MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 19TH SEPTEMBER 2024 - DAY 107

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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THE INQUIRY RESUMED ON THURSDAY, 19TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you. Good morning. Just before we start, can I do a bit of housekeeping. And I want to preface these remarks by appreciating that everybody, I know, is working hard to help us to complete both efficiently and effectively the remaining modules. 11:07

But at the moment the protocol on providing questions to counsel seem, frankly, to have gone out the window. It isn't helpful to provide counsel with a long list of questions on the morning of the witness being called, as happened this morning, especially when the witness was served on the 15th August. But can I say this: I do appreciate how important these witnesses are to CPs. Given that, obviously it's important that there is as early focus as possible, and I also want to say that I know that my counsel team will do everything that they can to assist, even when questions are submitted late. But I do ask everybody just to reflect on the job of the counsel team, which is hard enough as it is. 11:07 11:08

Can I mention also, it may be just the servicing of my new hearing aids, but there is a lot of clattering of keyboards, and that is actually being picked up on the feed, so could I just ask people to be aware. I understand people want to make notes and need to make 11:08

notes, but if either a silent keyboard could be purchased, or just be aware that things are going out live from this room and the microphones are very sensitive.

11:08

Finally just to remind everybody that the only drink allowed in this room is water. If I can stick to that, everybody else can stick to it. Okay. Shall we get the witness in.

INQUIRY SECRETARY: Sorry, can you speak up a bit? 11:09

CHAIRPERSON: Certainly. I cannot even blame the clattering of keyboards. Apologies. I'll speak up. Yes. Ms. Briggs, are we ready for the witness?

MS. BRIGGS: We are ready, Chair. The statement reference is 275 and the witness is Mr. Veitch. 11:09

MR. JOHN VEITCH, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: Good morning again, Mr. Veitch, you've 11:10 sat there once before, I think it was the 18th June when we last saw you, but that was obviously in relation to a very different topic. Thank you for returning, and I'll hand you over to Ms. Briggs.

1 Q. MS. BRIGGS: Thank you, Chair. Mr. Veitch, welcome 11:10 back. It was the 18th June when we last heard your oral evidence to the Inquiry, and that's in relation to the Ennis Investigation, and you have a separate statement about that, and that's reference 205.

We're here today in relation to your further statement to the Inquiry, the reference is 275, and it's in relation to Organisation Module 7. It runs to 31 pages of the statement itself, and then there are exhibits after that. The total length of your statement is 221 pages and it's dated 31st May 2024.

Are you content to adopt the contents of that statement as the basis of your evidence to the Inquiry? 11:11

A. Yes, I am.

2 Q. Just to refresh memories then, it's correct to say that you were the Co-Director for Adult and Children's Learning Disability Services from January 2011 until you retired in September '16? 11:11

A. That's correct.

3 Q. Okay. And your professional background is in social work; isn't that right?

A. That's correct.

4 Q. What was your prior experience working with people with learning disabilities before you took up post as the Co-Director? 11:11

A. Okay. Prior to taking up the post as Co-Director for Learning Disability, I was Co-Director specifically for Children's Disability Services, which included Learning Disability. Now, prior to that, my earlier career was mostly in family and child care social services work. So my only other experience of Learning Disability would have been very early in my career from '77 to 11:11

1986, when I would have generic social work responsibilities across all client groups, which have included Learning Disability. But in-depth clinical or specialist knowledge of Learning Disability...

CHAIRPERSON: Could I just stop you there because I think we're having trouble with the public hearing you. Is that right? 11:12

MS. ANYADIKE-DANES: Yes.

CHAIRPERSON: I don't know if we've got a loop that assists? Just take a break because I think it is really important that everyone can hear you. We'll just pause for a second. [Short pause]. Mr. Veitch, you'll also just have to keep your voice up, I'm afraid. 11:12

THE WITNESS: Okay. 11:15

CHAIRPERSON: Okay. Thank you.

5 Q. MS. BRIGGS: Mr. Veitch, I was asking you about your experience working with people with learning disabilities prior to taking up your post as Co-Director, and you had said that there was some experience gained in your previous role as Co-Director for Children's Disability Services. How long were you in that post for? 11:15

A. I think about three, four years.

6 Q. And how much experience did you gain in Learning Disability? 11:15

A. It would have been as Co-Director in terms of the Learning Disability Specialism, I would have been advised and informed in my management role by the

people with the detailed experience and expertise, including the clinicians.

7 Q. When you took up post as the Co-Director for Children's and Adult's Learning Disability Services, did you feel that you were adequately knowledgeable and experienced in relation to Learning Disability? 11:16

A. Yes, I saw my Co-Director role in terms of the job description and the personnel specification, and I was confident in terms of my interaction with the key professional and senior management staff that I was well equipped to conduct the duties of that post. 11:16

8 Q. Okay. Thank you. You described your role in respect of Muckamore Abbey when you gave oral evidence on 18th June this year, and I'm just going to read out what you said. You said: 11:16

"I would describe it as being responsible for all the services provided within Muckamore Abbey Hospital and being accountable for the quality of services provided at that location." 11:17

Would you say that that's accurate?

A. That is accurate.

9 Q. You also say in your statement today at paragraph 11 that you held managerial responsibility for all staff working within Children's Or Adult's Learning Disability Services, and that includes, therefore, managerial responsibility for all staff working at Muckamore, doesn't it? 11:17

A. Yes, it does. There was also a line for some of the clerical and admin staff to other managers within the Directorate, but I saw myself as Co-Director overseeing the service as managerially responsible for those people. 11:17

10 Q. Okay. And just to touch again upon your physical presence at Muckamore, because you were asked about that in June. You said in June that you probably would have been on site probably at least once a week, is that fair to say? 11:17

A. Probably on average once per week, yes.

11 Q. And you were asked that question in the context of the time of the Ennis Investigation. Would that be accurate for your entire time in post, that is the say up to 2016? 11:18

A. I think on average. There'd be some occasions that I would be there three times a week, but minimally I would have been there once every two to three weeks. But taking everything into account it probably averaged out at something like once per week. 11:18

12 Q. All right. If we can go on to page 4 of your statement there, there's a copy in front of you and it's on the screen as well. You, at paragraph 15, are talking about your role in engaging with HSCB, that's the Board: 11:18

"...in relation to the challenging financial and operational agenda and pressures confronting MAH through the hospital having to provide both in-patient

services and a range of quasi care placements, alongside a requirement for the incremental closure of wards. In order to address this major agenda, there were also significant additional pressures to try to enhance community services." 11:19

Can you help the Inquiry understand the financial pressures that were facing Muckamore while you were in post?

A. I think the first issue I would wish to highlight is for the Trust, this coincided with the Trust having to identify 3% cost savings per year. In order for the Trust to achieve such an amount, they looked pro rata towards each Directorate and each programme of care to contribute their proportion of that amount. Now, over my period in post, Learning Disability Services did not contribute anything like that degree of cost savings. And during my period in post, not only were there no savings in relation to Muckamore Abbey Hospital, there were significant over-expenditure and cost pressures which I had to resolve in - by - through discussion, involving my Director Catherine, with key members of the Trust Senior Management Team, and also by going directly at my level to the Board to seek their support and assistance in accepting the reasons why I could not meet such cost savings and, indeed, to seek the Board, which occurred on occasions, to give me extra finance so that I could address that in an appropriate manner. 11:19 11:20 11:20 11:21

PROFESSOR MURPHY: Was the cost savings problem in LD

due to MAH, or was it also due to overspending in community LD services?

A. It was almost entirely to do with Muckamore.

PROFESSOR MURPHY: Thank you.

DR. MAXWELL: Are you saying that you were talking about additional revenue directly with HSCB, rather than directly through Belfast Trust Board? 11:21

A. An example was at one point we foresaw a possible £3 million cost pressure, I think it was identified during 2014 - although I can't be - in terms of additional deployment of staff which was required for specialing or supervision of patients. Now, I know that was escalated by Catherine, and there were discussions that Catherine had with the Director of Finance and the, certainly the Director of HR. I would have been involved with our own Directorate accountant, but also an Assistant Director of Finance, and there were a number of meetings with the Board. I think, my recollection of the outcome of that is the Board identified an additional £1.5 million in year. 11:22 11:22 11:23

DR. MAXWELL: And who at HSCB were you talking with?

A. I was speaking to -- I can use the name, can I?

DR. MAXWELL: Well it won't be ciphered, so I think so.

CHAIRPERSON: No, I don't think...

A. It was an Assistant or Deputy Director level. 11:23

DR. MAXWELL: I think you can use the name.

A. I was dealing with Aidan Murray, who I think was the Assistant Director or the Deputy Director who had specifically responsibilities for LD and Mental Health,

and our own Deputy or, sorry, Assistant Director for Finance was involved in that meeting, as was the Board's divisional accountant for LD Services.

DR. MAXWELL: Okay. Thank you.

A. Sorry, can I go on with other financial pressures? 11:24

MS. BRIGGS: Please.

A. The other issue was, and this is in very, very general terms, the whole resettlement project was predicated on the incremental closure of wards. Now, in terms of the cash release from the closure of wards, in very general 11:24 terms the closure of a ward released around £1 million. That money was used by the Board to fund and release the funding for the alternative placements.

DR. MAXWELL: When you say the Board are you talking about HSCB or Belfast Trust Board? 11:25

A. Sorry, HSCB. I will try to bear that in mind. The Health and Social Care Board were reliant on that finance in order to fund the community alternatives. So in terms of the closure of a ward, there was no financial benefit accrued to the Trust. 11:25

DR. MAXWELL: But there was a bit of a catch-22 that you couldn't provide the services in the community to resettle people until you had closed a ward, and you couldn't close a ward until you had resettled people in the community? 11:25

A. Yeah. Stop me if I'm --

DR. MAXWELL: No, go on.

A. If I'm not answering the question. I would have a view coming into post in the first year or two that there

was an agenda presented to me in terms of taking forward this project, and it was not sequential, in the sense that I would have thought, not having previously worked within Learning Disability, that the community support and infrastructure should have been much further developed, and a work developed much further, in terms of a Core Group of potential voluntary, statutory, and independent providers in order to plan and progress more effectively the agenda. Having said that, I was where I was, and I had to take it forward as best I could. 11:26 11:27

I would want to be clear, however, that in taking it forward, I, and I think it's reflected by my other senior managers throughout that period in terms of Muckamore, which were Mairéad Mitchell, Colin Milliken, and Esther, that we had to be acutely aware of the issue of safe and effective care, and I did state on a number of occasions, and I think it is reflected in the minutes around March and June 2012 of the Core Group meetings, that we would not close a ward determined by a definite target date if our view was that that was not in the best interests and it could be -- of the patients -- and it could be dealt with more effectively through a postponement until we took things forward in terms of planning. 11:27 11:28 11:28

PROFESSOR MURPHY: Can I just double-check that most Trusts when they close a hospital have double funding for a period because of exactly the kinds of problems

you're describing. Are you saying there was no double funding during any period to take account of the fact that, you know, okay, community services weren't what you would have wanted them to be, but then they weren't very likely to be like that given there hadn't been such a demand for them before. So there's always a period where you need both funding in the hospital and funding in community services? 11:29

A. There were incremental funding streams ongoing during my period of time, but they were incremental in terms of developing community treatment and infrastructure within each of the Trusts in Northern Ireland, including the Belfast Trust. That was incremental funding from an extremely low basis, and I certainly saw within the Belfast Trust a priority for community treatment services led by a psychiatrist, and also a much more responsive service from a Monday to Friday 9-5 service, and we were looking towards a seven day, at least in the starting point, 8:00 a.m. to 8:00 p.m. funding. But when I departed in September 2016, I don't think the Belfast Trust was any less developed than any of the other two Trusts who were making the majority of the referrals to Muckamore Abbey Hospital, and at that point the Belfast Trust, when I left, did not have that service in place. But I don't know how quickly afterwards they did. 11:29 11:29 11:30 11:30

DR. MAXWELL: So you're telling us that there wasn't an adequate community service in order to resettle patients to close beds, and yet this was an HSCB

target, we've heard from other witnesses that there were targets for how many patients should be resettled each year. Did you, at these meetings with Aidan Murray, actually raise the fact that it would be impossible to meet the resettlement targets based on the current funding streams?

A. Not as starkly as that. What I did from time to time say, and I suppose my focus primarily was on the Belfast target, okay, but obviously in my role as Senior Manager for Muckamore it was impacted equally by the patients in the other two Trusts. But, you know, I did say to him, and I got relief - an example was we got a significant delay in the closure of Finglass, which I think was the first ward, but -- and you'll probably see it, and I'll probably be asked about it later in today's evidence, there were issues through my Hospital Modernisation Group, which I think we'll probably address that later, if that's an acceptable answer?

DR. MAXWELL: Yeah. I suppose what I'm trying to get at is, did Aidan Murray, who was responsible for the funding streams for LD and Mental Health, actually understand that there was this problem that you couldn't resettle people without the funding for the community services and, yet, you didn't have the funding until you closed the wards? Did the people at the meeting understand that?

A. Yeah, I do believe that Aidan did understand that, and he did understand the difficulties that that was

presenting to all the Trusts in terms of meeting their targets, but also more fundamentally the impact that it was having on Muckamore. And, again, it's referred to in my statement. What we tried to do was to use resettlement in order to enhance the clear identified skills deficit in terms of some of the professional omissions in the - and to highlight. But I think, you know, quite honestly with Aidan, Aidan explained to me that the constraints on him within the Board, in terms of being able to access funding, and the only potential early assistance that he could give me was through the resettlement project. 11:33 11:34

CHAIRPERSON: Could I just try and understand a bit more about how the funding actually works. Because the HSCT is an integrated Trust in the sense that it provides healthcare and social care. 11:34

A. Yes.

CHAIRPERSON: You told us that if -- just by way of example, if Muckamore closed a ward and saved itself say a million pounds, it probably wouldn't save as much as it thought it was going to because there are effects of closing a ward and there may be problems for other wards, but say it saves a million pounds, that doesn't stay in the Muckamore pot. Does that go back to the BHSCT. 11:34 11:34

A. That goes back to the Health and Social Care Board, and the Health and Social Care Board then reallocate that money to the Trusts, which is then used on a revenue basis to fund the community placements for the people

who have been successfully resettled.

CHAIRPERSON: And they may distribute that, not just within the BHSCT area, but across other Trusts in Northern Ireland.

A. Yeah, the Board, the Health and Social Care Board would receive that money back from the closure of the ward and then would allocate that. It would largely have been reallocated to the Belfast Trust, the South Eastern Trust, and the Northern Trust, who were the three primary of users. But it would have been up to the Health and Social Care Board, as it were. 11:35 11:35

CHAIRPERSON: But would it be ring-fenced to go into the community as opposed to going to another hospital site?

A. My knowledge - and it - was that it was used in a ring-fenced manner for specific patients. The resettlement agenda was predicated on the sum of 85,000 per person being the average of what their resettlement costs would be. Having said that, there were some where it was a little bit less, and a small number where their complex needs were such that their placements or alternative placements cost half a million pounds or more. 11:36 11:36

CHAIRPERSON: Yes.

A. But it was up to the Health and Social Care Board, in terms of Learning Disability, how they reallocated that money, but it was to fund alternative placements. 11:36

CHAIRPERSON: Okay. Thank you. Okay. Thank you very much.

13 Q. MS. BRIGGS: Thank you, Panel. Thinking then about those financial pressures, and returning to that in terms of its impact on staffing, you had said in your evidence in June that you had effectively inherited a situation where staffing at Muckamore was based on finance available rather than patient need. Is that fair? 11:37

A. Did I?

14 Q. You did.

A. No. My perception of that is that Muckamore had a funded staffing establishment. In terms of meeting patient need, if there were issues that arose that required a greater allocation of staffing to meet immediate needs and maintain a safe standard of care, that would have to be addressed. The funded staffing level would not be an impediment to me making strong representations and ensuring that staffing level to meet the assessed needs of the patients was not compromised. And I think that's demonstrated by the overspend, the projected overspend in one year of £3 million. 11:37 11:38 11:38

15 Q. Okay. We've discussed there in detail, and it's throughout your statement, your engagement with the Board, that's the HSCB, and you've provided examples of communication between yourself and the Board in your statement by way of looking at things like funding. Can you give the Inquiry an idea of how frequent communication was with the Board? 11:38

A. Excuse me.

16 Q. Take your time, Mr. Veitch.
A. I would have had -- there certainly wouldn't have been a month would have gone by that I would not have been in contact with senior officers at the Board in relation to Muckamore and the resettlement agenda. 11:39
While I was in post, no. 1, I convened and chaired a meeting once a month at Muckamore to look at identifying the patients from all the Trusts who were in a target group for resettlement, and that also included the unfunded delayed discharges. That was 11:40
attended by senior officer from the Board and the Board accountant. It was also attended by my own senior staff, some of my own senior staff at Muckamore, and senior staff from the other Trusts who were contributing to the resettlement project. I also would 11:40
have been in constant contact with Aidan Murray at the Board regarding service and financial pressures. I - and I don't think other Trusts did this - I would have made arrangements to have met with him, accompanied by the Belfast Trust Service Group accountant, to deal 11:40
with - and I would have presented an agenda for that, which would have been staff pressures, which would have been concerns, for example, about physical health needs of patients. It would have been a whole range of agendas from my perspective reflecting the pressures 11:41
and the issues that were being raised through Muckamore.

I would also have attended a meeting convened and

chaired by the Board in relation to progress of the Resettlement Board, which was pitched at the higher level than the meeting that I was chairing. I would also have met with the Board at a Co-Director's group across Northern Ireland, myself and my equivalents. So it was frequent and intensive engagement with the Board. 11:41

17 Q. And what about your line manager, the Director, Ms. McNicholl, how involved was she in that communication? 11:42

A. In terms of the formal aspect of resettlement and, again, it was at a higher level. There was a group convened by the Board which Catherine attended, which would have been attended by other key stakeholders at a very senior level of the resettlement agenda, for example the Northern Ireland Housing Executive, who were very profoundly involved in terms of developing new supported -- developing and helping us fund new supported living schemes. So, Catherine. And I think that group met on a quarterly basis. 11:42 11:42

The other aspect to it was, I was keeping Catherine fully informed of those high level discussions with the Board and about my engagement with the Board in a proactive way in trying to address issues as they emerged. So she would have been very involved in being aware of what we were doing within the Learning Disability Programme. 11:43

18 Q. How far beyond an awareness did her role extend?

A. Catherine's role as Director was having responsibility for Adult and Social Care Services within the Trust. So it would have been a broad and wide parameter of responsibility.

19 Q. Okay. I want to go now to community services, and it's something you've already discussed in detail in your evidence today. It's paragraph 16, page 4. You're describing there how: 11:43

"The Belfast Trust, through the Co-Director role, had to lead on a number of regional fora to try to expedite hospital discharges, and commission alternative community placements consistent with the concept of "betterment"." 11:44

Looking at the principle of betterment, what measure was used to decide if patients were better off in the community?

A. There's no general answer that I can offer for that. I think as part of my statement I attached a paper describing the process of planning which was pursued in relation to each individual patient who was the focus of a community integration programme. That effectively was based on consultation with the multidisciplinary team, the patient, their family, the advocate in terms of the assessment of need and planning the most appropriate community option which was available. Now, that was based on the premise - and it had to be sensitively addressed, because for a significant number 11:44 11:44 11:45

of these people they had been in Muckamore Abbey Hospital for, in some cases, decades, they regarded it as their home, and there was a major piece of work in each and every case of trying to ensure the buy-in and commitment of the patient and their families. It was very much, in terms of the principles, driven and informed by the work of Bamford and Equal Lives, but it had in every case to be taken at the pace of the individual patient. 11:46

DR. MAXWELL: The principle of betterment though as outlined in Bamford was improved quality of life. 11:46

A. Yes.

DR. MAXWELL: So - and this was a big programme with huge financial costs. Was there no audit or evaluation of the quality of life before and after resettlement? There are a number of quality of life measurement tools, and I understand there are some for Learning Disability. 11:47

A. There was work coordinated by the Board in terms of the use of advocacy, in terms of receiving feedback from -- 11:47

DR. MAXWELL: But no audit tool?

A. I can't say 100% on this. I can't recall it being presented as an audit document, but it may have been after I left.

DR. MAXWELL: So the Inquiry has heard that people went on trial settlement and sometimes their bed was held at Muckamore for up to six months in case the settlement didn't work out, and we've also heard there are a number of patients for whom resettlement wasn't a 11:47

success. Without any measure, how was the decision made that this is a successful resettlement and we'll release that bed, or this isn't a successful resettlement, the patient will come back to Muckamore?

A. My recollection of that was that during that trial period there continued to be regular reviews led by the consultant psychiatrist who - the funding of which we had been able to achieve from the Board - together with the key professionals, the new provider, the patient and their family, and that process would have informed the decision whether to discharge or release a bed or not. 11:48 11:49

DR. MAXWELL: And were there an agreed set of criteria for doing that assessment?

A. My understanding is that there was, but I can't, I can't quote it to you today. It would have been based on the health, the physical health, you know, how the person's mental health or adjustment about their engagement in social activities and, you know, I believe that that criteria was used to inform -- 11:49 11:49

DR. MAXWELL: So that was a professional assessment rather than asking the patient?

A. Well, the patient's view would have been - and I'm not aware of any instance where the patient, where a decision was taken contrary to the patient's view. I think that that would have been extraordinary and not good practice. 11:49

DR. MAXWELL: Okay. Okay.

CHAIRPERSON: Could I just ask this off the back of

Dr. Maxwell's question about betterment and the assessment of betterment. You can do an assessment of betterment and apply the tool and you may come to the view that actually the patient is not better off in their new resettled home or part of the community, but we've also heard that there was quite significant resistance to patients being re-admitted to Muckamore. So, first of all, were you aware of that resistance of patients being re-admitted to Muckamore, and how would that affect the decision? 11:50

A. Looking back on my time as Co-Director for that five year period, I can't recall anyone coming to me and saying 'We're discharging this person and they're not happy with that decision'. You know I do believe, and it was my understanding when I was in post, that the processes that I've just described during the three month or six month period, were completed in relation to each individual, and certainly their views, those of their family and any advocate involved, were taken into account. 11:51

Now, where a family or a patient said at the end of that trial period 'I'm not any better off, in fact I think I'm worse off', I think there would have to be -- it would be my expectation that there would be engagement in relation to each aspect of life that the patient was referring to and some assurances given in relation to that. I don't think in any instances that you can have a patient and their family saying there's 11:52

no betterment. It's incumbent on the Trust to be bringing patients and carers with you in terms of what substantial betterment is being demonstrated by the placement.

CHAIRPERSON: So you're saying that wouldn't have been a factor? 11:52

A. Well, it was a potential factor, but I can't recall in any instances brought to my attention that that was an issue.

CHAIRPERSON: Okay. 11:53

20 Q. MS. BRIGGS: Just thinking about community services, before I move on, you've made it very clear in your evidence and in your statement that the community structures, the support in the community wasn't really there, and that was a situation you inherited, and you said earlier on that when you departed -- 11:53

A. Well, let me say support in the community was there.

21 Q. Yes.

A. But it needed to be further developed in order to prevent the cycle, the continuing cycle of delayed discharges and inappropriate admissions. 11:53

22 Q. And you said then that when you departed in 2016 that the Belfast Trust wasn't any less developed than any other Trust. Reflecting then on progress or otherwise that was made in developing community services in your time in post, how would you categorise that? Would you say it was successful, progress was made? Would you say more progress could have been made? 11:54

A. I would say that incremental progress was made. But

there still, and I think it was demonstrated close to the end of my career where I was writing to the Board and highlighting it to the Board our concern about the continuation of what I perceived and the professionals within the Learning Disability Service were seeing as inappropriate admissions having to be facilitated through the continued underdevelopment of community alternative services. But it was being addressed, but incrementally.

11:54

23 Q. And when you say inappropriate admissions to Muckamore, by that are you talking about admissions that really are for perhaps social reasons rather than clinical reasons?

11:55

A. It's not just as straight a black and white dichotomy as that, but ones where if there had been a greater development I think in terms of two aspects of the service, home treatment and crisis intervention, the need for institutional care would not have been there.

11:55

24 Q. Just picking up at paragraph 16 again, you say that there were constant requests from other Trusts for new admissions to Muckamore?

11:55

A. Other Trusts and our own, sorry.

25 Q. Other Trusts and your own:

"...for new admissions to Muckamore, many of which could be largely attributed to the lack of adequate available community care and treatment services."

Would it be fair to say in your experience that there

were admissions to Muckamore that occurred because of a lack of community support and infrastructure, rather than meeting the clinical admission criteria?

A. Most of the admissions to Muckamore occurred when a patient presented risk to themselves or to others. 11:56
I think I've got to just refer back to my answer a few moments ago, that there were admissions to Muckamore continuing to occur at the time of my retirement which could have been prevented through community treatment and crisis intervention services being much further 11:57
developed, and community treatment would have been by far the preferred option for a high proportion. Now that's not to say there wasn't a significant number of appropriate admissions which continued throughout my time in post, but there was a high proportion which in 11:57
an ideal world, with a fully developed community crisis and treatment services, would have negated the need for an institutional admission.

26 Q. And who would you say is responsible for the lack of a fully developed community situation? 11:57

A. Well, there's no individual is responsible, you know, is accountable for that. You know, that has got to do with -- well, I would answer that by saying that when I came into post I saw Learning Disability as an underdeveloped service. When I first went round some 11:58
of the wards in Muckamore I was pretty shocked by dormitory living for patients, which I didn't think it was appropriate. So I think there was -- and, you know, people in LD who had worked there all their lives

said that it, it was almost a Cinderella service. Part of my job as Co-Director was to advocate for that, to kick up fuss, to support my staff in making representations to improve that. But we were where we were, and certainly Bamford and Equal Lives made it very clear what the concerns were and how we take it forward, and that's probably a more constructive way than who do you blame.

27 Q. I'm going to ask you about the Service Group, the recurring concern regarding admissions. Okay. And you refer the Inquiry to the minutes of the Core Group on 13th October 2015, and an email to the Board and the PHA dated 7th August 2015. I want to look at those documents specifically in the context of the bed pressures that were facing Muckamore, given the issues of delayed discharges and patients being admitted.

So at page 38 of your statement, this is a copy of the minutes of the Core Group on 13th October 2015, and we can see there that you chaired that meeting, and we can see that Mrs. Rafferty, Dr. Milliken, were also in attendance, and the Mairéad Mitchell, she gave her apologies on that occasion.

Further down that page then we can see that bed management is an item on the agenda, and there are concerns expressed about the increase of delayed discharge numbers. Mrs. Rafferty says about halfway down the second paragraph:

"Mrs. Rafferty informed the group that she raised the issue of delayed discharges at a recent Senior Midwifery Team and how there is no consistency in the Trust on how we deal with delayed discharges." 12:01

What is meant by "no consistency", can you recall what she meant by that?

A. I, I think you would have to ask Esther about that. But can I... from my point of view we had issues of 12:01 delayed discharges in Muckamore Abbey, and by 2015 a lot of those delayed discharges didn't want to be there, didn't have to be there, and shouldn't be there. Some of them would have been there for months, some of them would have been there for over a year. That would 12:01 not be tolerated in an acute centre, so why should it be tolerated in Learning Disability hospitals?

28 Q. Yes. But, Mr. Veitch, it says there that the group discussed this, they discussed the lack of consistency in the Trust, so it's something that has been discussed 12:02 and it's something that the Inquiry would like to understand is what is meant by that?

A. Well, you know, looking at that now, and I can't recall specifically that conversation, but looking at that now, you know from my perspective why should it be any 12:02 more acceptable for a patient to be a delayed discharge in a Learning Disability Regional Hospital than an acute regional hospital. And there seems to have been an acceptance, a tolerance of that, which wouldn't be

acceptable elsewhere, and that's where we needed to get to.

CHAIRPERSON: Sorry, is the reference to no consistency within the Trust therefore a reference to no consistency between different parts of the Trust, as opposed to no consistency in Muckamore in relation to the approach to discharge? Because this is "Muckamore Abbey Hospital Notes of Core Group Meeting". 12:03

DR. MAXWELL: And I suspect there's a typo here, because I think -- 12:03

A. Yes, I --

DR. MAXWELL: I think it was the Senior Nurse in the midwifery team meeting, rather than a senior midwifery meeting.

A. Yes. Yes. 12:03

DR. MAXWELL: Where I suspect the Senior Nurses from each Directorate were talking about their experience of delayed discharge.

CHAIRPERSON: Right. Which would cover the different sites of the Trust? 12:03

A. Yes, I think that's right. I think it's across the Trust in terms of different specialties and, you're right, because the midwifery --

DR. MAXWELL: Yeah, it's the Nursing and Midwifery --

A. Yeah, it's Nursing and Midwifery. 12:03

DR. MAXWELL: Because all the Assistant Directors of Nursing met with Brendan Creaney on a regular basis, didn't they? I suspect that was the meeting she is referring to.

CHAIRPERSON: Okay.

A. Yeah.

29 Q. MS. BRIGGS: Just looking again at those minutes. Just after that it says that you emphasised that this issue has been raised at every forum, and you say how there is a lack of funding availability for at least 40 of the delayed discharge patients. Thinking about where this could be escalated to, was the issue escalated or raised at a political level? 12:04

A. The matter was escalated on a day and daily basis to the Assistant Director of the Board, to Aidan. It was the focus of many of my meetings with Aidan. These 40 delayed discharge patients were drawn from a range of Trusts, not just the Belfast Trust. You know, I can't speak for Aidan, but he did release funding each year for a relatively small number of delayed discharges in addition to the PTL Group, and that was part of our target which was met in terms of achieving that. 12:04 12:05

I can't speak for Aidan, but I'm sure Aidan was reflecting that to the Chief Executive in his agency, the Health Board, and I'm sure that through the Health Board those pressures were being reflected to the Department. We would not, as public servants, be going to political reps about that. 12:05 12:05

30 Q. Over on page 41 then, this is the email I referred to earlier. This is an email from yourself to a number of others, and in particular we can see there Mr. Murray of the Board, and Molly Kane of the PHA. It's dated

7th August '15. I'm not going to read that email out in full, but you refer in it to the lack of admissions beds caused by the lack of movement of the delayed discharge patients, and there were 42 delayed discharges at the time of writing this email. You say that there are some within the Group for whom no funding is available to facilitate their discharge.

You refer in the third paragraph down to the high number of service users being presented almost on a daily basis for detained admission to the hospital and currently past beds and on occasions sleeping out arrangements are having to be deployed to try to maintain a safe environment.

What is a pass bed, what's meant by that?

A. If somebody goes out on trial, for example, that -- say somebody goes out on a resettlement trial period, that frees up their bed. It's their bed, but it was often used during that temporary period to facilitate acute presenting need.

31 Q. Does that mean that detained patients were then being placed on resettlement wards in pass beds?

A. I can't answer that. Maybe the pass bed was used for someone else and the new admission was accommodated in an acute bed.

32 Q. Because the Inquiry has heard that resettlement wards would have had lower registered nurse ratios, and perhaps staff lacking knowledge of acute mental health

interventions. You can't say whether that was --

A. On the basis of that it's unlikely that they were admitted, would be admitted to a resettlement ward. The decision would be taken by the consultant as the lead professional for admission in consultation with the other members of the clinical team in terms of where best to place the new patient, and how any vacant bed elsewhere would be redeployed. Because there were resettlement patients, a significant number on occasions, in acute beds. 12:08

33 Q. You go on in the email to state the impact that all this is having on medication changes, observation, you talk about the pressure on carers and families, and then in the final paragraph on that email on that page you say: 12:09

"Regrettably I have now been advised that the hospital has reached the point that it cannot at present safely facilitate any additional acute admissions pending an easement in the current bed pressures. We would therefore appreciate your urgent advice/comments and you will note that I have also shared this correspondence with colleagues in other Trusts as I suggest that in the immediate future there needs to be a regional approach to managing admissions when such an admission cannot be avoided."

So really overall the situation, Mr. Veitch, at this time was that delayed discharges, they were effectively

blocking up the beds in the hospital, and no new admissions, in your view, could take place. Is that a fair way to summarise it?

A. I'm saying to the Board, yes, we are under pressure here. All these new admissions are coming to us. We're at the point where we're feeling that this is compromising patient safety and we want more support from the Board and from the region in terms of the other acute LD beds to support this. 12:10

34 Q. And is this an exceptional example of you going to the Board or is this something that was happening fairly frequently, this type of communication? 12:10

A. We would go to the Boards about pressures. But this was an exceptional letter at a point of time.

35 Q. And how would you characterise the response? 12:10

A. Well, the response was at different levels, you know. I know that Colin had contact with the lead consultants in the other Trusts in terms of access to their beds.

DR. MAXWELL: How did the HSCB respond? You wrote a letter to two -- 12:11

A. Well, you know, what I'm trying to do here actually is, Aidan did try to support us in terms of the resources available to him, and we did gain sufficiently -- not sufficiently -- significantly at times in terms of Board financial support. I suppose to be honest the Board's response to that was "talk to your colleagues in the other Trusts", and there was no tangible solution. 12:11

DR. MAXWELL: So this sounds like a very high risk,

potentially somebody needed an acute admission would not be able to be admitted; did it make it on to the Risk Register?

A. I'll have to think back on that. Yeah, let me think. I'll come back to it. 12:12

DR. MAXWELL: It's pretty clearly a red risk.

A. Sorry, you couldn't scroll to the top of that again for me, please?

MS. BRIGGS: Yes, that should be it now up there.

A. Oh, right. This isn't a copout, but I can't recall. 12:12 The point that you make in terms of the Risk Register is a valid one, and I would like to look back and cross reference that with the Risk Register at that time.

DR. MAXWELL: The reason I'm asking is, obviously the principle of a Risk Register is you identify the risk, 12:13 you score it on the five by five matrix, and I think this would have come out at 25.

A. Yeah. Yeah, it would have. And it was a concern. Now it is - it is - this, from me, was also bearing in mind our staffing problems at that point, but it's a 12:13 separate issue, yes.

DR. MAXWELL: I understand. But my follow on point is; when you have a risk, particularly a red risk, you then have to say 'Can I mitigate this risk?', and I'm assuming that you were asking HSCB to help you mitigate 12:14 it?

A. Yeah.

DR. MAXWELL: And from what you've said they didn't help you mitigate it. So it was an unmanaged risk.

And so my second question would be, was this escalated to the Board?

A. I think -- yeah. Yeah. Now I'm not detracting from your point, yes. I think there was mitigation with the other Trusts, but I can't, I can't recall the detail. 12:14

DR. MAXWELL: But I can't see anybody -- well, I suppose I can't see anybody on this list who's on the Trust Board. Were Belfast Trust Board aware of the fact that you weren't going to be able to admit patients? 12:14

A. It's copied to Catherine, it's to the Assistant Directors in the other Trusts. I've copied in the Associate Medical Director for the Directorate, Maria O'Kane. Those are the significant others. But the point you make is a reasonable one and I'd like to 12:15 cross reference that.

DR. MAXWELL: Okay.

CHAIRPERSON: But it sounds as if you agree. It ought to have been, if it wasn't, it ought to have been on the Risk Register. 12:15

A. Yes, and if it's not, I'll accept any responsibility for my omission in terms of that. But in terms of the tone and the nature of that, yes.

CHAIRPERSON: Because there's reference to a crisis situation. 12:15

A. Yeah, yeah.

CHAIRPERSON: Okay. Thank you.

A. But it may have been my failure. I accept that.

CHAIRPERSON: All right. Thank you.

36 Q. MS. BRIGGS: All right. If we can go on to paragraph 21, page 6. You're referring there to the analysis of admissions to Muckamore via the Modernisation Group, which you chaired, and you provide the analysis in your exhibits at Tabs 4 and 5. But just looking towards the end of that paragraph, you say that the analysis found that: 12:16

"The two highest factors precipitating admission were constantly categorised as "situational crisis" and "challenging behaviour", with a review led by medical staff concluding that 75% of these admissions were potentially avoidable. It was anticipated that additional community care and treatment services when, operational, would assist in addressing this." 12:16

What options should ideally have been available for crises such as challenging behaviour?

A. The sort of -- and I can only give you a few examples of that. The sort of examples would be effective home treatment, would be the development of timeout placements to just diffuse living situations, perhaps, for example, as an annex of a residential unit, it could be intensive psychological and social work support counselling services. There would be a whole range of different potential options which would be tailored by the assessed need of the patient or client. 12:17 12:17

37 Q. Okay. And what was the outcome of this analysis? Obviously it's 2014, it predates the email we've looked

at to the Board and to the PHA and others, where did that analysis take us, take the hospital?

A. Okay. Assuming that you're aware of the analysis and the minutes from 2015, which I think are part of the attachments, this was -- well, I think it's important to say that senior managers from the other Trusts were part of this group. This was engagement as part of this group with the Assistant Director of Nursing from PHA and a senior officer who reported directly to Aidan Murray at the Board. So the whole purpose of establishing this Modernisation Hospital Board was to try, in the absence of any central direction to the Trust, to try and draw up a vision for what hospital services would look like post the completion of resettlement. 12:18 12:19 12:19

Now, there were a number of options which, dependent on the view of the different stakeholders, it didn't necessarily have to be into the future located as a central resource at Muckamore. Each Trust may well have wanted control of their own resource in order to develop potentially their own small local in-patient service. But I was basing it as an engagement with the key stakeholders to try and plan into the future based on the existing Muckamore model. 12:19 12:20

The other point of that was, I was acutely aware that there seemed to be a perception, a possible perception from the other Trusts, that when Muckamore retracted to

a significantly fewer number of beds, that that would release finance pro rata to each of the three major referring Trusts. Quite clearly the work of that Modernisation Board demonstrated that not only would there be no funding to release, to have a core hospital with 40 or 50 beds would require a significant additional resource and funding in order to address the skill mix deficits which we had identified and had highlighted over a number of years.

38 Q. Okay. I want to move on to some other issues you're asked about in your statement. If we go on to page 8? 12:21

CHAIRPERSON: Just so that people understand, what I am thinking of doing, if you're all right, Mr. Veitch, is carrying on for about ten minutes.

THE WITNESS: No, that's fine. 12:21

CHAIRPERSON: Then we'll take a break, we'll take an early lunch and come back at about 1:30. So that's the plan. All right?

THE WITNESS: That's fine. No problem.

CHAIRPERSON: Okay. Thank you. 12:22

39 Q. MS. BRIGGS: Thank you, Chair. At page 8 then you're being asked there a question by the Inquiry and it's about reports received by Muckamore managers on various important issues, like the use of seclusion, and the number of PRN, MAPA, complaints, and at paragraph 28 on page 8, you say that: 12:22

"...Seclusion, Physical Intervention, Incidents, Adult Safeguarding (then in the form of Vulnerable Adults)

and Complaints were regular, if not permanent, items on the Core Group Agenda."

Over at paragraph 30 on page 9 you're describing the review at the Core Management Group, the Core Group Management meetings in relation to reports detailing the use of seclusion, physical intervention, and the use of trend data. 12:22

If you think about restraint and seclusion first of all. Was the frequency of the use of restraint and seclusion constant, in your recollection, or did it change over time, for example, as the case mix changed? 12:23

A. I believe from my recollection that that tended to fluctuate, and it fluctuated on account of a number of factors, which would have included some patient's mental health or presentation changing during the course of their assessment and treatment. And, obviously, that may have affected the degree of presenting behaviours contributing to that. It could be, yeah, the mix of patients on occasions in terms of potential difficulties in the relationship between individual patients, which would have had to have been managed and addressed. So it wasn't constant, it tended to fluctuate. 12:23 12:24 12:24

40 Q. At page 70 we can see an example of a report that you've provided to the Inquiry. It's for July 2015. It should be on your screen there, Mr. Veitch, if you can see it.

A. Yeah.

41 Q. At page 71 we can show that just to illustrate the type of data that the Core Group were looking at. And that graph shows the various wards along the bottom and the use of physical intervention in each ward in June and July 2015, and one can see there from looking at that graph that Cranfield is by far and away the biggest number there, right over on the right-hand side. And then the data goes on - I'm not going to go through all of it - but page 73 we can see data showing the time of day that physical intervention was required. At page 74 we can see the reason for its use, and so on and so forth, and page 75 is duration. 12:25 12:25

And you can correct me if I am wrong, Mr. Veitch, but nothing in there seems to consider what triggers, such as noise, a lack of activity and so on, led to the use of physical intervention. To what extent did discussions at the Core Group level consider environmental triggers such as noise, disturbance, a lack of activities and so on? 12:26 12:26

A. In terms of looking at this information, and you rightly highlighted the figures in Cranfield Women's was it or ICU?

42 Q. I think it was Cranfield overall. 12:26

DR. MAXWELL: ICU.

MS. BRIGGS: ICU. Thank you.

A. And there was a figure there in terms of, was it Killead, which one month was 47 as opposed to - you

know, there were a couple of figures that - those would have been discussed at the meeting in terms of identifying triggers for that. It would -- the discussions would have related -- well, everybody would have contributed to that. I had what I considered a very strong Core Group membership, which included as a core member Mairéad, who had been involved in Muckamore right through from, I think, the noughties, in terms of a governance role, and Colin as Clinical Director. So we looked at -- and just in general terms, it tended to identify a small number of patients contributing to a very disproportionate number of the incidents. In terms of looking at how that could be reduced, yes, you know, that had to relate to the treatment and care plan for that individual at Muckamore Abbey Hospital, and considerations would have included the environment of the ward, the services provided in terms of day services, and how the factors contributing to the behaviours could be managed more effectively on site, including aspects of environment.

12:27 12:27 12:28 12:28

DR. MAXWELL: Did you look at, for example, when wards were merged? So we've heard that when patients were moved from one ward to another, some patients found that very distressing, particularly patients with autism who found the intense stimulus too much; and did you also look at staffing? Because we know about staffing on a global level, but we also know that staffing varies from shift to shift, did you look at whether, when there were periods of significant

12:29

shortages of staff, the use of physical intervention and seclusion went up?

A. Yeah, can I just -- in terms of the issue about the merging of wards, that tended to occur, I think, at times when we were closing a building. 12:29

DR. MAXWELL: Yes.

A. I do recall I think on at least two occasions when Esther and/or Colin came to me and said 'We have to close this ward' by, say, October 2014, 'We can't do that and we can't do it because' -- the thing about it 12:30 in terms of resettlement was, you couldn't say you have to close a ward and then just take the people out of that ward. You could maybe take three out of that ward, you know, it was never clean. So you were invariably confronted with the issue of having to merge 12:30 wards. I know, and it was discussed at senior management meetings as well as core groups, that a lot of work went into the analysis of the dynamics of merging groups and the things that were important to patients who were moving from one physical building to 12:31 another, and I do believe that on an individual basis planning was put round each individual in order to support them with that move.

DR. MAXWELL: But would you accept that even though the ward had to be closed because it was older state, and 12:31 even though planning was done, some patients found this very distressing?

A. Yes. Yeah, of course, yes.

DR. MAXWELL: And this might have --

A. All I'm trying to do is say to you is we did make major, major efforts to support.

DR. MAXWELL: Yeah.

A. And, you know, that would have included taking account of relationships that individual patients had with individual members of staff, and whether that member of staff could accompany them. 12:32

DR. MAXWELL: But in an ideal world, if one was looking at a hospital again, you know, I'm not saying that what you did was wrong. 12:32

A. Yeah.

DR. MAXWELL: But would you accept that some patients became distressed and that led to more physical intervention and seclusion being used with them?

A. I can't, you know I can't rule out, and I can understand that that would be a factor in it. I don't think it -- it didn't present to me at the time as being a major trigger, but I do accept that it could well have been. 12:32

DR. MAXWELL: And my second point about shifts that were significantly short-staffed, even if overall the ward was not badly covered, would the lack of staff have resulted in heightened tensions which led to more physical intervention and seclusion? 12:32

A. I would say it's not the numbers of staff, it's the nature of the staff engagement on any shift. But, of course, that will be influenced by the numbers. 12:33

DR. MAXWELL: Yes, if you haven't got enough staff they can't do the engagement, can they?

A. Yes, yes, yes. Yes.
PROFESSOR MURPHY: We've also heard from a witness the other day that there was a point at which day services were closed. Now that seems to me to be very likely to have been a trigger for higher numbers of incidents on the ward. Did you look at that in your analysis of incidents? 12:33
A. Daycare is central to maintaining the service at Muckamore Abbey Hospital and the engagement and diversion of patients through their being occupied is central to maintaining stable wards. 12:34
PROFESSOR MURPHY: Yes.
A. There was on a small number of occasions crises to such an extent in terms of the staffing of the wards that I think daycare might have been suspended, the daycare centre, for one or two days. Let me say that, in terms of any endorsement or decision, there was clear recognition that this is a vicious cycle in the sense that if you suspend day services you're going to shift the crisis back to the wards and we must get this reinstated fast and it is only as a last resort. 12:34 12:35
PROFESSOR MURPHY: So if we had had a witness saying that it was closed for several months, you think she would have been mistaken about that, it was just an occasional day here and there? 12:35
A. There was no day services closed that I can recollect for several months. If there was, that would have been a breach of our contract, I would remember that.
PROFESSOR MURPHY: Several.

CHAIRPERSON: Several months. Not seven, but several months. Could that have happened?

A. It's not resonating with me. You know with the passage of time I can't, you know. But that is not resonating with me because -- seven months, no. 12:35

DR. MAXWELL: But for several months there would be a number of sessions that were cancelled due to staff shortages? Because one of the things we heard is that sometimes when there were shortages on the ward the staff from the day services went to staff the wards? 12:36

A. Yeah, on occasions, on occasions, which may have impacted on a reduction. But it's not resonating with me that the day service was reduced to 50%, you know, or something as significant as that. Pragmatic decisions, some of which may not have reached my ears, 12:36 may have been taken.

CHAIRPERSON: I was just about to ask you that. At what level would a decision to close daycare be taken, who would make that decision?

A. I wouldn't make it without consulting the Director. 12:36

CHAIRPERSON: No --

A. I might make a recommendation.

CHAIRPERSON: But would it have to be your level, for the daycare centre actually to be closed for a day, just by way of example, because there was some crisis 12:37 on the ward and staff had to be pulled back, would that get to you or not?

A. Basically if it had to be closed for a day, maybe something arose at eight o'clock that morning where

five members of staff phoned in sick, okay.

CHAIRPERSON: Yeah.

A. I may have been at a meeting 30 miles from Belfast. I would expect Esther to take that decision if her view was that the service would not be safe. But I would expect her, if I was around, to tell me immediately. 12:37

CHAIRPERSON: Right. So that's what I was trying to get at, in general terms you would have expected that to reach your ears at least?

A. Yes. 12:38

CHAIRPERSON: Right.

A. And, you know, if it was closed for a day or two I would make sure that my Director was told.

CHAIRPERSON: And if it were to be closed for weeks, you would certainly expect to know that? 12:38

A. Oh that would be escalated right up.

CHAIRPERSON: Yeah. Okay.

DR. MAXWELL: So you said it would have been in breach of contract to close it for several months, did you do data returns to HSCB about the number of sessions of day services provided? Did you have to do returns for contract monitoring? 12:38

A. Certainly you did in the day centres in the community. I would think so.

DR. MAXWELL: So there would be returns somewhere saying how many day sessions were delivered? 12:38

A. I would think so for Muckamore, but it was something I never asked.

DR. MAXWELL: So that would be part of contract

monitoring which - is that through the Directorate IT and Performance in the Trust? Who does the contract monitoring? Well, we can ask.

A. The Director titles have changed over the years. It would have been... 12:39

DR. MAXWELL: There was a Performance Director.

A. I think it would have been through Shane Caldwell.

DR. MAXWELL: The Performance Director?

A. Yeah. Yeah. The Performance Director, that's correct, yes. 12:39

CHAIRPERSON: Is that a convenient moment?

MS. BRIGGS: I think so, Chair, yes.

CHAIRPERSON: All right. We've been going for longer than we normally would, we've been going about an hour and a half. So, Mr. Veitch, you'll be looked after 12:39 during the break, please don't talk to anybody about your evidence, and we'll start again at 25 minutes to two, just about half past one. Thank you very much indeed.

THE WITNESS: Thank you. 12:39

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS: 13:30

CHAIRPERSON: Thank you. Just give me one second. Okay. Welcome back. Thank you. Off we go.

43 Q. MS. BRIGGS: Thank you, Chair. Mr. Veitch, before the

break for lunch there we had discussed a little bit about Core Group meetings. Okay. Thinking about the Core Group and who attends at it, you've told us who that is in your statement, but was there a patient voice at Core Group. 13:43

A. No. Core Group was the senior management meeting in relation to Muckamore Abbey Hospital. It basically focussed on governance and improvement issues from a management perspective. Now, there was anybody of the four core members could bring issues in relation to 13:44 patient representations, but it was a management group meeting. It wasn't a patient group.

44 Q. If we can bring up page 10 of your statement, paragraph 33, on the screen. We had discussed earlier how the Core Group looked at data regarding seclusion, 13:44 physical intervention, and on this particular paragraph you're discussing how the Core Group would look at safeguarding and trend information regarding safeguarding. From your recollection were the frequency and occurrence of safeguarding incidents 13:45 constant or did they change over the time that you were in post?

A. I think like other categories that that tended to fluctuate.

45 Q. And what kind of factors would have precipitated that 13:45 fluctuation?

A. I imagine retrospectively some of the issues would have been as referred to earlier, the mixture of patients on individual wards. I'm trying to think in terms of the

safeguarding data, and it might be helpful just to look at the page in terms of the appendix for me to answer that.

46 Q. It's Tab 7, if you do want to have a chance to look at it. I'll get you the page reference. It starts at page 96, there is a Local Adult Safeguarding Partnership Report 2013-2014, and that's the example report that you provide for the Inquiry to explain how safeguarding was looked at by the Core Group, if that would assist you. 13:46

A. I'm just trying to... I'm sorry, you couldn't give me the page number of the statement?

47 Q. 96. 96.

A. Okay. Thank you.

PROFESSOR MURPHY: It'll come up on the screen. 13:46

CHAIRPERSON: But you may want to look at it to tell us which page you want to go to. So you've got the original, the hard copy there.

A. Yes, I have.

48 Q. MS. BRIGGS: Can I ask what page you're looking at, Mr. Veitch, just if you're going to refer to it, what exact page you're at now? 13:47

A. I'm on 92 at the moment. I'm not sure if that's the page.

CHAIRPERSON: No, I think it starts at 96, doesn't it? 13:47

MS. BRIGGS: The exhibit that's provided to the Inquiry about safeguarding starts at page 96.

A. Oh, yes, yes, yes. Yes.

CHAIRPERSON: There's numbers at the top.

A. Yes, yes, sorry. Thank you.

CHAIRPERSON: Don't worry.

MS. BRIGGS: No, that's okay.

A. It would be the section on Learning Disability. Yes, sorry, I'm at page 114. 13:47

49 Q. Yes.

A. I think page 114 really highlights that the majority of the reported incidents related to issues in relation to service users. So, you know, in terms of the factors, I think the factors would relate to the condition of 13:48 the patient, and I think it's demonstrated that during any episode of in-patient treatment, you know, there could be improvements and deteriorations. It would also be an issue in terms of the mixture of patients, potential conflict between individuals. It could be 13:49 issues such as the environment that we've discussed this morning in terms of the engagement of patients with their treatment plans and, you know, issues surrounding those themes.

PROFESSOR MURPHY: Did you ever analyse whether it 13:49 related to particular staff?

A. Sorry?

PROFESSOR MURPHY: Did you ever analyse whether it related to particular staff being on duty? So I'm just thinking that, you know, some staff are much better at 13:49 de-escalating things than others.

A. I do not recall us ever doing a formal piece of work in relation to that. But certainly that would be, that was an issue that I would have highlighted,

particularly with Esther. You know one of the issues that I brought from my childcare background was sometimes there were major problems in children's homes, you know, incidents, for example, of kids breaking all the windows of the home on occasions. 13:50
And at that stage in my career I would have attended, often late in the evening, early hours of the morning, and clearly for me as the Senior Manager at that point there was a correlation between the frequency of such incidents and individual members of staff being 13:50
present.

I think the other thing I learned from that experience was calling out a Programme Manager or a Director Of Children Services was of little benefit to calming the 13:51
situation, because ultimately the calming has got to do with the nature of the relationship with people who are involved in the day to day care of individuals.

PROFESSOR MURPHY: Indeed. But if you had realised that certain individuals, for example, were often on 13:51
shift when there were safeguarding referrals, then it would have given you a clue that they needed some extra training at the very least.

A. Absolutely, and that was the point I was making to Esther, to be aware and identify if there's any trend 13:51
of incidents being associated with particular members of staff being on duty and, if there was, to be taking action to initiate some evaluation of that compared to other periods.

PROFESSOR MURPHY: Thank you.
CHAIRPERSON: And do you know if that was done?
A. Sorry?
CHAIRPERSON: Do you know if Esther did that?
A. I assume so, but... 13:52
CHAIRPERSON: You didn't see the results.
A. That's not something I can...
CHAIRPERSON: Just for my own elucidation so that I don't make a mistake later, can we just go to the paragraph after the one at the bottom of the screen, it 13:52 should start "During the period", that's it. No, go back up. Yeah. Thank you. Can you just help me, it was noted that there was increased demand for ABE interviews. Now that's an expression I know so far as police interviews are concerned, but does that relate 13:52 to PSNI involvement or are ABE interviews part of your own process?
A. Can I just caveat by saying in preparing for today abbreviations such ABE and similar, I've a difficulty at times recollecting -- 13:53
CHAIRPERSON: It's Achieving Best Evidence.
A. Yes. And I think that is the joint clarification interviews conducted jointly by specialist Adult Safeguarding staff and the police.
CHAIRPERSON: Yes, I thought it might be. Thank you 13:53 very much.
50 Q. MS. BRIGGS: Were SAIs discussed at the Core Group?
A. Yes.
51 Q. Were there any difficulties deciding if incidents of

alleged abuse should go down the ASG route or the SAI route? How were those difficulties resolved if there were?

A. Just repeat the question again?

52 Q. So there's a route via the Adult Safeguarding process, there's a route via SAIs, was there ever any difficulty in determining what route an individual case should take? 13:53

A. No, I don't think there was. In terms of governance, risk management, we were fortunate, I believe, in having Mairéad, who was very much a specialist in terms of that and undertook in most cases for the Directorate the lead role in terms of interface with the Board, et cetera, in relation to that. When an issue of adult protection or for that matter child protection came in, it had to be addressed, obviously, in accordance with the procedures, and there were stages in relation to that. If there was a question that at the outset it didn't meet the criteria for an SAI and we proceeded with a protection investigation, the issue of measuring that against the SAI procedure was continuous at all stages, and if it met the SAI procedure threshold, it would have been reported as an SAI and the two processes to continue together. 13:54 13:54 13:54

PROFESSOR MURPHY: So if we take the example of Ennis, wasn't that an incident which started off going through the Adult Safeguarding route? 13:55

A. That's correct.

PROFESSOR MURPHY: But then there was a debate about

whether it should have gone the SAI route, which I think it never did?

A. That's correct. The Ennis Investigation -- well, the initial referral came in and I think, in terms of my evidence on the last occasion, I was on leave, I think, at that time, and didn't return. The decision had been taken, and I assumed the decision was taken, and I haven't clarified this, it would have been taken in my absence by Mairéad and Catherine, okay. My understanding in returning was that the SAI procedure at that stage, if measured against the referral, it wouldn't have met the SAI criteria. But it changed during the course of the lengthy process, or immediately afterwards, which coincided with the Board questioning the Trust decision. And my view was that the new criteria, if it had been in place at the time of the initial referral, would have rendered it an SAI. And I think in my last evidence and statement I did acknowledge that, you know, it's not a point worth arguing about, we should have responded and reported it as an SAI.

13:55 13:56 13:56 13:57

PROFESSOR MURPHY: But basically they can go both routes at the same time.

A. Yeah, no reason why not.

53 Q. MS. BRIGGS: The report that you've taken the Inquiry to at page 114, that's just one page in a 40-page report, but I think it's this section that deals with Learning Disability; isn't that right?

13:57

A. This section specifically, Learning Disability, sorry.

54 Q. Sorry, Mr. Veitch, I got you just as you were taking a drink. I'm not going to read it out, it's on the screen, we can see from the second paragraph really that the report is focussing on whether or not Adult Safeguarding protection plans should only be recorded if they are part of an ongoing safeguarding process, rather than perhaps what action could be taken or can be taken to keep patients safe on a more immediate basis? 13:58

A. Sorry, which paragraph is this? 13:58

55 Q. The second paragraph on page 114.

[Pause to allow witness to read the document]

DR. MAXWELL: So does this mean that - because we know that some referrals were screened out. 13:59

A. Yes.

DR. MAXWELL: But there might have been action that was triggered by the fact that a referral was made.

A. Yes. 13:59

DR. MAXWELL: Are those captured, or only the ones that are screened in and go on to a full investigation, and it seems as though you're debating that and asking for advice from the HSCB about what to do?

A. Yeah, I'm trying to get my head around it because reading it now it doesn't... I think that, you know, whether it is part of an active Adult Safeguarding investigation, or whether it is a safeguarding issue, I don't think that that should influence the recording 13:59

on a safeguarding plan.

DR. MAXWELL: But I think the question is did it, not do you think it should? So when we look at the figures that you've cited above, does that include all referrals or only those that were screened in and went on to a full investigation? It may be that you can't remember. 14:00

A. Yeah, I can't. But, you know, where there is a safeguarding issue that has been raised, whether it is screened in or screened out, you know any issue or concern about safeguarding a specific patient, a plan should be recorded. But, you know, I can't remember the detail of that. 14:01

DR. MAXWELL: Okay.

CHAIRPERSON: Could I just ask though: This is really focussing on how things should be recorded as opposed to focussing on what action should be taken to keep patients safe. Is that a fair or unfair comment? 14:01

A. Well, yeah, if there's a safeguarding issue there should be a safeguarding plan. 14:01

CHAIRPERSON: So there's an assumption --

A. And a safeguarding plan should outline actions to be taken to protect would be...

DR. MAXWELL: Well, assuming the concern was upheld, because aren't we presuming at the point of referral we're not making any assumptions? 14:01

A. Yes, yes, yes.

DR. MAXWELL: So actually if it was found that there was no safeguarding concern there wouldn't be an action

plan.

A. That's right.

DR. MAXWELL: So I think what we're trying to clarify is, do these numbers in the first paragraph relate to all concerns raised, concerns that were felt to be upheld and those that went on - or just those that went on to a full investigation? 14:02

A. When a safeguarding referral comes in, initial action is taken to decide whether the concern is consistent with the procedure in initiating an investigation. Where there is an investigation or where it meets the threshold -- therefore, meeting the threshold of a safeguarding matter, a safeguarding plan should be put in place at that point of the investigation and then continuously reviewed through the process. 14:02 14:03

DR. MAXWELL: Maybe another way to put this is, at the bottom of paragraph 2 it says:

"The service area would welcome the HSC Board view on this." 14:03

Did you get a response from HSC Board on this on precisely what should be recorded?

A. Not that I recall.

DR. MAXWELL: So potentially there was a little bit of confusion about what should be recorded? 14:03

A. Yes.

56 Q. MS. BRIGGS: If we take a step back then and think about the reports that you and the Core Group

considered, do you agree that those reports, be them on safeguarding, be them on seclusion, physical intervention and so on, do you consider that they were adequate to enable you and others to identify whether there was abuse of patients at Muckamore? 14:04

A. No, the report in itself cannot be conclusive because it's a statistical analysis. What, however, was important was that those meetings, asking the questions: 'How has that been taken forward? Who is pursuing it? Have the family been informed? Has the 14:04 patient been fully informed about the action being taken? Has that been taken back and reviewed in terms of the patient's care plan with the key professionals involved?', and those were the assurances that I was seeking. The statistics -- behind the statistics were 14:04 individuals, and I wanted to know that on an individual basis the appropriate plans and procedures were being implemented, and that the family and, importantly, the key worker, care manager in the Trust of origin, were involved in the process. Because all those actions 14:05 represented safeguards to the individual.

57 Q. Taking a step back again, the "Way to Go Report" is a report that the Inquiry has heard about in quite considerable detail, and that's 2017 that report, so it's just after you left post, and it relates to the 14:05 period between 2012 and 2017, so it aligns to some extent with your time in post, which is the 2011 to 2016, how do you reflect upon the findings of that report?

A. That's a very, very general question, you know. I would prefer to comment on individual issues. Having said that, it was a critical report and I accept that. The issues in terms of those highlighted, and an example for me would be the series of RQIA reports and 14:06
concerns about recurring themes, I accept that. Having said that, you know, in reviewing the RQIA reports, each and every one of them was reviewed by the members of the Core Group, sometimes within the meetings, sometimes without the meetings. There was a fair bit 14:07
of discussion about each individual report. There was action plans drawn up, and there was also a history in Muckamore and, you know, I did review those reports again just in the last couple of weeks. There were occasions where there were extremely positive reports. 14:07
There were also occasions where it could be demonstrated that where there was a negative report, very intensive action was taken in terms of a Quality Improvement Plan and it being enacted, and when RQIA came back a short time later, there had been such a 14:08
massive improvement. There were also occasions where there was a negative report, and I was concerned, I discussed the concerns with Esther, and I made it quite clear that action had to be taken and it basically was not acceptable. 14:08

You know it did - you know, those reports were occurring in the context in which -- it's well documented in terms of the staffing problems, etc.,

etc., but they were taken seriously and management action was taken to try and effect an improvement. So it's just really to highlight, when I saw that report, yes I understand the concerns when they were not addressed promptly and thoroughly and recurred, but there also were occasions where there were some very positive reports as well, and evidence of effective action being taken.

DR. MAXWELL: Where you had an RQIA report that raised concerns and you discussed it and you had got a plan, but you weren't able to make that improvement, you know what I'm going to say, did that go on to the Risk Register? Because it's an unmitigated risk?

A. Yeah, I've got to acknowledge it didn't go on to the Risk Register, and my contemporary thinking of that was this can be got right fast and it needs to be put right fast.

DR. MAXWELL: I can understand why the initial RQIA report didn't get on.

A. Yeah.

DR. MAXWELL: But you've said that there were some where you had discussions, some where you were able to resolve and it RQIA came back and acknowledged it was resolved, but some where it wasn't some time after it had been raised. So notwithstanding the limitations of the Risk Register, did you alert anybody else to the fact that 'Yes, we are very well aware that there is a significant concern here, we've tried, but we haven't been able to resolve it'?

A. The answer to that is, yes, in terms of the highlighting the concern, because these reports and the follow-up actions came into the organisation.

DR. MAXWELL: Did they come into the Chief Exec?

A. They came into the Chief Executive who then passed them to the Director for action, and I think at that point Catherine would have forwarded it simultaneously to Mairéad and myself to pursue. 14:10

The issue, and I understand entirely from the Inquiry's perspective why you're asking me about the Risk Register in terms of that, quite frankly contemporaneously, I was thinking this is an issue to support staff to put right or, as a last resort, discipline staff. But -- 14:11

DR. MAXWELL: So the report comes in formally to the Chief Exec's office, the Chief Exec probably doesn't see every single one, does the Chief Executive's office have a system for monitoring that action plans are in place and that they've been delivered? 14:11

A. I can't authoritatively answer that, but I would imagine it would - he or she would put that on their pending file for the relevant Director, which would be Catherine.

DR. MAXWELL: And was there any sense that you wanted to be seen to be successful to the Chief Executive and there was a reluctance to suggest that things hadn't been put right? Was it easy, was there an open just culture where you could go and say 'We've tried, but 14:12

this isn't working'?

A. No, I'm long enough in the tooth to say that if things, you know, if there's pressures and there's issues, and I think that I've acted appropriately and done all I can. I need to be open about that, because if 14:12 I tried to deal with it myself and fail, that's a failure on my part, which ultimately could be a disciplinary issue against me, you know. So where you have unresolved difficulties, you share, you're open, you're transparent, you're honest, and you -- 14:13

DR. MAXWELL: So you shared with Catherine the occasions when RQIA had raised concerns, and despite lots of work you hadn't been able to resolve them.

A. The reports came through Catherine when they came in. The Quality Improvement Plans would have been signed 14:13 off by Catherine.

DR. MAXWELL: And monitoring of the plans?

A. Well, the monitoring of the plans would have been probably mostly at Esther's level within the hospital, but I have a responsibility for that as well. 14:13

DR. MAXWELL: But you saw the monitoring results?

A. Yes, I did, and I often was dissatisfied by some of them and sent - gave them back to Esther, because there was a recurring theme of responses like "being actioned" and "ongoing". I wanted to see who was doing 14:14 what, who's doing what by what date.

DR. MAXWELL: So you were sending some things back to Esther saying: 'No, this isn't satisfactory monitoring, give me some more detail'. At what point

would you then say: 'No, I need to tell Catherine this isn't being delivered'?

A. I would have kept Catherine briefed in terms of recurring themes, and she should have seen the recurring themes in the reports as well. 14:14

DR. MAXWELL: So would you have said to her: 'I've had this report from Esther and I'm not satisfied with it, I've asked her to go back and provide more detail', would you --

A. Well, I would have said - not to personalise it to Esther, for any of my staff, yes. 14:14

DR. MAXWELL: Send it back.

A. To any of my staff that: 'Look, this is an important aspect of their work and I'm not happy about it'. But I wouldn't just tell her that. I would say 'And I've done X, Y and Z'. 14:15

DR. MAXWELL: Yeah. No, I understand that. So you are confident that Catherine, who attended Board, not an Executive Director, but attends Board, would have been fully aware of the RQIA recommendations which had not been met? 14:15

A. Yes, on the basis that the reports came through her, the responses came through her. RQIA, if they had concerns, would have written to the Chief Executive, who would have given it to her, and then it was through those processes it landed on my desk. 14:15

DR. MAXWELL: It's just that it was suggested in the Leadership and Governance Review that actually information wasn't flowing from the Trust up to the

Board, but you're saying somebody who attended the Board, Catherine, was cited on all of this?

A. You know, between Catherine and the Chief Executive. I didn't get involved in what was being given to the Board.

DR. MAXWELL: No, no.

A. But there was, you know, clearly in terms of the interface with RQIA, that embraced - that came through the Chief Executive's office, and I didn't sign off the action plans. I approved them, but my understanding and recollection is that Catherine signed them and returned them.

DR. MAXWELL: Thank you.

CHAIRPERSON: Just to be absolutely fair to you, "A Way to Go" was published in November 2018, so that was two years pretty much after you had retired, but obviously it dealt very much with a period when you were in post. Were you pulled back in to discuss the outfall, as it were, the outcome?

A. No.

CHAIRPERSON: Of the "A Way to Go Report?

A. No. I had no contact with the Trust at all in relation to that report.

CHAIRPERSON: What's going on?

MS. ANYADIKE-DANES: So the link apparently is not working.

CHAIRPERSON: Ah! We'll stop. Thank you. Let's find out what's going on [Short Pause]

MS. BRIGGS: I can see from my colleague's stream if

there was a...

CHAIRPERSON: Is it one individual or more?

MS. ANYADIKE-DANES: At least two.

CHAIRPERSON: Separately.

MS. ANYADIKE-DANES: As I understand it. 14:18

CHAIRPERSON: Sorry, Mr. Veitch, we have just got to make sure. [Short pause]. Mr. Veitch, sorry to have interrupted your evidence.

A. Just to respond whether I was consulted about "A Way to Go", no, I wasn't. The report came into the Trust and 14:22 I was unaware of it until it became part -- into the public domain. I would have been very happy if contacted by the Trust to have spent some time with them deriving my comments. I'm under no illusion there were significant shortcomings during my period in post, 14:22 as demonstrated by some of those negative RQIA reports.

CHAIRPERSON: Yeah.

A. But I would have welcomed an opportunity to have commented on the --

CHAIRPERSON: But you weren't given that opportunity? 14:22

A. No.

CHAIRPERSON: Okay.

DR. MAXWELL: And you weren't interviewed for the report?

A. No. 14:22

58 Q. MS. BRIGGS: If we go to page 12, paragraph 45, what you're saying here is that the Core Group sought assurance that families and key staff in referring Trusts were being:

"...promptly and fully appraised regarding any safeguarding issue and the deployment of restrictive practices including seclusion and physical intervention." 14:23

How did you satisfy yourself that families were being so assured?

A. Essentially that paragraph reflects the procedural requirements. Okay. Basically I was being assured by 14:23 Esther in relation to those matters who, in addition to that was advising me of the proactive internal monitoring and review arrangements that she had in place through her Assistant Service Managers in order to look at files, discuss with staff, and clearly those 14:24 are serious issues in terms of deprivation of liberty and adult protection.

59 Q. The Inquiry has heard some evidence that families have been dissatisfied, to put it in those terms, about the communication from Muckamore about their loved one and 14:24 the care that they received, can you provide any explanation for why that might be?

A. Well, I'm aware of such comments. That should not have occurred. Basically clearly -- of the two procedures pertaining to Learning Disability I think by far the 14:24 most important are those relating to deprivation of liberty and adult protection issues. They were afforded considerable attention in all my meetings, senior management meetings, and I think that that's

reflected in the notes and minutes of those. I've described my discussions and interfaces in relation to that, and it certainly shouldn't have happened and, you know, I can only apologise from my perspective in addition to the Trust, you know in terms of evidence, that that was not the case.

60 Q. Another meeting or group that you refer to is the Senior Management Team, and you refer the meeting, this is among the LD Directorate's Senior Management Team, and you provide some sample minutes in relation to those meetings. I just want to go to one of those sets of meetings. It's page 143. This document is titled "Senior Managers Meeting held on 26th January 2012", and the list of those present is on the screen there. We can see yourself there, and the likes of Mrs. Rafferty, and so on and so forth. 14:25 14:26 14:26

Over the page, on page 144, this is just returning to the topic of finance for a moment, we can see there that under the heading "Finance", that there is a Social and Primary Care underspend? 14:26

A. Yeah.

61 Q. Can you help the Inquiry understand as to why there was an underspend?

A. All I can do is to explain, as highlighted there, that I had an overspend of £831,000. And the date of that meeting again was? 14:27

62 Q. 26th January 2012.

A. Okay. The financial year would have ended 31st March,

so that's -- I can confidentiality say that would have been a protected overspend of a million pounds. The underspend of £1.308 million would have been derived from the Older People and Mental Health programmes of care. Now that -- sitting here now, 13 years later, I find it surprising that they were underspent, unless there was particular reason for that, but I couldn't begin to try and explain that.

63 Q. I'd like to go on to page 12, back towards paragraph 46, so the bottom of page 12. You're describing here how issues identified at Muckamore across the various meetings and reports, how they would be escalated and dealt with, and that's dealt with throughout that section of your statement. Paragraph 46 says that:

"On occasions some identified concern related to skill mix..."

- and that's a topic which I'll come to:

"...and other cost pressures at Muckamore. This was escalated within the Belfast Trust leading, for example, to the internal temporary redeployment of additional specialist adult safeguarding staff to Muckamore from the Belfast Trust's mental health services bringing, what I considered to be, the added advantage of "fresh eyes" to scrutiny of adult safeguarding at the hospital."

When were those fresh eyes brought in, can you remember?

A. I can't be definitive about this, I think about 2012.

64 Q. Okay. And --

A. Can I just say within that context that Esther's appointment to her Service Manager post on 1st January 2012, also represented to me the concept of bringing fresh eyes to Muckamore Abbey Hospital. In general terms, and it is in general terms, when I took up post I quickly became aware that, and it wasn't absolute, but staff in Muckamore tended to have started their careers in Muckamore and ended their careers in Muckamore, and some worked their way right up, and it seemed to be insular within that. Now Esther was appointed quite clearly because she was the best person for the job in terms of selection process, but she was also coming from a mental health background, and she had, in terms of her background, she had worked in in-patient care. So I certainly saw her appointment as bringing that additional dimension to the post. The person who came in as Band 7 - came from the Mental Health programme of care in terms of the reference you've made - he had worked most of his career in terms of Mental Health, and came in and took a pivotal role as designated social worker for adult protection, and I saw that as an additional dimension and potential assurance to me. 14:29 14:30 14:30 14:30 14:31

65 Q. So is it to that individual that you really are referring to, or are there other individuals that

you're referring to at paragraph 46?

A. In paragraph 46.

66 Q. When you're talking about the fresh eyes to the hospital?

A. Yeah, that person - I won't name him, but he was a Band 7 who was brought in from, transferred temporarily initially to the Adult Safeguarding, designated -- 14:31

DR. MAXWELL: So this was a social worker who had been working in safeguarding in Mental Health.

A. Yeah. 14:32

DR. MAXWELL: Who was coming and so got fresh eyes and could have a conversation with the people who worked a long time at Muckamore about whether there was a different way of looking at this?

A. Yes. Yeah, yeah, yeah. And he succeeded - I'm just struggling with naming names - he succeeded the senior social worker there as being the delegated officer, and he then presented the safeguarding reports to the Core Group, this new input from a mental health background and, you know, I saw his role as inevitably he would be coming in to LD from Mental Health, and if there was anything extraordinary or unusual, or he was concerned, I'm sure -- 14:32 14:32

DR. MAXWELL: So you're a social worker with a child, health and child protection background, and you now had a social worker with a Mental Health safeguarding or Vulnerable Adults background, so that's two fresh eyes really on safeguarding. Did you feel that safeguarding at Muckamore at that point in time was aligned with 14:33

best practice? Or did you feel it was perhaps slightly behind?

A. I had no reason to believe that the practice was anything but good at --

DR. MAXWELL: That's not quite the question I'm asking. I'm not saying it was unsafe, I'm saying was it best practice? 14:33

A. Yes, I didn't pick up any concern or deviation from standards. I was also reassured - and this is important, at least it was important to me - I was also reassured that prior to the Mental Health worker coming in, and I think it continued after he came in, Aine Morrison undertook annual reviews of safeguarding, and Aine was extremely thorough and extremely, I would say, demanding in terms of best practice. 14:34

DR. MAXWELL: Okay.

A. And certainly her input did not highlight any concern.

DR. MAXWELL: Okay.

67 Q. MS. BRIGGS: At page 13, paragraph 48, this paragraph describes ward closures and how the Core Group meeting, it was agreed there that: 14:34

"...the Belfast Trust would not action ward closures within scheduled timescales where the Belfast Trust considered it would pose potential harm to any patient through compromising their treatment plan or through the resultant mix of patients on a ward." 14:35

And you've spoken about that earlier. The Inquiry has

heard a considerable amount of evidence about ward closures and ward mergers and some of that has been negative; in particular there's a ward merger between Donegal and Killead, and I appreciate that that is after you left Muckamore, okay. That's 2018. The Inquiry heard evidence that that merger was rushed, that little consultation took place with families and patients, that it was led by a Service Manager without LD experience, and so on. Are you saying that that type of thing wouldn't have happened during your tenure? 14:35 14:36

A. I don't know the circumstances of that and the factors precipitating it. As you describe it, it sounds as if it was not acceptable. But I don't know the circumstances that prompted such a decision, and they may well have been exceptional circumstances where this represented the best outcome in terms of safe and effective care. So I'm in no position really to comment. 14:36

68 Q. I'm going to move on to another matter now which is the skill mix of staff at Muckamore. If we go on to page 16 and paragraph 59? 14:36

CHAIRPERSON: Can I just ask, are you okay to keep going?

THE WITNESS: Oh, yes, I'm happy. Basically this afternoon I'm quite happy to keep going to the end. Hopefully. 14:37

CHAIRPERSON: All right. I'm still going to keep an eye on it because witnesses do flag and if we need to

take a break we can just take a break.

69 Q. MS. BRIGGS: You say there that during your period in post:

"...concerns regarding the skill mix available to the hospital within its staffing establishment were highlighted and escalated through a number of mechanisms including the work of the Hospital Modernisation Group which I convened and chaired..." 14:37

And you provide minutes of that group's meetings. I'm going to pick up - and they're all 2015, there are three sets of minutes that you provide the Inquiry; the 9th January, 6th March and the 19th June 2015. I'm going to pick up on two of those. The first is the meeting on Friday, 6th March 2015, page 167. 14:38

We can see there that it's the modernisation meeting notes, the date is 6th March '15, and those present, there's quite a significant number, and you chaired that meeting. 14:38

If we can go to page 170 then. The first two paragraphs or paragraph and a half describes discussion on: 14:38

"...continuing and increasing concern regarding the current skill mix at Muckamore to function as a modern hospital. This was also an issue which was now being

highlighted repeatedly through RQIA Inspections and Improvement Plans in response to which the Trust did not have the available revenue funding to respond adequately.

14:39

Issues which had been highlighted and remained sources of acute concern included inadequate consultant sessions..."

And then it goes on to say that there was an: 14:39

"...inappropriate skill mix between Band 3 and Registered Nurses in response to which Mrs. Rafferty and Mrs. Kane indicated that they were already involved in analysing and seeking to address from their 14:39 professional perspective. It was however acknowledged that in order to do so may require significantly additional funding rather than any anticipated savings through the elimination of social care placements."

14:39

Then just for illustration, Mr. Veitch, before I ask you about them, I'm going to go to the other set of notes, minutes, page 172. This is then from the June of that year, and we can see there again the list of attendees. And then at page 174 we can see again the 14:40 Modernisation Group discussing the issue of skill mix. It says there that:

"It was again noted that the funded skill mix at

Muckamore Abbey Hospital was not fit for purpose for a modern hospital.

In relation to nursing, Mrs. Rafferty, in consultation with Mrs. Kane, continues to work on reviewing the skill mix which currently is 50:50 qualified and unqualified. This is work in progress but an acceptable standard would likely represent 70:30." 14:40

And then it says that that has to be aligned to local and national professional standards and expectations. 14:40

That's quite a statement that the funded skill mix was not fit for purpose for a modern hospital. How did the hospital get to that point? 14:41

A. When I came into post I took on responsibility for a hospital with designated skill mix and funding. As my time in post proceeded, it was clear in terms of the agenda having confronting the hospital that there needed to be an expansion of skill mix, an examination of skill mix in order to meet the future projected needs of the hospital into the future. I suppose again probably the Core Group took the lead on this, but it had to be seen within the context of the immediate needs of the patients and, again, in my statement, I make reference to the efforts and successful efforts I made to enhance the skill mix through additional OT, physio, psychology, social work within the hospital. Now that was done through repeated representations 14:41 14:42

at -- through a range of means with the Health and Social Care Board.

Now, in the documentation you'll note that the Health Board label this as to assist with resettlement. That reflects the fact that they said to me that that was the only funding stream which they could identify, some of it was temporary. Having said that, when those additional resources became available to Muckamore, I said to Esther, and through the Core Group, that we have got to be flexible about this, and if there's a greater need for some of that resource to be applied to a particular patient in a core ward, do it. 14:42 14:43

Taking it forward in a more strategic manner, I established that Hospital Modernisation Board in 2014. I insisted as best I could that there were senior representations from the other Trusts, from the Board, and from the Public Health Agency on that. That was to bring forward plans and proposals for what the hospital should be like post resettlement. It was also an opportunity for us to look at best practice, to look at our own experience of the skill mix that was required, and to almost start again, and that is reflected in the work and the minutes and appendices of that group. 14:43 14:44 14:44

CHAIRPERSON: Can I just ask: This meeting is back in June of 2015, and at that time you are pleading effectively for funds for OTs, social workers,

psychotherapists, all needed to make the life of the patients in the hospital better or bearable, yes?

A. Yes.

CHAIRPERSON: Do you remember at that point approximately how many patients you still had in the hospital? 14:44

A. There would have been 100/120. I don't know --

CHAIRPERSON: Right. So a significant number of patients.

A. Yes. Well, there was 40 delayed discharges. There was... yeah, yeah. There was 40 in treatment, 80, and there was at least 20 PLTs, so there was more than 100. 14:45

CHAIRPERSON: But the only way you could get funding was, as they frankly said to you, the only route would be if this was for the purpose of resettlement? 14:45

A. Well, what they said was --

CHAIRPERSON: That was the funding stream.

A. Yeah, their funding stream. To be fair to the Board and to Aidan, he was advising me of his constraints, you know. If he gave me money through the resettlement stream and he saw I was using 50% of it, and because the core ward needs were greater, I don't think he would have turned -- I do believe he would have turned a blind eye to it. 14:45

CHAIRPERSON: But up until this point, which seems some might think quite late in the day, the hospital didn't have that set of different disciplines that might have made the lives of patients rather better, is that a fair comment? 14:46

A. And to be fair I probably should have acted earlier too but...

CHAIRPERSON: Thank you.

70 Q. MS. BRIGGS: You mentioned earlier in your evidence and you describe it in your statement how the Board was able to provide short-term funding, but not permanent revenue for support, and for reference for the transcript that's at page 86 -- paragraph 86 page 25. Why was the Board unable to provide permanent revenue, can you recall? 14:46

A. Basically the Board, as I understand it, and I can't speak for the Board, but my recollection is the Board were able to provide us with the funding for those posts through slippage in relation to money to resettle people. They had money identified to resettle people, there had been a delay in that person's placement so the Board were sitting on that. So pro tem they were able to reallocate that short term to us to assist us. 14:47

DR. MAXWELL: Was this unique to Learning Disabilities or was it applying to the whole of the Directorate? These financial constraints. This slippage money and non-recurring revenue? 14:47

A. I would have assumed so, but not confidently so. You'd need to ask the Director of that.

71 Q. MS. BRIGGS: I want to look at the role of referring Trusts in supporting patients who were admitted to Muckamore, because we know that patients were admitted to Muckamore from all over Northern Ireland; isn't that right? How well would you say that patients at 14:48

Muckamore were supported by the referring Trust?

A. I had a background in child care, and when a child was placed in a hospital, and it applied to Iveagh, they were regarded as "looked after children", if you understand that concept? And that really meant that the Trust of origin were primarily responsible for the welfare of that child during their placement. They had to lead on everything in terms of care management, in terms of reviews, obviously not the clinical review, but they should have been central to attending that, and that the responsibility and accountability for the suitability of the placement lay primarily with the placing authority. 14:48 14:49

Now when I came in to Muckamore Abbey Hospital, and I think it's fair to say that practice across all the patients differed from one extreme to the other, but to me in some instances there seemed to be a feeling that when your patient from your area was placed in Muckamore Abbey Hospital, for the duration of that placement everything was the responsibility of Muckamore Abbey Hospital, and that came as a bit of a shock to me, because my background was one where the Trust of origin had primary responsibility for placement and all aspects relating to it. 14:49 14:49 14:50

So for individual patients there were key workers, care managers actively involved. I also understand that some of these placements were made 30, 40 years ago as

well. So that sort of tempers the context in which I was -- and I think some of the evidence that the Inquiry has heard as well has expressed the view that when they get to Muckamore they're Muckamore's responsibility.

CHAIRPERSON: Wouldn't there have been a Service Level Agreement with other Trusts?

A. There was a Service Level Agreement in relation to the funding. Just we would have received all the funding from the Board, from the Health Board for the Trust, but basically it was -- there was so much money attributed to the Northern Trust, so much money attributed to the Belfast Trust, so much money attributed to the South Eastern Trust, so the Board in many ways should have been giving the Northern Trust the money to give to us, the South Eastern Trust to give to us, but just --

CHAIRPERSON: Yes. But that wasn't happening.

A. No, what they did was they just gave it to us directly. Do you understand?

CHAIRPERSON: Right. Okay.

DR. MAXWELL: And they gave it as a lump sum rather than 'This is the amount for Patient A, this is the amount for Patient B'.

A. It was a lump sum. It was a lump sum.

DR. MAXWELL: Just like this is all of Northern Trusts.

A. Based on notional --

DR. MAXWELL: Yeah, notional budgets.

A. Notional patient. So to answer your question, and I'm

not criticising the other Trusts or any individuals within those Trusts, but there seemed for certain patients to be the view that Muckamore had almost total responsibility for them. Because I saw it as a safeguard, that if there was a safeguarding incident say in relation to an patient from the Northern Trust, and they were immediately alerted - I shouldn't have named a particular Trust - that they would prick up their ears, which would have been another potential safeguard for the whole of the institution. 14:52 14:53

DR. MAXWELL: Okay.

CHAIRPERSON: Sorry, I don't quite understand that. It doesn't matter if it's the Northern Trust, Eastern Trust, whoever it is. There's a safeguarding incident.

A. Basically what I'm saying is that if you're telling somebody in the community, regardless of what Trust it is, that this safeguarding incident has occurred, and this is the 31st this month. 14:53

CHAIRPERSON: Yes.

A. That the community social services or care management would be saying 'What the hells going on here?', and asking questions. 14:53

CHAIRPERSON: Yes. Yes. And are you saying that wasn't happening?

A. It didn't really happen. 14:53

CHAIRPERSON: So once a patient was in Muckamore, the Trust that you would have regarded as responsible for that patient effectively washed their hands of them?

A. Well, what I'm saying is there was a mixture of --

CHAIRPERSON: Of attitude.

A. Of attitudes.

CHAIRPERSON: Okay.

A. But there was part of it -- in some instances I got the impression, as Co-Director, that they weren't as actively involved, given their responsibilities as they should be, and it did contrast sharply with practice in child care. 14:54

DR. MAXWELL: So you were telling each of the home Trusts, whatever we're going to call them, every time there was a safeguarding incident. 14:54

A. Yes.

DR. MAXWELL: And you might have expected from your experience in child care that they might say, 'Gosh, this is the 30th safeguarding incident about Patient X who is our responsibility, I need to go and find out what's happening', they were just saying 'Thank you for the data, we'll file it'. 14:54

A. Well, yeah, it certainly wasn't coming back to my ears that the community Trusts were highlighting. 14:54

DR. MAXWELL: However, that didn't mean necessarily that you didn't have a duty to say 'What's going on? This is the 30th for Patient X'?

A. No. No, no, no. Yeah. Yeah. That does not in any way diminish my accountability and my staff's accountability. 14:55

DR. MAXWELL: No. So are you saying that there was or wasn't any difference in the way that patients from Belfast Trust were treated in Muckamore from other...

A. No.

DR. MAXWELL: So they were all treated exactly the same?

A. Oh, absolutely.

DR. MAXWELL: And essentially whatever the legal situation, you were taking responsibility for all the patients? 14:55

A. In fact, you know, I was responsible for both community and hospital, and at times the professionals in the hospital were pointing out to me that my other staff's responsiveness wasn't as it should be as well. 14:55

CHAIRPERSON: My understanding is what you're really saying is that where an incident happens with a patient from another Trust, you would have expected there to be a second pair of eyes on it. 14:56

A. Yes. Yeah, and I would draw the distinction between those in active treatment, assessment treatment, and those inappropriately placed, particularly those who are only in Muckamore because the Trust of origin, including Belfast, have not provided the appropriate placement for them. 14:56

CHAIRPERSON: Yeah.

A. They have grave responsibilities for the safety of that placement as well.

CHAIRPERSON: Thank you. 14:56

72 Q. MS. BRIGGS: Mr. Veitch, I'd like to move on to something else, and that's the arrangements for the clinical supervision of staff. It's something you're asked about specifically by the Inquiry and your answer

starts at page 19. You describe in your answer how supervision was achieved and who was responsible for supervision. In terms of protecting time to allow supervision to take place, how was that achieved?

A. I don't think it's protecting time, you know, I think that is a core responsibility and it has got to be prioritised. It's not something that is secondary, that you have to negotiate time for. It's a requirement. 14:57

73 Q. And do you think that the supervision arrangements worked well enough? 14:57

DR. MAXWELL: Can I break that down a bit because you say it's a requirement.

A. Yes, please do.

DR. MAXWELL: Actually there are different requirements for different professional groups. So social work supervision is a statutory requirement, medical appraisal and predecessors to that, but for other groups like nurses and healthcare assistants it's entirely discretionary? 14:57 14:58

A. Well, I believe that professional supervision is a requirement and I do believe that Esther and Brenda would ensure that appropriate --

DR. MAXWELL: So did you monitor that, or the staff within Learning Disability were getting supervision. 14:58

A. I didn't, I didn't actively monitor that, except to have the expectation that any failure was brought to my attention immediately. Because I didn't want any surprises in statutory functions reports or any

other...

DR. MAXWELL: So you were assuming that your direct reports were doing this, but you didn't have any data to confirm it?

A. No, I may have asked very occasionally, and I certainly would have paid heed to the Statutory Functions Report and other reports that would have... 14:59

DR. MAXWELL: But that would be for social work wouldn't it? It wouldn't have been for the other professional groups. 14:59

A. Yeah, yeah, yeah. But the other aspect in terms of nursing is, and it wasn't frequent but it was periodic, Moria Mannion and myself, one of us would have lifted the phone to the other.

DR. MAXWELL: Okay. 14:59

CHAIRPERSON: Ms. Briggs, can I just ask how long you think you've got?

MS. BRIGGS: Maybe about 20 to 30 minutes.

CHAIRPERSON: Can I just ask Mr. Hackett our stenographer? You're all right. Okay. 14:59

MS. BRIGGS: The Inquiry has heard evidence about Erne Ward, okay, and it has heard evidence that the quality of care at Erne Ward improved at 2017, which is after you've retired, and it has heard evidence that the quality of care in Erne Ward only improved after about 90% of the staff team were removed and replaced, because the team that had been in there before weren't willing to change their practice. That might suggest that the clinical supervision arrangements perhaps 15:00

weren't working, and I want to give you an opportunity to comment upon that?

A. I don't know what happened in 2017. I don't know what basis those observations were made. I can't recall what the last inspection of Erne Ward prior to my retirement highlighted, off the top of my head. So without knowing the context, the detail, the timescales, I can't really comment on that.

PROFESSOR MURPHY: Were you familiar, though, with teams of staff in certain wards where there hadn't been much changeover in staff sometimes getting very fixed in their ways and not being prepared to change, and being seen as, you know, dyed in the wool and we'll never get them to change? 15:01

A. I accept that there is always that potential. Having said that, you know, there are processes going on on a day-to-day basis in every ward in terms of multidisciplinary interaction, ward wards, action plans. A key role in this is the day to day monitoring by the Assistant Service Managers, and I would expect that any issue like that should be and would be very quickly picked up on and action taken. 15:01 15:02

PROFESSOR MURPHY: Yes. I think because it was a resettlement ward we understand that resettlement wards often didn't have an MDT every week, they would have one maybe once a month, and there was much less presence of the MDT on those resettlement wards. 15:02

A. Well, I can't comment obviously in terms of 2017. There was the consultant who we were able to secure the

funding for to lead on resettlement. When I left, that person, as I recollect, was still full-time committed to that leadership role, and it may have varied, but I understand that that person was convening weekly resettlement planning meetings within the hospital. 15:03
Now, that would obviously have been focussing on those patients who were actively being looked at at a point in time, but it should have included that ward. But I can't really comment in terms of --
PROFESSOR MURPHY: Yeah. It's not a familiar picture 15:04
to you then that there were some staff teams that were considered, you know, a bit beyond the pale?
A. No, no. In general terms, and Ennis was a bit of a surprise shock to me, but in general terms I had the impression of a very devoted, committed workforce doing 15:04
their best at times in adverse circumstances, but got up every morning to do their very best and a commitment to learning disability and to the patients.
PROFESSOR MURPHY: Okay. Thank you.
DR. MAXWELL: You did say earlier on that when you 15:04
arrived you noted that people had started their career at Muckamore and ended their career, and it was a bit insular, and that's why you thought having Esther Rafferty and the safeguarding officer from Mental Health was useful; the most difficult thing about any 15:05
management job is managing people, and while 90% of your staff might well be doing an excellent job, there's the whole issue about how do you manage the 10% who are not doing what you would like them to do, and

we've asked a number of times what training people got when they became Ward Managers or Assistant Service Managers, and we keep getting told they'd done all their mandatory health and safety training, which probably wouldn't help with that. So if you recognise that a lot of people had been there a long time and maybe their practice was based on when they started 40 years ago, what help would be given to Ward Sisters and Assistant Service Managers to manage people outside the capability disciplinary process? 15:05 15:06

A. Well, without wasting a lot of time going - because I'm sure you've heard it all before about the Personal Contribution Framework with everybody having their objectives, which would have applied to newly qualified management staff as well. Aligned to that was discussions with the line management about development needs and trying to, in terms of, not only mandatory and introductory training, looking at other training courses, whether professional or general, provided by the Beeches Management Centre, and they would in particular have run quite a lot of management courses, Living Leadership. But there would also be training provided by our own HR Department, and I vividly remember a training course that ran, and I think it was only a half a day or one day, which ran for years, and it was entitled "Managing Difficult People", you know, so there was, there were those arrangements in place. 15:06 15:06 15:07

DR. MAXWELL: So if I had been appointed as Ward Sister, my first Ward Sister post, and I was now

managing people who had been at Muckamore longer than me, I'm in a more senior band but actually they've been there a lot longer, or people who are related to people in more senior management posts, and I felt their attitude to patients wasn't what I wanted it to be, or they were sometimes a bit rough, but I was really anxious about how to manage that, where would I -- would I just get on with it, or ignore it, or where would I go for help? 15:07

A. Oh, no, you wouldn't just -- you would not just get on with that at all. You would be discussing that immediately with your line manager. 15:08

DR. MAXWELL: Right.

A. And you would be agreeing strategies in terms of training needs, but also in terms of management techniques and training courses and support systems with HR staff. There would be -- 15:08

DR. MAXWELL: So I would be able to call the HR Department to say 'This is tricky. How do I handle it?'. 15:08

A. Oh, absolutely. Absolutely.

DR. MAXWELL: And were you aware of people actually doing that?

A. I'm aware of a number of occasions when staff would have, senior staff would have said to me 'This is difficult', and I would have identified the precise person in HR for them to speak to. 15:08

DR. MAXWELL: Okay.

A. And HR were very supportive.

74 Q. MS. BRIGGS: Whose responsibility was it, Mr. Veitch, to maintain time for staff to undertake training and development?

A. Mine and their senior managers and their managers. Now, I say that very quickly. It's often not as simple as that, and when you look at the full context of Muckamore, there were occasions when Esther explained it proved difficult to release staff for training courses. In such circumstances sometimes that was unavoidable in order to maintain patient safety, but there was always the expectation and the monitoring to ensure that that was facilitated at the next and earliest opportunity and that there was constructive communication with staff in relation to that. 15:09 15:09

CHAIRPERSON: But do you agree that actually people missing training or supervision, because although they're meant to have protected time they can't because of staffing issues, it's a bit of a red flag? 15:10

A. Yes, yes, yes. And it --

CHAIRPERSON: It's not just missing training. 15:10

A. Yes, yes, yes. And it's also like this morning, you know, the issue about day care. If you suspend day care you're into a vicious circle, and unless you're managing that and trying to resolve it proactively, that will lead to greater deteriorations than the initial problem. 15:11

75 Q. MS. BRIGGS: I want to ask you about data analysis and trend identification, because it's a question that the Inquiry asked you about in your statement. And if we

can go to page 99, paragraph 99 on page 29. You're talking about data here and how it was looked at by the Core Group and others, and you're describing at this paragraph how.

15:11

"...a recurring issue of concern in the reports we received related to a very small number of patients/residents accounting for an extremely high proportion of incidents despite assurances that such interventions had been reviewed through line management and were in accordance with regional policy and procedures."

15:11

To what extent did the concerns that large numbers of incidents arose from a small number of patients lead to a complete review of those patients' care plans?

15:12

A. Just repeat the question for me, sorry?

76 Q. So in the knowledge that a small number of patients were accounting for a high number of incidents, I'm asking you about what action was taken in relation to that? For example, were those patients' care plans, were they overhauled?

15:12

A. The action was taken at a number of levels. You know one was, as senior members of the Core Group, Colin often undertook to discuss with the consultant responsible for the patient, in terms of Muckamore, if it wasn't himself. Esther would have undertaken to review it with her Senior Manager, the Assistant Service Manager. The second level was to review the

15:12

care plan, to look at all the factors contributing to this concern, to look at the configuration of the hospital in terms of the placement of the patients and are they best placed. A common theme with a lot of these difficulties related to challenging behaviour as a result of being inappropriately placed in an institution. And very often my view, and I think it was shared by the other members of the Core Group, the best and most patient-centred response to addressing this was getting this patient out to an appropriate placement. Because when people are inappropriately placed, they're more likely to display challenging behaviour. So I do remember going away from these meetings and part of the action plan for me was to speak to -- for me to speak to the person at my level in the Trust of origin, if it wasn't Belfast, and I can remember on one occasion suggesting, unsuccessfully, that pending community reintegration they would be better placed closer to home in their local LD hospital. 15:13 15:14 15:14 15:15

77 Q. What was the outcome of that?

A. I think they were ultimately found a placement, but there apparently was no free beds in their local hospital.

78 Q. And in the meantime when any individual patient like this displaying challenging behaviours, for whom perhaps the hospital wasn't in your mind the best place for them to be, what was done while their resettlement was being looked at? While they were in the hospital, 15:15

what was done for those patients to protect them to, protect staff and others?

A. There would have been a requirement to review their care plan, to review their safeguarding plan, and also the care plan and the safeguarding plan of those other patients impacted by the events. And the care plan would also have to take into account the multidisciplinary input to support the staff, the placement within the hospital, all those considerations. But I didn't take those decisions because they had to be person-centred planned multidisciplinary decisions. I couldn't sit and just dictate this or that, because I didn't have the knowledge and it wouldn't be person centred. 15:16

79 Q. I'd like to take you to a document that the Inquiry has been provided with by Mr. Hagan, the Medical Director in the Belfast Trust, and it's an exhibit he has to his statement, and the reference is STM-101, and these are overview charts that he exhibits to page 5490 of his statement and they're on the screen now. And, Mr. Veitch, you've had a look at those today, I know. Mr. Hagan, he says that the graph was produced by the Risk and Governance Team, and I'm specifically looking at the graph on the left. He says that it was produced by the Risk and Governance Team at the Belfast Trust to assist the Inquiry and the data was collected from Datix. 15:16 15:17 15:17

We can see there four different coloured lines on a

graph that's a time oriented graph, so it goes from 2009 through to 2022, and then numbers of incidents, behavioural incidents, January 2009 to 2022, and the different colour-codings represent different types of inappropriate or aggressive behaviour, and I say "type", I mean whether it was towards a patient, towards staff, whether it was by staff or by a patient. Okay. 15:18

And looking at the green line then, that green line represents inappropriate aggressive behaviour towards staff by a patient. We can see there that there's a steep increase in incidents of aggressive inappropriate behaviour towards staff by a patient, and it really seems to go up, on my reading, from 2014, and I think that the figure there is 682 per annum, and then it goes up to a height of 2,505 per annum, and that's in 2018, and it seems as if -- do you see that okay? You're following what I'm saying, Mr. Veitch, yes? 15:18

A. Yes. 15:19

80 Q. And then it seems as if there's a smaller rise in terms of inappropriate or aggressive behaviour by staff towards patients. What do you think caused those rises?

A. Okay. I only saw this this morning. 15:19

DR. MAXWELL: Does that mean you weren't aware of this trend until you saw this graph?

A. Let me finish.

DR. MAXWELL: Okay.

A. I saw this this morning, and it runs through to 2022. But, you know, in terms of up to '16 is obviously my responsibility. If I had had this in advance of giving evidence today, I would have wanted, before I could explain myself, to look at what is meant by a behaviour incident and what is encompassed by that? You know what is the - you know, is telling a member of staff to clear off included in this? Or is it high threshold assaults? Having said that, there's obviously an upward line, and I was aware when in post about certain peaks during certain periods. It does seem to level off a bit mid, a bit of a higher level between '16 and '17. I would like to take that away and look at it before I would feel able to... 15:20 15:20

DR. MAXWELL: But regardless of whether it was verbally aggression or physical aggression, does it not indicate that patients were more distressed, becoming increasingly more distressed in this period? 15:21

A. Well there's --

DR. MAXWELL: And was there anything that happened in 2014 which would have led to the patients being increasingly distressed, which was being exhibited by aggressive behaviour of whatever sort towards staff? 15:21

A. It's a very valid question, which I accept. I can't think back and compartmentalise 2014, you know, in that way. You know I would want, and I'm sure the Inquiry will want to correlate that maybe to resettlement activity, to ward closure activity, to other factors, but I can't. 15:22

CHAIRPERSON: If you wish in the future to revert to the Inquiry about that, we'll be in touch with you. All right.

THE WITNESS: Okay.

CHAIRPERSON: So that you have the opportunity of dealing with properly if you want to. 15:22

THE WITNESS: Okay.

81 Q. MS. BRIGGS: Mr. Veitch, the final matter that you're asked about in your statement is at page 30 and that's regarding your awareness of concerns about the abuse of patients by staff at Muckamore, and action taken in relation to concerns about abuse of patients by staff. You describe in your answer that a number of staff were subject to disciplinary sanctions whilst you were in post, but you don't remember individual cases and circumstances, other than Ennis, and you've already given detailed evidence to the Inquiry about Ennis. I want to ask you about the suspension and dismissal of staff more generally. 15:22 15:23

Certainly post 2017 the Inquiry has heard that the suspension and dismissal of staff led to major difficulties in staffing and it became perhaps a bit of a vicious circle really. Thinking back to your time in post, what might have been the best way to deal with staff that were subject to disciplinary sanction of that kind, without getting into a vicious cycle? 15:23

A. There's clear policies and procedures relating to adult protection and HR in terms of staff conduct and

behaviour. It clearly sets out and my expectation is that there is the threshold set out in terms of staff suspension, disciplinary investigation, child protection -- sorry, adult protection investigation, disciplinary hearings, and sanctions. And, you know, where there's inappropriate behaviour and the appropriate sanction is dismissal, it's dismissal, and the needs of the service will have to be addressed in terms of those staff no longer being available. 15:24

PROFESSOR MURPHY: While that might work quite well when it's a small number of staff, when it becomes a very big number of staff then the numbers being suspended leave the staff who aren't suspended who are doing the work very stressed, very anxious and, therefore, more likely to also be involved in incidents, and I think that was probably what had happened in MAH, after you left admittedly, and we're just wondering what you think might have been the way out of that? 15:25 15:25

A. I don't think there's really any easy way out of that, except by - and I'm speaking off the top of my head here - except by looking at those staff remaining, and what are their support needs, and the independence of such support needs, given the emotion around in terms of that, and the Trust's responsibility to facilitate that. Attendant to that, of course, is how the Trust is able to retain - recruit and retain, and the processes and systems for those people. And, again, there may be issues about independent support systems 15:25 15:26

outside the Trust, which the Trust or the Department or someone contracts, but it's not easy and I've no easy solution to that.

PROFESSOR MURPHY: Thank you.

MS. BRIGGS: Mr. Veitch, that's all the questions that I have for you. The Panel may have some questions. 15:27

CHAIRPERSON: Do you have anything? No. Okay.

Mr. Veitch, can I thank you for - that does complete our questions. Can I thank you for coming in and the fairly extended session that you've had. As I say, if you do want to revert to the Inquiry in writing in the future you can, of course, do so, and that will of course be published by the Inquiry. And to the extent to which you have accepted responsibilities for some of the things that have obviously gone wrong, I'd also like to thank you as well. You can now go with the Secretary to the Inquiry. Thank you. 15:27 15:27

THE WITNESS: Thank you.

CHAIRPERSON: All right. Sitting next Monday at ten o'clock. Thank you very much. 15:28

THE HEARING ADJOURNED TO MONDAY, 23RD SEPTEMBER 2024 AT 10:00 A.M.

15:29