MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 17TH SEPTEMBER 2024 - DAY 105

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

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1 THE INQUIRY RESUMED ON TUESDAY, 17TH SEPTEMBER 2024 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Thank you.
5 MR. McEVOY: Good afternoon, Panel. This afternoon's 13:34
6 witness is Catherine McNicholl, and she's ready to go.
7
8 MS. CATHERINE MCNICHOLL, HAVING BEEN SWORN, WAS
9 EXAMINED BY MR. MCEVOY AS FOLLOWS:
10 13:35
11 CHAIRPERSON: Good afternoon. Can I just welcome you
12 to the Inquiry, and thank you for coming slightly
13 earlier than you might have been expecting.
14 A. Thank you.
15 CHAIRPERSON: Thank you for your statement. We'll take 13:35
16 a break if you're still here after about an hour, but
17 if you need a break at any stage before that, please
18 just let me know.
19 A. Okay. Thank you.
20 1 Q. MR. McEVOY: Good afternoon, Ms. McNicholl. 13:35
21 A. Good afternoon.
22 2 Q. We met a few moments ago. As you know, my name is Mark
23 McEvoy and I'm one of the Inquiry counsel team. I'm
24 going to take you through your evidence this afternoon.
25 For your own reference, and for everyone else's 13:35
26 reference, there is in front of you a statement dated
27 the 28th August this year. It consists of 21 pages,
28 and I think 11 exhibits, and totals, therefore,
29 including the exhibits, 95 pages. Can I ask you

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1 firstly whether you want to adopt that statement as
2 your evidence to the Inquiry?
3 A. Yes, I do.
4 3 Q. So, as you may be aware, Ms. McNicholl, the statement
5 is publicly available on the Inquiry website and 13:36
6 therefore that saves us the trouble of having to go
7 through it unnecessarily. What I aim to do is to focus
8 on a number of areas that you have raised within --
9 A. Okay. Thank you.
10 4 Q. -- within the course of your statement. You have very 13:36
11 helpfully set out by way of your background your
12 employment history within the health service,
13 paragraphs 1 through 10. At 10 then you tell us that
14 in 2009 you became the Director of Performance and
15 Service Delivery in the Belfast Trust, and then in 13:37
16 September 2012 you became the Director of Adult Social
17 and Primary Care Services, or ASPC, or ASPCS, a role
18 you held then for four years before you retired in July
19 2016. And then, in fairness to you, you go on to say
20 that you would like to preface the answers to the 13:37
21 questions asked of you, and set out in the remainder of
22 the statement, by noting that you've been retired and
23 completely removed from the health service for almost
24 eight years now, and you say that your memory, recall,
25 and retained knowledge of the workings of the Trust, 13:37
26 its systems and processes, and specific events in the
27 Trust has faded.
28
29 So, bearing that in mind, I suppose though it might be

1 helpful if you can tell the Inquiry about whether or
2 not, on taking up that post as Director of the ASPC
3 Services in 2012, whether you personally had any
4 experience or qualification, or indeed other grounding
5 in the area of learning disability? 13:38
6 A. Actually, I had none.
7 5 Q. Okay.
8 A. Other than in -- I had obviously a lot of experience in
9 Director role.
10 6 Q. Yeah. 13:38
11 A. In overseeing all services. And the input that I had
12 in learning disabilities was from a performance
13 management.
14 7 Q. Yes.
15 A. Because I was the Director of Performance and Service 13:38
16 Delivery.
17 8 Q. Yes.
18 A. I was engaged with those teams with a previous Director
19 in having monthly performance meetings with them, and
20 along with the Chief Executive. So I had gained a bit 13:38
21 of knowledge and insight into that, but very little
22 experience otherwise.
23 9 Q. Okay. So it was essentially a management geared
24 competence that had you in that role, would that be
25 fair to say? 13:39
26 A. Yeah. Yeah.
27 10 Q. All right. And then you are asked and you do respond
28 then on the following topic, asked questions on the
29 following topic, about your role within the operational

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1 management of Muckamore Hospital, and the staffing area
2 for which you had leadership, and your day-to-day
3 responsibilities. So that we understand - and this is
4 on page 3 at paragraph 16 - you give us an overview,
5 paragraph 16 down to about 25, so that we can 13:39
6 understand the management structure as you have set it
7 out. Stop me if any of this summary is in any way
8 inaccurate, but you had overall management of the ASPC
9 Directorate. It covered 50 different sites and covered
10 a number of service areas, of which learning disability 13:40
11 was but one?
12 A. Yes.
13 11 Q. And then under you was a senior management team, which
14 I think you described then at paragraph 19. And one of
15 those managers, senior managers, was the Co-Director of 13:40
16 Learning Disability Services in the person of
17 Mr. Veitch, John Veitch?
18 A. Mhm-mhm.
19 12 Q. And he then was in turn responsible for the senior team
20 at Muckamore Abbey? Yeah? So would it be fair to say 13:40
21 then that Mr. Veitch was the link or the interface
22 between you and direct responsibility for the
23 management of the hospital?
24 A. What do you mean by direct?
25 13 Q. Was he -- did you look to him for direct, to be 13:40
26 directly responsible for the running of the hospital?
27 A. Well, John was directly responsible, and never shied
28 away from it.
29 14 Q. Yes.

1 A. You know, John was accountable and responsible for the
2 management of Muckamore Abbey site, through his
3 managers.
4 15 Q. As we touched on, there were over 50 sites within
5 ASPCS. Would it be right to say that Muckamore would 13:41
6 have been among the biggest of those sites?
7 A. Physically wise do you mean?
8 16 Q. Yes.
9 A. Or service wise?
10 17 Q. Well, in either respect I suppose. 13:41
11 A. So mental health was included. So you had the Mater
12 Mental Health in-patient wards.
13 18 Q. Yeah.
14 A. Which was a big facility. You had Knockbracken site,
15 where the Regional Intensive Care Mental Health, and 13:41
16 various other mental health. I think it was a huge
17 site. Ehm, older people had quite a number of older
18 people wards in the Belfast City Hospital, and the
19 stroke ward. So I'm not sure I would say it was - it
20 was a standalone, what I would describe it as, a 13:42
21 standalone hospital site outside of Belfast.
22 19 Q. Yeah. And later in your statement, towards the end of
23 your statement at paragraph 84, I needn't take you to
24 it, but you simply make the point that you would have
25 visited Muckamore regularly? 13:42
26 A. Mhm-mhm.
27 20 Q. How often would you have visited it?
28 A. Yeah, I was trying, I was trying to think of that in
29 the last number of weeks. There wouldn't have been

1 very many formal occasions.
2 21 Q. Yeah.
3 A. But I would have regularly visited the site for
4 different purposes. I would estimate, and it might be
5 an underestimation, I would think maybe six or eight 13:42
6 times a year during my four years.
7 22 Q. Okay. What was your impression of it?
8 A. Ehm, remember it was a new service to me. I was not
9 familiar with this type of service. I always had the
10 impression that it was run by a group of really 13:43
11 dedicated professional people who had forged real
12 relationships with the patients within Muckamore Abbey,
13 many who had lived a lifetime there, or many decades
14 there. Ehm, they were experienced in particular
15 struggles with the whole resettlement programme, which 13:43
16 had taken many more years than it should have, but it
17 was also really difficult because they really wanted
18 the best for the patients that were there in the
19 resettlement. Ehm, there were good relationships with
20 families. There were issues about nurse staffing and 13:44
21 creating - continuing to be able to provide a workforce
22 to an environment that they knew was going to change
23 significantly in the coming years.
24 23 Q. We'll come back and pick up on some of those themes.
25 A. Okay. 13:44
26 24 Q. The next topic that you help us with in your statement
27 concerns the structures and processes that were in
28 place for the operational management of Muckamore
29 Abbey. At paragraph 26 then you tell us from

1 recollection that the structures and processes in place
2 comprised the Co-Director, who we've mentioned, for
3 Learning Disability Services, in the person of
4 Mr. Veitch. He was assisted by staff in Directorate
5 wide support and professional positions, such as the 13:45
6 Quality, Governance and Service Improvement Manager,
7 Head of Psychology and the Associate Medical Director,
8 the Associate Director of Nursing, the Finance Business
9 Partner and the HR Business Partner. And then the
10 Co-Director of Learning Disability Services had 13:45
11 managerial responsibility also for staff members who
12 actually worked in the operational management of
13 Muckamore Abbey, such as the Muckamore Abbey Service
14 Manager. The Service Manager was responsible for the
15 operational management of the hospital's day to day 13:45
16 functioning, including each ward, and she oversaw
17 Assistant Service Managers.
18
19 Would it be right then to say that the Service Manager
20 was responsible for the day to day operational 13:45
21 management of the hospital, in your understanding?
22 A. Yes. Yes.
23 25 Q. And in your role as Director, would you have met the
24 Service Managers directly, if at all?
25 A. Yes. Well the Service Manager in Muckamore Abbey was 13:46
26 also the Associate Director of Nursing. So she was not
27 a member of my senior management team, but there were
28 meetings that I had that the Associate Directors of
29 Nursing were always at. Plus, on my visits to

1 Muckamore Abbey I would always have called into Esther
2 Rafferty's office in the first instance, so I regularly
3 would have been having conversations with her.
4 26 Q. Okay. And are we to take it from that description that
5 these were somewhat informal encounters then? 13:46
6 A. Yes. Yep.
7 27 Q. All right. And those meetings at which the Service
8 Manager that you mentioned would have been in
9 attendance, did they take place under sort of a formal
10 rubric? Was there a group or a board or anything? 13:47
11 A. Yes, it was my - I'm trying to think what meeting it
12 was - either my SMT or my governance meetings.
13 28 Q. Right. Thank you. And then at paragraph 27 where
14 you're asked for your view of how effective the
15 structures and processes were in ensuring adequate 13:47
16 oversight of operational management at Muckamore Abbey,
17 you tell us that during your time as Director, which we
18 know was between 2012 and July of '16, you say:
19
20 "I was not given cause to be concerned that the 13:47
21 structures and processes for ensuring adequate
22 oversight of operational management at Muckamore Abbey
23 were lacking."
24
25 And you go on and say: 13:47
26
27 "That is not to say that there were not difficult times
28 or concerning incidents. Rather, when difficulties
29 arose, or incidents occurred, I always considered that

1 they were thoroughly dealt with. If the outcome was
2 that a weakness in structures and processes were
3 revealed, I considered that the weakness was dealt with
4 appropriately."
5 13:48
6 At 29 then you tell us that it appeared to you that
7 checks and balances were working. Do you recall an ASG
8 report on Ennis Ward coming to your Directorate in
9 2013?
10 A. What's an ASG? 13:48
11 29 Q. Adult safeguarding?
12 A. Oh, and -- yes, yes, I do.
13 30 Q. I suppose having said that you had not cause to be
14 concerned about the oversight of Muckamore in your term
15 and during your time as Director of ASPC, the Ennis 13:48
16 Investigation was ongoing. Had you any role in what
17 was to be done in terms of next steps when Ennis
18 concluded?
19 A. I would actually say that my role was right from the
20 very start of it. 13:49
21 31 Q. Yep.
22 A. I haven't had access - I know Ennis has been the
23 subject of a lot of discussion and evidence.
24 32 Q. Yeah.
25 A. And I don't have access to the papers. But I can say 13:49
26 from my recollection the Ennis incident happened
27 literally within the first couple of months of me
28 taking up post. I immediately - John Veitch was on
29 annual leave at the time I remember, and I would have

1 been at least weekly in the Ennis Ward, and immediately
2 working very closely with Brenda Creaney as the
3 Director, Executive Director of Nursing, and we both
4 agreed then for a senior nurse to be several months in
5 Muckamore Abbey. And the action - we don't ever wait 13:50
6 for an Adult Safeguarding Report or whatever, the
7 action is taking place once the problem is identified,
8 and we immediately did a huge amount of work in putting
9 additional resources in, but also looking at practices.
10 DR. MAXWELL: Did the final report - so, you're right, 13:50
11 we've heard an awful lot about Ennis, and one of the
12 things that is clear is that the investigation took a
13 long time to complete and produce its final report.
14 Did the final report come to the Directorate Governance
15 meeting? 13:50
16 A. I can't actually recall, but I would think it probably
17 didn't, it's not the thing that would come to my
18 governance meeting. It would go to - there was a
19 separate, ehm, Social Services Assurance Group within
20 the Trust that the Director of Social Work chaired, 13:51
21 that report would have gone to that Board.
22 DR. MAXWELL: So an Adult Safeguarding Investigation
23 would go through an entirely separate route from
24 operational management, it would go from the social
25 worker to the Social Services group, chaired by the 13:51
26 Director of social work, and never through the
27 Directorate?
28 A. I'm not entirely sure. I would have received a copy of
29 it.

1 DR. MAXWELL: Right.
2 A. I would have met with John Veitch as the Co-Director to
3 identify was there any further action to be taken than
4 we had already taken.
5 DR. MAXWELL: So the Inquiry has heard from various 13:51
6 witnesses that there were some differences of opinion
7 over the investigation and what had happened, and the
8 extent to which it was significant for a wider - for
9 the hospital as a whole rather than just the ward.
10 Would that have been something that would have been 13:52
11 discussed with you, and more specifically with the
12 Directorate? Because you say there was nothing that
13 gave you concern, but then there does seem to be some
14 unresolved issues around Ennis.
15 A. Honestly, I don't have access to the papers. 13:52
16 DR. MAXWELL: Okay.
17 A. I don't have good recollection of it. My focus would
18 have been on the RQIA reports that were flowing from
19 that and their assessments continuing, and then we
20 would have picked up on those issues. 13:52
21 DR. MAXWELL: Right. So your main source of
22 information about that would have been the RQIA
23 reports?
24 A. Assessments. But also remember we had, was it Moira
25 Mannion was she called? 13:53
26 DR. MAXWELL: Yeah.
27 A. Yeah. Moira Mannion based in Whiteabbey. The
28 Executive Director of Nursing and myself met regularly
29 about it, and with John Veitch.

1 DR. MAXWELL: Okay. Thank you.
2 33 Q. MR. McEVOY: Okay. So the next topic then that you're
3 asked for your thoughts on was about regular meetings
4 at Directorate level and what you recollect about
5 those. And you're asked also then to provide 13:53
6 explanations of how often meetings occurred, and who
7 was in attendance, and agendas, reports, and so on.
8 At paragraph 41 you are discussing the ASPC
9 Directorate, which you put in brackets described as the
10 senior management meeting, and a governance meeting 13:54
11 then of the same Directorate, which you say was a
12 quarterly meeting with a set agenda. And I think if we
13 look across to - hopefully you'll keep me right - page
14 36. Is that sort of a sample of minutes of that group?
15 That governance meeting. 13:54
16 A. Of the governance meeting, yes. It's just an
17 illustrative example.
18 34 Q. Yeah. That's very helpful. Thank you. Looking across
19 within that exhibit to page 38, you'll see reference at
20 paragraph 7 to a Risk Register. Do you see it there? 13:54
21 A. Yes.
22 35 Q. And I know this is an example, but it tells us here
23 just by way of illustration those present were referred
24 to the current Adult Social and Primary Care Risk
25 Register contained within their papers. Currently 13:55
26 nothing on the Trust's Principal Risk Register, and the
27 Directorate's Risk Register, as reviewed by each
28 service group on at least a quarterly basis. Those
29 present noted staffing issues at Muckamore Abbey

1 Hospital and in Older People's Services should be
2 resolved by the end of the summer. I should say in
3 fairness to you, the date of this is 25th June 2015.
4 And then also then some reference to the issue of
5 profiling of beds. 13:55
6
7 Now, how did risks and concerns identified within your
8 Directorate get escalated, and how would they wind up
9 being dealt with in the context of this meeting?
10 A. Are you specifically talking about risks here? 13:56
11 36 Q. Well, yes, that's sort of the general point. I suppose
12 the general question first.
13 A. Again, I only have a vague recollection.
14 37 Q. Yeah.
15 A. But risks are identified. I mean our whole of our 13:56
16 service is full of risks.
17 38 Q. Yeah.
18 A. Right? And a risk management approach is about
19 minimising those risks or ensuring that systems are put
20 in place to mitigate against those risks as far as 13:56
21 possible. So it was a process to do risk assessments.
22 39 Q. Yeah.
23 A. There was some sort of formula or matrix that was used,
24 and a scoring system that would then tell you whether
25 it was a green, amber, or red risk. There was points 13:56
26 put to it or whatever. And then - but that's only the
27 identification of the risk. Then it was the manager's
28 duty to sit down and decide what actions could be taken
29 to reduce that risk or reduce the impact of the risk,

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1 and what actions, normally on a day-to-day process I
2 wouldn't be involved in that, but where you have a risk
3 that continues, like the staffing issue in Muckamore
4 Abbey, that there aren't any more actions at that level
5 that can be taken to try and reduce it, then it would 13:57
6 be escalated to John Veitch as Co-Director, or to me as
7 Director.
8 40 Q. The Inquiry has heard some evidence that at this time
9 staffing was red rated at the service level?
10 A. Mhm-mhm. 13:57
11 41 Q. Can you help us understand, and I know this is an
12 example but it's a helpful one because it maybe gives
13 you the opportunity to help us understand why it was
14 that at this meeting, this governance meeting within
15 your Directorate in June 2015, it seemed to have been 13:58
16 decided that the staffing issue would be resolved by
17 the end of the summer, and can you help us understand
18 whether the issue was, therefore, not escalated to the
19 Board?
20 A. Okay. Can I take the second one first? 13:58
21 42 Q. Of course.
22 A. I think there's a wording in there because there's a
23 difference between the Trust Principal Risk Register,
24 which is the Board level Risk Register, and a
25 Directorate Risk Register, and it didn't meet the 13:58
26 criteria, and I don't have the information here, but it
27 did not meet the criteria to be on the Trust Principal
28 Risk Register.
29 43 Q. Okay.

1 A. Okay. Go back to -- your first question was about?
2 44 Q. Yeah.
3 A. How did I think it was going to be resolved by the
4 summer?
5 45 Q. Exactly. There's a red rating in, and June there seems 13:59
6 to be confidence, if I can put it that way, that it's
7 going to be resolved by the end of the summer.
8 A. So, can I also just make the point that it may not have
9 been escalated to the Trust Board, but the Chief
10 Executive would have been well aware of it. I had 13:59
11 monthly one-to-one meetings with the Chief Executive.
12 I don't have access to those agendas, but I would be
13 fairly confident that it would have been discussed.
14 Plus, I know that it definitely was discussed in terms
15 of overall in Exec team, because if I go back to the 13:59
16 context of the financial situation in Northern Ireland,
17 there was at that time a moratorium on recruitment of
18 all permanent staff, and no permanent staff were able
19 to be recruited without departmental approval, because
20 of the unique situation in acute services, and the 14:00
21 issue of recruitment of doctors and nurses, but also
22 Muckamore Abbey was one of the other areas, because we
23 had a real problem with retaining and recruiting nurses
24 to Muckamore Abbey when they knew the site was changing
25 and we could only recruit them on a temporary basis. 14:00
26 So because of the unique position for acute services
27 and Muckamore Abbey, we got departmental approval, and
28 therefore Trust Board approval, and Chief Executive
29 approval, to make permanent appointments, to go out and

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1 advertise. And I worked with the Director of Nursing,
2 Brenda Creaney, and HR, and we had -- I can't remember
3 the date, but I think it was in and around 2015, maybe
4 May/June, I'm not sure -- where we held a big external
5 recruitment day, we had a one-stop-shop for a weekend 14:01
6 where we did occupational assessment, interviews,
7 clearances, all in the one weekend, and we got a
8 considerable number of Mental Health and Learning
9 Disability nurses appointed in that time.
10 DR. MAXWELL: Can I just go back to the Risk Registers 14:01
11 rather than the actions you took. So we've heard that
12 at the service level, or the divisional level, staffing
13 was rated as a red risk. It's not clear to me whether
14 it was rated as red in the Directorate Risk Register.
15 Can you remember? 14:01
16 A. No, I don't. Sorry could I ask what you meant by
17 divisional? You meant Muckamore Abbey Hospital site?
18 DR. MAXWELL: I meant the learning - well, at different
19 times people have told us different things and it was
20 called different things. 14:02
21 A. Yeah, I know.
22 DR. MAXWELL: But there was a division of either
23 learning disabilities that were intellectual
24 disabilities we've heard, which covered community and
25 the hospital. 14:02
26 A. Yeah.
27 DR. MAXWELL: And I think the people have said at that
28 level --
29 A. It was red risk.

1 DR. MAXWELL: There was a Risk Register and it being
2 red. Now the general principle of Risk Registers in
3 and out of health care is that anything that you
4 identify as a risk, you look for mitigations, and if
5 you can't mitigate it, it's red. That's the 14:02
6 definition.
7 A. Mhm-mhm.
8 DR. MAXWELL: Regardless of whether there's s any money
9 or supply, it's still a red risk. So my first question
10 was, having received that from the division and looking 14:02
11 at the other risks in the rest of the Directorate, was
12 this still identified as a red risk for the
13 Directorate? And you're telling me you can't remember?
14 A. My Directorate would have had a separate register which
15 would covered the risks across all of my programmes. 14:03
16 DR. MAXWELL: Exactly. And on that was Muckamore
17 staffing identified as red?
18 A. Sorry, I don't know.
19 DR. MAXWELL: Okay.
20 A. Have we had access to those documents? I don't know? 14:03
21 DR. MAXWELL: Well that's something we can pursue with
22 the Trust. You said in answer to Mr. McEvoy that
23 staffing didn't meet the criteria for being on the
24 Trust's Principal Risk Register.
25 A. Mhm-mhm. 14:03
26 DR. MAXWELL: If it had been identified through the
27 risk assessment that staffing shortages were presenting
28 a risk because of the consequence for the patients, and
29 that hadn't been mitigated in any way, I don't

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1 understand how that didn't meet the criteria for the
2 Principal Risk Register. So could you tell me how it
3 didn't meet the Principal Risk Register?
4 A. Sorry, I'm not helpful in that one either. That --
5 maybe the Executive Directors or the Board of Directors 14:04
6 would be able to explain that, but my memory is that in
7 the Board's principal - and it was called Principal
8 Risk Register - there were only a number of key high
9 level risks.
10 DR. MAXWELL: And I understand that. You can't have 14:04
11 all the risks from the whole organisation on a
12 Principal Risk Register. What I'm trying to understand
13 is the decision making process. As the Director of
14 Adult and Social Primary Care, you attend the Board
15 meetings. 14:04
16 A. Yes.
17 DR. MAXWELL: So, what would the process be for getting
18 the Board to even consider whether it should be on the
19 Principal Risk Register? Would you, as the Director,
20 have to put it forward to be considered, or does it 14:04
21 arrive through some electronic system? How does the
22 Board even get to the point of deciding what it wants
23 to put on the Principal Risk Register?
24 A. Sorry, I don't have any recollection of how that
25 happens either. If I may, can I go back to a point 14:05
26 that you're making? I do not want to in any way imply
27 that just because it's on my Directorate Risk Register,
28 or in John Veitch's Divisional Register, doesn't mean
29 that actions weren't being taken.

1 DR. MAXWELL: No, I understand that. I was asking
2 about the governance process, not actions you were
3 taking.
4 A. Okay.
5 CHAIRPERSON: And could I just ask, and I think it 14:05
6 follows on from the same line of questioning, you said
7 that you - it may not have been raised before the
8 Board, the issue of staffing, but you did raise it with
9 the Chief Executive. Can I just ask to what purpose?
10 What's the point of telling the Chief Executive as an 14:05
11 individual?
12 A. Because he is the person that ultimately is accountable
13 for the Trust. I report - I am a direct report to him.
14 Sometimes I would raise issues as just to tell him to
15 say, you know, "I'm dealing with this issue, but it's 14:06
16 okay, but I just want you to know." Other times, so
17 for instance the staffing is a good example, it was
18 about being able to have an exchange that says "Look,
19 I'm really struggling with my financial targets this
20 year. I am really - we have a real staffing issue in 14:06
21 Muckamore Abbey Hospital", and working with the Health
22 and Social Care Board to see if they can give us more
23 funding for a period of time. We were looking at ways
24 of -- and the other thing is that because of the
25 financial situation and the moratorium, the Exec team, 14:06
26 along with the Chief Executive -- I'm trying to think
27 of the term -- scrutiny I think it was called.
28 CHAIRPERSON: The Scrutiny Committee?
29 A. Scrutiny. So we weekly met and we all had to present

1 our staffing requirements for temporary staff, and they
2 were either approved by Exec team or not. Because of
3 the issue in Muckamore Abbey Hospital, because of my
4 discussions with the Chief Executive, and because of
5 the fact that I was able to demonstrate that we were 14:07
6 continuing to cover the staffing by using significant
7 amounts of overtime by the current staff, that I was
8 spending way more than it would take to appoint
9 temporary staff, and I got approval actually that my
10 recruitment - so long as I could always demonstrate by 14:07
11 recruiting temporary staff that the reduction in
12 overtime would be seen, then I didn't have to get
13 approval through Scrutiny for Muckamore Abbey Hospital.
14 CHAIRPERSON: So you were really talking to the Chief
15 Exec to inform him of the issues and whether or not 14:08
16 they were under control?
17 A. And sometimes to get his support.
18 CHAIRPERSON: Exactly. Well I was going to come on to
19 that. And then --
20 A. Yes. To get his support and to get his support as in 14:08
21 bringing it to the Exec team and supporting me, so
22 therefore the rest of the Directors would then also
23 support me.
24 CHAIRPERSON: Yeah. And then just coming back to
25 something else you said. You said that the Department 14:08
26 had imposed a moratorium on permanent recruitment.
27 A. Mhm-mhm.
28 CHAIRPERSON: But you managed to get round that.
29 A. Well, I got approval.

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1 CHAIRPERSON: Yes. All right.
2 A. We got -- the Trust, as in, you know, the Trust got
3 approval from the -- departmental approval -- on the
4 basis of need for permanent appointments to acute
5 services, particularly in and around Accident & 14:09
6 Emergency and Mental Health and Learning Disability.
7 CHAIRPERSON: So despite that being departmental
8 policy, you managed to get that shifted, as it were,
9 because of how acute the problems were in mental and LD
10 services. 14:09
11 A. Mhm-mhm.
12 CHAIRPERSON: Is that right? Sorry you're nodding.
13 A. Yes. Sorry, yes, it is. Sorry.
14 CHAIRPERSON: But despite the importance of that, it
15 still doesn't appear on the Trust Risk Register? 14:09
16 Despite the fact that you had actually had to go back
17 to the Department to get them to lift the moratorium,
18 it never appeared on the Trust Risk Register? Is that
19 right or...
20 A. Well, I don't know. I don't have access to the 14:09
21 Principal Risk Register. But my memory is it wasn't --
22 LD in particular was not on the Principal.
23 CHAIRPERSON: Staffing in LD?
24 A. Yes. Yes.
25 DR. MAXWELL: So there was really a workaround? Rather 14:10
26 than using the governance process and the risk
27 registers, you were having conversations with the Chief
28 Exec and talking to the departments outside the Trust's
29 governance process, which would have been the Principal

1 Risk Register and the Assurance Framework?
2 A. Sorry, I didn't quite catch all of that.
3 DR. MAXWELL: So the Trust has a governance process.
4 A. Mhm-mhm.
5 DR. MAXWELL: Which includes identifying risks, having 14:10
6 Risk Registers, and having an Assurance Framework, and
7 as far as you remember, and certainly from the minutes
8 on the screen, staffing at Muckamore never made it on
9 to the Trust's Principal Risk Register.
10 A. Yes. 14:10
11 DR. MAXWELL: But you're telling us the concern about
12 the staffing meant that you were having conversations
13 with the Chief Exec and the Department of Health, and
14 I'm just observing that this was happening outside the
15 Trust's governance process, which would have required 14:11
16 it to be on the Risk Register and the Assurance
17 Framework.
18 A. Just so I'm clear, I never -- it wasn't me that
19 approached the Department of Health.
20 DR. MAXWELL: No, I am not blaming you. I am just 14:11
21 stating a fact.
22 A. Yes, but it wasn't me approached the Department of
23 Health.
24 DR. MAXWELL: I am not putting the blame on you.
25 A. The other -- yeah. The other -- 14:11
26 DR. MAXWELL: I'm just clarifying there were two
27 different routes.
28 A. Okay. Yeah. The other thing I do want to clarify is
29 that even though the process about staffing, and the

1 Risk Register, at no time -- we were under pressure.
2 The issue was about the changing face of Muckamore
3 Abbey Hospital. With the reducing number of patients,
4 it was going to become an acute facility and,
5 therefore, it was difficult to recruit staff. At no 14:11
6 time did I feel that the staffing was an issue about
7 providing unsafe care. It...
8 DR. MAXWELL: Well, except that did come up in the
9 Ennis Report, and the Inquiry heard yesterday that a
10 review in 2016 found serious shortages of staff. So 14:12
11 there are clearly differences of opinion on that.
12 CHAIRPERSON: But you didn't feel it had got to the
13 stage of being so serious as to provide unsafe care,
14 and that's your evidence?
15 A. Yes. Yes. It was always a struggle. It was -- on the 14:12
16 site they were having to swap, and change, and move
17 around, get people to do additional hours, do overtime.
18 I have to triangulate the information that I'm getting.
19 Right.
20 CHAIRPERSON: Sure. 14:12
21 A. If you take, for instance, the unannounced inspections
22 from RQIA, yes, of course, on occasions they would have
23 identified that on particular shifts the balance didn't
24 seem right, that the staff were struggling with
25 recruitment, but I am not aware of at any time that 14:13
26 they actually said that on that day it's unsafe.
27 CHAIRPERSON: No. But it may be fair to say, you
28 probably agree, that setting of bar of "it's not
29 unsafe" is a pretty low bar, isn't it?

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1 A. Yeah.
2 CHAIRPERSON: Mr. McEvoy.
3 46 Q. MR. McEVOY: Thank you, Chair. Ms. McNicholl, maybe we
4 could then turn to touch briefly on the work of the
5 ASPC Modernisation Board, which you described at 46 and 14:13
6 47. You have helpfully included the first set of
7 minutes from that meeting and then a further example at
8 - I think they begin at pages 47 and 51 respectively.
9 You have taken us to a sentiment expressed by
10 Mr. Veitch within those minutes in terms of his 14:14
11 understanding of the modernisation plan at the bottom
12 of page 48. People who are in charge -- hopefully you
13 have it there, but it will be on screen in a moment for
14 you? The bottom of page 48:
15 14:14
16 "Mr. Veitch emphasised that the plan should be focused
17 on:
18 People who are in hospital and should not be there.
19 Resettlement and discharge."
20 14:14
21 And that is in relation to Learning Disability.
22
23 The purpose of the meeting, you tell us, was to oversee
24 the redesign of services, set direction, and monitor
25 progress against agreed plans. Can you help us to 14:14
26 understand from your recollection whether that Board
27 had data which informed it about the size of the
28 population with learning disability and the nature of
29 their needs?

1 A. This Modernisation Board?
2 47 Q. Yes.
3 A. It's the same group of people as my senior management
4 team.
5 48 Q. Yeah. 14:15
6 A. So --
7 49 Q. So you're looking at the question of redesigning
8 services, and Mr. Veitch has emphasised that it's about
9 resettlement and discharge and avoiding admission. And
10 I suppose I'm firstly asking you whether or not you 14:15
11 recollect whether you had data which would have helped
12 you understand the size of the population with learning
13 disability and the nature of their needs?
14 A. Not at this meeting.
15 50 Q. No? 14:15
16 A. No. That wouldn't have been the purpose of this
17 meeting. You remember this meeting is across my whole
18 Directorate.
19 51 Q. Yeah.
20 A. So it's about modernisation of all adult acute and 14:16
21 primary care services.
22 52 Q. Yeah. But just before I move on. As Mr. Veitch is
23 making clear, and as you've reiterated in the body of
24 your statement, one of the things that you're dealing
25 with is the redesign of services for people with 14:16
26 learning disabilities. So I'm just going to let you
27 have the opportunity just to clarify it just in case
28 we're talking at cross purposes. Are you saying that
29 at this meeting, redesigning services affecting people

1 with learning disability, that you didn't have data
2 which informed you about the size of the population
3 with learning disability or their needs?
4 A. At this meeting I didn't -- the data wasn't presented,
5 but I had huge amount of data in relation to that. It 14:16
6 was part of the Transforming Your Care Programme in
7 Northern Ireland. Then priorities for action.
8 Resettlement in Muckamore Abbey was one of the key
9 priorities for action in our annual targets, and from
10 that, John had a core group that was looking at the 14:17
11 redesign - I think there was a business case in my time
12 and my latter year of the future design of Muckamore
13 Abbey Hospital, what its patient cohort would look
14 like, and what the staffing would look like. We had a
15 very detailed resettlement programme. We knew exactly 14:17
16 the numbers of patients that were there that no longer
17 required to be in hospital, and what were the plans for
18 them to be resettled into the community.
19 53 Q. And so that we're clear then, was that exact set of
20 figures that you've described presented and discussed 14:17
21 at the Modernisation Board?
22 A. No.
23 54 Q. All right. Would the Board have discussed the extent
24 of suitable accommodation in the community with
25 appropriately trained or experienced staff for persons 14:18
26 with learning disabilities?
27 A. This Board? No. That would have been discussed
28 elsewhere.
29 55 Q. Okay. And would the same then apply to the question of

1 the break down of community placements, in other words
2 where placements in the community had broken down for
3 any number of reasons?
4 A. Not at this Board, no.
5 56 Q. Okay. You were then asked, and you've set out to help 14:18
6 us understand -- asked about, and you've set out to
7 help us understand the arrangements in place at
8 Directorate level to monitor:
9
10 "Staff implementation of and adherence to Trust 14:18
11 policies.
12 Nursing staff adherence to professional nursing
13 standards.
14 Clinical staff adherence to professional clinical
15 standards." 14:19
16
17 And looking specifically at the arrangements for
18 monitoring adherence to professional nursing standards,
19 on page 12 at paragraph 52 and 53, you observe that:
20 14:19
21 "A failure to adhere to professional nursing standards
22 is often identified and treated in the way that any
23 other failure to meet standards is identified, being
24 for example, an incident, a safeguarding issue, the
25 subject of a complaint or a disciplinary issue.
26
27 The Directorate of Nursing also retained Director
28 responsibilities for professional nursing standards
29 within the ASPC Service Area, through professional

1 lines of accountability."
2
3 Casting your mind back, would you have expected
4 concerns around nursing standards resulting in a
5 safeguarding issue to be escalated to you as Director, 14:19
6 or dealt with locally by the Service Manager involved?
7 A. Could you maybe just repeat that again so I'm clear?
8 57 Q. Yeah. Thinking back to your role as Director between
9 '12 and '16, would you have expected concerns around
10 nursing standards, resulting in a safeguarding issue, 14:20
11 would you have expected that to come to you as
12 Director? To be escalated, in other words, to you, or
13 would you have expected that to be dealt with at the
14 local level by a Service Manager?
15 A. The majority of occasions they would have been dealt 14:20
16 with locally and through the professional line
17 management structure.
18 58 Q. Okay. And were there circumstances in which you would
19 have expected some report on it to come to you as
20 Director? 14:20
21 A. Not if it wasn't a significant one. I'm just not sure
22 about the use of the term "safeguarding".
23 59 Q. Yeah.
24 A. Because there are numerous types of incidents that can
25 happen on a ward in relation to practice. 14:21
26 60 Q. Yeah.
27 A. And at that time they're all reported, and I think in
28 my time it actually was called Vulnerable Adults Policy
29 and maybe not Safeguarding? Now, I'm not sure if

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1 that's right or not. But that doesn't mean that there
2 actually -- it's reported by either a patient or
3 another member of staff, it doesn't mean that it's
4 valid at that stage or that some action has to be
5 taken. 14:21
6 61 Q. So I we cast it further, say a set further and say for
7 instance a nurse or a healthcare assistant for that
8 matter within the Trust, within the hospital, was to be
9 prosecuted for a criminal offence...
10 A. Mhm-mhm. 14:21
11 62 Q. Would you have expected to have been informed about
12 that?
13 A. Absolutely. And way before they're prosecuted.
14 63 Q. Okay.
15 A. And I do remember -- and I equally would have escalated 14:22
16 that to the Board.
17 64 Q. Yeah. And you do remember, sorry?
18 A. I do remember occasion that there was an incident that
19 happened before my time.
20 65 Q. Yeah. 14:22
21 A. And the prosecution of the nurses took place in I think
22 maybe 2012/2013.
23 66 Q. Okay.
24 A. And the minute that I was notified that the prosecution
25 was going... 14:22
26 67 Q. So the incident took place before your tenure?
27 A. Before my time.
28 68 Q. But notice of the prosecution happening --
29 A. Yeah.

1 69 Q. Okay.
2 CHAIRPERSON: So just so that there's clarity on that.
3 Any prosecution of any member of staff would have got
4 to the Board?
5 A. Yes. And I would - yes, the relevant Director would 14:22
6 have taken that to the Board via the Chief Executive.
7 CHAIRPERSON: And who would be the relevant Director?
8 Would you have been the relevant Director?
9 A. Yes. If it was a prosecution within Adult Social and
10 Primary Care Services, yes. I would also be fairly 14:23
11 certain that -- I mean I don't mean prosecution as in
12 the day that it's happening and they're prosecuted, if
13 prosecution was being taken, action being taken, that's
14 the stage that I would have alerted the Chief
15 Executive. 14:23
16 CHAIRPERSON: Right. Thank you.
17 PROFESSOR MURPHY: So can I just clarify? That
18 presumably applies to the Ennis Prosecutions as well,
19 does it?
20 A. It does, yes. 14:23
21 PROFESSOR MURPHY: Yes. So they did come through you,
22 the fact that staff were being prosecuted in relation
23 to the allegations in Ennis?
24 A. Yes. And my understanding - I don't have access to it,
25 you will have access to it, and you will see it in the 14:23
26 Exec team meetings where I reported that the members of
27 staff were being prosecuted, and you will also see it,
28 I think, in Trust Board minutes.
29 PROFESSOR MURPHY: I'm still struggling with your

1 statement right at the beginning that you had no
2 concerns about abuse in Muckamore. I mean, despite the
3 fact that there were those prosecutions going ahead,
4 you still had no concerns?
5 A. It's hard to describe about concern. This -- I'm 14:24
6 trying to think of how -- it's hard to describe what
7 you mean by "abuse", right. Ehm, the Ennis, which you
8 have heard about a lot, I was actively involved in that
9 and, yes, there were problems in that ward and, yes,
10 there was mistreatment of staff, but -- and we dealt 14:24
11 with that.
12 CHAIRPERSON: Do you mean staff, or patients, or both?
13 A. I mean mistreatment of patients by staff.
14 CHAIRPERSON: Right.
15 A. Ehm... 14:25
16 PROFESSOR MURPHY: But, for example, the person in
17 charge of the ASG Investigation in relation to Ennis
18 thought there was institutional abuse going on. But
19 did that not, did that not seem to you to be a major
20 worry? 14:25
21 A. No, I'm sorry, it didn't.
22 PROFESSOR MURPHY: Because you just didn't see it, is
23 that what you're saying?
24 A. No, no, it's not that I didn't see it. I didn't share
25 that view. Right. I have a much broader, overall 14:25
26 view. As I said earlier, I used the word about
27 triangulating all sources of information. Okay? I
28 have engagement with the staff, I have visited the
29 site, I have talked to relatives, I've talked to some

1 of the patients on occasions, I have RQIA - unlike
2 acute services, Muckamore Abbey Hospital was a
3 regulated service, subject to unannounced inspections.
4 I received every one of those inspection reports. I
5 signed off every one of those personally. The quality 14:26
6 improvement plans. I had my governance structure of
7 reviewing monthly accidents, incidents, complaints.
8 Mairead Mitchell, who was the Quality and Governance
9 Manager that covered complaints, accidents, incidents,
10 RQIA inspections, we met on a monthly basis. I signed 14:26
11 off every individual complaint within my Directorate
12 for four years, and ensured - not just did a response -
13 Mairead drafted the response through managers and
14 things, but I was always curious, always asking the
15 questions about, "Mmm, can you go back with the ward 14:27
16 and check about, well, why would the parent think
17 that?", you know. Mairead very often met with the
18 parent or relative that was making the complaint to do
19 a face-to-face. So I had to triangulate all of this
20 information, and I did not have - I do not share the 14:27
21 view about institutional abuse.
22 PROFESSOR MURPHY: Okay. Thank you very much.
23 70 Q. MR. McEVOY: We've talked about the example of whether
24 notification of prosecution would come on to your radar
25 and what you might do, and you've given your answer 14:27
26 there. What about instances where a nurse was reported
27 to the NMC, or a doctor, for that matter, to the GMC.
28 A. Yeah.
29 71 Q. Regulatory concerns or issues. Would you have been

1 notified in that instance?
2 A. Yes, I would have been notified of that probably by
3 either Brenda Creaney or the Medical Director, yes.
4 72 Q. All right. And would you then have escalated that in
5 the same way as a prosecution? In other words to the 14:28
6 Board or to the Chief Executive?
7 A. Actually I'm not sure about that, to be honest with
8 you. I think it might have been for the Executive
9 Directors to escalate that.
10 73 Q. Okay. You had touched on the RQIA there, and at 14:28
11 paragraph 58 at the top of page 14, and this is your
12 development really of issues, where were identified how
13 they may have been, if at all, escalated. And at 58
14 then you say that:
15 14:28
16 "Regular reports on RQIA inspections, action plans and
17 progress on improvements made were presented and
18 considered at my one to one meetings with John Veitch,
19 my SMT meetings, at ASPC Directorate
20 performance/accountability meetings and at Trust Board
21 /Trust Governance Group."
22
23 I suppose it might be useful then to turn across also
24 to paragraph 85, I think, which is on page 20. It is
25 towards the end of your statement, but for completeness 14:29
26 say sake you observe there that you:
27
28 "...forged a constructive relationship with RQIA as a
29 Regulation and Inspection Agency and I relied on the

1 reports as an "outside" view of the standard of care
2 being provided."
3
4 So the Inquiry has heard evidence, not least from Chief
5 Executive of the RQIA and others, that there were five 14:29
6 serious concerns meetings held by the RQIA in respect
7 of Muckamore between 2014 and 2016, in other words
8 during your tenure. Do you recall being aware of those
9 serious concerns meetings?
10 A. Mmm. Have you any more information you can give me? 14:30
11 74 Q. Well, do you recall attending serious concerns meetings
12 with the RQIA about Muckamore? One would have thought
13 - put it like this, one would have thought that it's
14 the sort of thing you might remember? If you don't,
15 you don't. 14:30
16 A. I don't. I recall, ehm, having annual meetings with
17 RQIA doing a review of their concerns across Mental
18 Health and Learning Disability. I recall having
19 meetings with the RQIA about another facility in LD,
20 Iveagh Centre. 14:31
21 75 Q. Mhm-mhm.
22 A. But if you have maybe more information would help jog
23 my memory?
24 76 Q. Well, if you don't recall being at serious concerns
25 meetings, you don't recall being at serious concerns 14:31
26 meetings, if I can put it like that?
27 A. Well, yes, but I might be able to be jogged - my memory
28 jogged, if you were, you know.
29 77 Q. Well, if you don't recall being at serious concerns

1 meetings, and there were five of them during the course
2 of your tenure, according to the RQIA who have given
3 evidence, and the evidence is on the Inquiry website,
4 who do you think would have been in attendance from
5 your Directorate at those sorts of meetings, or who 14:31
6 would you have expected to have been in attendance?
7 A. I would have expected at the very least John Veitch.
8 78 Q. Okay. You don't recall seeing any reports prepared by
9 the RQIA during that time which caused you to be
10 concerned at any point of time, or do you? Do you 14:32
11 recall?
12 A. About these meetings or not?
13 79 Q. Yes. Or indeed any RQIA meeting.
14 A. Well, I saw every RQIA inspection report.
15 80 Q. Right. 14:32
16 A. And I was always concerned about them. There were
17 always very worthwhile recommendations in it. I
18 previously said I signed off in every one of those,
19 because you have do a quality improvement plan from
20 those, and I signed those off and they went through the 14:32
21 Chief Executive's office.
22 DR. MAXWELL: So did you have a system for monitoring
23 that those improvement plans were being delivered?
24 A. Yes.
25 DR. MAXWELL: And can you just tell us what that was 14:32
26 and how you assured yourself that every recommendation
27 they made had been addressed?
28 A. It was through John Veitch as the Co-Director. So
29 every, every RQIA report actually came in to my office,

1 it would have been on the agenda of the meeting with
2 John that month. Mairead Mitchell was the person then
3 that worked with the teams to come up with the quality
4 improvement plans to meet the recommendations. I
5 introduced actually a system that once we submitted the 14:33
6 quality improvement plans I then wrote to the ward to
7 acknowledge the inspection, to talk about the good
8 points, and to say that there are a number of
9 recommendations and I look forward to hearing, and then
10 Mairead would have done a review, I think it was every 14:33
11 quarter. And actually we had to -- I presented then to
12 Trust Board, not the detail, but the high level, that
13 there were three inspection reports with six
14 recommendations made - this is to Trust Board - and we
15 have achieved four to date and two are outstanding, and 14:34
16 then RQIA would have done a repeat inspection.
17 DR. MAXWELL: So you're saying you would have signed
18 off the quality improvement plan and Mairead Mitchell
19 would have been doing a regular review that the actions
20 were being delivered? 14:34
21 A. Yes. But at the end of the day it was for Esther
22 Rafferty and the team on the Muckamore Abbey site to
23 implement.
24 DR. MAXWELL: No, they were responsible for doing it,
25 but Mairead was providing the assurance. She was going 14:34
26 and checking regularly with Esther Rafferty and others.
27 A. Yeah. No, they were giving Mairead -- it was really
28 for John Veitch to assure himself on a month by month
29 basis that it was being delivered.

1 DR. MAXWELL: So are you saying Esther Rafferty was
2 supplying information to Mairead Mitchell?
3 A. Yes.
4 DR. MAXWELL: And she wasn't doing an independent
5 evaluation of the information she was given, she was 14:34
6 just entering it on to --
7 A. Yes. Yes.
8 DR. MAXWELL: And that the responsibility for making
9 sure that what was said was being done was actually
10 being done, was with John Veitch? 14:35
11 A. Well, I would probably say with Esther Rafferty.
12 DR. MAXWELL: But if she was the one providing the
13 information -- so often you have two -- you've talked
14 yourself about triangulation. Often you want a number
15 of sources to reassure yourself. So he was her line 14:35
16 manager, so he was the person ultimately responsible?
17 A. Yes. Yes.
18 DR. MAXWELL: Okay.
19 81 Q. MR. McEVOY: The next topic then you were asked to help
20 us with was performance management processes which 14:35
21 might have been in place to monitor and improve the
22 performance of all staff, including those in leadership
23 positions at the hospital. And at paragraph 59 then
24 you tell us that:
25
26 "Each Directorate was subject to regular accountability
27 and review meetings with the Chief Executive and other
28 professional Executive Directors. The performance of
29 Directorates was measured against both the

1 Directorate's annual plan and objectives, and the
2 Belfast Trust's Corporate Plans and objectives."
3
4 A little bit earlier in your statement you mentioned
5 the Board Assurance Framework. Was performance 14:36
6 measured against it as well?
7 A. Ehm, I don't recall.
8 82 Q. Okay.
9 A. I don't recall.
10 83 Q. You have included at tab 9 - looking across to page 15 14:36
11 and paragraph 63 - you've included at tab 9 the
12 Investors In People Report for the ASPC, and you've
13 noted then that:
14
15 "...the Directorate Management Plan described in detail
16 the complexity and range of services provided to
17 service users across 50 locations in the Belfast
18 Trust."
19
20 You tell us that:
21
22 "The report was very positive about the performance
23 management of staff within ASPC. For example, it
24 concluded that ownership and responsibility are
25 encouraged, evaluation results in improvements,
26 self-review techniques and information from external
27 reviews and used to improve people management
28 strategies."
29

1
2 Can I ask you just to open page 67 within that report,
3 and looking down - this is a paragraph headed "Areas
4 For Development", and looking down through that
5 paragraph, sorry, through that passage, we see at 14:38
6 paragraph 3 the report writer commenting that:
7
8 "Although it may seem a simplistic approach, I would
9 suggest, that if the leadership and management issue is
10 addressed, other issues will be positively impacted." 14:38
11
12 The report writer then goes on to comment:
13
14 "The evidence presented in this report suggest that
15 there is a considerable degree of inconsistency in the
16 application of agreed strategies and processes for
17 leading, managing and developing people. There is no
18 doubt that the processes and strategies are in place
19 however, levels of ownership and accountability for
20 their implementation vary across the management team
21 and within service areas."
22
23 The report writer then goes on to observe:
24
25 "That is not to say that managers are not doing their
26 jobs; people are very committed to the work they do and
27 their teams. There are many examples of excellent
28 practice, but I believe that everyone in a
29 leadership/management role could benefit from exploring

1 the role to gain an understanding about the
2 capabilities and behaviours that are needed to be
3 effective in the role."
4
5 Is there anything you would like to say about what is 14:39
6 said in those paragraphs within the IIP Report?
7 A. Only to say actually I saw that as a wonderful
8 opportunity, because it was in a report where they had
9 awarded us and they had awarded the Trust a Bronze
10 Award, and it was a great opportunity that here were 14:39
11 the areas of development for the Directorate. And when
12 it talks about the teams, you've got to remember they
13 interviewed 120 staff face-to-face at all different
14 levels in the organisation, across all my programmes of
15 care, and I saw it as an opportunity. I actually just 14:39
16 retired shortly after this report was implemented/, and
17 that they would be able to devise a plan to do further
18 work in the years ahead.
19 84 Q. So you feel then that the recommendations and the
20 observations made there were recognised and implemented 14:40
21 to some extent?
22 A. I would think so, yeah.
23 85 Q. Right. Now at paragraph 68, you are addressing the
24 question of workforce monitoring within your
25 Directorate and within your SMT in particular, and you 14:40
26 have exhibited, again helpfully, an example of the
27 Workforce Information Report, and you've set out for
28 us, listing them, the various heads and fields of
29 information within the report: The number of staff,

1 number of bank staff, number of staff on career break,
2 new starts and leavers, temporary staff, the amount of
3 spend, absence rates, and the age profile. Do you
4 recall whether figures would have included specific
5 numbers for the use of agency staff as against 14:41
6 permanent staff at each hospital over a set period of
7 time?
8 A. As in each hospital, what do you mean? I only had one.
9 I had only the Mental Health and Learning Disability.
10 86 Q. Yeah. 14:41
11 A. Yeah.
12 87 Q. Yeah. I mean for the purposes of your own Directorate,
13 would you have had specific data which would have
14 allowed you to look at specific numbers of agency
15 versus permanent staff within a given time frame? 14:41
16 A. I'm not sure if I understand your question. We always
17 - staffing - we always know the number of permanent
18 staff, okay, and the staff in post, and then this
19 information here was telling you the number of bank
20 staff. 14:42
21 88 Q. Yep.
22 A. And the number of career breaks and things.
23 89 Q. Yes.
24 DR. MAXWELL: But do you not collect shift by shift
25 fill rates and say that "On average in this month 20% 14:42
26 of shifts were filled by agency"? Were you collecting
27 that sort of data?
28 A. Not me personally.
29 DR. MAXWELL: Well, did you see data like that?

1 A. I would have seen data in particular that showed about
2 the amount of overtime.
3 DR. MAXWELL: So it would tell you the percentage of
4 shifts filled by overtime, would it?
5 A. No, it would have been the overtime hours. 14:42
6 DR. MAXWELL: Because there's a difference between
7 collecting hours, which is for finance, "how much has
8 this service costed me?", and actually working out the
9 percentage of work done through overtime or agency,
10 which tells you much more about the quality of the 14:43
11 service, and you're saying you were just being told the
12 total number of hours of each type?
13 A. Yes, and I'm not sure - I don't know and I can't
14 answer, but I'm not sure that it would have been looked
15 at that way then. I'm not sure. 14:43
16 DR. MAXWELL: Okay.
17 90 Q. MR. McEVOY: Then at paragraph 69, the next paragraph,
18 you tell us that when you became Director of ASPC you
19 were aware of the nurse staff challenges, staffing
20 challenges within Muckamore Abbey. You observed that: 14:43
21
22 "With a well-established regional resettlement
23 programme and wards closing and/or merging, the patient
24 population was reducing. This made the recruitment and
25 retention of staff in Learning Disability services a
26 challenge."
27
28 I suppose one conclusion, and it may not necessarily be
29 the right one, but one conclusion that one could form

1 on reading that is that staffing, and the issue of
2 staffing at the hospital, could have been compromised
3 in order to release funds for resettlement, whether
4 deliberately or unintentionally, that's one conclusion
5 that one could draw from what you've set out there. 14:44
6 Would you accept that? And I suppose if you disagree,
7 please, say so.
8 A. It was never -- if I've understood your question right,
9 was it a financial issue?
10 91 Q. Yes. 14:44
11 A. Right. No, it was never due to lack of funding, or
12 support of funding, or the transition between, you
13 know, Muckamore Abbey and resettlement. There was a
14 big issue about insufficient funding in the community
15 to make this all work, but in relation to Muckamore 14:45
16 Abbey, the staffing issue was not about money.
17 DR. MAXWELL: So was there ever any suggestion that we
18 - in order to unblock this issue of getting people into
19 the community, which is better for them, that we should
20 move some of the funding from Muckamore Hospital into 14:45
21 the community so that we can resettle more patients?
22 A. My understanding is, is that's - that was part of the
23 plan was this transition, as wards closed then the
24 money was transferred to the community.
25 DR. MAXWELL: And we heard yesterday that there were 14:45
26 targets set for managers about the number of
27 resettlements.
28 A. Yes.
29 DR. MAXWELL: So is it possible that any managers felt

1 "We need to close this ward in order to release money
2 to help resettle patients"?
3 A. No.
4 DR. MAXWELL: Because we have heard that some wards
5 closed quite suddenly. We've heard two or three 14:46
6 occasions where people said they closed very suddenly.
7 A. Yeah.
8 DR. MAXWELL: That wasn't to release money for
9 resettlement?
10 A. It wasn't to release money for the community or 14:46
11 resettlement. I remember on occasion -- so as you are
12 reducing the patient cohort in Muckamore Abbey
13 Hospital, what you might do is there might have been
14 patients from two different wards, and maybe you end up
15 with -- and we had a planned programme of when wards 14:46
16 would close based on when the resettlement would take
17 place, but sometimes things changed and it was a
18 different patients, or we got different community
19 placements. So you could end up with a ward, two
20 wards, with say only 10 patients in them. And when you 14:46
21 have an issue about staffing and ensuring that you have
22 adequate staffing across the site, there is a core
23 minimum staffing level, so therefore to staff two
24 10-bedded wards takes more staff pro rata than to staff
25 one ward. So I do recall, I can't remember what wards 14:47
26 they were, but on occasions where a decision was made
27 that we will close this ward earlier and move the
28 patients into the other ward to make it into a bigger
29 ward so it would be easier to staff.

1 CHAIRPERSON: You say that that wouldn't result in
2 movement of money from the hospital to social care, but
3 it would have resulted in a saving for the hospital?
4 A. It would have eventually moved money. My memory is
5 that some of the money from Muckamore Abbey funding 14:48
6 would eventually move to the community, but in the
7 interim years, and I think it was through the Health
8 and Social Care Board, there was like interim funding
9 to bridge that gap so that we weren't relying on,
10 "Right, we have to close this ward because the 14:48
11 community needs this money for the patients to come
12 in", so that there was like an interim bridging finance
13 to allow that to happen.
14 CHAIRPERSON: So the closing of a ward would be, would
15 have a dual purpose, I suppose? First of all, it would 14:48
16 make staffing, or it looks like it makes staffing
17 slightly easier.
18 A. Mhm-mhm.
19 CHAIRPERSON: And it saves a bit of money.
20 A. Saves a bit of money - for Muckamore Abbey Hospital? 14:48
21 CHAIRPERSON: Yeah. Does it not work like that?
22 A. No. Saving a bit of money was never the issue or the
23 purpose.
24 DR. MAXWELL: Because you're still employing the same
25 number of staff, you're just putting them on one ward. 14:49
26 Is that what you're saying?
27 A. Ehm, remember we had a large number of temporary staff
28 because - and the issue wasn't about funding there, it
29 was that people were not available or were not

1 interested in temporary posts. We weren't going to
2 recruit into permanent posts.
3 DR. MAXWELL: The question I'm asking is, if you decide
4 to merge two wards...
5 A. Yes. 14:49
6 DR. MAXWELL: Does that mean that everybody on the two
7 separate wards goes to work on one ward?
8 A. Yes.
9 DR. MAXWELL: Or does it mean that you increase the
10 staffing slightly on that one ward, and some of the 14:49
11 temporary staff you don't need any more?
12 A. Generally it was all the staff were needed in the
13 Muckamore Abbey Hospital site. Yeah. What we maybe
14 would have done was reduced over time. But, again,
15 that wasn't the purpose of it. The purpose of it was 14:50
16 to provide safe effective care within, you know, the
17 staffing structure that we had.
18 PROFESSOR MURPHY: Was it always in the patient's best
19 interests then, do you think?
20 A. Resettlement? 14:50
21 PROFESSOR MURPHY: No.
22 CHAIRPERSON: No.
23 PROFESSOR MURPHY: The combination of wards?
24 A. Ehm, was it disruptive them? Sometimes, yes, probably.
25 Ehm, but in their best interests, yes. If the 14:50
26 professional judgment was that it was better to manage
27 the staffing and provide the staffing and the cover,
28 then I think it was in their best interests.
29 CHAIRPERSON: And when you say professional judgment...

1 A. Yeah.
2 CHAIRPERSON: Which profession?
3 A. The nurses and the doctors on site.
4 CHAIRPERSON: So that would be led by the nurses and
5 the doctors, would it, not by the management? 14:51
6 A. No, management would make the decision, but they're
7 taking advice and information from Esther Rafferty, who
8 was the Associate Director of Nursing, would be saying
9 "I'm really struggling to provide cover in both these
10 wards, it's a battle every day, I'm moving people 14:51
11 around. Look, we've only eight patients in this ward
12 now and we've only six in this", and then she would
13 have talked to John Veitch about that and they would
14 have said "Right, we will bring forward then the
15 amalgamation in the ward." 14:51
16 CHAIRPERSON: And would an amalgamation like that have
17 reached your desk, or would it be --
18 A. I would, I would have imagined that John would have
19 said it - told me about it in the one-to-ones.
20 DR. MAXWELL: Was that after he had done it or was he 14:51
21 seeking your permission?
22 A. No, as he, as he was planning it, yeah.
23 DR. MAXWELL: So he was seeking your permission?
24 A. He was seeking my support.
25 DR. MAXWELL: Well, ultimately there has to be a chain 14:52
26 of who is making the decision, and I'm asking were you
27 the person who had to make the final decision to agree
28 to do it?
29 A. Ehm, yes, that's probably fair to say. Yeah.

1 CHAIRPERSON: And would you have enquired about what
2 the process was in terms of speaking towards staff,
3 making sure they knew well in advance what was
4 happening, preparing patients who might take quite a
5 bit of preparation, would that be part of your sort of 14:52
6 assuring that patients weren't harmed as a result?
7 A. Well, that would have been part of my probing and my
8 questioning, yeah. I think the other thing is I'm
9 nearly sure that on those occasions, whether it was
10 approval or whether it was discussion with RQIA and the 14:53
11 Health and Social Care Board, would have taken place
12 before that was done.
13 CHAIRPERSON: What, before a ward was amalgamated?
14 A. Yes. In advance of the plan.
15 CHAIRPERSON: To seek the RQIA approval? 14:53
16 A. Well, as I said, I'm not sure about approval. It would
17 have been to say to them, listen, you know...
18 DR. MAXWELL: So do they regulate the hospital or the
19 ward? Because if they regulate the ward, they'd have
20 to give approval, but if they're only regulating the 14:53
21 hospital, the way the patients are dispersed within it
22 wouldn't require their permission?
23 A. I think the - again, I don't know. RQIA would need to
24 answer that. But my view is they're not regulating the
25 hospital or wards, they're regulating the service. 14:53
26 DR. MAXWELL: But part of that is regulating the
27 provision of the service and the way it's provided.
28 A. Yes.
29 DR. MAXWELL: Which would be at ward level. But, yeah,

1 we can ask the RQIA.
2 92 Q. MR. McEVOY: You were then asked what you recall about
3 processes in place to provide career development
4 opportunities at Muckamore Abbey to ensure staff had
5 the required specialist skills to deliver care in a 14:54
6 learning disability facility. And you tell us then
7 that, the Co-Director, that's Mr. Veitch:
8
9 "...had managerial responsibility to ensure that there
10 were effective arrangements in place for training and
11 career development opportunities."
12
13 You also then go on at 73 to say that:
14
15 "...it would have been the role of the Service Manager
16 (who was also the Associate Director of Nursing), with
17 input from the Clinical Director, Psychology services
18 and Social Work, to determine what specialist skills
19 were required to deliver care and what opportunities
20 were required in order to provide staff with those
21 specialist skills."
22
23 Did your Directorate monitor whether Muckamore Abbey
24 staff had the requisite skills to meet patient needs?
25 A. I am not sure whether I can answer that. The 14:55
26 specialist skills and knowledge that's required to do
27 that is in the recruitment process of the professionals
28 on the ground, so we already know they meet that. All
29 members of staff within Belfast Trust had annual

1 appraisal system which was also about development and
2 skills enhancement, and the professional lines all had
3 professional supervision, which was like on a monthly
4 basis, which was the opportunity to look at challenges
5 and the skills and opportunities for development. 14:56
6 93 Q. Okay.
7 DR. MAXWELL: But you had a Directorate Modernisation
8 Group, and that was looking at different ways of
9 providing services as new evidence comes on board.
10 A. Yes. 14:56
11 DR. MAXWELL: And so even if you've recruited people
12 who had the right skills, by the time you recruited
13 them life and treatments move on. An example of that
14 in MAH might be Positive Behaviour Support. So a lot
15 of people had been in post a long time before that was 14:56
16 an approach that was being adopted, and presumably to
17 introduce a new approach like that, you would have to
18 have a view that, "Well, we need 20 people trained this
19 year in Positive Behaviour Support." Did you have that
20 sort of discussion and monitoring of whether the staff 14:56
21 had the skills to implement new approaches?
22 A. Personally myself, I wouldn't think so. I don't recall
23 that. However, I do recall that - and I don't recall
24 the name of the group that Brenda Creaney chaired that
25 was all about nursing workforce. 14:57
26 DR. MAXWELL: But Brenda wasn't the person to decide
27 what the skill sets needed at Muckamore Abbey were,
28 because --
29 A. As Executive Director of Nursing she had oversight of

1 all of that, and then she had the various Associate
2 Directors of Nursing as part of her team, of who Esther
3 Rafferty was one.
4 DR. MAXWELL: So I can understand that she might be
5 responsible for the delivery because she was talking to 14:57
6 ECG about what to commission for post-Reg education,
7 and I understand that, but surely it's the Directorate
8 that has to say "We're moving in a new direction with
9 treatment and, therefore, our existing staff need to
10 develop skills in X", in order for Brenda to then say 14:57
11 "Okay, how are we going to deliver this?". It's not
12 for Brenda to decide whether you use Positive Behaviour
13 Support in Muckamore?
14 A. You've given that one example, which I can't really
15 talk to. 14:58
16 DR. MAXWELL: Okay.
17 A. I don't recall that. I think it comes both ways,
18 because there would have been a lot of things that
19 Brenda would have become aware of, and she would have
20 raised it through the group, and also it would have 14:58
21 come from Esther Rafferty. And sometimes it would have
22 come from places like RQIA. I can remember the example
23 of the Iveagh incident again, where there was an issue,
24 and I don't know whether it's called positive behaviour
25 or whatever, but there was an issue about the way staff 14:58
26 engaged with the young people, and how to - rather than
27 de-escalate, which people were trained to do, was to do
28 positive behaviour so that it doesn't escalate in the
29 first place to de-escalate. And we did a huge piece of

1 work around that, and it was RQIA with a lot of advice
2 and guidance, and we ended up doing training for I
3 think all of the staff in the Iveagh Unit.
4 DR. MAXWELL: So when you were in post, did Belfast
5 Trust have an electronic staff record? So in - sorry 14:59
6 to invoke England, which isn't necessarily a centre of
7 excellence, but in some English Trusts they have an
8 electronic staff record where they will list all the
9 training. So as a manager you can ask them to run a
10 report saying how many of my staff who have been 14:59
11 trained in Positive Behaviour Support, did you have
12 access to anything like that?
13 A. Yes, I think so. I don't know what we would call it.
14 The other thing is you've got to remember, I think, I'm
15 nearly sure, we had mandatory training it was called. 15:00
16 DR. MAXWELL: Yes, but that wasn't usually clinical,
17 was it?
18 A. I think there was a clinical module in that.
19 DR. MAXWELL: Okay.
20 A. And it was reported on and measured. And, for 15:00
21 instance, the annual appraisals for professional staff.
22 DR. MAXWELL: Yep.
23 A. It had to be recorded every year. It was produced to
24 Trust Board.
25 DR. MAXWELL: And that went on electronic record rather 15:00
26 than paper record?
27 A. I'm nearly sure. I don't know, but maybe ask somebody
28 else. But certainly I had information that would have
29 - and I think it's in one of these reports maybe - that

1 80% of my staff had their annual appraisal this year.
2 DR. MAXWELL: Okay.
3 94 Q. MR. McEVOY: Okay. You're then asked to provide
4 details of any occasions on which you became aware of
5 concerns over the abuse of patients by staff at 15:00
6 Muckamore Abbey, and to describe your recollection of
7 action taken at Directorate level to address such
8 concerns.
9
10 At paragraph 78 on page 19 you say that there was only 15:01
11 one occasion which you can recall a concern of abuse of
12 patients by staff, that being Ennis, which we touched
13 on, and I don't propose to go back over it.
14
15 At 79 you say then that: 15:01
16
17 "There were other occasions on which there were
18 allegations of staff on patient incidents having
19 occurred. The majority of these allegations were
20 reported and investigated at local level."
21
22 Now, do you recall - it would have been during your
23 tenure that CCTV was installed at Muckamore Abbey
24 Hospital in 2015. Do you recall the decision being
25 taken? 15:01
26 A. Okay. So I have a very vague - I remember last year
27 when I was thinking about this and looking at some
28 papers, and forgive me if this isn't all right - isn't
29 correct.

1 95 Q. That's fine.
2 A. But I have a very vague memory. We had a process -
3 CCTV fits in with IT equipment, or something like that,
4 and there was like a Board that met every three months
5 that approved Directorates' business cases for whatever 15:02
6 the next software, or whatever. Right.
7 96 Q. Can you remember the name of that Board off the top of
8 your head?
9 A. It was chaired by the Director of Performance Planning
10 and IT. 15:02
11 97 Q. Was that at Trust level?
12 A. Yes, it was at Trust level. So it might have been
13 Shane Devlin or somebody like that chairing it. And I
14 have a memory that Brendan Ingram was - I don't know
15 what his title was? Was he like a Business Manager in 15:02
16 the Muckamore Abbey Hospital site? So Brendan was
17 doing a business case for CCTV in Muckamore Abbey
18 Hospital.
19 98 Q. Mmm.
20 A. And the process seemed to take quite a number - a long 15:03
21 time. All right. And then he -- each quarter I was
22 presenting a lot of, particularly older people and
23 Social Services, a lot of bids. We only had a budget
24 of like 15,000 a year, but Brendan Ingram then
25 presented this to the Capital meeting, I think it might 15:03
26 have been called "Capital Bids Meeting" or something
27 like that, and got approval to that.
28 DR. MAXWELL: So this was funding additional to the
29 15,000 that you held? You said you had a budget of

Gwen Malone Stenography Services Ltd.

1 15,000 for the whole Directorate.
2 A. Yes.
3 DR. MAXWELL: Which does sound very small.
4 A. I know.
5 DR. MAXWELL: Are you saying that Brendan produced a 15:04
6 business case that went to the Trust wide committee?
7 A. Yes.
8 DR. MAXWELL: And they found money in addition to that
9 15,000 that you held?
10 A. I think that's the way it worked, I think that 15:04
11 centrally they held some extra. I think the business
12 case might have been several times to this meeting, but
13 was never prioritised, because when you've a small
14 budget like that and there are so many schemes across
15 the whole Trust. So I think it took several goes at 15:04
16 the meeting before it was approved.
17 99 Q. MR. McEVOY: Okay.
18 A. After that, I have no memory of it actually physically
19 being installed. It would have had to have gone out to
20 tender, I assume. 15:04
21 100 Q. All right. And then in fairness to you at paragraph
22 80, a little bit earlier we talked about escalation and
23 how you might have come to be aware of them, and we
24 just talked about instances of prosecution or
25 regulatory proceeding. And here, in fairness to you, 15:05
26 you go on to say then you would be advised of such
27 matters by Mr. Veitch, who would have kept you
28 appraised of, as appropriate, incidents he deemed
29 significant:

1
2 "...where the RQIA or other agencies were involved, where staff were suspended, where the incident met the criteria for an Early Alert or SAI as per regional
5 policy." 15:05
6
7 Was there any type of, not something as formal,
8 perhaps, as a policy, but was there any kind of
9 document that set out between yourself and Mr. Veitch
10 where an incident might have been escalated to 15:05
11 Directorate level?
12 A. No, we would have -- John was a very experienced
13 Co-Director.
14 101 Q. Yes.
15 A. And we would have had the discussion. And I think 15:05
16 escalation to me means a couple of things.
17 102 Q. Yeah.
18 A. Escalation can mean just letting me know, right, just
19 letting me know so that you know, Catherine. John
20 might have lifted the phone to me to say "Look, I just 15:06
21 want to tell you that the RQIA Inspector is in today,
22 you see their feedback at lunchtime, just I'm not
23 entirely happy about it. Right. You don't need to do
24 anything, Catherine, but I'm just letting you know."
25 Or escalation might have been, this has happened, and 15:06
26 can we meet? I need your support, or I need your
27 guidance, or I need you to escalate it to the Chief
28 Executive. So it would have had different levels of
29 escalation.

1 103 Q. Yes. So much turned on the positive working
2 relationship between you and Mr. Veitch, as opposed to
3 a requirement for written records, or an audit trail,
4 as such, of encounters where these sorts of matters,
5 escalations and those sorts of related issues might 15:06
6 have been detailed?
7 A. Well, where you would see it generally is in my
8 one-to-ones with John, and I've exhibited an example.
9 104 Q. Yeah.
10 A. It might have been useful if I'd had them to exhibit 15:07
11 more examples.
12 105 Q. Yeah.
13 A. Page 55.
14 106 Q. 55 I think, yeah.
15 A. And I mean this is 2013, and you can immediately see 15:07
16 Muckamore Abbey Hospital discharges on it.
17 107 Q. Yeah.
18 A. Staffing in Muckamore Abbey Hospital. And No. 10
19 Muckamore Abbey Hospital Investigation, would have been
20 the Ennis Ward. 15:07
21 108 Q. Yeah. Yeah. Okay. So this is the outcome of a
22 one-to-one --
23 A. No, that's the agenda for the one-to-one.
24 109 Q. That's the agenda? Right.
25 A. We didn't do any minutes. 15:07
26 110 Q. Right. All right. And how often did one-to-ones take
27 place?
28 A. Once a month.
29 111 Q. Right. Okay.

1 A. Every month.
2 112 Q. Okay. All right. Now, turning then to paragraph 80
3 and what you say about not being informed about
4 concerns over individual incidents of abuse unless they
5 required escalation. Was there any means by which you 15:08
6 might have been advised of trends, for example, or high
7 concentrations? In other words, are there trends of
8 patient abuse or concentrations of such incidents in
9 particular wards at Directorate level?
10 A. Okay. So I'm not going to use the word "abuse", okay, 15:08
11 but, ehm, I'm going to refer to "accidents and
12 incidents" is the term that we use, is the language we
13 used in the Trust. There would have been hundreds - I
14 think it's somewhere in there. If we just take
15 Learning Disability, there would have been hundreds of 15:08
16 reported accidents and incidents, and the system was,
17 so it could be staff to staff, staff to patient, or
18 patient to staff, or miscellaneous. It would have been
19 everything from let's say a patient presented with
20 quite a large bruise on their arm one morning and a 15:09
21 nurse noticed it, right?
22 113 Q. Mhm-mhm.
23 A. But we're not aware of anything that went on. That
24 would be recorded as an incident, and then somebody
25 would have tried to do an investigation on it. Or if a 15:09
26 patient tripped on their way and banged against a wall,
27 that would have been recorded as an incident. If a
28 patient said "Nurse so and so pulled my hair", so
29 there's a whole range, there'd have been hundreds.

1 They were all analysed and produced in a report that my
2 senior management team, and I'm nearly sure the
3 governance meeting of mine, would have seen them on a
4 monthly and a quarterly basis.
5 DR. MAXWELL: So actually on page 42 you have got one 15:10
6 of those, your ASPC Governance Dashboard?
7 A. Yes.
8 DR. MAXWELL: And I think the point Mr. McEvoy is
9 trying to make is, it's quite stunning there that the
10 number of abusive, violent, disruptive, or self-harming 15:10
11 behaviours in LD Services rose from an average of 46 a
12 month in 2015/16, to 300 a month in 2016/17. So
13 whatever the explanation behind them, there was clearly
14 a lot of incidents happening. Do you - did you have a
15 discussion about this and why this might be? 15:10
16 A. Okay. Just, can I just clarify something about this
17 report?
18 DR. MAXWELL: Yeah.
19 A. The contents of it is valid, as in what it was
20 recording, but this actual report - and, apologies, I 15:11
21 maybe shouldn't have included it in that, it was just
22 illustrative - it was not in my time. So this report
23 which reflects the '16/'17 year wouldn't have been
24 produced until the summer. So I'm not the author of
25 it. 15:11
26 DR. MAXWELL: I appreciate that. But I think if we go
27 up we'll get the '15/'16 one.
28 A. Oh, great. Thank you.
29 PROFESSOR MURPHY: I think the line you were looking

1 at, Elaine, I think I had seen that before and I think
2 that's an error, the 46.
3 A. So do I.
4 PROFESSOR MURPHY: Because it says it's an average, but
5 it isn't the average. 15:11
6 DR. MAXWELL: Well, I haven't kept full notes, and I
7 apologise, but I went through your notes and noticed
8 this, and it may well be an error, but I'm just
9 wondering if there was any discussion about whether
10 there was an upwards trend. Because we have heard from 15:11
11 other people that there was an upwards trend in violent
12 and aggressive behaviour, mostly that was reported as
13 patient-on-patient or patient-on-staff,
14 A. Mhm-mhm.
15 DR. MAXWELL: But if there's an increase in that 15:12
16 general sort of tension and incidents, it's not going
17 to be safe for anybody, and potentially staff are
18 responding and there is unreported staff-on-patient.
19 A. Yeah.
20 DR. MAXWELL: So were you aware of any changes in the 15:12
21 number of these type of incidents before you left?
22 A. Ehm, I recall we would have frequently -- because
23 that's just data.
24 DR. MAXWELL: Yeah.
25 A. We would have frequently had discussions about "What 15:12
26 does that data mean? What is it telling us?" At my
27 senior manage -- that's a very high level dashboard.
28 At my senior team meeting level it was broken down into
29 staff-on-staff, patient-on-staff, staff-on-patient. We

1 would have debated, and I think there were occasions
2 where we saw an increase. Sometimes it wasn't
3 particularly to do - it could have been an increase
4 because of the reporting arrangement.
5 DR. MAXWELL: Well that's one of the things I was 15:13
6 wondering is, was there a change in the way this --
7 because often data changes when you change the way you
8 collect it.
9 A. Isn't that right? I don't recall precisely, but I do
10 know that we talked about it and I remember in one of 15:13
11 the meetings that we had when we were looking at
12 incidents, and Muckamore Abbey Hospital in particular,
13 and we were trying to get underneath it to see, that
14 when we did further analysis - and I'm not sure who had
15 provided the information for us - we were able to see 15:13
16 that the majority of incidents were happening between
17 three young - three - three of the male patients in
18 Muckamore Abbey.
19 DR. MAXWELL: So there were three patients with a very
20 high number of incidents? 15:14
21 A. Yes. And then we had the discussion about "So, what is
22 it about the three and why? If we concentrate on
23 reducing the impact of these incidents on these three
24 individuals, then that will have a big impact
25 elsewhere", and the teams were then tasked to go away 15:14
26 and look at that.
27 DR. MAXWELL: And just following up the point that
28 Mr. Kark made before, was this in any way related to
29 merging wards? Because we've heard some patients found

1 that very distressing?
2 A. I don't have a recollection of it being - I think two
3 of the patients might actually have been, I'm not sure,
4 in the Intensive Care Unit, so it's not impacted by
5 ward closures. 15:14
6 DR. MAXWELL: Okay. Thank you.
7 114 Q. MR. McEVOY: Then at paragraph 84, in response then to
8 the last matter, which was really an opportunity to you
9 to draw the attention of the Panel to any other matters
10 not covered in the questions which could assist in the 15:15
11 Panel's consideration of the Terms of Reference. At 84
12 you say that during your time as Director, you visited
13 Muckamore Abbey on a regular basis, often calling in to
14 speak to the Service Manager - which is something that
15 we spoke about a little bit earlier. 15:15
16
17 You say then:
18
19 "...sometimes to visit particular wards..."
20 15:15
21 Can you recall which particular wards you might have
22 visited?
23 A. Ehm, Ennis I was in.
24 115 Q. Yeah.
25 A. Well I was in on a weekly basis for a period of time 15:15
26 after the other thing.
27 116 Q. Yeah.
28 A. Ehm, the Intensive Care Unit.
29 117 Q. Yeah.

1 A. I was in at least two or three times. Erne.
2 118 Q. Mhm-mhm.
3 A. Is there a Donegore?
4 119 Q. Mhm-mhm.
5 A. Ehm, I met - I'm trying to think where it was. I 15:15
6 remember meeting with two or three of the patients...
7 120 Q. Yeah.
8 A. ...who were shortly to be resettled into the community.
9 I remember meeting them. Actually it might have been
10 in a house in the Antrim area somewhere. 15:16
11 121 Q. Yes.
12 A. Ehm, that's what I can remember.
13 122 Q. And you attended events such as the annual Carol
14 service and Friends of Muckamore meetings. And you
15 observed then you found: 15:16
16
17 "...a workforce who were dedicated, professional and
18 caring, despite working in difficult circumstances."
19
20 Which you take to mean then the changes being made to 15:16
21 the hospital, the needs of its patient population, and
22 continuing to care for patients who should have been
23 long since resettled into the community.
24 A. Could I just also add something about...
25 123 Q. Of course. Of course. 15:16
26 A. I have huge admiration for the professional staff that
27 work in that field. It takes a particular type of
28 person. I am Acute background all my life, I'm a nurse
29 by profession, and I think they had very specialist

1 skills and knowledge to work in that field day in and
2 day out for years.
3 124 Q. Okay. And, indeed, you go on then to praise your team;
4 Mr. Veitch, Ms. Mitchell, Ms. O'Kane and Ms. Rafferty.
5 And you say then at paragraph 88. 15:17
6
7 "...the professional Directors of Nursing, Social Work
8 and Medicine, along with the Chief Executive, were
9 always interested, supportive and professional..."
10
11 - when you needed their input or intervention.
12
13 As a final note then you say that you were particularly
14 taken aback and devastated to hear that patients were
15 being mistreated in Muckamore Abbey, when the staff 15:17
16 with whom you worked cared genuinely about the patients
17 in the hospital.
18
19 Is there any further reflection you want to add to
20 that? 15:18
21 A. Other than I, when I still think about it, it's still
22 distressing, just the thought that this can happen,
23 MR. McEVOY: Those are my questions, Ms. McNicholl, but
24 the Panel may have some extra questions in addition to
25 those already asked. 15:18
26
27
28
29

1 MS. McNICHOLL WAS THEN QUESTIONED BY THE PANEL AS
2 FOLLOWS:
3
4 125 Q. CHAIRPERSON: Could I just ask, in order to be fair to
5 you and really to understand where Muckamore lay in 15:18
6 your role, you were the Director of ASPC for what was
7 it, four years or thereabouts?
8 A. Mhm-mhm. Yes. Four years, yes.
9 126 Q. CHAIRPERSON: How much of your time was spent - how
10 much of your work was actually spent focusing on 15:18
11 Muckamore, in comparison to the other hospitals which
12 you had a responsibility for?
13 A. Are you looking a rough percentage?
14 127 Q. CHAIRPERSON: Yeah. Yeah. It's not an exact science,
15 I don't imagine. 15:19
16 A. Well, can I go back a wee bit to -- that if you -- you
17 have to take the percentage of my role that was a
18 corporate role as a Service Director sitting on the
19 Exec Team, contributing to the Trust.
20 128 Q. CHAIRPERSON: Yes. 15:19
21 A. That might have been 50% of my role. So let's say my
22 corporate role was 50% of my role, and then my service
23 role was another 50%. Okay. So I would say - I think
24 it was fairly equal between Older People Services,
25 Mental Health, and Learning Disability. 15:20
26 129 Q. CHAIRPERSON: And, of course, Muckamore is an important
27 part of Learning Disability, but it's not the entirety
28 of Learning Disability?
29 A. But it would have been the majority. The rest of it

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1 really was not a, you know, complex issue, the
2 community services.
3 130 Q. CHAIRPERSON: And we've asked you a bit about Ennis,
4 and you told us that Ennis effectively happened right
5 at the beginning of your role? 15:20
6 A. Yes.
7 131 Q. CHAIRPERSON: Did that not mean that there was or
8 should have been a greater focus on what was happening
9 at Muckamore, as compared to the rest of your
10 responsibilities, or did you have similar problems 15:20
11 elsewhere?
12 A. There was always similar problems. I mean the whole
13 older people issue vis a vis acute services, and
14 maintaining care in their home, and avoiding
15 admissions, was a huge piece of work, and a huge 15:21
16 strategic piece of work for the Trust in redesigning
17 acute services.
18 132 Q. CHAIRPERSON: But...
19 A. I give all - a lot of my attention. Ennis is a good
20 example. So maybe to answer your question, it changed 15:21
21 over time. So there might have been a time in the
22 period, the Ennis period, I maybe spent 60% of my 50%
23 concentrating on Muckamore Abbey Hospital, and then
24 when I felt satisfied that the issues were resolved,
25 and then I moved on to reduce that input. 15:21
26 133 Q. CHAIRPERSON: Yeah. Okay.
27 A. I relied -- John Veitch was such a responsible
28 professional and he was really good at keeping me
29 updated. I had no concerns about John's ability to

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1 ensure that services were delivered effectively on
2 Muckamore Abbey Hospital site.
3 CHAIRPERSON: Well he might be watching us, I don't
4 know, because he's coming here on Thursday, so we can
5 ask him about it. 15:22
6
7 If there are no other questions, can I thank you very
8 much for giving us your time this afternoon. I know
9 you've had an extremely long journey to get here
10 effectively, but can I thank you very much indeed. 15:22
11 A. Thank you.
12 CHAIRPERSON: Okay.
13 A. Thank you.
14 CHAIRPERSON: Can I just mention Thursday? As I've
15 just mentioned, as you know we're having John Veitch. 15:22
16 In fact we've decided to move Esther Rafferty, because
17 there is further material to put to her and we think
18 it's fairer to give her the opportunity of reviewing
19 that. So, in fact, we will be calling John Veitch in
20 the morning. He can be here at 11 o'clock. So we'll 15:23
21 have a slightly later start on Thursday, 11:00 o'clock,
22 and it's Mr. Veitch alone I think. All right. Thank
23 you very much indeed.
24
25 THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 18th SEPTEMBER 15:23
26 AT 10.00 AM.
27
28
29