placed to advise. More generally, a measure of any society is how it protects the most vulnerable and particularly those who have limited voice in speaking for themselves. That a health service whose purpose is to provide care to the most vulnerable, and professionals within that service who are there to provide that care, should deliberately and intently cause harm is unconscionable. Such action was undoubtedly a profound breach of trust and relevant statutory responsibilities and diminishes all with responsibility for health and social care in Northern Ireland at many levels.

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

45. I am not a member of MDAG therefore I am unable to answer this question. As co-chairs of the MDAG the then CSWO and CNO may be best placed to advise.

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:

46. **Were you aware of it?** I do not recall that I personally received or was asked to consider data demonstrating a rise in incident reports from 2011-2018 regarding inappropriate or aggressive behaviour by patients towards staff or

that any such matters were brought to my attention for professional medical advice. I would expect such matters to have been identified within the governance and reporting arrangements within MAH and the BHSCT, and that such data would be reviewed with appropriate consideration of potential contributory factors and escalated as appropriate within the BHSCT to ensure appropriate action was taken to address given the duty of care to patients and staff.

47. **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?** Again, I do not recall that I personally received notification of any operational changes with respect to the closures of wards at MAH that were made over the relevant period arising from that data. Operational decisions of that nature would normally have been matters for the BHSCT who I would have normally expected to address and to advise and escalate to the HSCB as the commissioner if there were wider matters with consequence for the current service provision given the regional nature of the services provided at MAH to three other HSC Trusts, or in circumstances requiring a change to service provision. As the commissioner of the service, the HSCB would normally expect to receive assurance on the appropriateness of the decisions being taken in relation to changes or closure of wards and would normal have advised relevant professional and policy officials in the Department if this represented a significant service change or was a cause of concern. I would also have expected the Trust to have advised RQIA as the regulator of any such decision and action with respect to changes to and closures of wards and potential consequences.

48. **What action(s) should have been taken?** I am not in a position to answer this question which would be best directed to the BHSCT and potentially relevant policy and professional leads within Social Services Policy Group and CNOG in the Department and the relevant service and professional leads in HSCB as the commissioner of services (now SPPG in the Department). I do not know the extent of their awareness of this data, their understanding of its

significance and their assessment of the appropriateness of the actions taken by the BHSCT in response if actions were taken. I am conscious that, looking back, the significance and relevance of such information and intelligence always appears clearer. However, even now in the general circumstances of the specific nature of service and the vulnerable individuals for whom that service was provided in MAH, I would have expected that data: to have been analysed in the first instance by the BHSCT to understand potential causation and contributory factors; an assessment of its relevance in the context of other intelligence and the appropriateness or otherwise of the mitigations and action taken with respect to changes in ward and ward closures; a review of the complexity of individual patient care and needs, and whether these were being adequately met by the skill mix of staff. I would also have expected this to have been shared with the HSCB, as commissioners of the service, and assurances to be provided to the relevant policy and professional leads in the Department as necessary if this data and analysis was of significant concern. Again, I make these points generally in the absence of knowledge of the details of the data, without an understanding of the factors thought to be contributing to the increase in the behaviour described, the appropriateness of the specific action taken, and in the absence of knowledge of assurances provided to or sought and by the HSCB as the commissioner and the Department from a policy perspective. As indicated previously I have no general or specialist knowledge in Learning Disability.

49. **Was this data significant in relation to the staff shortages reported by RQIA across the same timeframe?** As no such data was shared with RQIA sponsor branch, QSID within CMOG, CMOG more generally or myself, I am not in a position to answer the question as to the significance of the data demonstrating an increase in inappropriate or aggressive behaviour by patients towards staff over the time in question. More generally, given the vulnerability and dependency of people receiving care in MAH, taken in the context of what I am now aware, having reviewed all the information previously shared, were ongoing staff shortages, I would have thought that such data was significant and would and should have been a cause for

concern. In my view the data clearly suggests that investigation is required but contains limited information upon which conclusions might be drawn. I am conscious again that this is with the benefit of knowledge of subsequent events.

M10: Department of Health – Questions for Department Witnesses

50. The Inquiry has asked me the following questions in relation to the Department. I wish to advise that in order for me to answer these questions, input has been sought and provided to me from colleagues within the Department. I can identify those departmental colleagues who assisted me with information or documentation should the Inquiry consider this necessary. I have exhibited relevant documentation or identified where it might be found elsewhere in the evidence. I am content to the best of my knowledge that these responses are accurate.

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.

51. I was appointed to the post of Chief Medical Officer (CMO) for the Department in September 2006, a post I continue to hold. As CMO I have policy and strategic responsibilities for all domains of population health, including leading strategic policy development and providing advice to Minister and the Department on matter of population health improvement, health protection, emergency planning, environmental health including policy on quality improvement and HSC Research and Development.

52. At the request of the then Health Minister, and the Chair of the Belfast Trust, I took up the post of acting Chief Executive of BHSCT from December 2014 (see Exhibit 1 above) serving to February 2017. I combined this with my role as CMO. This was an unusual arrangement, and one I was hesitant to agree to given the considerable demands of both roles and potential conflicts of

interest, however it was the then Ministers view that the particular circumstances required my input as CEO for an interim period pending a substantive appointment. This was the result of particular circumstances, arising from the resignation of the previous CEO to take up another post. As the largest HSC Trust providing regional services across NI, I understand it was believed my appointment on an interim basis would ensure strategic organisational leadership within the Trust at that time. Although it was intended that this would be for a relatively short period and firewalls were put in place to ensure there were no conflicts of interest, the arrangement was not ideal. Combining the roles and responsibilities of both offices was professionally and personally demanding.

53. With the agreement of the Permanent Secretary, I appointed a Deputy Chief Executive in the Trust to support me in both my role as CEO and particularly to lead on Trust matters were there may have been a potential conflict with my role as CMO and to cover the two full days each week I spent in the Department. At all times I was available in both capacities. During this period, I recused myself from meetings of the Departments Top Management Group (TMG) given potential conflicts of interests.

54. As a member of TMG and the Departmental Board, in my role as CMO I would normally have expected any material issues or significant concerns in respective of Learning Disability Services or Muckamore Abbey Hospital specifically to have been raised through these accountability and reporting mechanisms. I do not recall any such matters be raised. Strategic operational matters of significance are still flagged through this process, as well as via the Sponsorship and Accountability arrangements for the BHSCT and RQIA which are coordinated by respective policy teams on behalf of the Department, which I will outline later in my statement.

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?

55. A summary of the evolution of HSC structures over the 20-year time period being examined by the Inquiry from 1999-2021, along with the associated oversight and accountability arrangements, is set out 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] This summary covers the establishment of Health and Social Services (HSS) Trusts and HSS Boards in the 1990's, the changes to HSC structures resulting from the Review of Public Administration in Northern Ireland in the 2000's which saw the amalgamation of 18 HSS Trusts into 6 HSC Trusts and the replacement of the 4 HSS Boards by a single regional Health and Social Care Board, and the subsequent dissolution of the HSCB in 2022 This is consistent with my own professional and personal understanding of these arrangements, and while I have summarised relevant aspects I have therefore not duplicated these in my statement.

56. 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] This includes a summary of the relevant reviews and reforms which have informed the development of oversight structures. As CMO I would have not been directly involved in the oversight of Learning Disability Services given my wider responsibilities policy and professional responsibilities. I am not a member of nor have I been a member of any groups relating to MAH. I am therefore not best placed to provide a fully informed professional view on how effective the structures and processes were in ensuring adequate oversight of MAH at Departmental level.

57. Paras 4.4 – 4.6 [MAHI - STM – 089] make reference to the HSC Framework document as the overarching summary of HSC governance and accountability

arrangements and is consistent with my understanding of the arrangements at the relevant time period.

58. In addition, at para 4.7 [MAHI - STM – 089], it also identifies a number of additional time-limited oversight arrangements for learning disability services which would also likely have related to MAH, either peripherally or in total. These were the Bamford governance structures (paras 4.8 – 4.10 [MAHI - STM – 089]), the Learning Disability Service Framework oversight arrangements, the establishment of MDAG (para 4.12) and commissioning arrangements (para 4.13 [MAHI - STM – 089]). None of these additional time limited arrangements were a substitute for the extant roles and responsibilities for HSC organisations as providers or commissioners of care or their extant statutory responsibilities. I had no direct involvement in the Bamford governance structures or in the MDAG arrangements.

59. A full copy of the Department's statement of 13 February is at [MAHI - STM - 089].

60. Some comments were made with respect to the general effectiveness of these oversight arrangements in terms of Learning Disability Services at MAH and the resettlement programme, are considered within a review commissioned by the HSCB, the "*Independent Review of the Learning Disability Resettlement Programme in Northern Ireland*," by Bria Mongan and Ian Sutherland dated July 2022 (See Exhibit 2 above - in particular section 5 with respect to Leadership and Governance). Furthermore, the effectiveness of the arrangements within the Belfast Trust and escalation of concerns are considered within "*A Review of Leadership and Governance at Muckamore Abbey Hospital*," 31 July 2020. I have fully considered these reports and their findings and recommendations which I believe to be informed and balanced are generally consistent with my own experience of oversight arrangements although some aspects of these reports I have reviewed with the benefit of hindsight. With respect to the effectiveness of these arrangements given that they did not prevent or identify the abuse and systemic failings in MAH this

may suggest that these arrangements were not effective. Consideration also needs to be given to the circumstances of concealment which arguable limits the effectiveness of any system which may not then fully prevent or identify such failings.

61. Given the scale and complexity of health and social care services by necessity the Department and the then HSCB relies on a delegated system of accountability within an extant governance and accountability framework which recognises the inherent risks in healthcare provision. Unfortunately, even in normal circumstances despite the commitment and dedication of staff things will sometimes go wrong and preventable harm occurs. This is covered more fully in paragraphs 72 to 74 below. These oversight arrangements are critically dependent on: strong partnerships between the Department and its ALBs within an evidence informed policy framework and aligned standards; sufficient and effective resource allocation; effective performance management based on robust data analysis; informed by user, patient and carer experience; and a service that is committed to learning from experience and innovation. All these elements are essential in the effective delivery of high quality public services to population we serve, and those relationships must be based on trust, shared outcomes, transparency and candour and clear lines of accountability and responsibility when things go wrong with commitment to learning and making amendments.

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

62. While incident reporting and learning when things go wrong or harm is caused is critically important as described in paragraphs 63 to 65, neither the Department nor the HSCB as the lead commissioner of services supported by the PHA, or HSCT Trusts should be solely reliant on incident reporting in respect of the oversight and assurance in respect of services provided in any HSC service including those provided in MAH. An absence of incident reporting does not provide assurance that “all is well.” More generally a robust system of governance and accountability must be based on problem

sensing and the provision of robust assurances. There are a range of reporting mechanisms which provide the HSCB as the commissioner with its extant responsibilities and the Department with information on front-line service delivery which includes those services provided at MAH. These mechanisms range from the formal reporting arrangements outlined in Q2 above through to other more specific reporting requirements such as the Delegated Statutory Function Reports associated with various statutory requirements as well as safety and quality policy functions as described at paragraph 65 and paragraphs 67 – 69 and 73. All such arrangements are dependent on how effectively they are used and need to be keep under review and updated in the evident of emerging learning and evidence of effectiveness.

Patient Safety

63. "First do no harm" is the most fundamental principle of any health care service. It should never be the case that anyone should be harmed in health and social care as a direct and deliberate action of those providing care. Despite the efforts over many years, unintentional and avoidable patient harm remains a global challenge in developed and developing healthcare systems. Patient safety is defined as "the absence of preventable harm to a patient and reduction of the risk of unnecessary harm associated with health care to an acceptable minimum" recognising the inherent risks associated with healthcare. Put simply, patient safety is a framework of activities that creates cultures, processes and procedures, behaviours, technologies and environments in health and social care that lower risks, reduces the occurrence of avoidable harm, makes error less likely and reduces the impact of harm when it does occur. Learning from examples when the experience of care is poor through complaints or when things go wrong through adverse incident reporting is an essential element. Most of the mistakes that lead to harm do not occur because of the practices of one individual or a group of health and care workers or a deliberate act, rather they are due to system or process failures that lead those providing care to make mistakes and/or

prevent them from occurring. In the case of unintentional and avoidable harm, understanding the underlying causes of errors in care is essential to a system-based approach to learning. In this, it is recognising that most errors are attributed to poorly designed system structures and processes, and that those working in health care facilities are under a considerable amount of stress in complex and rapidly changing environments. Moving from a blame to a just culture does not overlook negligent or unprofessional behaviour of those providing care. As former Chief Medical Officer for England Sir Liam Donaldson, speaking in 2004 said: "*To err is human, to cover up is unforgivable and to fail to learn is inexcusable*." (Perspectives in Health-The magazine the Pan American Health Organisation Volume 10, November 1, 2005.)

64. Ensuring the safety and quality of services has long been a key priority for the Department. This includes system and process arrangements which enable staff and service users to raise any concerns, and following investigation, receive a response or explanation addressing those concerns. A seminal report was published in December 1999 by the Institute of Medicine (IOM) in the USA '*To Err is Human: Building a Safer Health System*' (Exhibit 31) which confirmed that healthcare was not as safe as could or should be. It reported that although errors may be more easily detected in hospitals, they occur in every health care setting. The Committee found the majority of medical errors do not result from individual recklessness but because of systemic flaws in the way the health system is organised. To improve patient safety, while recognising that there were no "magic bullets", the IOM Committee made a number of recommendations that would lead to a safer health care system. This included mandatory and voluntary reporting systems to learn when harm occurs and to prevent future occurrences. It further suggested that Health care organisations must create an environment in which safety is a top priority for clinicians and Executives. This report was extremely influential in informing the policy approach to patient safety throughout the UK in early 2000's. In response, in 2000 the CMO in England, Sir Laim Donaldson published "*An Organisation with a Memory*" (Exhibit 32). This report set the scene for

improving patient safety in the NHS and further policy development throughout the UK.

65. Examples of specific reporting arrangements relevant to all HSC services (which again included MAH) include information on compliments and complaints (as outlined in Mark McGuicken's 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 McGuicken's second statement at paragraphs 66.1-66.2 [MAHI - STM - 118 – 54]), adverse incident reporting and the Early Alert (EA) system (Mark McGuicken's statement of 13 February 2023, paragraphs 13.1 – 13.21 [MAHI - STM - 089 – 57 to MAHI - STM - 089 – 63]). Examples of incidents that would have been reported through these mechanisms included staff shortages, preventable harm caused during clinical care, and incidents of abuse.

66. The policy approach taken by the Department has resulted in the development of evidence-based governance and risk management arrangements across its arms-length bodies to improve and protect patient safety. Section 13 of Mark McGuicken' s statement of the 13 February 2023 in paragraphs 13.1 to 13.21 [MAHI - STM - 089 – 57 to MAHI - STM - 089 – 63] provides an overview of mechanisms for identifying and responding to concerns and policy development by the Department. The development of this policy is part of the ongoing drive to continually improve services including risk management and planning changes of policy, see Section 14 paragraphs 14.1 to 14.11 [MAHI - STM - 089]. This included the publication by the Department of '*Best Practice, Best Care*' in 2001 which set out a framework for setting standards. These included links with the National Institute for Health and Care Excellence and the Social Care Institute (NICE) for Excellence, improving clinical governance, improving regulation of the workforce, the introduction of a statutory Duty of Quality and establishing what became the Regulation and Quality Improvement Authority. Article 34 of HPSS Order 2003 introduced a statutory duty of quality on HSC Boards and HSC Trusts to "*put and keep in*

place arrangements for the purpose of monitoring and improving the quality of health and personal services which it provided to individuals; and the environment in which it provides them", in other words, a system of clinical and social care governance (see paragraph 10). In 2003 the Department issued a circular to HSC organisations on '*Governance in the HPSS – Clinical and Social Care Governance: Guidelines for Implementatio*n' (Exhibit 33), requiring the development and implementation of clinical and social care governance arrangements in their organisations. In 2004 the Department issued a circular providing interim guidance on the need for the Department to be informed immediately about incidents regarded as serious, provided a definition of what constitutes a serious adverse incident and advised that the Department would collate information on incidents reported to it and provide relevant analysis to the Health and Personal Social Services (HPSS) organisations and agencies. These arrangements were augmented in 2003-2004 when the Department also introduced the system of Controls Assurance Standards to Health and Social Care organisations. A Clinical and Social Care Governance Support Team was appointed by the Department in 2004 to support the implementation of the statutory duty of quality across the HPSS and produced 'Social Care Governance: A Practice Workbook in 2007 and a subsequent 2nd edition in 2013. From 1 September 2008, I established the new HSC Safety Forum replacing the Support Team to proactively support the promotion of a safety culture in health and social care across Northern Ireland. The Safety Forum produced a 2009-2010 annual report outlining collaboratives being held and support on specific areas being provided to Trusts; I have included a copy of this at (Exhibit 34) From April 2009, following the establishment of the HSC Quality Improvement forum (HSCQI), the HSC Safety Forum was incorporated into that new structure.

67. Following the introduction of the 2003 Order, and specifically Article 3 of the Order, the new independent HPSS Regulation and Quality Improvement Authority was established and formally came into existence in April 2005. Under Articles 4 and 5 of the 2003 Order, it has an important role in relation to the inspection and investigation of the performance in HPSS organisations

(Health and Social Services Boards, Health and Social Services Trusts and special agencies) and reporting on their findings to the Department and informing the public through publication of their reports. The Department issued further circulars setting out arrangements for managing Serious Adverse Incident reporting in May 2005 (Exhibit 35 and in March 2006 (Exhibit 36). These circulars provided updates on work being taken forward by the Department, reinforced the need for HPSS organisations to report serious adverse incidents and near misses to the Department as part of arrangements for establishing a system of clinical and social care governance as outlined in line with the wider policy direction for quality and safety set out in 'Best Practice Best Care', and requested detail of senior managers within HPSS organisations who had responsibility for the reporting and management of adverse incidents. In March 2006, the Department published Quality Standards for Health and Social Care to underpin the statutory duty of quality on the HSC Boards and HSC Trusts. They were designed to complement standard and other guidelines already in use by organisations and provide a baseline against which organisations could assess themselves and demonstrate improvement. I have attached a copy of the Standards which have been provided to the Inquiry at Exhibit 13 above.

68. The Department also issued '*Safety First: A Framework for Sustainable Improvement in the HPSS*' in 2006 (Exhibit 37). This document outlined a commitment to the ongoing development of a safer service to improve outcomes and service user experiences in clinical and social care settings and a policy focus on linking quality and safety. In April 2006, the Department issued further guidance on adverse incident the '*Guidance Document – How to classify incidents and risk*' (Exhibit 38) providing guidance for HPSS organisations in developing or reviewing processes to assess adverse incidents and risk implications. Further circulars on amendments to the SAI process were issued by the Department in 2007 regarding the reporting and follow-up on Serious Adverse Incidents. This included HSS(SQSD) 34 2007 HSC Regional Template and Guidance for Incident Review Reports (2007) (Exhibit 39). The Department at that time had responsibility for identifying

system learning from adverse incidents and sharing this with the HSC. The Department issued '*Supporting Safer Services*' reports to HSC organisations in June 2006 and December 2007 providing an overview and key learning from Serious Adverse Incidents reported to the Department in the previous financial year and a further report was issued in September 2011 (Exhibit 40) covering learning from Serious Adverse Incidents reported to the Department between April 2007 and April 2010 before responsibility for the identification and dissemination of learning transferred to the Health and Social Care Board and Public Health Agency.

Early Alert Process and Serious Adverse Incidents

69. In January 2009 the 2009 Act came into effect. This Act restructured the Health and Social Care system with a view to putting in place a modern, citizen-centred, accountable and high-quality system of public administration and restated at Section 2 the duty on the Department to promote an integrated system of health care. Section 2(3)(i) sets out a duty on the Department to make and maintain effective arrangements to monitor and hold to account health and social care bodies for the discharge of their functions. Section 25 transferred the duties of the former Mental Health Commission to RQIA, those duties are set out in Article 86 of the Mental Health (Northern Ireland) Order 1986. In March 2009, the Department wrote to Health and Social Care organisations about a review of arrangements for the reporting of Serious Adverse Incidents. I attach a copy of the circular at MMcG/132 [MAHI - STM - 089 – 5750]. A further Departmental circular on revised arrangements for Severe Adverse Incidents, issued on 30 April 2010, advised that HSC organisations were to cease routinely reporting SAIs to the Department from 1 May 2010 and, in line with operational guidance issued by the HSCB and PHA, reporting of all incidents meeting the SAI criteria should be to the HSCB from 1 May 2010 (MMcG/133 [MAHI - STM - 089 – 5754). In keeping with these new arrangement on 28 May 2010, the Department issued the circular '*Establishment of an Early Alert System*' which provided guidance on the operation of a new Early Alert System intended to ensure that the Department

was made aware in a timely fashion of significant events occurring within HSC organisations. (MMcG/134 [MAHI - STM - 089 – 5763]) The Department issued further circulars on the operation of the Early Alert system in 2014, 2016, 2019 and 2020. MMcG/136 [MAHI - STM - 089 – 5792] Circular HSC (SQSD) 07 14 Proper use of the Early Alert System Reminder (2014); MMcG/137 [MAHI - STM - 089 – 5795] Circular HSC (SQSD) 64 16 Updated guidance on the operation of the Early Alert System (2016); MMcG/138 [MAHI - STM - 089 – 5801] Circular and MMcG/139 [MAHI - STM - 089 – 5810] Circular HSC (SQSD) 05 19 Use of the Early Alert System with respect to COVID 19 incidents (2020). In terms of the Department's process, on receipt of the Early Alert proforma, the Department's Early Alerts Team will circulate to the appropriate policy lead/leads within the Department to consider what further action (if any) they need to initiate in relation to their policy area. This may include liaising with the HSC organisation to ascertain further details surrounding the event, reminding the HSC organisation to give proper consideration as to whether or not the event also meets the criteria to be categorised as an SAI, liaising with the Private Office, the Press Office and other relevant policy areas regarding handling arrangements including preparation of a formal submission to Minister, an HSC (SQSD) letter to the service, or any other immediate action deemed necessary. Internal Departmental guidance for the operation of the EA procedure and actions for officials receiving this alert has been provided to the Inquiry MMcG/141 [MAHI - STM - 089 – 5825]. In September 2011, the Departments issued the Framework Document to meet the duty placed upon it under section 5(1) of the 2009 Act (MMcG/149 [MAHI - STM - 089 – 5956] and MMcG/310 [MAHI - STM - 129 – 451]).

Quality 2020

70. In November 2011 the Department launched "*Quality 2020 (Q2020) - a 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*." CMOG within the Department led on and coordinated its development. Objective 1 set out that as part of an increased emphasis on

high quality services, a key element to gauge the success would be an increase in the number of adverse incidents and near misses being reported as the outworking of a stronger reporting and learning culture, with a related decline in the number of serious adverse incidents (MMcG/135 [MAHI - STM - 089 – 5768]). As is outlined in Mark McGuicken's addendum statement to the MAH Inquiry of the 30 May 2023 (paragraphs 62.1 to 62.9 [MAHI - STM - 118 – 52 to MAHI - STM - 118 – 53]), the strategy included a steering group which I chaired supported by the Quality 2020 implementation team. The implementation team was co-chaired by the Director of Public health and the Director of Nursing in the PHA and was responsible for ensuring that the strategy was delivered in line with implementation plans approved by the Quality 2020 steering group. Reporting against implementation of Quality 2020 actions was organised through a number of workstreams to manage particular projects as directed by the Q2020 steering group. The strategy itself had five strategic goals and ten key supporting objectives with indicators to measure improvement. HSC organisations continue to publish their annual quality reports in November each year to coincide with World Quality Day reporting on activity under the Quality 2020 five strategic goals of: 1. transforming culture, 2. strengthening the workforce, 3. raising the standards 4. measuring improvement and 5. integrating the care.

71. It is important to note that HSC Trusts under the HPSS Order 2003 have a statutory duty of quality which requires them to have in place organisational arrangements to monitor and improve the quality of health and social care services. This duty of quality extended to the services commissioned from trusts by the HSCB until the revision to legislation in 2022 with the formation of SPPG. The duty still applies to services commissioned by the Public Health Agency. Quality 2020 did not alter these statutory requirements.

Clinical and Social Governance and Accountability Arrangements

72. Given the delegated nature of the accountability for HSC services, their quality, safety and effectiveness, the Department has developed evidence-

based governance and risk management (see section 14 of Mark McGuicken' s statement of the 13 February 2023 in paragraphs 14.1 to 14.11 [MAHI - STM - 089 - 63 to MAHI - STM - 089 – 65] and again in section 15, paragraphs 15.2 to 15.11 [MAHI - STM - 089 - 66 to MAHI - STM - 089 – 68]). Mark McGuicken describes the policy approach arrangements across arms-length bodies to improve and protect patient safety and the arrangements by which the Department seeks assurance regarding adherence by HSC organisations to standards and policy. As described, the Department commissioned HRRI Healthcare Risk Resources International consultants in 1998 to undertake a survey of the preparedness of HPSS bodies to deliver sound risk management. The survey results in 1999 provided the Department with baseline information on all of the dimensions of risk management across the HPSS, including the reporting of adverse incidents, and this provided further impetus for the work of developing the policy guidelines on risk management and governance which were set out in the '*Best Practice, Best Care*' consultation paper in 2001 (MMcG/117 [MAHI - STM - 089 – 5342]). In March 2002 a common model of risk assessment was adopted for the Department and all of its associated bodies, including the HPSS. The Australia/New Zealand model of risk management, which was already in use in the NHS in England, was adopted and promulgated to the HPSS through circulars on Corporate Governance and the Statement of Internal Control relevant I attach circulars have been provided (MMcG/142 [MAHI - STM - 089 – 5831] and MMcG/143 [MAHI - STM - 089 – 5836]).

73. As described in paragraphs 66 – 67, in January 2003, the Department issued guidelines to the HPSS on the implementation of clinical and social care governance MMcG/144 [MAHI - STM - 089 – 5839]. The circular stressed the importance of organisations taking corporate responsibility for performance and for providing the highest possible standard of clinical and social care. The circular also placed an emphasis on adverse incident management. In April 2003, the statutory duty of quality on HPSS organisations came into effect and core risk management standards were introduced as part of the establishment of controls assurance standards across the HPSS. These arrangements also

emphasised the need for an adverse incident reporting system to be in operation and the specific Controls Assurance Standard for Risk Management included a criterion on adverse incidents which requires '*an agreed process for reporting, managing, analysing and learning from adverse incidents*' to be in place. An example of the Standard has been provided at MMcG/145 [MAHI - STM - 089 – 5857]. In 2005, a project was convened under the auspices of the Safety in Health and Social Care Steering Group to enhance systems and processes in the HPSS to better manage adverse incidents and risk arrangements. This Group was mainly associated with governance and providing assurance around operating systems and processes. The Group was formally stood down in February 2020. I attach a copy of the relevant e-mail correspondence at MMcG/146 [MAHI - STM - 089 – 5883]. In April 2006, the Department issued guidance to the HPSS on how to classify incidents and risk to assist organisations in developing or reviewing processes to assess adverse incidents and their risk implications. I attach a copy of the guidance at MMcG/126 [MAHI - STM - 089 – 5580]. This was a product of the Safety in Health and Social Care Steering Group I referenced above and was designed to promote greater consistency of approach within the HPSS and to facilitate sharing of learning arising from adverse incidents. '*Promoting Quality Care*', which I have attached at MMcG/41 [MAHI - STM - 089 – 2049], provided guidance on the assessment and management of risk in mental health and learning disability services, and supported organisations in managing the potential risk that service users may cause harm to themselves or others.

74. In 2018, the Department replaced the Australia/New Zealand model of risk management with an updated approach on the basis that the Australia/New Zealand model had not been updated since 2009 and had since been superseded by an International Organisation for Standardisation (ISO) standard; ISO 31000:2018. The Department wrote to its arms-length bodies in June 2018 to advise of the change in approach. A copy of this letter has been provided to the Inquiry (MMcG/147 [MAHI - STM - 089 – 5884]).

75. After the emergence of the abuse allegations in 2017, I have been advised that from January 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. While I did not receive these, I now understand that they were sent to the then CSWO and CNO for their review and consideration.

76. While I was not directly involved, I understand that face to face monthly update meetings between the Department and the Belfast Trust were introduced from April 2019 by Social Services Policy Group following the receipt of the RQIA Article 4 letter. I understand these meetings were introduced to provide assurances in relation to the various strands of work involved in ensuring the ongoing safe operation of MAH delivery on the SAI report recommendations and the Permanent Secretary's commitments which I have referred to earlier. I understand that these meetings were attended by Departmental officials, senior staff in the BHSCT and HSCB. A copy of the action points from meeting in April 2019 that includes attendees can be found at (Exhibit 41) Policy and professional colleagues in Social Services Policy Group and CNOG will be best placed to provide detail of these meetings and progress that was made in relation to emerging issues and concerns and the commitments previously made.

77. I understand that these monthly meetings were subsequently stood down following the establishment of MDAG in August 2019 which is referenced at paragraph 36. While I was not directly involved, it is my understanding that Social Services Policy Group policy and professional colleagues in the Department commissioned update reports from the Belfast Trust on Adult Safeguarding and 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?

78. Depending on their nature, concerns may have been reported under the Serious Adverse Incident (SAI) Procedure. Mark McGuicken's statement paragraphs 13.5 [MAHI - STM - 089 – 58], 13.9 [MAHI - STM - 089 – 59] and 13.14 – 13.16 [MAHI - STM - 089 - 60 to MAHI - STM - 089 – 61] and exhibits MMcG/119 – MMcG/133 [MAHI - STM - 089 - 5408 to MAHI - STM - 089 – 5754] refer and describe several updates to the SAI procedure during the period 2004 to 2010.

79. HPSS (PPM) 06/04 - *Reporting and Follow-up on Serious Adverse Incidents: Interim Guidance* - issued in July 2004 provided interim advice to HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses, pending the issue of more comprehensive guidance on safety. Amongst other matters, the guidance highlighted the need for the Department to be informed immediately about incidents which were regarded as serious enough for regional action, where it is likely to be of public concern or where an independent review of the incident is required (MMcG/119 [MAHI - STM - 089 – 5408]).

80. A subsequent Departmental circular, issued on 30 April 2010, on revised arrangements for Serious Adverse Incident advised that HSC organisations were to cease routinely reporting SAIs to the Department from 1 May 2010 and in line with operational guidance issued by the HSCB/PHA, reporting of all incidents meeting the SAI criteria should be to the HSCB from 1 May 2010 (MMcG 133 [MAHI - STM - 089 – 5754]). As per paragraph 5.24 in Mark McGuicken's statement, in response to the findings of '*A Way To Go*', the level 3 Serious Adverse Incident review of safeguarding arrangements in Muckamore Abbey Hospital which was completed in December 2018, the Department developed the Muckamore Abbey Hospital HSC Action Plan. A copy of the original Action Plan can be found at MMcG/49 [MAHI - STM - 089 - 24 25].

81. Depending on the nature of the concern, I have been advised by Social Services Policy Group that these concerns may have been triggered through

the Department's Early Alert System (EA). This was introduced in June 2010 when responsibility for oversight of Serious Adverse Incident reporting transferred from the Department to the HSCB/PHA.

82. The Adult Safeguarding arrangements are outlined in Mark McGuicken's first statement of 13 February 2023 (pages 33-37 paragraphs 8.1 to 8.21 [MAHI - STM - 089 – 33 to MAHI - STM - 089 – 37]). I understand that there is no separate requirement to report Adult Safeguarding incidents directly to the Department or SPPG apart from those which also meet the EA criteria despite the delegated and statutory nature of these responsibilities and the professional reporting arrangement previously described in the same statement (pages 69 to 70 paragraph 15.14 to 15.18 [MAHI - STM – 089]).

83. This Early Alert 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 (Exhibit 42). The criteria and guidance provided to HSC Organisations to inform their decision for reporting incidents through the Early Alert system are as follows:

1. 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;

2. 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;

3. 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;

4. The event may attract media interest;

5. 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.

6. 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;

   iv. allegations that a child accommodated in a children's home has committed a serious offence; and

   v. any serious complaint about a children's home or persons working there.

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

84. The full guidance on the arrangements for the Early Alert reporting system is available at Exhibit 42 above.

85. Similarly under the Adult Safeguarding arrangements in Northern Ireland (the evolution of which is set out in Mark McGuicken's statement of 13 February 2023 (paras 8.1-8.21 [MAHI - STM - 089 – 33 to MAHI - STM - 089 – 37]; exhibits MMcG 68-73 [MAHI - STM - 089 – 3466 to MAHI - STM - 089 - 3716)]), "Adult Safeguarding, Prevention and Protection in Partnership" 2015, paragraph 3 outlines the specific the policy aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;

- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;

- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;

- encourage organisations to work collaboratively across sectors and on an interagency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;

- establish clear guidance for reporting concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be responded to;

- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect; and

- promote a continuous learning approach to adult safeguarding.

86. Chapter 9 of the Adult Safeguarding Policy, which is exhibited at MMcG/72 (p27 [MAHI - STM - 089 – 3680]) to Mark McGuicken's statement of 13 February 2023 [MAHI - STM – 089] described the responsibilities of professionals, provider organisation, commissioner and the RQIA. Chapter 10 (p32 [MAHI - STM - 089 – 3685]) outlines the Referral Pathway for Safeguarding Concerns, risks assessments, thresholds for referral and escalation including the arrangements for large scale or complex investigations. Policy and professional colleagues within Social Services Policy Group and SSPG will best placed to advise on the details of this policy and the referral and escalation arrangements.

87. RQIA is also required to keep the Department informed about the provision of services and in particular about their availability and their quality; encouraging improvement in the quality of services. The Adult Safeguarding, Prevention and Protection in Partnership requires RQIA to notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service.

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.

88. The Department, through Social Services Policy Group and respective policy and professional leads 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 Muckamore Abbey Hospital. This

information would not have been routinely shared with CMOG or me. This may include direct information regarding the operation of the hospital which has been commissioned for a specific reason, for example information required with respect to the resettlement programme; updates for the 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 and Trust sponsorship and accountability 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

89. During the operation of the Service Delivery Unit, from around 2006 until 2009, Patient Administration System (PAS) downloads and BSO data warehouse extracts on activity were received from BSO 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.

90. 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 Abbey Hospital (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. Following the dissolution of HSCB the SPPG, through its Performance Safety and Service Improvement Directorate, continues to collate detail on HSC system performance although the format of this information has changed. Social Services Policy Group and SPPG will be best placed to advise on these revisions and the granularity of the data now received by the Department.

91. Also, as part of previous HSC commissioning processes, following consideration and review, 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. These TDP would have been considered by the relevant policy and professional lead/leads in the Department. 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. The annual cycle of the issuing by the Department of annual Commission Plan Direction identifying priorities and targets was paused during the pandemic and then altered significantly with the close of the HSCB. SPPG will be best placed to advise of the rationale for these changes and details of these new arrangements.

92. The Department's HSC Trust sponsorship branch receives information related to governance from the BHSCT including sponsorship checklists, copies of the Trust's Board minutes, 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. During the period in question, I do not recall any relevant matters being brought to my attention through these accountability arrangements.

Delegated Statutory Functions

93. While not matters within my professional or technical competence, it is my understanding that in respect of professional oversight of the discharge of Delegated Statutory Functions (DSF), there are arrangements in place for ongoing professional oversight to deal with any issues as raised. These have

been previously described as the requirement to "maintain an unbroken line of professional oversight arrangements of such functions." The "*Leadership and Governance Review*" made recommendations for changes to the DSF reporting arrangements. I understand these arrangements were reviewed as part of HSCB migration work with the establishment of SPPG and revised reporting arrangements are set out in three OSS circulars which were exhibited to Mark's McGuicken's statement of 12 April 2024 in relation to Adult Social Care and Children's functions (Exhibit 43, Exhibit 44 and Exhibit 45). In addition, I understand the Department via Social Services Policy Group and respective professional and policy leads receives a yearly overview report on the Discharge of Statutory Functions, provided by the HSCB during its existence. SPPG continue to collate and provide the report.

Information Analysis Directorate

94. In preparation of this statement, I understand that 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 Hospital, as outlined below on a quarterly or annual basis.

95. Information includes detail on:

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

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

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

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

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

96. Detail on the format of these returns is available at (Exhibit 46, Exhibit 47, and Exhibit 48). I would not normally be sighted on this level of operational detail.

Muckamore Departmental Assurance Group (MDAG)

97. It is my understanding although the co-chairs of this group will be better able to confirm, as part of the operation of the Muckamore Departmental Assurance Group (MDAG) over its lifetime, from August 2019 to date, a variety of update material has been, or continues to be, received to help inform reporting to the Group at each meeting. I have been advised that this has included:

- 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); and

- Ad-hoc ASG process maps from the Belfast Trust.

System Audit/Accountability Reports

98. The Department received copies of health-related Northern Ireland Audit Office (NIAO) reports once published such as the NIAO General Report on the Health and Social Care Sector by the Comptroller and Comptroller and Auditor General for Northen Ireland that ran roughly annually from 2003/04 to around 2018. These reports would have at times contained references to audits of specific services, such as the administration and safeguarding of clients' monies, in mental health and learning disability wards in the Belfast Trust and would have been considered by professional and policy colleagues within Social Services Policy Group.

99. Reports in relation to mental health and learning disability would also be received from the RQIA and shared with Social Services Policy Group for consideration and any appropriate action. Examples of these include:

- Review of the Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in HSC Trusts, 2008 MMcG/248 [MAHI - STM - 118 – 1863];

- Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, 2013 (Exhibit 49);

- A Baseline Assessment and Review of Community Services for Adults with a Learning Disability, 2013 (Exhibit 50)

- RQIA Mental Health and Learning Disability Directorate Annual Report produced 2013/14 (Exhibit 51).

- Review of Adult Learning Disability Community Services – Phase II, 2016 (Exhibit 52) ; and

- Review of Emergency Mental Health Service Provision across Northern Ireland, 2019 (Exhibit 53).

100. While I would not necessarily have reviewed these, relevant reports were also received from the NI Assembly's Public Accounts Committee. Examples include:

- PAC Report on the Resettlement of Long Stay Patients from Learning Disability Hospitals, 2010; and

- PAC Report on the Safety of Services Provided by HSCTs, 2013 (Exhibit 54).

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

101. I understand soft intelligence to refer to information which arises outside the formal HSC reporting arrangements and while this does not necessarily lend itself to straightforward assessment when triangulated with other data such intelligence may be indicative of wider cause for concerns. In general, such soft intelligence may be identified by the Department 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 or carers of patients, members of the public, or staff raising concerns. Similarly, RQIA in addition to formal reviews and inspection would have access to soft intelligence which they would have used to inform their more formal processes. Other sources of such intelligence may have been occasionally provided to me through interactions with and visits to frontline services or interaction with Trust Medical Directors and similarly with other chief professionals in the Department. Prior to the emergence of allegations of abuse in MAH no soft

intelligence or concerns were raised with me and I had no concerns with respect to any systemic issues in MAH.

102. Any such soft intelligence would be triangulated 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. The HSCB and the Trust involved would also be asked to provide information on the issue raised or any areas of potential concern. Information gathered through these channels would be reviewed by the policy lead to identify any emerging trends or learning and to inform any direct intervention that may be required by the Department.

103. I understand that the Department has been unable to identify any records of specific work carried out to examine the impact of staff shortages on patient outcomes at MAH. I understand and am aware from minutes of meeting reviewed in preparation of this statement that RQIA raised issues with its sponsor branch which identify staffing issues which were I understand shared with policy colleagues. Policy colleagues will be best placed to advice of any concerns with respect to staff shortages and patient outcomes and the triangulation of soft intelligence with other data sources.

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

104. I had no role and was unaware of any decision to install or operate CCTV. It is my understanding that the decision to install and operate CCTV at MAH was an operational one for the Trust as the service provider and therefore the Department or the then HSCB now SPPG would not have been directly involved in this process. The BHSCT would be best placed to provide details on this decision. I have now been advised that the Belfast Trust notified the Department of a business case for the installation of CCTV on Cranfield and

Sixmile wards in Muckamore in 2014/15 at a cost of £127k. However as this expenditure was below the Delegated Limit set by the Department for expenditure by its ALBs, it was the responsibility of the Belfast Trust to consider within its own allocated budget. The Department selects by random sample a number of business cases for test drilling to assess compliance with financial management requirements, and it does not appear this case was one of those selected for test drilling.

105. I have been advised from a search of Departmental records, it appears the Department was first 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 now understand that 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.

106. I have been advised that 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.

107. The report of the Review of Leadership and Governance at MAH notes that a business case for the installation of CCTV was developed and approved in 2014 and cameras were first installed in MAH in 2015 (p124 – 131). I understand that no records can be found of the Department being formally advised of either of these processes.

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

108. In the course of my preparation of this witness statement, I have become aware that 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 was not directly involved in providing professional advice on the investigation of these allegations and some predate my time in the Department as CMO and others will therefore be better placed to provide additional information to assist the Inquiry if required.

Historic abuse allegations

109. I understand 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.

110. In understand that the Eastern Board with the North and West Belfast Trust undertook an initial investigation in 2005/06 focused on a particular inpatient file and related contacts. This revealed a number of concerns in relation to possible sexual abuse of other patients in the 1960s, 1970s and early 1980s. PSNI and the Department had been liaising on this and I have been advised that it was also discussed at a meeting between the then Head of the Northern Ireland Civil Service (Nigel Hamilton), Andrew McCormick, the then Permanent Secretary, and the PSNI in 2006. In order to co-ordinate and take forward the investigation, the PSNI and Health and Social Services formed a Strategic Management Group (SMG) in May 2006, chaired by the Chief Executive of the former Eastern Board, Paula Kilbane.

111. In this phase of the investigation, a further 296 Muckamore Hospital case files were retrieved and reviewed in line with police requirements (64 patient files were previously reviewed during phase 1. A 100% check of patient files targeted on the most vulnerable, i.e. children/minors and those in high-risk forensic and admission wards, in Muckamore Hospital was conducted.

112. Concerns raised as a result of that review of files were shared with PSNI in August 2007; and for the group of cases where there was a primary indication of concern, the SMG put forward two options to be considered to take forward the remainder of the investigation:

- Option 1 - to fully investigate all complaints elicited from the file search; and,

- Option 2 - to investigate only the most serious offences.

113. Following consultation with the Chief Executive of Belfast Trust, PSNI, Chief Executive of Eastern Health and Social Services Board, and in keeping with the recommendation of the SMG, it was agreed with the Department (at a meeting in June 2008) that Option 2 would be accepted.

114. As a consequence, I have been advised that interviews were carried out with a number of patients, which resulted in a number of allegations. In April 2011 the Public Prosecution Service announced in the press that, following an extensive police investigation, they had ruled out bringing anyone to court. Thus, the outcome of this comprehensive review of the issues at Muckamore did not lead to any prosecutions or convictions.

115. I understand that the SMG did, however, produce a series of five recommendations arising from this historical investigation into Muckamore as follows:

    - Accountable Officers of commissioning, providing and regulatory bodies, under the Governance duties, were to ensure that best practice in relation to the protection of children and vulnerable adults was evidenced in learning disability services.

    - A position should be reached as quickly as possible that enabled adolescent services to be commissioned in separate facilities from adult services.

    - Until this position could be reached, Trusts were asked to undertake a review of current arrangements to satisfy themselves that they had taken all reasonable steps to protect children.

- Trusts should reference the Vulnerable Adults policy and its implications for practice in situations such as these.

- All organisations were required to produce an action plan following receipt of the RQIA report on the protection of children and vulnerable adults in mental health and learning disability services.

116. I understand that the Department fully endorsed these recommendations and Andrew McCormick issued them to the HSC service for immediate action in October 2008.

117. I have been advised by policy and professional colleagues with specialist knowledge that as soon as the historic Muckamore issue came to light, the first concern was to establish that risks to children and vulnerable adults were being managed in the present day in line with current best practice.

118. I now understand that Andrew McCormick wrote to all Chief Executives of the Trusts responsible for mental health and learning disability inpatient facilities in September 2006 seeking an assurance that appropriate procedures were in place to prevent abuse of children and vulnerable adults and to ensure that any incidents that do arise are dealt with properly and effectively. He also asked that Chief Executives consider the need for a retrospective review of patients' notes. I do not have an independent recall of this albeit it is against a background of my having taken up the post of CMO on 11 September 2006 and not being directly involved.

119. I have been advised that assurances as to extant procedures from each relevant Trust were received in the Department between 2nd October 2006 and 3rd November 2006. I have been informed that the Department has been unable to locate copies of these.

120. It is also my understanding that Andrew McCormick also wrote to RQIA in September 2006 seeking an independent assurance that appropriate

procedures were in place to prevent abuse of children and vulnerable adults in mental health and learning disability hospitals on these matters.

121. Work to deliver this request took place during 2007. I understand the RQIA Overview Report of the Review of the "*Safeguards In Place For Children and Vulnerable Adults In Mental Health and Learning Disability Hospitals*" in HSC Trusts dated June 2008 MMcG/248 [MAHI - STM - 118 – 1863] was received by the Department in August 2008.

122. I understand that whilst the report identified a number of examples of good practice, there were concerns identified about the work which remained outstanding, especially in relation to staff training and the number of children and young people being treated in adult wards.

123. In light of this report Andrew McCormick wrote in October 2008 to Trust Chief Executives conveying recommendations arising from the work of SMG and requesting production of Trust action plans in response to the RQIA report.

124. In preparation of this statement, I have become aware that in January 2009 he again wrote to RQIA seeking assurance that the Trust action plans were appropriate. This assurance was I understand received from RQIA in November 2009.

125. In May 2007 I understand the Department's Deputy Secretary with responsibility for mental health and learning disability policy wrote to the five new Trust Chief Executives reiterating the need for a retrospective sampling exercise and convened a meeting with Trusts on 28 June 2007. At this meeting it was agreed that a 10% sampling exercise would be performed in each Mental Health and Learning Disability Hospital throughout Northern Ireland covering the period 1985 - 2005. I do not recall being asked to participate in, or to provide input to this meeting and this engagement and sampling exercise was led by the then relevant policy lead.

126. I believe that the Trust reports of the sampling exercise were received by the Department between September 2008 and December 2009.

127. The Department's medical, nursing and social services professional advisors reviewed the retrospective sampling reports from Trusts. While the reports were not reviewed by myself as CMO, I understand the SMO in MHLD may have contributed to the reviewing the reports given his specialist knowledge and experience. The conclusion was that the exercise had not been executed in a uniform or robust manner and options on a way forward were provided.

128. I understand that following a meeting with the PSNI in June 2011 all material obtained from the retrospective sampling exercise was handed over to the PSNI to consider and advise on how to move forward.

129. It is my understanding that the PSNI confirmed in August 2011 after a preliminary consideration that in their view there were indeed instances which would merit further investigation. As a first step, the PSNI and the HSCB agreed to reconstitute the SMG between the HSC and the PSNI which had been in operation during the early parts of this exercise in 2006-2008. The SMG led by the HSCB and the PSNI, was established to identify gaps or issues arising from the reports conducted by the EHSSB into Lissue and Forster Green Hospitals and from the wider review of MH and LD hospitals. All cases in which abuse was suspected were referred to PSNI for criminal investigation.

130. It is now my understanding in preparation of this statement that the key findings of the SMG report (Exhibit 55) were as follows:

- 77 incidents were referred to the PSNI for consideration. Where it was possible to identify either the victim or the alleged perpetrator, criminal concerns / issues were passed to the PSNI for investigation;

- PSNI identified a number of challenges including: de-criminalisation of some offences since that time; absence of identifiers, including names, of alleged victims or perpetrators in records; a number of incidents are statute barred; and some patient records have been destroyed;

- There were no prosecutions as a result of the retrospective sampling exercise or the review of the exercise, for the reasons set out above.

131. I have been advised that the Strategic Management Group was stood down once the PSNI had confirmed that the aims and objectives of the retrospective sampling process had been achieved and that the SMG had achieved its function and could be formally closed. The letter from PSNI can be provided if required.

132. I have been advised that by September 2014, the HSCB and PSNI were content that the retrospective sampling exercise was concluded and that all incidents had been investigated as far as possible. To the best of my recollection, I was not asked to provide any professional input or advice into this process or assessment and to the best of my knowledge I had no direct involvement.

Ennis Ward abuse allegations

133. I understand that 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. As head of RQIA sponsor branch, I and the then CEO of the HSCB were copied into correspondence on 1 February 2013 from the then CEO of RQIA to the then CEO of BHSCT. This correspondence related to an unannounced inspection of Ennis Ward on the 29 January with a focus on adult safeguarding arrangements. This letter confirmed that this was part of ongoing monitoring and scrutiny of Ennis Ward following allegations of abuse of patients which was currently being investigated as part of adult safeguarding investigation being led by the PSNI. The letter indicated that this inspection was further to previous unannounced

inspections on 13 November and the 20 December. The correspondence indicated RQIA's concerns in relation to staffing, behavioural support, environment and protection plans. This correspondence was also directly copied to the then CSWO as policy and professional lead and to policy colleagues within Social Services Policy Group.

134. I understand that an investigation was conducted by the Belfast Trust with the PSNI under Adult Safeguarding Joint Protocol arrangements. Two members of staff were referred to PSNI and their investigation into the allegations resulted in the prosecution of two members of hospital staff in 2014, one of whom was convicted of assault on a patient, while the other was acquitted. While I do not have the details, I note from the "*Review of Leadership & Governance at Muckamore Abbey Hospital*", 31 July 2020 that the circumstance of these allegations and the subsequent Ennis Adult Safeguarding Review are considered (paragraph 6 of the Executive Summary and pages 93 to 124, paragraphs 8.1 to 8.80 and in the Summary Comments and Recommendations).

135. As outlined above, RQIA sought assurances from the Trust and conducted a number of unannounced inspections on the ward following the allegations.

136. It is now my understanding on information I have subsequently considered that the report of the Adult Safeguarding investigation was completed in October 2013. The report identified and investigated a total of 22 incidents. These included concerns over the physical treatment of patients, the verbal treatment of patients and the lack of supervision of patients.

137. I have been advised that the Department, despite the HSCB being advised by RQIA in writing of the ongoing PSNI investigation in correspondence from RQIA dated 1 February 2013 and the Department having received an EA on 9 November 2012, that the Department only became aware of the existence of the Adult Safeguarding Report on the allegations of abuse in the Ennis Ward following media reports in October 2019, and then requested a copy

from the Belfast Trust. The Department's awareness of the concerns raised, and actions taken including correspondence with the HSCB and RQIA is addressed in paragraphs 103 to 109 of the then CSWO's statement. While I do not recall that I was not personally aware, I understand from Departmental colleagues that there may have been some awareness that an Adult Safeguarding Investigation was going on. However, I understand that such reports are not normally shared with the Department. I understand it was only provided to the Department by the Trust on 17 October 2019, and that a synopsis of the Report was considered at the MDAG meeting held on 27 November 2019. Other than the statement of the then CSWO and the review of the Ennis Ward abuse investigation by the Leadership and Governance Review I am not personally aware of action taken by way of escalation or follow up of these matters by the BHSCT to inform the HSCB or by RQIA by way of follow up with the Department. I now understand that the report was not shared with the Executive Team or Trust Board of the Belfast Trust, and no SAI investigation was completed or shared with the HSCB.

2017 abuse allegations

138. While I had no involvement, I understand that 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.

139. I have been informed that 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.

140. Following inquiries from Departmental policy and professional 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. I am not aware what reports or investigations were made under the Adult Safeguarding policy and protocols to chief professionals and policy colleagues within the Department, nor can I advise of the appropriate applications of this guidance and the associated protocols. Further EAs I understand were subsequently provided by the Trust advising that more safeguarding concerns had emerged following viewing of CCTV footage. The Department I understand immediately followed these up with the Trust and, as result of concerns about the Trust's reporting and handling of the allegations, I understand that the CSWO and CNO wrote jointly to the Trust on 20 October (Exhibit 56) to seek assurances that effective arrangements would be put in place to address the issues. The Department also, I understand, requested monthly updates to be provided to allow progress on actions taken to be monitored. Further details of the allegation of abuse and the Departments response could be best provided by relevant policy and professional colleagues within the Department.

141. I understand that on 3 November, Martin Dillon provided a Trust response to the letter of 20 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. I have been advised that Professional colleagues met with senior Trust staff on 17 November to discuss the detail of the letter of 3 November, and a subsequent briefing report which was prepared for the Trust's Quality Assurance Committee. I understand that the Department has been unable to locate any record from this meeting.

142. Following that meeting, I understand the CSWO and CNO wrote again to the Trust on 30 November (Exhibit 57) to seek further written assurances on a range of issues which were raised during the 17 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. 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.

143. I have been advised that the Trust’s response was received on 22 December (Exhibit 58) 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 also acknowledging the difficulties the Department faced in securing details and timely information from the Trust in relation to the incidents in August and October.

144. An independent Level 3 SAI review was I understand commissioned by the Belfast Trust in January 2018 into the allegations of physical abuse of patients by staff at Muckamore Abbey Hospital. It is my understanding that the Department expected the SAI process would be handled without any unnecessary delay, and subsequently raised concerns about the length of time it took for the report to be completed and signed off (Exhibit 59).

145. I have been informed that 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 met with the families on 17 December 2018 and issued a statement accepting the recommendations and committing to expediting resettlement of patients’ resident in Muckamore (MMcG/99 [MAHI - STM - 089 – 4829]). I was not asked to attend or participate in this meeting, and I understand that no record or note of the meeting has been located.

146. On 30 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 which I attended. A copy of the note of this meeting can be found at (Exhibit 60).

147. 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 20 February 2019.

148. I now understand that the monthly report for February submitted by the BHSCT raised some concerns about the current protection and safeguarding arrangements for patients in MAH and that the Department sought urgent assurance. I have been informed that the Department subsequently wrote to the Belfast Trust (Exhibit 61) and in a response from the Belfast Trust it was suggested that the Trust and Department of Health colleagues should meet formally on a monthly basis so that the Trust could provide the assurances sought given the level of operational detail and the evolving nature of this investigation (Exhibit 62). While I was not directly involved in providing professional advice on this proposal in my view this appears to have been a proportionate and appropriate arrangement which was subject to review as necessary.

149. Following two unannounced RQIA inspections at MAH on 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) 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 (see paragraph 36 above).

150. MDAG, I understand was also intended to provide support to the BHSCT staff team at Muckamore and provide a mechanism for escalating any issues they may encounter, members of the group including the BHSCT will be best placed to advise on how effective this support arrangement was. The Group I understand was also to oversee, 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 and MDAG remains in place, currently meeting on a bi-monthly basis. CMOG is not currently represented on this group although the SMO in MHLD who has since retired was previously a member representing CMOG. Unfortunately, at present, this SMO post has not been replaced.

151. I understand that a letter was sent jointly from CSWO and CNO in May 2019 (Exhibit 63) in relation to the findings of the RQIA inspection and specifically around the staffing concerns that had been identified. I have been informed that this letter requested that the Belfast Trusts priority should be to stabilise the current position including contingency planning should the MAH be unable to sustain safe and effective services. The letter I understand also reiterated the aim to resettle patients from the hospital.

152. It is my understanding that this resettlement programme which was I believe being coordinated by the HSCB had lost some momentum despite significant initial progress with no sustained progress over a number of years for a variety of reasons. While the challenges and complexity should not be underestimated, as a consequence, it is my professional view that too many people with a learning disability remained in an outmoded, outdated model of care were MAH had in effect become their home as a consequence of delays in developing and resourcing a more appropriate community-based model of care. While in all of this there were no easy or straightforward answers, in my general view with the benefit of hindsight there were some challenges with respect to policy implementation, the commissioning of appropriate services and the accountability for and performance management for the resettlement programme over a number of years. The details of this and some of the

potential barriers have been considered more fully in the Independent Review of the Resettlement Programme in Northern Ireland by Mongan and Sutherland and the conclusions which I understand have been accepted by the Department are broadly consistent with my own views. I do however accept that others may have a more considered and informed understanding and view. In this context it might be argued that the some of the circumstances and transition arrangements which arose with respect to patient environment, appropriate care and staffing may have possibly been averted. That said, none of this in anyway diminishes the responsibility of HSC provider and commissioning organisations for the quality of care provided or excuses the reprehensible abuse and deliberate harm that occurred which was a fundamental abuse of position and a breach of trust. In this respect the findings of "*A Review of Leadership & Governance at Muckamore Abbey Hospital*" referencing the loyalties of people working at MAH as reflected in "*A Way to Go Report*" are apposite at stated at page 66 paragraph 6.121: "This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust." Whilst this is ultimately a matter for this Inquiry this may be an important learning point with significant wider implications.

153. I have been informed that the Permanent Secretary and CSWO met with the Belfast Trust in a series of Liaison meetings in September 2019 (6, 13 and 25) Exhibit 64, Exhibit 65, Exhibit 66 to address concerns about the stability of the services being provided at MAH. I was not asked to participate in these meetings and the Permanent Secretary was supported by the CSWO as policy and professional lead as was appropriate.

154. I have been advised that 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. The then CSWO, Sean Holland and Rodney Morton, the Deputy Chief Nursing Officer wrote jointly on 5 July 2019 to formally ask the HSCB, as the commissioner of services in MAH in keeping with it then statutory responsibilities for quality of service commissioned as further described in the then Framework Document, 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. Work by the review team started in January 2020 and a final report was provided to the Department in August 2020.

155. Following the publication of this report, I have been advised that the Review Chair, David Bingham met with families on 5 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 with oversight and assurance on progress and implementation I understand considered by MDAG.

156. In September 2020, Minister Swann made the made the decision to call a Public Inquiry into the abuse at MAHI 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.

157. I understand the Minister met with families and carers on 7 December, 9 December and 10 December 2020 alongside 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.

158. A full chronology of MAH Adult Safeguarding related events is attached separately (Exhibit 67).

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.

159. A summary of Departmental arrangements for Workforce planning for disability care services is provided in Mark McGuicken's first statement (paragraphs 17.1 – 17.14). [MAHI-STM-089-74 to MAHI-STM-089-77]. This outlines the Department's role in strategic long-term planning across the HSC and makes clear that immediate workforce planning to deliver commissioned services is the responsibility of the Trusts. A history and overview of the related Frameworks, Strategies and reports published by the Department in this area is also included. I had no direct involvement as CMO in workforce planning and monitoring and staffing levels at MAH and colleagues in Social Services Policy Group and SPPG will be better placed to advise. While they are specialist areas outwith my professional competence, more generally given the acuity and dependency of individuals requiring care and support in MAH, appropriate skill mix and staff staffing levels are a prerequisite in providing safe and effective supportive care. In the absence of this there is a risk of detriment to both patients and staff in terms of the quality and safety of care.

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.

160. Responsibility for day-to-day operational service delivery including workforce planning at MAH is the responsibility of the BHSCT as the employer and provider of the service at MAH. Appropriate workforce planning should address issues such as effective service delivery and consideration of the quality and safety of care, safe staffing levels, operational vacancy management and recruitment. Undoubtedly the availability of specialist

nursing and medical staff trained in Learning Disability and of Health Care Support workers and resourcing constraints will have been factors that all Trusts will have found challenging. As CMO I had no direct involvement in any matters raised with the Department with respecting to ward staffing at MAH and would not normally have been involved in operational matters of this nature. With respect to any identification of staffing issues raised with sponsor branch (within QSID in CMOG) in bi monthly meetings with RQIA referred to in paragraph 42 above, I would have expected any significant matters of this nature to be raised directly by RQIA with the HSCB and PHA in their commissioning role and respective policy and professional leads in the Department to be advised if there were material concerns and assurances sought on action being taken to address. Furthermore, I would normally have expected sponsor branch to relay any significant concerns to policy colleagues for follow-up action as appropriate.

161. The Department and Workforce Policy Directorate in Health Care Policy Group (HPG) in particular has policy responsibility for longer-term strategic workforce planning and oversees a rolling programme of long-term, regional workforce reviews for this purpose.

162. 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. Issues have been flagged through the Early Alert system, and also through RQIA inspections. Examples of these are outlined below, however, the Department is cognisant of its duty to the Inquiry and continues to consider documentation in respect of all of the questions asked by the Inquiry and if any further relevant material becomes available this will be provided to the Inquiry. These would have relayed to relevant policy and professional leads for consideration as these related to nursing staffing, consideration of service implications and for appropriate action including as would normally be the case further engagement with the BHSCT and or the HSCB as the commissioner of these

services. I had no professional involvement in these considerations, nor was I asked to provide any professional advice to the best of my recollection.

Early Alerts

163. In preparation of this statement, I am now aware that issues in relation to staff shortages on wards within Muckamore have on occasion been raised with the Department through the EA process, for example EA 108/21 [Exhibit 68].

164. The operation of the Early Alert process has been outlined in Mark McGuicken's first statement (paras 13.17, 13.19 – 13.21). The operation of the Early Alert system is outlined in Mark McGuicken's statement of 13 February at paras 13.17- 13.21. [MAHI - STM - 089 – 61 to MAHI - STM - 089 – 63], this includes the various updated circulars issued by the Department on the Early Alert process and steps taken when an incident occurs.

2014/15 – 2016/17 Ward Closures/Staff Reductions

165. Mark McGuicken's Addendum statement of 26 May (paragraphs 14.1 – 14.4) set out reasons for an underspend on staffing linked to the reduction in staffing levels associated with resettlement. These are not matters which I was asked to provide advice on, and I was not previously aware.

166. A copy of Mark McGuicken's statement of 26 May statement is at [MAHI - STM – 118].

RQIA Unannounced Inspections 2019 – Article 4 Letters

167. Further to two unannounced inspections at Muckamore Abbey Hospital 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 as referenced at paragraph 33

above. This Article 4 letter was addressed to me as head of RQIA sponsor branch and copied to the CSWO in an email with the letter attached (see Exhibit 12 above). Given the significance I forwarded the letter to the policy team in Social Services Policy Group and the Director of Nursing in the PHA for consideration and further action. Following correspondence with the Department, and a follow up unannounced inspection at Muckamore, RQIA subsequently wrote to the Department again on 30 April 2019. In the absence of the CSWO and Permanent Secretary at the time of receipt, I have indicated the actions that I took on the 2 May 2019 in paragraph 30 above. 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.

Adult Safeguarding Policy

168. I am not aware of any concerns or reports, other than those previously described, being raised with respect to adult safeguarding through the then extant policy in relation to concerns about ward staffing and the potential impacts on patient wellbeing and reduction of risk and prevention of harm. While others more familiar with this policy and the professional technical aspects of adult safeguarding may be better placed to advise in my view this may be of relevance as this relates to relevant aims of this policy as described at paragraph 85 above in relation to: prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion; to promote an individual's capacity to keep themselves safe and to prevent harm occurring.

169. Further to the assurance gaps identified by the Department in the response received from the Belfast Trust on 20 June 2019, I understand that a professional Nursing advisor, Mr Francis Rice, was appointed by the CNO on 18 September 2019 to work alongside the clinicians and management in the Belfast Trust. It is my understanding that this was designed to provide professional assistance with the stabilisation of the nursing workforce

amongst other professional matters. The then CNO and CSWO would be best placed to advice of the details of this appointment and the outcome as a consequence. In preparation of this statement, I have been advised that as a result of the work undertaken in conjunction with Francis Rice, that 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 Mr Rice to the Department in February 2020 (Exhibit 69) and I have been advised that this 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.

15% Pay Enhancement

170. While I had no involvement, I now understand that due to the difficulties with staffing shortages at Muckamore which were believed to be partly 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, I now understand that this enhancement was also offered to registered nurses and healthcare assistants in Muckamore. I understand that travel costs for those willing to relocate was also agreed for reimbursement in line with existing terms and conditions of employment. I have been informed that 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

171. While I was not a member and had no active involvement professionally, 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.

172. To address this action, I understand 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. This work I have been informed is currently paused pending progress with the work on the Learning Disability Strategic Action Plan.

173. I have been advised that the HSC Action Plan also included an action for the Department at A30 to complete a review of Learning Disability Nursing. I understand a review had been commenced by CNOG in 2019, with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) then asked to undertake a review of the work following the appointment of Maria McIlgorm as Chief Nursing Officer. While I have had no direct involvement, 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). I understand that 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.

MDAG – Assurance Reporting

174. While not a member I understand that 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

Learning Disability Nursing initiatives

175. I understand that 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 on 20 June 2014. I have been advised the Action Plan sought to maximise the contribution of the learning disabilities nursing profession across Northern Ireland to ensure that the small, and highly specialist resource of Learning Disability Nurses were used to the best effect within the HSC system. I understand it was intended that implementation would be taken forward with the development of a Regional Implementation Collaborative, supported and facilitated by NIPEC through an annual progress report to the CNO.

Bengoa Report

176. 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. As a member of the then Departments Top Management Group (TMG) and the Transformation Implementation Group (TIG) this document would have discussed and considered at these meeting prior to its approval.

177. 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.

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?

178. I did not provide any professional advice or policy support to the Delivering Care Policy framework which was launched as a policy by the then Health Minister, Edwin Poots in 2014. I understand that 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. I have been advised 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. The CNO and policy colleagues in the Department and relevant professional and service leads within the PHA and the HSCB will be better placed to advise on progress on Phase 9 of the programme in relation to Learning Disability nursing, and what consideration was given to accelerating this phase when concerns at MAH arose in 2017. More generally workforce planning is complex particularly as how care and support is provided, and service models continue to evolve in the context of planned service reform as was relevant in this instance and given significant financial constraints. In addition, all workforce planning will also have had to factor in and secure the additional funding for the required increase in undergraduate training.

179. Priorities for implementation under the Framework I understand were agreed through the Chief Nursing Officer (CNO) in discussion with Executive Directors of Nursing in HSCTs and the PHA. These decisions were, I understand, informed using professional judgement, consideration of emerging service priorities, and were based on a few factors including local intelligence and regional strategic priorities. The CNO I believe commissioned

each phase formally, in written correspondence, 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.

180. I understand that 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 I have been advised having formulated an agreed normative workforce model for each phase, costed the normative standards and secured agreement with Director of Commissioning in the HSCB prior to submission to the CNO for approval. Financial constraints remain a significant challenge in workforce planning. I understand that the funding of each phase was subject to available resources and as a consequence the implementation of each approved phase was often incremental over several years.

181. While the CNO and respective policy colleagues will be best place to advice I understand that the 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.

182. The primary responsibility for safe and effective staffing however remained the responsibility of each HSCT and their respective Board notwithstanding the availability of specialist nurse staff and healthcare assistance. In turn, during this period the commissioners of services also had a statutory duty of quality with respect to all services they commissioned (see paragraph 10).

183. Initial concerns regarding abuse at Muckamore Abbey Hospital (MAH) came to light in August and September 2017. This was an emerging picture and I understand it took some time to fully understand the full scale and extent. The

CSWO as professional and policy lead for Mental Health and Learning Disabilities Service took the lead in this work. I have been advised that the CNO took the decision to seek further information to understand the complexity of the problem, the implications and action required for nursing.

184. I am now aware that on 24 November 2017 the CNO 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 HSCTs, specifically related to learning disability nursing and mental health nursing. I now understand that the report was provided to the CNO in February 2018. I do not believe that I aware of this report at the time. A recommendation from this review was to consider the inclusion of learning disability nursing in the regional Delivering Care Programme. I have been advised that at the time there were no senior registered nurses in the field of learning disability either in the Department or at the Public Health Agency to provide expert regional leadership to the programme of work and to effect Delivering Care Phase 9. The CNO subsequently secured resources to appoint a Nursing Officer for Learning Disability and this position was filled in Spring 2019. It was I understand the then CNO's view that there was need for a fundamental review of learning disability nursing services, and she duly commissioned this review as a priority on the appointment of the new nursing officer with the intent that the outcome of this review should also inform the development of phase 9. The then CNO and the Executive Director of Nursing in the PHA will be best placed to provide further details of this work.

185. A factor of significant relevance to the development of any future workforce model was the future service model to provide care and support to people with a learning disability. In 2018, the Department had 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,

an 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 have consequently significantly changed the nursing staffing requirements of Delivery Care phase 9.

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

186. 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?

187. The Department does not itself operate a systems to ensure adherence by staff to relevant professional standards. By necessity and design there is a delegated system of accountability within the Health and Social Care system within extant legislative, governance and accountability arrangements. Every professional is professionally accountable for their action to their professional regulatory body. Every doctor myself included has a professional duty to adhere to the standards set out by the General Medical Council in Good Medical Practice (GMP). The same would generally pertain to other professions although I am less familiar with the regulatory arrangements for other professions. It is the responsibility of the Belfast Trust as the employer of MAH staff, to ensure effective Human Resource policies are in place for the

recruitment and employment of staff (including agency staff), ongoing Access NI checks and continuing professional development and regulatory processes. It is also the role of the Belfast Trust to ensure that there are effective clinical and professional governance processes in place to ensure the delivery of save and effective care.

188. The Department is responsible for setting guidance and frameworks on professional standards. The operational day-to-day oversight of individual employees' and their adherence to 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 the quality and safety of care. These include the Medical Director, Director of Nursing, Director of Social Work, Acute Specialty and Clinical Directors and Clinical Leads in Trusts. The HSC Trust's Board, made up of Executive and Non-Executive Directors, has an overarching responsibility for all aspects of governance including clinical and corporate governance and must provide assurance to the Department through established channels of accountability including through Sponsorship Review meeting with the relevant sponsor branch and Accountability Review with the Departments Permanent Secretary an Accounting Officer.

189. Prior to the introduction of the Health and Social Care Act (NI) 2022, HSCTs were also accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. Prior to the introduction of this Act in 2022 and its dissolution, the HSCB also had a statutory duty of quality with respect to all the services that they commissioned. The HSCB may be able to provide further details of the previous service monitoring and performance meetings with HSC Trusts by which they sought such assurance.

190. 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, either through whistleblowing or other intelligences received as necessary.

191. An important aspect of ensuring adherence to professional standards is through the responsibility of professionals to adherence to professional standards at set out by their professional regulatory body including for the medical professionals to undertake an annual appraisal as a condition of their employment and to be subject to revalidation as described at paragraphs 9 above. There are similar employer led and professional standards requirements for other professional groups. Similarly, system regulators such as RQIA have a specific role in legislation in monitoring and ensuring that organisations comply with their own particular service or quality standards as set out by the Department within the regulatory framework within which they operate.

192. 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.

193. 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 to raise those concerns.

194. The document '*Maintaining High Professional Standards in the Modern HPSS*,' outlines the processes for use where there is a serious concern involving conduct, clinical performance and health of dental and medical employees. This sets out a framework for doctors and dentists' disciplinary and capability procedures. It covers action to be taken when a concern first

arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice. This process is currently being reviewed.

195. 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 which is set out in the Belfast Trust's Assurance Framework. These are as follows:

- **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;

- **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

- **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.

196. Statutory Professional Regulators, for example the General Medical Council (GMC) and the 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, placing restrictions on practice or ultimately removing individuals from the register and preventing them from practising. Professional Regulators are in turn overseen by the Professional Standards Authority (PSA) for Health and Social Care which operates on a UK-wide basis.

197. While less familiar I am aware that 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.

198. I am now aware that Standards for Nursing Assistants employed by HSC Trusts was published by the Department in February 2018 (Exhibit 70) 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.'

199. As described at paragraph 16, The Department did, 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.

200. 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.

201. Information on the Nursing Alert system was provided in Mark McGuicken's first statement (para 6.20 [MAHI - STM - 089 – 30]), and the reasons for discontinuing this system was provided in Mark McGuicken's second statement (paras 34.1-34.2 [MAHI - STM - 118 – 32]). I had no direct involvement in this system. As indicated at paragraph 16, CMOG maintains a professional alert procedure for doctors.

202. In respect of social work, since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards. Arrangements for professional oversight are designed to ensure that statutory functions are discharged in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions.

203. I understand that the Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the then HSCB (currently SPPG in the Department) to the CSWO, and then to the Health Minister, as set out in Circular HSS (Statutory Functions) 1/2006. This requirement and the relevant circulars has been previously described at paragraph 93.

204. I have been advised that the responsibility for the professional oversight of the system for the performance management and quality assurance arrangements for the discharge of certain specified Delegated Statutory Functions in Social Care rests with the Office of Social Services (OSS) within the Department. To manage the performance management and quality assurance arrangements for these functions, the OSS issue circulars providing frameworks, guidance and detail on legislative and structural arrangements.

205. The CSWO, I have been advised, is responsible for issuing and keeping under review all relevant circulars, professional standards, guidance or directions in respect of arrangements for the discharge of relevant functions and will best place to advise of these arrangements.

206. In terms of reporting, I understand that professional oversight is an ongoing process and takes place throughout the year with arrangements in place for any issues raised to be dealt with. The Department also receives a year end overview report on the Discharge of Statutory Functions, from the HSCB (now from SPPG within the Department), to identify any issues requiring escalation. I understand that this report is considered by the CSWO. To my knowledge it is not shared more widely outside of immediate professional and policy teams.

207. It is my understanding the end year overview report should reflect both operational performance and strategic issues and assist the HSCB and Department in their respective governance, accountability and strategic planning roles including: overview and analysis of Trusts' performance in

respect of Delegated Statutory Functions (DSFs), including good practice and performance gaps; level of compliance with the law, professional standards and targets; outcomes of in-year audit and improvement activity; emerging pressures and/or concerns; and regional comparison and trends.

208. The responsibility for the performance of the HSCB and Trusts in respect of DSFs rests with each organisation's Accounting Officer who is accountable to their respective Boards and is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs.

209. 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. Mental health and learning disability professionals' benefit by continually developing their knowledge, skills, competence and confidence to provide the best care for service users in a protected, supportive environment. For managers, supervision is an opportunity to ensure that policy is being followed and professional standards are being maintained.

210. 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 in order to maintain their skills, knowledge and competence.

211. Within the HSC all medical professionals are required to complete an annual appraisal and provide evidence of their practice across the relevant domains of the GMCs "Good Medical Practice." This includes providing evidence of their clinical practice, participation in clinical audit of treatment and care, any involvement in Serious Adverse Incidents and examples of reflective practice and learning which following discussion with their assigned appraiser culminates in the production of an annual Personal Development Plan (PDP). Consideration of these annual appraisals subsequently informs the decision of

their Responsible Officer (RO) at the end of every five year period to make a recommendation to the GMC to revalidate or not as previously outlined as paragraph 9. Within Trusts the responsibilities for annual appraisal for the CEO, Medical Director and Human Resources Director are outlined in relevant guidance. The system of annual appraisal and five yearly cycle of revalidation is designed to ensure that doctors maintain their skills, knowledge and competence and that patients receive care from doctors who adhere to the standard in GMP.

212. I understand the Northern Ireland Social Care Council (NISCC) was established in October 2002 as the body for accrediting, regulating and monitoring the social care workforce and the development of professional standards and training arrangements. While I have no involvement, I understand that the NISCC also deals with issues of professional malpractice.

213. The professional accountability for medicine are as follows: all substantive doctors including consultants are professionally accountable for their clinical practice to the General Medical Council, they are also accountable via the extant service line management structures within their organisation to the relevant Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director or equivalent and are managed using *'Maintaining High Professional Standards in the Modern HPSS – A Framework for the initial handling of concerns about doctors and dentists in the HPSS.'* (Exhibit 71). It outlines action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice. It is expected that local trust policies and procedures including those relating to misconduct complement MHPS, ensuring that MHPS is used where the conduct relates specifically to professional misconduct. The extant MHPS framework is currently being reviewed.

214. It is the professional duty of every doctor to ensure they maintain their skills and knowledge and deliver care in keeping with the standards in GMP. It is the responsibility of the Trust as the employer through its systems of governance and assurance including systems and process such as Clinical Audit, learning from Complaints and Serious Adverse Incidents and the dissemination and implementation of relevant guidance to ensure that its medical workforce is equipped to provide the best health care that can be achieved within existing resource. This is normally through investment in education, appraisal, appropriate job planning and where issues arise that are appropriate to Maintaining High Professional Standards that these are dealt with using the appropriate procedures, involvement of National Clinical Assessment Service where necessary and regulatory bodies such as the General Medical Council and General Dental Council.

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?

215. Departmental policy on resettlement, along with associated Departmental actions to deliver the policy, is set out in Mark McGuicken's first statement (section 11 [MAHI - STM - 089 – 45 to MAHI - STM - 089 – 51]). This outlines the overarching policy on resettlement from the early 1990s when the concept of "betterment" was introduced and provides an overview of subsequent work to progress resettlement, in particular the publication of the Bamford Report 'Equal Lives' in 2005. I had no direct professional involvement in the resettlement programme or oversight of its implementation.

216. I am aware that the Resettlement Programme has also been a priority for the Executive as is evidenced, for example by the 2008 PfG target that: *"By 2013,*

anyone with a learning disability is promptly and suitably treated in the community and no one remains unnecessarily in hospital".

217. It is undoubtedly challenging and complex to ensure safe and appropriate care in the community particularly for people with a Learning Disability many of whom have complex needs. Resettlement planning depends upon the availability of appropriate accommodation and continuing care and support and the associated funding for people former care for as hospital patients. It is undoubtedly the case that for too many people and for too long, hospital became their home.

218. I have subsequently ascertained in preparation of this statement that in relation to funding, additional resources of £54m (£27 recurrent) for mental health services and £33m (£17m recurrent) for learning disability services were secured under the Comprehensive Spending Review (CSR) for the period 2008-2011 to provide a range of additional services for people with a mental health and a learning disability, including the resettlement of long stay patients from mental health and learning disability hospitals.

219. I have been informed that a key difficulty in progressing resettlements was the misalignment of budgets between the DHSSPS (the Department) and Department for Social Development (DSD) for the CSR period 2008-11, where DSD revenue monies were baselined and those for DHSSPS were not. While I may have had some awareness of this issue in or around 2014, I have now been informed that for the CSR period 2011-15, the drive to increase resettlements meant the misalignment of budgets became acute. 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.

220. To address this, I now understand that DSD and DHSSPS agreed to the principle of transferring resources from the Supported Living budget to that of Resettlement, specifically for patients moving to supported living accommodation to permit the delayed schemes to progress. It was

subsequently agreed that the DSD would transfer £2m in 2012/13, increasing to £4m in 2013/14 and £6m in the current year (2014/15). I understand that DSD withdrew this £6m revenue funding in 2015/16 even though the costs of caring for the people who were resettled to supported living schemes were a recurrent and on-going cost to Trusts.

221. In September 2022, Minister Swann accepted the recommendations of the Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (See Exhibit 2 above), and confirmed he was considering options for the future of MAH.

222. The Minister subsequently announced on 24 October 2022 that signalling a clear intention to close MAH would help to support and accelerate the delivery of the long-standing policy aim on the resettlement of long-stay patients. The Department simultaneously launched a public consultation on the Minister's proposal which closed on 24 January 2023.

223. In light of the consultation findings, and also the clear direction of travel for the future of the hospital, the Permanent Secretary decided to use the powers available to him under the Northern Ireland (Executive Formation etc) Act 2022 to confirm the Minister's proposal to close the hospital. Work is continuing to resettle all remaining in patients in MAH before the hospital closes.

224. The Independent Review of the Learning Disability Resettlement Programme in Northern Ireland, Bria Mongan and Ian Sutherland dated July 2022 (see Exhibit 2 above) also identified a number of barriers to the resettlement programme.

225. Paragraph 5.2.11 (p28) notes that *'The review team felt that this balance* (between improving quality and safety of care and progressing resettlement) *wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady*

and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes.'

226. Paragraph 5.2 notes that: "*Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland… The emerging picture of extensive institutional abuse in MAH in 2018 refocused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a state of health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved*."

227. Paragraph 5.2.7 in addition notes the importance of performance management: "*Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the way of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns about the safety of MAH*."

228. Paragraph 5.3.2 further notes that while there were a number of groups including: the Mental Health and Learning Disability Leadership Group comprising directors across the HSCB and Trusts; the Regional Learning Disability Operational Group (RLDOG) reporting to the former and chaired by the HSCB. "*At times it was unclear what role the HSCB held within the RDLOG – whether their role was as a convenor and facilitator, or to lead the coordination process and undertake a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff within HSC Trusts could be variable. More clarity about leadership within the*

RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful." Again, at paragraph 5.3.3: "*The learning disability resettlement programme in Northern Ireland did not have a over-arching programme or project plan … this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population…but overall there was a sense of that the programme was fragmented.*" Furthermore at paragraph 5.3.4: *"In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more preoccupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly*."

229. Workforce issues were also identified as a barrier, as outlined in paragraph 8.2.1 of the review, *'The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.'*

230. Other known barriers include a lack of placement availability, with bespoke packages having to be provided for a number of inpatients. This has caused a delay of the progression of patients being resettled.

231. The impact of Covid-19 on the HSC undoubtedly also materially delayed the resettlement programme, with an inability to maintain many 'business as usual' activities and other health service priorities.

232. I have been advised that the ongoing work to agree a Learning Disability Service Model will seek to address these barriers and provide guidance for the future infrastructure of Learning Disability Services.

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?

233. I had no professional role in overseeing the implementation of the Bamford Vision or considering or advising on reductions in operational budgets and inpatient beds. The work coordinating the delivery of the Bamford Vision was led by the CSWO and his policy team within Social Services Policy Group. The Department would not normally have any direct role in the operational running of any Trust service including those provided by MAH. The commissioning of services to meet the needs of people living with a Learning Disability including appropriate inpatient services such as in MAH was the role of the HSCB as the service commissioner working with the Trust as the service provider.

234. In the course of my preparation of this statement, I am aware that the Department, under the 1972 Order, was responsible for providing funding for mental health and learning disability services within the overall funding available for HSC services through four Health and Social Services Boards as the commissioning bodies up until 1 April 2009. These four Boards were subsequently replaced by a single Regional Health and Social Care Board (HSCB) which took on the commissioning role regionally. As such the HSCB was responsible for commissioning, identifying population need and associated service planning and performance management. On 1 April 2022, the functions of the HSCB, including the role of commissioning were transferred into the Department, through the Strategic Planning and Performance Group which has effectively retained most of the functions of the HSCB. These include the Delegated Statutory Functions which were reviewed as part of the formation of SPPG within the Department and revised reporting arrangements are set out in three OSS circulars which were exhibited to Mark McGuicken's statement of 12 April 2024 as described in paragraph 93.

235. The commissioning process included the management of performance and resources and was previously overseen by the Department through a commissioning plan. The Health and Social Care (NI) Act 2022, in excluding Section 8 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, removed the statutory requirement for a Commissioning Plan and therefore SPPG no longer carries out this process of developing a commissioning plan. A new commissioning process is currently being developed through the Integrated Care System and colleagues in SPPG will be best able to advice on the current and future arrangements.

236. While I was not directly involved, I have been informed that one of the actions arising from both the Bamford Action Plans 2009-2011 and 2012-2015 was to implement a regional bed management protocol for those with a learning disability. This action was to be taken forward by the HSCB and for the HSCB to lead in collaboration with the HSC Trusts as set out in action 58 (page 56) of the Action plan.

237. The evaluation of the Bamford Action Plan 2012-15 (Page 6, Annex A) confirmed that, '*The HSC Board also completed a learning disability bed management protocol to govern how beds are allocated in the event of a bed shortage, which is a rare occurrence in the learning disability sector.'*

238. I have been informed that further work was undertaken as part of the MAH HSC Action Plan to progress work on a regional bed management protocol (Action 39). This involved the recruitment of a Regional Bed manager who was appointed in October 2022. Relevant colleagues in Social Services Policy Group or SPPG (formerly the HSCB) will be best place to provided additional information.

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

239. I was not personally involved in the arrangements to monitor the effectiveness of the resettlement strategy. The Departments policy on resettlement, along with associated Departmental actions to deliver and monitor the policy, are set out in Mark's McGuicken's first statement of 13 February 2023 (section 11 [MAHI - STM - 089 – 45 to MAHI - STM - 089 – 51]0). I have summarised some of the findings and recommendations of the Independent Review of the Learning Disability Resettlement Programme in Northern Ireland, Bria Morgan and Ian Sutherland dated July 2022 (see Exhibit 2 above) which the Department has accepted. This report with respect to my professional knowledge of the wider health and social structural arrangements and processes appears to also identify a number of barriers to the resettlement programme including strategic leadership, governance, commissioning, planning and performance management.

240. I understand that progress on resettlement was initially monitored through the Bamford governance structures. I was not involved in these arrangements and was not a member of any oversight or monitoring groups and others who were will be better to advise of the effectiveness of these arrangements. I understand that 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.

241. In addition, resettlement targets have also been included in the Executive's Programme for Government, and in Commissioning Plan directions. As outlined in paragraph 185, in 2018 the Department had commissioned the 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 the development of a new service model of how learning disability services would be delivered particularly the

balance across acute inpatient services and the community with concomitant changes for nursing staffing requirements.

242. 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. The need for the development of a Learning Disability strategic framework was identified by the "*Way to Go*" Report as one of its two key recommendations with a focus on the closure of the long stay hospital and a vision for a full life cycle pathway across children and adult services. The Independent Review of the Resettlement Programme by Bria Morgan and Ian Sutherland further confirmed this was needed. I understand that a draft new service model was submitted to the Department in July 2021 by the HSCB. It was decided that further work was required on this. In March 2023, the Department established a Learning Disability Task & Finish Group, underpinned by sub-groups, to include finalisation of the Learning Disability service model. I have been advised that a draft service model was presented to Trusts in March 2024, and received positive feedback and support. I understand that work is now underway to develop a costed implementation plan with a draft shared with the Task & Finish Group in May 2024.

243. The Independent Review of the Learning Disability Resettlement Programme found that the pace of resettling patients out of Muckamore was too slow and recommended the establishment of a Resettlement Oversight Board. The overarching aim of the Oversight Board was to ensure a consistent approach to resettlement across the system. As part of the work of this Board I am aware that a resettlement tracker tool was developed to monitor resettlement options for each individual patient. Work to complete the resettlement programme is continuing, with MAH set to close upon its completion. I have been advised that the Department is continuing to work with SPPG and Trusts, and other partner organisations such as the Department for Communities and the NI Housing Executive, on enhancing the current resettlement process.

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.

244. As CMO I had no professional role or direct involvement in the resettlement programme, or its implementation nor was I asked to provide professional advice to relevant policy colleagues. Professional and policy colleagues in Social Services Policy Group or in Trust sponsor branch will be better able to advise whether or not any concerns were raised by the Trust Board of the BHSCT or other stakeholders in respect of the resettlement programme and the nature of any concerns. It is important to note that the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities has been the stated overarching policy direction of the Department since the early 1990's. This I understand has been progressed in line with the ethos of betterment; in other words, 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.

245. 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. I understand that while complex and challenging some other parts of the UK have made significantly greater progress in providing care and support more appropriately in community setting and moved more quickly to close institutional care settings.

246. I have been advised in the preparation of this statement that 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 did not agree with the resettlement programme, and from patient representative groups associated with Muckamore Abbey Hospital. In addition, I understand that concerns have also been raised by patients and families on the length of time that resettlement is taking. I have been informed that these have been raised via a number of means, including correspondence received from families or elected representatives to the Minister, the Department, as a consequence of Judicial Reviews or Pre-Action Protocol letters, representations to MDAG, and the Departments ALB Accountability processes.

247. While I have not considered the detail of these concerns, I have set out below an overview of the information provided to me to assist the Inquiry in response to this question as I have had no direct involvement in these matters.

Correspondence

248. 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. I have been advised that in response the Department sought assurances from the Trusts involved on planning and implementation of resettlement for individual patients. In some instances, I believe that meetings were offered with the Health Minister or Departmental officials to hear these concerns firsthand.

Judicial Reviews/Pre-Action Protocol Letters

249. I understand that 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.

MDAG

250. Issues in relation to resettlement have I understand 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. In response to these concerns, I have been advised that the then CSWO, wrote to the Independent Providers and Directors of Adult Services in HSC Trusts on 15 September 2020 [Exhibit 72] to emphasise the need to ensure that community placements were to be treated as forever homes, and that people should not be being pressured to move and should any moves be required these were to be on the basis of the Betterment principle with appropriately planning and implementation.

251. The reluctance of some remaining patients at Muckamore to be resettled out of Muckamore Abbey Hospital I understand has also been raised. In response, the then CSWO, Sean Holland wrote to the Chief Executive of the Belfast Trust on 15 September 2020 [Exhibit 73] to ask that the Trust explore the potential for an onsite option for the resettlement of those considered suitable for such provision. The relevant Trusts, led by the Belfast Trust, carried out preliminary work to identify those patients who wished to remain onsite which I understand was four or five patients, the model of care that would be required for those patients including bespoke nursing care, the accommodation options, and associated costs involved.

252. I understand that 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 an independent review of resettlement.

253. The final report of the review, including its recommendations, was endorsed by the Health Minister on 29 September 2022 (Exhibit 74) and published on the Departmental website.

254. As a result of the recommendations, the Department established the Regional Resettlement Oversight Board, led by Dr. Patricia Donnelly, to expedite resettlement arrangements for the remaining patients in Muckamore. The Board commenced work in October 2022, reporting directly to the Permanent Secretary on progress on achieving resettlement for all patients in Muckamore. To date I am aware that the Board has achieved 12 resettlements from a baseline of 36 patients in Muckamore in August 2022. Currently there are 24 patients remaining in Muckamore with placements identified for 19 of these patients. Planning continues to expedite all remaining delayed discharges from MAH.

255. I have been advised that at an operational level the Regional Learning Disability Operational Delivery Group (RLDODG) was established in 2019, and chaired by the then HSCB, to coordinate and progress the resettlement programme, and updates from this Group were provided to MDAG. Terms of reference for this group can be found MMcG/272 [MAHI - STM - 118 – 2426]. Notwithstanding the significant challenges, I am not in a position to advise on the effectiveness of RLDODG or MDAG however I note these bodies are considered at page 25, paragraph 5.2.5 and page 29 paragraph 5.3.2 of the Independent Review of the Resettlement Programme in Northern Ireland. Following the publication of the Independent Review into Resettlement in September 2022, RLDODG was replaced in October 2022 by the Regional Resettlement Oversight Board.

256. During its lifetime, I understand that issues raised with RLDODG included the need for increased provider development and issues with housing, including caps on housing benefit and how this and universal credit were impacting on placements. RLDODG met monthly from Sept 2019 (apart from February to December 2020 due to the Covid-19 pandemic) to provide oversight regarding

the Permanent Secretary's commitment on resettlement made in December 2018, and to ensure that the development of enhanced and regionally consistent community services for people with a Learning Disability and their carers were designed to support and sustain people in their communities and avoid the need for inappropriate inpatient admission. As described in paragraph 255, the RLDODG was stood down in 2022 when the current LD Resettlement Oversight board chaired by Dr Patricia Donnelly was established.

257. The provision of housing is a key interdependency to the Resettlement programme. This requires sufficient housing units, housing support services and health and social care to enable a person with learning disabilities to be adequately supported in the community.

258. Across learning disability services, there is a growing need to provide more bespoke accommodation solutions for individuals with very complex needs and to expedite discharge from inpatient settings, and for this to be underpinned with more specialised health and social care support and in particular more investment in community based services. In terms of costs, I have been advised that the necessary care packages can range from £500k to £1.5 million per annum for a single service user, dependent on assessed need. However, the provision of housing and associated support services falls within the remit of the Department for Communities and the NI Housing Executive highlighting the need for interdepartmental work in order to progress.

259. I have been advised that at the end of 2022, the Permanent Secretary of the Department for Communities approved an uplift to the Supporting People budget, matching recent DoH uplifts to residential care, domiciliary services and supported living.

260. I understand that the Department and the Department for Communities engage frequently at a senior official level to develop policy and ensure that,

where possible, there is parity in financial support for the sector. A joint policy forum has been established to consider funding options for the continued collaboration between health and housing services.

261. In addition, I have been informed that departmental colleagues and Trusts work closely with the NIHE to ensure effective planning and commissioning to expedite the Muckamore Resettlement programme.

Trust Board

262. As part of the Accountability arrangements between the Department and the Belfast Trust, I have been informed that 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.

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

264. Updates provided since the allegations of abuse in Muckamore came to light in 2017/18 have I believe 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.

265. 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 and the timely implementation of the resettlement programme. These matters would not have been routinely shared with me.

266. Since the allegations of abuse came to light, while I have not been directly involved 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 effectiveness and delivery of the resettlement to enable well planned and effective resettlements to take place. This was I understand through groups such as MDAG and also through the work of the Regional Resettlement Oversight Board which has from my personal knowledge brought a continued focus and greater coordination and momentum 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?

267. 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 and following this there were a number of reviews and actions taken both locally and nationally.

268. The Department of Health (DH), England led a review to investigate the failings surrounding Winterbourne View, to understand what lessons should be learned to prevent similar abuse; and explore and recommend wider actions to improve quality of care for vulnerable groups. The Care Quality Commission carried out inspections at similar units and the findings contributed to the interim report. There were a number of reports published both during and after the review. (Exhibit 75)

269. I was aware of the strategic aim across the UK to reduce the over reliance on inpatient units and to provide more appropriate supportive care for people with a Learning Disability in the community in keeping with the Bamford Vision in "*Equal Lives*." Professionally, it was my view that the provision of appropriate care and support in the community with arrangements for short term assessment and respite and a reduction on the reliance on inpatient beds and the closure of institutional care provision was entirely appropriate. While familiar with the strategic policy direction in NI, I did not specifically review or consider the policy approaches in other jurisdictions. Following the abuse and failings identified in Winterbourne View Hospital as head of RQIA sponsor branch I sought assurance from RQIA with regard to regulated services for people with a learning disability. RQIA's response set out their existing systems aimed at maintaining oversight of the range of regulated and statutory sector learning disability services by way of inspections and unannounced visits and its ability to respond to incidents and other forms of "information and intelligence" that may give rise to concerns about the way in which services are being provided. A copy of the RQIA response is at (Exhibit 76).

270. In addition, the Health and Social Care Board, the Public Health Agency and the five HSC Trusts were asked to comment on the RQIA overview and add their comments and suggestions for improving the safeguards, guidelines, training and regulation in the various settings in which services for people with learning disability are delivered. These responses provided a range of assurances and also helped identify areas for further work and action covering additional guidelines, (i.e. on Advocacy Services, Challenging Behaviours and reviews of care needs day care and alternative approaches and staff training needs. I have sought these reports which I understand cannot currently be accessed and will provide these once located to assist the Inquiry.

271. The CSWO 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 to failings identified in Winterbourne View Hospital. A copy

of this is at (Exhibit 77). Tab 2 to this e-mail provides an initial draft assessment by Social Services Policy Group of action required in NI to implement locally the recommendations from the DH Transforming Care report. Social Services Policy Group will be able to advise of the detail of how this was progressed.

272. I do however understand that a number of the actions were taken forward in Northern Ireland through existing policies or as part of the development of new policies such as Transforming Your Care (TYC), the Bamford Review of mental health and learning disability services, and existing regulations and standards, the Mental Capacity Bill and the Paediatric Care Strategy.

273. Subsequently 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) [MMG/72 MAHI - STM - 089 - 3653] and 'Protocol for Joint Investigation of Adult Safeguarding Cases' (2016) [MMG/73 MAHI - STM - 089 - 3716].

274. I understand a change to the disclosure and barring arrangements for preventing unsuitable individuals from working with vulnerable groups was implemented. Subsequently CMOG initiated work to develop a service framework for mental health and learning disability. This was launched in 2013 and revised in 2015. 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 and the HSCB as the lead commissioner supported by the PHA would have used the Service Framework to set relevant standards.

Service Frameworks

275. As described in the first Witness Statement of Mark McGuicken, Director of Disability and Older People, Department of Health 13 February 2023 in paragraph 5.14 – 5.17 [MAHI - STM - 089 – 23], Service Frameworks set out clear standards of health and social care that were both evidence based and measurable. They set out the standard of care that service users and their carers should expect and were also used by health and social care organisations to drive performance improvement through the commissioning process. The service frameworks were developed for Cardiovascular health and well-being; Respiratory health and well-being; Cancer prevention treatment and care; Mental health and well-being; Learning disability; Older people; Children and young people's health and well-being.

276. The Service Framework for Learning Disability built on the approaches to supporting people with a learning disability proposed in the Bamford Review and the first Bamford Action Plan. The learning disability service framework, launched in 2012, contained 34 standards for learning disability services along with associated key performance indicators and anticipated outcomes. The 34 standards covered key thematic areas; safeguarding and communication; involvement in the planning delivery of services; children and young people; entering adulthood; inclusion and community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; aging well and palliative care and end of life care from stop. The standards provided guidance to the sector on how to: improve the health and well-being of people with a learning disability, their carers and families; promote social inclusion; reduce health inequalities and health and social well-being and improvement of the quality of health and social care services by supporting those most vulnerable in our society. Performance against service frameworks was overseen by the Service Framework Programme Board which I chaired. Implementation and monitoring of progress towards delivery of each of the framework was the joint responsibility of the HSCB and PHA as commissioners of health and social care services, who provided twice yearly progress reports to the program board.

277. The Service Framework Programme did not substitute or diminish the respective roles and responsibilities if HSC organisations in the commissioning and the provision of health and social care services or the extant statutory duty of quality for those services. The safety and quality of services was not dependent on a relevant Service Framework being in place. Service Frameworks were designed to build in quality indicators as an aid to commissioning and to supplement and build on extant arrangements for ensuring quality of services in the commissioning and delivery of services; not to replace or remove any of these extant arrangements or requirements.

278. Arrangements for ensuring safety, quality and improvement of services are outlined in Mark McGuicken's Addendum Witness Statement paragraphs 24.1 to 24.3 dated the 26 May 2023 [MAHI - STM - 118 - 24 to MAHI - STM - 118 – 25] and are also referenced at paragraph 10 in this statement. These include but are not limited to:

- The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 which established a statutory duty of quality on HSC Trusts under which they must have in place organisational arrangements to monitor and improve the quality of health and social services provided and the environment in which they provide them. The duty of quality extended at that time to the services commissioned by Trusts, by the former HSCB and by the Public Health Agency.

- HSC Trusts must ensure that that they have appropriate organisational management, clinical governance and risk management arrangements in place to provide them with assurance and satisfy themselves in respect of services delivered to individuals.

- The former HSCB (at that time) supported by the PHA must ensure the quality of commissioned services through the responsibilities for

commissioning, performance management, service improvement and resource allocation.

- The duties and responsibilities of the RQIA under Article 3 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The 2003 Order makes provision for the duties and responsibilities of the RQIA. These can be summarised as three main aims: Keeping the Department informed about the overall state and provision of health and social care services, and in particular, about their availability and their quality; Encouraging improvement in the quality of services by conducting reviews of health and social care organisations' clinical and social care governance arrangements against quality standards; and thematic and service reviews; and specific investigations as directed by the Department; Regulation of a range of establishments and agencies.

279. In 2018 the Service Framework Programme Board decided not to renew the Learning Disability Framework. I attach a copy of a letter advising of this decision at MMcG/45 [MAHI - STM - 089 – 2523]. As described in the Addendum Witness Statement of Mark McGuicken, 26 May 2023 [MAHI - STM - 118] in paragraphs 20.1 to 22.9 the Service Framework Programme Board agreed in December 2018 that the Learning Disability Service Framework had come to the end of its lifecycle. The Department decided not to commission the then HSCB and the PHA to develop a new Service Framework in this area.

280. There was general consensus among Programme Board members that the value-added purpose and role of service frameworks more generally had become unclear. In particular given the range of other evidence-based practise and standards that existed and underpinned quality of care, for example, NICE standards, and the process of developing was complex, resource intensive in terms of time and people. As I recall at the time HSCB colleagues believe there were more efficient approaches to the

commissioning of service against relevant standards. In that context, it was determined that the RQIA would carry out a review of the Service Framework Programme and its continuing utility. However, due to competing priorities, this work was paused in September 2018 and the review did not proceed, although a review of the Cardiovascular health and well-being service framework was as I recall completed by the PHA. It is worth noting that National Service Framework programmes in England and Wales were also discontinued around the same time. I have been advised that the intelligence developed through the LD Service Framework process informed the business case for a new Learning Disability Service Model (LDSM), and work to develop this new Service Model commenced in 2018.

Adult Safeguarding Training

281. While I had no involvement, arising from the Winterbourne View Hospital Scandal I am aware that a safeguarding vulnerable adult training programme targeted at the voluntary, community and independent sectors was also developed. The training programme was commissioned from Volunteer Now and was based on the guidance and standards that the Department commissioned the Volunteer Development Agency to develop, called 'Safeguarding Vulnerable Adults – A Shared Responsibility'. The aim of the Guidance was to improve safeguarding outcomes for some of the most vulnerable adults in Northern Ireland by establishing standards of acceptable practice across a range of organisational activities, including the recruitment, selection, management and supervision of staff.

282. The Department published minimum standards for day care settings in January 2012 to enhance protection arrangements for vulnerable individuals accessing care services outside of a hospital setting.

283. Professionally I am aware of and familiar with the need to avoid the unnecessary and prevent the unnecessary use and harm associated with the over medication of people with range of conditions including older people,

those living with dementia, a Learning Disability or autism. Inappropriate polypharmacy (taking multiple medicines) can lead to negative effects including adverse drug reactions, increased risk of hospital admission and increased mortality, and older people including those in care homes are at particularly high risk.

284. In Northern Ireland, pharmacy services provide individual patient-centred care for patients at increased risk of medication related harm to help them gain the best possible outcome from their medicines. These services are provided by pharmacists in different sectors who are integral members of multi-disciplinary teams, with expertise and responsibilities for reviewing medication, monitoring high-risk drugs, and considering the impact of polypharmacy for each individual. Initiatives include structured medication review by pharmacists in general practice, systematic review of medicines management processes by community pharmacists, and provision of an in-depth clinical pharmacy service to care home residents with complex medication needs by specialist clinical pharmacists in the regional Medicines Optimisation in Older People (MOOP) team. I do not now recall whether I was specifically aware of the work being progressed in England and the use of the acronym of STOMP and STAMP. Both have been subsequently included 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.

Medicines Management

285. More generally the Departments policy in respect of medicines management and optimisation and the auditing of prescribing practice is set out in paragraphs 42.1 to 43.1 [MAHI - STM - 118 – 36 to MAHI - STM - 118 – 37], pages 36 and 37 of Mark McGuicken's addendum statement dated 3 April 2023. Health policy in NI and elsewhere in the UK with respect to medicines management prior to 2016 sought to support regional best practice relating to Pharmaceutical Care and Medicines Management through the introduction of a range of services and systems for the safe and effective use of medicines,

often associated with the “five rights: ”The Right Patient; The Right Medication; The Right Dose; The Right Time and Frequency of Administration; The Right Route. With more than 14 years of expertise in developing good practice in the area of Pharmaceutical Care and Medicines Management, Northern Ireland was recognised in 2013 as one of the leading regions in Europe with 3 star reference site status for medicines management.

286. In March 2016 the NI Medicines Optimisation Framework was launched (Exhibit 78). Medicines optimisation is defined by the National Institute for Health and Care Excellence (NICE) as “a person-centred approach to safe and effective medicines use to ensure that people obtain the best possible outcomes from their medicines.” In Northern Ireland the change to medicines optimisation started with the implementation of NICE Guideline NG5 “*Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes*,” March 2015 and the recommendations of the Regulation and Quality Improvement Authority (RQIA) “Review of Medicines Optimisation in Primary Care.” However, to deliver sustainable and measurable improvements it was recognised that at a regional level a strategic approach was needed, and the Medicines Optimisation Quality Framework was developed to provide the necessary direction to support this.

287. In 2020, the Department published its ‘Transforming Medication Safety in Northern Ireland (TMSNI)’ strategy (Exhibit 79) in response to the World Health Organisation’s (WHO) Third Global Patient Safety Challenge ‘Medication without Harm’. The goal of the third Global Patient Safety Challenge on Medication Safety is to gain worldwide commitment and action to reduce severe, avoidable medication related harm by 50%, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems. The key commitments in the TMSNI strategy set out the strategic direction for improvements in medication safety across HSC organisations. An extensive Programme has been established underpinned by an implementation plan, aligned to the TMSNI Strategy, which will take forward these key commitments. Responsibility for the implementation phase

of the strategic plan now sits with Strategic Planning and Performance Group (SPPG) of the Department of Health.

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?

Structural Change and System Fragility

288. There have been a number of wider system changes and challenges in the recent years which I believe provide relevant context from a policy, commissioning and provider perspective which the Inquiry may wish to consider. Many of these are not unique to NI, rather they reflect the changing and increasing health and social care need of the population and a need to change and improve models of care with a greater emphasis on prevention, innovation and anticipatory care with greater care provide in the context of significant financial constraints, an ageing population and increasing healthcare costs.

289. In November 2015, the decision was taken by the then Health Minister, Simon

Hamilton to close the Health and Social Care Board (HSCB). This was confirmed by the then Health Minister Michelle O'Neill in October 2016 as part of the wider transformation agenda, with the intention of enhancing strategic system leadership, improving integration, and making the decision-making process more streamlined. In February 2020 the Health Minister, Robin Swann, endorsed the decision to migrate functions and staff from the HSCB by 31 March 2022.

290. During the intervening period work was underway to close the HSCB which remained as a separate entity until its dissolution under the Health and Social Care Act 2022. The functions of HSCB were in the main transferred to the newly established Strategic Planning and Performance Group (SPPG) which

now sits within the Department's structure with SPPG subsequently reporting directly to a Deputy Secretary within the Department, rather than as an ALB as has been addressed earlier. The transfer of responsibilities for the former HSCB to SPPG took place on 31 March 2022 and while I understand this proved to be relatively a straightforward transfer it did represent a major system change and was associated with some turnover in some experienced staff in the then HSCB.

291. I believe that during this period the HSCB suffered from a combination of the loss of experienced staff due to the Voluntary Exit Scheme and when trying to recruit staff may have suffered from the uncertainty arising from the publicly announced decision to close the HSCB. The absence of the Executive and functioning Assembly meant that it was not possible to deliver on the Health Ministers decisions to close the HSCB, leaving the organisation and its staff to some extent with a degree of uncertainty about the future although there were extensive efforts made by the HSCB and the Department to provide appropriate assurances.

292. The expert panel report titled "*Systems, Not Structures: Changing Health and Social Care*" published on 25 October 2016 (Bengoa Report) highlighted the substantial health inequalities in NI and the impact on the operation of the Health and Social Care system and recommended a transformational reform of NI health services. In response, in 2016 the Department published '*Health and Wellbeing 2026: Delivering Together*' setting out the Department's response to the recommendations included in the Bengoa Report and the steps to stabilise, reconfigure and to transform Health and Social Care services. Since the launch of '*Delivering Together*' in October 2016, three reports on the progress of the ring-fenced transformation funding projects have been published in 2017 (Exhibit 80), 2019 (Exhibit 81) and 2021 (Exhibit 82).

293. Moreover, there remains a fundamental need to invest more in population health, in prevention, early intervention and anticipatory care models, in

diagnostics and new treatments, and the current financial constraints and funding model constrained this shift. Whilst policy and professional colleagues in social services and nursing would be better placed to make comments, I believe that the same statements about lack of sufficient investment can be made in respect of adult social care, learning disability services, family support and children's services and community mental health services. While NI has an integrated health and social care system with health and social care provision the responsibility of health Trusts, many would argue that the full benefit of that integration has not been realised and that funding of social care services have for many years suffered because of the more visible profile of hospital waiting lists and delays at Emergency Departments.

294. Between 2017 and 2020 in general terms, in the absence of the Executive, the Department had very limited ability to take any long-term strategic decisions which was further compounded by the absence of a multi-year budget, which in turn inhibited longer term strategic planning due to uncertainties in relation to recurrent funding. While initial preparatory work on much needed wider system reform including several services reviews as described earlier had progressed, the changes required to deliver on the outcome of these reviews had yet to be implemented. Therefore, in my professional view the health service was increasingly unable to meet for example the changing health needs of an ageing population in a timely way with demands exceeding its ability to meet those demands one example of this being the unacceptable waiting times as a consequence. Others will be better able to comment on the impact on mental health and learning disability services and adult social care.

295. There has been investment and progress, and in some instances significantly so, to address some of these challenges in health and social care provision. In my view this has been more constrained that those working in frontline services or those receiving care would have wished. The Department has for example published strategies for mental health, elective care and cancer

services and has moved to the implementation stage of the review for urgent and emergency care. In addition, the Department has progressed a review of Pathology Services and an Imaging Services Review and is in the process of implementing an integrated Electronic Health and Care Record systems across the health service (encompass) and a new Laboratory Information System (LIMS). Together, with Health and Wellbeing 2026, these strategies articulate an ambitious trajectory aimed towards delivering on the recommendations of the Bengoa report in NI. Delivering this agenda will require sustained recurrent funding and public and professional support for the change required and political decisions to fully implement.

Commissioning and Performance Management

296. Sir Liam Donaldson's review of the quality of health and social care provision in Northern Ireland "*The Right Time the Right Place*" (the Donaldson Report) published in December 2014, highlighted concerns about the effectiveness of the current arrangements in Northern Ireland (Exhibit 83). In response the then Minister commissioned a review of the commissioning arrangements.

297. The Donaldson Report noted that: "There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position." (page 39, 5.2.1 Exhibit 83).

298. The Donaldson Report noted that the "*quality of the commissioning process is a major determinant in the quality of care that people ultimately receive*"

(Donaldson, 2014: 44). The Donaldson report concluded that the existing commissioning arrangements in NI are not operating as effectively as they could. Donaldson recommended that the NI commissioning system should be redesigned to make it simpler and more capable of reshaping services for the future, and that a choice must be made to adopt a more sophisticated tariff system or change the funding flow model altogether (Donaldson, 2014: 44). In addition, it is important to note that the Donaldson Report found no evidence of fundamental safety problems within the HSC in Northern Ireland, and indeed it emphasised that services here are likely to be no more or less safe than in other part of the UK. More generally, it is however generally recognised that the quality and effectiveness of commissioning is affected by several factors including resource allocation and the authority to make decisions which may be at times politically difficult. In this regard a study of integrated care in Northern Ireland, Scotland and Wales found that whatever structures are in place, the delivery of seamless integrated care is challenging (Ham et al, 2013).

299. Nonetheless, the clear perception among stakeholders in the subsequent Review of HSC Commissioning Arrangements Final Report – October 2015 commissioned by the Minister following the Donaldson Report was that there was too much emphasis placed on monitoring activity.

300. Page 21 of the report noted in the Summary of key points:

- "*need to address the perception that safety and quality of services and patient experience are not given sufficient priority in the commissioning process.*

- *potential for greater engagement with the public on the design and delivery of services, and on longer-term plans for the future of health and social care services*."

301. Page 24 of the report notes:

"*A number of interviewees expressed a view that performance management, rather than commissioning, is the primary focus of the current system. Some considered that the approach to performance management was adversarial and focused on numbers and activity rather than service improvement, quality of care, or patient outcomes*."

302. In October 2020, the Health Minister approved a programme of work on the development of an Integrated Care System (ICS) model in NI. Work is currently underway by SPPG to develop and implement the ICS model. It is intended that the ICS will provide the future framework for commissioning health and social care services based on collaboration and partnership at both area level (Area Integrated Partnership Boards) and regionally (Regional Integrated Care System Partnership Forum). This will see key stakeholders from Health and Social Care come together with representatives from local Councils, the Voluntary and Community Sector, and service users and carers to identify, understand and consider the needs of the population. The groups will focus on key areas of priority, identifying the collective assets and resources available and considering how they can be used to deliver improved outcomes for that population.

M9: Trust Board

Q1. Please identify:

- **i. The time period in which you were a member of the Trust Board.**
- **ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).**

303. I have completed this M9 as required by the Inquiry to the best of my knowledge and recollection. In the interests of transparency, to aid my memory I have sought and obtained additional information from the Trust to

inform my response and identified where I have done. While I am aware the Belfast Health and Social Care Trust will be providing evidence to the Inquiry, if it is of assistance to the Inquiry, I am willing to consider any additional identified information or documentation held by the Trust which I have not had access to. Once any further relevant documentation is available, I will consider it and with the Inquiry's permission provide an addendum statement should I consider, I can provide further relevant evidence.

304. In December 2014, at the request of the then Health Minister, and Chair of the Belfast Health and Social Care Trust (BHSCT) I was appointed Chief Executive of the BHSCT, (Exhibit 1) serving until February 2017 and during this time I was a member of the BHSCT Board. I performed this role in an acting capacity while fulfilling my responsibilities as CMO for NI. This was an unusual arrangement, and one I was initially hesitant to agree to considering the significant demands of both roles and potential conflicts of interest. Initially I did not believe it possible to manage the significant demands of both roles. I was also concerned about what I perceived to be real and potential conflicts of interests for example, being a member of the Departments Top Management Group (TMG) and Departmental Board while a CEO of an HSC Trust accountability to the BHSCT and as Accounting Officer to the Department's Permanent Secretary for the performance of the Trust. Although it was intended that this would be for a relatively short period and firewalls were put in place to ensure there were no conflicts of interests the arrangement was not ideal. Combining the roles and responsibilities of both offices was professionally and personally demanding. However, it was the then Ministers view that the particular circumstances arising from the resignation of the previous CEO to take up another post, that my appointment would ensure strategic organisational leadership within the largest HSC Trust providing regional services across NI. My appointment as CEO was in an acting capacity pending a substantive appointment and I understood that this would be for an interim period only. I was subsequently reassured that my concerns of perceived conflict of interest could be addressed and additional support arrangements were agreed to support me in my dual role as CMO and CEO.

Nevertheless, the demands personally and professionally to commit fully to the demands of both roles were significant.

305. With the agreement of the Permanent Secretary, I appointed a Deputy Chief Executive in the Trust to support me in both my role as CEO and particularly to lead on Trust matters were there may have been a potential conflict with my role as CMO. In addition the Deputy CEO covered the two full days each week I spent in the Department. At all times I was available in both capacities. During this period, I recused myself from meetings of the Departments TMG given potential conflicts of interests. My appointed as CEO and Accounting Officer of the BHSCT in December 2014 at the request of the then Minister, was with the agreement of the Chair of the BHSCT and an Accounting Officer letter was issued by the Permanent Secretary of the Department of Health confirming my suitability for my appointment to this role.

306. During this time, I attended Assurance Committee meetings. This committee was approved and established by the Trust Board of Directors as a standing committee whose purpose was to have oversight of all aspects of corporate governance, excluding finance, and to ensure a robust assurance framework is maintained. Membership of the Committee consisted of the Chairman and Non-Executive Directors of the BHSCT, with a quorum being three members. While not members of the committee the following senior Trust staff would have been in attendance:

- Chief Executive (I would have normally attended meetings between December 2014 and February 2017)
- Deputy Chief Executive/Director of Human Resources
- Medical Director
- Director of Social Work / Children’s Community Services

- Director of Nursing & User Experience

- Head of Office of Chief Executive / Co-Director Risk & Governance

- Corporate and Service Directors

307. Further information on the Assurance Committee can be found in the Terms of Reference (Exhibit 84)

308. An Assurance Group was also established to advise and assist the Assurance committee in its work. The Assurance Group would reported to the Assurance Committee through the Executive Team and I, as Chief Executive, would have chaired the Assurance Group.

309. Membership of the Assurance Group was comprised of:

- Chief Executive

- All Directors of the Trust

- Co-Director Risk & Governance

- Head of Office of the Chief Executive

310. The key duties of the Assurance Group was to provide advice to the Assurance Committee, while monitoring the assurance framework agenda for the Trust as follows:

- Review and approve the assurance updates from the Steering Groups;

    - Learning From Experience Steering Group

  - Social Care Steering Group
  - Governance Steering Group
  - Safety and Quality Steering Group
  - Equality, Engagement and Experience Steering Group

- Review of the Principal Risk Document and Corporate Risk Register prior to endorsement by the Assurance Committee and Trust Board;

- Identify gaps in Controls Assurance processes and systems and ensure action planning against these; and

- Ensure the provision of annual reports from relevant areas.

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

311. Given the passage of time I am unfortunately unable to recall the detail of the arrangements, structures, and processes in place at that time for oversight and monitoring of specific services and their effective and safe delivery. The same position pertains in respect of SAI Reviews, complaints, and ensuring learning identified and reporting and assurance arrangements to the Trust Board and the HSCB. In the interests of transparency, I have sought and obtained additional information from the Trust to inform my response and identified were I have done so to aid my memory although in all cases the recollections are mine.

312. Similarly, with the passage of time I am unfortunately unable to recall the detail of the arrangements, structures, and processes in place at that time for oversight and monitoring. Given the scale, scope and complexity of health and social services provided within the BHSCT by necessity and by design a delegated system of governance and accountability along with associated organisational structures and processes were in place to ensure the oversight of all service delivery. Within this delegated system ultimate responsibility for all aspects of governance and accountability resided with the Trust Board and with myself as Trust CEO and Accounting Officer over the period from December 2014 to February 2017.As Trust CEO and Accounting Officer , I was accountable to the Trust Board and in turn to the Department for delivering on Departmental service priorities in line with the relevant Departmental standards and guidance within existing resources. I was supported in these responsibilities by the Executive Team as the senior management team (SMT) of the Trust which met weekly. The Executive Team compromised the Divisional Directors, with whom the primary responsibility resided for the oversight of operational service performance along with the Director of Performance. The res then Divisional Director were supported by the Director of Human Resources on Human Resources policy and procedures with respect to recruitment, organisational development and induction. The Executive Team and Divisional Directors were supported by professional input from the Director of Nursing and the Medical Director and the Executive Director of Social Work as required. The Director of Finance and Deputy CEO were also member of the Executive Team.

313. The governance structure of the BHSCT is defined by a comprehensive Assurance Framework, which assigns the Board of Directors the responsibility for ensuring safe, high-quality care through effective governance systems. This framework delineates corporate objectives, identifies key risks, and implements controls to manage these risks. The Board relies on various internal and external sources of assurance, including performance management, audits, and regulatory reviews, to monitor the effectiveness of these controls. Internally this assurance would have been sought by the

Assurance Committee and Assurance Group through the Steering Groups which reported to it. The robustness of governance arrangements were dependent on matters that required MAH staff - clinical and managerial, including at Director level – to escalate concerns and to ensure appropriate intervention and action. The Assurance framework also integrates the Trust's Corporate Management Plan and Delivery Plan, aligning them with the Department of Health's performance targets and efficiency goals. Accountability mechanisms included regular reporting and dynamic risk management, ensuring that the Trust meets its statutory obligations and organisational objectives efficiently.

314. Whilst in post as CEO I had no reason for concern with respect to the oversight arrangements in place with respect to MAH. I do not recall any particular concerns being raised with me during this period. I had no concerns that there any systematic or cultural matters which required action. Given my subsequent knowledge of events which may have been occurring for some time, it is now clear that these oversight arrangements for MAH were not adequate or were not used as intended with serious matters of concern not being appropriately escalated to the Executive Team, or Trust Board. There can be no excuses, the reprehensible abuse and deliberate intentional harm caused in MAH could and should have been prevented. The reasons for why concerns which were identified within MAH including the are considered in "A Review of Leadership & Governance at Muckamore Abbey Hospital," 31 July 2020. In particular Chapter 7 of this report (pages 73 to 92, paragraphs 7.1 to 7.50. and Summary Comments and Findings) considers the leadership, management and performance management arrangements within the BHSCT, MAH, Learning Disability Directorate and Trust Board level. The report is critical of these arrangements and outlines a number of findings and contributory factors which were not factors I was aware of during my time as acting CEO.

315. The abusive behaviour that occurred was a fundamental abuse of position and a breach of trust which diminishes all concerned. I have anxiously

reflected on whether as CEO I was too accepting of the management, oversight and assurance arrangements then in place, especially given the vulnerability of the people with Learning Disability in MAH. I have also considered, and it will ultimately be for the Inquiry to decide to what extent any normal oversight arrangements would have detected what appears to have been such aberrant and criminally abusive behaviour perpetrated upon vulnerable patients largely unable to voice their concerns in circumstances where it was in the perpetrator's interest to conceal and cover up the abuse.

316. While I note all of the findings in the Leadership and Governance Review into the BHSCT, the findings of "A Review of Leadership & Governance at Muckamore Abbey Hospital" referencing the loyalties of people working at MAH as reflected in "A Way to Go Report" may be apposite as stated at page 66 paragraph 6.121:

"This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust."

317. Whilst this is ultimately a matter for this Inquiry this may be an important learning point with significant wider implications with respect to systems of assurances in certain environments.

Q3. To your recollection, how often was MAH included on the agenda of:

i. Meetings of the Trust Board.

ii. Meetings of the Executive Team.

318. I do not now recall the frequency with which Learning Disability Service more generally or MAH specifically was included on the agenda of Executive Team meetings or meeting of the Trust Board although I do not recall that this was frequent or regular. As I recall, there were arrangements in place to consider and review the annual report on Delegated Statutory Functions at meeting of Trust Board, Assurance Committee and Executive Team. In addition a Social Care Committee was established by the Chair of the Board, chaired by a Non-Executive Director to review these reports and more generally to consider adult and children's social care and community services. I had no reason at the time to believe that there was any deficiency in these oversight arrangements or the frequency with which Learning Disability Services generally or MAH specifically were considered at Executive Team or Trust Board. Executive team members and Divisional Directors would normally have provided updates on particular services or escalated areas of concerns to the Executive Team and I would have expected that they would do so as necessary

319. The Trust Board and Executive Team seldom included individual facilities on their respective agendas. Given the scale and complexity of the Trust, to my recollection, issues which were discussed at that level generally focused on services and matters would have been raised to the Trust Board on an escalated issue or exceptionality basis. As CEO I would have reasonable expected any such concerns to be brought to my attention by relevant Directors and discussed at meeting of the Executive Team and Trust Board as was the case with other services.

320. According to documentation provided by the Trust for my consideration, MAH was not specifically included on the agenda of either Trust Board or Executive Team meetings. Following review of the documents there are 12 instances in which MAH was referenced within papers provided to the Trust Board during my time as acting CEO, however, the references are not material as they do not report issues or concerns at MAH. The minutes of these meetings do not reflect that MAH was specifically discussed. There are 3 high level references

to MAH within the minutes of the Executive Team meetings which are in relation to organisation of meetings held at MAH and do not discuss issues or concerns at MAH. These references include: At the Executive team meeting on 29 April 2015, my reflection on recent visits to Old See House and Muckamore Abbey Hospital and suggestion that a future Trust Board meeting could be held on this site; At the Executive team meeting on 1 July 2015, it was noted that there was a lack of WiFi available in the MAH boardroom ahead of the Trust Board meeting scheduled for 2 July 2015; The Executive team meeting on 3 February 2016 was held at the MAH site. Both the Trust Board Meeting 2 July 2015 and the Executive Team meeting 3 February 2016 are expanded upon in question 4.

Q4. Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

321. I did have occasions to visit the MAH on a number of occasions during the period December 2014 – February 2017. In my time as CEO I established the arrangements whereby meetings of the Executive Team and Trust Board would rotate it’s meeting location around various Trust facilities and sites and to introduce a senior management team “walkabout” prior to or after the Executive Team meetings and to provide an opportunity to engage directly with frontline staff. This included an Executive Team meeting in MAH which occurred at least once during this time (on 3 February 2016 (Exhibit 85) this meeting had a standard agenda and I do not recall MAH as being specifically discussed. On 2 July 2015 a Trust Board Workshop was held at MAH (Exhibit 86), to my recollection again MAH was not specifically discussed and nor where any concerns raised in relation to the treatment of patients at MAH. As I recall the Trust Board received a presentation from a service user with a Learning Disability during this meeting. These visits were not as a result of issues escalated to myself, the Executive Team or the Trust Board rather visits to Muckamore Abbey Hospital that I initiated.

Q5. Did the Trust Board receive reports on the following (and if so, please indicate how often):

i. Safeguarding of patients at MAH.

ii. Seclusion rates at MAH.

iii. Complaints relating to MAH.

iv. Resettlement of patients from MAH.

iv. Staffing (both establishments and vacancies) at MAH.

322. In addition to formal meetings of the Executive Team, Trust Board and various Executive Committees and Committees of Trust Board, during my time As CEO I would have at least regular weekly meetings with the then Chair of the Trust Board. The Chair would have also had regular meetings with the other Executive Directors of the Trust.

323. To my recollection the Trust Board did not receive any reports specifically relating to MAH in my time as CEO and this service was not a standing agenda item. Reports received by the Trust Board were focused on service delivery across the BHSCT and individual facilities would only have been discussed if an issue was escalated to the Executive Team and in turn to the Trust Board.

324. MAH was referenced on page 28 of the Adult Safeguarding report (Exhibit 87) which was shared with the Trust Board as a paper for the meeting held on 7 July 2016. Reference to MAH was with regards to dedicated safeguarding staffing:

"Muckamore Abbey Hospital (MAH) continues to have one Band 7 Designated Officer post although the post holder has just retired. Recruitment for a replacement is underway. The community service is now fully staffed with 1.5 WTE Band 7 staff although this has only recently been the case. This service takes referrals about abuse where a staff member is the alleged perpetrator or where issues of care quality in a group setting are such that they could be categorised as neglect. It is therefore this service which leads on most of the large scale complex institutional care investigations. The Service Area has benefitted greatly from the specialist dedicated resource but part of its strength lies in its very close working relationships with other Service Area staff who know the service users very well."

325. This report was part of the Discharge of Statutory Functions papers prepared by the Social Work Governance Directorate, however to my recollection and according to the minute of the meeting this report was not discussed individually.

326. The Delegated Statutory Function report (DSF) (Exhibit 88) was tabled and discussed at the Trust Board meeting of 7 July 2016. The Trust Board minutes (Exhibit 89) record that the report is prepared on a HSCB template used by all five Trusts designed to address the assurance arrangements underpinning the delivery of these services across the individual Service Areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions and identifies on-going and future challenges in the provision of such services. The minutes record that Trust Board members were reminded that the Trust, as a corporate entity, is responsible in law for the discharge of statutory social care functions delegated to it under the Health and Personal Social Services (NI) Order 1994 and that the Trust is accountable to the HSCB for the discharge of such functions and is obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge and that the Scheme for Delegation provides the overarching assurance framework for the discharge of statutory social care

functions. The minutes further record the establishment of a new Social Care Committee chaired by Ms Anne O'Reilly, Non-Executive Director and attended by Professor Martin Bradley, Non-Executive Director.

327. References to MAH included: Mental Health Review Tribunals; Patients admitted to MAH due to lack of availability of beds within the Western Trust; Complex needs of patients resettled from MAH presenting with co-morbid drug and alcohol addiction or mental illness; staffing and the role of the core social work team within MAH and recruitment of a replacement following the departure of a temporary social worker. The DSF did not highlight any patient safety concerns.

328. To my recollection and following review of the minutes of the Trust Board meeting of 7 July 2016, a high level discussion was had in relation to the DSF, however no single facility including MAH was individually discussed.

329. I have no recollection of reporting regarding seclusion or complaints related to MAH being discussed at the Trust Board, however the Assurance Group and Assurance Committee received a quarterly Complaints and Compliments Report, which I have detailed under Q7.

330. I suggest that the BHSCT is best placed to answer this question. Should any further documentation be identified by the Trust or the Inquiry I should be happy to consider this and provide any further information that might arise.

Q6. If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

i. Who prepared those reports?

ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?

iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

331. I do not recall any specific reports on MAH, and due to the passage of time I cannot recall who prepared each individual report. The matters set out in 5 (i)-(v) would not have been monitored at board level due to the high-level overview contained within reports to the Trust Board. Matters discussed at Trust Board level were focused on service delivery across the BHSCT and individual facilities would only have been discussed if an issue was escalated to the Trust Board.

332. As CEO I would have been expected matter or reports of significant concern to be escalated to the myself, to the Executive Team and to Trust Board for their information and consideration and to provide assurance on action being taken to address.

Q7. Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

333. I have no recollection of any concerns being raised at the Executive Team for my attention or being considered at Trust Board.

334. In my capacity as CEO and chair of the Assurance Group I would have attended the Assurance Committee as an observer but did not have membership. Further reports that contained reference to MAH were received by the Assurance Committee and Assurance Group, to my recollection these reports would have been at a very high level and not specifically detailed issues or concerns individual facilities unless specifically escalated. These reports included:

i. RQIA/ASPC inspection reports, which I have further detailed in Q13

ii. Legal Services quarterly and annual reports, which provided the Assurance Committee a high-level overview on volume claims of negligence both professional and clinical across BHSCT. example **(Exhibit 90)** References to MAH include: “Bostock House, RGH site: Responsible for the management of all Clinical Negligence Claims relating to the RGH, Mater, MPH and Muckamore Abbey hospitals. Coroner’s Inquests relating to the above hospitals are also managed from this office”. Referenced on Table 2 “NEW PROFESSIONAL NEGLIGENCE CLAIMS - APRIL 2011 - MARCH 2016” with three complaints over this time period. Referenced on Table 4 - "As well as the year of treatment (as above) the following table shows the Service Groups and hospital/community locations to which the 241 new claims have been assigned :-" one compliant prior to April 2001. Table 8 Expenditure - one Claim with damages of £30,000 - Table 9 confirms the allegation was "failure to supervise" but does not provide further information.

iii. Trust Incident reports provided a breakdown of the incidents reported Trust-wide during the period, including Independent Sector Nursing Homes and Domiciliary providers. Incident information is provided on the type of person affected, Directorate, severity and category and is presented in graphs and tables. The top 5 incident categories are then further broken down to provide more detail. These reports would have been provided to the Assurance Group for noting by the Medical Director. Example **(Exhibit 91).** Referenced in tables ‘Abuse etc of staff by patients’ & ‘Abuse etc of patient by patient’.

iv. MAH was referenced in the quarterly Complaints and Compliments report, a high level report to the Assurance Group and Assurance Committee which provided updates in relation to formal complaints received by BHSCT across all services and facilities **(Exhibit 92)**. These reports were focused on volume of complaints across the BHSCT and provided assurance that relevant procedural process was being followed. The reports did not give details of specific complaints and was not a means to raise concerns or substitute for formal escalation

v. IPC (Infection Prevention Control) Annual report

vi. Water Safety Annual Report

vii. Catering Food Hygiene and Nutrition Annual Report

viii. Fire Safety Annual Report

Q8. What arrangements were in place at Trust Board 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 Trust Board to ensure that MAH staff skills matched MAH patient needs.

335. Matters with respect to appropriate staffing levels and skill mix would have been normally managed as appropriate at Divisional and Directorate level within existing operational service line management arrangements with input from relevant professional leads and human resources. Issues would only have been escalated to the Executive Team and the Trust Board if deemed to be significant and serious. During this time I have no recollection of concerns being brought to my attention at Executive Team or raised at Trust Board.

Q9. Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

336. I have no recollection of the Trust Board's approach to cost savings and efficiencies in relation to MAH specifically with exception of: Reference in the Annual Report 14-15 (Exhibit 93) regarding use of donations and fundraising to assist the provision of multisensory therapy equipment and updating of the swimming pool at MAH; Reference to the sale of surplus land at the MAH site as detailed in the 2016 Trust delivery plan (Exhibit 94) which was tabled for

discussion in draft form at a meeting of the Trust Board 06 August 2016, I cannot recall MAH being specifically discussed at this meeting. During my time as CEO as I recall there were significant challenges across the HSC with the requirement of all Trusts to make financial savings.

Q10. From 2010 onwards, following bed closures at MAH:

i **How did the Trust Board assure itself that the reorganisation of wards was safe?**

337. I was CEO of the Trust from December 2014 to February 2017. I do not recall being briefed on bed closures at MAH and the reorganisations of wards during this period. Such matters would have been the immediate responsibility of the Divisional Director and managerial and service teams. I would have expected any concerns with respect to the quality or safety of services to have escalated and discussed at the SMT with input from the Director of Social Work, the Director of Nursing and Medical Director as appropriate. As appropriate the Trust Board would normally have sought assurances on arrangements and the oversight of any significant service reorganisation and similarly the HSCB and the Department.

ii Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

338. I do not recall significant concerns regarding staff levels being brought to my attention as CEO or raised at meeting of the Executive Team or Trust Board during my time as CEO. I would normally expect and require significant concerns of this nature, should they be identified, to be appropriately escalated so assurance on appropriate action could be confirmed and mitigation put in place to manage any attendant risks. The Delegated Statutory Function report (DSF) (see Exhibit 88) was tabled and discussed at

the Trust Board meeting of 7 July 2016. (Adult Safeguarding Report April 2016.pdf) - Referenced on page 28, "The Service Area continues to have a number of dedicated safeguarding staff. Muckamore Abbey Hospital (MAH) continues to have one Band 7 Designated Officer post although the post holder has just retired. Recruitment for a replacement is underway. The community service is now fully staffed with 1.5 WTE Band 7 staff although this has only recently been the case."

339. The minute of the Trust Board meeting also references to the recent transfer of Trust recruitment processes to the Business Service Organisation and some delays in recruitment and selection processes as a consequence: "After an enquiry from Mr McNaney, Ms O'Reilly commented that there were concerns with regard to the lengthy recruitment process, Dr McBride advised that this now sits with the Business Services Organisation and that all service areas are reporting delays in recruitment, Human Resources are working hard to remedy the situation and staff from the HR Directorate in Belfast meet weekly with BSO to assist with the recruitment issues. Any pause in the rollout of the recruitment function would dilute the service. A recovery plan is being developed and the situation appears to be improving, workforce leads provide updates for the weekly meeting."

Q11. Were any issues relating to MAH ever included in:

i. The Delegated Statutory Functions Report?

ii. The Corporate Risk Register?

If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

340. As discussed in response to question 5, the Delegated Statutory Function report (DSF) (see Exhibit 88) was tabled and discussed at The Trust Board

meeting of 7 July 2016. References to MAH included: Mental Health Review Tribunals; Patients admitted to MAH due to lack of availability of beds within the Western Trust; Complex needs of patients resettled from MAH presenting with co-morbid drug and alcohol addiction or mental illness; Staffing and the role of the core social work team within MAH and recruitment of a replacement following the departure of a temporary social worker. The DSF did not highlight any patient safety or quality of service concerns at MAH.

341. To my recollection and following review of the minutes of the Trust Board meeting of 7 July 2016, a high level discussion was had in relation to the DSF, the effectiveness of the additional oversight of arising from the work of the new Social Care Committee however no single facility including MAH was individually discussed **(see Exhibit 89)**.

342. I have no recollection of MAH being included on the Corporate Risk Register which would have been prepared by the Executive Team for discussion and agreement by the Trust Board. The Trust would also have been required to provide input into the Departments Assurance Statement prepared by the Permanent Secretary of the Department as principle accounting officer and CEO of the HSC with respect to any matters requiring escalation. To the best of my knowledge no concerns with respect to MAH were escalated during my time as CEO.

Q12. Were SAIs which occurred at MAH always reported to the Trust Board? If so:

i. What information did the Trust Board receive in respect of SAIs?

ii. Were SAIs discussed at Trust Board meetings?

i. What actions did the Trust Board take in response to SAIs?

343. Given the passage of time I am unable to directly recall the arrangements in place at that time for oversight and monitoring of SAI Reviews, ensuring learning identified and reporting arrangements to the HSCB and the Trust Board. In the interests of transparency I have sought and obtained information from the Trust to inform my response.

344. The SAI Review and Complaints Review group reported to the Learning from Experience Steering Group which would in turn report to the Assurance Group. To my recollection when SAI's or Early alerts had been tabled as an agenda item I would normally have declare a potential conflict of interest caused by role as CMO and be excused from the meeting (Exhibit 95). If such SAI were raised as an Early Alert with the Department such matters might be anonymised in general terms and brought to my attention for professional input and advice within the Department by policy colleagues or by one of my DCMOs and this ensured no real or potential conflict of interest.

Q13. How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

345. I am not aware nor do I know recall any inspection reports with recommendations for action or improvement notices being issued by RQIA to the Trust Board during my time as CEO of the Trust.

346. During my tenure as CEO the Assurance Group and Assurance Committee received RQIA inspection reports regarding announced and unannounced inspections of BHSCT facilities. The reports received by the Assurance Group and Committee detailed where an inspection had been conducted, if it was announced or unannounced and if recommendations were made. The reports did not provide further detail as to the nature of recommendations.

347. Following review of the Adult Social and Primary Care (ASPC) Inspections documents provided by BHSCT, there are 12 references to inspections of MAH facilities that had been shared with the Assurance Group and Assurance Committee, ten and two respectively. Example of reports received (Exhibit 96) (Exhibit 97). These reports provide a high level overview of inspections conducted across a number of service areas and BHSCT facilities. Within (Exhibit 96) RQIA carried out unannounced inspections of three wards within MAH. The report provided a view of total number of recommendations [Cranfield Women (0 Recommendations), Moylena (1 Recommendation), Killead (14 Recommendations)] for each ward but provided no further detailed information as to the nature of these recommendations. (Exhibit 97) is an example of an ASPC Inspection Document which was originally provided to the Assurance Group prior to receipt by the Assurance Committee prior to the Assurance Committee meeting 7 February 2017, to which I had not been an attendee. The report again details a high-level overview of inspections conducted across a number of service areas and BHSCT facilities. One unannounced inspection was conducted in a MAH ward [Killead (1 recommendation)] and specific findings from this inspection are not detailed nor is information regarding RQIA recommendations.

Q14. Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

348. I do not directly recall that the Trust Board or I during my time as Trust CEO formally corresponded with the Department in relation to problems such as staff shortages. It is possible that concerns may have been raised with the HSCB (now SPPG within the Department) or in the course of other regular meeting with Departmental policy or professional leads.

349. On 6 December 2016 I wrote to the then Permanent Secretary of the Department of Health (Exhibit 98) in relation to resettlement challenges faced, raising that the resettlement process was far from complete and the number of people on delayed discharge continues to grow and requesting the Department of Health and Department for Communities jointly consider how to meet the future housing needs for these vulnerable citizens who should not have a hospital ward as their address. Appendix of this letter provided a summary BHSCT funding & proposed funding from NIHE in relation to Supporting People Schemes, reporting an annual short fall of £0.6M.

Q15. Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

350. I have no recollection of the matter of the installation and or operation of CCTV camera at MAH ever being discussed at the Trust Board or at the Executive Team. I do not have any recollection of being advised of this during my time as CEO.

Q16. Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

351. I do recall not any occasions during my time in the Trust as CEO were concerns of abuse of patients by staff at MAH were brought to my attention or raised at Executive Team meetings. I believe given the seriousness with which I would have taken such matters I would have immediately responded and sought to ensure that the concerns were being properly investigated, reported and escalated in accordance with the relevant procedures. In particular, my primary concern at all times would be the protection of and safety of vulnerable patients for whom the Trust had a statutory of care. This would have included escalating and informing the Trust Board, the HSCB, the

Department and the PSNI depending on the relevant policy and procedure including the adult safeguarding and SAI arrangements.

Q17. 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 Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

352. The serious and systematic maltreatment and abuse of residents with learning difficulties in Winterbourne View Hospital were highlighted in the BBC Panorama programme on the 31 May 2011 and following this there were a number of reviews and actions taken both locally and nationally. The reviews and actions taken locally in NI predated in the main my time as CEO in the BHSCT from December 2014. The CEO and Trust Chair at the time will be best placed to advise on the specific action taken in the Trust at that time. I can advise on the action that I took as CMO at that time and summarise the actions taken by the Department. More generally matters considering the model of commissioned services including the type and number of inpatient beds and the relative provision of inpatient service as opposed to community support and services for people with a learning difficulty are matters primary for the commissioner of service, the then HSCB within the policy context and framework as determined by the Department. It is my understanding, and I would have known when I was CEO that the Department's policy aim for some considerable time had been to move away from institutional models of care to greater provision of care and support in the community in keeping with the Bamford Vision as outlined in the second report "Equal Lives."

353. While not specifically relevant to this statement as I have addressed above in answer to the questions surrounding my CMO role, I was aware that the Department of Health (DH) England led a review to investigate the failings

surrounding Winterbourne View, to understand what lessons should be learned to prevent similar abuse and explore and recommend wider actions to improve quality of care for vulnerable groups. Subsequently the Care Quality Commission carried out inspections at similar units and the findings contributed to the interim report. There were a number of reports published both during and after the review, as described at para 268 above.

354. As described in my M10 Witness statement, as CMO and head of sponsor branch for the Regulation and Quality Improvement Authority (RQIA), I sought assurance from RQIA with regard to regulated services for people with a learning disability in 2011 in response to the failings and abuse in Winterbourne View Hospital. RQIA’s response (see Exhibit 76) set out their existing systems aimed at maintaining oversight of the range of regulated and statutory sector learning disability services by way of inspections and unannounced visits and its ability to respond to incidents and other forms of “information and intelligence” that may give rise to concerns about the way in which services are being provided.

355. In addition, at that time the Health and Social Care Board, the Public Health Agency and the five HSC Trusts, which included the BHSCT, were asked to comment on the RQIA overview and add their comments and suggestions for improving the safeguards, guidelines, training and regulation in the various settings in which services for people with learning disability are delivered. These responses provided a range of assurances and also helped identify areas for further work and action covering additional guidelines, for example on Advocacy Services, Challenging Behaviours and reviews of care needs, day care and alternative approaches and staff training needs.

356. As outlined in paragraph 271 above, the Chief Social Work Officer issued an e-mail on 22 April 2013 to Departmental policy and professional leads in respect of the 2012 DH response to failings identified in Winterbourne View Hospital commissioning input to a DHSSPS response to the DH. A copy of this is at Exhibit 77. Tab 2 to this e-mail provides an assessment of action

required in NI to implement locally the recommendations from the Department of Health England, Transforming Care report.

357. It is my understanding that a number of the actions were taken forward in Northern Ireland through existing policies or as part of the development of new policies such as Transforming Your Care (TYC), the Bamford Review of mental health and learning disability services, and existing regulations and standards, the Mental Capacity Bill and the Paediatric Care Strategy although I had no involvement in these arrangements.

358. Subsequently 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.

359. I also understand a change to the disclosure and barring arrangements for preventing unsuitable individuals from working with vulnerable groups was implemented and a Mental Health and Learning Disability (MHLD) service framework for the was developed as referenced in my M10 CMO statement. The MHLD service framework set standards, specific timeframes and expected outcomes designed to improve the health and wellbeing of people in Northern Ireland, promote social inclusion, reduce inequalities in health and improve quality of care.

360. While I had no involvement, I am aware that a safeguarding vulnerable adult training programme targeted at the voluntary, community and independent sectors was developed. The training programme was commissioned from Volunteer Now and was based on the guidance and standards that the Department commissioned the Volunteer Development Agency to develop, called ‘Safeguarding Vulnerable Adults – A Shared Responsibility’. The aim

of the Guidance was to improve safeguarding outcomes for some of the most vulnerable adults in Northern Ireland by establishing standards of acceptable practice across a range of organisational activities, including the recruitment, selection, management and supervision of staff.

361. The STOMP and STAMP have been subsequently included 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. I have included further action taken by the Department on improving prescribing practice in my M10 CMO statement .

Q18. 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?

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 (Michael McBride)

Exhibit 1: Accounting Officer Letter from the Permanent Secretary to Michael McBride appointing him as Interim Chief Executive of Belfast HSC Trust, dated 22 December 2014.

Exhibit 2: Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Bria Mongon and Ian Sutherland, dated July 2022

Exhibit 3 : Memo to Policy leads regarding reporting of Early Alerts, dated November 2018

Exhibit 4: Note of bi-monthly meeting between DHSSPS and RQIA on 10 January 2012, dated 10 January 2012.

Exhibit 5: Note of bi-monthly meeting between DHSSPS and RQIA on 15 May 2013, dated 26 June 2013

Exhibit 6: Note of Mid-Year Assurance and Accountability Meeting between DHSSPS and RQIA 26 November 2012, dated 27 November 2012

Exhibit 7: Submission to Maura Briscoe on Learning Disability issues for the RQIA Accountability meeting on 23 July 2013, dated 16 July 2013

Exhibit 8: RQIA Bi-monthly update report January 2018, dated 18 January 2018

Exhibit 9: Memo from Paddy Woods to TMG, sharing the RQIA bi-monthly update report for January 2018, dated 24 January 2018

Exhibit 10: Email from Sponsor branch to Departmental policy leads notifying them of RQIA’s unannounced inspection of MAH from 28-30 July 2021, dated 29 July 2021

Exhibit 11: Email from RQIA to Department attaching 3 improvement notices in respect of MAH, dated 16 August 2019

Exhibit 12: Email from RQIA to Michael McBride attaching an Article 4 letter in relation to MAH, dated 6 March 2019

Exhibit 13: Quality Standards for Health and Social Care, dated March 2006

Exhibit 14: Letter from Belfast HSCT to Department, dated 8 March 2019

Exhibit 15: Email from RQIA to Paddy Woods attaching an Article 4 Letter in relation to MAH, dated 14 March 2019

Exhibit 16: Submission to the Permanent Secretary from Mental Health, Disability and Older People's Directorate, dated 20 March 2019

Exhibit 17: Letter from Permanent Secretary to RQIA, dated 22 March 2019

Exhibit 18: Email from RQIA to Michael McBride attaching an Article 3 Letter in relation to MAH, dated 30 April 2019

Exhibit 19: Submission to Michael McBride from RQIA Sponsor Branch, dated 3 May 2019

Exhibit 20: Email from CMO to CSSO and CNO re meeting held on 2 May 2019 in relation to MAH and the establishment of a Departmental Assurance Group, dated 2 May 2019

Exhibit 21: RQIA Bi-monthly update paper November 2018, dated November 2018

Exhibit 22: Note of mid-year assurance and accountability meeting between DHSSPS and RQIA on 26 November 2012, dated 19 February 2013

Exhibit 23: Email from sponsor branch to Maura Briscoe, sharing RQIA correspondence to Colm Donaghy, BHSCT, following an unannounced inspection of Ennis Ward on 29 January 2013, dated 11 February 2013

Exhibit 24: RQIA update on MHLD Bi-lateral liaison meeting with the Department on 14 September 2016, dated 13 September 2016

Exhibit 25: RQIA Bi-monthly update report, dated 8 March 2017

Exhibit 26: RQIA Bi-monthly update report March 2018, dated 14 March 2018

Exhibit 27: RQIA Bi-monthly update report April 2019, dated 9 April 2019

Exhibit 28: RQIA Quarterly Update Report January 2020, dated 7 January 2020

Exhibit 29: Memo from Sponsor Branch to TMG sharing RQIA quarterly update report from January 2020, dated 11 February 2020

Exhibit 30: Medical Leaders Forum paper with Organisation Updates, dated 14 January 2019

Exhibit 31: To Err is Human: Building a Safer Health System (Institute of Medicine), dated 2000

Exhibit 32: An Organisation With a Memory Report, dated 2000

Exhibit 33: Departmental Circular - HSS PPM 10 2002 - Governance in the HPSS - Clinical and Social Care Governance: Guidelines for Implementation, dated 2003

Exhibit 34: HSC Safety Forum Annual Report 2009-2010, dated October 2010

Exhibit 35: Circular HSS ppm 05-05 reporting of SAI's in the HPSS, dated 10 June 2005

Exhibit 36: Circular HSS(PPM) 02/2006 - Reporting and Follow Up on Serious Adverse Incidents , dated 20 March 2006

Exhibit 37: Safety First: A Framework for Sustainable Improvement in the HPSS, dated March 2006

Exhibit 38: Guidance document – How to classify incidents and risk, dated April 2006

Exhibit 39: HSS(SQSD) 34 2007 HSC Regional Template and Guidance for Incident Review Reports, dated 12 September 2007

Exhibit 40: Supporting Safer Services report, dated September 2011

Exhibit 41: MAH – BHSCT monthly update meeting key action points, dated 10 April 2019

Exhibit 42: Circular HSC (SCSD) 64/16 – Early Alert system, dated 28 November 2016

Exhibit 43: Departmental Circular (OSS) 01/2022: (Statutory Functions) Legislative and Structural Arrangements, dated 15 March 2022

Exhibit 44: Departmental CIRCULAR (OSS) 02/2022 Social Care and Children's Functions (Statutory Functions) - Management and Professional Oversight (amended 2 November 2022), dated 16 March 2022

Exhibit 45: HE1/22/145347 Departmental Circular (OSS) 03/2022 (Roles and Responsibilities of Directors) Revised 2 November 2022, dated 16 March 2022

Exhibit 46: Template KH15 / KH15b: Admissions under Mental Health (NI) Order 1986: legal status, undated

Exhibit 47: Template: Annual Mental Illness/ Learning Disability Census MILD, undated

Exhibit 48: Template kh03a: Summary of available and occupied bed days, discharge, deaths and day cases, undated

Exhibit 49: RQIA Report on Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, dated February 2013

Exhibit 50: RQIA Report A Baseline Assessment and Review of Community Services for Adults with a Learning Disability, dated August 2013

Exhibit 51: RQIA Mental Health and Learning Disability Directorate Annual Report, dated 2013/14

Exhibit 52: RQIA Review of Adult Learning Disability Community Services – Phase II, dated 2016

Exhibit 53: RQIA Review of Emergency Mental Health Service Provision across Northern Ireland, dated September 2019.

Exhibit 54: PAC Report on the Safety of Services Provided by Health and Social Care Trusts, dated February 2013

Exhibit 55: Strategic Management Group: Review of Retrospective Sampling Exercise in Mental Health and learning Disability Hospitals Final Report, dated December 2013

Exhibit 56: Letter from CSWO and CNO to BHSCT, dated 20 October 2017

Exhibit 57: Letter from CSWO and CNO to BHSCT, dated 30 November 2017

Exhibit 58: Letter from BHSCT to Department to provide assurances in regard to an SAI, dated 22 December 2017

Exhibit 59: Letter from CSWO to HSCB raising concerns about SAI, dated 4 December 2018

Exhibit 60: Note of the HSC Summit Meeting, dated 30 January 2019

Exhibit 61: Letter from Department to BHSCT regarding a public interest disclosure, dated 22 February 2019

Exhibit 62: Letter from BHSCT to Department regarding a public interest disclosure, dated 27 February 2019

Exhibit 63: Letter from CSWO and CNO to HSCB re RQIA Inspection, dated 17 May 2019

Exhibit 64: Note of the MAH Department and Belfast Trust liaison meeting, dated 6 September 2019

Exhibit 65: Note of the MAH Department and Belfast trust liaison meeting, dated 13 September 2019

Exhibit 66: Note of the MAH Department and Belfast trust Liaison Meeting, dated 25 September 2019

Exhibit 67: Chronology of MAH Adult Safeguarding related events, dated June 2024

Exhibit 68: EA 108/21 Early Alert about MAH staffing, dated 19 March 2021

Exhibit 69: Francis Rice report on professional nursing assurance at MAH, dated February 2020

Exhibit 70: Standards for Nursing Assistants, dated February 2018

Exhibit 71: Maintaining High Professional Standards in the Modern HPSS – A Framework for the initial handling of concerns about doctors and dentists in the HPSS, dated November 2005

Exhibit 72: SH439 Letter from Sean Holland to Independent Providers and Directors of Adult Social Services in HSC Trusts, dated 15 September 2020

Exhibit 73: SH438 Letter from Sean Holland to Chief Executive of Belfast HSCT regarding the regional resettlement process, dated 15 September 2020

Exhibit 74: Statement from Department of Health – Health Minister welcomes findings of resettlement review, dated 29 September 2022

Exhibit 75: DH Transforming care: A national response to Winterbourne View Hospital, dated 2012

Exhibit 76: RQIA Assurance report arising from Winterbourne View report in England on maltreatment of residents, dated June 2011

Exhibit 77: Memo from Sean Holland to Departmental Colleagues about the DH action Plan, dated 22 April 2013

Exhibit 78: Northern Ireland Medicines Optimisation Quality Framework, dated March 2016

Exhibit 79: Transforming medication safety in Northern Ireland, dated 2020

Exhibit 80: Health and Wellbeing 2026 12 Month Progress Report, dated October 2017

Exhibit 81: Health and Wellbeing 2026 Progress Report, dated May 2019

Exhibit 82: Health and Wellbeing 2026 Progress Report, dated 2021

Exhibit 83: The Right Time The Right Place, dated December 2014

Exhibit 84: BHSCT Assurance Framework Committee Terms of Reference, dated April 2016

Exhibit 85: BHSCT Minutes of the Executive Team meeting, dated 3 February 2016

Exhibit 86: BHSCT Trust Board Workshop Agenda, dated 2 July 2015

Exhibit 87: BHSCT Belfast Local Adult Safeguarding Partnership Report, dated 2015/2016

Exhibit 88: BHSCT Regional Reporting Template for Delegated Statutory Functions, dated March 2016

Exhibit 89: BHSCT Minutes of Trust Board meeting, dated 7 July 2016

Exhibit 90: BHSCT Legal Services and Coronial Matters Annual Report, dated 1 April 2015 – 31 March 2016

Exhibit 91: BHSCT Trust Incident Report 2014/ 2015, dated 28 May 2015

Exhibit 92: BHSCT Complaints and Compliments Summary Report, Dated July – September 2015

Exhibit 93: BHSCT Annual Report and Accounts 2014/2015, dated June 2015

Exhibit 94: BHSCT Trust Board paper 6.3 Revised Trust Delivery Plan 2016/ 2017, dated 6 October 2016

Exhibit 95: BHSCT Assurance Group Minutes, dated 22 April 2015

Exhibit 96: BHSCT Adult Social and Primary Care Directorate report on RQIA Inspections Oct - Dec 2015, dated January 2016

Exhibit 97: HSCT Adult Social and Primary Care Directorate report on RQIA Inspections Oct - Dec 2016, dated February 2017

Exhibit 98: Letter from BHSCT to Department of Health regarding Supporting People to live in their community and the role of supported housing, dated December 2016