MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 23RD SEPTEMBER 2024 - DAY 108

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

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1 THE INQUIRY RESUMED ON MONDAY, 23RD SEPTEMBER 2024 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Thank you.
5 MS. KILEY: Good morning Chair and Panel. This morning 10:05
6 we're stepping outside the organisational modules for a
7 brief period and back to the staff evidence and we're
8 hearing again were Moira Mannion who first gave
9 evidence as part of the Inquiry's examination of the
10 Ennis Report and Investigation, but you will recall we 10:05
11 didn't get finished her evidence that day.
12 CHAIRPERSON: Yes, quite.
13 MS. KILEY: So she has come back and we're dealing
14 discretely with the issue of her staff evidence today.
15 CHAIRPERSON: Fine. Thank you very much indeed. 10:05
16
17 MS. MOIRA MANNION, HAVING BEEN SWORN, WAS EXAMINED BY
18 MS. KILEY AS FOLLOWS:
19
20 CHAIRPERSON: Ms. Mannion, can I welcome you back to 10:06
21 the Inquiry. I think you were last here on the 17th of
22 June telling us about Ennis. We've moved on from that.
23 Thank you for your statement, and I'm going to hand you
24 over to Ms. Kiley who is going to be dealing with your
25 evidence. 10:06
26 A. Thank you.
27 MS. KILEY: Good morning, Ms. Mannion. As the Chair
28 says, welcome back. You attended to give evidence on
29 the 17th June, and just to remind everyone else that

1 was in relation to the discrete phase of the Inquiry
2 that was examining the Ennis Report and Investigation.
3 But we didn't get finished up with your evidence that
4 day and so you have come back to deal with your
5 experience as a staff member both attending Muckamore 10:06
6 Abbey Hospital and with responsibilities for the
7 hospital.
8
9 And just to remind everyone, you have made two
10 statements to the Inquiry. So your first in time was 10:07
11 dated the 19th September 2023. It has statement
12 reference STM-168, and it's that statement that details
13 your experience in various roles that you had in
14 connection with the hospital between December 2007 and
15 February 2020. So it's that statement that I'm going 10:07
16 to be focusing on today. And just to remind everyone,
17 you have made a second statement, and that was the
18 statement dated the 19th January 2024, reference
19 STM-192, it related to your experience of the Ennis
20 Report and Investigation, so I'm not going to touch on 10:07
21 that statement today. And in fact, whenever you last
22 attended, because we had anticipated dealing with both
23 parts of your evidence, you have already adopted both
24 statements as your evidence, so I don't need to deal
25 with that formality again. 10:07
26
27 And I want to move on now then and look at your first
28 statement. So you can see it up on the screen and I
29 think you have a copy in front of you as well, isn't

1 that right?
2 A. Yes.
3 1 Q. You should also have a list of ciphers. So if you are
4 in doubt and unsure of whether you can refer to a name,
5 please just refer to that list, and if in doubt you can 10:08
6 check with the Secretary and we will keep you right?
7 A. Thank you.
8 2 Q. But when you last attended then we established your
9 roles, but just to remind everyone, you were the
10 Co-Director of Nursing Education and Learning, and you 10:08
11 held that role from around 2007 to 2018, isn't that
12 right?
13 A. That's right.
14 3 Q. And then in 2018 you took on the role of Deputy
15 Director of Nursing and Workforce Education, Regulation 10:08
16 and Information Technology, is that right?
17 A. Yes.
18 4 Q. You retired from that post in 2019, isn't that right?
19 A. That's right.
20 5 Q. Can you recall the month in 2019? 10:08
21 A. October.
22 6 Q. October. But you then returned to work shortly
23 thereafter, because in November 2019 to February 2020
24 you worked as part of the CCTV Investigation Team at
25 Muckamore, isn't that right? 10:09
26 A. I did, yes.
27 7 Q. So I'm going to ask you a little about each aspects of
28 those roles. So if we can turn firstly to your role in
29 Nurse Education and Learning, which you deal with

1 commencing at paragraph 4 of your statement, if we
2 could turn that up, please? I won't take you through
3 all of this, but you explain that part of your role as
4 Co-Director for Nursing Education and Learning was to
5 ensure that student nurses obtained the training they 10:09
6 required to qualify as Registered Nurses.
7
8 At paragraph 5 there you give some statistics, and you
9 say when you began your employment with the Belfast
10 Trust, a minimum of 7,000 Registered Nurses were 10:09
11 employed, and furthermore a minimum of 700 student
12 nurses were supported by placements in a wide range of
13 services to meet their learning and skill objectives as
14 set out by the Nursing and Midwifery Council and other
15 organisations. 10:10
16 A. Mhm-mhm.
17 8 Q. I just want to check; what time period are you
18 referring to there? Whenever you say there were around
19 700, a minimum of 700 student nurses, what time period
20 would that have been correct for? 10:10
21 A. Well that would have been at the commencement of my
22 role, and over a period of time then there may have
23 been adjustment in figures over the years, over the 10
24 years, but primarily when I say 700 students there
25 would have been Year 1, 2 and 3, and there would have 10:10
26 been students from Queen's University, Open University,
27 and the Ulster University, so there were a range of
28 universities that we were supporting the students to
29 avail of placements across the environments for their

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1 learning objectives.
2 9 Q. Yes, so across all services?
3 A. Yes.
4 10 Q. You weren't just dealing with Learning Disability
5 nurses? 10:11
6 A. No, it was, you know, acute, older people. It was
7 each, each field of nursing, including Midwifery, where
8 the students would have been coming through from
9 Midwifery placements as well.
10 10:11
11 The infrastructure, just for some detail. There was a
12 practice, a team practice education facilitation team,
13 so I would have had a person who was a Service Manager
14 of that team, and each member of the team then would
15 have been watchful and ensuring the placements 10:11
16 according to their practice area. So there would have
17 been someone allocated to Children's and Midwifery,
18 there would have been someone allocated within the
19 Adult District, then Mental Health and Learning
20 Disability. So although I had the overarching 10:11
21 responsibility, then there were a team of individuals
22 who then worked very closely with the Ward Sisters and
23 environments, assuring themselves by the audits that
24 they completed, they would have been known as learning
25 audits, so each environment needed to meet the 10:12
26 expectation and the standards so that students could
27 avail of a placement in that area.
28 11 Q. Okay. And you tell us a little bit about funding in
29 your statement too. Just to be clear then, funding for

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1 pre-registration nursing training was provided by the
2 Department of Health, isn't that right?
3 A. Yes.
4 12 Q. And also it was the Department of Health that provided
5 funding for post-registration training, isn't that 10:12
6 right?
7 A. Yes.
8 13 Q. And if we could scroll down to paragraph 7, please?
9 Here you flag up that in and around -- just scroll down
10 a little bit more, please? More please to the entirety 10:12
11 of the paragraph. Just pause there. Thank you. And
12 you flag up that in and around 2011/2012, funding was
13 reduced for both pre and post-registration training.
14 Can you say by what percentage, even roughly, that
15 funding was reduced at that time? 10:13
16 A. From my memory about 3%.
17 14 Q. Okay. And in fact just at the bottom of that paragraph
18 you then I think talk about a different period of time,
19 because you say:
20 10:13
21 "Securing approval for post-registered training became
22 more difficult as over time funding was further
23 reduced."
24
25 So, could you estimate by how much in a percentage the 10:13
26 further reduction was?
27 A. The whole of Northern Ireland had access to - for the
28 post-reg commission would have been approximately
29 around 11 million, and that was brought down to 7

1 million. Now that budget, it's initial phase of
2 reduction, it's important for me to say there had been
3 a supplementary part of that budget which was for
4 practice development initiatives and research
5 development, and then the research and development 10:14
6 agency would have also had funding from the Department
7 to support application for fellowship and moving
8 forward with doctorates. So there were different
9 sections to the budget and different methods of access
10 to the budget, but, again, it was an important to have 10:14
11 an awareness of what was happening in relation to that
12 and also what was the strategic direction in the
13 organisation matching with the development needs of the
14 Department. So there was quite a lot of thought went
15 into how that budget could be adjusted to support 10:14
16 research, development and/or indeed a particular
17 approach that the Department wished to have all of the
18 Trusts go in direction of.
19 15 Q. And --
20 A. An example of that would have been when they decided 10:14
21 that the ED Department, the Emergency Departments,
22 needed to be built up with very significant roles, the
23 Advanced Nurse Practitioner roles. So there would have
24 been an expectation, not negotiable, that we would have
25 funded in that direction for that development, and 10:15
26 although we would have made an argument about how that
27 had an impact on smaller services, it was recorded as a
28 concern, but it wouldn't have been necessarily changed
29 direction.

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1 16 Q. Yes. So are you saying the Department allocate funding
2 for training, but they also set priorities, as it were,
3 for your training?
4 A. Yes. Yes.
5 17 Q. And do you recall the Department setting a priority in 10:15
6 your tenure for Learning Disability training?
7 A. No.
8 DR. MAXWELL: Can I just ask, the Department
9 administers this money through the Nursing and
10 Midwifery ECG, doesn't it? 10:16
11 A. Yes. Yes.
12 DR. MAXWELL: And did you sit on the ECG?
13 A. Yes.
14 DR. MAXWELL: So you had an opportunity to discuss with
15 the other Trusts and the CNO what the priorities of 10:16
16 funding would be?
17 A. Yes. Yes. Yes.
18 DR. MAXWELL: Did you ever raise Learning Disability as
19 a priority area?
20 A. We did. 10:16
21 DR. MAXWELL: At the ECG.
22 A. We did.
23 DR. MAXWELL: And what was the response to that?
24 A. The Director, the Director of Nursing who was managing
25 the ECG, would have taken that information back to the 10:16
26 Chief Nurse, and when she came back we then were asked
27 to do a three year education plan. So as an example,
28 Forensic Services and Mental Health, they were quite
29 depleted in access to training programmes, so then we

1 were able to say, together, the collective five Trusts
2 were able to say: 'Well, let us all support', so then
3 there would have been adequate number of students to go
4 into a programme that was very costly at the university
5 to achieve that. So we were able to influence the 10:17
6 Chief Nurse in many aspects of the --
7 DR. MAXWELL: And you raised at one point there that
8 actually you needed a critical mass of students for the
9 university to run the course.
10 A. Yes. Yes. 10:17
11 DR. MAXWELL: They wouldn't run a course for two
12 students from Belfast Trust.
13 A. No. No. We - at one point in time we were able to
14 access education programmes across the water, both
15 Scotland and England, renowned universities, excellent 10:17
16 output with the students, very successful nurses
17 returning from those programmes, and it politically
18 became difficult for that to be acceptable, and the
19 universities in Northern Ireland were asked to put
20 forward what they might be able to develop that would 10:17
21 meet the needs locally to mean that students didn't
22 have to leave the country to go to study.
23 DR. MAXWELL: And can you remember roughly what year
24 going outside of Northern Ireland became frowned upon?
25 A. Hmm. It may have coincided with 2011. 10:18
26 DR. MAXWELL: Around 2011?
27 A. I think it may have.
28 DR. MAXWELL: Give or take a few years.
29 A. Yeah. Because then we would have worked closely with

1 the, for example, the University of Ulster were
2 successful in attaining the Advanced Nurse Practitioner
3 programme. So just to use this as an example. So I
4 would have worked closely with the university in their
5 development of the programme. We had members of nurses 10:18
6 from the Emergency Department who had gone to Advanced
7 Nurse Practitioner programmes across the water, so they
8 were coming from a knowledge position. We had an
9 external person from one of the universities that came
10 to the University of Ulster to work with the university 10:18
11 in how to create that programme. And at the same time
12 then the Chief Nurse would have commissioned NIPEC to
13 develop the policy that would underpin the role of the
14 Advanced Nurse Practitioner. And simultaneously there
15 was discussion strategically to influence that the 10:19
16 Advanced Nurse Practitioner role may develop outside
17 the Emergency Department, so in other areas of
18 strategic need that that would have happened. I
19 wouldn't have been associated with the medical
20 discussions, but there were parallel discussions about 10:19
21 medical changes, and medical assistance changes, and
22 the concept, as I was aware of it at the time, was that
23 the two would merge and that indeed the Advanced Nurse
24 Practitioner role would hold a significant role and
25 contribute but not replace doctors. So that -- there 10:19
26 was different streams of work at the same time.
27 DR. MAXWELL: But on specific clinical skills, so
28 Positive Behaviour Support, we've heard from staff
29 witnesses that some staff went for training in Kent,

1 one witness told us they went to Bradford University,
2 and we've heard a lot about the importance of Positive
3 Behaviour Support, but also the difficulty of embedding
4 that philosophy. When this missive not to go outside
5 Northern Ireland came in, who provided very specific 10:20
6 clinical skills training, such as Positive Behaviour
7 Support? Because we haven't heard that any of the
8 universities within Northern Ireland provided that?
9 A. I'm really sorry, I can't tell you who did that.
10 DR. MAXWELL: Okay. 10:20
11 A. That's not in my mind at the moment, but if it comes
12 back...
13 DR. MAXWELL: Okay.
14 A. But I'm sorry I just can't answer.
15 DR. MAXWELL: That's fine. That's fine. 10:20
16 A. I do know that I would have been negotiating for the
17 individuals to go to Kent and other places, because
18 there was also a forensic course that we were
19 negotiating placements external, and my argument into
20 the ECG would have been very much that the timeliness 10:21
21 of the development of a new programme, we're not going
22 to meet the needs of the patients, or indeed the
23 service being able to operate for the needs of patients
24 in relation to forensic care, as an example.
25 CHAIRPERSON: Could I just ask, Dr. Maxwell has called 10:21
26 it a missive, but when you get that sort of political
27 indication that it was not acceptable that students
28 should be going out of Northern Ireland to get this
29 training, what's the route by which you get that? Is

1 that via the Chief Nurse? How do you here that it's
2 politically unacceptable?
3 A. There was a group that the Chief Nurse would have
4 chaired and managed of Directors, Executive Directors
5 of Nursing, and it would have been at that meeting that 10:22
6 there would have been the discussions about - whereas
7 Executive Director of Nursing, they believed the
8 priorities should be with the Chief Nurse. But
9 ultimately when that decision was made, then Brenda
10 Creaney, my Executive Director of Nursing, would have 10:22
11 given me the direction that this is now what we are
12 going to do, in line with the agreement at that Chief
13 Nursing meeting.
14 CHAIRPERSON: Okay.
15 A. I can't remember the full title it used to have, but 10:22
16 there was a meeting, and there would have been the
17 independent sector of Directors of Nursing would have
18 been at that meeting as well, but it wouldn't have been
19 a meeting I would have been at.
20 CHAIRPERSON: No. Okay. Thank you. 10:22
21 18 Q. MS. KILEY: Ms. Mannion at the outset of your answer to
22 Dr. Maxwell's question, you refer to a three-year
23 commissioning plan for training.
24 A. Yes.
25 19 Q. And you refer to that in detail at paragraph 8 of your 10:23
26 statement, but just so we understand it correctly, are
27 you saying then that whenever funding was reduced in
28 and around 2011/2012, and whenever nurses weren't able
29 to avail of opportunities in the rest of the UK, was

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1 the purpose of the three year commissioning plan then
2 to look at how training could be provided in Northern
3 Ireland. Is that right?
4 A. That would have been one of the focuses, and the other
5 focus would have been -- so as an example, it wouldn't 10:23
6 have been unusual that you might have been asking for
7 four placements in a programme, that would normally be
8 delivered for maybe 16 participants, and then it wasn't
9 deemed to be financially astute to use that programme
10 because then it would have been an incredibly expensive 10:23
11 programme to provide for four individuals. But if the
12 Trusts, or when the Trusts coordinated together and you
13 maximised even 12 placements, and at that point there
14 was an negotiation that external others could fund and
15 access those placements. So the placements in the 10:24
16 universities were protected for the Trusts, but in
17 making a three-year plan, if there was a space
18 available after the Trust had commissioned placements,
19 then it was open for other participants to self-fund or
20 indeed an agency to fund them access into that course, 10:24
21 and then it was deemed to be financially more
22 acceptable.
23 20 Q. And you said that that approach worked well for large
24 service areas, but that it created difficulties, I
25 think it's fair to say, for smaller service areas. Was 10:24
26 Learning Disability one of those smaller service areas?
27 A. That would have been perceived to be so, yes.
28 21 Q. Okay. And so does that mean it was one of the courses?
29 So specific training for Learning Disability nurses

1 post-registration, is that one of the courses that
2 people had to wait a number of years for, for there to
3 be enough participants to make it viable to put on a
4 course like that?
5 A. There would have been an expressed interest and 10:25
6 expressed need for particular programmes. So the ward,
7 Six Mile, was a forensic environment in Muckamore, and
8 we would have placed an argument into the ECG that the
9 running programme, the forensic running programme in
10 Northern Ireland, how come it couldn't extend it to 10:25
11 being a programme available for Learning Disability
12 nurses. And then again there was an influence with the
13 Chief Nurse that we were able to work with the
14 University of Ulster so that the forensic course then
15 opened up to accepting Learning Disability nurses as 10:25
16 well as Mental Health nurses. So, supporting nurses to
17 be able to articulate what the differentiation was for
18 a Learning Disability nurse in the forensic environment
19 or a Mental Health nurse in the forensic environment
20 was a very key issue, but we were able to influence 10:26
21 that, and then that opened up an opportunity for the
22 staff to go to that programme.
23
24 The other strategy from Equal Lives, which was the
25 Bamford Review, talked about integrating services for 10:26
26 individuals with experience of Learning Disability. So
27 there was an understanding that adult services,
28 emergency services, and other services, the staff
29 needed to become more skilled in how to communicate and

1 to work with an individual who was living with a
2 learning disability. So we were actually supporting
3 the nurses in that field, but we were also trying to
4 support Learning Disability nurses who wished to become
5 health visitors. So, again, there was a Professor 10:26
6 Brown from Scotland who was talking about the tsunami
7 of young children with a need, so again supporting the
8 health visitor fraternity with people who had Learning
9 Disability understanding working with families at an
10 early stage. So that was a strategy that we were able 10:27
11 to influence.
12
13 Now what we had to keep a very watchful eye on is that
14 when you took that move, the balance of staff back at
15 unit to provide the day-to-day care had begun to have 10:27
16 an impact, because you were actually supporting
17 individuals to be skilled to work in the community and
18 move away from the hospital environment.
19 22 Q. Mmm.
20 A. We then went to the ECG and back through the Director 10:27
21 of Nursing who managed that on our behalf, and I would
22 have had conversations with Brenda Creaney my Executive
23 Director of Nursing on a regular basis, and she would
24 have brought that information into the higher meeting
25 with Directors of Nursing, but what we would have said: 10:28
26 'We need more placements in pre-reg nursing for
27 Learning Disability'. And the other area of expressed
28 interest from Muckamore were individuals who were
29 senior healthcare assistants who were applying to go on

1 the adult pre-reg programme in Open University,
2 supported by ourselves, the mental health pre-reg
3 programme in Open University, but there was no Learning
4 Disability Open University for healthcare support
5 workers. And there were 50 placements - now forgive 10:28
6 me, I won't remember the exact year, but there was
7 approximately 50 placements for Learning Disability
8 nurses, which were meant to service the whole of
9 Northern Ireland. Now we did make an argument, myself
10 and my other workforce colleagues, that that would not 10:28
11 - when you look at the demography and the opportunity
12 for people to retire, or choose to be in a different
13 workplace, that was never going to meet the needs in
14 the Learning Disability area. And just before I
15 retired, Open University were engaged, they were being 10:29
16 commissioned to look at the Learning Disability and the
17 adjustment of pre-reg programmes, they were beginning
18 to look at the adjustment for more placements.
19 23 Q. Yes.
20 A. I don't know if that succeeded. 10:29
21 24 Q. I'm going to come on to that actually, but I just
22 really want to understand the effect of the reduction
23 in funding that you're talking about, because you've
24 described the measures that you took in response, and
25 it sounds like what you were trying to do was finely 10:29
26 balance the needs of all the services. But thinking
27 particularly about Learning Disability training, was
28 the effect of the reduction in funding a reduction in
29 available placements for specific training for Learning

1 Disability nurses and the frequency at which those
2 placements became available?
3 A. Not apparently.
4 25 Q. Okay.
5 A. Not apparently. The coinciding activities, as I 10:30
6 remember it, is because the strategic direction was
7 perceived to be that the individuals who were availing
8 of the service were going to be living in the community
9 for very - it was meant to have been quite a long time
10 ago - the expectation is that the community 10:30
11 infrastructure was going to be more of social care
12 background environment and that it would not
13 necessarily need nurses, and that was one of the
14 discussions we encouraged our Executive Director of
15 Nursing to have, that the role of the Learning 10:30
16 Disability nurse would still be needed even within a
17 social care environment to support the specific needs
18 of individuals, and that was part of what we began to
19 influence in relation to additional places for pre-reg
20 programmes and also then the supplementary Advanced 10:31
21 Nursing programmes for people who already were Learning
22 Disability nurses, but wanted to refine their skills in
23 certain areas.
24 26 Q. Yes.
25 A. Health visiting, forensic. 10:31
26 27 Q. And you referred earlier to the development of a
27 specific Learning Disability Nursing Programme?
28 A. Yes.
29 28 Q. And at paragraph 9 of your statement you say that prior

1 to your retirement:
2
3 "...we were working with the Department of Health and
4 the Open University to develop a Learning Disability
5 Nursing Programme. At that time it was recognised 10:31
6 there was a need to build the Learning Disability
7 Nursing workforce to meet increasing service demands."
8
9 Just to orientate us in time; you retired in October
10 2019, isn't that right? 10:31
11 A. Yes.
12 29 Q. It might be surprising for some to hear that there was
13 only a Learning Disability Nursing Programme, it was
14 only being looked at being developed in 2019. Was
15 there a reason why it wasn't developed sooner than 10:32
16 that?
17 DR. MAXWELL: Can I ask what you mean by that? Because
18 obviously there had been pre-registration Learning
19 Disability Nursing Programmes --
20 A. No, no, there is, there is -- forgive me if I'm 10:32
21 misleading, and that's not my intention. There was the
22 Learning Disability Pre-Reg Programme in Queen's.
23 DR. MAXWELL: Yes.
24 A. And the -- but the Open University provided an
25 opportunity for individuals who were healthcare 10:32
26 assistants to progress towards nursing. So it was a
27 different programme and they didn't -- they had it in
28 England, but they didn't have it here, and we were --
29 DR. MAXWELL: So this was a bridging programme?

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1 A. Yes.
2 DR. MAXWELL: For healthcare assistants. Because the
3 Open University had been providing a pre-reg --
4 A. Mental Health.
5 DR. MAXWELL: -- programme for Learning Disability 10:32
6 students.
7 A. Not in Northern Ireland. At that time not in Northern
8 Ireland.
9 DR. MAXWELL: Okay.
10 A. They do -- I believe they do now, but not at that time. 10:33
11 DR. MAXWELL: Yes, because they came and gave evidence
12 and talked about it. So you're saying that wasn't in
13 operation in 2019?
14 A. No, it would have been the Pre-Reg Learning Disability
15 Programme in Queen's, which was an excellent programme, 10:33
16 around about the 50 placements.
17 DR. MAXWELL: But you could have supported, Belfast
18 Trust could have supported healthcare assistants to do
19 the programme at Queen's.
20 A. Yes, and there would have been one or two individuals 10:33
21 that would have been successful at that. The Royal
22 College of Nursing and other trade unions individuals
23 would have done bridging programmes for individuals in
24 preparation for going on to the pre-reg programmes.
25 DR. MAXWELL: Okay. So this was just an additional 10:33
26 provider?
27 A. This was additional, yeah.
28 DR. MAXWELL: Can I just ask you, you said earlier that
29 one of the reasons for not investing more in LD was

1 that the post-Bamford vision was a social care model,
2 most people would be cared for in the community by
3 social care workers, was there ever any joined up
4 thinking between those commissioning social care
5 workers training and those commissioning nursing and 10:34
6 support worker training? Because if it was reducing in
7 the nursing and care worker support training, on the
8 assumption that they were building up this workforce in
9 the community, did anybody ever check that that was
10 being built up whilst reducing the number of nurses and 10:34
11 healthcare assistants?
12 A. That I don't know.
13 DR. MAXWELL: So you weren't ever --
14 A. It would have been very separate lines of --
15 DR. MAXWELL: So even though Belfast Trust, being an 10:34
16 integrated Trust, provides social care, you, as the
17 lead for Nursing Education, weren't talking to anybody
18 in Social Services about what they were doing to build
19 up the social care workforce for LD?
20 A. The discussions that I would have had would have been 10:34
21 in and around Safeguarding, because at that time the
22 approach by our social work colleagues and the approach
23 by nursing were a little discordant with one another,
24 and there was a need for joined up thinking and joined
25 training opportunities. So that would have been an 10:35
26 area that I would have had discussions with the person
27 who was responsible for Education and Social Services.
28 But that would have preceded my deeper understanding of
29 Muckamore and what was happening.

1 DR. MAXWELL: But you weren't having a discussion about
2 a skilled workforce to look after people who were
3 resettled into the community?
4 A. No.
5 DR. MAXWELL: We'd have to ask somebody else what was 10:35
6 happening.
7 A. Yeah. No, I didn't.
8 DR. MAXWELL: And do you know who we would ask in
9 Belfast Trust about that? Who was responsible for
10 education of social care workforce? 10:35
11 A. There was a lady there called Sandra Grey, but I think
12 she probably retired in and around the same time as
13 myself.
14 DR. MAXWELL: Okay.
15 CHAIRPERSON: But what was her role, sorry? 10:35
16 A. She would have -- oh, gosh. Forgive me, I won't be
17 able to remember exactly, but she would have had a
18 responsibility for making sure that her colleagues,
19 social work colleagues, maintained their education and
20 standards. 10:36
21 CHAIRPERSON: Okay. Thank you. Sorry.
22 PROFESSOR MURPHY: I think we were told by a witness
23 from QUB that they did start a Masters course which had
24 joint entry from Nursing and from Social Care.
25 A. Okay. 10:36
26 PROFESSOR MURPHY: Were you aware of that one?
27 A. I was aware of a programme we were developing which was
28 meant to expedite nurses into a Masters programme,
29 but, again, I would have just retired from work as that

1 programme was being delivered.
2 PROFESSOR MURPHY: Yeah. Yeah. And can I just ask
3 you, in relation to things like the Forensic course
4 that you were describing, you managed to get opened to
5 Learning Disability Nurses at Ulster University, that 10:36
6 sounds as though it was politically quite tricky to do.
7 How did nurses know that this would now be available to
8 them, because we haven't heard from many forensically
9 trained nurses at Muckamore?
10 A. Okay. Well, the route that -- often a lot of the 10:37
11 discussion that I'm speaking about this morning, it
12 would have been translated back to the Associate
13 Director of Nursing in the area, and then he or she
14 would have communicated that with their Senior Managers
15 and the Senior Managers would have shared that, or 10:37
16 should share that with the Ward Sisters and the teams,
17 because each year there was an expectation that a
18 learning needs analysis was completed at ward level
19 through your appraisal, and the information from that
20 would then predict what was requested by the Ward 10:37
21 Sister through the Service Manager, through the
22 Associate Director of Nursing through to myself, and
23 then through to the ECG.
24 PROFESSOR MURPHY: So probably it would have come down
25 to line managers -- 10:38
26 A. Yes.
27 PROFESSOR MURPHY: -- remembering to discuss it with
28 likely candidates in their annual appraisal?
29 A. Yes. So it may officially - again I would have had an

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1 individual person working with me who would have been
2 out on sites working with staff around that, but it
3 might be that I would not get an opportunity to do a
4 programme I desired to do. It would be in line with --
5 the commissioning intent was about the strategic need 10:38
6 in the unit that you're in.
7 PROFESSOR MURPHY: Mhm-mhm.
8 A. So it wasn't unusual that some nurses would have
9 negotiated either some part funding for a programme
10 they wished to develop themselves or they would have 10:38
11 negotiated leave, some time off to go to a course. So
12 they still had an opportunity to progress along a line
13 of professional development they desired, but the
14 commissioning process was about the desire of the --
15 PROFESSOR MURPHY: Yeah, what the Trust needed. 10:39
16 A. -- the service need.
17 PROFESSOR MURPHY: Thank you.
18 30 Q. MS. KILEY: Mrs. Mannion I want to move on now, so from
19 your education role, to part of the role that you
20 undertook as the Governance For Nursing Co-Director. 10:39
21 You deal with this commencing at paragraph 10 of your
22 statement, and this was in the period - you describe
23 how in June 2011 you took on responsibilities for some
24 of the aspects of the role of Governance for Nursing
25 Co-Director, and that was for a temporary period, isn't 10:39
26 that right?
27 A. That's right.
28 31 Q. Can you say how long for?
29 A. Gosh, it was probably the most of one year.

1 32 Q. Okay. And you undertook those duties in addition to
2 your substantive role, isn't that right?
3 A. Yes.
4 33 Q. And what percentage of your time then would you have
5 spent on the Governance for Nursing Co-Director duties? 10:40
6 A. Well, the first thing I had to do was talk with the
7 team of people I worked with and, indeed, the new teams
8 that would have worked in Governance, and I needed to
9 talk about delegated activities and delegated
10 responsibilities with those individuals so that then I 10:40
11 could be assured that I am going to the right meetings,
12 that I am actually receiving the information that I
13 need to make the decisions and arguments that may be
14 needed in relation to each aspect, and then manage the
15 team's expectations, because there was some 10:40
16 disappointment with my own teams about loss of as much
17 contact with myself.
18 34 Q. Yes.
19 A. There was some concern with the new teams about whether
20 I had the skill set to do this job. So you were 10:40
21 managing that new dimension, and also then looking at
22 the priorities and then thinking about the action plan
23 in relation to the business plan.
24 35 Q. Yes.
25 A. So there was a business plan that we had each year, so 10:41
26 I would have had to learn about the business plan for
27 Governance and attended that through the team that was
28 working with me.
29 36 Q. Yes. So you're doing that on top of all your other

1 substantive duties?
2 A. Yes.
3 37 Q. And is it possible to put a figure on the amount of
4 time you would have spent in respect of those new
5 duties? 10:41
6 A. It varied in relation to priorities. So, for example,
7 when RQIA were making visits into the established
8 Trust, it was very important for me to divert my
9 attention to that important aspect of work.
10 38 Q. Yes. So it was reactive in some ways to what was going 10:41
11 on?
12 A. Very much so.
13 39 Q. And you mentioned there that there was some concern
14 about whether you had the skill set to take on the
15 role. Did you feel that you did? 10:41
16 A. I did.
17 40 Q. And prior to this, did you have specific training in
18 Learning Disability?
19 A. No.
20 41 Q. No. And did you get any as part of this role to take 10:41
21 on these interim duties?
22 A. No. Now the Governance role wasn't specifically
23 Learning Disability. That comes at the next part.
24 42 Q. Okay.
25 A. But I think, well I believe that Brenda Creaney's 10:42
26 assessment of myself in the history of being a Mental
27 Health Nurse for quite a number of years and having
28 worked in learning, with children with learning
29 disability while I worked in Child and Adolescent

1 Mental Health, it was her decision that I was able to
2 take responsibility for that. But that that would have
3 then come up in our discussions on our monthly
4 supervision. So if I had have been concerned about any
5 aspect, I would have been able to bring it to her. 10:42
6 And, indeed, one of the things that I would have done
7 is I would have made it a priority to be at the Trust
8 Governance meetings that my other colleague who had
9 left the Trust would have been at, and through that
10 vicarious education in relation to, well, why are we 10:43
11 paying attention to this and what are the activities we
12 need do, and what do I need to do to assure you that
13 we're meeting those expectations? So as an example,
14 there would have been a quarterly report that was
15 required at the Department around supervision standards 10:43
16 for Nursing. So ultimately obviously I had to learn
17 about that very rapidly and assure myself that it was
18 happening in the different areas, and then would have
19 worked closely with the Associate Director of Nursing
20 to get them to give me assurance that they were 10:43
21 encouraging the ward environments to meet the standards
22 that was expected by the Department of Nursing.
23 43 Q. So you were learning on the job, as it were?
24 A. Absolutely. And then because I had worked closely with
25 my colleague who had left the Trust for promotion, in 10:43
26 our meetings as Co-Directors with Brenda I would have
27 been aware of what was happening in different areas
28 from her report to the Director of Nursing.
29 44 Q. Yes. One of the things that you describe is carrying

1 out leadership walks, and you particularly recall
2 carrying out a leadership walk in early 2012 on Erne
3 Ward and Finglass - this is at paragraphs 11 and 12.
4 So you say that that was early 2012. Was that the
5 first time that you went in and walked the wards, as it 10:44
6 were, of Muckamore?
7 A. I would have been in Muckamore under the remit of
8 Education.
9 45 Q. Yes.
10 A. So I would have been there with a different lens. But 10:44
11 - so I was there before, but on this occasion it was
12 responsive to the RQIA visit from the Governance
13 perspective.
14 46 Q. Yes, so they were - so to put it in context, there were
15 earlier RQIA inspections and they had raised issues 10:44
16 with Erne Ward and Finglass Ward, is that right?
17 A. Yes.
18 47 Q. And part of your role was to go in in response to that.
19 A. Yes.
20 48 Q. Were you feeding in then to the drafting of improvement 10:44
21 plans?
22 A. I would have seen the improvement plans that the staff
23 members were actually putting together, but I wouldn't
24 have been the person that would have drawn them up.
25 But I would have drawn it to their attention if I felt 10:45
26 that they hadn't met the given recommendations that
27 RQIA would have been suggesting to them that needed
28 improved.
29 49 Q. And at paragraph 11 you say essentially you found Erne

1 in good order, but it appears that that wasn't the case
2 for Finglass. So if we can look at paragraph 12 there
3 you say that the same day that you visited Erne Ward:
4
5 "...Esther Rafferty and I also reviewed the Finglass 10:45
6 Ward. On entering the Finglass Ward I noticed that the
7 environment was different to the Erne Ward. Several
8 patients were out at day care, but there were some
9 patients who remained on the ward. The remaining
10 patients seemed to be less engaged in activities. I 10:45
11 remember a television was switched on with patients
12 sitting in the area, although they were not necessarily
13 watching the television. There were not many staff on
14 the ward and we were told that several staff were
15 supervising the patients that were attending day care. 10:45
16 I am unable to recall the name or description of the
17 individual who told us why there were few staff on the
18 ward."
19
20 And you refer to the improvement plan looking at the 10:46
21 review of staffing.
22
23 But you go on later in paragraphs 13 and 14, which I
24 won't read out, to describe various observations that
25 you made on Finglass Ward that day, and you describe, 10:46
26 for example, residents toiletries all being pooled
27 together and you describe seeing soiled toilet bowls
28 and staff not wearing the correct uniform. Is it the
29 case then that the Service Manager, Esther Rafferty,

1 then went -- she was responsible for implementing an
2 improvement plan to Finglass, isn't that right?
3 A. Well, she was -- well, actually, she would have had a
4 Service Manager working to her, so that person would
5 have been responsible for that, but Esther would really 10:46
6 then have said to the Service Manager and the Ward
7 Sister 'These are the activities that need to be
8 improved'.
9 50 Q. Yes.
10 A. Because clearly in the RQIA standards at that time it 10:47
11 wasn't acceptable that you had a collective of
12 toiletries that should have been individualised, as an
13 example.
14 51 Q. And, so, again to put this in context, RQIA had raised
15 issues, but really when you did the walk around you 10:47
16 could see the issues for yourself, is that right?
17 A. Yes.
18 52 Q. And an improvement plan was drafted, but as part of
19 your role did you ever go back to Finglass Ward and
20 check whether improvements had been implemented and 10:47
21 whether --
22 A. I did go for a visit back with Esther and we would have
23 met with the Service Manager and the Ward Sister --
24 53 Q. Do you recall when that was?
25 A. -- and there were improvements. I'm sorry. But I do 10:47
26 know that I did go back, and equally I would have had
27 reports from Esther, and Esther would have reported
28 into the nursing meeting with Brenda about how things
29 were improving.

1 54 Q. Whenever you did go back, did you observe improvements
2 for yourself?
3 A. There were improvements, yeah.
4 55 Q. And Finglass I think ultimately closed shortly after,
5 isn't that right? 10:48
6 A. Yes, yes.
7 56 Q. In October 2012?
8 A. Yes.
9 57 Q. Was that as part of a result of what --
10 A. It had been intended to close. It was a very old 10:48
11 traditional ward with dormitory style bedrooms, and
12 there was very little personalised, you know, clothing,
13 and there was a lack of screens, you know. So the
14 second visit that had been, the screens were there, the
15 toiletries were separate, and the cleanliness had 10:48
16 improved, and there did seem to be a little more
17 activity on the ward. There was still a lot of staff
18 reluctance about staff uniforms and about the fact that
19 they may get injured by patients. So, again, it was
20 working with the staff and encouraging them to use the 10:48
21 materials that are there to support them not being
22 injured by having their arms covered but still being
23 able to wear uniform. But there was a reluctance of
24 staff, and I know that the Service Manager and Esther
25 would have continued to do that work with the staff. 10:49
26 But it was intended to close because some of the
27 patients were having homes in the community.
28 58 Q. Yes.
29 A. And some of the patients who had not yet met that point

1 in time were being moved to another ward.
2 59 Q. And you have described attending Erne and Finglass for
3 a reason, so in response to the RQIA Investigation and
4 Report. But did you, having observed issues on
5 Finglass Ward, did it cause you to go and check other 10:49
6 wards to see if the issues prevailed on other wards in
7 Muckamore Hospital?
8 A. I wouldn't have used the word "check", but when I was
9 on site I would have walked through other wards, and I
10 have to say at that time the other wards were -- I 10:49
11 wouldn't have been concerned. But the conversations
12 that I would have had with Esther and the Service
13 Managers then would be that I would have expected them
14 to keep watch for that. I would have encouraged --
15 although now Esther was of the same mind, and it was a 10:50
16 model that was happening in another part of the Trust,
17 where a Ward Sister would go to another person's
18 environment and walk through, because fresh eyes could
19 see things differently. So we would have encouraged a
20 bit of internal 'this is the standards, walk through 10:50
21 next door to see'.
22 60 Q. Yes.
23 A. And that's one of the activities we started to
24 encourage to happen so that people could not be blinded
25 by 'This is how it is today'. 10:50
26 PROFESSOR MURPHY: We understood - sorry to interrupt -
27 we understood that senior nurses covered several
28 different wards.
29 A. Yeah.

1 PROFESSOR MURPHY: Like say three. Wouldn't it have
2 been their jobs to spot --
3 A. Yes.
4 PROFESSOR MURPHY: -- what was happening in Finglass?
5 A. Yes. Yes. 10:51
6 PROFESSOR MURPHY: And also what was happening in Erne,
7 because we've certainly had witnesses here describing
8 Erne as very poor, much the way you describe Finglass?
9 A. It would have been the Service Manager and the Ward
10 Charge, Ward Sister's key responsibility, and the 10:51
11 expectation on -- it's not unusual right across the
12 Trust that a Service Manager would have many service
13 areas to have responsibility for, but that individual
14 will be expected to work through the Ward Sister,
15 Charge Nurse, or indeed the appropriate person in that 10:51
16 post to actually assure themselves that the standards
17 have been met in the areas. So, yes, it should have
18 been.
19 PROFESSOR MURPHY: So what would they have said if you
20 had said to them, you know, 'How did these two wards 10:51
21 get into such a bad state that we were getting a lot of
22 criticism from RQIA?', would they have said: 'Well,
23 the Ward Sisters just weren't willing to change', or
24 that they didn't spot anything?
25 A. That did come up. That did come up on one occasion. 10:52
26 And then the conversation - again, I need to be
27 cautious here because these are -- they're
28 conversations that if I had it with Esther and then
29 Esther had with the Service Manager, so I just want to

1 be cautious about that. But through the reporting part
2 of Esther speaking to me about it, reluctance on some
3 individual Ward Sisters for change was apparent, and
4 then the encouragement in their development plan and
5 their staff appraisal, it was very important for 10:52
6 whoever was doing that to have that courageous
7 conversation and look at the developmental needs of
8 that individual, and the support needs that that
9 individual may have, and what was the rationale behind
10 the reluctance? Because later on in my statement when 10:52
11 I was back up in 2018, there were occasions when staff
12 communicated with me and I had a different appreciation
13 of what their reluctance might have been about, and
14 indeed actually something might have needed to happen
15 to alter that reluctance. Sometimes it was about being 10:53
16 very open about communication: 'This is the intended
17 outcome, this is the pathway of communication we wish
18 you to have on the ward and we need your commitment to
19 continue with this strategy for that person', i.e. the
20 person with a learning disability. 10:53
21 PROFESSOR MURPHY: Thank you.
22 CHAIRPERSON: But it sounds from what you've described
23 on those wards that the manager, the Nurse Manager or
24 the Ward Sister, had come to a point where they were
25 used to a certain set of standards and perhaps didn't 10:53
26 see that they were inappropriate, or did see but didn't
27 think they could do anything about it?
28 A. Well I think there were a number of individuals who
29 were very assertive, which is good, and they would have

1 brought up through their IR1 forms their concerns about
2 staffing, or their concerns about a range of
3 activities, and certainly they would have made it known
4 that they were uncomfortable, incredibly uncomfortable
5 with the mix of patients that were being expected to be 10:54
6 cared for in quite old buildings, and then my
7 understanding through the Service Manager and through
8 Esther is then they would have had those discussions
9 with the clinical team to look at, well, if someone is
10 profoundly autistic they do need space, they do need an 10:54
11 environment that is sensitive to their sensory needs,
12 and some of the old wards were very echo'ey, and loud,
13 and lacked space, so they weren't ideal, but it was
14 what was there.
15 CHAIRPERSON: I understand that. Sorry, Dr. Maxwell. 10:55
16 A. Sorry.
17 CHAIRPERSON: I understand that, but you've said that
18 when you proposed changes to try to get things better,
19 the uniforms, the toiletries, there was resistance.
20 A. Yes. 10:55
21 CHAIRPERSON: So it sounds as if there was an
22 acceptance that the way that things were being done was
23 acceptable.
24 A. Yes.
25 CHAIRPERSON: Right. Sorry. 10:55
26 A. Yes, that is fair to say.
27 DR. MAXWELL: Can I ask, so you've said that a number
28 of Ward Sisters raised their concerns on Datix forms,
29 IR1s, and certainly we've heard evidence of that at the

1 Inquiry. If this was being repeatedly raised and the
2 Ward Sisters couldn't do anything about it, how was
3 this being escalated to a higher level? Because the
4 plan from above was: 'This will all disappear soon
5 because the wards will close because the patients will 10:56
6 be resettled', and yet they weren't being resettled.
7 How were the concerns about the conditions in which
8 patients were living raised up through the Trust? I
9 mean you were aware of them.
10 A. Yes. Certainly what I am aware would have happened is 10:56
11 certainly the Co-Director then -- I'm not sure if I can
12 call him by name?
13 MS. KILEY: Yes, you can say. Yes.
14 A. John Veitch, he was a very good listener and he would -
15 he supported Esther. Although Esther was in a role 10:56
16 that was about moving the individuals into the
17 community, he would have then expected her to have a
18 greater role in the hospital, and between them they
19 would have looked from the budget point of view for
20 remediation activities around the wards to make the 10:57
21 ward a more liveable, comfortable space. So there was
22 that activity that did take place with John and Esther
23 in relation to furniture, curtains, you know, the
24 aesthetics that would make things more comfortable.
25 Ensuring that there was a bus for transport to 10:57
26 activities, that I think one was broken down and there
27 was a lack of another and, again, they would have
28 ensured that that came back so that activities could
29 happen for patients so the socialisation processes

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1 could continue. So there were activities that I would
2 have been aware of through conversation with Esther,
3 and then Esther on behalf of the Learning Disability
4 would have reported any activities that they were doing
5 back into the nursing meeting that I would have been at 10:57
6 with the Executive Director of Nursing.
7 DR. MAXWELL: Is this the Senior Nursing and Midwifery
8 Team meeting?
9 A. Yes. Yes.
10 DR. MAXWELL: So I take your point that they were 10:58
11 trying to remediate within their budget, but we've also
12 heard about constraints on budgets and overspends.
13 We've also seen the presentation of a summary of a
14 review of the staffing, which showed that at least some
15 of the wards were significantly underfunded, quite 10:58
16 apart from vacancies. These are not things that Esther
17 Rafferty and John Veitch could resolve themselves.
18 A. No.
19 DR. MAXWELL: It would need to be raised at a higher
20 level in the Trust. 10:58
21 A. Yes.
22 DR. MAXWELL: And you've given evidence that you were
23 aware of some of the problems. Where were these
24 problems being raised? Because although people were
25 taking actions, it's like a recurring theme from 2010 10:58
26 onwards, where in the Trust was it recognised that
27 whatever was in place wasn't working and patients were
28 still living in inadequate environments?
29 A. Well, I am aware that John and Esther would have taken

1 it to their divisional senior team. I'm not aware
2 whether it got to the Executive and the Board, I'm not
3 aware that of.
4 DR. MAXWELL: But you are aware that Esther raised it
5 at the Senior Nursing and Midwifery meeting? 10:59
6 A. Yes. Yes.
7 DR. MAXWELL: Which the Director of Nursing, Brenda
8 Creaney, was present at.
9 A. Yes. Yes.
10 DR. MAXWELL: So Brenda would have been getting regular 10:59
11 reports from Esther --
12 A. She would have had -- yes.
13 DR. MAXWELL: -- saying that these patients are living
14 in conditions that are not satisfactory.
15 A. Yes. Yes. 10:59
16 61 Q. MS. KILEY: Mrs. Mannion, can you recall the point in
17 time that those reports would have been made by Esther
18 Rafferty?
19 A. It was a monthly meeting, but I wouldn't be able to
20 give you the year, I do apologise, there was so many 10:59
21 pieces of activity going on. But each month there
22 would have been a meeting with the Executive Director
23 of Nursing. There would have been a Governance
24 meeting. There was the General Strategic Business Plan
25 meeting, and there was also a Nurses in Difficulty 11:00
26 meeting, which was all about regulatory activities.
27 And the other meeting was about, oh, hygiene and
28 cleanliness. So there were several meetings, and
29 different people went to, or different Associate

1 Directors, they were expected to go to all of them, and
2 at the time I was doing Education I would have been at
3 the general one and then the area of Education.
4 62 Q. We have discussed your own observations of the wards,
5 as it were, on Erne and on Finglass, and then at a 11:00
6 later point in time you were able to make your own
7 observations again whenever you returned to Ennis Ward
8 as part of the investigation team, and we've already
9 dealt with your evidence on that, that you returned to
10 Ennis Ward around December 2012, isn't that right? 11:00
11 A. Yes.
12 63 Q. And we've dealt with that already from your second
13 statement. You do address it in this statement at
14 paragraph 24 onwards. I'm not going to ask you to go
15 through it all, but just touching on the matters that 11:01
16 you've already described about your own observations.
17 Could we bring up paragraph 24, please? At paragraph
18 24, like you did with Finglass, you describe the
19 observations that you made whenever you looked at Ennis
20 Ward and when you were walking around it. If you 11:01
21 scroll down to the next page, please, you can see you
22 list some of the observations that you made. For
23 example, the first one there at (a) was that Ennis was
24 an old building and needed building and furniture
25 replacements, similar to the sort of thing that you 11:01
26 were saying just now about Finglass. But for example
27 there, you also describe how - if we scroll down to (b)
28 please, there was a lack of administrative support for
29 the ward. If we just scroll down to (h) then as well,

1 please? You say personal activities plans were not
2 always completed. And scroll down until we see the
3 rest of that, please, and just pause. Thank you.
4 There was no appointed patient support and recruitment
5 had stopped. 11:02
6
7 So, whilst there were those environmental issues that
8 we just looked at, and you've described in point (a),
9 the latter points are perhaps more wider issues,
10 perhaps are not such -- can't accurately be described 11:02
11 as environmental, they might be described as more
12 systematic issues. So having encountered those at that
13 time, did that not cause you to conduct a wider review
14 of the wards, of all wards in Muckamore, to see if
15 those systematic style issues existed elsewhere? 11:02
16 A. No, it didn't, but we would have directed Esther and
17 the Service Manager team to do that and to give us the
18 information back, back into the Director of Nursing
19 meeting.
20 64 Q. When you say "we would have done that" do you have a 11:03
21 recollection of directing Esther to do that?
22 A. I might not have called it "directing", but I would
23 have said to her: 'I believe you need to do this with
24 the Service Managers', and I know that -- I know,
25 because I would have had regular conversations with 11:03
26 Esther that she did do that.
27 65 Q. And do you recall the point in time that you directed
28 Esther to do that? Even if you can tell us roughly?
29 Was it as a response to the -- was it before or after

1 Ennis?
2 A. It would have been in and around the time of Ennis
3 that, you know, that there was a lot of activity around
4 Ennis and the expectation, not just of myself but the
5 Director of Nursing, would be that we need to do a 11:03
6 watchful eye into some of the other wards.
7 66 Q. And do you ever recall receiving feedback on that
8 having been done and how it went?
9 A. Oh, that would have come back into the Director of
10 Nursing meeting. Now there were at that time - there 11:04
11 was another disquiet at that time in that there were a
12 number of staff that Esther needed to progress through
13 the Nurses in Difficulty process, partly to do with her
14 more leadership roles around that area.
15 67 Q. This was in respect of the Ennis Investigation? 11:04
16 A. In and around the same time. So there were areas of
17 concern of practice that she began to pay a lot more
18 attention to. Now, it is important for me to make a
19 distinction in that that had not been her role, that
20 had been the Service Manager's role, but then because 11:04
21 of what had happened in Ennis that Brenda Creaney would
22 have said: 'I now want you do this', with the Service
23 Managers.
24 68 Q. I want to move on then to your next role, as it were,
25 which you took up in August 2018. If we could turn to 11:04
26 paragraph 26, please? And here, just while we're
27 waiting for it to come up on screen, you set out your
28 experience from August 2018 to February 2020, and this
29 is following the allegations that came to light in

1 respect of CCTV in 2017. And you describe how you
2 became involved in the investigation, and Esther
3 Rafferty first contacted you in or around August 2018,
4 isn't that right?
5 A. Yes. 11:05
6 69 Q. And you say just halfway down that paragraph:
7
8 "She reported that the level of incidents were greater
9 than first presented by another member of the
10 Divisional Leadership Team. I recall Esther said that 11:05
11 she believed that potentially Brenda Creaney and Marie
12 Heaney were receiving incorrect information from the
13 CCTV Review Team about the level and scale of the
14 alleged abuse."
15 11:06
16 Do you recall if during that conversation Esther gave
17 you any further information about why she believed
18 Brenda Creaney and Marie Heaney were receiving
19 incorrect information?
20 A. That's not -- that detail is not in my memory. She -- 11:06
21 well I took the call because she was trying to reach my
22 colleague who was in an acting position in the
23 Governance role, and it wasn't unusual that the
24 Associate Director of Nursing, if they couldn't get me
25 they might have rang my colleague or, likewise, if they 11:06
26 couldn't get my colleague they would have rang me. And
27 my advice to Esther is that this needed to be urgently
28 escalated if she had that concern. So, no, I didn't
29 have to remind Esther about the NMC and the expectation

1 of escalation, and the options that I would have
2 discussed with her and others was 'You can do this on
3 your own merit. You can - I can do it with you, I can
4 do it for you, but this is absolutely something that
5 needs to happen today, now', and Esther made a 11:07
6 commitment that she would bring it to Ms. Heaney and
7 Brenda Creaney that day.
8 70 Q. That she was going to do that herself?
9 A. Yes.
10 71 Q. And then you in fact went on holiday for a time. 11:07
11 A. Yes.
12 72 Q. And you describe then returning to a message from
13 Brenda Creaney asking you to attend a meeting.
14 A. Yes.
15 73 Q. And the meeting was on the 17th August. The meeting 11:07
16 was with Brenda Creaney and Martin Dillon, the Chief
17 Executive, isn't that right?
18 A. Exactly, yeah. Yes.
19 74 Q. And you say then, this is at paragraph 27, that at that
20 meeting those persons asked you to return to Muckamore 11:07
21 to support the Divisional Leadership Team. Can you
22 tell us more about what you were actually asked to do?
23 A. I tried to get clarity on that and it was suggested to
24 me at that meeting that Terms of Reference would
25 follow. They had informed me -- okay, so I had 11:08
26 discretely been continuing with my other activity, and
27 Brenda and Marie Heaney were asked to do extra
28 responsibilities in Muckamore at a time, and my other
29 colleague, who I haven't named, but in a similar role

1 to myself only in the Governance role, would have been
2 very active in Muckamore, and at that time, this is
3 pre-August, the expectation is that I would continue
4 with other activities and do delegated activities for
5 the Director of Nursing, as she was more actively 11:08
6 involved in Muckamore.
7 75 Q. And when you say "other activities" are you talking
8 about Governance activities?
9 A. No, no, I had -- I had -- well, you never stop
10 Governance activities, but the Governance aspect was 11:08
11 attributed to a different person.
12 76 Q. Yes. So what other activities do you mean?
13 A. I'm talking about education strategy meetings, I'm
14 talking about - she may - she did ask me on a couple of
15 occasions to go to the Chief Nurse meeting. So there 11:09
16 were other meetings that she wasn't in a position to go
17 to that she would have asked me to go to as delegation
18 on her part.
19 77 Q. Okay. And then at this meeting on 17th August, you say
20 you tried to get clarity on what your role was? 11:09
21 A. Yes.
22 78 Q. You were told that there were going to be Terms of
23 Reference?
24 A. Yes.
25 79 Q. But they never materialized, isn't that right? 11:09
26 A. No.
27 80 Q. But how did you leave the meeting? What did you
28 understand that your role was going to be?
29 A. I understood from what Martin Dillon said is that I was

1 to provide assurances to Brenda, and Marie, and
2 himself, that the environment was safe. But that's a
3 very large ask, but that was, that was my
4 understanding.
5 81 Q. Yes. But is it fair to say from what you describe in 11:10
6 your statement that you weren't totally clear about
7 what the parameters of your role were?
8 A. No.
9 82 Q. And one of the things you describe being asked to do
10 was to support the Divisional Leadership Team, and if 11:10
11 we could just scroll to paragraph 28, the end of that,
12 please, you just set out who the Divisional Leadership
13 Team were. So just to make sure that we're correctly
14 orientated, at that time the Divisional Leadership Team
15 was chaired by the Clinical Director? 11:10
16 A. Yes
17 83 Q. And then it comprised the Co-Director, the Senior
18 Social Worker, the Psychologist, and Esther Rafferty,
19 who at that time wasn't available for work. But what
20 did you understand your support function of that team 11:10
21 to be?
22 A. My understanding was to assist them to maintain the
23 accountability around operationalization of the
24 services.
25 84 Q. And what does that mean in layman's terms? 11:11
26 A. In layman's terms, it was to try and help them stay
27 focused on the job in hand providing a safe service for
28 patients.
29 85 Q. Okay. And was that because there was a perception that

1 there hadn't been that focus prior to you taking up the
2 role?
3 A. That was not said, but that was the feeling.
4 86 Q. You describe at paragraph 29 onwards your first
5 encounters at Muckamore, and you refer to the senior 11:11
6 team, halfway down there you say:
7
8 "I found senior staff acted in a passive aggressive
9 manner towards me."
10 11:11
11 And then further down at paragraph 30 you say:
12
13 "I cannot say that the senior staff were directly
14 against me but I regularly felt unwelcome."
15 11:11
16 A. Yes.
17 87 Q. Can you tell us a little bit more about how you were
18 welcomed at Muckamore and what you encountered in
19 respect of the senior staff's attitude?
20 A. It didn't feel like a welcome. However, I totally 11:12
21 understand that it wouldn't, in that when I was
22 introduced at the meeting Marie Heaney chose to say
23 that I was there to watch them or that they could be
24 stood down.
25 88 Q. Was this your meeting with the Divisional Leadership 11:12
26 Team?
27 A. Yes.
28 89 Q. On the 21st August?
29 A. Yes.

1 90 Q. So you've described that in your statement. Okay.
2 A. Yes. So that's not going to start off a good
3 relationship in that circumstances. And rightly so
4 they asked for clarity around objectives, about what I
5 was there to do, and was I there to assist them in 11:12
6 activities, and they were told that I wasn't
7 operationally involved but that I was there to give
8 them assurances, Marie Heaney and Brenda Creaney, but
9 it was Marie Heaney that was sharing that information
10 with the team. Now that was a meeting that hadn't -- 11:13
11 there was no administrative person there to record that
12 meeting, so I would be very surprised if there's a
13 record of that meeting. And I totally appreciated the
14 reaction that the members of the divisional team
15 offered, which was 'We don't need Moira here and we're 11:13
16 functioning very well', and there was an indication
17 that they would - they didn't need that support, but
18 they were informed by Marie Heaney that I would be
19 there.
20 91 Q. And was it explained to them why Marie Heaney and the 11:13
21 Chief Executive felt that they needed your support?
22 A. Not in front of me, and I'm not aware if there was an
23 explanation.
24 92 Q. And you have said because you didn't receive the Terms
25 of Reference that you yourself had some uncertainty 11:14
26 about your role?
27 A. Yeah.
28 93 Q. Is it fair to say the Divisional Leadership Team then
29 probably had uncertainty about your role, if you didn't

1 know what it was?
2 A. Absolutely. Absolutely. And that's why I wouldn't be
3 punitive towards them about it. I have had the
4 opportunity in the organisation to be in parts of the
5 organisation where there's been very high anxiety when 11:14
6 the Trust was in special measures, for example the
7 Hyponatraemia Review, the Neurology Review. There's
8 very sadly a number of reviews that can happen. And
9 one of the things that I learnt from that activity is
10 that your introduction to the individuals, and the 11:14
11 clarity of the role that you may have, and indeed that
12 may change, but again if it's fluid and it is changing
13 you can begin to communicate that fluidity with the
14 individuals you're working with. That sets the
15 standard of what might happen, and on this occasion 11:15
16 that didn't happen in a very positive way, which I then
17 felt I needed to reach out, and simple things like
18 'Let's have lunch together, let's have a cup of coffee
19 together, please appraise me in the timely way about
20 the meeting that I'm meant to be at to get an overview 11:15
21 of the accountability framework, to get an overview of
22 the assurance mechanism that you're using, for an
23 overview of the business plan that you're engaged in'.
24 So although I didn't have a place in that plan, or I
25 didn't have an action that I was meant to engage in, 11:15
26 there was an expectation from Marie Heaney and Brenda
27 for me to have an overview of are they functioning and
28 are they continuing to work on that? And, again, they
29 may have perceived me as an equal from a grade

1 perspective, so again that may have been part of why it
2 was difficult for them to accept me watching over them.
3 94 Q. And you describe the need to have a solid introduction.
4 Who do you think - who ought to have been responsible
5 for giving you that introduction to the Divisional 11:16
6 Leadership Team?
7 A. I still think that Marie Heaney would have been the
8 responsible person, because she was the Director, and I
9 don't know whether Marie had any great clarity about
10 what it was that she wished me to do. So for me, as a 11:16
11 member of staff, I would have liked them to pause,
12 think about the objectives they wished me to achieve,
13 even if it was just the first three weeks, and that was
14 what we would have opened up the meeting with: 'Moira
15 is here, and this is the purpose, and these are the 11:16
16 three activities we're asking her to do', and it might
17 have made a difference in the introduction.
18 95 Q. Are you saying that you were asked to go in to bring
19 focus, as you have described it, to the Divisional
20 Leadership Team, but those who asked you to go in 11:17
21 didn't bring any focus to your role.
22 A. No.
23 96 Q. Is that fair to say?
24 A. I have to say Brenda Creaney did, because she was
25 asking me very clearly from a nursing perspective. So, 11:17
26 you know, I knew that she wished me to meet with the
27 Ward Sisters, I knew that she wished me to have
28 leadership walkarounds. So Brenda would have been very
29 directive about what she expected from a nursing

1 perspective.
2 97 Q. Okay.
3 A. But it was less so from the Divisional Team.
4 98 Q. Yes. And you say more about the Divisional Team at
5 paragraph 34, and I want to go to that, please. It'll 11:17
6 be up on your screen shortly. Will you zoom in,
7 please, on paragraph 34. You say there:
8
9 "Marie Heaney initially told the Divisional Leadership
10 Team that they must stand down while the investigation 11:17
11 was ongoing. This did not occur during the time I
12 attended MAH."
13
14 Are you saying that that didn't occur because it wasn't
15 implemented, or are you saying that the Divisional 11:18
16 Leadership Team refused to stand down?
17 A. I don't - I don't know if there was a difference? It
18 just didn't happen.
19 99 Q. And you say further down paragraph 34, just the final
20 line there and across the page: 11:18
21
22 "The Divisional Leadership Team included staff from..."
23
24 - can you scroll up just until we see the last
25 sentence, please? Just pause there: 11:18
26
27 "...different professional backgrounds who had strong
28 professional views."
29

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1 If we just scroll down, please.
2 CHAIRPERSON: Next page.
3 MS. KILEY: Pause:
4
5 "It seemed unclear if they had support to develop a 11:18
6 team vision. My perception was that they would often
7 disagree on how to improve policy or practices that
8 aimed to be in the best interest of patients and staff.
9 As a result, the team did not appear to gel. I felt at
10 times that people were not given the right resources to 11:19
11 get things resolved in a timely manner. Some meetings
12 with the Divisional Leadership Team were not recorded
13 as there was no administrative staff to take notes and
14 minutes. I do not know how many meetings were held
15 where minutes were not taken. Eventually 11:19
16 administrative support was brought in to keep a record
17 of the meetings. During these meetings confidential
18 and sensitive information was discussed and there were
19 times that before 5 p.m. on the day of the meeting the
20 Irish News reported what was discussed. For example, 11:19
21 details of the number of staff who had been suspended.
22 I wondered who present at the meeting relayed this
23 information to the Irish News. We never found out who
24 shared this information, which did not help the team to
25 come together in a trustful manner." 11:19
26
27 Now reading that and what you have said about your
28 welcome by the Divisional Leadership Team, it sounds
29 like the Divisional Leadership Team was dysfunctional.

1 Is that a fair description?
2 A. That would have been - that would have been my
3 perception.
4 100 Q. And was leaking in fact at one stage in respect of very
5 serious and sensitive matters, is that fair? 11:20
6 A. Yes.
7 101 Q. You were brought in and you encountered this situation.
8 Did you report back up to the Executive Team what you
9 discovered?
10 A. Yes. I would have reported to Marie Heaney, Brenda 11:20
11 Creaney. There was one occasion when Brenda was on an
12 annual leave and I was unable to access Marie Heaney
13 and I reported it to Jacqui Kennedy the HR Director,
14 and I also --
15 102 Q. What were you reporting? What were you saying about 11:20
16 the Divisional Leadership Team?
17 A. I was reporting that they were actually finding it
18 really difficult to continue to work in the environment
19 that they were at. So as an example, there was - one
20 of the team was actually asserting that another member 11:20
21 of the team was being abusive to staff, and there
22 didn't appear to be anything to substantiate that. So
23 they were really opposed to one another in an
24 argumentative manner. So that would have been what I
25 would have been reporting to. And what I was concerned 11:21
26 about is, if there was that level of disquiet among
27 these individuals, who already felt very watched, there
28 is another level underneath, that, you know, the
29 Service Managers are not going to have a positive

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1 impact when you've individuals that are, who are
2 perceived leaders, who are not able to have a
3 consensual conversation about issues.
4 103 Q. And in your observations did you observe -- what was
5 the impact of those difficulties in the Divisional 11:21
6 Leadership Team on the wards?
7 A. What I would have noticed is that certain individuals
8 would have gravitated towards the person who was making
9 the accusations, with more information about perceived
10 poor practice in areas, and you were always concerned 11:22
11 is; is this their truth? A truth? Is it a perception
12 because people are asking you to be more accountable
13 for your practice? So it was a very, very, very
14 difficult environment.
15 104 Q. And when you were reporting these things back up, what 11:22
16 was being done to change and to bring some focus and
17 some --
18 A. Well some activities, for example, is that they did
19 attribute an administrative person to the meetings.
20 105 Q. But what about the relationship issues that you have 11:22
21 described?
22 A. Well, there was offer of counselling for the members of
23 the team. One person would have said they didn't need
24 it, the other person would have said that they did.
25 There would have been - there was an offer of mediation 11:23
26 as well in relation to it. So there were attempts to
27 change what might have been happening in the
28 relationship.
29 106 Q. Were those attempts successful?

1 A. Not apparently. I do believe they did engage, but I --
2 the time I was there I didn't witness a big change.
3 What you would have observed is they would have
4 functioned at the meeting and then just left, there was
5 no supplementary conversation, and that in itself is 11:23
6 not necessarily a bad thing, but it's about how do you
7 negotiate the next step in that action plan? How do
8 you progress that in the person-centred,
9 patient-centred way, you know? So, yes, there's a
10 point where you can function and do an action, but it's 11:24
11 the supplementary bit that makes it a comfortable
12 environment for patients that you need that discussion.
13 So again trying to get people to open up and have a
14 discussion.
15 11:24
16 What you would have been -- what I would have been
17 involved in is hearing one person's voice above another
18 person's voice, and then I might have - and I'm not shy
19 - I would have been assertive enough to say: 'This
20 sounds as if we're shouting at one another. Can we 11:24
21 take the volume down?'. That is what I would have said
22 at some meetings. Now, that was not necessarily
23 welcome, but then there were occasion that they took
24 that lead and then they would have taken the level
25 down. But I would describe it as politeness around how 11:24
26 a meeting should function, and what I mean is that, you
27 know, if it's my turn to give a report, you might - I
28 might say 'This will take me five minutes to give you a
29 recall of this', and I invite questions during my

1 recall or I invite questions afterwards. There would
2 have been interruptions, there would have been talking
3 over each other, there would have been wanting to sound
4 a bit louder than the other, and it often felt as if we
5 had an hour's discussion with no progressive changes to 11:25
6 the --
7 CHAIRPERSON: Who was chairing these meetings?
8 A. Marie Heaney would have chaired some of them and
9 Mairead Mitchell would have chaired some of them.
10 CHAIRPERSON: And it sounds as if you were sent in, you 11:25
11 put it to provide clarity, but really to perhaps knock
12 some heads together?
13 A. There was a bit of that.
14 CHAIRPERSON: Yeah. But you didn't have the authority
15 to do it? 11:25
16 A. No.
17 CHAIRPERSON: Or did you?
18 A. Which meant that I didn't feel very welcome a lot of
19 the time. So it was very difficult.
20 CHAIRPERSON: I understand. 11:25
21 A. And because I would have attempted not to raise my
22 voice unless I felt I needed to take the volume up and
23 take it down very quickly, ehm, I always had to think -
24 this sounds a bit bizarre, but I had to think about
25 where strategically I sat in the room and what 11:26
26 authority that might offer me in relation to what was
27 going on.
28 CHAIRPERSON: Well that was what --
29 A. So it wouldn't have been unusual for me to sit not far

1 away from the eyeline of the Chair, in an attempt that
2 if I felt that the meeting's temperature was raising,
3 that I might be able to encourage a diversion of that.
4 So I was very conscious of my actions in those
5 meetings. 11:26
6 CHAIRPERSON: Is there any way of defining where your
7 seniority lay? There's a hierarchy normally to these
8 things. Where did you lie, as it were, in those
9 meetings in terms of seniority?
10 A. My perception was that I was perceived by Marie Heaney 11:27
11 as an equal of the Divisional Team. So my perception
12 was that she found it difficult when I challenged her.
13 DR. MAXWELL: She felt you were junior to her?
14 A. Yes. And my perception was that I was there as a
15 deputy to her. So a little above the Divisional Team, 11:27
16 but not at her level, but that I -- I professionally
17 believe that if I'm working with someone who is in a
18 higher office than myself, if I have a perception or
19 belief that their behaviour is such that I need to
20 bring it to their attention, my preference is to do it 11:27
21 in a discrete way, but I still have the professional
22 responsibility to bring it to their attention that
23 something needs to change.
24 DR. MAXWELL: You talk about these meetings, and it
25 sounds like they weren't very well chaired, and 11:28
26 chairing a meeting is a skill that not everybody has.
27 A. Yes. Yes.
28 DR. MAXWELL: Was there ever any suggestion that there
29 might be some development days to set some ground rules

1 for how teams work together, how to chair meetings?
2 A. That suggestion did go in and the leadership centre
3 were asked to do some development work, and then
4 individuals in the Divisional Team were encouraged to
5 go into the improvement science course that Scotland 11:28
6 was providing to Northern Ireland. But, again, my view
7 is because they weren't actually in as a team --
8 DR. MAXWELL: I was going to ask that.
9 A. -- they were developing on their own. But it's that
10 collective didn't appear to be... 11:28
11 DR. MAXWELL: So there was no recognition that this
12 team wasn't working and they needed some team
13 development?
14 A. Yes.
15 DR. MAXWELL: It was all about individual development. 11:29
16 107 Q. MS. KILEY: And you have described the difficulties
17 that you faced because of your level of authority in
18 addressing the issues with this team, but who in the
19 Trust had the level of authority that ought to have
20 been capable of addressing the issues with the 11:29
21 Divisional Leadership Team?
22 A. The Director.
23 108 Q. And are you saying that through your reporting was the
24 Director aware of the issues --
25 A. Yes. 11:29
26 109 Q. -- with this team. But are you saying that the
27 measures that were implemented were not sufficient to
28 address the problems?
29 A. Well I understand that when you ask someone to go into

1 a development programme, whether that's with the
2 leadership centre or whether it's another programme,
3 releasing staff who have, who have a lot of
4 responsibilities, and each member of that team had a
5 lot of responsibilities, if you make a commitment to go 11:30
6 to the programme, that's one thing, but you can be
7 distracted with the busyness of the day and believe
8 that you can't release yourself to go to the
9 development day, and it can be a challenge. I'm unsure
10 about whether they believed they had the freedom to say 11:30
11 "I am going to that development" or -- and I cannot say
12 for certain, and I couldn't say for certain if the
13 busyness helped them not go into the programme of
14 development.
15 110 Q. But ultimately the observations that you have made and 11:30
16 shared about the team persisted during the time that
17 you were at Muckamore, is that right?
18 A. Yes.
19 DR. MAXWELL: Can I -- you said in answer to the
20 question that the Director was ultimately the person 11:30
21 with the authority to do something, and the Director
22 was Marie Heaney.
23 A. Yeah.
24 DR. MAXWELL: Who was chairing these meetings that were
25 at best not productive. So was the Director actually 11:31
26 part of the problem?
27 A. Yes.
28 DR. MAXWELL: So ultimately it was the Chief Executive
29 who would be the Director's line manager.

1 A. Yes.
2 DR. MAXWELL: Who was responsible for sorting this.
3 A. Yes.
4 DR. MAXWELL: And, he, together with Brenda Creaney,
5 had asked you to go in. Did you ever do any reports 11:31
6 directly back to the CEO that this team wasn't working
7 and the Director wasn't --
8 A. I did to the Deputy Chief Executive. That would have
9 been Cathy Jack at the time. I did report back to her.
10 DR. MAXWELL: To Cathy Jack? 11:31
11 A. Yes.
12 DR. MAXWELL: So Cathy Jack, acting for the CEO, was
13 aware that the team wasn't working. Part of that
14 responsibility lay with the Director, Marie Heaney. Do
15 you know if anything was done or was that something you 11:32
16 wouldn't expect to know because she was senior to you.
17 A. I wouldn't expect to know, but certainly I also
18 encouraged Marie to avail of the support with her
19 executive social work colleague who held executive
20 responsibility for social work, and she dismissed that 11:32
21 suggestion. Because I felt she was a very well
22 intentioned individual, a very professional individual,
23 so I have no -- but I think she was quite overwhelmed
24 by what was happening, 'Am I being told the truth?
25 What is the depth of this reality?', and I felt she 11:32
26 needed to -- if she felt that I was subservient to her,
27 she needed someone at her level, or her perceived
28 level, to give her the support that she may need to
29 address such issues.

1 DR. MAXWELL: But you are clear that somebody more
2 senior than her, Cathy Jack --
3 A. Did know about it.
4 DR. MAXWELL: -- was aware that these dysfunctional
5 relationships was quite intense and they were impeding 11:33
6 a proper responsibility to the allegations.
7 A. Yes.
8 CHAIRPERSON: I think we've gone on much longer than we
9 normally do before we taking a break, so we'll take a
10 break now. It looks to me as if we might have to sit 11:33
11 into the luncheon adjournment, but we'll see where we
12 get to.
13 MS. KILEY: We'll see. If we take perhaps the usual 15
14 minutes now?
15 CHAIRPERSON: Yeah. Okay. 11:33
16 MS. KILEY: Thank you.
17 CHAIRPERSON: We'll take a 15-minute break. You'll be
18 looked after. Thank you very much. And can we try and
19 stick to the 15 minutes because we're under a bit of
20 time pressure. Thank you. 11:33
21
22 THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS
23 FOLLOWS:
24
25 CHAIRPERSON: Right. 11:48
26 111 Q. MS. KILEY: Okay, Mrs. Mannion. Before the break we
27 were discussing the Divisional Leadership Team. I'm
28 going to move on from that now, but I just want to
29 clarify a point in time with you, if I can? In answer

1 to Dr. Maxwell's question you referred to having raised
2 the issue with the Deputy Chief Executive at the time,
3 Cathy Jack. Can you say even roughly when you raised
4 that issue with Cathy Jack?
5 A. I'm sorry, I won't be able to recollect that. At the 11:49
6 time it would have been during -- it would have been in
7 the winter time.
8 112 Q. Okay.
9 A. It wouldn't have been too long into the time when I was
10 -- 11:49
11 113 Q. So winter 2018?
12 A. It would have been prior to the Christmas.
13 114 Q. Okay.
14 A. It would have been before Christmas, because at
15 Christmas there was a major concern about staffing 11:49
16 issues that we had to close a ward.
17 115 Q. Yes.
18 A. So it would have been preceding that.
19 116 Q. It preceded that. And I'm going to come on to ask you
20 about that shortly actually. 11:49
21 PROFESSOR MURPHY: Before we go on, could I just ask
22 one quick question about this team that you felt was
23 dysfunctional. It was a time when matters were very,
24 very difficult within Muckamore, and sometimes teams
25 become dysfunctional when there are major stressors 11:50
26 that they can't seem to solve, it may be difficult to
27 answer this, but, do you think they were dysfunctional
28 before the 2017 allegations of abuse came out?
29 A. My perception was that they were, and what I can say to

1 you is that the Trust had initiated a concept called a
2 Triumphant Management Structure, which was this
3 leadership level, and in other parts of the Trust it
4 would have been - a Chair was a Medical Chair with the
5 expectation of greater insight to managerial activities 11:50
6 by the medics, because at that time there was a report
7 in Northern Ireland about lack of leadership in the
8 medical fraternity. This is a model I believe that had
9 occurred in other places in England, so it was adopted
10 here. So the relationship would have been the 11:51
11 Co-Director, who would have had ultimate operational
12 service responsibilities, the medical individual, and a
13 senior nurse, and it would have been the three were
14 expected to work together. And in other aspects of the
15 Trust they were engaging in a development programme to 11:51
16 work as a team, to look at professional issues and
17 matters, and then they would have worked with their
18 service management colleagues and then the team
19 colleagues. The understanding of that Triumphant Model
20 was to release the Executive Team to focus on greater 11:51
21 strategic matters and not meet necessarily meet
22 frequently on issues they believed that the service
23 teams could complete. In Mental Health and Learning
24 Disability there was a significant disquiet, they did
25 not believe in the model, there was a lack of 11:52
26 understanding about the model, there was access to
27 visit environments that operated the model very
28 successfully in England, and then there was a
29 competitiveness with the multidisciplinary approach,

1 you know. So in Mental Health they believed you needed
2 to have the social worker involved and you needed --
3 you know. So they were appealing to not it being a
4 Triumphant, but being a more collective, and they had a
5 preference for it to be a different name. 11:52
6
7 So the team in Muckamore, you would have had the
8 Co-Director, who at that time had moved from being the
9 Governance person into a Co-Director role, who was of a
10 nursing background, who held, in my perception, a 11:52
11 belief that they didn't need a nurse on the team
12 because they understood nursing. So they were
13 rejecting of the nurse being part of the team. The
14 medical person didn't appear to see the importance of
15 their involvement because they had so many other 11:53
16 activities that they had responsibilities for. The
17 psychologist of the team was part of the Trust
18 Psychology Team, so, therefore, the time apportion that
19 they may be able to give to the Divisional Team, and
20 then the person who was of a social work background had 11:53
21 a very, very significant eye to Safeguarding, and
22 didn't always quite appear to think about themselves in
23 the context of that collective. So that was happening
24 before the news and that -- and, again, when new teams
25 form we will know that it takes a while for people to 11:53
26 form and norm and storming -- older language maybe,
27 maybe it's more modern now that I'm gone -- but, you
28 know, you know the teams will take a time, but that
29 there was a dysfunctional level beforehand.

1 PROFESSOR MURPHY: Thank you.
2 117 Q. MS. KILEY: Okay, Mrs. Mannion, I want to move on now,
3 because at paragraph 33 of your statement, if we could
4 bring that up on screen, please, you discuss the CCTV
5 reviewing process that was ongoing at this time 11:54
6 whenever you returned to Muckamore in 2018, so I want
7 to look at that, please, paragraph 33.
8
9 I won't read all of this out, but to summarise it, you
10 describe two levels of review, I think. So the first 11:54
11 is a level by external staff, and the second is by the
12 Safeguarding Team, internal, if I can put it that way.
13 Is that a fair summary?
14 A. Yeah.
15 118 Q. And so you have these two teams reviewing the same 11:54
16 footage, isn't that right?
17 A. Mhm-mhm.
18 119 Q. And observing that, did that not ultimately delay
19 things, because it meant that teams weren't acting --
20 teams were acting sequentially essentially. So the 11:55
21 first level was reviewing it first, the second level
22 was then reviewing it. So it took longer for a
23 safeguarding referral to come through the system, is
24 that what was happening?
25 A. There will be two parts to this, so, sorry, if I can't 11:55
26 be too short in my answer.
27
28 There was an independent group of individuals who were
29 recruited to watch every minute of the CCTV and try to

1 make a determination on whether it needed to go into
2 safeguarding or whether it needed to be a professional
3 practice issue.
4 120 Q. And that's the first level, the external?
5 A. The first. External. 11:55
6 121 Q. Okay.
7 A. And there was a Service Manager individual who would
8 have provided them support. It was a room quietly
9 discretely at the bottom of the administrative
10 corridor. Then that Service Manager would have 11:55
11 reported to the Co-Director. Then the Co-Director
12 would have reported to the Director, and then the
13 Director would have reported it into the Board team.
14 The Safeguarding Team at that stage were only two
15 individuals. So the Trust -- I think no-one understood 11:56
16 that it was to the gravity that it became. So there
17 was two individuals then trying to do the second level
18 assessment, but they also had an experienced MAPA
19 assessor in that team, and those individuals would have
20 assessed for whether the movements of staff were 11:56
21 congruent with MAPA and how you approach a situation to
22 calm and de-escalate a situation, and then equally the
23 safeguarding would have done. And then the expectation
24 is that they would make a referral and then the
25 sanctions would have been applied as per the 11:56
26 Co-Director. And that continued discretely, and I
27 wouldn't have been involved in that, but would have
28 been aware of just that it was happening.
29 122 Q. Yes.

1 A. Then there was a period of time that the police voiced
2 their concern about the material being on the Muckamore
3 site. Now, from memory there was a talk about whether
4 or not it was an electrical interruption and whether
5 that may have led to either some of the material not 11:57
6 being as available as it could be on the CCTV material,
7 but the police did indicate to the Trust that they were
8 taking all of the material off the Muckamore site and
9 did so.
10 123 Q. That was at a later point in time, isn't that right? 11:57
11 A. Yes. Yes.
12 124 Q. And I think you describe that later on as part of the
13 role that you return to Muckamore after your
14 retirement, isn't that right?
15 A. Yes. Yes. 11:57
16 125 Q. Okay. Well I'll pause that and come back to that then.
17 But just thinking about this point in time then and the
18 two-level review that you weren't part of but you
19 observed. You refer at paragraph 33 to Brendan Ingram,
20 who the Inquiry has heard from, and you say that: 11:58
21
22 "The CCTV footage in Muckamore Abbey Hospital was
23 reviewed by external staff at first level who then
24 presented their review to Brendan Ingram and the
25 Co-Director." 11:58
26
27 I just wanted to check that with you. The Inquiry has
28 heard from Mr. Ingram and he has essentially told the
29 Inquiry, and I am summarising, that his role was

1 effectively an administrative one and he was collating
2 the forms to give to external viewers, so that he
3 didn't have an integral role in this process. Was that
4 your understanding or are you saying that he had
5 something -- 11:58
6 A. No, that would, that would describe.
7 126 Q. Okay.
8 A. But I suppose the one that I would add is that he was
9 expected - that report was meant to be going to Mairead
10 so that Mairead could take it for assurance purposes 11:58
11 into the system.
12 127 Q. Okay. But Mairead Mitchell, is that then?
13 A. Yes.
14 128 Q. Was the decision-maker in that process?
15 A. Yes. 11:59
16 129 Q. Okay. You then go on to describe observations that you
17 made at the wards at various times. If we could go to
18 paragraph 33, please? And, again, just to be clear,
19 whenever you were at Muckamore at this point in time,
20 this was the time that you were exercising the function 11:59
21 of bringing focus to the Divisional Leadership Team.
22 So you didn't have a formal role in respect of the
23 observations of the wards, but these were observations
24 that you were making when you were there, is that
25 right? 11:59
26 A. [No verbal reply]
27 130 Q. So paragraph 35, please. You describe at paragraph 35
28 reviewing nursing practices on Cranfield 1 and
29 Cranfield 2, and you describe -- if we could just pause

1 there, please? You describe, for example, the volume
2 in the ward, and it being noisy and understaffed, and
3 echo'ey, and that relates to the environment, I
4 suppose. But aside from those things, did you make any
5 observations about the nursing practices that were 11:59
6 taking place on Cranfield 1 and 2 and how they were?
7 A. Certainly my observation was that the -- well the
8 registered nurses and the healthcare support workers
9 were working as a team, and I believed they were doing
10 as much as they possibly could. The Ward Charge in 12:00
11 Cranfield Assessment Ward -- I always get confused
12 about which one is 1 and 2, but the Assessment Ward was
13 endeavouring for the nurses to make timely reports on
14 the records on PARIS system. So he was actively
15 encouraging his staff to engage constantly in different 12:00
16 things, but they were receptive to that, and certainly
17 at some of the handovers that I would have gone by
18 invitation, or sometimes just I would have gone in, and
19 it was working as a very good team, as was the ward on
20 the other side. 12:00
21 131 Q. As was?
22 A. The other Cranfield.
23 132 Q. Cranfield 1 and 2?
24 A. If I say 1 and 2 I'll get them confused, but there was
25 the Assessment Unit and then there was the continuous 12:01
26 treatment side, and --
27 133 Q. And both in your view were working well?
28 A. Both were functioning well. They were very, very
29 concerned if, for example, I was the nominated person

1 who would be the response nurse, so in other words if
2 an incident happened next door that day, when the alarm
3 would go off I would have to respond to support the
4 team on the other side, and their staff numbers were
5 depleting in such a way because of suspensions, and 12:01
6 sickness, and maternity leave, and other family matters
7 for some members of staff, they were getting concerned
8 about then the safety of the ward that they were on.
9 134 Q. Yes.
10 A. And then that would have been brought back to Mairead 12:01
11 and the team to look at.
12 135 Q. So are you saying this was something that you observed,
13 and did you bring it back to Mairead and the team to
14 look at?
15 A. Yes. Yes. And would I have encouraged the ward. 12:01
16 There was a feeling that the Ward Sisters, they didn't
17 feel that people were listening to them. They didn't
18 feel that they were being communicated with clearly.
19 So what you found is that the initial couple of visits
20 people chose just to tell me I suppose maybe what they 12:02
21 thought I wanted to hear, but when they became more
22 comfortable with me in the environment they then began
23 to bring to my attention the things that they were
24 concerned about. So just to give you an example, there
25 was a young nurse who would have been in her 12:02
26 preceptorship period, which is you are now a Registered
27 Nurse but for six months you get additional supports to
28 become confident in your role as a nurse, that
29 individual on Cranfield, it would have been on the left

1 side, so it's the one that's closest to the admin
2 building, she brought it to the attention of RQIA that
3 they were short-staffed and RQIA came to visit, and
4 when I went to visit her to thank her for bringing it
5 to the RQIA's attention, and also to ask her: 'What can 12:03
6 we do to make it feel safe for you?', and what we
7 discovered is because of the rostering, nurse rostering
8 system, on that ward had not been as well attended to
9 as it could be, you were never sure who you were going
10 on shift with the next day, or whether or not you had a 12:03
11 mix of experienced staff to actually function safely on
12 the ward. So with her and the Ward Sister - I also had
13 a responsibility for the bank and rostering team in the
14 Trust at the time, and I asked the team to come and
15 support them to look at the rostering, to look at the 12:03
16 equation and the balance of seniority and experience
17 and, you know, how they attribute that across the
18 thing, and that made a big difference, and certainly
19 that young lady three/four months later came and
20 thanked me that I had listened. So staff started to -- 12:04
21 and I know that wasn't necessarily my role, but I also
22 believed that if I could resolve some of the day-to-day
23 issues with the staff, and giving them the
24 assertiveness to bring things up and suggest solutions,
25 that we might begin to see a difference in the culture. 12:04
26 So that's just one example that made a big difference.
27 DR. MAXWELL: Can I just ask you about the staffing,
28 because the Inquiry has heard lots of times from 2012
29 on when people have raised serious concerns about the

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1 funded establishment, so we'll set aside vacancies for
2 a moment, and lots of times people went in and did
3 Telford, although they were never clear what the
4 criteria around the professional judgment was, but
5 every time they did it they found it was significantly 12:04
6 underfunded. So we saw a roster analysis in 2015 that
7 suggested Cranfield 2 only had half the funded
8 establishment it should have had, but now you're here
9 and there are still vacancies, there's still shortages,
10 and I think you did you another -- 12:05
11 A. I did.
12 DR. MAXWELL: You were one of the people who did a few
13 of these reviews. Why was the funded establishment
14 never right?
15 A. Oh. Well when I -- I met with the finance officer. My 12:05
16 first response there would nearly have said "I don't
17 know", but when I couldn't understand the finer detail
18 of finances, I met with the gentleman who was the
19 responsible finance officer, and at a point in time
20 there had been an understanding that some monies needed 12:05
21 to be saved, I can't remember whether it was gain or
22 more, but there were different strategies over
23 different periods of time that there needed to be
24 saving of money within the Department post Applebee and
25 other reports, forgive me if Applebee wasn't connected 12:06
26 to Learning Disability, but it's that type of review
27 which suggests you need less of and you need -- so at
28 that time that had happened, and the finance officer
29 took me through how he believed that if we got the

1 vacancies covered that that would be the first step to
2 making an argument for looking at the financial aspect
3 of looking for more funding from the Department. Well
4 not the Department at that point, we would have gone to
5 the Public Health Agency for the funding, because they 12:06
6 were the Commissioners of Services.
7 DR. MAXWELL: So are you saying there would be reviews,
8 and the Telford model, or later a different model,
9 would say 'Actually, based on these patient's needs
10 this is the number of staff you need, this is the mix 12:06
11 between - the percentage of Registered Nurses', and
12 that might be funded, and then there'd be a round of
13 costs savings, usually it was 3%, wasn't it?
14 A. Yeah. Yeah.
15 DR. MAXWELL: And that that would be cut. 12:07
16 A. Yeah.
17 DR. MAXWELL: And then something would happen and
18 there'd be another review of staffing where somebody
19 would say 'This isn't the right' --
20 A. Yeah. 12:07
21 DR. MAXWELL: So that was happening on a cycle?
22 A. It was happening --
23 DR. MAXWELL: -- of getting it right, cost savings.
24 A. Yeah, yeah. And certainly the other strategy that was
25 happening at the time with the delivering care model, 12:07
26 which was about patient safety and about having the
27 right number of staff for the needs of the individuals
28 on the ward, and at that time the focus was on the
29 acute services rather than on Learning Disability, and

1 that was being requested by ourselves through ECG,
2 through the Director of Nursing, through to the Chief
3 Nurse, and that would have been the last year of my
4 work where we were really saying that Mental Health and
5 Learning Disability, both districts needed to have a 12:08
6 building up of the skill set in relation to - and a
7 true review, because no-one could find a model that was
8 easy to use for Learning Disability and Mental Health,
9 it hadn't been created at the time, and there was --
10 hopefully I don't get this person's name wrong -- 12:08
11 Professor, I think it's Jane Bell, had done a lot of
12 work about if you've less nurses --
13 DR. MAXWELL: Jane Ball.
14 A. Yes. Yes, thank you.
15 DR. MAXWELL: The Care Left Undone. 12:08
16 A. Very significant work. So when we would have put her
17 argument in saying, well, if this is what's happening
18 in Learning Disability, her outcome measures are - we
19 can't say they would be attributed to Learning
20 Disability. So there would have been a lot of 12:08
21 discussion and putting forward that things needed to
22 change. Certainly Esther Rafferty did several
23 workforce reviews. She would have worked closely with
24 -- I had an incredible young woman who did work for me
25 in the workforce team who would have went up and worked 12:09
26 in the area, and at the same time we also then expected
27 the bank to have an external contract for bank and
28 agency staff. We sat with the Ward Sisters and said
29 what the criteria needed to be, so in other words what

1 are the skill sets they absolutely needed to be. They
2 needed to have Learning Disability qualifications and
3 they needed to have the MAPA qualification to come into
4 the ward. That was achievable at the start of this
5 process when I was there. As things progressed, more 12:09
6 staff started to choose not to work in Muckamore, as
7 well as then some staff being asked not to work, and it
8 became much more complicated.
9 CHAIRPERSON: It sounds as if the feeling was until you
10 had filled the funded posts that you had, there was no 12:09
11 point going back to ask for more money.
12 A. That certainly was the -- that came from the finance
13 officer, and then I would have brought that attention
14 to Marie Heaney and the Co-Director. Because what I
15 was saying to them is, we can't only be driven by 12:10
16 finance. If we really believe that this is about a
17 patient's need area, we need to say that may justify
18 that expenditure.
19 CHAIRPERSON: But you had to fill those posts.
20 A. There was a lot of money being spent. 12:10
21 CHAIRPERSON: Yeah.
22 DR. MAXWELL: But there's two problems with that. One
23 is you're disguising the true level of lack of
24 staffing.
25 A. Yeah. 12:10
26 DR. MAXWELL: Because if you're only trying to get to
27 the funded establishment, and that's only half of what
28 you actually need, the message isn't getting out there
29 how few staff you have to meet these patient's needs.

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1 And, secondly, that might be one of the reasons nobody
2 wants to work there, because it's not funded to the
3 level that's required. So even if you do go there,
4 you're going to have an environment where you're not
5 going to be able to deliver the care you want to 12:10
6 deliver. So there are real reasons --
7 A. Yeah.
8 DR. MAXWELL: -- why that was a bad move.
9 A. Mhm-mhm.
10 DR. MAXWELL: But you're saying that the view was we 12:11
11 would only look at the funded establishment, whether it
12 was right or wrong?
13 A. At that point in time. And, hence, why I would have
14 started making arguments. And I do remember that I was
15 told that that wasn't the role that I was there to do, 12:11
16 but it's important for me to question why would we
17 depend on that aspect? And also I did support Esther
18 Rafferty in that within the delivering care model there
19 was some funding that came across to have the Deputy
20 Ward Sister role in each ward so that the Ward Sister 12:11
21 could, Charge Nurse, could take responsibilities as
22 they needed to, and that this person would be a
23 supplementary positive leader. And we also put through
24 -- and Brenda Creaney led on this one -- that they
25 would fund at loss. In other words, we would create 12:11
26 Band 6 roles in Learning Disability, even though they
27 weren't funded. Initially they went in as temporary,
28 and that in itself has complications for staff in
29 relation to just their own needs and the security of

1 whether it's a permanent thing, but as this unfolded
2 then that became a permanent Band 6 role. So there
3 were activities, you know. So as I brought information
4 back to Brenda, she would have then had different
5 arguments. I might not have known what the argument 12:12
6 was, but I might have known the outcome of the funding
7 from the about PHA through the Director of Nursing
8 office in relation to nursing.
9
10 So, for example, when I said earlier about the lack of 12:12
11 admin staff, another part of that delivering care was
12 releasing time to care, so that the Ward Sisters were
13 getting some admin time to do some administrative
14 activities and releasing that Ward Sister/Charge Nurse
15 to be doing what they believed they needed to be doing. 12:12
16 That funding did come in to the acute side of the
17 Trust, but it hadn't been attributed to Learning
18 Disability or Mental Health. And, again, when that
19 information came through to Brenda's office, she then
20 was able to make the argument and the admin support did 12:13
21 go into Muckamore. Small things, but they were
22 beginning to make differences.
23 136 Q. MS. KILEY: And were those small things that were
24 introduced, introduced after the CCTV revelations in
25 Muckamore? 12:13
26 A. Yes.
27 137 Q. So this was in and around 2018, the time period that
28 you were there. And you referred earlier to one of the
29 results of staff shortages being the closure of PICU.

1 It was closed temporarily in December 2018, isn't that
2 right?
3 A. Yes.
4 138 Q. You refer to this at paragraph 37, and if we could turn
5 there, please? And you say that: 12:13
6
7 "By December 2018 the PICU and other wards across MAH
8 had many staff on a weekly basis calling in unfit to
9 work."
10 12:14
11 And you describe that generating serious concerns. And
12 then halfway down you say:
13
14 "Due to staff leave plans for the Christmas period in
15 2018 many patients were not to be on the MAH site, 12:14
16 therefore PICU was temporarily closed on 24th December
17 2018. Staff and families were unhappy about this. I,
18 along with members of the Divisional Leadership Team,
19 undertook daily update calls over the Christmas period
20 with e-mail communication..." 12:14
21
22 - with the bodies that you outline there, and you
23 describe also making daily visits. Can you tell us
24 more about how long PICU was closed for?
25 A. It was still closed when I left. 12:14
26 139 Q. And whenever you left in --
27 A. '19, 2019.
28 140 Q. August '19?
29 A. Sorry, October, October '19.

1 141 Q. Whenever you -- but at the time you've described it as
2 a temporary closure there, so at the time --
3 A. That was how it was described.
4 142 Q. That's how it was described. And can you say anything
5 more about the staff and families response? You've 12:15
6 described them both as being unhappy. Can you tell us
7 more about that?
8 A. As there was an understanding that the staff levels
9 were becoming depleted, and I would have brought that
10 to the Co-Director's attention that I now believed that 12:15
11 we needed to do something exceptional because it was
12 now getting to be unsafe, and what I meant by that at
13 that time is staff were saying to me that they weren't
14 getting toilet breaks, they weren't getting home on
15 time, they were really quite concerned about being 12:15
16 injured because there was very few staff on the area.
17 So the operational -- the Divisional Team met and made
18 an assessment about how many patients would potentially
19 use PICU over Christmas, and it was a small number, I
20 think two. Others that were there would have been 12:16
21 having Christmas leave. So it was determined that
22 based on the need of the patients and the opportunity
23 that was there, that that unit could be closed
24 temporarily with the intention of engaging HR to meet
25 with staff, to have Occupational Health referrals for 12:16
26 staff, to increase the security on the site in
27 Muckamore, because staff were saying they were
28 terrified of walking to their car, because they did
29 talk about being under duress even in shopping centres

1 where people were saying 'This is what you're doing to
2 patients in Muckamore'. So there was a loft of anxiety
3 and a lot of concern. So the security was increased,
4 Occupational Health referrals were increased. The
5 psychologist came on site. The counsellor that was 12:16
6 available there became available for more hours, and
7 then we actually sat and met with staff and said --
8 because it wasn't working for staff, if, for example, I
9 was working here today, and then I was working there
10 tomorrow, and then I was working over there, it wasn't 12:17
11 consistent for patients, patients were being disturbed,
12 so we appealed to the staff saying 'We need you to be
13 rostered on another unit for a period of time, for
14 consistency for the patients', they were the
15 paramountcy of concern, 'and also to make it easier for 12:17
16 you to work on a team', and number of people
17 volunteered and then we did rostering again so that
18 there could be some sense of consistency.
19
20 I also, with the Co-Director, said that there needed to 12:17
21 be much more on site senior team visibility, Service
22 Manager visibility, and everybody was expected to look
23 at annual leave over Christmas period and it needed to
24 be adjusted, so that that gave a sense of security to
25 the teams around Christmas time. 12:18
26
27 I also appealed to Marie Heaney and the Director,
28 because at that stage there were a lot of important
29 people wishing to visit Muckamore and that in itself

1 caused disturbance on the wards. So I was of the
2 belief if we had a daily briefing where the Chief
3 Nursing Officer, the individuals who needed to be
4 reported to in RQIA, the individuals in the Board
5 needed to be reported to were on this conference 12:18
6 call/e-mail where different people had said, you know,
7 so, for example, the Chief Nurse rightly so said 'This
8 is the number of nurses you need to have on the unit
9 each day', so it meant that for a few weeks you could
10 actually anticipate on the roster that that would 12:18
11 actually be the case. However, people and lives, if
12 someone was off sick it very quickly could change
13 because we didn't have a big baseline of staff. So,
14 yes, Christmas was spent in Muckamore.
15 143 Q. Part of the issue with that baseline and the fact that 12:19
16 you didn't have the right baseline of staff was because
17 of the number of precautionary suspensions, isn't that
18 right?
19 A. Yes, they were growing at this stage.
20 144 Q. And the closure of a ward must be the nuclear option, 12:19
21 it's the last resort, is it?
22 A. Yes.
23 145 Q. But how then -- if precautionary suspensions were being
24 implemented as a result of the CCTV revelations, and so
25 was it not foreseeable that the type of staffing issues 12:19
26 would result, and were there not measures taken to try
27 and mitigate the issues with staffing so that you
28 didn't get to the stage of having to use that nuclear
29 option of closing a ward?

1 A. The Co-Director would have had responsibility of
2 receiving the referral from Safeguarding and MAPA about
3 whom should be considered for precautionary suspension,
4 and then ultimately that person would have made the
5 decision that it was going to happen or which sanction 12:20
6 they could do. I won't be able to give you insight
7 into her thinking around that, but certainly I would
8 have been saying to her - without knowing who was being
9 referred, because I was being kept separate from that
10 at that time. 12:20
11 146 Q. Yes.
12 A. I was getting very concerned about the balance, and I
13 would have brought it to her attention, I brought it to
14 Marie Heaney's attention, I brought it to Brenda
15 Creaney's attention, and I also brought it to Cathy 12:20
16 Jack's attention.
17 147 Q. When were you doing that?
18 A. And that would have been in the December month.
19 148 Q. And having done that were you presented with any
20 strategic measures that were going to be implemented to 12:20
21 specifically address those concerns?
22 A. The Director of Nursing met with the Chief Nurse and
23 other Directors of Nursing and appealed to other Trusts
24 for staff to move from Trusts to Muckamore. There was
25 also a strategy of providing the staff on site with an 12:21
26 additional payment to, I suppose to make it a little
27 less uncomfortable for them to contribute the
28 additional hours that they were working, because one of
29 the things that I had asked the bank office team to do

1 is that if they were noticing that there was a small
2 number of individuals who were doing excessive hours, I
3 would be worried about that individual, not that I'm
4 worried they're going to do something to a patient, but
5 I'd be worried for them that they're getting themselves 12:21
6 so tired they're more vulnerable to do something that
7 they may not wished to have done as a professional
8 person. So, again, the office team would have been, or
9 the bank office team would have been watching for me on
10 that and then bringing to that person's attention to 12:21
11 maybe do less hours or to be referred to Occupational
12 Health.
13
14 Internally in the Trust we appealed to our Mental
15 Health Nurses to see if they would come, because again 12:22
16 the balance, if we were in a position to have two
17 thirds of the staff that had the Learning Disability
18 qualification on the ward and you had then one third
19 that was Mental Health, you then have a balance where
20 you can support that individual, and we did provide, 12:22
21 with the support of the Clinical Education Centre, an
22 update programme, which was a two day/three day
23 programme that individuals who were coming from Mental
24 Health to work in Learning Disability, that they would
25 have -- and they would also get access to MAPA training 12:22
26 urgently, you know, if they hadn't already had that in
27 their Mental Health training.
28
29 So the -- I also worked closely with Queen's

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1 University, because my colleagues, my team, Service
2 Manager and her facilitators from the education point
3 of view, we needed to keep an eye on whether there were
4 adequate mentors, whether we could keep the environment
5 open for students to be there or not, and whether we 12:23
6 needed to close it down for an opportunity, because,
7 again, you would leave a student vulnerable in an
8 environment that weren't meeting the learning
9 assessment needs or, indeed, the practice for
10 person-centred care for patients. And Queen's would 12:23
11 have worked very closely with myself and with my team
12 in relation to that and provided additional time with
13 their lead teacher from Learning Disability to be up in
14 Muckamore. We did have to suspend students coming for
15 a period of time because it wouldn't have been 12:23
16 conducive for the student to have a positive learning
17 experience.
18 149 Q. Yes. And setting aside students for the moment though
19 and thinking about the workforce, you've described the
20 various measures that were implemented to try and make 12:23
21 Muckamore a more attractive place to work and to try
22 and encourage other staff to come to Muckamore, but
23 does the closure of PICU on Christmas Eve 2018
24 demonstrate that those measures weren't enough?
25 A. They weren't enough. 12:24
26 150 Q. Can we move then to paragraph 41 of your statement?
27 You describe and list other, what you describe as
28 projects of change on the work plan. So are these
29 other things that were happening in Muckamore at the

1 time, other changes effectively? I won't go through
2 all of them, but I have a question about the last one.
3 At 41(g) you say:
4
5 "One of the things that was happening was improved 12:24
6 partnership working with the PSNI and Six Mile Ward,
7 the forensic ward."
8
9 Does that mean that there was a problem with the
10 working between the PSNI and Six Mile Ward prior to 12:24
11 that?
12 A. The staff had a perception that there was a difficulty.
13 When I met with the staff they brought it to my
14 attention - the female member of staff had alleged that
15 she had been abused by a patient, and the need was to 12:25
16 record that with the police, and the police response at
17 that time was that the patient is in a place of safety.
18 Now the occurrence had happened in the bedroom where
19 there isn't a camera. And we met then with the
20 officers who would be responsive to Six Mile to say 12:25
21 'Well, can we look at how this can be a different
22 relationship, that it can work when the staff do
23 report, that they feel that they're supported', because
24 the staff member believed that they were being
25 assaulted and not being supported by the police, and 12:25
26 that was addressed, and the police then had regular
27 meetings and met with staff. Now I wouldn't tell you
28 how that has come to fruition, but certainly they had
29 started that process before I retired.

1 151 Q. Okay. So the issue was a communication one and it
2 resulted in new regular meetings being scheduled, is
3 that right?
4 A. Yes.
5 152 Q. Okay. Moving on then to paragraph 42, you describe 12:26
6 staff training in MAPA techniques, and the Inquiry has
7 heard a lot about that. But you describe the training
8 that all nursing staff and support workers had, but
9 then at paragraph 43, if we can scroll down there,
10 please, you say that: 12:26
11
12 "...ward staff were worried about patient safety and
13 using MAPA, considering the allegations, as CCTV
14 recording was still ongoing in MAH."
15 12:26
16 So are you saying that staff expressed concerns to you
17 about using MAPA?
18 A. Yes.
19 153 Q. And can you describe the type of concerns that they
20 had? 12:26
21 A. Well, staff groups - and it is a small enough staff
22 group - and there were members of friends, family, that
23 they had obviously communicated with one another that
24 -- I'm going to pause. I think the challenge was that
25 Mairead and others who were enacting the sanctions from 12:27
26 the safeguarding situation, had been informed that you
27 can't tell a lot to the person because that might
28 prejudice the legal aspect of it. So what you were
29 able to say to the individual as you were precautionary

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1 suspending them was limited. Now I have insight from
2 the next bit, but at that time it would have been
3 limited, which left a vacuum where the individual could
4 say - and obviously people had said "it was because I
5 was doing MAPA wrong". So what you then seen is that 12:27
6 staff hesitated or didn't engage in a timely way when
7 an event was beginning to happen, because they thought
8 'If I do this I'm going to be seen on the camera in the
9 room, I'm going to end up on suspension', was the
10 concern that they had. 12:28
11
12 So to address that, I suppose ideally I'm not the
13 person that should have been doing all of this, the
14 Service Manager should have been doing this. But when
15 I picked this nuances and very important information 12:28
16 up, I then brought it straight to individuals to do
17 something about it. So we got a refresh MAPA training
18 programme on site, and a couple of the sessions I
19 joined and sat with staff and observed them practicing
20 again the moves with MAPA, and the MAPA instructor was 12:28
21 very good and very clear about the importance of early
22 intervention, the importance of the de-escalation
23 strategies before the physical activities of MAPA. So
24 he was really reassuring them, and we asked them to do
25 some leadership spot-checks and audits around the wards 12:29
26 to support staff to re-engage so that then the
27 potentially the patient is safer and the staff are
28 safer.
29 154 Q. At what point in time did that MAPA refresh training

1 happen, can you say?
2 A. This all would have been happening in sort of December,
3 January. As staff became a little bit more confident
4 in me being around, I got told a lot, and then I
5 started bringing it to their Service Managers and their 12:29
6 Co-Directors to address the issue.
7 155 Q. One of the things you also say in paragraph 43 is that
8 when you spoke with staff:
9
10 "...they told me they were not aware that the CCTV was 12:29
11 still recording."
12
13 So this is post CCTV revelations, and in fact towards
14 Winter 2018, so a year on. But are you saying that
15 staff were surprised that CCTV was still recording in 12:29
16 the wards at Muckamore?
17 A. Yes. Yes.
18 156 Q. And were they objecting to the use of CCTV?
19 A. Their objection was not being told.
20 157 Q. So what were they saying to you? 12:30
21 A. So, for example, they were very perplexed that it had
22 been on before they had been informed that it was
23 switched on. So that was the very early stage. And
24 then, and it may have been, I don't want to speculate
25 too much, but it may have been that people were told 12:30
26 this is not for conversation, so it might have been
27 that that meant people didn't communicate to staff.
28 But there was no formal communication to the wards
29 about what stage of progress or lack of progress that

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1 anything was happening. So in that vacuum of poor
2 information, staff were making all kinds of
3 speculation. So when I spoke with Marie Heaney about
4 the need for even a bi-monthly meeting, where we would
5 say 'This is the ongoing CCTV which have a team of 12:31
6 people who review it, and deal and manage with it right
7 there and then, and then there's the historical CCTV
8 which is the alleged issue, and that has a system and
9 process of its own', that very first meeting actually
10 staff did come away feeling, 'Yes, we now have a better 12:31
11 understanding of this', but they had been really
12 annoyed that they hadn't been told there was a
13 distinction and that it was continuing.
14 158 Q. So the issue was that in that year period between the
15 CCTV revelations occurring and you attending Muckamore 12:31
16 in your role, the staff didn't have an understanding of
17 what was happening with CCTV?
18 A. No. And the other confusion was, when a report would
19 have gone through to Marie Heaney and Brenda, it would
20 have been suggestive that the review was complete, but 12:31
21 actually, it was the Level 1 review that may have been
22 complete in a particular ward, not in all of the wards,
23 and it hadn't been at the stage of progress of the
24 Level 2, and then the recommended actions after that.
25 So that distinction was not as clear as it could be. 12:32
26 So, again, I asked people to start making that clearer
27 for our senior staff in relation to what actually we're
28 talking about when we say the CCTV review is complete.
29 159 Q. You described in answer to my question one meeting, and

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1 I think you said the first meeting, so were there
2 further meetings of that kind where that information
3 was given?
4 A. Yes. Yes.
5 160 Q. Okay. And one of the other things that you describe 12:32
6 happening during this period was that the relationship
7 between staff and families at Muckamore became
8 strained, and did you have a role in engaging with the
9 families at that time?
10 A. No. 12:32
11 161 Q. Okay. Can we scroll down to paragraph 46, please? And
12 just pause there. You describe a concern that the PSNI
13 had at that time.
14
15 "PSNI were concerned that the actions taken by a member 12:33
16 of staff as witnessed on their viewing of CCTV footage
17 was illegal. A female PSNI officer, I am unable to
18 recall the name or rank of the officer, expressed the
19 PSNI's concern that the Belfast Trust was not listening
20 to what they had to say, so the PSNI bought their 12:33
21 concerns to Richard Pengelly, the Permanent Secretary
22 of the Department of Health."
23
24 And you then describe attending a subsequent meeting.
25 But can you say any more about what you understood the 12:33
26 PSNI's concerns to be? What was it that they felt that
27 the Belfast Trust was not listening to?
28 A. My impression was they felt that we were not as
29 responsive in a timely fashion that they wished, and

1 they obviously were looking at the CCTV from a legal
2 perspective, and there was an action that they seen
3 that they believed the Trust needed to act on, on that
4 day. There's a couple of pieces to that jigsaw, in
5 that all of the activities I'm telling you about, and 12:34
6 the projects that were happening during that period of
7 time, we're probably talking Spring 2019, and at that
8 time the Department made a decision to have a greater
9 support from a gentleman called Francis Rice, and a
10 group of individuals who would then take forward the 12:34
11 operational changes and the project changes, because it
12 was clear they weren't moving in an expedient fashion.
13 So, Francis then joined, and then there was a period of
14 time where both of us worked a little bit together, and
15 then I was taken to start doing other activities in 12:34
16 relation to Muckamore on my own activities, or continue
17 with my own activities, and during that period of time
18 there was - well, I don't know what the communication
19 was, but there would have been a communication with
20 Cathy Jack, and I got a phone call from Cathy Jack 12:35
21 asking me to go to Antrim Road Station to review the
22 CCTV, and it was at that time, I can't remember the
23 date, I'd have to look back at diaries, but it was at
24 that stage that I was made aware that there might be an
25 approach, because there was concern we weren't being as 12:35
26 responsive as we should.
27 162 Q. And the timeliness of the Belfast Trust's response, was
28 that as a result of resource issues? So PSNI were
29 reviewing at the same time as the Belfast Trust was

1 reviewing, isn't that right, but PSNI were reviewing
2 quicker, is that the issue?
3 A. Well, when I said earlier about them taking the
4 information away, there was a need for technology that
5 would support the activities and obviously not the loss 12:36
6 of the information/evidence, and that meant that there
7 was a period of time that there was no activity of
8 observation of the CCTV of the historical information
9 by the Trust because it was with the police. Now, who
10 was involved in all those discussions? It was most 12:36
11 likely the Directors. But what I'm aware of is that it
12 then was returned and by request of the police it came
13 to off site with Muckamore, they believed it was safer
14 off site from Muckamore, and it was taken to Musgrave,
15 and then the Trust had to be responsive with technology 12:36
16 that would support our enablement of reviewing it. At
17 the same time the two individuals who had been doing
18 safeguarding information, which is a very small team,
19 there was a significant amount of material coming
20 through, they were moving into another area and there 12:36
21 was a recruitment phase of a new larger Safeguarding
22 Team who were going to work from Musgrave. So there
23 were a period of time, wouldn't be able to say how
24 long, but there was a period of time that there wasn't
25 the review, and there wouldn't have been the 12:37
26 suspensions or even the re-education sanction for
27 staff. So that all was probably happening at that same
28 time that it appeared as if we may not have been
29 responsive, I do not think the Trust was intending for

1 that to be the case, it was they didn't have the
2 material to do it, and the Safeguarding Team were not
3 quite in place at that time.
4 163 Q. And you then describe attending a meeting with
5 representatives from DoH, RQIA, PSNI, and the Belfast 12:37
6 Trust Executive Team, and one of the outcomes of that
7 was the establishment of the Executive Governance Team,
8 isn't that right, and the Investigation Operational
9 Management Team?
10 A. Yes. 12:38
11 164 Q. And in fact your role was later changed to be on the
12 Investigation Operational Management Team?
13 A. Yeah.
14 165 Q. Isn't that right? And that's just referred to as IOMT?
15 A. Yes. 12:38
16 166 Q. Is that right? Okay. And can you tell us more about
17 what that team did?
18 A. So we had a HR representative from the Trust on that
19 team, and there was an individual from RQIA on that
20 team. There were a minimum of two police officers on 12:38
21 that team. There was a safeguarding leader of the new
22 Safeguarding Team from the Trust at that meeting, the
23 person who had executive understanding of MAPA was at
24 that team, and then I was there as their Senior Nurse.
25 167 Q. And, so, was the idea that that would be a first level 12:38
26 review and then that you would come to a recommendation
27 as to appropriate action?
28 A. Okay. So the first level review would have already
29 been concluded.

1 168 Q. Yeah.
2 A. The second level of review by the police from a legal
3 perspective would have been concluded. The MAPA and
4 the Safeguarding Review would have been concluded, and
5 then it would have come to this meeting with a list of 12:39
6 activities that each of these respective teams wished
7 myself and the HR person to enact on behalf of the
8 Trust.
9 169 Q. So you're looking at all the recommendations and
10 deciding which is appropriate? 12:39
11 A. Adjudicating on that for Nursing.
12 170 Q. Yes. But there were other members of the team too, you
13 described the MAPA and HR. So was it the case that you
14 were all endeavouring to agree on an appropriate
15 action? 12:39
16 A. In certain circumstances it wasn't difficult to agree.
17 171 Q. Yes.
18 A. But, yes, it was about agreement. And if we had a
19 dissent or concern, we had the opportunity to bring
20 that to the Governance Executive, and that Cathy Jack, 12:39
21 Marie Heaney, Brenda Creaney, this executive social
22 worker was on that team, and they then in turn -- and
23 Jacqui Kennedy from a HR Director perspective -- then
24 they would have brought it through to the Executive
25 Team. 12:40
26 172 Q. Okay. So that's where the Executive Governance Team
27 that you described, that was also set up afterwards?
28 A. Yes. Yes. And they also had a Non-Exec member on that
29 meeting.

1 173 Q. Mmm. And so did the Executive Governance Team only
2 look at the cases that the IOMT couldn't come to a
3 consensus agreement about?
4 A. No, they looked at all of the data and all of the
5 information and the decisions and actions that were 12:40
6 taken, but particularly if there was something that was
7 of a matter of concern and there wasn't an agreement in
8 the room, there was an exceptional raising concern.
9 That didn't happen very often. I think it only
10 happened on one occasion. 12:40
11 174 Q. Okay. And then if we can turn to paragraph 51, please?
12 This is coming towards the end of your time in that
13 role in August 2019, and you describe preparing for
14 your retirement. 51, please. And as part of that
15 preparation you say you met with Dr. Cathy Jack, Brenda 12:41
16 Creaney, and Marie Heaney:
17
18 "...wherein I recommended that a Co-Director be
19 appointed on a temporary basis as well as an Associate
20 Director of Nursing and a Service Manager. This 12:41
21 recommendation was acted upon with temporary
22 appointments being made."
23
24 So in August 2019, you were recommending that three
25 posts essentially be appointed? 12:41
26 A. Yes. Well the Co-Director had retired. The Associate
27 Director of Nursing was still not returned to the
28 Trust, and I was very concerned that there wasn't the
29 senior team there. Yes, Francis Rice and his team were

1 working and endeavouring to do a lot, but you needed to
2 have service operationals, people who were actually
3 taking the service forward and paying attention to the
4 needs of patients. I'm not saying Francis didn't, but
5 it's that kind of internal structure needed to be in 12:42
6 place.
7 175 Q. And why weren't there people in those posts?
8 A. Well, retirement primarily.
9 176 Q. Is that not a foreseeable action?
10 A. Yes. 12:42
11 177 Q. But are you saying that those people retired out of
12 those posts and then they simply weren't filled?
13 A. No. For myself, my perception is, as a Director if I
14 had known X might retire in October, J might retire in
15 November, I would have been saying earlier on 'Can I 12:42
16 get out an ad to look for recruitment?', but -- and I'm
17 not saying it wasn't brought to the attention, it may
18 well be, it may not be just that it was not shared with
19 me, but I would have thought that anticipatory action
20 should have been taken in place to -- you know because 12:43
21 at that point in time Marie Heaney and myself were
22 actually on-call, you know, week alternatively, you
23 know. The staff depletion was really very obvious and
24 I kept bringing it to people to say: 'We need to pay
25 attention to this very seriously'. 12:43
26 178 Q. So, was that --
27 A. I didn't quite feel heard until I met with everybody in
28 the room together, but I think they heard me then.
29 179 Q. Are you describing this meeting in August?

1 A. Oh, they heard me then. That would have been probably
2 September, because I retired at the end of October.
3 180 Q. Okay. And what do you mean you didn't feel heard
4 before?
5 A. Well, when I brought it up, they were like, "yeah, 12:43
6 yeah, yeah. Yeah, yeah, yeah."
7 181 Q. You brought up the gaps in these posts?
8 A. Yeah. That's the kind of approach would have been
9 taken by the Director at the time, "yeah, yeah, yeah".
10 182 Q. You -- 12:44
11 A. Now I totally appreciate she was incredibly busy, I
12 don't want that to sound like a criticism, but I just
13 thought we need to get this out and that was why I
14 proposed an internal trawl first of all. And Trish
15 McKinney became the Interim Associate Director of 12:44
16 Nursing. I hope I'm not out of place saying names, but
17 Gillian Traub was the person who came up as Co-Director
18 at that time. So people began to -- and then at that
19 stage too Bernie Owens was asked to take
20 responsibility. 12:44
21 183 Q. And how quickly did that happen after you made that
22 recommendation at that meeting?
23 A. It was in the few weeks.
24 184 Q. Okay. Then finally on to the final phase of your work
25 at Muckamore, there's the period from November 2019 to 12:44
26 February '20. This is at paragraph 52. So you
27 retired, but then ultimately you immediately went back,
28 isn't that right? It was a retirement in name but you
29 were back --

1 A. I took the statutory month because I was retired early,
2 so I needed to respect the legality of how you retire,
3 so I needed to be minimum out of the organisation by a
4 month and then I came back.
5 185 Q. And you were asked to come back to be part of the CCTV 12:45
6 Investigation Team, isn't that right?
7 A. Yes. And, again, I couldn't come back on a full-time
8 basis, because again the legality around retirement, I
9 could offer them two days a week. So, again, I was
10 quite clear in what contribution I could make. And the 12:45
11 negotiation at that stage was that I needed great
12 clarity of who I was reporting to, what my authority
13 was in that reporting, lessons learnt, and the other
14 part was that they absolutely needed to get a
15 recruitment process going, because I had made a 12:45
16 commitment to do it from November to June, but it was
17 very clear to see that it was going to take longer than
18 November to June to resolve the matters that needed to
19 be reviewed.
20 186 Q. And was your role, was the title of that Senior Nurse 12:46
21 Advisor?
22 A. Yeah.
23 187 Q. That was your role at that time. And that was part of
24 the investigation process?
25 A. Yeah. 12:46
26 188 Q. You've described it generally as CCTV Investigation
27 Team, but that's something different to the IOMT that
28 you were on earlier?
29 A. The IOMT role was part of that.

1 189 Q. So it was more nuanced?
2 A. That would have been your -- so there was the actions
3 of what you were doing looking at material and meeting
4 with staff, so when I started doing that activity for
5 me the IOMT was the assurance group which was holding 12:46
6 me to account, but also for feeding into the governance
7 group.
8 190 Q. Yeah. So you're in some ways a level or a step below
9 the IOMT in this new role, because you're actually
10 reviewing the CCTV, is that right? 12:46
11 A. I was reviewing the CCTV by request of the Directors.
12 191 Q. Yeah. And you describe then --
13 A. That would have been after the police had reviewed it
14 and after the safeguarding reviewed it, and the
15 expectation from Brenda Creaney and Marie Heaney at the 12:47
16 time, and subsequently Bernie Owens, who took
17 responsibility, is that that gave them assurance that
18 the adjudication that I made as a senior professional
19 nurse, that if we were suspending someone that there
20 was concern. 12:47
21 192 Q. Yeah. So that was the purpose of your role, to review
22 and to --
23 A. Most often I could review the material that was given
24 to me by the police and the material that was given to
25 me by the Safeguarding Team. There were occasions that 12:47
26 I would have sought to look at patient notes, because
27 in your patient notes if there has been an incident of
28 harm, or suspected harm, there is a body chart, and
29 there is obviously a recording system that you can

1 record that, and your BRAAT system and governance
2 systems you could go back to look at. So there were
3 occasions that I wanted to look at all of those aspects
4 to be assured in myself when I was supporting a
5 decision that I had looked at all the information that 12:48
6 was necessary to say that that person didn't pay
7 attention to practice or, indeed, that they had stepped
8 into an area that would be perceived to be safeguarding
9 matters.
10 193 Q. And the various actions that you might recommend are 12:48
11 set out at paragraph 53, you have listed them there.
12 So you might consider plans of actions such as
13 protection plan, re-education, enhanced supervision. I
14 won't read them all. But if we scroll down to (f)
15 please and pause. One of the things that might have 12:48
16 been a possible action was the commencement of a
17 process of an NMC referral and a possible Chief Nursing
18 Officer Alert. But the Chief Nursing Officer Alert was
19 only available in relation to nursing staff, isn't that
20 right? 12:49
21 A. Yes.
22 194 Q. But was there an equivalent process that you were able
23 to implement in respect of healthcare assistants?
24 A. I'm most likely going to get the title of the
25 organisation wrong, but if someone has done something 12:49
26 -- is it vetting and barring?
27 195 Q. The DBS?
28 A. Yes.
29 196 Q. The disclosure and barring service?

1 A. So you could have made a referral alert to them that
2 that - there was a concern over that person's
3 behaviour.
4 197 Q. So if you observed a concern --
5 A. My colleague -- my HR colleague would have made that 12:49
6 referral, but that would have happened for healthcare
7 support workers.
8 198 Q. Okay. But were you focusing on nurses?
9 A. Yeah.
10 199 Q. And you do describe other members of the team as well. 12:49
11 You've talked about your HR colleague there. There was
12 a MAPA expert I think also. And so ultimately though
13 who was responsible for making the decision about
14 suspension?
15 A. At that time for nurses it was myself. 12:49
16 200 Q. Mhm-mhm.
17 A. Hence why I wanted to look at all of the material to be
18 assured, because it's a life-changing moment, even
19 though it's a precautionary sanction, it is still
20 life-changing experience for a member of staff. 12:50
21 201 Q. Just finally then at paragraph 53, if we scroll up just
22 to the top of that paragraph, you do describe it as a
23 challenging time, and you describe the challenge there
24 as:
25 12:50
26 "...in the pursuit of recruitment of a new larger
27 Safeguarding Team, viewing of CCTV footage by the
28 Belfast Trust had not progressed as rapidly as the PSNI
29 review."

1
2 So that sounds like some resourcing challenges. Were
3 there any other challenges in that role?
4 A. Ehm, certainly there was an endeavour always to be
5 clear about the professional perspective, and what I 12:50
6 mean by that is occasionally the Safeguarding Team
7 would have been, you know, even if you were a witness,
8 or you were in the vicinity, that you should be
9 precautionary suspended, and that would have guided me
10 to go back and look at the CCTV, because we had to 12:51
11 think about the balance of staff on the wards as well,
12 and certainly I would never endeavour to have anyone
13 who is at risk of behaving badly with a patient on the
14 ward, but what I needed assurance of is when we say the
15 person was within the vicinity of the incident, had 12:51
16 that person taken professional responsibility and
17 recorded it in the Datix? Had that person activated a
18 medical intervention for clinical review of the patient
19 if they had been potentially hurt? So, again, you
20 know, so there were occasions that you would have 12:51
21 watched the CCTV, and because of the design of the ward
22 the person might have been way over here round the
23 corner, but put down on the record as a witness. And I
24 don't believe on that occasion that person -- because
25 the CCTV was clear, you could see the person's eyes 12:52
26 were looking in a different direction, but --
27 202 Q. So the challenges were in identifying the
28 responsibilities, and particularly in respect of
29 bystanders or other people on the ward?

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1 A. Yes, there are --
2 203 Q. But what about did you encounter any of the management
3 type difficulties that you have described earlier on
4 with the Divisional Leadership Team, was that still
5 persisting at that time? 12:52
6 A. I wasn't working with them then.
7 204 Q. Okay. I have no further questions for you,
8 Ms. Mannion, because at the end of that period, I
9 should say February 2020, you stood down from that post
10 and that was a permanent retirement, isn't that right? 12:52
11 A. Well what actually happened is the alleged behaviours
12 of myself came into the Trust and I was invited to a
13 meeting and the -- well the information was extracted
14 that was in relation to myself and shared with me.
15 205 Q. Yes. 12:53
16 A. And on principle, professionally if there's a doubt of
17 my practice I needed to stand down, so with immediate
18 effect I stood down that day.
19 206 Q. Yes. And then we have the rest of that puzzle in your
20 earlier evidence, because these were the concerns that 12:53
21 have been raised by Aine Morrison, isn't that right?
22 A. Yes. Yes.
23 207 Q. And we discussed those and you commented on those on
24 your first evidence session, so I won't ask you any
25 more about that. 12:53
26 A. Okay. Thank you.
27 MS. KILEY: So I have no further questions. Thank you.
28 A. Thank you.
29

1 MS. MANNION WAS THEN QUESTIONED BY THE PANEL AS
2 FOLLOWS:
3
4 208 Q. CHAIRPERSON: Just on a point that you touched on a
5 moment ago in relation to healthcare support workers, 12:53
6 obviously where you have a nurse you have the NMC, a
7 doctor you can go to the GMC, and various other
8 professions also have the HCPC, but healthcare support
9 workers have no regulator.
10 A. No. But some of the healthcare support workers in 12:53
11 Muckamore were registered with the social care...
12 209 Q. CHAIRPERSON: Social Care Council.
13 A. Yes. And then we could refer them to them.
14 210 Q. CHAIRPERSON: Well that's what I just wanted --
15 A. They weren't all of them. 12:54
16 211 Q. DR. MAXWELL: But that's voluntary, it's not a
17 statutory regulation as it is for other professions.
18 A. No. No, it's not. Yes, absolutely.
19 212 Q. CHAIRPERSON: And that's just what I wanted to explore
20 with you very briefly. If you saw something serious by 12:54
21 a healthcare support worker, obviously they could be
22 suspended by the Trust, and potentially you could
23 report them to the Disclosure and Barring Service.
24 A. Yes.
25 213 Q. CHAIRPERSON: But, short of that, if there is a 12:54
26 professional issue which would leave you short of
27 suspension, obviously you could raise that presumably
28 with the healthcare support worker directly?
29 A. Yes.

1 214 Q. CHAIRPERSON: And was that happening?
2 A. It did.
3 215 Q. CHAIRPERSON: And do you know how many people were
4 reported to the DBS for disbarring? I've probably got
5 the name of it wrong, but... 12:55
6 MS. KILEY: Disclosure and Barring Service.
7 CHAIRPERSON: It is the DBS, yes.
8 A. I wouldn't have been clear on the numbers. I'm
9 guessing that my colleague in HR who is still --
10 216 Q. CHAIRPERSON: But it did happen. 12:55
11 A. It did happen, yeah.
12 CHAIRPERSON: Yeah. Can I thank you for a second time
13 for coming to assist the Inquiry. I think I can say
14 that will be the last time you're asked to come and sit
15 in that Chair. 12:55
16 A. Thank you.
17 CHAIRPERSON: So thank you very much indeed for the
18 care with which you've answered these questions and for
19 your time in both making a statement and this morning.
20 A. Thank you. 12:55
21 CHAIRPERSON: We've got quite a long afternoon, so we
22 might try and sit at ten to two. Can I also just
23 mention this, that the first part of - he's not
24 ciphered is he - Dr. Milliken's evidence will be given
25 in his role as a member of staff, so that will not be, 12:56
26 as it were, broadcast publicly, but it will be
27 available to CPs to watch via the Zoom link. We will
28 then break, we'll have a short break, because he will
29 then move on to deal with his management role as part

1 of OM7, which we are putting on to the public feed, and
2 that's just for consistency with how we have treated
3 every other member of staff and every other person who
4 is giving evidence in an OM7 capacity. So CPs who are
5 watching will be able to switch to the link on the 12:56
6 website. Okay. Thank you very much indeed.
7 A. Thank you.
8 CHAIRPERSON: Right. 1:50.
9
10 LUNCHEON ADJOURNMENT 12:56
11
12 THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS
13 FOLLOWS:
14
15 CHAIRPERSON: Mr. McEvoy. 13:44
16 MR. McEVOY: Good afternoon, Panel. As the Chair
17 helpfully indicated just before the lunch break, this
18 afternoon's witness is Dr. Milliken, who has made two
19 statements to the Inquiry and, Chair, you've already
20 indicated the way we hope to proceed. So the statement 13:56
21 references for those viewing at present are statement
22 of 13th May, which is 290, and 24th July, which is 312.
23 With that, the witness can be brought in, Chair.
24 CHAIRPERSON: And which one are you starting with?
25 MR. McEVOY: I'm going to start with the staff 13:57
26 evidence, Chair, which I think is what you had
27 indicated prior to the break, and that is 312, the
28 statement of 24th July.
29 CHAIRPERSON: So that's the second one?

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1 MR. McEVOY: Yes.
2 CHAIRPERSON: Thank you. Has it been explained to
3 Dr. Milliken how we're going to deal with it?
4 MR. McEVOY: It has.
5 CHAIRPERSON: Thank you. 13:57
6
7 DR. COLIN MILLIKEN, HAVING AFFIRMED, WAS EXAMINED BY
8 MR. McEVOY AS FOLLOWS:
9
10 CHAIRPERSON: Dr. Milliken, welcome to the Inquiry. 13:58
11 Thank you very much indeed for your two statements. I
12 gather it has been explained to you how we're going to
13 deal with those two, we'll have a short break in
14 between, but we're going to start with your statement
15 in relation to your role simply as a member of staff. 13:58
16 Okay?
17 A. Yes.
18 CHAIRPERSON: We normally break anyway after about an
19 hour and a quarter, but if you need a break before that
20 at any stage will you just let me know? 13:58
21 A. Yes, thank you, Mr. President.
22 CHAIRPERSON: Mr. McEvoy.
23 217 Q. MR. McEVOY: Good afternoon, Dr. Milliken. I'll let
24 you get some water there.
25 A. Yes, thank you. 13:58
26 218 Q. Doctor, we met a few moments ago. As you know, my name
27 is Mark McEvoy, I'm one of the Inquiry Counsel Team,
28 and I'll be taking you through your evidence this
29 afternoon. If we can get the formality of your

1 statement adoption out of the way. There are two
2 statements. The first is a statement made for the
3 purposes of the staff phase of evidence, and that is
4 one made and signed on 24th July of this year, is that
5 right? 13:59
6 A. That's correct, Mr. President, yes.
7 219 Q. And then there is a second statement which is your
8 Organisational Module statement, and that is the 13th
9 May of this year, and it is 12 pages in length, there
10 are no exhibits with that statement. Do you want to 13:59
11 adopt that statement as your evidence as well then to
12 the Inquiry?
13 A. Yes, please, Mr. Chairman.
14 220 Q. Doctor, by way of introduction then, you have in your
15 staff statement then very helpfully set out your 13:59
16 professional background and the various roles that you
17 have held, and it would probably be fair and suffice to
18 say that you've spent a large part of your professional
19 career at Muckamore Abbey Hospital?
20 A. Yes. 14:00
21 221 Q. And you've detailed indeed, perhaps picking up at
22 paragraph 9 on page 3, that in February 2001 you were
23 initially appointed as an Acting Consultant at
24 Muckamore and then a substantive consultant in May of
25 that year? 14:00
26 A. That's correct.
27 222 Q. And then other than a spell of a year at the Iveagh
28 Centre in 2017 to 2018, you held that post until you
29 left at the end of 2022?

1 A. Yes.
2 223 Q. And you're currently then employed as a consultant
3 psychiatrist within the Southern Trust?
4 A. That's correct.
5 224 Q. And then you go on to tell us at paragraph 11 that in 14:00
6 addition to that role in 2003 you took on the role of
7 Clinical Director?
8 A. Yes.
9 225 Q. And that meant that you were the line manager for all
10 the doctors working at Muckamore Abbey Hospital? 14:01
11 A. Yes.
12 226 Q. Okay. In paragraph 10, just above, you tell us that
13 just by way of background and describing your, let's
14 say your earlier memories of your time at Muckamore,
15 that you worked on Movilla Ward, which is a male 14:01
16 patient admission ward, and you moved to different
17 continuing care wards such as Moylena, Finglass, Foybeg
18 and Ennis?
19 A. Yes.
20 227 Q. For varying lengths of time, depending on what the 14:01
21 service required. But your focus was on developing the
22 forensic patient service, which was initially at Mallow
23 Ward, which then became Six Mile in 2006?
24 A. Yes.
25 228 Q. I suppose casting your mind back to that period, did 14:01
26 you notice a difference in, let's say, the physical
27 quality, the physical environment of each ward? Were
28 there some where you walked in where you wouldn't have
29 wanted a member of your family to be treated?

1 A. I think it's fair to say that throughout the early part
2 of my career at Muckamore all of us had concerns about
3 the physical environment, and all of us would have
4 wanted it to be better, to provide better care for the
5 patients. That was the driver that led to funding 14:02
6 being secured for new build accommodation, which there
7 was obviously a process around, but it opened in 2006.
8 229 Q. Yes.
9 A. So it was a better quality environment for the
10 patients; individual bedrooms, en suite bathrooms, more 14:02
11 clinical space, more day space, a much better physical
12 environment. There was a range of environments in the
13 other wards, some of which were better than others I
14 would say, and some of which were better designed for
15 that sort of patient care than others. 14:03
16 230 Q. Okay. At paragraph 12 you make a general observation,
17 which is that you found the culture on all wards that
18 you worked on to be positive, with a genuine wish to
19 help patients and give patients the best treatment
20 possible. Is there a time frame to which that 14:03
21 observation applies?
22 A. I don't think so. In all of the wards that I worked I
23 found that the multidisciplinary team wanted to do the
24 best work that they could, they wanted to help the
25 patients in the best way they could. I don't think 14:03
26 that there is particular timescales that that applies
27 to.
28 231 Q. And the sentiment that you found the culture to be
29 positive, is that one that relates not just to your own

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1 medical profession but the other professions and staff
2 members?
3 A. Yes, indeed.
4 232 Q. Would you have been aware, however, from patients and
5 their relatives, that that view mightn't have been a 14:04
6 universal one?
7 A. I think there would have been examples when patients or
8 their relatives expressed frustrations about their stay
9 in hospital, there might have been various aspects to
10 that, but... 14:04
11 233 Q. Can you give us a bit more of an idea about what you
12 mean by that?
13 A. Well often patients and their families would have been
14 concerned, as we were, about the length of stay, and
15 the fact that we had a considerable number of patients 14:05
16 who had had their period of assessment and treatment in
17 hospital but who were forced to remain in the hospital
18 because they had no discharge solution, no discharge
19 destination, that certainly was prominent, and that was
20 to their detriment. I think that was the main feature. 14:05
21 There would have been individual cases, no doubt, where
22 either patients or their relatives expressed doubts or
23 concerns about aspects of their care, but, in general I
24 certainly, the colleagues that I worked with I found to
25 be positive and genuine in their wish to help. 14:05
26 234 Q. At the end of paragraph 12 you observe that you were
27 aware, you recall that you were aware of a number of
28 familial relationships among non-medically qualified
29 staff, but no concerns about that were ever raised with

1 you.
2 A. Yes.
3 235 Q. Did you harbour any concerns of your own about it?
4 A. I can't say that I did. I was obviously aware that
5 there were familial relationships amongst some of the 14:06
6 staff. I didn't witness any difficulty with that.
7 They tended not to work in the same ward, but I didn't
8 - I wasn't aware or made aware of concerns about that.
9 236 Q. Okay. In paragraph 12 you've talked about formal
10 settings or formal interactions, one being 14:06
11 multidisciplinary team meetings and the other being
12 ward rounds. Can you - you were there for a long time
13 of course, but are you able to give us a summary of
14 your experience of what ward rounds would have
15 entailed, in other words, how frequently they would 14:07
16 have taken place, and essentially what they would have
17 involved from your perspective?
18 A. Yes. Well through most of my time at Muckamore there
19 were multidisciplinary team meetings, usually on a
20 weekly basis, usually chaired by the responsible 14:07
21 medical officer for the ward, the consultant
22 psychiatrist for the ward, and there would have been a
23 range of disciplines involved in discussing each
24 patient. The patient's care would have been discussed,
25 any changes or alterations, any treatment progress, any 14:07
26 change to risk, issues about their physical health,
27 issues about their medication would have been reviewed,
28 issues about future planning and discharge planning
29 would have been part of that, where that was possible.

1 A review of their activity, day care activity and other
2 activities during the week. A review of their care
3 plan. So that weekly meeting would have been like a
4 business meeting, there would have been other meetings
5 in between times about particular aspects of particular 14:08
6 often complex cases. So, reviews of risk assessments,
7 reviews of complex treatment, positive behaviour
8 support plans perhaps, complicated medication regimes,
9 and there would have been discharge planning meetings
10 as well, to which members of the Community Trusts 14:08
11 responsible for those patients were invited.
12
13 Later in my career, Muckamore and Belfast Trust adopted
14 a slightly different model for ward rounds. The model
15 was called Purposeful In-Patient Admission, or PIPA for 14:09
16 short. It was a model taken from acute admission,
17 psychiatric admission wards, and it was really focused
18 on meeting more frequently and focusing on making sure
19 that tasks were completed for those admissions.
20 237 Q. Did PIPA have its roots, I suppose so that we 14:09
21 understand this, did PIPA have its roots in mental
22 health medicine?
23 A. Yes.
24 238 Q. And bearing in mind that Muckamore is first and
25 foremost a learning disability hospital, how was it 14:09
26 adjusted to reflect that fact?
27 A. Well I think we recognised that it didn't directly read
28 across for all wards.
29 239 Q. Yes.

1 A. It was more applicable to admission wards, particularly
2 when it was possible to have relatively short
3 admissions for assessment and treatment in male and
4 female admission wards. We recognised in Six Mile, for
5 instance, that it didn't always, it wasn't always 14:10
6 applicable, because the lengths of stay were longer and
7 the treatment aims were different, so we adapted it
8 slightly to focus at each of our meetings on different
9 aspects of care, which might have been future planning
10 one day, medication or physical review the next. 14:10
11 Family meetings as well. So we did adapt it certainly
12 in wards where the patients were necessarily going to
13 be there for longer.
14 240 Q. And you've given the example of PIPA, but bearing in
15 mind your long, your long period of service - and I 14:11
16 mean that in the most respectful way - at Muckamore,
17 did your approach to ward rounds, since we're on the
18 topic, change or evolve to reflect changes in practice
19 in terms of looking after people with learning
20 disabilities? 14:11
21 A. Well I think, and referring to my work in Six Mile in
22 particular, there was a recognition in Six Mile that
23 other disciplines had particular expertise in the
24 treatment of those patients. Most of the patients in
25 Six Mile had -- their needs were for psychological 14:11
26 treatment more than medical treatment, so we had
27 allowed other disciplines to Chair meetings and to
28 encourage them do that, to recognise their competence
29 and seniority and their focus on the particular aspect

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1 of the care that we were talking about.
2 CHAIRPERSON: Before we move on, can I just go back to
3 a couple of things. Care plans, first of all, you said
4 would be reviewed always on a ward round?
5 A. No, the entirety of the care plan would have aspects of 14:12
6 the care plan where there were difficulties perhaps, or
7 changes, would have been reviewed, but not the entirety
8 of the care plan.
9 CHAIRPERSON: Right.
10 A. There would have been other meetings held outside that 14:12
11 business aspect where the entirety of the care plan
12 might be reviewed.
13 CHAIRPERSON: And how often would you expect that to
14 happen?
15 A. I think it's difficult to generalise, Mr. Chairman. I 14:12
16 think it depended on the clinical - the particular
17 case. There wasn't, I don't think, a routine review of
18 that.
19 CHAIRPERSON: Notices of a maximum period where you
20 would think 'Gosh, we had better have a look at this 14:13
21 patient's care plan and review it'? A month, six
22 months, a year?
23 A. I think different for different wards. I think in the
24 more active wards every few months. In the continuing
25 care wards, particularly prior to resettlement, there 14:13
26 were annual reviews.
27 CHAIRPERSON: Annual reviews?
28 A. In the early part of my career where there were
29 resettlement wards that later closed.

1 CHAIRPERSON: And can I just ask whose duty would it be
2 to ensure that a care plan is reviewed, at least
3 annually? Would that fall under your authority, as it
4 were, or one of your duties, or would that fall to a
5 ward manager or where would it be? 14:14
6 A. Well it would be a team responsibility, but I would --
7 generally it was the nurse in charge, the Ward Manager
8 of the ward, that ensured that those reviews happened.
9 CHAIRPERSON: But if you noticed that a care plan
10 hadn't been reviewed after a certain period of time you 14:14
11 would presumably be able to say --
12 A. Yes.
13 CHAIRPERSON: -- this needs reviewing.
14 A. Yes.
15 CHAIRPERSON: And did that ever happen? 14:14
16 A. I'm quite sure that it did, yes.
17 DR. MAXWELL: Can I just ask, when you did review a
18 care plan, did you set a date for the next review?
19 Because often in a goals based care plan it will be
20 stated when this needs to be review. Was that your 14:14
21 practice to put a date for review?
22 A. I believe that there would have been a target date set
23 for another review, yes.
24 DR. MAXWELL: And then the nurse in charge of the ward
25 would keep a note when these review dates were due? 14:14
26 A. I believe so, yes.
27 CHAIRPERSON: And the second thing I wanted to ask you
28 about just before we lose it, was, you didn't really
29 have any concerns about familial relationships between

1 members of staff, but if you've got a senior ward
2 member and a more junior ward member and they're both,
3 you know, they're cousins, or brothers or whatever they
4 are, that might, I suppose, make things difficult for
5 other members of staff potentially if they wanted to 14:15
6 report something, or create an issue, or mention an
7 issue in relation to the junior member of staff, but
8 did you never come across that? Or rostering, things
9 like that?
10 A. It wasn't an issue, Mr. Chairman, that I was aware of. 14:15
11 CHAIRPERSON: So not on your radar?
12 A. No, I wasn't aware of senior and junior members of
13 staff who were familially related being on the same
14 ward. That may have happened, but I wasn't aware of
15 it. 14:16
16 CHAIRPERSON: And it wouldn't actually have caused you
17 any concern if you had seen it?
18 A. I think it didn't, it didn't arise for me, no.
19 CHAIRPERSON: Okay. Thank you. Sorry to interrupt,
20 Mr. McEvoy. 14:16
21 241 Q. MR. McEVOY: And you told us about care plans a moment
22 ago and how those were constructed and reviewed. You
23 also mention in paragraph 13 Positive Behaviour Support
24 plans, and about halfway down the paragraph, which
25 appears on paragraph 5, you talked about how 14:16
26 behavioural support services provided input into the
27 care plan, which you've talked about, which is managed
28 by clinical psychology. You go on then and say that:
29

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1 "Specialism developed and used Positive Behavioural
2 Support Planning as a basis for their work."
3
4 You didn't have a role in delivering Positive
5 Behavioural Support Plans, and these were mainly 14:17
6 implemented by nursing staff, but you did encourage
7 their discussion and encouraged their use at
8 multidisciplinary meetings and amend them if necessary.
9 Did you, perhaps as part of a team, audit Positive
10 Behaviour Support plans or otherwise keep them under 14:17
11 review?
12 A. The Positive Behaviour Support Plans, as I've said in
13 the statement, were developed by our Behavioural
14 Support Services.
15 242 Q. Yeah. 14:17
16 A. Because they involved a holistic application throughout
17 each day, the nursing staff, supported by Behavioural
18 Support Planning, were responsible for their delivery.
19 Aspects of the Positive Behaviour Support Plan would
20 have been discussed as clinically required by the 14:17
21 multidisciplinary team, particularly if there were
22 management difficulties or patients for whom the
23 Positive Behaviour Support Plan didn't seem to be
24 effective. So that would have brought a more acute, or
25 brought forward a review either through the ward round 14:18
26 or through a specific meeting outside of the ward
27 round. I believe the Positive Behaviour Support Plans
28 were reviewed and overseen and audited by our
29 Behavioural Support Services.

1 243 Q. Yeah?
2 A. Supported by Psychology.
3 244 Q. But you do say then you were able to amend them, if
4 necessary?
5 A. Yes. Contribute to their amendments. 14:18
6 245 Q. Yes.
7 A. Yeah.
8 246 Q. Okay. At paragraph 14 then you tell us something about
9 your own clinical work and how it depended on the ward
10 you were working in. Talking about Six Mile, you had a 14:19
11 weekly ward round with members of the multidisciplinary
12 team, and that increased to more often than weekly, and
13 you say then:
14
15 "Patients were invited to join in, some wanted to 14:19
16 attend and some did not."
17
18 A. Yes.
19 247 Q. Can you tell us something about strategies that might
20 have been used to encourage their participation? 14:19
21 A. Well, again, as I've said in my statement, some
22 patients were keen and anxious to attend and were happy
23 to do so.
24 248 Q. Yeah.
25 A. And some, for a variety of their own reasons, didn't 14:19
26 wish to or didn't feel able to. I think we would have
27 used our relationships with staff, that the staff had
28 to encourage patients to attend, to describe the
29 usefulness of their attendance. Patients had different

1 relationships with different professionals. So
2 sometimes I might have been involved in encouraging
3 patients to attend, other would have been their named
4 nurse or other professionals that they had particularly
5 good relationships with. 14:20
6 249 Q. I was about to ask that. Would you personally have
7 encouraged them or would you have seen it more as a
8 nursing responsibility?
9 A. No, it was all of our responsibility I think.
10 Sometimes we would have used the patient's advocates as 14:20
11 well to help us with that, or even their key workers
12 from Community Trusts, whoever had the best
13 relationship and was best able to encourage.
14 250 Q. And on the point about advocates, over the page in the
15 same paragraph at the top of page 6, we're told that an 14:20
16 advocacy service developed over time, advocates being
17 invited to attend multidisciplinary team meetings and
18 some did on occasion, and you recall advocates
19 attending from Bryson House, Mencap, and Disability
20 Action. 14:21
21
22 Can you recall when, to the best of your ability
23 approximately, advocates would have started attending
24 multidisciplinary team meetings?
25 A. Advocacy developed I think as part of the resettlement 14:21
26 programme that was an ministerially led directive when
27 the long stay wards at Muckamore were able to close,
28 and I think advocacy, professional advocacy developed
29 as part of that. So each patient, depending on their

1 Trust of origin, had access to advocates from Bryson
2 House, Mencap, or Disability Action, so that the
3 resettlement programme was approximately the early
4 2000s onwards. That's one model of advocacy. I think
5 staff tried to advocate for the patients as well, and 14:22
6 certainly I was involved in advocating for patients,
7 particularly in terms of their discharge planning and
8 the lack of progress that we were able to make often
9 with that. And as I've said, we recognised that many
10 of the patients were - had their families as advocates 14:22
11 for them as well, and that was often very powerful, or
12 - and the patients were helped to advocate for
13 themselves as well. So there was a particular project
14 called "Tell It Like It Is" or TILII, which was
15 developed between the hospital and the Association For 14:22
16 Real Change to train individual patients to advocate
17 for themselves, both individually and as a group.
18 251 Q. In paragraph 15 you touch on PIPA, which we've already
19 discussed. You say that it was a model which aimed to
20 create momentum towards being able to discharge the 14:23
21 patient. You say your:
22
23 "...colleagues and I were anxious to discharge patients
24 in a safe and timely way."
25 14:23
26 Can you explain what you mean by the use of the word
27 "anxious" there?
28 A. Yes. All of us were conscious that patients who were
29 required to be admitted for assessment and treatment,

1 when that treatment was complete, should have been
2 discharged to an appropriate and safe placement,
3 whatever that involved, and in a timely way, which
4 didn't involve unnecessary stay in hospital. All of us
5 were aware of the size of that problem and the 14:23
6 detriment to the patients were they delayed in their
7 discharge, and we were most anxious to avoid that, most
8 certain that it, in many cases, had detriment, and all
9 of us were involved in advocating for our patients to
10 try to avoid delayed discharge. 14:24
11 252 Q. Given the concerns that you've just articulated there
12 about the risks and the reality of delayed discharge,
13 do you think that safe, a safe and timely discharge
14 was, as an objective, achieved, or was it more of an
15 aspiration? 14:24
16 A. It was certainly an aspiration. Unfortunately in many
17 cases it wasn't achieved, certainly in a timely way.
18 253 Q. The Inquiry has heard evidence about instances where
19 patients might have been discharged prematurely and
20 have had to be re-admitted, sometimes promptly. Do you 14:25
21 recall any audit being carried out in relation to such
22 patients?
23 A. I'm not aware of, I'm not aware of cases where it was
24 felt that they were discharged prematurely. It may
25 have been that their management required skills, or 14:25
26 consistency, or resilience that wasn't available in
27 their community placement. So, from a practical point
28 of view they were more easily managed by the staff
29 teams that we had compared to community placements at

1 times.
2 254 Q. When you say "easily managed" can you help us
3 understand what you mean by that from a medical
4 perspective?
5 A. I think I mean readily managed with staff teams that 14:26
6 had skills to assess, to de-escalate, to provide
7 treatment in a way that in community placements
8 sometimes wasn't possible.
9 255 Q. At paragraph 17 then you tell us that all consultations
10 that you had with patients took place on the wards. 14:26
11 You didn't conduct consultations with patients say in
12 your office?
13 A. Yes.
14 256 Q. Patients were admitted with a variety of different
15 psychiatric and/or behavioural presentations and you 14:27
16 followed the biopsychosocial model when formulating
17 treatment plans for individual patients. Bearing that
18 in mind, were there measures in place to give patients
19 a measure of privacy to raise issues that they might
20 have had during consultations with you? 14:27
21 A. Yes. No, there was. My office was in a separate
22 building to any of the admission wards, so it wouldn't
23 have been practical really, or it made more sense
24 practically for me to go to the wards, but there was
25 always privacy where that was required. 14:27
26 257 Q. And how can you give us a practical example of how that
27 would have been achieved or realised?
28 A. All of the wards had space, private space, where those
29 consultations would have taken place. The patients

1 were asked whether they wanted to be with me just on my
2 own or whether they wanted a trusted nurse to be with
3 them, or another professional, but there was certainly
4 space, particularly after the new builds they had
5 dedicated space for us to meet with patients. 14:28
6 258 Q. And it is possibly hard and it may be a little unfair
7 of me to ask you to give us your general impression,
8 but did patients prefer a measure of privacy in
9 consultation with you or otherwise?
10 A. In terms of having someone with them? 14:28
11 259 Q. Yes, or in terms of their preference to have
12 consultations with you in a more private or discrete
13 setting?
14 A. I think it varied between different patients. Some
15 patients were very happy to meet on their own and were 14:28
16 very able to do so.
17 260 Q. Mhm-mhm.
18 A. Some preferred to have help and input from other
19 professionals, often their named nurse or the nurse in
20 charge of the ward, to help them sometimes with 14:29
21 advocates as well.
22 CHAIRPERSON: Can I just ask how often these
23 consultations took place?
24 A. Well, every week. Any time I was on the ward some of
25 those would have taken place. 14:29
26 CHAIRPERSON: But how often would you get round all of
27 the patients that you were responsible for?
28 A. I would have been in the Six Mile Ward probably three
29 times per week, so I would have seen any patient that

1 wanted to see me, and I would have seen them weekly,
2 possibly as part of the ward round or slightly outside
3 that. Less so for other wards, I would say, the longer
4 stay wards, patients who were less verbal or less able
5 to have those one-to-one consultations. 14:29
6 CHAIRPERSON: And were there ever any occasions where a
7 patient raised an issue in relation to how he or she
8 was being treated by a member of staff and how would
9 you take that forward?
10 A. Patients would have raised issues about their treatment 14:30
11 in general. I don't recall any example of a patient
12 making directly an allegation to me about
13 mis-treatment, but they would have raised issues, or
14 raised queries or questions about their treatment, and
15 that would have been addressed with them, with other 14:30
16 members of the staff, and would have been discussed
17 with the multidisciplinary team when next we met.
18 CHAIRPERSON: So such as what, sort of medication, or
19 day care, or food, what would it cover?
20 A. Often medication. Often day care activities and 14:30
21 perhaps wanting different day care activities. I don't
22 recall food necessarily with me being an issue, other
23 than discussions about weight and healthy eating and
24 the need to make progress with that often with
25 dietetics. 14:31
26 CHAIRPERSON: Okay. I think we'll come back to
27 medication in due course.
28 261 Q. MR. McEVOY: You tell us in paragraph 17 that:
29

1 "At times treatment plans were discussed with families,
2 some patients wanted to have a more active involvement
3 in their treatment plans than others. Families were
4 invited to annual reviews."
5 14:31
6 And you would have attended annual reviews for your
7 patients. What were the deciding factors as to whether
8 families should be involved in discussions, for example
9 like treatment plans, and who would have been involved
10 in that decision? 14:32
11 A. Well, we would have discussed it within the
12 multidisciplinary team and it might have depended on
13 how involved or actively involved families were. Some
14 were very involved and some less so. It would have
15 included the patient's wishes themselves, so sometimes 14:32
16 they said they didn't want families involved, sometimes
17 they did. I think we would have involved advocacy in
18 some of that as well, where there were any
19 uncertainties or difficulties.
20 262 Q. In what way? Can you give us an example? 14:32
21 A. Well, I think if perhaps there was discord or
22 disagreement between a patient and their family, for
23 instance, the advocate would have had an important role
24 in helping the patient to have their own voice in that
25 and to give their views and to resolve that issue. 14:33
26 263 Q. In other words, if the family's preference was for one
27 thing to be done and the patient had a different view?
28 A. That sometimes was the case, yes.
29 264 Q. And are you aware of instances where families had

1 raised concerns about not being included in
2 discussions?
3 A. I don't recall any specific examples raised with me,
4 but there may be, there may have been examples when
5 families either didn't agree with their level of 14:33
6 involvement, and I think if they, if that issue was
7 raised by families we would have sought to meet with
8 them and to discuss it with them.
9 265 Q. So you don't recall ongoing issues about families
10 expressing a view that they should have more to do, 14:34
11 more input in their relative's care?
12 A. I don't recall any specific examples.
13 266 Q. Yes.
14 A. As PIPA developed we tended to include family meetings
15 as part, one of those elements of PIPA, and we had more 14:34
16 meetings with families, or at least invited them. In
17 some of those meetings the families would have queried
18 aspects of treatment or wanted more detail about that,
19 and that would have been welcomed.
20 267 Q. Yeah. And how would you have sought to address them 14:34
21 then in a meeting where the family were present, how
22 would you have sought to address a concern expressed?
23 A. I think we would have got as much detail about their
24 concern as possible, tried to understand what their
25 objection was, tried to explain the rationale for our 14:34
26 treatment or our risk assessment, and tried to reach a
27 solution with them that was safe and which worked for
28 the patient.
29 268 Q. In the following paragraphs then you talk about the

1 types of treatment that were provided at the hospital.
2 At paragraph 18 you make the point that treatments
3 differed depending on the ward and the patient. So on
4 Six Mile, the principal treatments were psychological,
5 and there were two forensic psychologists, specific 14:35
6 psychological therapies, individual and group for their
7 type of offending and to reduce further offending, and
8 you used approaches such as Dialectical Behaviour
9 Therapy, and that was conducted, as you've indicated,
10 both individually and as part of a group. 14:35
11
12 We've touched on Behavioural Support Planning work, and
13 you mention that again:
14
15 "A lot of work undertaken in Six Mile was around risk 14:35
16 management in order to allow patients to become more
17 independent and safer outside of the ward for discharge
18 and planning into the community."
19
20 You then move on to talk about medication, and you say 14:36
21 that:
22
23 "People with an intellectual disability have higher
24 incidents of mental illness and of physical health
25 issues, such as epilepsy, than those without. In order 14:36
26 to care for patients in the hospital we were often
27 required to prescribe medication as one element of the
28 treatment. All medication has the potential to cause
29 side effects. The treatment of patients with

1 intellectual disabilities is very complex. For
2 example, a patient with autism who had sensory feelings
3 may be more prone to feeling pain which could be a
4 trigger for behavioural disturbance. People with
5 autism can find hospitals difficult due to the noise 14:36
6 and general commotion of the running of the ward."
7
8 You indicate that you had:
9
10 "...concerns for those patients being in the hospital 14:36
11 beyond the point where they required in-patient
12 treatment and where their discharges were delayed, as
13 their needs were unable to be met by community
14 services."
15 14:37
16 Can you just give us some more I suppose background or
17 colour in terms of what you mean by patients with
18 autism and how they found the hospital environment
19 difficult, practically what that meant for their
20 treatment? 14:37
21 A. Yes. I think a high proportion of the admissions that
22 we had, and often the longer stay patients as well, had
23 a diagnosis of autistic spectrum disorder, and that
24 would be the case in our out-patient work as well.
25 People were autism have difficulty with sensory inputs, 14:37
26 in understanding those sensory inputs and integrating
27 them and tolerating them, and environments which are
28 unpredictable which are, at times, can appear crowded,
29 where routines that they expect can't be maintained,

1 for various reasons. It's a difficult environment for
2 anybody with autism. We would have recognised that.
3 We've sought to avoid, where possible, admissions for
4 people about autism, but that didn't prove possible at
5 times. 14:38
6 269 Q. Do you know whether on a case-by-case basis, or whether
7 as a matter of policy, use was made of medication on a
8 PRN basis to manage behaviours that would have resulted
9 directly or indirectly from that difficult environment
10 for persons with autism? 14:39
11 A. Well, each patient had an individual assessment of each
12 aspect, so we used a biopsychosocial model and we would
13 have looked at each aspect of their care. Biologically
14 some patients had mental illness and some didn't,
15 that's common in all in-patient hospitals for people 14:39
16 with intellectual disability across the UK, so
17 medication was used particularly where other inputs,
18 behavioural inputs or environmental treatments didn't
19 prove successful in managing behaviour. We would have
20 sought to minimise the use of medication and we would 14:39
21 have sought to minimise the use of PRN medication as
22 well.
23 270 Q. The last sentiment in that paragraph about your
24 concerns for those patients being in Muckamore beyond
25 the point where they required in-patient treatment, did 14:40
26 you escalate that concern to senior management?
27 A. Yes, that was a concern that all of us had, that we
28 had, that dated back to the early part of my consultant
29 career, it was discussed I think at every level of

1 senior management, both in the hospital and with
2 commissioners.
3 271 Q. So would it be fair to describe it as a chronic
4 concern?
5 A. Yes. We, in the early part of my consultant career, 14:40
6 there was what was called a Special Advisory Committee
7 where we met with the Department of Health on a yearly
8 basis, and it was discussed then in the early part --
9 now it no longer runs, but it was in the early part of
10 the 2000s. So it definitely was a chronic issue. 14:41
11 DR. MAXWELL: Can I ask how you raised it?
12 A. It would have been raised, those concerns would have
13 been discussed very frequently both at the hospital
14 management team, the senior learning disability
15 management team in Belfast Trust. 14:41
16 DR. MAXWELL: Who do you mean by that?
17 A. There was a weekly hospital management team meeting,
18 there was a monthly meeting in Belfast Trust for the
19 senior management in Learning Disability Services and
20 it would have been discussed there. 14:41
21 DR. MAXWELL: Did you just go outside that? So we
22 heard from the Assistant Medical Director from the
23 Directorate, did you ever discuss it with her?
24 A. I believe I did, yes.
25 DR. MAXWELL: And would you have formally raised it in 14:42
26 writing or just verbally?
27 A. Well, it was discussed in various ways. I met with the
28 Associate Medical Director, we would have discussed it.
29 I met with the Medical Director and discussed.

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1 DR. MAXWELL: With the Medical Director.
2 A. Yeah.
3 DR. MAXWELL: So was that Tony Stevens, or Cathy Jack,
4 or both.
5 A. Dr. Jack. 14:42
6 DR. MAXWELL: With Dr. Jack?
7 A. Yes. It was raised with -- each Community Trust was
8 involved as well. So we had meetings with - admission
9 and discharge planning meetings with other Trusts as
10 well where their delayed discharge patients were 14:42
11 discussed.
12 DR. MAXWELL: So you think it would have been minuted
13 in a variety of meetings, do you?
14 A. I expect that it was. I think it was very widely known
15 as a chronic and very important issue. 14:43
16 DR. MAXWELL: And do you think when you raised it with
17 Dr. Jack, would that have been in writing anywhere?
18 A. Well Dr. Jack and I met at times to discuss what the
19 important issues were when she became Medical Director,
20 and it was one of the issues that I discussed with her 14:43
21 and I prepared some written kind of briefing notes for
22 her.
23 DR. MAXWELL: You prepared briefing notes which you
24 sent to her, did you?
25 A. Yes. 14:43
26 DR. MAXWELL: So there would be a briefing note in
27 writing?
28 A. Yes.
29 DR. MAXWELL: That you sent to her before a meeting.

1 A. Yes.
2 DR. MAXWELL: Thank you.
3 CHAIRPERSON: Could I just ask, are you coming back to
4 medication?
5 MR. McEVOY: Yes. 14:43
6 CHAIRPERSON: You are.
7 272 Q. MR. McEVOY: Yes. On that very point, you tell us at
8 the start of paragraph 20 that you would have:
9
10 "...conducted reviews of patient's medications 14:43
11 regularly to ensure they were receiving the most
12 appropriate medication at the most appropriate dose."
13
14 And you tell us how you followed prescribing
15 guidelines, guidance in the British National Formulary 14:44
16 and the National Institute of Clinical Excellence, or
17 NICE, and you would have consulted various text books
18 and spoken to colleagues in complex cases.
19
20 "Medication was discussed at multidisciplinary team 14:44
21 meetings and at ward rounds and therefore there was a
22 continuous review of medication for patients, which
23 included the use of PRN medication."
24
25 Did that review process, doctor, ever reveal any 14:44
26 concerns about the use of PRN?
27 A. We - those sorts of medication reviews happened
28 regularly and essentially routinely, but in more
29 frequency or in more detail if there were obvious

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1 problems in the patient's management where medication
2 was an issue and medication changes were being made.
3 As I've said in my statement, we would have followed
4 guidance from other sources, so the British National
5 Formulary, the National Institute of Clinical 14:45
6 Excellence. We would have consulted sources such as
7 the Maudsley text book, which gives advice about
8 complex management. I would have sought second
9 opinions at times from others or discussed with
10 colleagues difficult cases. We always sought to 14:45
11 minimise medication and sought to, where possible,
12 avoid or minimise the use of PRN medication, so it was
13 better to review the regular medication rather than
14 have the PRN medication as a more prominent part of the
15 medical management. 14:46
16 PROFESSOR MURPHY: Can I just ask you about PRN,
17 because we understand that incidents, seclusions,
18 physical interventions were all counted and plotted on
19 a monthly and so on basis, but I don't think PRN was
20 subject to that kind of trend analysis. What you're 14:46
21 talking about here is how you adjusted it individually,
22 but did you feel that it should have been subjected to
23 some kind of trend analysis?
24 A. I think with hindsight it would have been helpful. We
25 relied on those individual MDTs, individual responsible 14:46
26 medical officers reviewing the PRN along with
27 colleagues, and making judgments about that. We did
28 have -- from time to time we had ad hoc audits carried
29 out of PRN usage, but, as you say, it wasn't part of

1 the more detailed reports that we got. We would have
2 avoided the use of PRN medication -- when we were
3 looking at those individual cases we would have avoided
4 straying outside the BNF Guidelines, for instance.
5 DR. MAXWELL: Can I just ask you about the prescribing. 14:47
6 So the actual act of prescribing would have been done
7 by one of the, what we used to call junior doctors, but
8 in England at least are now residents. How often would
9 they have to renew the PRN prescriptions? How many
10 days did the prescription stand for on the Kardex? 14:47
11 A. Well the Kardex and the PRN usage, particularly if it
12 was evident that PRN was an active issue, the use of
13 PRN, would have been reviewed by the MDT on that weekly
14 ward round. I'm asking about how often they would
15 rewrite the Kardex? 14:48
16 DR. MAXWELL: Yeah. So if I'm a nurse on the ward, I
17 have the discretion to use PRN medications, and the
18 drug chart will have a section for the regular drugs
19 that are given at specified times, then it will have a
20 separate section which is for the PRN drugs which could 14:48
21 cover a range of things; it could cover pain relief, it
22 could cover sedative type medicines or something to
23 help people with bowels, or a whole range of things.
24 And I've asked a couple of witnesses and it's a bit
25 unclear how long a PRN prescription is valid for before 14:49
26 it has to be re-prescribed. In acute hospitals it is
27 14 days, which means that there has to be a review by a
28 prescriber every 14 days, but I've been told it's a
29 longer period in Muckamore?

1 A. In my experience the medication, certainly in my MDT
2 meetings the medication was reviewed each week at the
3 MDT. It may have been reviewed as the junior doctor
4 was rewriting the Kardex they would have been aware of
5 the PRN prescription. It think it probably depended on 14:49
6 the nature of the ward and the clinical case that was
7 being reviewed. I don't think there was necessarily a
8 standard of 14 days.
9 DR. MAXWELL: So in the resettlement wards, for
10 example, where we've heard the MDTs weren't as 14:50
11 frequent, the junior doctor, would they just keep
12 prescribing it because it had been on the previous
13 sheet, or would they actively review how often it had
14 been used, what the nursing progress report said about
15 how it had impacted patients? 14:50
16 A. I would have expected the resident doctor, the junior
17 doctors, to review that. I would have expected nursing
18 staff on continuing care wards to raise any concerns or
19 cases where PRN seemed to be being used with them. I
20 would have expected that it would be discussed at the 14:50
21 next ward round, or with the responsible consultant in
22 between times, where it was really felt to be an issue.
23 DR. MAXWELL: And can I ask then, there are, certainly
24 my experience in acute hospitals is quite often some
25 drugs would be written up in the PRN just in case, you 14:51
26 don't necessarily expect them to be used, but actually
27 it can be difficult to call a doctor back in the middle
28 of the night, so they'll often be written up for
29 Paracetamol, even though they might not have expressed

1 any need for it. Was there any tendency to write up
2 Lorazepam just in case, or did you only get a PRN if
3 there had been an incident which required it?
4 A. I wouldn't have expected a PRN medication like
5 Lorazepam just to be written up routinely without 14:51
6 discussion about the need for it.
7 DR. MAXWELL: So there would have been a trigger
8 incident?
9 A. Yes, or a triggering description of agitation or
10 distress which seemed to warrant that. 14:51
11 DR. MAXWELL: And would you expect the junior or
12 resident doctors to write that prescription without
13 reference to a consultant, or would it always involve a
14 discussion with the consultant before it was
15 prescribed? 14:52
16 A. I think during normal hours it would have involved a
17 discussion with the consultant. It would have occurred
18 out-of-hours as well at times, I imagine, and that
19 would have been brought to the attention perhaps the
20 next morning of the ward team that that sort of 14:52
21 incident took place or that prescription had been made.
22 Sometimes -- we always have a consultant on-call and
23 sometimes there would have been a discussion with the
24 consultant on-call about the need for those sorts of
25 medications in particular circumstances. 14:52
26 DR. MAXWELL: So are you saying that if any sort of
27 sedative PRN was prescribed, you would expect the
28 supervising consultant to know within 24 hours?
29 A. I would have thought so, depending perhaps at weekends

1 it would have taken a little longer, but I would have
2 thought so.
3 CHAIRPERSON: So just so that I understand. First of
4 all not every patient would have a PRN prescription?
5 A. Yes. 14:53
6 CHAIRPERSON: Not every patient?
7 A. That's correct.
8 CHAIRPERSON: It would require a trigger incident that
9 allowed a junior doctor to write a prescription?
10 A. Either an incident, or a concern, a clinical concern 14:53
11 that the patient was agitated or distressed or required
12 that sort of medication.
13 CHAIRPERSON: Right. That PRN prescription, would that
14 automatically be looked at by somebody at your level,
15 or could that stand on the patient's file for a fairly 14:53
16 significant period of time, having been written by a
17 junior doctor?
18 A. Well I would expect -- I think it would depend on the
19 circumstances to a degree, but I would expect in
20 particular circumstances I would have wanted to - it 14:54
21 would have been discussed the next day. In other
22 circumstances at the next ward round. But if the
23 concerns were so great that a junior doctor felt the
24 need to prescribe it overnight, I would have expected
25 to hear about that the next day. 14:54
26 CHAIRPERSON: And we've heard that a particular dose of
27 medication, whatever form it takes, might affect
28 different patients in very different ways. So how
29 would that assessment be undertaken? Say there's a

1 prescription for PRN, it has to be used on a particular
2 occasion, how would you get feedback on the assessment
3 of how that medication had actually affected a
4 particular patient?
5 A. Well the circumstances of its prescription would be 14:55
6 discussed with either me or a medical colleague at the
7 next opportunity, and as I've said, whether that might
8 be the next day or the next ward round, but we would
9 have had a description of its effect, whether it was
10 effective or not, whether it brought benefit or not. 14:55
11 CHAIRPERSON: Sorry, can you say that again?
12 A. Whether the PRN -- we would have sought a description
13 from nursing colleagues about whether the PRN
14 medication was effective or not.
15 CHAIRPERSON: Well I understand it's easy in one sense 14:55
16 to see if its effective or not, it may be harder to see
17 if its too effective. So how would you assess whether
18 too much was being given?
19 A. I think partly by ensuring that any PRN medication was
20 given within guidelines, or in the BNF in particular, 14:56
21 the British National Formulary, but I would have
22 expected a description or a concern raised about
23 oversedation being a very prominent part of the
24 discussion when --
25 CHAIRPERSON: So that ought to be in the patient's 14:56
26 notes. If a nurse was concerned or whoever was
27 concerned that a patient had been oversedated, that
28 ought to be, that ought to appear --
29 A. Been part of the MDT discussion.

1 CHAIRPERSON: And in Datix or not?
2 A. Pardon?
3 CHAIRPERSON: In the Datix?
4 A. It may well have been. If there were particular --
5 DR. MAXWELL: I think you mean the PARIS, don't you. 14:56
6 CHAIRPERSON: Yes, PARIS.
7 DR. MAXWELL: In the PARIS reports.
8 CHAIRPERSON: Yeah.
9 DR. MAXWELL: Not the Datix.
10 A. Yes. Yes. 14:56
11 CHAIRPERSON: Yes. And, again just help me, because
12 you appreciate I am a civilian in one sense. Apart
13 from PRN, were there other drugs that were regularly
14 prescribed to patients that might sedate them?
15 A. Yes. I think all medication has the potential to have 14:57
16 side effects, and we sought to avoid that, but some
17 patients who were particularly agitated or distressed
18 were prescribed anti-psychotic medication, for
19 instance, which was prescribed to help them be less
20 distressed or less agitated, but certainly could have 14:57
21 had a side effect of sedation, all of those medications
22 can, and that's very well recognised.
23 CHAIRPERSON: And who would be responsible for writing
24 those prescriptions, the regular prescriptions?
25 A. Again, they would have been directed by the responsible 14:57
26 medical officer, the consultant, at ward rounds.
27 CHAIRPERSON: So somebody at your level?
28 A. Yes.
29 CHAIRPERSON: Right.

1 DR. MAXWELL: The actual act of writing it would
2 probably be the junior doctor?
3 A. Probably in most cases, yes.
4 DR. MAXWELL: And rewriting the prescription chart
5 because they don't have an infinite -- 14:58
6 A. Yes.
7 DR. MAXWELL: -- validity. Would be the junior doctor.
8 A. Yes.
9 DR. MAXWELL: But under your direction.
10 A. Yes. 14:58
11 CHAIRPERSON: And, again, just dealing with unwanted
12 affects of potential oversedation, would you expect
13 those to be brought to your attention?
14 A. Yes.
15 CHAIRPERSON: Can you remember occasions when those 14:58
16 affects were brought to your attention?
17 A. I'm -- yes, I'm sure there were cases where concerns
18 about medication and oversedation were brought to my
19 attention, discussed at the multidisciplinary team, and
20 medication reviewed with a view to rationalising 14:59
21 medication or to look at its effectiveness in the
22 lowest possible dose, and the benefits and risks of the
23 medication.
24 CHAIRPERSON: And that should appear in the patient
25 notes? 14:59
26 A. Yes.
27 CHAIRPERSON: Do you recall any occasion where a carer
28 or a parent or relative raised with you concerns about
29 overmedication of their loved patient?

1 A. I think I can think of particular examples where that
2 was raised, yes. That might have happened in the
3 hospital occasionally. It's not confined to the
4 hospital, it's confined to out-patient work as well,
5 and families would have always sought to discuss 14:59
6 medication and raise concerns about side effects, but I
7 think there were small number of cases in the hospital
8 where that was raised with me.
9 CHAIRPERSON: And finally this, sorry, just so that I
10 really understand it, would it be fair to say that 15:00
11 oversedation of a patient, in other words where we've
12 heard descriptions of "zombified", and it's a horrible
13 phrase, but you probably understand what is meant by
14 that, would that always be an unwanted side effect, or
15 are there occasions when actually that is an 15:00
16 appropriate affect?
17 A. As you've said, Mr. Chairman, that is an unpleasant
18 term.
19 CHAIRPERSON: No, but I think we all understand what
20 that might mean, somebody who doesn't -- 15:00
21 A. None of us would want a patient to be described in that
22 way. Sometimes patients were very distressed and
23 aggressive, and medication was used genuinely to try to
24 reduce that, and for their own safety, but it was never
25 the aim to produce, deliberately produce oversedation I 15:01
26 don't think, it was to produce decreased levels of
27 agitation and aggression, and sometimes sedation was an
28 unfortunate side effect of that.
29 CHAIRPERSON: Okay. Thank you.

1 273 Q. MR. McEVOY: Picking up on that last point from the
2 Chairman. If side effects from medication which had a
3 sedating effect, be they prescription or PRN
4 medication, would you have expected that loved ones
5 would be told about side effects, would be advised or 15:01
6 indeed warned about how it might impact on family
7 member's presentation?
8 A. I would have expected where that was an issue that that
9 would have been discussed with the family by the
10 patient's named nurse, yes. 15:01
11 274 Q. And would that have been a responsibility of you and
12 your medical team?
13 A. At times. At times. The communication --
14 275 Q. At times what would have justified that being the
15 responsibility of your team? 15:02
16 A. I suppose the more regular communications with families
17 and updates after ward rounds and so on to the families
18 were provided by their Ward Manager or by the patient's
19 named nurse, but where these were prominent issues I
20 would have certainly been happy to discuss those with 15:02
21 families, and that did occur at times.
22 276 Q. At paragraph 21, the Chair has already touched on the
23 point with you about the perception of patients being
24 "zombified", and I have put to you I suppose the
25 question about side effects and presentation of 15:02
26 medication on relatives, but you say:
27
28 "I was aware that on some occasions families expressed
29 concern about the effects of medication on their

1 relatives. However, there was always a justification
2 which related to the level of disturbance or aggression
3 that the patient was presenting."
4
5 I suppose the human and immediate reaction one might 15:03
6 have on reading that might be: 'Well, how can you be
7 so sure?', that there was always a justification in
8 other words?
9 A. I think the issue of sedation or concerns about
10 patients being oversedated was one that we took very 15:03
11 seriously, and the descriptions of "zombified" and
12 "spaced out" are very unpleasant and quite distressing.
13 We were dealing, however, with patients, particularly
14 if higher levels of medication were being used, or PRN
15 medication being used, where there was marked distress, 15:04
16 or agitation, or physical aggression, and we were
17 seeking to help the patient avoid that in as best way
18 as we could, and we did try other modes of medication,
19 but sometimes those weren't effective. So we
20 recognised that all of those medications had side 15:04
21 effects. We sought to minimise the use of medication
22 and to minimise side effects, but -- and I know that
23 the justification for that would have been discussed
24 clinically, and we wouldn't have used those lightly in
25 any way. 15:04
26 277 Q. We noted your recoil at the use of terms such as
27 "zombification" and being "spaced out" or "not in the
28 room", those are sentiments expressed by family members
29 in their evidence. Might it be, doctor, that family

1 members were expressing that impression or perception
2 of their loved ones because there was inadequate
3 communication with them of the side effects of
4 medication?
5 A. I'm sure that's possible. I think I would have hoped 15:05
6 for communication about those side effects, either
7 from, you know, the nursing team or from me, but I'm
8 sure there were instances where families didn't feel
9 there was enough communication, no doubt.
10 278 Q. You say then: 15:05
11
12 "All medications have the potential to cause side
13 effects and I only prescribed medication, however,
14 where I felt it was clinically appropriate."
15 15:05
16 That is you speaking in a personal capacity,
17 presumably?
18 A. Well, personally, but that's what I would have expected
19 from all of my colleagues.
20 279 Q. You were for a large part of your time at Muckamore in 15:06
21 Six Mile?
22 A. Yes.
23 280 Q. And had, therefore, if we understand what you've told
24 us already in your evidence, less need or resort to the
25 use of medication, would that be fair? If it's unfair 15:06
26 please?
27 A. No, no, no, certainly the bulk of my clinical work, not
28 all of it, but the bulk of my clinical work at
29 Muckamore was in Six Mile, and medication played a

1 smaller part than in some other wards.
2 281 Q. Yeah.
3 A. There were patients who were disturbed, or aggressive,
4 or had active mental illness, and we did use
5 medication, but less so than in an admission ward, for 15:06
6 instance.
7 282 Q. Okay. Well, can we maybe pause with the statement at
8 paragraph 21 there. I'd like to bring up on screen, if
9 it can be done, there was a bundle of material shared
10 with you, I understand, last week, doctor? 15:07
11 A. Yes.
12 283 Q. And if that can be brought up on the screen, hopefully
13 we can go to the particular document in question, which
14 is the first one I'd like to look at, please, is on
15 page 8. Hopefully you'll see it on the screen in front 15:07
16 of you. So this is a letter dated 4th July 2016, and
17 it's a letter addressed to you from the RQIA?
18 A. Yes.
19 284 Q. And it relates to an unannounced inspection which took
20 place at the Donegore Ward between the 28th and 30th 15:07
21 June 2016. And the RQIA go on to detail the basis for
22 the inspection in law and tell that you it was
23 undertaken as part of their planned programme of
24 inspection for '16 and '17.
25 15:08
26 Then if we can scroll the page down a little bit?
27 Thank you.
28
29 "I write under the provision of the RQIA's escalation

1 policy to draw your attention to a serious concern
2 noted by the Inspector relating to the lack of medical
3 consultant input in the ward both managerially and
4 clinically."
5 15:08
6 And then we can see you're asked to attend a meeting on
7 the 7th July.
8 A. Yes.
9 285 Q. Can we move -- sorry, you recall seeing that letter of
10 course, we presume? 15:08
11 A. Yes.
12 286 Q. Yes. We can turn down to page, or scroll down to page
13 10, please?
14 CHAIRPERSON: Has the doctor seen the whole bundle?
15 287 Q. MR. McEVOY: You have seen the bundle, haven't you? 15:08
16 A. Yes.
17 288 Q. You've seen this material?
18 A. Yes.
19 289 Q. Right. You'll see an e-mail from you of 6th July 2016?
20 A. Yes. 15:09
21 290 Q. And this -- would it be fair to say then this is -- you
22 recognise the e-mail as being an e-mail from you?
23 A. Yes.
24 291 Q. In anticipation of a meeting then to take place with
25 the RQIA on the 7th July? 15:09
26 A. Yes.
27 292 Q. And you say then that you have summarised below your
28 plan at present and it might require some amendment
29 when more detail is available from RQIA.

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1
2 If we can just scroll down just a little bit further,
3 please. The first immediate action there is that you
4 have contacted Dr. Oscar Daly -- pausing there. Was
5 Dr. Daly the psychiatrist who assisted the RQIA in 15:09
6 their inspection?
7 A. Yes, he was.
8 293 Q.
9 "...and received assurance that no immediate patient
10 safety concerns are raised and that there is no 15:09
11 evidence of high dose anti-psychotic prescribing."
12
13 Now, can you just tell us a little bit about the
14 interaction that you mention there with Dr. Daly? Was
15 it a conversation or was it a documented discussion? 15:10
16 A. I believe I had a telephone conversation with Dr. Daly.
17 294 Q. And what way do you recall the conversation was left
18 with him? In other words, what way was it left in
19 terms of this concern being taken forward?
20 A. Well, I was very keen to ensure that there was no, as 15:10
21 I've said, there was no immediate patient safety
22 concern raised, and I was reassured that there wasn't
23 any evidence of high dose anti-psychotic prescribing.
24 295 Q. Okay.
25 A. I think that Dr. Daly was expected to be part of the 15:11
26 meeting on the following day.
27 296 Q. Yes.
28 A. So I thought that we would have a further chance to
29 discuss the concerns that he had, and we had a

1 discussion -- I think I remember having a discussion
2 with him about, you know, the concerns he had about the
3 anti-psychotic prescribing.
4 297 Q. Okay. And then if we could turn across within that
5 bundle, please, to I think it's page 38? It should be 15:11
6 page 38, please. This then is the minute of the
7 meeting with the RQIA on the 7th July, you recognise
8 it?
9 A. Yes.
10 298 Q. And we can see then from the list of attendees, you're 15:11
11 there, together with Mr. Veitch, Ms. Rafferty,
12 Mr. Convery from the RQIA, and Dr. Daly, who is
13 described then as the Sessional Inspector?
14 A. Yes.
15 299 Q. And then if we can just go down to the next page, 15:12
16 please? You can see that Mr. Convery has outlined the
17 following specific concerns that have been identified:
18 One relates to regular medical records in the PARIS
19 system. Two relates to regular MDT meetings being
20 cancelled on the morning of the meeting. Thirdly then: 15:12
21
22 "Issues of polypharmacy with psychotropic medication
23 whereby more than one medication was in use before the
24 maximum therapeutic dose of one drug had been
25 prescribed." 15:13
26
27 And then:
28
29 "Concerns noted in relation to patients waiting to hear

1 the outcome of an MDT meeting. This does not happen
2 without an explanation and this can cause patients
3 undue distress and frustration."
4
5 So those are the four specific concerns identified as 15:13
6 headlines in the meeting by the RQIA. I suppose, can
7 you help us understand, with particular regard to issue
8 three there around polypharmacy and the use of
9 psychotropic medication, in the e-mail that we've just
10 looked at, and we can go back to it if we need to, in 15:13
11 the e-mail to colleagues you are giving them to
12 understand that Dr. Daly has assured you that there
13 isn't an issue, and then in the minute the next day we
14 see an issue around polypharmacy and the use of
15 psychotropic medication arising. So in fairness to 15:14
16 you, doctor, the Inquiry would welcome any light that
17 you can throw on this?
18 A. Well the -- if we could perhaps go back just to the
19 note about my --
20 300 Q. Yes, that's page 8. That's the e-mail? 15:14
21 A. Discussion with Dr. Daly.
22 301 Q. That should be page 8, please. I'm sorry, page 10.
23 A. Yes. Thank you. So the contact I made with Dr. Daly
24 as an immediate action was a reassurance that there
25 wasn't any evidence of high dose, specifically high 15:14
26 dose anti-psychotic prescribing. So high dose tends to
27 be -- is regarded as -- there's a reference made --
28 there's a lot of different anti-psychotics, as you'll
29 appreciate. There's a reference made to the overall

1 psychotic dosage, and it's changed to -- it's measured
2 against the maximum dose of chlorpromazine which is a,
3 one particular anti-psychotic. So there's a level of
4 anti-psychotic prescribing above which would be
5 regarded as high dose, and I was reassured to say that 15:15
6 there was no evidence of that.
7
8 If we could go back then to the second?
9 302 Q. Yeah. So this will be page 39, hopefully.
10 A. Yeah. So issue three refers to polypharmacy which 15:15
11 refers to the use of more than one anti-psychotic or
12 other psychotropic medication, which differs from the
13 high dose issue, and the concern that RQIA had was
14 that, or Dr. Daly had raised and RQIA took forward, was
15 that it seemed that there were patients with more than 15:16
16 one anti-psychotic prescribed and the dose of one
17 hadn't been maximised before another one had been
18 introduced. That was the impression or the concern
19 that Dr. Daly had raised.
20 CHAIRPERSON: Is that regarded as bad practice? 15:16
21 A. It's something that we always try to avoid, but it
22 often is -- can be unavoidable. It's not particularly
23 unusual to find patients sometimes in hospital,
24 sometimes outside of hospital who are on more than one
25 anti-psychotic, and there can be different reasons for 15:17
26 that. As I've said, it's something we would always try
27 to avoid, or to minimise, but I think some of these
28 patients had probably been in hospital for a long
29 period of time, and over that time various medications

1 had been tried, because the patients presented with
2 particularly complex problems or challenges in
3 management. So whilst we try to avoid using more than
4 one anti-psychotic, it does happen. There are
5 particular combinations of anti-psychotics which are 15:17
6 recommended at times. To augment the effect of one you
7 add another, and there's some rarely use examples of
8 that.
9 DR. MAXWELL: And is that recognised in the BNF?
10 A. Not in the BNF, but in the literature there are 15:18
11 discussions about where, particularly relating to
12 psychosis and treatment resistant psychosis, where
13 drugs like Clozapine might be used, and almost as a
14 last resort, and even if Clozapine isn't effective
15 other anti-psychotic medication can be used to augment 15:18
16 that.
17 CHAIRPERSON: So if it is fairly common practice, why
18 is Dr. Daly raising it as an issue?
19 A. I wouldn't say it is fairly common practice, it's
20 hopefully relatively unusual, but it does happen. I 15:18
21 think he just had a concern about the combinations
22 and...
23 DR. MAXWELL: Did you discuss, when you telephoned him
24 -- so your e-mail and you said you had spoken to him on
25 two things, you didn't think it was an immediate 15:19
26 patient safety concern and it wasn't about a high dose,
27 so did you ask him why he had raised it if neither of
28 those conditions --
29 A. It's difficult to remember, this was eight years ago or

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1 so, but I do remember discussing it with him and he
2 just had that concern that the dose of one didn't seem
3 to have been maximised before another one was
4 introduced.
5 DR. MAXWELL: And can you remember how many patients he 15:19
6 had observed this in on Donegore?
7 A. I don't, Mr. Chairman. I believe there was nine
8 patients in the ward.
9 DR. MAXWELL: Nine?
10 A. I think so, but that -- 15:19
11 DR. MAXWELL: And you don't know how many of those
12 patients this referred to?
13 A. No. One of the actions though was to have all of the
14 patients reviewed by the then clinical lead for quality
15 and governance, along with our most experienced 15:20
16 clinical pharmacist.
17 DR. MAXWELL: So this was a consultant with a
18 pharmacist doing a review of each patient?
19 A. Yes.
20 DR. MAXWELL: And do we know what they concluded? 15:20
21 A. It's referred to in some of the bundles. I think they
22 examined all of the patient's prescriptions,
23 rationalised -- I don't have numbers, but they looked
24 at all of the patients, they rationalised where they
25 could and wrote, documented a rationale for that 15:20
26 prescription.
27 DR. MAXWELL: But that often -- well, often pharmacists
28 will talk about reconciliation where they'll change the
29 prescription. Do you recall whether this review by the

1 pharmacist and the clinical lead for safety concluded
2 that there was nothing wrong with the prescription and
3 didn't change it?
4 A. Could I check the bundle?
5 CHAIRPERSON: Yes, of course. 15:21
6 DR. MAXWELL: Yes, please.
7 CHAIRPERSON: Just to remind ourselves, we're in 2016,
8 aren't we?
9 A. Yes. So later in the bundle, it is on my page 28, I'm
10 not sure if it's the same for you, one of the review -- 15:21
11 yes.
12
13 "In response to this recommendation the Clinical
14 Medical Lead For Patient Safety and Governance and the
15 Clinical Pharmacist have reviewed all current 15:21
16 medication prescriptions in relation to the use of
17 polypharmacy within Donegore Ward and have changed the
18 prescription where possible or provided a rationale as
19 to why the prescription has not been changed when not
20 possible." 15:21
21
22 DR. MAXWELL: But we don't know how many prescriptions
23 were changed and how many were not changed?
24 A. At this time I don't.
25 DR. MAXWELL: Would that have been recorded somewhere 15:22
26 if we were to go back and check?
27 A. Yes. Sorry, it's elsewhere in the bundle. My page 33,
28 towards the bottom of that page. There was a meeting
29 with those two members of staff on 27th July '16:

1
2 "...to discuss medications of all patients on Donegore
3 and a very detailed to PARIS under medication
4 monitoring only."
5 15:22
6 By that doctor on this.
7
8 "Acted on their...and medication adjusted accordingly
9 and all have been acted upon."
10 15:22
11 And those entries were made in PARIS.
12 DR. MAXWELL: So there will -- a justification will be
13 on PARIS?
14 A. Yes.
15 DR. MAXWELL: And is that a case conference in relation 15:22
16 to each individual patient or one for the ward MDT?
17 A. I believe that that was -- PARIS records entries in
18 different ways.
19 DR. MAXWELL: Yeah.
20 A. And I think that is the tab that that would be held 15:23
21 under.
22 DR. MAXWELL: So that would be a discussion about the
23 whole ward rather than about an individual patient?
24 Because PARIS I think is based on individual records,
25 isn't it, or does it record -- 15:23
26 A. Yes.
27 DR. MAXWELL: -- ward based decisions.
28 A. I think that specific case conference refers to every
29 patient.

1 DR. MAXWELL: Okay. So that will be on PARIS? That
2 would be quite easy to...
3 A. It should be.
4 CHAIRPERSON: And if we -- sorry to stay on this, but
5 if we go back to the serious concern meeting minutes, 15:23
6 and I'm afraid I haven't got a page for that?
7 Mr. McEvoy, if you can help?
8 MR. McEVOY: So that it should be page 38 to 40.
9 CHAIRPERSON: Page 38. Yeah. And over the page. So
10 the first entry there actually relates to the PARIS 15:23
11 note system, and it says:
12
13 "There is no evidence of regular medical records/notes
14 in the PARIS system. Previous paper notes date up
15 until January '15 and no evidence of notes recorded 15:24
16 since this date."
17
18 So does that mean that the patient medication notes
19 hadn't moved onto the PARIS system for every year?
20 A. I don't know, Mr. Chairman. The Trust moved at around 15:24
21 that time from that paper system to the PARIS system,
22 and there was some delays and uncertainties around the
23 use of the PARIS system, but --
24 CHAIRPERSON: There always are with new --
25 A. -- I'm not sure if paper records were kept or not in 15:24
26 the meantime.
27 CHAIRPERSON: But would that concern you that patient
28 notes hadn't moved on to the electronic system?
29 A. It would certainly concern me if there was no --

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1 CHAIRPERSON: Sorry.
2 A. It would certainly concern me, Mr. Chairman, if there
3 was record of an MDT discussion.
4 CHAIRPERSON: And whose duty would it be to ensure that
5 the patient notes had been transferred to the PARIS 15:25
6 system?
7 A. I think that was done in different ways. Sometimes
8 nursing staff recorded MDT discussions. We -- at
9 various times different wards got administrative
10 assistants, so we had a ward clerk which did that, and 15:25
11 I had -- as one of the actions I had reminded
12 colleagues of the importance of recording their
13 clinical input in all the patient records.
14 CHAIRPERSON: And when you go on a ward round do you
15 use the PARIS system? 15:25
16 A. The -- sorry?
17 CHAIRPERSON: When you go on a ward round and you're
18 looking at a patient's medication, what system would
19 you be using?
20 A. If we're looking at medication we'd be examining the 15:26
21 patient's medicine Kardex.
22 DR. MAXWELL: Which is a paper?
23 CHAIRPERSON: Which is a paper.
24 A. Yes.
25 CHAIRPERSON: So I just want to understand, this is 15:26
26 saying that the medical records had moved to the PARIS
27 system, but that Kardex, would that still be on the
28 paper system?
29 A. Yes.

1 CHAIRPERSON: Right. Okay. Thank you. Sorry,
2 Mr. McEvoy.
3 303 Q. MR. McEVOY: So we can see, doctor, if we can just
4 scroll on down, please, at page 39, and just to the top
5 of 40, please? So the action that was agreed at No. 3 15:26
6 there:
7
8 "A review of all current prescription medications..."
9
10 - which you have taken us to or mentioned: 15:26
11
12 "...within Donegore Ward and all wards in Muckamore
13 will be completed. Dr. Milliken will contact the
14 Senior Manager in the Northern Trust to seek assurance.
15 No concerns have been raised regarding out-patient work 15:27
16 as the consultant for the ward has out-patient
17 responsibilities."
18
19 Now, I suppose on reading that action and the extent of
20 it, in other words there's to be a hospital-wide review 15:27
21 of current prescription medications, and indeed going
22 beyond the confines of the hospital to the Trust, that,
23 I suppose to the uninitiated, looks like quite a
24 serious and important and urgent piece of work that
25 requires to be carried out. Would you agree? 15:27
26 A. Certainly I have no doubt about the importance with
27 which it was - the RQIA findings were viewed.
28 304 Q. And did it set -- thinking back to it, I know it was
29 eight years ago, but did it set any sort of alarm bell

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1 ringing within the team that was at the meeting?
2 A. Yes, we were very anxious to ensure that practice was
3 seen to be safe and reviewed in Donegore Ward, but also
4 across the site that we had safe practice.
5 DR. MAXWELL: And as part of that review, did it throw 15:28
6 up any examples of poor prescribing that did put
7 patients at risk?
8 A. I'm not aware at the moment of that.
9 DR. MAXWELL: So to your knowledge as the Clinical
10 Director at the time, there had been this review on 15:28
11 Donegore of a practice which isn't that common but
12 isn't unheard of, of prescribing two psychotropics at
13 the same time, some of the patients didn't have their
14 prescription changed, some did, but we don't know how
15 many of each, and you didn't find any concerns about 15:28
16 this practice on any other ward in Muckamore?
17 A. Not specifically, no. We always had concerns about
18 medication prescription, about the use of multiple
19 medications, but we didn't find example, examples of
20 poor practice. 15:29
21 DR. MAXWELL: And did RQIA follow this up? I mean they
22 raised a concern. Presumably they wanted to monitor
23 what actioned been taken. Do you know if they were
24 satisfied with the actions?
25 A. Well I think that they were satisfied with the plans 15:29
26 that we had to address their concerns. I'm not aware
27 of their scrutiny of the follow-up.
28 DR. MAXWELL: And you don't know if they followed up
29 the audit results?

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1 A. I expect that they did, but I'm afraid I don't know.
2 DR. MAXWELL: And are you aware of them raising this
3 concern again after July 2016?
4 A. No.
5 CHAIRPERSON: We've been going a very long time, partly 15:30
6 due to our questions, but these are important topics.
7 MR. McEVOY: They are.
8 CHAIRPERSON: And I suspect you've still got more to do
9 on this staff statement.
10 MR. McEVOY: Yes. 15:30
11 CHAIRPERSON: We mustn't rush it. We must give the
12 witness the time that is needed. We can sit a bit
13 later this evening, if necessary, but if necessary,
14 Dr. Milliken, can you come back tomorrow morning?
15 A. If that's necessary, yes. 15:30
16 CHAIRPERSON: Okay. We hope to avoid that, we haven't
17 had do it so far, but it is important evidence. All
18 right, we'll take - we will take a quarter of an hour
19 break because you need a break.
20 A. Thank you. 15:30
21 CHAIRPERSON: And then again we'll take another short
22 break when we switch to the other statement. Okay.
23 Thank you. 15 minutes.
24
25 THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS 15:37
26 FOLLOWS:
27
28 CHAIRPERSON: Thank you. We'll go as far as we can
29 this evening, Dr. Milliken, and if we can possibly

1 finish you, we will.
2 A. Great.
3 CHAIRPERSON: But obviously there are a number of
4 people we have to consider. Okay.
5 305 Q. MR. McEVOY: So, doctor, we have been looking at that 15:46
6 2016 unannounced inspection meeting, and the minute,
7 the follow-up minutes, and your proposals around
8 action. So I don't want to labour it too much longer,
9 but if I can explain the purpose in putting it to you.
10 The documents were provided by the Trust, the Belfast 15:46
11 Trust, to afford you an opportunity to examine them,
12 which you have done, and you've given your evidence
13 about them. On the question of medication, you have
14 said in your statement that medication was discussed at
15 multidisciplinary team meetings, and I'm reading from 15:47
16 paragraph 20:
17
18 "...and at ward rounds, and therefore there was a
19 continuous review of medication for patients which
20 included the use of PRN medication." 15:47
21
22 You have said then at paragraph 21 on page 8 - I'll
23 just wait for it to come up on screen:
24
25 "There was always justification which related to the 15:47
26 level of disturbance or aggression that the patient was
27 presenting..."
28
29 - in terms of the concern expressed by families about

1 the effects of medication. And then in your statement
2 that you only prescribed medication where you felt it
3 was clinically appropriate, and in your evidence you
4 extended that to the hope that your team would conduct
5 themselves likewise. 15:48
6
7 So I've taken you to a series of documents and we've
8 looked at them, which demonstrate that there was a
9 concern within the hospital about the management of
10 medication, that the concern was established by the 15:48
11 RQIA, a plan was then put in place to address it, which
12 included a hospital-wide review. Would you say that
13 that material causes you to review maybe the more
14 general statements that you had made in these
15 paragraphs about how things were kept under - how 15:48
16 medication was kept under continuous review and how
17 medication was only prescribed where appropriate and
18 that there was always a justification?
19 A. No, I wouldn't -- the RQIA review caused understandable
20 concern to all of us. It, however, had not done so 15:49
21 before or since.
22 306 Q. I think in fairness it's indicated that it was the
23 first time it had been raised as a concern, isn't that
24 right?
25 A. Yes. And wasn't, to my knowledge, raised again about 15:49
26 any other ward or multidisciplinary team.
27 307 Q. Yeah.
28 A. So I think the statements in paragraph 21 stand, but it
29 was very disappointing, of course, to have these

1 concerns raised in the way that they were.
2 308 Q. We can move on then to look at the topic of seclusion,
3 if that's all right, at 23. You recall how:
4
5 "...Six Mile Ward did not have a seclusion suite but 15:49
6 there was a purpose designed seclusion suite within
7 Cranfield and the Psychiatric Intensive Care Unit.
8 Where it was appropriate patients..."
9
10 - you say: 15:50
11
12 "...might have been subject to seclusion in line with
13 the seclusion policy. When any of my patients had been
14 subject to seclusion, or if someone else's had been
15 secluded out-of-hours..." 15:50
16
17 - while you were on-call then you would have been
18 informed that the patient had been secluded.
19
20 Can you help us understand what steps you would have 15:50
21 taken in either circumstances, in other words whether
22 it was one of your patients or a colleague's while you
23 were on-call, what you would have done then on being
24 informed of an episode of seclusion?
25 A. Well, whether it was my -- if we were informed 15:50
26 out-of-hours duty perhaps, I would have discussed the
27 patient with the nurse in charge of the ward.
28 Sometimes -- in most cases I probably would have known
29 of the patient, but that wasn't always the case. I

1 would have discussed their progress in seclusion, it
2 was always the hope that the duration of seclusion
3 would be minimised, and we would have discussed the
4 plans to move forward from there to get the patient out
5 of seclusion. There was a part of the policy was aimed 15:51
6 at that, so there was review, and that if in a very
7 unusual situation where a patient was in seclusion for
8 four hours, there would have been a direct review done
9 by the consultant, whether it was out-of-hours or not.
10 But an emphasis on trying to move the patient out of 15:51
11 seclusion as quickly as possible.
12 309 Q. And, again, I suppose with the caveat that we're
13 talking about quite a long period of time in terms of
14 your experience in the hospital, can you give us an
15 idea of the timeframe within which you would have been 15:52
16 informed of an episode of seclusion?
17 A. The policy included informing medical staff. That was
18 done within the hour.
19 310 Q. Mhm-mhm.
20 A. So that might have been -- there was an on-call system 15:52
21 with different levels of staffing on that, but I would
22 have expected to hear about episodes of seclusion.
23 311 Q. Within the hour?
24 A. Yes.
25 312 Q. Yes. Any instances whereby that wasn't adhered to? 15:52
26 A. Well a member of the medical staff was always informed
27 within the hour.
28 313 Q. Okay.
29 A. I don't think that I would have been informed every

1 time within the hour, but if there were any concerns
2 that anyone had about the progress of seclusion, or the
3 duration of seclusion, I would have been informed, and
4 certainly if -- I was involved at times in reviews
5 where it went on for longer. 15:53
6 314 Q. And, again, the same caveat applying, we're talking
7 about, you know, a long period of time, but do you
8 recall having concerns about or were you aware of
9 concerns about the use of seclusion within the hospital
10 generally? 15:53
11 A. I think we would have always been concerned about
12 seclusion. Seclusion is a restrictive intervention
13 that all of us would have been concerned about using.
14 315 Q. Yes.
15 A. I think it was one of -- if you think of physical 15:53
16 intervention and the use of PRN medication as well, all
17 of those would have required careful consideration, and
18 seclusion would have been used as - never as part of a
19 patient's care plan, but as an urgent action which was
20 felt to be safer for the patient than perhaps physical 15:54
21 intervention, PRN medication might have been. Some
22 patients the nursing staff would have had a better feel
23 for what was effective for that patient, but seclusion
24 was certainly something that all of us would have been
25 concerned about and viewed as a very serious 15:54
26 intervention.
27 316 Q. And as an adjunct to that, in terms of the use of
28 physical restraint, when would you have been expected
29 to have been informed about that? In other words, the

1 use of it on a patient?
2 A. Well I would have been told about that in various ways.
3 So it was audited or reviewed as part of the hospital
4 management team's reports that we received, so that
5 certainly would have been one way that I would have 15:55
6 heard about physical intervention. But rather like PRN
7 medication, if it was -- if there was significant
8 physical intervention, I would have expected to hear
9 about it either, you know, at the next - beginning of
10 the next day or at the next ward round, depending on 15:55
11 the circumstances.
12 317 Q. Was there a reason, whether medical or other, why there
13 was a distinction between the approach in terms of
14 consultants being informed or the medical team being
15 informed about the use of seclusion vis a vis physical 15:55
16 restraint, if you understand me?
17 A. I think seclusion was viewed as being particularly
18 important and requiring to that particular scrutiny,
19 and it was part of the seclusion policy that it would
20 be, that medical staff would be informed in a way that 15:56
21 I don't believe was part of the physical intervention
22 policy. Physical intervention was a nursing
23 intervention that the nurse in charge took at the time,
24 but it was subject to scrutiny as well. It's also
25 reviewed as part of the hospital management team's 15:56
26 discussions.
27 318 Q. And when you say "subject to scrutiny", do you mean
28 that you brought medical scrutiny to bear, in other
29 words from your perspective as the consultant

1 psychiatrist, to bear on the use of physical restraint?
2 A. We would have discussed that at the next available ward
3 round. If there were particular concerns about an
4 incident it might have happened more quickly, and we
5 had fairly detailed reports about physical intervention 15:57
6 as part of the hospital management team scrutiny.
7 319 Q. And I suppose prior to the allegations of abuse coming
8 to light in 2017, and we'll come on to look at it, but
9 prior to that point in time had you - did you ever
10 harbour concerns about the use by the nursing team of 15:57
11 physical restraint?
12 A. I would always have been concerned that that sort of
13 intervention was necessary.
14 320 Q. Yes?
15 A. I would have been concerned for the patient that they 15:57
16 were so distressed and agitated or aggressive that that
17 was felt to be necessary, and I would have wanted
18 different or better ways to address that sort of
19 problem. But we had nursing teams that as far as I
20 know or knew were trained in detail in physical 15:57
21 intervention, and knew their patients, and felt that
22 that was the safest or least restrictive intervention
23 at that time for that patient.
24 321 Q. Are you saying you harboured a bit of a philosophical
25 concern about the use of physical restraint? 15:58
26 A. No, I recognise that it was an intervention that was
27 necessary at times to keep people safe and was safer
28 than perhaps the use of PRN medication might have been
29 for that patient, or seclusion, so I didn't have a

1 philosophical difficulty, but a practical one, in that
2 I didn't want patients to be physically intervened upon
3 if that could be avoided.
4 322 Q. At 25 then you talk about safeguarding.
5 15:58
6 "Everyone in the hospital had a role in the
7 safeguarding of patients. Prior to the Ennis Report,
8 safeguarding was overseen by the hospital's senior
9 social worker. After the report an additional social
10 worker was employed to focus on adult safeguarding. 15:59
11 From 2017 onwards additional adult safeguarding staff
12 were recruited."
13
14 And you had training in adult safeguarding and child
15 protection every two years, and you would have attended 15:59
16 safeguarding meetings if one of your patients was
17 involved.
18
19 On Ennis, and the Inquiry, you may be aware the Inquiry
20 has heard extensively about it, the Ennis Report and 15:59
21 its outworkings. You were Clinical Director at the
22 time in the hospital. Had you - have you a reaction to
23 it when the report emerged?
24 A. Absolutely. I was both Clinical Director for the
25 hospital and the Responsible Medical Officer for Ennis 16:00
26 at the time and, you know, from both, I was very
27 shocked and distressed by those events and what
28 happened in Ennis.
29 PROFESSOR MURPHY: Did you detect shock and distress

1 amongst patients as well around those times in Ennis in
2 2012, and particularly in the other wards in the new
3 hospital in 2017?
4 A. The Ennis patients, those that were involved in the
5 allegations were less able and less verbal. We had 16:00
6 paid very careful attention to them and to the other
7 patients at that time to look for changes or distress.
8 I think the Ennis Report described quite a lot of
9 changes of staff at the time, concerns amongst the
10 staff about the allegations and the investigation, 16:01
11 concerns about the scrutiny that the ward was put
12 under. So those patients, at times, appeared to be
13 distressed by unfamiliar people being on the ward, or
14 more people than usual being on the ward, and perhaps
15 not understanding why they were there. 16:01
16
17 There was another group of patients in Ennis who were
18 more able, more verbal, but they weren't, as far as I
19 am aware, involved in the allegations. And for at
20 least some of them their families didn't wish them to 16:02
21 be interviewed as part of the investigation.
22
23 So certainly with the 2017 allegations, I was similarly
24 shocked, angered, and distressed, and have real
25 concerns about the patients that were involved in those 16:02
26 initial allegations, yes.
27 PROFESSOR MURPHY: Did you end up needing to use more
28 PRN because patients were distressed?
29 A. I don't believe so, not in Ennis anyway, I don't think

1 so. I wasn't the RMO for the ward where the initial
2 allegations in 2017 were focused, but all of us had
3 real concern for those patients and for their
4 well-being, given what had apparently happened, but I'm
5 not sure if whether increased uses of PRN was a 16:03
6 feature.
7 323 Q. MR. McEVOY: At paragraph 27 then you refer to the Core
8 Management Team within the hospital, of which you were
9 a part, and it was led by the Director,
10 Mrs. Somerville, and then John Veitch, followed by a 16:03
11 series of different individuals taking the position for
12 short terms at a time after 2017. Other members of the
13 team were Mairead Mitchell, the Governance and Acting
14 Co-Director, the Co-Director of Nursing and Business
15 Manager, and then also Ms. Rafferty. 16:03
16
17 "The Business Manager tended to provide input on estate
18 and business issues. There was input from other
19 disciplines on occasion as and when appropriate."
20 16:03
21 Touching on what you describe as different individuals
22 taking the position for short terms at a time after
23 2017, did that resolving door so to speak of management
24 lead to any lack of consistency of approach within the
25 team? 16:04
26 A. I think it was probably unhelpful to have changes of
27 staff. That seemed to happen quite frequently. A lot
28 of the -- the Director of Mental Health at the time
29 came to work at the site and did provide consistent

1 input, which was helpful, but in terms of, you know,
2 forming relationships with new management and being au
3 fait with all of the issues, it wasn't helpful to have
4 a lot of change at that time.
5 324 Q. Yeah. Two members of the team, Mr. Veitch and 16:05
6 Ms. Rafferty, came from a Mental Health background as
7 opposed to a Learning Disability background, the
8 Inquiry has heard. Do you think that -- I'm not sure
9 if you're aware of that? I presume you are aware of
10 that? 16:05
11 A. Of?
12 325 Q. The background of Mr. Veitch and Ms. Rafferty being in
13 Mental Health as opposed to Learning Disability.
14 A. Yes. Yes.
15 326 Q. Do you think that that presented an obstacle to the 16:05
16 work of the hospital?
17 A. No, I don't. I think the work of the hospital depended
18 on good work from people who knew the patients, and I
19 don't think that that required people to necessarily
20 come from a Learning Disability background. I think we 16:05
21 had excellent work from a variety of people who didn't
22 necessarily come from Learning Disability.
23 327 Q. You say then at 29 you witnessed many good examples of
24 good care being delivered at Muckamore.
25 16:06
26 "The design and delivery of the new buildings in the
27 hospital from 2006..."
28
29 - which was something you mentioned earlier in your

1 evidence this afternoon:
2
3 "...was an important part of providing good care."
4
5 And you were part of the project team. Again, you 16:06
6 described earlier how the new hospital was a contrast
7 to the old buildings, dormitories, the new set up with
8 individual bedrooms and bathrooms, et cetera.
9
10 You then move on to talk about how there were 16:06
11 developments in the care provided in Six Mile Ward,
12 particularly around sexual offender treatment, which
13 wasn't available anywhere else in Northern Ireland.
14 You developed the practice of risk assessment and used
15 specific forensic tools to address those. 16:06
16
17 "There were developments in day care opportunities for
18 patients, such as forensic patients being able to leave
19 the Muckamore site to get access to education."
20 16:07
21 There was a rollout, you say, of development of
22 Positive Behavioural Support Planning, which was
23 introduced in Iveagh in 2014/2015.
24
25 "It was very positive for the care of patients." 16:07
26
27 From that point you say you advocated for its
28 introduction in Muckamore, which had also been a
29 recommendation from RQIA. It was a process which took

1 longer than you would have liked because of recruitment
2 and planning, but was finally implemented in 2017.
3
4 So that the Inquiry is clear, does that mean that
5 Positive Behaviour Support Plans weren't introduced at 16:07
6 all prior to 2017?
7 A. No, we always had behavioural support, a behavioural
8 support specialism.
9 328 Q. Yes.
10 A. It would have sought to use positive reinforcement as 16:07
11 one of their mainstays of their involvement, but their
12 practice developed over time and became known within a
13 broader framework of positive behavioural support, and
14 that was introduced more formally in the Iveagh Centre
15 in 2014/2015. I advocated that we needed to introduce 16:08
16 that broader framework of PBS, and there was a steering
17 group for that. It took longer than any of us would
18 have wanted, for various reasons I think.
19 329 Q. Yeah.
20 A. Availability of staff, budgets perhaps. 16:08
21 330 Q. At the end of the paragraph you say that you never
22 witnessed poor care or abuse, but you were concerned
23 that the delayed discharge issue was detrimental to
24 some of your patients who could not be discharged in a
25 timely or appropriate way. 16:09
26
27 A little bit earlier this afternoon we talked about the
28 question of delayed discharge, and you also talked
29 about your concern in relation to it, and how you

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1 escalated it and how it was chronic, as far as you were
2 concerned. Did the -- did the effect of detrimental --
3 the detrimental effect that you describe of delayed
4 discharges reflect itself in patient behaviour?
5 A. I think at times, yes. I can certainly understand the 16:09
6 patient's frustration if their expectation is that
7 they're coming into hospital for assessment and
8 treatment, and when treatment is complete they need to
9 -- they should have left hospital. So that's certainly
10 a source of frustration for the patients, no doubt for 16:09
11 their families and for those looking after them as
12 well. I'm sure that frustration was a cause of
13 behavioural challenge at times, yes. Some patients
14 were coming in to hospital for treatment of mental
15 illness, and it was certainly a concern and a 16:10
16 frustration if we were able to help them by treating
17 their mental illness, they were unable to be
18 discharged, and then the risk of -- there was a risk of
19 relapse of that mental illness before they were
20 discharged, so the discharge was prolonged in that way. 16:10
21 331 Q. Okay. Now you have indicated that you didn't witness
22 any poor care or abuse, but at paragraph 30 you then
23 describe how in the summer of 2017 you received a
24 telephone call from Dr. Jack advising you of the
25 allegations of abuse by staff towards patients in the 16:10
26 hospital, and her then describing to you how CCTV
27 footage had been viewed and that there were concerns
28 that the allegations were wider than had been initially
29 reported. You indicated that you had mixed emotions at

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1 this revelation. You felt shock, anger, and despair.
2 Your work in the hospital relied on others having the
3 right attitude and providing the right care. The abuse
4 allegations have been the most difficulty event in your
5 professional life. 16:11
6
7 Now, it's noted that you say you never witnessed any
8 poor care of abuse. Prior to this conversation with
9 Dr. Jack had anyone else in the hospital raised
10 concerns with you about staff-on-patient abuse? 16:11
11 A. No, I don't believe so. We received, as a hospital
12 management team, very detailed reports about incidents.
13 So the vast majority of those incident reports seemed
14 to relate to incidents involving a patient and their
15 behaviour towards another patient. Much smaller number 16:12
16 involved patients and staff, so patients assaulting
17 members of staff. Occasionally there were allegations
18 made by patients sporadically. There didn't seem to be
19 any -- I wasn't aware of any pattern to that or any
20 particular ward involved in that, and they were 16:12
21 investigated by the line management for the staff
22 involved.
23 332 Q. Now, you have noted feeling shock, anger and despair,
24 but you also describe mixed emotions. What other
25 emotions did you feel? 16:12
26 A. I think shock, anger and despair were the emotions that
27 I felt. I mean I was absolutely horrified by this and
28 heartbroken, I would say, by these allegations.
29 333 Q. Yeah.

1 A. As I said in my statement, this sort of work involves
2 working with a group of other people with the right
3 attitudes and who wanted to provide the right care, and
4 it's extremely difficult to accept that that wasn't the
5 case. 16:13
6 CHAIRPERSON: Could I just ask you more specifically,
7 presumably - and I don't want you to name names, for
8 obvious reasons - but you must now be aware of the
9 names of some of the patients who are said to have been
10 badly treated? 16:13
11 A. Yes.
12 CHAIRPERSON: Were any of them under your direct care?
13 A. I believe now that they were, yes.
14 CHAIRPERSON: How many of them? Do you know?
15 A. No, I don't. I can think of particular examples, but I 16:14
16 couldn't say an exact number.
17 CHAIRPERSON: You described your shock, but does it
18 surprise you that actually you didn't pick up at any
19 stage that your patients were being mistreated?
20 A. Yes, it shocks me. 16:14
21 CHAIRPERSON: And how do you think that could have
22 happened? You were having weekly ward rounds, you were
23 having consultations. Can you help the Inquiry at all
24 as to how that could have happened and it didn't filter
25 through to you? 16:14
26 A. That's obviously something, Mr. Chairman, that I've
27 reflected at length about, and I'm not sure that I can
28 answer that. We were -- I was not in the ward all of
29 the time, so the clinical work was 50% in the hospital

1 on different wards. I'm not sure I can -- I don't
2 think I know the answer to that question.
3 CHAIRPERSON: No. No. All right. Okay. Again, just
4 so that I understand your responsibility for an
5 individual patient, would you have been the named 16:15
6 consultant for those patients that you've just been
7 talking about?
8 A. Yes. In Six Mile, yes.
9 CHAIRPERSON: So does that mean that if any member of
10 staff has a concern about that patient, they should 16:15
11 bring it to you?
12 A. I would have expected so, and initially with the Ward
13 Manager, assuming it was member of the ward staff, the
14 nursing team, I would have expected the Ward Manager
15 and me, yes. 16:16
16 CHAIRPERSON: Because you're not in charge of the ward,
17 as it were, but you are -- you certainly have a high
18 degree of responsibility for each your named patients.
19 Is that fair?
20 A. Yes. Yes. 16:16
21 CHAIRPERSON: And at no stage did anybody, any member
22 of staff or any patient, come to you and say 'This
23 patient is being mistreated'?
24 A. I don't believe so.
25 CHAIRPERSON: Yes. Thank you. 16:16
26 334 Q. MR. McEVOY: Can I summarise the next couple of
27 paragraphs, doctor, just briefly? At paragraph 32 you
28 talk about your involvement in the investigation of
29 complaints relating to doctors, and occasionally

1 complaints that related to decisions of the
2 multidisciplinary team. You describe how you would
3 have consulted with relevant staff and spoken to
4 families about their concerns. You would have reviewed
5 the relevant patient records and spoken to colleagues 16:16
6 and shared your conclusions with the senior managerial
7 colleagues. The complainant would have received a
8 written response from the Director of Mental Health or
9 another senior manager. Do you recall any instances of
10 that? Did that process always work well, or were there 16:17
11 instances where it might not have worked so well, that
12 you can recall? Dissatisfaction with the complaints
13 process, if I can put it that way.
14 A. I can't think of any particular examples. I was
15 involved in investigating any complaints that directly 16:17
16 were about medical colleagues, and at times about the
17 multidisciplinary care that particular patients
18 received. I'm not sure of examples that I investigated
19 where there wasn't satisfactory conclusion.
20 335 Q. Okay. In the next paragraph then you give a 16:18
21 recollection of an incident about which you were
22 uncomfortable. We needn't go into it in detail, but it
23 revolves around a patient on Six Mile Ward and the
24 handling of the situation by the police pursuant to the
25 Memorandum of Understanding between the police and the 16:18
26 hospital. You weren't happy about the way the police
27 handled the situation and raised your concerns with the
28 Adult Safeguarding Team. You wanted the CCTV footage
29 to be reviewed, which it was, and your concerns were

1 agreed with by the Adult Safeguarding Team, and
2 advised, they advised that they would report the matter
3 to the Ombudsman. You're not sure what the outcome of
4 that was.
5 16:18
6 At 34 then, you say that you advocated for the best
7 physical healthcare that could be provided to patients
8 in the hospital. You advocated for the employment of
9 primary care specialists for a long time. You had
10 historical arrangement with a number of local general 16:19
11 practitioner services. How long were you advocating
12 for the introduction of such an arrangement?
13 A. Well, for a long period of time I think we had an
14 awareness that all of our patients had primary care
15 needs that would best have been addressed by primary 16:19
16 care physicians in the same way as all of us would
17 expect. That resource wasn't made available to us. So
18 there was the routine primary care in hours or within
19 the normal working week, and then the primary care
20 input out-of-hours. We were able to make progress with 16:20
21 improving the out-of-hours care with changing the
22 arrangement from the local general practitioner
23 services providing that to the Beldoc arrangement. So
24 there was a rota that GPs were on-site for a number of
25 hours each evening, and on Saturdays and Sundays as 16:20
26 well, and were able to provide more specialist primary
27 care and direct and prompt input for those times. We
28 advocated long and hard for the resource to employ
29 primary care specialists during the ordinary working

1 week as well, and as I've said in my statement, John
2 Veitch and I met with the Eastern Board to advocate for
3 that as well and had e-mail correspondence with
4 commissioners about the need for that, and it certainly
5 didn't happen as quickly as I would have wanted, but it 16:21
6 was a very welcome addition when it did arrive.
7 336 Q. And that's the appointment of Dr. Kingsley?
8 A. Yes.
9 337 Q. And can you recall when that was, just off the top of
10 your head, if you can? 16:21
11 A. I think it was around 2017, or perhaps slightly earlier
12 than that, but I'm not exactly sure.
13 338 Q. Yeah. And you advocated also, I think you tell us
14 later in the same paragraph, for a clinical pharmacist
15 for the hospital? 16:21
16 A. Yes.
17 339 Q. And was that successful?
18 A. Eventually. In the early part of my consultant career
19 we did have a clinical pharmacist who then retired and
20 we were either unable to recruit or didn't have the 16:21
21 budget perhaps, or availability of staff, to have a
22 clinical pharmacist, until eventually we were
23 successful and Ms. Murray joined us.
24 340 Q. Did the lack or absence of one create an issue in terms
25 of your care for your patients? 16:22
26 A. I think clinical pharmacists are particularly helpful
27 in particular expertise in all sorts of issues around
28 medication, and I always felt that and always advocated
29 strongly for it.

1 341 Q. At 35 then you observe:
2
3 "The community multidisciplinary teams, of which we are
4 a part, tried to avoid admissions. Some patients did
5 need to be hospitalised." 16:22
6
7 It was common for you to feel that a hospital admission
8 might have been avoided if other community based
9 treatment options had been available. There were
10 limitations to the care available in the community for 16:22
11 patients, especially out of hours. But are we to take
12 it from what you say though that there were occasions
13 when patients were admitted to Muckamore unnecessarily
14 in your clinical opinion?
15 A. There were certainly admissions that I would have hoped 16:23
16 could have been avoided.
17 342 Q. Yeah.
18 A. That I felt could have been avoided if there were other
19 community treatment options, either through therapeutic
20 intervention from a community team, or from support to 16:23
21 a provider who were struggling to provide what was
22 required, and I would have been particularly keen to
23 avoid repeat admissions. So there were some patients
24 who were admitted more than once in the same
25 circumstance. 16:23
26 343 Q. And how would you have, how would you have managed that
27 in terms of your dealings with the patients themselves
28 and of course their families?
29 A. Well, all of us - I had involvement with a community

1 team, a Community Learning Disability Team in the South
2 Eastern Trust.
3 344 Q. Yes.
4 A. Belfast Trust provided those services to South Eastern
5 and Northern Trusts as well, so each of those teams had 16:24
6 one of us as part of their team where there were
7 difficulties, where there were concerns that someone
8 might need admitted, we would have met as a
9 multidisciplinary team in the community team and
10 discussed and sought ways to avoid that admission and 16:24
11 to provide the individual with treatment where they
12 were. That wasn't always possible, though frequently
13 we were able to avoid admissions. Sometimes
14 unfortunately out-of-hours those supports weren't
15 available, and unfortunately there were -- a lot of the 16:24
16 admissions occurred out-of-hours without that sort of
17 ability to plan.
18 CHAIRPERSON: And was that because there was no crisis
19 intervention available in the community very often?
20 A. Very often, yes. 16:25
21 CHAIRPERSON: And one of the issues we heard about from
22 relatives would be that there would be such a crisis,
23 and what was meant to be a short-term admission to deal
24 with that crisis would turn into a very much longer
25 admission. 16:25
26 A. Yes.
27 CHAIRPERSON: Do you recognise that scenario?
28 A. Absolutely, yes.
29 CHAIRPERSON: And that's because there was insufficient

1 community support to let that patient out again.
2 A. Yes.
3 CHAIRPERSON: One other issue that we heard about, and
4 I don't know if you can comment, we heard that for a
5 number of patients who were admitted their relevants 16:25
6 weren't able to visit them, weren't allowed to visit
7 them for a number of weeks. I think we heard in one
8 instance at least that there was a six week period when
9 they were told no visitors. Was that a policy?
10 A. No, no, not that I was aware of. There might have been 16:25
11 -- there certainly was no such policy and I'm not aware
12 of particular cases where that occurred. There may
13 have been times when families were asked not to visit
14 for a very initial phase to allow someone to settle,
15 but there was certainly no policy -- 16:26
16 CHAIRPERSON: What sort of length of --
17 A. Well I would have thought if that was the case it would
18 have been very short. I would have been very surprised
19 to hear of weeks. I've never been aware of any case
20 like that. 16:26
21 CHAIRPERSON: So a couple of days perhaps.
22 A. Yes.
23 CHAIRPERSON: But you're saying -- so it should have
24 happened, if it happened?
25 A. I don't think it should have, no. 16:26
26 CHAIRPERSON: Okay. Thank you.
27 A. I'm not aware of it happening.
28 MR. McEVOY: Panel, those are my questions on the staff
29 phase.

1 CHAIRPERSON: What we'll do, we'll take a very short
2 break. I mean I can say this I think, because the next
3 statement is going to be, or has been published, we do
4 not need to go through the statement in the way that we
5 have done for members of the public in terms of staff 16:26
6 witness statement, so we can take it as short --
7 MR. McEVOY: Certainly. As read, so to speak, yeah.
8 CHAIRPERSON: Yeah. All right. We'll take a five
9 minute break. Will that be long enough? Yeah, five
10 minutes, and then we'll start again. Thank you very 16:27
11 much.
12
13 THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS
14 FOLLOWS:
15 16:32
16 CHAIRPERSON: Right. So the last section of your
17 evidence - we've dealt with a lot of material relating
18 to you as a member of staff. We are obviously not
19 going to rush this. If we do finish by five, all well
20 and good, but if not then we'll have to make 16:32
21 arrangements. Okay.
22 MR. McEVOY: Thank you, Chair. So, Dr. Milliken, for
23 those members of the public who are following along,
24 this part of your evidence relates to a statement which
25 you provided to the Inquiry on 13th May of this year. 16:32
26 It's available on the Inquiry's website, and I
27 therefore don't propose to read from or summarise it
28 any more than is strictly necessary. But at the outset
29 of your statement you've set out your qualification and

1 positions, and then you move to deal with what your
2 statement focuses on, which is a number of queries from
3 the Inquiry arising from the operational management of
4 Muckamore hospital.
5 16:33
6 At paragraph 6 you are telling us about your role as
7 Clinical Director, where you had management or
8 relationships responsibility for the doctors within
9 Muckmore Abbey Hospital, but you hadn't management or
10 leadership responsibility for other staff, in 16:33
11 particular nurses and healthcare assistants. Were you
12 part of a collective leadership team, however, within
13 the hospital?
14 A. Yes, I was. So in terms of direct line management
15 responsibility, I was responsible for the doctors, but 16:34
16 I was part of a team that was responsible for
17 delivering treatment services at the hospital.
18 345 Q. And as a sort of -- as the title would suggest, a
19 collective leadership team connotes decisions being
20 taken on a collective basis, and therefore 16:34
21 cross-cutting, though you had line management
22 responsibilities you would you have cross cutting
23 responsibility for the delivery of care throughout the
24 hospital?
25 A. Well, yes. I think the term "collective leadership 16:34
26 team" refers to much later. It was the Core Hospital
27 Management Team that I was part of.
28 346 Q. Yes.
29 A. But whilst I had line management responsibility for the

1 doctors, certainly I was part of that team which -- and
2 would have provided medical advice to the management of
3 the hospital site.
4 347 Q. Okay. If we can touch on a historical point then at
5 paragraph 8? Your in-patient responsibility was for 16:35
6 the forensic ward, but you were consultant psychiatrist
7 for various other wards during your time at the
8 hospital. Prior to the opening of the core hospital,
9 can you help us understand which was the forensic ward,
10 if there was one, within Muckamore? 16:35
11 A. Yes. Before the new buildings were opened the forensic
12 service was based at Mallow Ward.
13 348 Q. Yes. Then at 9 you describe your responsibilities,
14 among other things, as Clinical Director. Reviewing
15 and assigning roles for doctors, line management and 16:35
16 leadership for those doctors, and providing input at
17 the Core Hospital Management Team and providing
18 clinical device on the development and delivery of
19 treatment. Presumably overall care of patients was the
20 overarching objective of that role? 16:36
21 A. Yes.
22 349 Q. You were asked then to assist us, assist the Inquiry
23 with an understanding of your role and the admission to
24 and discharge of patients from Muckamore. You have
25 discussed the process of admission and referral. 16:36
26 Looking at page 5 and paragraph 13, a point which was
27 raised with you is as follows:
28
29 "Did a lack of resources or delay in availability of

1 support in the community impact on whether a patient
2 was referred to Muckamore? If so, please explain?"
3
4 You begin your response by saying "I believe so", and
5 you say then: 16:37
6
7 "Patients with complex needs required input from
8 specialist staff not often available in the community."
9
10 You didn't leave Muckamore until 2022, is that right? 16:37
11 A. That's correct.
12 350 Q. Had you seen any improvements in the community by that
13 time?
14 A. Yes, I think that there had been improvements, not
15 perhaps consistent improvements, but certainly some 16:37
16 improvements in certain areas. Particular Trusts, the
17 Northern Trust in particular had -- we had -- where
18 historically we were involved in managing services in
19 the Northern Trust, at a point it was agreed that the
20 Northern Trust would be better doing that themselves, 16:37
21 so we handed that responsibility to them and they had
22 an opportunity to develop some better crisis response,
23 I think, out-of-hours. Belfast Trust certainly were
24 trying their best I think to provide those Behavioural
25 Support Services in the community, though they were 16:38
26 slow to develop at times and weren't always as
27 responsive as we would have wanted them to be to avoid
28 admissions. I think similarly in the South Eastern
29 Trust as well. All of the Trusts were trying to

1 provide crisis response home treatment services with
2 varying degrees of responsiveness and success, so I
3 think there were improvements, but we were still
4 admitting people who in other circumstances admission
5 might have been avoided. 16:38
6 351 Q. Would closing the wards to new admission have had the
7 consequence of shifting the problem elsewhere?
8 A. Closing to admissions after the --
9 352 Q. Yes.
10 A. Yes. Yes. Yeah, it did unfortunately at times. I 16:39
11 think it resulted in the Community Trusts having to
12 respond differently and to perhaps take a greater risk
13 at times where there was concerns about risk to self or
14 others when admission might have happened at other
15 times. Other patients were admitted necessarily to 16:39
16 adult mental health beds in other Trusts; Belfast,
17 South Eastern Trust, and I think Northern Trust as
18 well.
19 353 Q. Now you go on then to say that:
20 16:39
21 "Families provided excellent care to patients but would
22 sometimes reach a point where they were unable to
23 manage a patient's complex behavioural needs in the
24 community and they may have experienced a lack of
25 hands-on support..." 16:40
26
27 - especially out-of-hours. The Inquiry heard from John
28 Veitch who was the Co-Director that in and around 2014
29 medical staff reviewed admissions, most of those were

1 within the normal working hours, and around, according
2 to Mr. Veitch, 80% were unnecessary, but due to a lack
3 of community services. Do you know whether that data
4 was captured and whether anything was done with it?
5 A. I recall an audit being done of that work. I'm quite 16:40
6 sure that it was used to promote the development of
7 stepped community care.
8 DR. MAXWELL: I think Mr. Veitch said the medical staff
9 had undertaken this review. So it wasn't a management
10 review, it was a clinical audit by medical staff, and 16:41
11 you were the Clinical Director at this time.
12 A. Yes.
13 DR. MAXWELL: So presumably you had oversight of the
14 Clinical Audit Programme?
15 A. Yes, I'm aware of the audit that took place. I think 16:41
16 there was a similar audit done by other disciplines as
17 well, which perhaps differed in some of the
18 conclusions.
19 DR. MAXWELL: In what way?
20 A. In the analysis of risk and how that might have been 16:41
21 managed. So there was at times different views
22 possibly of whether admissions could have been
23 prevented or not.
24 DR. MAXWELL: So I think Mr. Veitch's evidence was that
25 the medical review, was that 75% to 80% of admissions 16:41
26 were avoidable if there had been appropriate resources
27 in the community. Was that an opinion you shared?
28 A. Well I would have shared the view that quite a number,
29 you know, I'm not sure of the percentage, but I would

1 have been sure that a significant percentage of
2 admissions, if we had a fully planned, fully resourced
3 community service, could have been avoided, yes.
4 DR. MAXWELL: And do you think admitting a patient to a
5 hospital setting like Muckamore, when it wasn't 16:42
6 required, was potentially harming patients?
7 A. I think all of us would have wanted to avoid that
8 situation, would have done everything we could have to
9 avoid that situation. We would have been particularly
10 concerned if the patient was known to us and had an 16:42
11 existing assessment and had periods of treatment but
12 were being re-admitted essentially for the same
13 problem. We talked earlier about people with autism
14 and how difficult they can find those sorts of physical
15 environments, so that's something we would have been 16:43
16 very concerned about.
17 DR. MAXWELL: So when you have a clinical audit that
18 has such a stark finding, how does that work its way up
19 through the governance system in the Trust?
20 A. The audit was, from memory, was discussed at various 16:43
21 levels, so the Hospital Management Team, the Learning
22 Disability Senior Management Team. I'm not sure that
23 the conclusions were shared by everyone because the
24 high percentage wasn't agreed with at times by some
25 people who felt those admissions weren't avoidable. 16:43
26 And it would have added to our discussions for, you
27 know, advocating for better community services, for
28 smaller number of admission beds, that was something
29 that we felt --

1 DR. MAXWELL: So you've got a finding, disputed, that a
2 finding that at least some people believe there's a
3 high number of unnecessary admissions that may actually
4 cause patients harm, and you hadn't been able, at this
5 moment, to reduce that risk. Do clinical audits ever 16:44
6 find their way on to the Risk Register and get
7 escalated up to the Trust Board?
8 A. I'm not aware of that. It may have. I think we
9 responded to it. Around that time we became
10 increasingly aware of quality improvement as a vehicle 16:44
11 for service improvement, and we had a working group, it
12 was called IMPACT, it was an acronym, I'm sorry I can't
13 remember what the acronym stood for, but prevention of
14 admission was one of the targets for that.
15 DR. MAXWELL: But if I was a Non-Executive member of 16:45
16 the Board I'd have been oblivious to the fact that the
17 grand vision for resettling patients out of Muckamore
18 was not going to be achieved, despite the targets that
19 had been set, because nobody was feeding back up to the
20 Board that actually not only were we not resettling 16:45
21 them we were admitting people who shouldn't have been
22 admitted because of the lack of community services. As
23 a Non-Exec I would have no mechanism for knowing this?
24 A. Unless it was on the Risk Register possibly, yes.
25 PROFESSOR MURPHY: Can I just ask, you had community 16:46
26 psychiatry duties as well, didn't you?
27 A. Yes.
28 PROFESSOR MURPHY: And in your community post did you
29 have a Risk Register for the patients who you thought

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1 were most likely to be at risk of being admitted to
2 Muckamore, and did they have crisis management plans,
3 just as a way of trying to avoid their being admitted?
4 A. I don't think there was a formal register in that way,
5 but the team in the community patch where I worked 16:46
6 would have had awareness of a relatively small number
7 of patients who were at risk of admission, and I think
8 we would have met about them. I'm not sure if we had a
9 formal plan in the way you suggest, but we would have
10 discussed them at our weekly meetings. 16:46
11 PROFESSOR MURPHY: Okay.
12 354 Q. MR. McEVOY: So at the top of page 6 then you're asked
13 then for your response on the question of how it was
14 decided when a patient was ready for discharge from
15 Muckamore Abbey, and you tell us then that the clinical 16:47
16 decision was made by the MDT.
17
18 "The key decision was whether the patient was medically
19 fit for discharge. The problem that led to delayed
20 discharge was that there was often nowhere suitable for 16:47
21 the patient to go, so patients ended up staying in the
22 hospital much longer than they needed to, with
23 resulting detriment to the patient's mental state and
24 behaviour."
25 16:47
26 Was it ever considered that a patient simply wasn't
27 appropriate for the hospital? And just to give you an
28 example, one of many that the Inquiry has heard about,
29 a patient in Six Mile who had an abnormally high number

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1 of seclusions, and this patient needed a medium secure
2 placement, what -- in other words what sort of measures
3 would have been taken to safeguard him, and other
4 patients and staff?
5 A. For a particular patient who required medium -- 16:48
6 355 Q. A medium secure placement, yeah?
7 A. Yeah. The Inquiry, I'm sure, will be aware that we
8 didn't have access to medium security in Northern
9 Ireland, and actually to maximum security either. We
10 had maximum security, in the very rare cases where that 16:48
11 was required, was sought from colleagues in Carstairs
12 in Scotland. In my experience, we had a very small
13 number of patients who were, for whom medium secure
14 placements were sought out of the jurisdiction. Where
15 that process either took a long time, or wasn't 16:48
16 forthcoming in terms of the funding for that, we would
17 have had to use the resources that we had. So we often
18 had greater staff numbers, consideration about nursing
19 staff numbers, perhaps enhancements to the nursing
20 staff team, enhancements to the behavioural support 16:49
21 services. More frequent case review.
22 DR. MAXWELL: Did HSCB give you extra funding for these
23 patients?
24 A. I don't believe so, no. If they, if the request was
25 for funding for them to go to a medium secure 16:49
26 placement, that request was made on a case-by-case
27 basis.
28 DR. MAXWELL: So in order to protect other patients and
29 staff from somebody who had very distressed behaviour,

1 and therefore was a risk to them, resources were
2 effectively diverted from other patients in order to
3 manage this patient?
4 A. Well I think we would have sought additional resource
5 from the resources available to the hospital. 16:50
6 DR. MAXWELL: But I think you said you didn't get any
7 additional funding for this type of person who was
8 probably a medium secure?
9 A. Well, not funding, but we would have sought -- if we
10 needed extra staffing we would have drawn that from the 16:50
11 staff resource that we had.
12 DR. MAXWELL: Which meant that other patients who were
13 supposed to have that resource didn't have it.
14 A. Well that's possible.
15 356 Q. MR. McEVOY: With wards being closed, the patient mix 16:50
16 was changing.
17 A. Yes.
18 357 Q. And potentially becoming more unstable?
19 A. Well, when wards closed certainly it became less
20 stable. Wards were changing, staff teams were 16:51
21 changing, multidisciplinary inputs were changing, so it
22 did become less stable, yes.
23 358 Q. One of the changes in terms of staff would have been
24 that there would have been a requirement for more of
25 them presumably? 16:51
26 A. There were. After the beds closed there was certainly
27 concerns about the availability of staff and
28 availability of resources for that, yes.
29 359 Q. Was that perceived as a risk by MDT?

1 A. Yes.
2 360 Q. And what was done about it?
3 A. I think there was very considerable input. In the
4 period of time post the 2017 allegations, there was
5 very considerable input from Nursing, the Senior 16:51
6 Nursing Management in particular, the Director of
7 Nursing. There was an extra, an additional senior
8 nurse manager on site, very regular reports to Trust
9 Board. There was a weekly situation report provided to
10 the Medical Director and to the Chief Executive. 16:52
11 361 Q. At 19 then you're asked in relation to the topic of
12 seclusion whether you, as a member of the Muckamore
13 management, would have received regular reports on the
14 use of seclusion. You say you did, and I know we've
15 talked about it already this afternoon, but just for 16:52
16 present purposes, medical approval was needed prior to
17 seclusions or certainly --
18 A. Not prior to seclusion, but we were informed of the
19 seclusion. The decision about seclusion was taken by
20 the Ward Manager present at the time. 16:52
21 362 Q. Yeah. And when called on the phone would you have
22 actually gone down to the ward if you were in the
23 building or on the campus?
24 A. I think during normal hours -- it was very unusual --
25 we didn't have a seclusion room in Six Mile, so it was 16:53
26 very unusual in my clinical work to be involved in
27 seclusion.
28 363 Q. Yeah. Okay.
29 A. Out-of-hours if we were called and it was a prolonged

1 seclusion, we would have gone to be part of a four-hour
2 review of seclusion.
3 364 Q. And do you think that for the professional staff
4 involved there was a clearly understood division
5 between self-isolation and seclusion? 16:53
6 A. I'm not sure what you mean by "self-isolation".
7 365 Q. So where a patient might want to say that he or she
8 wanted to be alone in order to, or indicating that they
9 wanted to be alone to de-escalate?
10 DR. MAXWELL: They often called it low stimulus. 16:53
11 MR. McEVOY: Yeah.
12 A. Right. I think there would have been a firm
13 understanding of the difference between those two
14 things. We took the definition of seclusion very
15 seriously, in my experience. So that differs from the 16:54
16 use of maybe that self-isolation or a period of time to
17 calm.
18 PROFESSOR MURPHY: Would you have been concerned then
19 if a particular patient had frequently chosen to go
20 into the seclusion room voluntarily for so-called low 16:54
21 stimulus time?
22 A. Yes, I think I would have been. I think I would have
23 sought to explore that and sought to understand why
24 that was.
25 PROFESSOR MURPHY: But it wasn't something you came 16:54
26 across in Six Mile?
27 A. No.
28 366 Q. MR. McEVOY: And I know we've looked at this earlier on
29 in your evidence today, doctor, but as a general

1 proposition do you think that physical interventions
2 and seclusion were overused at Muckamore?
3 A. I think all of us would have wanted, all of us would
4 have wanted less restrictive intervention, that was
5 something we did take very seriously, all of us would 16:55
6 have wanted to avoid seclusion and avoid physical
7 intervention. That wasn't always possible. Whether or
8 not it was used too often, given the clinical
9 presentation of the patients, I'm not sure. In my
10 experience in Six Mile seclusion, well it was only used 16:55
11 for one particular patient, physical intervention at
12 times, but always in the context of worrying or direct
13 physical aggression.
14 PROFESSOR MURPHY: Were you aware of the Restraint
15 Reduction Network? 16:56
16 A. Only towards the end of my managerial time at
17 Muckamore, I did become aware of that. We had regular
18 input both in -- well we were trained in breakaway, not
19 in physical intervention techniques -- but we had
20 regular input and discussion with people who were 16:56
21 trained in the management of actual or potential
22 physical aggression. There was -- we received the
23 reports as a management team. We had intermittent
24 input. One of those instructors would have come to the
25 hospital management team to discuss the reports about 16:56
26 physical intervention and look at particularly
27 difficult episodes, if they had occurred.
28 PROFESSOR MURPHY: We understand that there was
29 relatively little emphasis on de-escalation in the

1 original MAPA training, and that later on it did
2 actually change, and obviously de-escalation is really
3 important in avoiding things like physical intervention
4 and seclusion. Did you ever see that being enacted on
5 the wards? 16:57
6 A. Yes. I'm surprised to hear - we weren't trained in
7 MAPA, but I'm surprised to hear that de-escalation
8 wasn't the first and most prominent part of that.
9 PROFESSOR MURPHY: It was in the training, but it
10 wasn't as prominent as it much later became. 16:57
11 A. De-escalation certainly I think probably the most
12 important element of the training that we received in
13 breakaway techniques, and I did see evidence on the
14 wards of staff trying their best to de-escalate
15 situations. 16:58
16 PROFESSOR MURPHY: So it wasn't your impression that
17 people kind of went straight for physical intervention
18 when there was a disturbance?
19 A. That wasn't my impression, no.
20 367 Q. MR. McEVOY: Doctor, two brief questions around PRN, 16:58
21 which I know we've looked at again earlier on today.
22 Is the Inquiry correct in its understanding that PRN
23 was not monitored, the use of PRN was not monitored for
24 trends?
25 A. Not in the same way as the seclusion, physical 16:58
26 intervention and incidents were, no.
27 368 Q. And upon reflection do you think that there ought to
28 have been monitoring and trend analysis for PRN?
29 A. I am sure that would have been helpful, yes.

1 369 Q. Were you aware of STOMP, or Stop Over-Medicating
2 People.
3 A. Yes, very much so. I'm sure the Panel will be aware of
4 the STOMP campaign. I think that it arose around 2017?
5 It's an NHS England direction that hasn't been formally 16:59
6 adopted in Northern Ireland, as far as I know.
7 370 Q. Yes.
8 A. But it's one that we were all aware of, and in my
9 community work, and in the hospital, we were very aware
10 of that. 16:59
11 371 Q. And did it have implications for your practice and that
12 of your medical colleagues?
13 A. Yes, it did. I mean the Royal College of
14 Psychiatrists' Position Paper on STOMP wasn't there
15 until 2021, actually, so there was a delay with that. 16:59
16 But all of us were keen to avoid unnecessary medication
17 or to reduce anti-psychotic medication, if that was
18 possible.
19 372 Q. Now in terms of the extent to which you received
20 reports on safeguarding, at paragraph 22 you've told us 17:00
21 that you don't recall receiving regular reports on
22 safeguarding prior to 2011. From that time onwards
23 there was a safeguarding social worker who provided
24 reports perhaps quarterly to the Core Hospital
25 Management Team. When you -- after that time, in other 17:00
26 words after 2011 when you began to be cited on
27 safeguarding and the number of incidents, were you
28 alarmed at the number of them on the wards?
29 A. Well, I was alarmed of course by the Ennis Report. I

1 was aware of the increased focus on safeguarding as an
2 issue. I was reassured to some extent by the
3 improvements in the resourcing of safeguarding. We
4 were -- the need for us all to train in safeguarding
5 was emphasised as well. I'm not aware of -- I think 17:01
6 there was -- after the Ennis Report there was a
7 considerable increase in the recording of adult
8 safeguarding incidents. So that was concerning, yes.
9 373 Q. Do you recall at management team level a debate going
10 on amongst the social workers and other professionals 17:01
11 about ASG thresholds, in other words the threshold for
12 what should be considered a safeguarding matter or
13 incident?
14 A. I think there were those discussions, I can't remember
15 the specifics of them, but there were discussions about 17:02
16 thresholds, discussions about the need for police
17 involvement and so on, yes.
18 374 Q. Now, in terms of the preparation of reports and how
19 concerns identified from reports are escalated, at
20 paragraph 24 you describe how reports in relation to 17:02
21 seclusion and physical intervention were provided
22 regularly to the Hospital Management Team and to the
23 Learning Disability Senior Management Team. You had
24 limited ability to analyse data from statistical
25 perspective, but in around 2017 you remember receiving 17:02
26 training in quality improvement and statistical
27 significance, and you were better equipped from that
28 point onwards to identify trends from the data.
29 Did you consider after that training, after receiving

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1 that training, did you consider using a statistical
2 process chart to monitor care?
3 A. Yes. After -- the training was really in quality
4 improvement techniques and statistical analysis of
5 those trends. We also had better and more resource 17:03
6 from data collection specialists as well, so we got
7 better quality reports. And around that time our
8 training or our awareness in quality improvement
9 suggested that we should have quality improvement
10 projects to try to improve the service. 17:03
11 375 Q. And you benchmarked data against similar hospitals
12 across the UK?
13 A. Yes.
14 376 Q. Can you recall which ones and who the benchmarking was
15 organised by? 17:04
16 A. There was an NHS, a UK-wide NHS benchmarking exercise
17 in I think 2018 and we took part in that. There was
18 quite a lot of data collected about both community
19 learning disability services and hospital services.
20 The hospital services section of it did include data 17:04
21 about incidents, about complaints, about medication
22 errors and so on, and compared where we were compared
23 to the national norm, so we assumed --
24 DR. MAXWELL: So it normally reports in quartiles. Do
25 you know which quartile you were in? 17:04
26 A. No, I'm sorry, I don't remember the detail.
27 DR. MAXWELL: Can I just ask you about the quality
28 improvement. This is presumably the IHI programme, and
29 you would have been in PDSA cycles?

1 A. We didn't - I don't think we reached that point. The
2 benchmarking, that was our first involvement in 2018
3 with the benchmarking exercise. The intention
4 certainly was to have quality improvement projects
5 involving PDSA cycles, yes. 17:05
6 DR. MAXWELL: But they hadn't actually started?
7 A. No.
8 DR. MAXWELL: So there wasn't a PDSA project in
9 Muckamore?
10 A. No. We had the beginnings of that with the IMPACT 17:05
11 group that I referred to earlier on, but I think partly
12 because of events which were ongoing, it just wasn't
13 possible, and there's so many changes in staffing that
14 didn't prove possible.
15 CHAIRPERSON: Sorry, PDSA? 17:05
16 DR. MAXWELL: Planned-Do-Study-Act. It's based on --
17 well I can bore you with it at a later date, but it's a
18 recognised quality improvement methodology that
19 Northern Ireland invested in very heavily at that time.
20 CHAIRPERSON: Indeed. Thank you. Thank you. 17:05
21 PROFESSOR MURPHY: Of course benchmarking yourself
22 against other hospitals and finding you are not much
23 different doesn't necessarily tell you that your
24 quality of care was good, does it?
25 A. No. 17:06
26 PROFESSOR MURPHY: It may just say quality of care in
27 hospitals is poor across the board?
28 A. I agree that it doesn't tell us our care is good, yes.
29 377 Q. MR. McEVOY: And I suppose it's also premised on the

1 data being that is recorded being accurate. In other
2 words, say for example if seclusion isn't being
3 accurately recorded, then it could skew the outcome?
4 A. If that was what was happening that would skew the
5 outcome, yes. 17:06
6 CHAIRPERSON: Mr. McEvoy, how long do you think you've
7 got to go because I'm very aware of our stenographer
8 who had an extremely long day.
9 MR. McEVOY: Well, yes. I have three more questions,
10 so I don't want to give a time on it, because it's 17:06
11 usually counsel's estimate plus VAT, but...
12 CHAIRPERSON: Can we do five or six and minutes?
13 (Short discussion with stenographer). If you can keep
14 it tight and focused.
15 378 Q. MR. McEVOY: Yes. At paragraph 25 then, the topic of 17:07
16 co-production was raised with you. Families were
17 invited to review meetings throughout patient's
18 admissions and you mention a resettlement project from
19 2010 to 2013. How often were the reviews for patients
20 which relatives would be invited? 17:07
21 A. Again it would depend on the ward and the nature of the
22 case. So for the resettlement type group, historically
23 it would have been an annual review, then as the
24 resettlement project proceeded there would have been a
25 lot more frequent meetings with families, because of 17:08
26 the need for them to be involved in their relative's
27 discharge. For the core hospital admission patients,
28 there would have been a number of different sorts of
29 meetings. So there would have been a post-admission

1 meeting where the views of families, where that was
2 possible, would have been sought. There would have
3 been a review of, at various stages of the, you know
4 the care plan. There would have been discharge
5 planning meetings, which again I would have expected 17:08
6 families would have been asked for their input to, and
7 as part of PIPA, certainly in Six Mile we began sort of
8 formally asking families to meet with us.
9 379 Q. And were you and your medical colleagues easily
10 contactable in between those reviews by families? 17:09
11 A. Well I hope so. I think that was my experience. I
12 certainly responded to, either by telephone or meeting
13 with patients whenever I was asked to, the families
14 would have been asked to contact me via my secretary.
15 I'm sure that was the case for others as well. 17:09
16 380 Q. Okay. Finally from me then, doctor, at Question 9 you
17 were asked about the arrangements for clinical
18 supervision, the practice of staff across all
19 disciplines. Fairly you say you weren't involved with
20 the supervision of healthcare assistants, but you were 17:09
21 involved in the clinical supervision of doctors, and
22 then you tell us about the process. Did any of your
23 trainees ever raise concerns or worries in the process
24 of supervision with you about abuse or poor practice
25 within the hospital? 17:10
26 A. I don't believe so. I don't recall anything like that.
27 And if they had, I would certainly have been most
28 concerned and alarmed and would remember it.
29 MR. McEVOY: Thank you, Dr. Milliken.

1 CHAIRPERSON: Thank you. Just give me one second.
2
3
4 DR. MILLIKEN WAS THEN QUESTIONED BY THE PANEL AS
5 FOLLOWS:
6
7 381 Q. CHAIRPERSON: I've just got one very generalised
8 question and it's in relation to clinical governance.
9 Is it an unfair remark to make, I'll put it like that,
10 that the failure to pick up the issues, either 17:10
11 originally on Ennis or the issues that we now know
12 about in 2017, do indicate fundamentally a failure of
13 clinical governance, or is that an unfair way of
14 looking at it?
15 A. Clearly the events around Ennis and the more recent 17:11
16 events are extremely concerning and regrettable, and I
17 would have hoped that they would have been avoided
18 through the clinical governance process, but I felt
19 that we did have good governance structures. There was
20 a range of people who were involved in those governance 17:11
21 structures, there was a governance lead, and at the
22 time I felt that we had good governance structures.
23 382 Q. CHAIRPERSON: Do you still think that?
24 A. Well, it's very disappointing that these things
25 happened and that the governance structures we had 17:12
26 didn't avoid them happening. I'm not sure that was the
27 only -- there was a range of factors about why they
28 happened.
29 CHAIRPERSON: Right. I'm sure it was. All right,

1 Dr. Milliken, can I thank you for your time this
2 afternoon, that completes both sections of your
3 evidence.
4 A. Thank you.
5 CHAIRPERSON: And I don't think we will be having you 17:12
6 back, so thank you very much.
7 A. Thank you very much indeed.
8 CHAIRPERSON: Okay. Quite a late evening, particular
9 thanks to our stenographer. I think tomorrow will be a
10 bit shorter, but we'll sit at 10:00 o'clock. Thank you 17:12
11 very much.
12
13 THE INQUIRY ADJOURNED TO TUESDAY, 24TH SEPTEMBER 2024,
14 AT 10:00 A.M.
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