MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 9TH SEPTEMBER 2024 - DAY 100

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

100

GWEN MALONE STENOGRAPHY SERVICES

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY KC MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MS. AMY KINNEY BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	MR. TOM ANDERSON O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MS. CLAIRE DEMELAS MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

THE INQUIRY RESUMED ON MONDAY, 9TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you.

MS. BERGIN: Good afternoon, Chair and Panel. We are recommencing the staff evidence this afternoon with the Witness H223. Chair, you granted a Restriction Order in relation to this witness on the 24th May 2024 - that's R072 - and that provides that the witness will be referred to by cipher and not by name. 14:00 14:01

The witness's internal statement reference is STM-263, and unless there's anything further they can be called.

CHAIRPERSON: No, I mean in relation to staff evidence, we are, I think practically finishing it this week. There are a few stragglers, as it were, who will be giving evidence certainly by the end of this month, and then next week we're moving on to M07. OM7, sorry, Organisational Module 7. 14:01

Also, in relation to the organisation modules, I think it is right to say that almost all of it, almost all of it has now been served and published. 14:01

Again, there are a few outstanding statements and we're still processing what we've received from the PSNI.

And I should also mention that we have tracked down now somebody who can speak about the role of the Mental Health Commission and we'll be taking a statement from them. 14:02

But other than that, I think we're ready for the

witness. Although it is quite a short statement I think the afternoon might be quite long, isn't that right.

MS. BERGIN: Yes, I think so.

CHAIRPERSON: Okay. There's a lot to ask him. 14:02

WITNESS H223, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: H223, can I just welcome you to the 14:03
Inquiry. We have met before, indeed you've met all the Panel I think when there was a visit to the hospital, but otherwise we haven't met I don't think. And I'll hand you over to counsel.

MS. BERGIN: Thank you. 14:03
Good afternoon H223. As you know, my name is Rachel Bergin, and I am one of the Inquiry counsel. We have briefly explained to you how we'll be dealing with your evidence this afternoon. You should have a copy of your statement in front of you. Now, it's dated the 14:03
22nd May 2024, and can I ask, do you have any notes on that statement that you've written?

A. Just a few handwritten notes to remind me of a few points.

1 Q. And have they been prepared by you or by anyone else? 14:04

A. By myself.

2 Q. Okay.

CHAIRPERSON: That's fine.

3 Q. MS. BERGIN: With that in mind then, are you content to

adopt your statement as your evidence to the Inquiry?

A. Yes.

4 Q. You should also have a cipher list in front of you? You will have a cipher list momentarily in front of you, and as we move through the evidence if I could just remind you to refer to staff and patient names by cipher. If you're unsure or can't find the cipher, please just write the name down and the secretary will be able to help. 14:04

14:04

As I've already explained to you, we won't be reading your statement aloud. I will begin by briefly summarising it and then I will be taking you to various paragraphs and asking you about that. And very finally, you will see that we have a stenographer in the room, so if I could ask you please to speak as clearly and as slowly as you can into the microphone? 14:04

A. Yes.

5 Q. Chair, I'm content while we're waiting for the cipher list to begin? 14:05

CHAIRPERSON: Yes, please do.

6 Q. MS. BERGIN: Thank you.

So H223, if you turn to your statement. At the beginning of your statement from paragraph 1 onwards, you outline that since 2017 you have been a Consultant Psychiatrist at Muckamore, and you provide details of your medical qualifications and training in psychiatry before you went to Muckamore. 14:05

In 2017, when you began, you initially shadowed the Clinical Director for a month, and you were assigned then to Donegore, which is a female ward, and also a community patch within the Northern Trust, and you describe your first impressions of Muckamore as positive and a place that you observed compassionate patient centred care from committed multidisciplinary teams. Is that correct? 14:05

A. That is correct, yes. 14:06

7 Q. And in 2019 you no longer had community responsibilities, so you took on oversight of Killead Ward and Erne Ward, which subsequently merged to Killead Ward, and you were assigned to this ward until late 2022 when you were then assigned to Cranfield Ward. Then between August 2021 and July 2022, you were appointed as the Interim Clinical Director at Muckamore on a temporary basis. And throughout your statement you also refer to your experience as a member of the Collective Leadership Team for a time, and also your experiences in relation to ward rounds, resettlement, adult safeguarding processes, PRN, your approach to the care and treatment of patients and your experiences at Muckamore. Is that all correct? 14:06 14:06

A. That is correct, yes. 14:06

8 Q. So if we could begin with paragraph 3 of your statement, please?

A. Yep.

9 Q. And here you outline that during your medical training,

your initial medical training, in 2001 you spent some time at Muckamore as a trainee. Can you recall which wards you worked on at that stage?

A. In those days the wards were called Fintona. Fintona North and Fintona South were the main wards I was attached to, but as a ward doctor or a core trainee you'd have covered other wards as required as well.

10 Q. And at paragraph 3H you say that when you moved from a previous role in an eating disorder service to learning disability at Muckamore, the peer support and learning from five other consultants at Muckamore was vital because you had no other formal training in intellectual disability, apart from those previous six months at Muckamore. So did you have any other experience in learning disability at all before you began working at Muckamore in 2017? 14:07 14:07 14:08

A. No, not really, no.

11 Q. Do you consider that your training and experience that you had then coming into that role was sufficient to equip you with the skills that you needed for this type of a role? 14:08

A. I think when I first joined the staff at Muckamore I wasn't fully aware of what the job would entail. So, it was a lot of on-the-job training for me. I had an unusual path towards that role, I suppose, having done a different speciality or subspeciality of psychiatry beforehand, not the usual path of going through higher training in intellectual disability psychiatry as others would have. So I was conscious about that and, 14:08

hence, particularly keen to learn from my experienced colleagues and draw as much from them as I could. I was aware quite, from quite early on, that I had a lot of transferable skills that I could bring from my previous role into this new role.

DR. MAXWELL: Would it be unusual to appoint a consultant psychiatrist in intellectual disability who hadn't done their higher training in that subspeciality?

A. I can't speak for the employers. I would guess so, but I'm also aware of the difficulty in finding suitably qualified specialists in the area and the gaps in service provision and, hence, there's an openness to look wider than just the candidates who've had particular training in the field. 14:09 14:10

CHAIRPERSON: I can -- I'm sorry.

DR. MAXWELL: Sorry. On the converse side, is there some advantage in having somebody who has got other specialisms to compliment the team? So you were eating disorders I think, one of the areas you had worked in, and did that give you a skill set to help with some of the patients that other consultants didn't have? 14:10

A. Yes. Yes, I would say so. I would say conversely I would have brought certain skills and experience from my previous job which would enhance my role in intellectual disability, yes. 14:10

CHAIRPERSON: And all that I wanted to ask was, you say in your statement that you began shadowing the then Clinical Director for a month. Does that mean you were

let loose on your own after a month, as it were?

A. Pretty much so, yes.

CHAIRPERSON: Did you feel that was sufficient induction into this particular field?

A. I did actually. I found those first, that first month to be very helpful in finding my way around, learning how the system worked, getting some basic theoretical knowledge in place. So after that month I felt quite confident to take on the role thereafter. 14:11

CHAIRPERSON: Okay. 14:11

12 Q. MS. BERGIN: If we could look at paragraph 6 then, please? And here you outline that in 2019, when the Northern Trust took over its own psychiatry provision, you then took on additional wards, as I've already outlined at Killead and Erne, due to being able to relinquish your community responsibilities. Were you involved at all in any decision making or preparatory work with patients in respect of the merger of the wards? 14:12

A. Yes. Yes, very much so. 14:12

13 Q. Could you tell us something about that, please?

A. Yes. I remember the necessity for the merger arose out of primarily infrastructure problems with Erne Ward at the time. The building wasn't fit for purpose. And so we had to find a solution to that. And with decreasing numbers in Killead, it seemed the most feasible option was to move the patients from Erne into space that was made available in Killead. And so we, you know, were quite focused on that. And actually I do remember that 14:12

we took quite a joined up approach in that staff from the different wards, managers, nursing leads, all came together and tried to find a way to make it happen. So I was quite pleased with how that went actually, that particular project. 14:13

14 Q. Do you, going back to the question, was there any specific patient focused work to prepare the patients themselves for those moves?

A. Yes, yes. As far as possible some of the patients would not be able to understand the direct explanation 14:13 as to what was going on, but we were very careful to make sure that, you know, familiar staff remained in place, that there wasn't too much of a change in their day-to-day routine, in their day services, et cetera. So as far as possible I think we did it at a good pace 14:14 for the patients and for the organisation itself.

PROFESSOR MURPHY: Did you worry that it was really a case of financial pressures - in other words, avoiding improving the Erne building - leading clinical decisions? 14:14

A. My understanding - yes, I'm not sure whether, you know, the best thing to do would have been to refurbish or renovate Erne itself, or whether -- you know, the building was, as I understood it, clearly not fit for purpose and something had to be done, and it is seemed 14:15 reasonable to me to refurbish Killead to meet the needs of the patient, rather than to try and, if I can use the word "salvage" the other building.

I should say there was considerable work done on Killead prior to the move to make that more fit for purpose.

PROFESSOR MURPHY: But given these are patients who often have autism and find having lots of people and lots of noise difficult, did you worry that clinically this wasn't a good idea? 14:15

A. There were some worries that -- yes. Well first of all, change itself was a worry.

PROFESSOR MURPHY: Yes. 14:16

A. And there was a concern that the total numbers of patients on that ward would have gone up, albeit slightly, there was concern about how that would impact on the patients and the peer interactions and peer relationships. To me, thankfully, Killead - or the refurbished Killead - afforded a considerable amount of space where we could space the patients out and give every patient their own dedicated living area or day area on the ward. So they had their bedroom, and they also had an additional day space that they could use for themselves. 14:16 14:16

Now one of the patients from Erne was actually moved to the old PICU, so he had a ward to himself, and that was, that was quite a marked improvement in his environment actually going from quite a segregated setting on Erne to a spacious setting in the old PICU. The others, we were able to create I think quite suitable environments for them on Killead. 14:17

PROFESSOR MURPHY: So the number of incidents, for example, didn't go up? Were people keeping an eye on that? Because it would be one measure of how things were going.

A. Yes, I didn't get the sense that the number of incidents went up. I don't have the figures, but I didn't get the sense, you know, doing ward rounds every week, that we were seeing an increased number of incidents, no. 14:17

DR. MAXWELL: Can I ask whether the case mix, whether the patients' needs were the same on Killead and Erne, or were you creating quite a different case mix by merging them? 14:18

A. I felt we had done our best to take into account the different case mix. There would inevitably be some variation between individual patients, because they are all quite unique in themselves, but I felt the general ethos was compatible overall, that there wasn't anybody who stood out as needing something very different from the rest. 14:18

DR. MAXWELL: Except for the patient who went to the old PICU? 14:18

A. Yes.

DR. MAXWELL: Because presumably he went - that patient went there because you felt that patient's needs were quite different? 14:18

A. Correct, yes. He needed, he needed more space than could be made on Killead itself. So, yes. So he was, he would been an exception, yeah.

DR. MAXWELL: So prior to the merger, what sort of patients would have been on Killead and what sort of patients would have been on Erne?

A. Both. On both wards the - by that stage the category I would put them in was complex continuing care. 14:19

DR. MAXWELL: Okay.

A. So patients who were not in active treatment, most of them had stable medication regimes by this stage, and the primary aim was to work towards effective resettlement and discharge. So that was a feature in 14:19 common on both sides, on both wards at the time.

DR. MAXWELL: So their behaviours would have been quite stable?

A. In as much as the behaviours were well recognised and well documented and positive behaviour plans in place. 14:20

DR. MAXWELL: Right.

A. You know, it was still, it was still a stressful environment, the hospital, to me a hospital under considerable stress, and I do believe that our patients pick up on that and that can cause them to be more 14:20 unsettled themselves with unstable staffing, lack of familiar staff, familiar staff leaving, et cetera. So in that sense there was still challenges in trying to help patients be as settled as possible.

DR. MAXWELL: Okay. And this was February 2019. So 14:20 this is the point at which there was a high number of agency ward staff? Did that apply to Killead as well?

A. The merger took place a couple of years after that. So I think it was 2021 before the actual merger took

place.

DR. MAXWELL: Okay.

A. But we were still in the height of staffing challenges in the hospital.

DR. MAXWELL: Thank you. 14:21

15 Q. MS. BERGIN: If we look then at paragraphs 9 onwards. So at paragraph 9 you outline that you currently work at Muckamore as a consultant psychiatrist, alongside H42, another psychiatrist; H242, a specialty doctor for physical health, who is available at the hospital two 14:21 days per week; and one to two junior doctors at any given time.

At paragraph 10 you then outline a typical working week for you would be two days per week at Muckamore, 14:22 including ward rounds, patient reviews, and resettlement meetings; two days of community based work, out-patient and home visits; and then one other day of administrative or teaching or dealing with any urgent clinical matters. 14:22

At paragraph 11 you then outline that you lead a weekly ward round for three wards with 16 patients under your case. The frequency and nature of patient reviews depends on their clinical needs, which can change, and 14:22 patients with more acute difficulties could have face-to-face reviews once or twice a week. But the majority of patients are clinically stable, as you've already outlined, and their main focus is on

resettlement.

You have weekly ward rounds and up to twice weekly reviews, potentially, of some patients. So how much time do you spend on the wards outside of these? 14:23

A. If I may update on this? This - I finalised the statement towards the end of May when I had 16 patients under my care at that time. Now, thankfully we've made, I think fairly good progress with resettlement from then until now, so I'm down to seven patients 14:23 on-site, with seven patients on trial resettlement, still on the books of the hospital but have moved to their new identified placement, and then two patients discharged since then. So just to bring that right up-to-date. 14:23

As a consequence, I do the weekly ward round for each ward Killead, Donegore on a Tuesday, Cranfield on a Wednesday, and I find I can contain my necessary input on those in one day a week itself, and I don't really 14:24 need to be on the ward outside of that time, given the stability of the patients and the availability of junior medical staff to attend to physical health problems and changes, making changes in the Kardex.

DR. MAXWELL: How was it when you started in May 2017? 14:24 How much time would you have spent on the wards outside ward rounds then?

A. When I first started Donegore Ward on its own then, that would have been three times a week. So I'd have

been on the ward Monday, Wednesdays, Fridays, and then in the community on Tuesdays and Thursdays. So it would have been more at the start.

DR. MAXWELL: And did you spend time on the ward outside the ward rounds? 14:25

A. Yes, yes, yes. Depending on clinical need. So if there was a patient who was particularly unwell or unsettled, then that would have involved direct patient assessment on the ward outside of the ward round.

DR. MAXWELL: So, sorry, can I just labour that point? 14:25
We've heard some people talk about taking patients off the ward to interview rooms. Are you saying you actually watched them interact on the ward as part of your assessment, or did you interview them in an interview room? 14:26

A. Very much ward based, and almost always with a member of nursing staff or a medical colleague. Now, that might have been in their bedroom on the ward as opposed to a common area, but sometimes the observation would have taken place in the shared day area where there 14:26 would be other patients as well. But very seldom would you take them off the ward.

DR. MAXWELL: Okay.

CHAIRPERSON: Can I just understand, you've got seven patients on-site at the moment. Has the hospital 14:26 effectively closed its doors to the admission of patients in crisis?

A. Yes.

CHAIRPERSON: So what happens if one of your

resettlement patients, an ex MAH patient, has a crisis in resettlement? Do they come back into Muckamore or not?

A. At the moment, no.

CHAIRPERSON: So where do they go? 14:27

A. It is - it is an ongoing issue. It hasn't been, that hasn't been fully tested, in that patients who have struggled, we've tried to increase the support in the community, and so far that has worked. We haven't yet had anyone who has required readmission or an acute 14:27 admission. So it hasn't fully, as I said, been tested.

CHAIRPERSON: But can I just ask this, obviously if Muckamore has been resettling patients for many, many years, is the reality is that the threshold now for readmittance has gone up much higher than it would have 14:27 been say 10 years ago? Do you understand the question that I'm asking?

A. Absolutely. I mean the threshold has - is now - patients aren't being admitted to Muckamore for, really for any reason at this stage. 14:28

DR. MAXWELL: But you said there's seven patients under your care who are resident and seven who are on trial but still on the books. So the seven who are on trial, two questions really: One, are you actively assessing how they're doing, or are you waiting for the placement 14:28 site to contact you if there's a problem? That's my first question. And the second question is, if it's not working, because they're still on the books can they still come back to Muckamore?

A. Your first question, everyone on trial resettlement has a system of weekly multidisciplinary review with the hospital, the provider, and the community team. So that's where we hear about how they're doing and trouble shoot. Now I'm not able to get to every one of those meetings all the time, but there's usually medical staff representation, and certainly if there are any issues, that will come to my attention. 14:29

The second question, in theory, yes, patients can return to the ward whilst they're on trial resettlement. So that that is -- yes, in theory they can. It hasn't happened yet, and it hasn't, I suppose, been tested fully to the point where somebody can't be supported anymore in the community and has to return. We haven't experienced that yet. 14:29 14:29

DR. MAXWELL: Can I have one more question? So you said that you just wouldn't admit anybody as a new acute admission and that thankfully you haven't reached that situation where you've had to think about it, but if you're on-call today and you get a call and say "There is somebody with intellectual disabilities needs to be admitted under Mental Health Order", where would they go? 14:30

A. This is a massive problem. It depends on what Trust they're from. If we just focus on the Belfast Trust. 14:30

DR. MAXWELL: Yes.

A. If it was a patient with a more mild intellectual disability than an acute mental illness, there is more

likelihood, more acceptance, that they will be admitted to the adult mental health in-patient unit in Belfast. Those are -- we've had a few of those over the past number of years, and those are usually admitted, those patients are usually admitted to the adult mental health in-patient unit. 14:31

Where the difficulty arises is if it's somebody with a more severe disability, perhaps non-verbal, displaying challenging behaviour, difficult to work out what's happening, needs a particular kind of environment to facilitate their recovery, extremely difficult. Some patients have been admitted to the Adult Mental Health Unit, but that has caused significant difficulties in those settings. Some patients have had to take up several rooms at the same time to create enough space for them, which has a major knock-on effect. 14:31 14:32

Now, you may or may not be aware, having said what I said earlier about no admissions, within the last six months, I think, there was a patient transferred from the Adult Mental Health Unit to Muckamore in a very exceptional circumstance, following direction from the courts, as there was really nowhere else for him to be admitted to. 14:32 14:32

PROFESSOR MURPHY: So, can I just ask you, is there nowhere that provides respite care for people who have severe learning disabilities and challenging behaviour whose service is in crisis?

A. There is, but limited. So before -- so it goes without saying that before we're thinking about admission, we're exhausting every possible community option, including increased support at home, emergency respite, short-term placements, additional team input. So those would have been -- we would have explored all that before admission is even considered. But the number of places where people can go for emergency respite is very limited. And, hence -- so we're getting into problems when there is no other option but to consider in-patient care. 14:33 14:33

DR. MAXWELL: And are these respite options independent providers?

A. It varies in different Trusts, but it's usually a combination. So a person in crisis, their key worker or their social worker would be ringing around everywhere they can think of, not necessarily within their own Trust itself, and it's a combination of Trust facilities and independent providers. 14:34

DR. MAXWELL: And Belfast Trust -- so I'm aware that Northern and Western, and I think Southern, have got small acute units for people with learning disabilities. Belfast Trust doesn't have anything other than Muckamore, which is closed to admissions? 14:34

A. That is correct. 14:34

DR. MAXWELL: And if these patients are admitted to the mental health facility, do they get the mental health psychiatrist or do they get additional intervention from an ID consultant such as yourself?

A. It has varied, and it's been a topic of discussion and debate within services. There's been experiences where patients with mild disability, severe mental illness, have been managed very capably by general adult psychiatrists, like anybody else they manage. There have been other situations where patients with a more severe degree of disability have been managed by the intellectual disability psychiatrist, who effectively is the patient's consultant on the ward. So we've seen both arrangements happen, and it probably boils down to what level of disability and specialist input that patient requires. 14:35 14:35

PROFESSOR MURPHY: So a lot of learning disability experts would say hospital isn't the right place for people, especially for people with severe learning disabilities and challenging behaviour, and I'm presuming that the Belfast Trust would say exactly that. So, has it -- but obviously people's placements will sometimes break down. So, has the Belfast Trust, to your knowledge, planned to increase the number of respite care places? Because if you're closing the hospital, that's obviously going to be one of the things that you need? 14:36 14:36

A. I don't -- I haven't -- I'm not involved in that side of strategic planning, so I can't really comment on that. I don't know. Certainly from a psychiatry point of view, it's no, you know, it's no secret that we need a smaller number of beds for patients with more severe disability who are in acute crisis and for whom 14:36

community management is just unsafe. And, you know, I believe there's business cases ongoing for that. Again, I'm not directly involved in the planning for that, but the need for a small number of beds is - to me anyway, is there. 14:37

PROFESSOR MURPHY: Thank you.

CHAIRPERSON: All right. I think we'll let Ms. Bergin ask a couple of questions.

16 Q. MS. BERGIN: Thank you. So picking up again then at paragraph 11, H223, and we were asking you about ward rounds and your time on wards. In your experience of being on the wards in Muckamore, did you ever notice a change or a difference in atmosphere on the wards when there were different staff on? 14:37

A. I think, I think as a general principle, the more familiar and the more confident the staff you have on creates a more stable settled environment, in general, and a ward which is also well led by an effective, you know nursing leader who is delegating well, who knows what's going on, in my view you can tell when that's in place. And, conversely, when there aren't as many familiar confident staff around, things do feel less clear, and less contained, and less settled, in general. 14:38 14:38

17 Q. We're going to ask you, or move on, rather, to safeguarding in some more detail in just a moment, but staying on the topic of ward rounds, was adult safeguarding, or the safeguarding arrangements, were they reviewed as part of ward rounds? 14:39

A. The arrangements and the way it was done, not so much, because, you know, we felt we were limited in what we could do in a ward round which had a clinical focus in relation to how the process was working. In terms of the actual incidents themselves, so those would have been discussed regularly. If an incident arose we'd be examining what happened there and what could we do to prevent it from happening, if indeed it did happen. So we would have discussed more of the, you know, what actually happened and the impact on the patient, but not so much the -- to review the processes themselves, no. 14:39 14:40

DR. MAXWELL: So we have heard from some of the ward staff that some patients were on one-to-one supervision as part of a protection plan, for years, and this was often related to peer to peer incidents, and that that had a knock-on effect on staffing, and therefore the ability do therapeutic interventions or activities. So given that some patients could be on these protection plans for years, were they ever reviewed, particularly in terms of the lost opportunities to do other things? 14:40 14:41

A. So I'm not entirely sure I understand what that means in terms of a protection plan. To me we had and still have patients who require one-to-one supervision and support because of their care needs and their vulnerability, and that if they were left alone, really for any length of time, they could be subject to common dangers and hurt themselves. So I don't see those arrangements as being part of a protection plan due to 14:41

safeguarding concerns, if you know what I mean. I see it as their care need, their ongoing care need. And I see those -- I see that as being something which should facilitate better quality-of-life, because that one-to-one supervision or one-to-one support could engage the patient in structured activity and meet their needs on a continuous basis.

DR. MAXWELL: So we have heard that -- I take your point it can be a clinical decision, but we have heard that sometimes when there's been a safeguarding review by the social workers, the DAPO has asked for one-to-one supervision, rather than it being a clinical decision. We've also heard that that reduces the number of staff to take patients out on activities, because obviously it's more labour intensive. So I suppose if I put the question in a different way: did you review all patients on one-to-one supervision to ensure that it was the most appropriate thing to do, and there wasn't any negative effect of that in terms of being unable to take any of the patients out of the ward, given that staffing shortages got worse?

A. Yeah. Yeah, yeah, yeah. No. So in terms of the review of level of supervision and support, that would have been a standard thing to look at at ward rounds. And the need for it, the usefulness of it, the value of it, would be under regular review.

I take your point about those who would have had one-to-one put in place purely for protective reasons.

Yes. We would have, we would have considered those. And, again, I suppose I would -- I suppose there's also a thought that if they were on one-to-one it wasn't just for protective reasons, but we'd want to make use of that to facilitate meaningful activity, you know. So we tried not to think of it just as about, you know, protection only.

DR. MAXWELL: Okay. Thank you.

18 Q. MS. BERGIN: Moving on. In your evidence you've just described a clinical focus to the ward rounds, and if we then move to paragraph 13, and here you say that you aim to take a holistic approach to the care and treatment of patients, and you then outline in some detail a particular review framework that you keep in mind. Now, I'm not going to go through it in a lot of detail, but the components include general, physical, pharmacological, psychological, social, families, carers, and other issues including financial management, medico-legal issues, and dealing with concerns or keeping abreast of safeguarding matters. Where does this review framework come from?

A. I would see this as pretty standard clinical management or case management and, you know, when we gather as a multidisciplinary team with people from different professions, each contributing their thoughts and their views about the case, these are the things that inevitably come up and represent the -- just a comprehensive way of thinking about the case and the important things to be thinking about when we're trying

to progress a case. So, standard clinical management, just putting a structure around what I believe any clinical team would be doing in a ward round setting or in a clinical setting.

19 Q. Is this something that was articulated though in a document or that would have guided those ward rounds or... 14:46

A. No.

20 Q. No?

A. No. No. 14:46

21 Q. So do you know if your other colleagues, the other consultant psychiatrists that you currently work with or previously work with, would have been guided by the same approach?

A. Oh, I would be confident that they would have had the same headings, or same topics, same areas in mind. Whether they followed the same structure of thinking as myself, I can't comment. But there's nothing there which would have been unusual and, you know, not commonly thought about by any clinical team. 14:46 14:47

22 Q. At paragraph 13B, if we pick up on some of the specific areas in this framework, you say that:

"The physical health care of patients at Muckamore improved significantly following the appointment of Dr. H242, a GP with particular interest in the physical health care needs of patients with intellectual disability." 14:47

Prior to Dr. H242's appointment, what was the position so far as regular assessments of the physical health of patients?

A. It would have come down to the existing clinical team, usually led by the consultant psychiatrist and then the trainee psychiatrists at different stages of their training. So it would have been, you know, quite psychiatry led, and psychiatry as a speciality of medicine, you know, we -- psychiatrists, the more senior you become you do get a bit detached from general medicine and all the developments that take place in other specialities, to me quite naturally. So it does get hard to keep on top of physical health issues. Consultants are often reliant on junior staff who have more recently worked in general medical settings to deal with physical health issues. Once in a while we would get trainees who are GP trainees, so they would be on a path of training in a very general sense and would have more knowledge of physical health conditions, which would be very helpful. But to have somebody with a general practice background with an interest in the field and with the time to focus on the physical health, was a game-changer to me, and it really increased our ability to focus on the physical health needs of the patients. 14:47 14:48 14:48 14:49 14:49

23 Q. How did that come about in 2019? Were there concerns raised? You've said you thought it was a significant change, so how did it come about then?

A. Again, I wasn't involved in the arrangement for it, but

just as I recall the then Clinical Director was looking at how to improve the physical healthcare of patients on-site. Bearing in mind that these patients have been there a long time and have lost touch with their own GPs, or rather haven't had input from their GPs for many -- in fact some of them aren't registered with their GPs anymore, so they would have missed out on health screening, for example, annual health checks, being in hospital for so long. So I think the need for improved physical healthcare was recognised by managers at that point. 14:50 14:50

CHAIRPERSON: Could I just ask, and my colleagues probably know the answer to this, but as one of the consultant psychiatrists, presumably you were in charge, as it were, the named person for a particular number of patients. Is that right? 14:50

A. Yes, correct.

CHAIRPERSON: And does that mean that you, therefore, have overall responsibility not only for their mental health but their health? 14:51

A. Yes.

CHAIRPERSON: So if somebody needs a GP, it's your responsibility to call them, to get them seen. Is that right?

A. Or rather if they are in a hospital setting, or their health care falls under the remit of the hospital, so if they need anything done in terms of their physical health. 14:51

CHAIRPERSON: Yeah.

A. We should be able to do it in a hospital setting.
CHAIRPERSON: No, I understand that. But if -- say a nurse comes to you and says "X has hurt his leg", is it then your responsibility to ensure that X's leg gets seen to, if he's one of your patients? 14:51
A. Yes, in an overarching sense. In practice the nurse would ring the ward doctor or the duty doctor.
CHAIRPERSON: Right.
A. And they would usually sort it out, without me even knowing about it. 14:51
CHAIRPERSON: Right. And if for any reason that couldn't be sorted out, you would have to step in.
A. Yes. Yes.
DR. MAXWELL: But are we not talking about two different things here? There's the acute response to a 14:52 new presentation, which the psychiatry doctors would deal with, whereas the GP is dealing with ongoing screening and management of physical health, which isn't presenting as a new symptom at that moment in time, because even though you've got a GP, they're not 14:52 on 24/7 call. So if somebody hurts their leg, it's still the psychiatry junior who has got to deal with it. Is that correct?
A. Yes. There's a difference between acute and new problems that need to be addressed, but also, health 14:52 promotion, screenings, routine checks, which -- again, I wasn't there at the time, but probably weren't getting as much attention.
CHAIRPERSON: As they should have done.

A. As it needed.

CHAIRPERSON: Yes. Thank you.

24 Q. MS. BERGIN: And if we look at paragraph 13E then, and the area here in terms of the Review Framework that you have articulated is social, and here you say that: 14:53

"A key component of the patient's care and treatment plan is structured purposeful activity."

And then -- I'm jumping around somewhat, but it's a related paragraph. At paragraph 23 you say that: 14:53

"Within the context of staffing pressures it was difficult to ensure patients had sufficient daily structured activity." 14:53

But you recall Muckamore staff working hard to address this issue. For example, by expanding therapeutic day services to include therapeutic pets, social farming and street soccer. 14:53

Going back to the ward rounds that we discussed previously, did they consider the presence or lack of meaningful activities, and any impact that that would have on patient behaviour or well-being? 14:53

A. A very regular topic of discussion at ward rounds. And, you know, a desire to see patients suitably engaged with meaningful activities. So that would have been, and still is, a big focus of clinical discussion.

DR. MAXWELL: And was that ever escalated? So I'm thinking in terms of clinical governance, if there weren't enough staff to administer medications, that would have gone up as an incident, it would have been red rated and got on to the Corporate Risk Register. Was therapeutic activity considered in the same light? Did it get escalated through clinical governance?

A. That's a good question. I don't remember personally doing that myself, maybe once in a while. I would like to think somebody was raising concerns, perhaps nursing staff, occupational therapy staff, but it's not something I would have been actively raising a lot formally myself.

DR. MAXWELL: And to be fair I think a lot of people would see that as a different category of activity from drug administration, but maybe, maybe it's as important?

A. Definitely as important, if not more so at times.

25 Q. MS. BERGIN: During your time at Muckamore, staying on the topic of activities for patients, did you see the use of day care decrease or stay the same from 2017 onwards?

A. The use of day care from 2017, I think certainly up until recently, up until the announcement of the impending closure of the hospital, I think it was -- I think it would have increased. In those early years after the allegations came out there was a recognition that we need to bolster the activity schedules of the patients on-site, and I do remember, you know, quite a

lot of effort going into developing day services, some of those activities that you mention there came onboard. I remember a staff member who was employed to increase activity or to coordinate increased activity. So I felt that there was a push towards increasing day services for patients. 14:57

Now with the reduction in numbers and the impending closure, that's going the other way now and the provision is reducing. 14:57

DR. MAXWELL: Are you saying that there isn't enough provision at the moment for the patients that remain there?

A. It's getting harder to -- there's less day services provision by the separate day service and separate day service staff, so there's more onus on ward staff, on the nursing staff, to maintain structured activity for patients. 14:57

DR. MAXWELL: And do you still have a very high use of agency nursing staff who aren't LD trained? 14:57

A. Yes.

DR. MAXWELL: So that's unlikely to be easy for them to do?

A. It's not easy. It's not easy. We have a high level of agency staff, thankfully quite a number of them have been with us for longer than we would expect an agency staff member to be, and they've become quite familiar with the patients and the systems and are able to do quite a number of things to facilitate activities. 14:58

26 Q. MS. BERGIN: When you say that a lot of that responsibility has been picked up, and I'm paraphrasing, by some of the ward staff now due to shortages in other staff, does that mean that then patient activities that might have otherwise been outside of the wards in daycare facilities or elsewhere, or day care, rather, or elsewhere, are now remaining on the wards, or are patients still being able to avail of opportunities outside of the wards? 14:58

A. The aim is to maintain the activities out of the wards, but there's less capacity for the patients to go to the day services building on site, which used to be a place where patients could go from the ward during the day. So the capacity for that has reduced. Ward staff still try and take patients out for walks, or to the shops, or home visits, so that they're not on the ward all the time. 14:59 14:59

CHAIRPERSON: But is the day services building still open?

A. It's still open. 14:59

CHAIRPERSON: Right.

A. But much, much contracted service at the moment.

27 Q. MS. BERGIN: If we could look at paragraph 13F then, please, and the area here you've outlined is "Families and Carers", and paraphrasing again, you say that you view family involvement as being crucial and that you would not infrequently arrange ad hoc meetings to discuss matters with families and carers. I appreciate you've said they're ad hoc, so in terms of the 14:59

frequency can you give us any idea, perhaps not the most recent period of time when there's only seven patients, but prior to that when you had 16 patients with the three wards?

A. I remember a scenario where a family were quite concerned about their family member's medication regime. In their view was he getting too much medication? And I would have been in touch with the family on a once or twice a week, either on the phone, via e-mail, sometimes in person, just to try and understand what the concerns were, try and give some background to why this current regime was in place, trying to understand what their worries were about it. So, you know, it can go -- there can be periods of quite a lot of contact with families over a particular issue. 15:00 15:00 15:01

28 Q. So rather than, I suppose, a regular meeting scheduled with families, it's more ad hoc based on needs that present themselves or issues?

A. Yes. Yes. 15:01

29 Q. We're going to move on to PRN in a moment, so we will come back to that topic.

A. Okay.

30 Q. But can I ask you, were there ever family advocates, or any organisations that help advocate on behalf of patients, that attended any meetings with you with families? 15:01

A. Yes, yes. Quite a lot, quite frequently. There were -- the patients increasingly had an independent

advocate for themselves, and then the families had a carer advocate for the families, and one example of their involvement would be when the resettlement process is becoming more active, i.e. when there's an identified placement, when there's commencement of In-Reach, when there's care planning towards the community, that's when the advocates would be invited to every meeting and be able to represent both the patient and the families.

31 Q. When you say that that's something that has occurred increasingly, you began at the hospital in 2017 and the allegations came to light thereafter, can you give us a rough point in time when you think the engagement with those advocacy services increased? 15:02

A. I can only be very vague about it. To me it went in tandem with the, you know, the understanding that we had to double the efforts to find suitable community placements for patients who had been in the hospital a very long time and were, you know, who didn't need to be there, who shouldn't be there, who should be given a chance at community living. So it seemed to, it just seemed to tie in with the efforts towards that goal that more emphasis was placed on obtaining suitable advocacy for the patients and their families. 15:03

32 Q. In your experience, when you engaged with families and advocates in this way, either in relation to the resettlement process or as you've indicated earlier when other issues arose, did you find those meetings assisted in terms of resolving matters? Were they 15:04

useful?

A. I believe they were. Almost always. It's partly the way I like to do things and try and talk things through with key people. So if the families were having a query, or an issue, or even a complaint, my approach is usually to try and deal with it head on, face-to-face, directly, and in my experience I find that's the best way of resolving things, or at least progressing it to a point where we can agree on what the plan is.

33 Q. And you've referred in your statement to you suggesting or contacting families to organise meetings. Were families easily able to make contact with you, do you think, to request meetings or to discuss patients with you? 15:04

A. Yes, I believe so. Yes. I make myself quite available to families. I would, I personally would have, would make myself available via e-mail as well, so families could e-mail me directly. 15:05

34 Q. If we can move to paragraph 16, please? And just while the screen is catching up, here you state that: 15:05

"In my role as the consultant psychiatrist for the designated wards in Muckamore, I see myself as a clinical leader who seeks to facilitate effective team working and have oversight over a patient's care and treatment plan." 15:05

And you also then detail your duties under the mental health legislation, and you go on to say:

"I believe a consultant also has the role of providing psychological support and reflective containment to the multidisciplinary team, helping colleagues to co-regulate effectively, particularly when we are working in stressful settings."

In what ways did you provide reflective containment to the MDT?

A. So this is something which I think the consultant psychiatrist trains for and is geared up for, you know, throughout their training to become a consultant, it's a six/seven year path post qualifying from medicine, and during that time, you know, in addition to developing clinical skills and knowledge, I think we are exposed to complex scenarios, difficult interpersonal relationships, complex team dynamics, and we sort of learn how to provide leadership in that scenario so that there can be containment of the team. So in practice this is done by taking a lead in team discussion, allowing for people to honestly express their views about a matter, being able to bring people in to feed into discussions, being able to manage my own feelings and reactions so that I'm not contributing to the anxiety in the system. I think it also involves being able to practically do something where that's possible and needed. So if an issue needs to be resolved and it takes, you know, a senior clinician to speak to a senior manager to try and unlock a situation

15:06 15:06 15:07 15:07 15:08

or to make a particular resource available, I think that's where a consultant can really, really contribute to the team. So a lot of listening, a lot of facilitating discussion and taking action where possible and where necessary, a summary of that. 15:08

35 Q. Chair, I'm conscious of the time. I wonder is that an appropriate time? We are just under half way through I'd say?

CHAIRPERSON: Okay. Can I ask the witness, I was going to keep going for 10 minutes. 15:08

MS. BERGIN: Certainly. Certainly.

CHAIRPERSON: But would you like a break?

A. I'm okay. I'm okay. Whatever you think. I'm fine.

CHAIRPERSON: Don't be brave about it.

A. Okay. 15:09

CHAIRPERSON: Well let's carry on for 10 minutes.

A. Okay.

CHAIRPERSON: If that's all right?

MS. BERGIN: Yes, thank you.

CHAIRPERSON: Okay. 15:09

36 Q. MS. BERGIN: If we can look at paragraph 17, please? And we're now moving on to the allegations of abuse at Muckamore, and here you say:

"As far as I can remember, the allegations of abuse at Muckamore came to light in November 2017. I first heard about the matter when the then Co-Director H287 arranged a meeting with the consultants to inform us that very concerning staff behaviour had been observed 15:09

via recently introduced CCTV monitoring on the wards. I would say that I noticed a dramatic change in the way the hospital was after the revelations."

And we don't need to go to it because it's a very brief extract I'm going to read out, but at paragraph 41, for the transcript, you state: 15:09

"I have not personally witnessed anything that I would call abusive behaviour by staff." 15:10

So in relation to that, were you ever concerned about staff treatment of patients before the 2017 allegations of abuse came to light?

A. No. Bearing in mind I was only there for a very short time, I joined the staff in May 2017, so it was a very short time before this came to light. I had no -- nothing concerned me as to what I observed in the early days of my time in Muckamore. 15:10

37 Q. Earlier in your evidence we discussed how relatives might or articulate concerns to you. Did any patients or relatives report concerns about abuse or mistreatment to you? 15:10

A. No.

38 Q. And before the 2017 allegations came to light, and I appreciate you've already said you were there for a short period of time before that, although you hadn't seen abuse you've said, were you aware of any bad practice? 15:11

A. No, I wasn't.

39 Q. You will be familiar with positive behaviour plans. Had you seen those being put into practice on the wards before the 2017 allegations came to light?

A. Yes. Again, a short period of time. I think it should be said that, if I'm not mistaken that was quite a new -- the introduction of a Positive Behaviour Support ethos was quite a new endeavour in 2017, so I don't think every patient would have had a PBS plan done up at that point, if I'm not mistaken. I do remember discussions around PBS plans in ward rounds were still at the stage of discussing what the approach was, trying to educate staff, trying to bring staff along with the way of thinking, and I do remember in those early days, and I might have referred to it later on in the statement, there was some challenge in bringing people around to the PBS way of thinking, moving away from, you know, a more consequential approach to managing behaviour. So that's a very long response to your question, but I think it felt very, in the early stages of PBS, of embedding PBS in the system back in 2017. 15:11 15:12 15:12 15:13

40 Q. After that perhaps initial reluctance --

DR. MAXWELL: Sorry, can I just clarify what you meant by the staff resistance? So you said they were using a more consequential approach? 15:13

A. So one example that struck me when I first joined the team and we were discussing PBS plans for patients.

DR. MAXWELL: Yeah.

A. There did seem to be some difficulty in getting heads around - let's say a patient had been unsettled and displayed challenging behaviour on a particular day, the PBS approach would be trying to understand what's gone on there, understand the function of the behaviour and improve the environment and the quality of life to prevent it from happening again and trying get back into a regular routine as soon as possible.

So let's say the patient had been unsettled in the morning, the PBS approach would be "Okay, let's get them out again in the evening or in the afternoon, as long as they're safe. Let's get them active. Let's get them out to the shops or for an activity", whereas there was some pushback to that by staff who felt "Oh, no, no, they're too risky to go out in the afternoon/the evening, we need to keep them on the ward in case something else happens."

DR. MAXWELL: So was it because they were concerned about the risk or was it a more old school behaviourist approach that you can't have rewards if you haven't been good?

A. I think there was a bit of that, what you've just said. I got the sense that that's where the tension came. That, you know, you shouldn't reward bad behaviour.

DR. MAXWELL: Bad behaviour. Yeah.

PROFESSOR MURPHY: I think you said in your statement that that came from agency staff more. Is that right?

A. I would need to go back to that paragraph, but I felt

that wasn't just limited to agency staff. I would need to check if I said that in the statement, but I certainly meant to say -- I wasn't implying that it was just agency staff.

DR. MAXWELL: And that approach was a mainstream approach a number of decades ago. So it sounds like there was a change in philosophy happening at Muckamore with this move to positive behaviour from a behavioural approach. 15:16

A. Yes. Yes. 15:16

DR. MAXWELL: And yet we haven't heard anything about work done with staff about "Okay, you've worked here for 30 year on this approach, this is how and why we're changing", were you aware of any work being done? I suppose particularly with the health care assistants because they have the most contact time. 15:16

A. Yeah.

DR. MAXWELL: We've heard they didn't get a lot of training or development.

A. Yeah. 15:16

DR. MAXWELL: And if you're suddenly changing the goalposts, that's quite difficult for them?

A. Yeah. I think you hit the nail on the head. This was an issue, and my feeling was that because this was 2017 and then the allegations came to light, that took over everything, and attempts to -- I think if nothing, you know, if there hadn't been the allegations, I would like to think that there would have been a more focused intensive induction training programme to embed PBS 15:17

into the system, but because of what happened and the impact of that on a large scale, it made it very hard then to implement this other project of trying to get PBS embedded. Even at a very practical level, once staffing became severely affected with suspensions, and sickness, and people leaving, it was very hard for the PBS team to organise training sessions, you know. They would organise training sessions and no-one would be able to come because nobody could be released from the wards to attend the training sessions, which usually happened during the day. So you were into very practical issues of how do you take forward this, you know approach, in a situation that was under so much pressure? 15:18 15:18

PROFESSOR MURPHY: I think we were looking for where you said in your statement that the staff taking a more consequential approach, as you described it, were agency staff, and it's in paragraph 22 where you're saying that the number of new staff who didn't have an intellectual disability background had a different way of thinking about behaviour support plans. 15:18 15:19

A. Yes, I see where that's referred to. That would -- that would be true, what I've stated. I think what I didn't state here, which has been just brought up there, was the change in approach as it related to some of the longstanding staff members, including healthcare assistants who had been there for a long time and had worked in a certain way for many years. 15:19

CHAIRPERSON: So not just the new staff?

A. So not just new staff, yes.
PROFESSOR MURPHY: Understood. Thank you.
CHAIRPERSON: And also, just so that we can identify the wards or remind ourselves of the wards that you're speaking about where you worked. You started off I think in Donegore? 15:20
A. Donegore, yeah.
CHAIRPERSON: Then Killead when it took over from Erne, and you ended up in 2022, at the end of 2022, in Cranfield. 15:20
A. Cranfield, and Killead, and Donegore.
CHAIRPERSON: Yeah. And so is that evidence about the approach to PBS the same across those wards, or was there any distinction in the way that various staff on various wards approached PBS? 15:20
A. I think it's a fair comment to apply across the board. What I would say is, it was perhaps more striking in the earlier days of my time there, 2017, 2018, 2019, because as time went by and even the agency staff stayed with us longer, eventually people, I felt, have come round to a new way of thinking, in spite of the difficulties in, you know, in implementing it. Over time I feel people have, staff have been more receptive to a PBS approach. 15:21
CHAIRPERSON: And was this something you were directly involved with? In other words, talking to staff about PBS and trying to get them to understand how -- 15:21
A. Yeah. Yeah, I would have, I would have, I would have been an enthusiast about it and championed it quite a

bit and sought to understand why staff wouldn't see it as the way forward. So, you know, I suppose as the years went by and you just keep trying to promote it, people do listen, and there has been a few -- just recently there's a particular case I'm thinking of where an agency staff member was introduced to a way of working with a patient based on PBS principles, which has worked, and he himself has said "I was sceptical at first, but I can see the benefits now", you know. Now that's -- he has been with us for five years, so I think it just takes a long time to implement that kind of cultural change. 15:22 15:22

CHAIRPERSON: Are we moving on from PBS?

MS. BERGIN: Yes.

CHAIRPERSON: Right. Shall we take a break? 15:23

MS. BERGIN: Yes, I think so.

CHAIRPERSON: All right. We'll try and take a 10-minute break, and you'll be looked after. Obviously don't speak to anybody about your evidence. Thank you. 15:23

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Yes.

41 Q. MS. BERGIN: Yes, we're picking up at paragraph 17, please. And between paragraph 17 and 21, and I'll go between the two, you say that: 15:40

"After the allegations of abuse came to light in

November 2017, a significant number of initial staff suspensions led to immediate staffing pressures and this was the beginning of further exodus of skilled, experienced staff. There was a high turnover of staff and the staff who were there found it difficult to cope."

And as the Inquiry has already heard in your evidence this afternoon, there was an increasing reliance on agency staff who had mainly mental health rather than learning disability backgrounds and less training in understanding the complex needs of the patients at Muckamore. 15:41

At paragraph 21 then you say, staying on the same theme, that: 15:41

"The impact on patients was very significant."

And you describe how some patients really struggled with the amount of change, and some patients unsurprisingly became more unsettled as time went on, and that some patients with a higher ability level could follow some of the publicity around Muckamore, which was anxiety provoking for them. 15:41 15:42

In terms of those initial staff suspensions, did you feel personally that they were providing safeguarding for patients?

A. Could you say that -- you mean?

42 Q. So the initial staff suspensions that I've referred to in your statement?

A. Yeah. Yes.

43 Q. Did you feel that those suspensions were providing a mechanism of safeguarding for the patients at Muckamore? 15:42

A. Right. Not able to comment, because, you know, I would not be privy to the reason for the suspensions and how, you know, justified they were. I just wouldn't be involved in that. So, I think, I think I can only comment on the impact of the loss of those staff on the patients. 15:42

44 Q. We'll move on to, in more detail in just a moment, some more of what you discuss in your statement about safeguarding and referrals and impact on staff, but was the impact then, as you've described of this unstable or changing workforce, was the impact of that on patients something that was discussed at management? And, if so, were you involved in any steps to escalate that? 15:43 15:43

A. Yeah. This, I think, would have been the -- often been the main topic of discussion, because it was so pervasive and affected everything we did. So it was not possible to have a ward round without reflecting on how the dynamics of the ward have changed with the staffing changes, and staffing absences, and how this was impacting the patients. Now this would have been regularly escalated up the nursing management line, a 15:44

regular topic of discussion at governance meetings. So I would say a very, a very live topic.

DR. MAXWELL: Can I ask if it was discussed amongst the social work teams? Because there's a balance, isn't there, that your first reaction might be the best thing to do for the patient is to suspend the member of staff while you investigate, but there were all these unintended consequences which the nursing staff had no control over because they weren't the ones making the safeguarding discussions. Do you -- and there was a social worker who attended the meetings. 15:44 15:45

A. Yeah.

DR. MAXWELL: You know, was it discussed with social work colleagues, or was it just left with the nursing team to try and fill the gaps? 15:45

A. Certainly with the social worker who was part of the ward team. Again, I wouldn't know what further discussions will have taken place with the wider social work system or the social work managers, but certainly involving the ward social worker, yes. 15:45

DR. MAXWELL: And as -- were you Acting Clinical Director at that time in 2017?

A. No, no.

DR. MAXWELL: So you may not know the answer to this, but I'm wondering if there was any escalation up the medical management model? Did it get discussed with the Associate Medical Director of the Directorate, as far as you know? 15:45

A. I'm not sure. I don't know.

DR. MAXWELL: Okay.

A. Yeah.

45 Q. MS. BERGIN: If we could turn to paragraph 24 then, please? And we're now moving on to the topic of PRN. And here you say that you are aware that the use of sedative medication on a PRN basis has been the subject of focused examination, and you say: 15:46

"My role is to help ensure that PRN medication is properly prescribed and administered and I do this through the ward round process and individual patient reviews." 15:46

And you then go on to say that you have not seen examples of PRN medication being prescribed inappropriately in terms of the types and quantity based on the British National Formulary limits. 15:46

"The use of sedative PRN medication has been in response to severe anxiety or agitation and to prevent or de-escalate significant incidents." 15:47

You then continue further on to say:

"I have not witnessed staff administering PRN medication without good reason or come across patients who have been inappropriately or excessively sedated through the use of PRN medication." 15:47

Now, earlier in your evidence to the Inquiry you gave the example of families raising concerns with you about medication as one of the issues that was discussed at some of your meetings. So with that in mind, how was the use of PRN monitored through the ward rounds and patient reviews? What did you actually do to keep track of it?

A. So at every ward round we would have a -- there'll be myself, a junior doctor, and a pharmacist. Now when I say "every ward round", sometimes people are on leave and you don't get everyone at the same time, but in general. And the way I would run the ward round is the pharmacist and the junior doctor would be looking at the medication Kardex where all the medication administration is recorded. So they would be surveying what's happened over the week, the number of PRN administrations over that week, et cetera, et cetera, and then raise any concerns if they spot something which they need further clarification about. So that's the way I did it.

As part of the nursing -- as part of the ward round, the nursing team would give their report of the week and how the patient has been, and would include detail like have they required any physical intervention, PRN medication as well? So it would be sort of embedded in the ward round discussion.

DR. MAXWELL: And was this happening when you started or was this something that was introduced as a result

of allegations being raised?

A. There was -- I get the sense that there was more emphasis put on the, on the reviewing of PRN medication as time went by, and we became more aware that one of the concerns about practice in the hospital centred around the use of PRN medication. So there was more emphasis put on it as time went by. 15:50

DR. MAXWELL: So does that mean it wasn't happening at all when you first started, or it was, but it was expanded? 15:50

A. It would have been, it would have been done, because medication reviews is again standard part of ward round business, but probably not in the forefront of our minds in terms of PRN medication.

DR. MAXWELL: And most hospital prescription charts they have to be reviewed every, re-written every 14 days, and that's usually the job of the junior doctor. Would you have expected your junior doctor to look at how much it had been used before they rewrote the prescription? 15:50 15:51

A. Probably not. No. No. Our Kardexes, as we call them, were long stay Kardexes. So they lasted, I think, longer than in an acute hospital, if I'm not mistaken. So a Kardex could have two months or so.

DR. MAXWELL: Oh, okay. 15:51

A. We could have kept a Kardex going, if I'm not mistaken, for at least two months, or around two months, before it had to be written. It wasn't every 14 days.

DR. MAXWELL: And you don't think the junior doctors

would have reviewed how much administration there had been when they rewrote it?

A. I don't -- I wouldn't have expected them to and I don't think they did.

DR. MAXWELL: Okay. 15:52

CHAIRPERSON: I'm sorry, just so that I understand. Who was keeping an eye on how much PRN was used in relation to each patient? Who would have the overview of that? Was that your role or somebody else?

A. Collectively myself, the nursing team, and that was then reported into the live governance, the weekly live governance meetings. So PRN medication for all the wards, broken down into individual patient usage, would have been brought to the live governance meetings. 15:52

CHAIRPERSON: So if there was a trend of increasing use of PRN with a particular patient, would you be expected to pick that up? 15:52

A. Yeah. Yes.

CHAIRPERSON: Was that the sort of thing you'd be looking for? 15:52

A. Yes.

CHAIRPERSON: Thank you.

46 Q. MS. BERGIN: And during your time at Muckamore did, in your experience, the use of PRN increase, decrease over time, stay the same? 15:53

A. I felt it was quite consistent, but then again I only came shortly before things got very difficult for the hospital, so I don't have a long, you know, pre-crisis period to compare with. But during my time there I

felt it's been quite consistent.

47 Q. The Inquiry has heard from parents and loved ones that their patient relative was, to use the term "zombified", or they were so overmedicated that they didn't know what was going on. Did you ever experience that? 15:53

A. No. No, I haven't, I haven't seen that and I haven't come across examples where I would reach that conclusion myself, no.

48 Q. Can you give an explanation for how that would occur? 15:54

A. You mean as described by the families?

49 Q. Yes?

A. How that could be... You mean are we...

CHAIRPERSON: Well, how would that happen to a patient? If the families description of that is accurate. 15:54

A. Yeah.

CHAIRPERSON: In what circumstances could that happen to a patient and would it ever be right?

A. Well, I mean if, if, if the family are saying that their loved one is "zombified", to me that means that they are being oversedated. 15:54

CHAIRPERSON: Yes.

A. By sedative medication, which means that they're getting -- they've been given too much of it for what they need, based on their clinical presentation. So that would imply, you know, that there hasn't been proper assessment of what the patient needs and has been given more than what they require. That may not be above and beyond what's prescribed. 15:55

CHAIRPERSON: No.

A. The prescription might still be within limits, but if somebody is oversedated then they've been given too much medication at some point for some reason.

PROFESSOR MURPHY: Do different individuals react very differently to the same dose? 15:56

A. That's possible.

PROFESSOR MURPHY: Yeah.

A. That's certainly possible. That's certainly possible.

DR. MAXWELL: And what about rapid tranquillisation, which is part of the Trust policy, that in crisis situations there can be, including I think with Haloperidol, in the immediate aftermath of that somebody may look very sedated, surely? 15:56

A. Yes, yes. 15:56

DR. MAXWELL: So potentially a family could see somebody after rapid tranquillisation and they would look oversedated, but that doesn't mean they were permanently oversedated.

A. That's a fair point. That's a fair point, yeah. 15:56

CHAIRPERSON: Can I just ask, again my colleagues will know this, but just to help the civilian, as it were. How is -- when you say it is appropriately prescribed, how do you write a prescription for PRN? What does it actually look like? 15:57

A. So on the medication Kardex you write the name of the medication, the dose, and then you specify the interval that's necessary between repeated doses, usually every four hours.

CHAIRPERSON: Yes.

A. And then you write the maximum amount in a 24-hour period.

CHAIRPERSON: So how would you assess that if you don't know the patient or how they'd react? Because as Professor Murphy just pointed out, different patients will react differently to the same dose. So how do you actually titrate it for the right? 15:57

A. Through clinical experience. So the initial prescription follows the guidance in the BNF, so these are recognised limits that we follow. If that proves -- and then if that's tried and it's felt to be too much, then it needs to be scaled down to be lower than the BNF limits. 15:57

CHAIRPERSON: And how would you know that? 15:58

A. From doing it and assessing response.

CHAIRPERSON: But you're not there, you're only there two days a week.

A. All right, yeah.

CHAIRPERSON: So how do you actually know? 15:58

A. So I'm dependant on nursing staff or junior medical staff telling me.

CHAIRPERSON: Yes. Yes. Okay.

A. Definitely.

50 Q. MS. BERGIN: Can I just clarify. Earlier in your evidence, I think in response to the Chair's question about whether you would be looking out for increases in PRN usage for particular patients and that those were included in the multidisciplinary team meetings, aside 15:58

from those weekly reports, or however frequent they were, one imagines that they deal with, I suppose, a picture in isolation for each patient, but was there any system, or documentation in place, or person responsible for looking at this at a broader view so they could basically chart a patient for say six months and actually sit down and assess whether there was actually an increase or decrease, or was it more ad hoc, as you say, that you're reviewing it weekly and if you noticed something then it would become apparent to you then? 15:59 15:59

A. For some patients the behaviour team would have done a more in-depth analysis over time, particularly if behaviour has been unsettled for a persistent length of time and we're wanting to understand what's been going on. So that would be one example. So then the behaviour practitioner would review the notes and chart the use of PRN, the use of physical intervention, what was going on in the person's life, what changes have taken place, let's say over a six month period. So that's one example of someone taking a more panoramic view of PRN usage and trying -- with the aim of seeing if there's any connection with environmental stressors, changes, physical health, that could explain why they were more unsettled in the first place to require PRN. 15:59 16:00 16:00

51 Q. And if we turn to the next paragraph, in fact, paragraph 25, here you say that you've been conscious about how systemic factors, including staffing levels, familiarity of staff and consistency of patient

activity schedules, can contribute towards an increase in patient agitation and distress and that this can lead to PRN being considered. And we've already explored with you in your evidence the theme of patients being more settled perhaps with familiar staff and less settled with those that they don't know as well. And you say at paragraph 25 that you have struggled to know how this issue can be resolved, apart from trying to address the wider systemic factors as far as possible. 16:01

So in this paragraph are you saying that you think there were occasions where PRN was administered as a result of one or a combination of these issues at the hospital? 16:01

A. Yes, yes, yes. And I really struggled with this, because it seemed evident to me that the patient's unsettled behaviour was at least in part, linked to the level of stress, and unsettledness of the ward itself, and the staffing team itself. And to me, the answer is very clear, we need to sort out the environment and get stable staffing in and get familiar confident staff in, but that can't happen straight away, you know. That is something which we struggle to put in place. Certainly on a, you know, any time soon. So I really struggled with what do you do in those situations, because the patients are unsettled and they could be at risk of harming themselves or others, and they do need some form of calming, and we're trying non-medication 16:02 16:02

approaches, you know, but the problems seem so related to the environment that they're in, and the dynamics in the staff team and the staffing situation that are not easily resolved. So it's a real dilemma.

52 Q. Before we move to paragraph 26, and I'm going to ask you about the thresholds for referral and the collective leadership team, but just to contextualise that, if we could jump to paragraph 34 and 35, please? And here you say, and I'm going to paraphrase, that your brief experience of being Interim Clinical Director was both rewarding and challenging, and you describe facilitating fortnightly medical staff meetings which allowed for sharing of information and peer support. 16:03 16:04

And then in paragraph 35 you go on to say that at the same time there was some lack of clarity about the role, partly due to the lack of a Chair of Division who you could directly report to. 16:04

And you say: 16:04

"It felt as if I was taking on some of the roles of the Chair of Division, for example, being part of the collective leadership team for some things, but at the same time I was not included in other things which a Chair of Division would usually be invited to. This left me with some uncertainty as to whether I was actually part of the CLT or not." 16:04

Can you tell us what is the collective leadership team? What's the purpose of it and who is part of the team?

A. The collective leadership team is the senior management team for that division. So you have the directorate of mental health learning disability and psychological services divided into three divisions, one of which is the division of intellectual disability, and the CLT is the senior management team for that division, which comprises the co-director, the divisional nurse, the divisional social work and the Chair of Division, who is a medical doctor. So it's the most, it's the most senior management team in the division of intellectual disability. 16:05 16:05

DR. MAXWELL: So it's at the divisional level and not at the hospital level? So it includes community. 16:05

A. Yes. Yes.

DR. MAXWELL: As well.

A. Yes, yes, yes.

53 Q. MS. BERGIN: And in this role as Interim Clinical Director, that's between August 2021 and July 2022 that you were performing that role? 16:06

A. Yeah.

DR. MAXWELL: Sorry, can I just clarify? What's the difference between the Clinical Director and the Chair of Division? 16:06

A. Seniority. So the Clinical Director reports to the Chair of Division.

DR. MAXWELL: But the responsibility -- so if the

division is for all ID services, including community and children's, is the Clinical Director just for Muckamore?

A. No, no, it's for the whole service as well.

DR. MAXWELL: So there's a Chair of Division who is a medical doctor supported by Clinical Director. 16:06

A. Yes.

DR. MAXWELL: And they have the same area of responsibility?

A. In terms -- if there was a, if there was a Chair of Division in place, they would be more strategic and operational and sitting with the other members of the CLT, whereas the Clinical Director would be more reporting to the Chair of Division and having -- being -- and line managing medical staff. 16:06 16:07

DR. MAXWELL: Yeah. But across children services and community as well as MAH?

A. Yes, yes, yes.

CHAIRPERSON: So it sits outside the hospital? It's not within the hospital management structure, as it were? 16:07

A. The?

CHAIRPERSON: The CLT?

A. The CLT?

CHAIRPERSON: Yes. 16:07

A. The CLT...

CHAIRPERSON: Is that focused purely on MAH or does it have wider responsibilities?

A. Wider. So it's the whole division of intellectual

disability, which includes MAH, and the community, and Iveagh, the children's unit.

CHAIRPERSON: Yeah. Sure. Sorry, and out of interest, when you would meet on the CLT, where would those meetings be held? Where would you go for a meeting? 16:08

A. In my time, in Muckamore.

CHAIRPERSON: Right.

DR. MAXWELL: And there was a separate team doing the operational management of Muckamore.

A. Yes. 16:08

DR. MAXWELL: With a Service Manager?

A. Yes. Yes.

DR. MAXWELL: And the Clinical Director would attend?

A. Not usually.

DR. MAXWELL: Oh, okay. 16:08

A. No, no, no.

54 Q. MS. BERGIN: I appreciate that you've said in your statement that you had thought there was a lack of clarity about what your role was, but what did you understand your role to be? 16:08

A. I had difficulty in understanding, in understanding that. I think it did stem -- because there wasn't a Chair of Division in place at the time, so I didn't really have a next in line to report to. So I found myself sitting in on with the CLT meetings about, 16:09 talking about issues going on in the hospital, trying to make plans for that. But there were some things which -- that the CLT were involved in at a Trust level, including reporting to the Executive Team, which

I wasn't expected to be part of myself. So I was in it for some things but not in it for other things.

55 Q. Okay. If we could move then back to paragraph 26, please, and here you say in the first few years following the 2017 allegations, you were concerned about how safeguarding processes were undertaken. 16:10

"Whilst there was an absolute need to make adult safeguarding a top priority and put robust processes in place, over time, in that initial period, it seemed to me that the process became over-reactive and unwieldy, to the point of creating new challenges in itself." 16:10

And at paragraph 27 you then continue to say that: 16:10

"There were issues with thresholds for referral and disputes about whether something observed was a practice or a safeguarding issue with a leaning towards the latter and, hence, a protection plan put in place which was perceived by some as being premature or excessive." 16:10

And you go on to say there was often a lack of information as to what staff had allegedly done wrong, and the length of time that it took to resolve referrals became a major problem, with some cases extending for years, and that all of this contributed to staff demoralisation and burnout, which further exacerbated the staffing pressures facing the hospital. 16:11

When you say that adult safeguarding referrals and protection plans were sometimes excessive, what would you describe as the boundary between poor practice and abuse? 16:11

A. Abuse would be, you know, deliberate intent to harm someone, or a willful neglect to provide care to someone. To me there's some intent behind it and some, you know, harmful motive. Practice, a practice issue would be if somebody is genuinely trying their best to 16:12 care for a patient with the training that they've been given, but they haven't, you know, perhaps understood what's required of them, they haven't, they haven't put in practice the training that they've been given, they've missed something important, but on the whole 16:13 they've been trying to do their best for the -- in the best interests of the patient, that's kind of...

PROFESSOR MURPHY: Can I give you an example and you can tell me what you think about this? Supposing a patient has been to day care, is coming back to the 16:13 ward, he doesn't want to go into the ward, and the nursing staff pushes him into the ward. Now, they may not be deliberately trying to abuse the person the way you're describing it, but would you call that poor practice or abuse? 16:13

A. That is...

PROFESSOR MURPHY: They're pushing and shoving the person.

A. That's abuse. Yeah, that's abuse.

PROFESSOR MURPHY: Yeah. Even though they didn't intend to harm the person, they were trying to get them to go back into the ward? It's tricky, isn't it? It's a very tricky thing.

A. It's tricky. No. Yeah. I was going to say it's bordering on abuse. I can't think of any scenario where it is clinically appropriate to push a patient, so on that basis I can't excuse that on the basis of, you know, "We didn't realise it wasn't right to push someone", so I would lean towards abuse on that example. 16:14 16:14

56 Q. MS. BERGIN: And how would an incident be dealt with then if it was deemed to be a poor practice rather than a safeguarding incident?

A. Standard performance management, line management involvement, review of what happened, a chance to reflect on what's happened, getting some sense for how insightful the person is in relation to what they've done, can they see, can they recognise the error or the shortcoming, and then some plan to have additional training and supervision until the manager is convinced that the person has, you know, learnt from their mistake and is going to act differently in the future. 16:15 16:15

57 Q. I've already read this aloud, but I'm going to do it again just for these further questions. So again at paragraph 27 you say: 16:16

"There were issues with thresholds for referral and disputes about whether something observed was a

practice or a safeguarding issue."

The Inquiry has heard that not all safeguarding incidents were reported. Were you aware of confusion around the threshold for reporting or referring incidents? 16:16

A. In my experience the confusion lay in terms of "What is safeguarding and what is practice issues?", rather than "Should I refer this in the first place?", because I got the sense that everything was referred. So, do you know, I wasn't aware of situations where something wasn't referred for safeguarding consideration, you know, because there was a doubt whether or not it met the criteria. The issue for me lay that almost everything was referred. 16:16 16:17

58 Q. So one issue that the Inquiry has heard about in evidence is about the lowering of the threshold for referrals without that having been approved in governance processes. First of all, were you aware of the Trust's safeguarding policy? 16:17

A. Yes. Yes, yes, in as much as mandatory training, yes. So I would have been aware of the policy.

59 Q. And when you say that your impression was that everything was being referred, were you aware of lowering of the threshold for referrals? 16:18

A. That was the impression I got. Part of the problem, part of the problem is that the person involved would not know specifically what, what concerned had been raised, and that there seemed to be difficulty in

giving the person specific information as to what they're meant to have done wrong. So you've got a situation where somebody is told that they can't work with a person anymore, that they're on a protection plan, that they can't work on the ward, but they're not told -- as I understood it, they actually weren't, it wasn't explained to them what were they meant to have done wrong. Now. So I suppose it's hard then to know whether its an appropriate threshold if we're not even sure what the alleged issue is. 16:18 16:19

DR. MAXWELL: The Inquiry has heard though that there was, peculiar to MAH, a decision to deviate from the Trust policy on safeguarding, which has a level of incident which can be decided by the local manager, and if they decide it's a safeguarding issue they refer to the social work DAPO, and that actually a decision was made in Muckamore to remove that, although the Trust policy never changed. So I suppose the question is: Was that ever authorised or was that just a unilaterally decision by the social workers at Muckamore that they imposed, and did all the staff understand that there was a difference between the policy that the Trust had that was available on the intranet and the working practice at MAH? And from your response, it sounds like you didn't have a clear understanding of that either? 16:19 16:19 16:20

A. No. That's right. That's right, I didn't. I didn't. Only in hindsight. At the time I wasn't aware that there was this change or that there was a difference.

DR. MAXWELL: So changed happened, but that wasn't clearly communicated to the staff in MAH.

A. Not to me anyway.

DR. MAXWELL: Okay.

CHAIRPERSON: And could I just ask, because you've distinguished earlier in your evidence between what might be regarded as safeguarding or what might be dealt with by standard performance management. Would the suspension of a member of staff ever be regarded as standard performance management? In other words, if you're going down the performance route, would a member of staff ever be suspended? 16:20 16:20

A. I probably don't have enough experience in management to know, to know from experience. I would - I suppose if there's been a serious error, you know, an administration of a medication that's caused harm, serious harm due to an oversight, I presume that could lead to a, could lead to a suspension. 16:21

DR. MAXWELL: And there are Trust policies on managing poor performance which would guide you? 16:21

A. Yeah. Yeah, yeah, yeah. As I said I don't think I've enough experience in management to know.

CHAIRPERSON: Fair enough.

60 Q. MS. BERGIN: Was the approach to safeguarding in terms of either your own perception that everything was being referred, or a general, I suppose, experience of referral thresholds being lower, was that ever brought up by you or were you at any CLT meetings where that was discussed? Was that on the radar at all? 16:21

A. It was probably the biggest thing on the radar, and a topic of regular discussion and escalation by, I would say by all professions in different settings ranging from ward round to CLT discussion. It was just so pervasive at the time and it seemed to be such an obvious challenge that we were facing as a hospital, that there were protection plans being put in place for what felt like things that wouldn't have met the safeguarding criteria, compounded by staff not knowing what they're meant to have done wrong, compounded by the length of time it took to process. So I had countless staff coming to me exacerbated that months down the line, sometimes even years, they're still under a protection plan for which they're not sure why and they've had little feedback as to where things stand now. So I can remember, you know, the period when that dominated life in the hospital. 16:22 16:23 16:23

61 Q. MS. BERGIN: Would you say at those collective leadership team meetings that the views of those at the meetings were harmonious in terms of the approach to safeguarding, or was there disagreement as to this approach that was being taken? 16:24

A. I could -- it wasn't talked about very openly in my relatively brief time in the CLT, but I could sense that there was difference of opinion, and this was a source of significant conflict within the CLT itself, and I think relationships between the CLT at one point were quite strained and difficult. 16:24

62 Q. The Inquiry has heard that the Department of Health

raised concerns in 2021 that safeguarding incidents were still being identified on contemporaneous CCTV. Were you aware of that?

A. Yes.

63 Q. And did the CLT - that would have been I think during the time you were involved - did the CLT accept that these were safeguarding rather than poor practice incidents? 16:25

A. Both. Both. They were certainly all referred on to the safeguarding team. I think again there was a leaning towards considering them as safeguarding incidents rather than practice issues. 16:25

64 Q. And were you aware of any escalation plan for safeguarding concerns which required all staff on patient incidents to trigger an automatic adult safeguarding review? 16:25

A. I believe that's what was happening. I don't remember, you know, and perhaps I wouldn't expect to have been formally told about that. But, yes, that seemed to be what was happening. 16:26

DR. MAXWELL: Why did you not expect to be told? Because as the line manager of the doctors you would have seen any Datix incident and came forward and it would have been your responsibility to make the referral, surely? 16:26

A. Yeah, I think, I think whilst I was CD I would expect -- I think I'm thinking about my seven years in Muckamore to date, with the CD role being quite a small part of that, so I'm talking more in terms of

non-manager.

DR. MAXWELL: But when you were Clinical Director you would have been expected to understand those policies.

A. Yes, I would be expected to understand that, yes. Yes.

65 Q. MS. BERGIN: At paragraph 28 then you say that: 16:26

"Somewhat ironically at times I felt that a system designed to protect patients could be inadvertently leading to indirect adverse effects on them." 16:27

And then you outline the difficulties, including staff leaving or having practice restricted and the impact on patients not having familiar staff who knew how to address their needs, and then you say: 16:27

"This could potentially result in an increased number of incidents which in turn might generate more safeguarding referrals, creating a vicious circle."

You're critical of how the safeguarding process was applied, and we've heard that in your evidence this afternoon, including the suspension of a large number of staff. In the circumstances, what other options do you think the Trust had? 16:27

A. Perhaps what's happened since, perhaps what's in place now, where there's a more measured response to incidents being raised, to referrals being brought to the safeguarding team, there's much better relationships between safeguarding team, ward staff, 16:27

hospital managers. There's more conversations taking place. There's more ability to understand the nuance of a situation, there's less reactivity, less automatic implementation of restrictive protection plans. So, I think if that would have been the approach back then, it would have been a healthier approach, a less stressful environment. I speculate perhaps we could have held on to staff who have since left, who knows, you know. But I think a more relational way of working, and taking time, and not feeling under pressure to make a quick decision about, you know, every referral that comes through. 16:28 16:29

66 Q. At paragraph 29 and 30, you give two examples of what appear to be instances where colleagues were engaged with complaints having been made and your concerns about those, and at paragraph 29 you give an example during your time as Interim Clinical Director of supervising a colleague on a protection plan due to something seen on CCTV, and that that process of investigation lasted for over two years, which impacted your colleague who had to work under restrictions at that time, and you say that you found it difficult to expedite the process or obtain more information. What, in your view, could senior management have done to alleviate that type of issue specifically? 16:29 16:30 16:30

A. I appreciate that when the police are involved there's another agency to liaise with, and that the Trust were limited in information, in the information flow from the police, and that delayed things a lot of the time.

One of the things I think the Trust could have been better at is more formal updates to the colleague in question, and even if there was no update to give, you know, some sort of checking in that "We're still trying to get the information from so and so, that's the reason for the delay in the case" and, you know, "Sorry, as soon as we hear more we'll be in touch, but we'll check in with you in a months time or in two months time", I think that would have gone some way in at least letting the staff member know that, you know, he's being thought about and there were efforts to try and resolve the situation as soon as possible. I think it's when there's no information and there's no feedback, that's very difficult for staff. 16:31 16:31

67 Q. Yes. And in fact at paragraph 30 you go on to give an example of a consultant colleague who, following issues being raised by a patient's family, was advised by phone to step back from the patient's case, and your understanding is that they hadn't been informed about the progress. So would it be fair to say that you're really describing similar type issues there also in terms of communication with staff? 16:31 16:32

A. Yeah, yeah. Yeah.

68 Q. If we then turn to paragraph 31.

DR. MAXWELL: Sorry, before we get there, you do say at paragraph 30 that complaints became safeguarding issues. Was this just one occasion or was it always default to safeguarding? 16:32

A. This is paragraph?

DR. MAXWELL: In paragraph 30 you say you thought the issue could have been dealt with through the normal complaints process.

A. Yes.

DR. MAXWELL: And have local resolution. 16:32

A. Yes.

DR. MAXWELL: But instead of doing that it went straight to safeguarding?

A. Yes.

DR. MAXWELL: And we talked about the fact that 16:32 everything became a safeguarding referral. Was this, was this just one complaint or was it that any concern was automatically a safeguarding investigation?

A. Certainly in this case here, whether -- I suppose I can't comment on whether all complaints became 16:33 safeguarding issues, I don't know. This was a particularly difficult example to observe because it brought home to me that this is an overreaction to something that would normally be dealt with in a certain way. It didn't have to get to this stage 16:33 straight away.

DR. MAXWELL: And who made the decision that it should be dealt with as a safeguarding? You say "the Trust".

A. Yeah. Yeah.

DR. MAXWELL: But there must have been an individual 16:33 who made that decision?

A. Yeah, I think -- I don't know which specific individual, but it was the direction of the CLT with the backing of the, you know, I presume with the

backing of the Executive Team.

DR. MAXWELL: Okay. Thank you.

69 Q. MS. BERGIN: If we turn to paragraph 31 then, please? And before I read this part aloud, I've already indicated to you, H223, that you refer here to the Executive Summary of an investigation report, and I've indicated that we won't be going into a lot of detail about that today. 16:34

CHAIRPERSON: No. We have a copy of the report and we are examining how we can best ensure that Core Participants receive as much of that as possible. There are sensitivities around it, as people will probably understand. But in due course I very much hope that all Core Participants will be able to receive at least the relevant parts, but for that reason we can't now use it with this witness. 16:34 16:35

MS. BERGIN: Yes. Thank you, Chair. And here you say:

"I did feel the need to express my concerns to the Chief Executive. I received a helpful response and she advised that I could utilise the Trust's whistle-blowing mechanism. I proceeded with this and my concerns were incorporated into a wider investigation that was being commissioned by the Trust in light of other staff members raising similar concerns. I have recently seen the Executive Summary of the investigation report which acknowledges that there were significant issues with the safeguarding processes at the time which needed to be addressed." 16:35 16:35

So you seem to imply that there was discord between the safeguarding team and the clinical staff. Can you tell us a bit more about how that manifested itself at the hospital? 16:36

A. It was particularly in relation to the nursing staff team who bore the brunt of this in terms of staff being put on protection plans without, without the staff themselves fully understanding why. What have I, what have I done wrong? So this then just places an already 16:36 stretched staff team under further stress to make up rotas and to make up numbers on the ward and to fill shifts. So the medical staff were somewhat removed or a step removed from this. You know, we had to consider the impact of the situation on the patients and their 16:37 clinical presentation, but we weren't, you know, we didn't have the same impact as the nursing staff who were struggling to make up numbers.

70 Q. You have described in your evidence and the statement before the Inquiry what appears to be a focus on team 16:37 work and working with other colleagues, and you've also then described this discord that you were aware of. Is there anything that you did personally to try and help resolve these issues between members of staff, even joint meetings or working together? 16:37

A. Yeah. I think probably the most significant thing is the examples in paragraph 29 and 30, once -- because I felt this was, this was affecting medical staff as well, albeit in much smaller numbers. I felt I had

then to escalate the issue with the Collective Leadership Team, with the Chief Executive, and then, you know, took part in a whistle-blowing process and the subsequent investigation looking at the issues of concern. So I felt that was the best way I could try and do something about it. 16:38

71 Q. You had referred to impact on patients. Do you know if patients were made aware of ongoing adult safeguarding referrals or concerns? Was any of that explained to them? 16:38

A. I'm not sure to what extent. A significant number of our patients wouldn't have the ability to understand that or engage in a meaningful discussion about that. A small number might have been able to -- I'm not sure how appropriate it would have been to have had direct discussions about those issues with them. But in answer to your question, I'm not sure how much patients were told. 16:39

72 Q. And when you whistle-blew, did you feel supported having done that? 16:39

A. Yes. Yes. Yes, there was a clear process, and it was good that there was already an existing investigation that was being, being organised or being put together. So I was able to link in with that and join a wider investigation and, you know, I felt that I was able to express my concerns and they were taken on board. 16:40

73 Q. If we can move to paragraph 32, please, and we don't have too much further to go, Chair and Panel.

CHAIRPERSON: No, sorry, when you say -- I'm so sorry.

When you say they were taken on board, what changed?

A. As I described earlier, there were several changes to the safeguarding team in the hospital itself, and at some point the, you know, the team and the manager of the team took a different approach.

CHAIRPERSON: We understand that.

A. Yeah.

CHAIRPERSON: And that may have affected safeguarding referrals going forward. But in the meantime you had a lot of people suspended who didn't know why they'd been suspended, and it looked like they might be suspended indefinitely because there was a PSNI investigation. Was that blockage able to be shifted at all?

A. I don't know. Not fully, and I know that in more recent times as efforts to try and expedite investigations that were, that have been taking a long time to go through the system, in addition to the new ones, but I'm not aware of how successful or how much progress there has been with dealing with the ones that had been...

CHAIRPERSON: Already suspended.

74 Q. MS. BERGIN: And at paragraph 33, staying on this topic, you in fact go on to say that now, today, the safeguarding processes in Muckamore, you feel, have improved a lot. There are better relationships between the safeguarding team and the staff, and decisions about screening and referrals in and out are more thoughtful and measured. And unlike previously, you hardly have any frontline nursing staff complaining to

you about the current safeguarding processes?
A. That's correct, yes.
75 Q. You have -- in answer to the Chair's question you have given evidence about some changes to personnel. Is there anything else in particular that you think contributed to this change in how safeguarding processes are now taking place at Muckamore? 16:42
A. I mean it was an issue that had to be resolved, so I think we got there eventually. Now, as I think you'd know, there were also changes in the CLT composition over time, and I think eventually, you know, we arrive at a situation where the management structure within the hospital recognised this to be an issue that needed to be addressed and, you know, took necessary steps to have a different approach. 16:43
76 Q. Would you say that at the time, as this was improving, that there was a clear strategy for dealing with adult safeguarding issues at the hospital, or was the lack of such a clear strategy perhaps part of the problem?
A. The latter. The latter. 16:43
DR. MAXWELL: Can I just ask you about that? So most safeguarding is one person and a few alleged perpetrators. This was a very different scenario because it was allegedly a large number of patients, a large number of alleged perpetrators. Did that strategy look at the system issues? I mean you've talked already about the environmental conditions that can lead to a vicious circle, and resettlement, you know, the ongoing concerns about people being in 16:44

hospital who didn't need to be there. Did this safeguarding strategy see this as a whole system problem or was it still focused on bad people doing bad things as individuals?

A. I don't know really. I'm not sure I could speak for the safeguarding -- if you're asking... 16:44

DR. MAXWELL: Well I'm just -- from your perception as a doctor working there, as a consultant, did you feel that everything was being looked at in the round? Did you think they were looking at the conditions that had given rise to the abuse and addressing that? I mean you talked earlier about the need to create the conditions that allow for good practice? 16:45

A. No, I don't think so. And I'm referring to the period where this particular issue was most prominent and the tensions were significant. I think, you know, I think people were trying to do their best to resolve a very, very difficult situation, but were getting caught up in dynamics and issues and expectations that clouded the ability to stop and think bigger picture, and think wider consequences, and think personal impact. So, I would say, no, at the height of it. It's much better now. 16:45

CHAIRPERSON: But so far as you were concerned on the Collective Leadership Team, which is a relatively senior strata, as it were, of management, you weren't aware of it, of raising those issues on a holistic scale as Dr. Maxwell has been asking you about? So you, on your CLT, were not saying "Well, how have we 16:46

got to this point?"

A. Not in my time...

CHAIRPERSON: No.

A. ...in the CLT, no.

CHAIRPERSON: Okay. 16:46

77 Q. MS. BERGIN: The final topic, you'll be glad to hear that I want to ask you about, is resettlement, and we're looking at paragraph 40, but also jumping to paragraph 14. So I'm going to begin by summarising paragraph 14, and here you say that you have found the 16:47 ongoing resettlement process is not straightforward:

"The remaining patients in Muckamore have highly complex needs and require robust community placements that can manage the significant risks presented. 16:47 Families and carers can be apprehensive, and the patients, particularly if they regard Muckamore as their home, can also have a negative view about resettlement to the community."

16:47

And you say:

"There is considerable pressure to progress with the resettlement agenda, not least to enhance the patient's autonomy and quality of life, but also because of the 16:47 impending closure of Muckamore."

And you've already given evidence to the Inquiry this afternoon about resettlement and admissions to

Muckamore.

And then at paragraph 40, you say:

"At present, the impending closure of Muckamore is bringing its own challenges. There is uncertainty as to exact timescales and where staff will be working in the future. There may be pressure to move people on before they or community services are ready. The provision of alternative assessment and treatment beds is not yet clarified." 16:47 16:48

So when you say there may be pressure to move people on, resettle them before they or community services are ready, where would that pressure be from? What are you referring to there? 16:48

A. There can -- given that Muckamore is on a very clear path towards closure, and it is, you know, it is -- it's difficult to sustain a hospital that's on a pathway to closure, I can understand why there would be a managerial drive to try and, you know, achieve the closure as soon as possible, which has to involve moving patients out of the hospital to alternative placements. And I suppose the pressure can come when that sort of organisational pressure, the need to carry out the project and to complete the task, you know, has to be balanced against what's actually happening with how patients are doing, how families are feeling, and what's there for them in the community. Now that, I 16:48 16:49

must say, is a role of the MDT. So we are quite firm about not allowing organisational pressure to trump clinical readiness and clinical need, and we often push back on, you know, a proposed discharge date, or a suggested rate of progression, to say, you know, "Well, we're not - this isn't in place yet", or "We're not ready for this yet, we're going to need more time to arrange this", so I hope that explains? 16:50

78 Q. It is perhaps -- apologies, I didn't mean to cut across you. It's perhaps and obvious maybe answer that you may give, but what are the potential consequences of resettling someone before the patient is ready or, indeed, before the community facility is equipped and ready to take them on? 16:50

A. Yeah. Placement breakdown really. And then what next? Because, as we said earlier, the options for bringing someone back to Muckamore are closing and the impact of a failed resettlement on the patient and their families is very significant. So we can't push things before they're ready. 16:50 16:51

DR. MAXWELL: Can I just ask you, you said, you know, the organisational pressure which you understand from a business point of view to close Muckamore, how is that organisational process expressed to you and, more specifically, by whom? 16:51

A. One example would be, you know, I would be -- we'd be in a ward round discussing plans for resettlement, and the Ward Manager might say, you know, "We heard from, we heard from other managers that this person's

discharge date is in three weeks time", and that might be something which I might be hearing for the first time.

DR. MAXWELL: And who are these other managers who are telling the ward managers this? 16:52

A. I would often, I would often hear it in that way.

DR. MAXWELL: Okay.

A. Without knowing specifically where that's come from.

DR. MAXWELL: So we know in acute hospitals that there will be performance targets, you know, you have to be 16:52 seen in A&E within four hours, you have to have your surgery within 26 weeks or whatever the target happens to be. Have you been set targets for the number of resettlements required?

A. No. 16:53

DR. MAXWELL: You haven't?

A. No. No. No.

CHAIRPERSON: I don't quite understand how a patient's discharge date can be fixed without the consultant understanding how it's been fixed? 16:53

A. It could be Chinese whispers. It could be that, you know, someone has said "Oh, we're aiming - all being well we hope the person would be discharged by this particular date."

CHAIRPERSON: But that's a bit different though, isn't 16:53 it, from...

A. Yes, yes, but that can get translated into "so and so said this person is being discharged on so and so date."

CHAIRPERSON: But you've heard that said, "this patient's discharge date is the 15th" or whatever, yes?
A. Yes.
CHAIRPERSON: And you have heard that on your ward rounds? 16:53
A. Yes, yes, yes.
CHAIRPERSON: Without quite understanding what the resettlement, how the resettlement was going to work?
A. I should say though that in my experience so far, you know, we've always been able to push back on that and 16:54 clarify it.
CHAIRPERSON: Right.
A. So I've never - I've kind of heard that, but I've always said "No, this is a clinical decision. We will decide what the discharge date is within the MDT", and 16:54 I've never had, you know, a discharge date imposed upon us.
CHAIRPERSON: Okay.
PROFESSOR MURPHY: So you weren't getting discharge dates as a performance target, but do you think someone 16:54 else in the Trust was? So higher management may have been given performance targets of exactly that kind and they were then kind of passing them down to you?
A. I don't, I don't know for sure. I do know that, you know, the hospital managers report to Trust managers 16:54 who report to departmental managers. So there is a line there. I just -- I'm not privy to that, so I don't know.
CHAIRPERSON: And, finally, just so that I understand,

when you discuss one of these cases in MDT and you're pushing back on the discharge date has been suggested, do you have sufficient information on the MDT to say "Right, at this point this resettlement has a good chance of working and everything is in place", is that information that you would receive?

A. Yes, yes, yes.

CHAIRPERSON: And at that point clinically you would say "I'm satisfied this patient is good to go", as it were. 16:55

A. Yes. Absolutely. And it's not just -- when I say "MDT", I include the hospital team, the community team, and the provider as well.

CHAIRPERSON: Yes.

A. So collectively we all need -- and families and advocates. So we all collectively need to be coming to that conclusion together. 16:55

CHAIRPERSON: Thank you.

MS. BERGIN: I have no further questions.

CHAIRPERSON: No, I don't think we have either. I think we've asked quite a lot of questions as we've gone along. So, H223, can I thank you very much for coming along to assist the Inquiry. Thank you. 16:56

A. Thank you.

CHAIRPERSON: That concludes in fact what I believe is the 100th day of evidence of this Inquiry. Tomorrow morning, as I think you've already been alerted by a Box message, with our apologies we're not able to sit because the witness isn't able to be here. But what we 16:56

might try and do is start somewhere between 1:30 and 2:00, just so we may have another long afternoon tomorrow. So could I ask everybody to be ready for 1:30 and we will start as soon after that as we can. All right. Thank you very much indeed. 16:56

THE INQUIRY ADJOURNED TO TUESDAY, 10TH SEPTEMBER 2024, AT 1:30 P.M.