MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 24TH SEPTEMBER 2024 - DAY 109

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

109

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INDEX

THE INQUIRY RESUMED ON TUESDAY, 24TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Right, just a few words before we start. I just want to set out the plan for closing submissions and to give you as much notice as possible as to what will be expected.

First of all each Core Participant group or organisation will be given the opportunity of making closing submissions in accordance with Rule 11 of the Inquiry Rules. Written submissions in skeleton form should be filed in advance of oral submissions as I'm going to indicate, and I'm going to set out some maximum times for oral submissions which, please, are not to be exceeded but do not have to be met.

The written submissions in skeleton form, there will be further directions on this, but could I just invite everybody to remember that where there is reference to restricted evidence, in some form that will need to be separated from unrestricted evidence and it should be clearly marked, but we'll give further directions in due course.

All written submissions should be provided to the Inquiry by 16:00 hours on Friday, 22nd November. All written submissions will be cross served on all CPs and consideration will be given to whether they can be

published on the website. Obviously that is with the exception of any restricted material.

The timetable for oral submissions is proposed as follows: The usual mid morning and mid afternoon breaks will be observed, and oral submissions should be focused on the contents of the written skeleton. Again, reference to restricted evidence should be clearly indicated, so we may have to move into closed session at an appropriate point. 10:06

So the oral submissions will start on Tuesday, 26th November, and the morning session will be devoted to AFM and SPFM between 10:00 o'clock and 1:00 o'clock. So a morning session. 10:07

Group three, represented by O'Reilly Stewart Solicitors, will be given an afternoon session between 14:00 hours and 16:00 hours approximately. 10:07

Wednesday, 27th November, the morning session will be devoted to PSNI, RQIA and PCC. At the moment it's proposed to give the PSNI one hour between 10:00 and 11:00, RQIA one hour between 11:15 and 12:15, and PCC 45 minutes from 12:15 to 13:00 hours. 10:07

The afternoon session on that Wednesday will be devoted to the Department of Health.

Moving to Thursday, 28th November, the morning session, the whole of the morning session will be given to the Trust, the HSCT, and I'm hoping at present that counsel to the Inquiry will begin their closing address in that afternoon session on the 28th November, that may spill over into the following week. 10:08

So that's the plan. We will issue that in a written form, but I thought it would be helpful to give everybody as much notice as possible so that you can devote the appropriate amount of time to written submissions. 10:08

I will be placing some sort of restriction on written submissions, for perhaps obvious reasons, and if I can say now, what I hope to avoid is large sections of transcripts or statements simply being copied and pasted into a written submission, which isn't going to help us at all. 10:09

10:09

All right. I hope today we will not have as late a session as we did yesterday. We did sit late yesterday because otherwise Dr. Milliken was going to have to cancel his clinical list, and that was the only reason. I have made my peace now with the stenographer. 10:09

Right. I think we're ready for the next witness.

MS. BRIGGS: Yes, Chair. This morning's witness is Dr. Hughes. The statement reference is 311. Before we

start, Chair, there is a paragraph of this witness' evidence to which a Restriction Order applies, that's Restriction Order 9, and it's paragraph 31 of the statement. So my submission is, Chair, that we will require a brief restricted session at the end of the evidence in order to deal with that specific paragraph, Chair.

CHAIRPERSON: Well that's because that specific evidence was given itself in wholly closed session.

MS. BRIGGS: That's right, Chair. 10:10

CHAIRPERSON: Yeah. Sorry, do come in. Good morning.

DR. DAMIEN HUGHES, HAVING AFFIRMED, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

10:10

CHAIRPERSON: Dr. Hughes, can I just welcome you to the Inquiry. Thank you for coming to assist us. Thank you for your statement. We'll normally break after about an hour and a quarter, something like that, but if you feel the need for a break at any earlier stage, please 10:11 just let me know and we'll stop.

A. Thank you.

CHAIRPERSON: All right. So I'll hand you over to Ms. Briggs.

A. Thank you. 10:11

1 Q. MS. BRIGGS: Thank you, Chair. Dr. Hughes, good morning. As you know I'm going to be asking you questions about the statement you have provided for the Inquiry, and the reference is 311, and you have a copy

of that in front of you, and also you'll be able to follow along on the screen that's in front of you as well.

If I can just remind you to avoid using ward staff or patient names where you can, and you have a cipher list in front of you, Dr. Hughes, which you can consult in the first instance. 10:11

Your statement is dated the 31st July 2024, and it's 18 pages long. Do you wish to adopt the contents of that statement as the basis of your evidence to the Inquiry? 10:11

A. Yes, please.

2 Q. I'm going to ask you questions about the statement and we'll go to certain parts of it on the screen, but I'm going to start of with the periods of time that you worked at Muckamore, and this is at paragraph 2 on page 1, and you say there that you worked at Muckamore August 1996 to January 1997 as a Senior House Officer, and then August 1999 to July 2000 and August 2001 to July 2002 as a Senior Registrar, and 2002 to 2018 as a consultant, is that all correct? 10:11 10:12

A. Yes.

3 Q. Okay. If we can go on to paragraph 7 of your statement, page 3. About halfway down that paragraph, Dr. Hughes, you're describing how in October 2006 Cranfield opened, and you had been offered the role of consultant for Cranfield, and you describe this as an exciting time for the hospital. Can you tell the 10:12

Inquiry a bit more about why it was an exciting time for the hospital?

A. A number of reasons really. The main one, I suppose, was it was a time when it was obvious to all of us who worked in the hospital or around the hospital that it was no longer fit for purpose in terms of the buildings and the surroundings. So the development of brand new carefully designed wards in which we could better meet the needs of our patients was an exciting development. Time was taken to engage with a number of stakeholders, but most reassuringly with patients and families around what this "new hospital", in inverted commas, would look like. I think from memory it was the first time that patients had single rooms, and not either shared rooms or even dormitory style accommodation, but from a professional perspective it was a time when we were able to I suppose separate in a lot of ways acute hospital services from longer stay or continuing care, and we were excited by the prospect of that, that we would have a dynamic ward that patients flowed in and out of. Patients came in unwell, recovered and went home. And there were I think a number of very senior staff who, as I say, were excited and looking forward to the prospect of being able to do that.

10:13 10:14 10:14 10:15 10:16

4 Q. Okay. The Inquiry has heard that perhaps the core hospital was more institutionalised and less homely, what would you say about that?

A. I think it's fair comment. You know, I did, as I've outlined in my statement, I did for brief periods have

responsibility for some of the continuing care wards, and the environment in some of them, if not all of them, was pretty stark. You know, you did have very little space where patients could be by themselves or take part in activities that interested them, and only them, so there was a sense that it was, you know, a group of people brought together and had to share some quite dilapidated surroundings, and the impact of that on people's lives was significant. 10:16

5 Q. And in terms of the views of the patients in terms of the move to the core hospital, how were those obtained and then reflected in the design of the new hospital? 10:17

A. I'm not really best positioned to answer that. That work was done obviously prior to the new facilities opening and, as I say, I only took up the post when it opened in 2006. But my understanding, my memory is that there were a number of focus groups. There was a group for patients, there was a group for families. The TILII Group I remember them being called - Tell It Like It is - were very heavily involved, and I can remember a number of away days and, you know, strategy development days around ward processes, some of which I was involved in at a later stage but not in the early stages. But the sort of excitement and positivity that I described earlier wasn't just amongst staff, I can remember patients being similarly excited by the prospect. 10:17 10:18 10:18

6 Q. Okay. And how did the opening of the core hospital, how did that affect the model of care given to

patients?

A. That's a very good question. I hadn't worked in the acute side of the hospital for a number of years before 2006, but I do recall in the late 1990s, maybe around the turn of the millennium, that it was difficult for multidisciplinary teams in Fintona and Movilla, which were the two complexes that would have catered for the acute side, the admissions, the assessment and treatment, it was difficult for the multidisciplinary teams to focus on that because they also had to meet the needs of a very different group of patients who had been in the hospital for a very long time, and I can only imagine, and having worked there as a trainee psychiatrist, I did get a flavour of just how difficult that was. 10:19 10:19 10:20

CHAIRPERSON: Sorry, what do you mean it was difficult for them to focus on that?

A. The business of assessing and treating acute psychiatric illness is very different to meeting the needs of those requiring continuing care or those in recovery, and I suppose there are parallels with what happened then later on with the resettlement process, where the business of discharging patients who had been in hospital for a very long time is very different to the acute assessment and treatment. So the demands that were placed on the multidisciplinary team in terms of having a group of patients who were acutely unwell, who required a treatment plan, a treatment plan that was fluid, that required review and monitoring, and at 10:20 10:21

the same time you had another group of patients.
CHAIRPERSON: A mix.
A. Yes. Yes.
CHAIRPERSON: Yes. Okay.
A. Yes. 10:21
CHAIRPERSON: Thank you.
7 Q. MS. BRIGGS: Towards the end of that paragraph on page 4, this is after you had been offered the role of consultant for Cranfield in 2006, and you say that unfortunately you had also learned that you would 10:22 retain some out-patient responsibility and you would, therefore, not be in a position to entirely commit yourself to the patients under your care in Cranfield. Was that the North and West Belfast Trust, as it was then, that you retained responsibility for? 10:22
A. Yes. Yes.
8 Q. Yes. And I think later on in your statement you say you relinquished your role as a community consultant. When was that? Was that between 2009 and 2011 I think you say in your statement? 10:22
A. It was 2009. For the first three years of my time in Cranfield I did have half of Belfast in terms of a community sector.
9 Q. And after 2009 then, just so we get a sense, did you have any community role after that? 10:22
A. No.
10 Q. No?
A. No. I had other hospital roles. I don't think until the latter stages of my time in Cranfield, I don't

think my job plan allowed me to entirely focus on Cranfield. I always had other responsibilities within the hospital.

11 Q. Okay. Well we'll come to that and we'll come to your workload and the demands on your time. But just thinking about your time as a community consultant between 2006 and 2009, I'd like to ask you a little bit about that and your experience of community services. The Inquiry has heard an abundance of evidence about a lack of resourcing in the community for patients and that this may have led to crisis admissions, and later in your statement you say that crisis admissions were much more common than planned admissions, isn't that right? 10:23 10:23

A. Very much so, yeah. 10:23

12 Q. Would you agree that a lack of community services impacted the occurrence of crisis admissions to Muckamore?

A. I would, undoubtedly. For those three years I had direct experience of both sides of what was happening in the community, what services were being provided to patients, and likewise in the hospital, and I wish it was better today, but I'm not sure services have developed much in the last 15 or 20 years with regards to community. My role in the community sector between 2006 and 2009 isn't particularly different to what my role has been since 2018 since I became a community psychiatrist again, a lot of it is crisis management. 10:24 10:24

13 Q. Okay. Thinking back then to your time in 2006 to 2009,

were you able to make or effect any changes in the community in terms of its servicing, in terms of its resourcing, that might have impacted crisis admissions?

A. Ehm, no. Well, I suppose I was able to relay my experience and indirectly then the experience of the patients to people within the Trust, to managers within the Trust, there were opportunities for us to do that. But resources were so scarce that it was very difficult for me to do anything other than clinical work at that, at that time. As I say a lot of it was crisis. It was -- probably reflecting on it, it was the most, in terms of workload, it was the most challenging time of my career, those three years. 10:25 10:25

14 Q. I think Dr. Maxwell has a question.

DR. MAXWELL: Did you raise your concerns about the lack of resources in the community at that time? 10:26

A. Yes. I mean it's a long time ago but, yes, I do recall that, you know, any opportunity we had we took. When I say "we", I mean as a group of professionals within community teams, but also as a group of consultants in the region. 10:26

DR. MAXWELL: So who did you raise it with?

A. Well initially it was to, you know, my own sort of line management structure.

DR. MAXWELL: So that would have been the Clinical Director? 10:26

A. That would have been to the Clinical Director. And there was a sense that they -- they were also, you know, doing similar work.

DR. MAXWELL: Did you raise it with the Medical Director of either Trust that you worked for?

A. Ehm, I'm not -- I don't recall ever doing that, no. I don't recall ever having meetings with medical directors at that time. 10:27

DR. MAXWELL: And given that there was a lack of community services, do you think that any patients came to harm as a result of, or would the presence of community services prevented any harm coming to patients? 10:27

A. I can't think of any examples of patients directly being harmed.

DR. MAXWELL: Okay.

A. But there's no doubt that the psychological well-being of patients was affected by a lack of services. 10:28

DR. MAXWELL: Did the lack of services cause any harm to any of their carers?

A. Undoubtedly, yes. The accounts that I received from patient's families and carers would indicate that there was, and remains, considerable stress in the lives of a 10:28 significant number of family members and carers of patients with intellectual disabilities.

DR. MAXWELL: Thank you.

15 Q. MS. BRIGGS: Dr. Hughes, have you seen any improvements in community services over the years that you'd like to 10:29 tell the Inquiry about, comparing say now with 2006?

A. There obviously have been some developments within services. I don't recall in 2006 having things like intensive support services, or Positive Behaviour

Support services, they're called different things in different Trusts and different sectors, but that is, that is a development, a positive one. But, again, those services are under-resourced. Approaches are quite piecemeal. A lot of them are 9 - 5 services, and when it comes to crisis management that doesn't do much to help people who enter a crisis outside of those hours, as they often do in the evenings and weekends. But in terms of some of the other services, I'm not sure we're much better off for day services, for respite services, to name just two, than we were in 2006. 10:30 10:30

CHAIRPERSON: Could I just ask about crisis management, because presumably that's part of the intensive support services that you've referred to. Who would be involved in crisis management? Say there's a patient in the community, and for whatever reason something goes wrong and there's consideration of having to admit that patient to a hospital, who would be there to intervene and see if the community could continue to cope? Is that how it would work? 10:30 10:31

A. Yeah, there are a number of ways, Chair, that those patients at those times come to our attention. The vast majority are known to services, so often it will be direct contact between the patient themselves or their family/carers and a member of the team, usually maybe a social worker, or a community nurse, or myself or someone, but quite often there's an indirect route through the GP where the patient will make contact, or 10:31

someone on their behalf will make contact with the GP, and then a crisis referral almost is made, and that will trigger a response amongst the team. And that could be anything. I mean it would depend very much on the initial impression of the presentation of the patient and where their immediate needs might lie and might best be met. So that can be a social problem that requires a social solution, and that will be maybe the social workers leading on that. It could be a medical problem, a psychiatric problem. It could be related to a degree of challenging behaviour, and in that case it would be the Intensive Support Team or the Positive Behaviour Support Team who would lead. But generally, there is a multidisciplinary response to that. 10:32 10:32 10:33

DR. MAXWELL: And --

CHAIRPERSON: Sorry, can I just finish very quickly. Why is that only available sort of 8:30 or 9:00 o'clock, 9:00 until 5:00? It seems quite odd because, as you say, a crisis can happen at any point within the 24-hour clock? 10:33

A. Yes. Yes. I know that there have been, within one or two of the Trusts, there have been efforts made to expand that service into the evenings and even at weekends, and I think that sort of pilot projects -- I'm not sure if that -- did indicate that there wasn't much demand in each of the Trusts. So I think a lack of joined up sort of regionality to those services is what has hampered them in their development. 10:33

CHAIRPERSON: Yes. Yeah. Thank you. Sorry, Dr. Maxwell.

DR. MAXWELL: You seemed to imply that the Intensive Support Team was only for challenging behaviour, is that correct? 10:34

A. In many instances, yes. Now, they will, of course, almost immediately do - if the presentation is related to challenging behaviour, they will do an assessment of that and of the - the ideology is one of the things that they assess, and depending on that, that may 10:34 dictate future assessment and treatment. So, you know, if there's an aspect of the presentation that relates to mental illness that is triggering some challenging behaviours, then that will -- and, you know, and other things. 10:35

DR. MAXWELL: So if I'm the primary carer for my relative and I am suddenly taken ill this afternoon, is there no system of supporting my relative in the home while my acute illness is managed?

A. There sometimes is, but not always, and it is 10:35 increasingly difficult to provide families with what they need at those times.

DR. MAXWELL: And so that adds to the harm that you said was happening to carers in response to my question about the lack of community service and the effect on 10:35 carers?

A. I think so, yes.

PROFESSOR MURPHY: You said I think a bit earlier on that you knew who was likely to have a crisis within

the community teams, very often. Was it possible to put in crisis management plans for those individuals where you knew that, for example, they had bursts of challenging behaviour under circumstance X, Y and Z?

A. That work does go on, it does form some of the work that our multidisciplinary teams in the community do, but to be honest, so much of what we do is actually fighting fires and... 10:36

PROFESSOR MURPHY: So it's reactive --

A. -- and managing crisis. That crisis prevention is unfortunately secondary to crisis management in an under-resourced service. 10:37

PROFESSOR MURPHY: So there's not very much proactive work?

A. Not as much as we would like, yeah. 10:37

PROFESSOR MURPHY: Thank you.

16 Q. MS. BRIGGS: Just to close off this topic, Dr. Hughes. Thinking about avoidable admissions to Muckamore, the Inquiry has heard evidence from Mr. Veitch, and he gave evidence about the hospital's Modernisation Group, which he chaired, and an analysis of admissions that that group carried out during 2014. I know you're aware of this exhibit and you've had a chance to consider it. I think we can pull the first page of that on to the screen. It's Inquiry reference STM-275-46. 10:37 10:38

Now the audit goes on for a number of pages, but I'm just going to refer you to the first page, it's on your

screen as well, Dr. Hughes. But we can see there that it's headed:

"The future core hospital.
Review of NHST admissions to Cranfield, Muckamore, during August to November 2014, with a medical opinion/view on the potential preventability of admission."

And then towards the bottom of that page, in fact at the very bottom, it goes through the various admissions, and at the bottom there it says that: 10:38

"18 out of 24 (i.e. 75% of admissions) during this period were potentially avoidable." 10:39

And the document goes on to break that down into different months so that the statistics change slightly as it's broken down, but really it's in and around that 75% for that period August to November. 10:39

Were you aware of that audit, first of all?

A. Yes, I was involved in it. I was involved in providing some of the medical opinion.

17 Q. Some of the medical opinion. So there are obviously other consultants, or doctors, or nurses involved in providing some of the medical opinion? 10:39

A. Yes. Yes.

18 Q. Okay.

A. Yes. Yes.

19 Q. And it is Cranfield, so it's the ward that you were responsible for?

A. Yes. Yes.

20 Q. Okay. How do you reflect upon that figure that 75% were potentially avoidable? 10:39

A. I think it's important to sort of set the context. The hospital modernisation process was developed at a time when the demand for beds was extremely high. The austerity/cuts that really sort of came into effect around the start of that decade had really begun to bite and, you know, some of the services that I referred to earlier in terms of those that patients with learning disabilities can access, had really begun to struggle; day centres, respite facilities, and that... 10:40 10:41

CHAIRPERSON: Is the decade 2010 to 2020?

A. Yes, sorry.

CHAIRPERSON: It is. Sorry.

A. Sorry, yes. Yes. So -- and as well as that, and just touching on maybe over the page a wee bit, Ms. Briggs, about where it documents the presentation, the sort of initial reason for admission of some of the patients, and you'll see an awful lot of reference there to suicidal ideation. 10:41 10:41

21 Q. MS. BRIGGS: I think we can show that on the screen, and it goes on page 47 and page 48 are the pages that I think Dr. Hughes is referring to.

A. Yeah. So I think that is indicative of also maybe some

of the -- I mean the province, the city of Belfast, certain areas within the city of Belfast were experiencing extremely high rates of suicide, and when, you know, compared to other regions on these islands, suicide rates were in some cases remarkably high for certain areas, and obviously there was an awareness of that, and at that time the process of admission to hospital for patients with learning disabilities was different to mental health wards, was different to those, to that that existed for patients without learning disabilities, in that there was no triage or filter system in place. It was a direct phone call from a GP to the hospital, usually to the consultant or to one of the medical staff, and the admission was arranged. So, I mean I can't obviously recall those individual cases, but I can recall a trend where, you know, a GP would be called to a house where there was a lot of worry, a lot of concern, a lot of maybe expressed emotion, tension, and the patient was expressing these ideas, and in the absence of any filter there was almost an inevitability about admission.

10:42 10:43 10:43 10:44 10:44

DR. MAXWELL: Can I ask, when you say these are potentially avoidable, at the point at which you receive the call was the patient so distressed that admission was the only option, and you're saying actually if there had been intervention by mental health teams earlier that might have been avoided. Or are you saying at the point at which you received the

phone call, if there had been good community mental health services then you could have avoided the admission at that point in time?

A. I think both.

DR. MAXWELL: Right. 10:44

A. There was certainly very little focus on, you know, promoting good mental health amongst our patient group, but there was undoubtedly also a lack of alternative to hospital admission in this type of crisis. And, you know, one example that I can give is that, you know, 10:45 the impact of home treatment and home treatment teams on Mental Health Services was quite dramatic in terms of admission reduction. Obviously without that layer, I suppose, of service, it was inevitable that we would come under pressure against a backdrop of some of the 10:45 things that I described about services and what was going on in communities in Belfast.

So, yes, I was never completely happy with - I acknowledge that a profiling exercise like this was 10:46 necessary, but I was always cautious that we couldn't read too much into it. It didn't feel very scientific, and it maybe feels even less so looking back on it now. But I suppose what we were trying to capture, what Mr. Veitch and Senior Managers within the Trust were 10:46 trying to capture, was some sort of flavour of how community services needed to develop to prevent admissions, and a good starting point is to profile the people who were coming in to hospital and trying to

work back-ways to see what might have prevented their admission.

PROFESSOR MURPHY: So nowadays would you say that in these kinds of cases it would be down to mental health teams to intervene, or would it still be the community learning disability teams intervening? 10:47

A. It varies. Personally I think that the majority of my patients could have their needs met, probably well met and probably better met within Mental Health Services.

PROFESSOR MURPHY: And did Mental Health Services acknowledge that people with mild learning disabilities were part of their job? 10:47

A. No.

PROFESSOR MURPHY: Or did they say 'No, learning disabilities goes to the Learning Disability Team'? 10:47

A. Yes. Yes.

PROFESSOR MURPHY: Has that changed?

A. Not significantly.

DR. MAXWELL: And you said in answer to Professor Murphy that you think your patients could be well or better managed by mental health teams, do you think then that admitting them to Muckamore in this situation actually produced any harm for them? 10:48

A. I'm not aware of it, and actually this is perhaps going to sound paradoxical, but the vast majority of patients who presented in this way recovered well in Cranfield. 10:48

DR. MAXWELL: So why do you think they would do better in a mental health setting?

A. I think they could also have recovered well somewhere

else.

DR. MAXWELL: But you said "better". Do you want to revise that view that they would have been better in a mental health setting?

A. A mental health setting that was able to treat them at home, for example. 10:49

DR. MAXWELL: So you mean mental health practitioners in their own home?

A. Yes. Yes. I mean within --

DR. MAXWELL: Rather than admission to the Mental Health Hospital. 10:49

A. Yes, I mean -- sorry, I should have made that clear. I meant being able to avail of Mental Health Services.

DR. MAXWELL: Right.

A. Both out and in-patient, but certainly out. Those with mild and moderate learning disabilities I have to stress. 10:49

DR. MAXWELL: And given that this report identified a real gap in services, do you know what happened to the report? Because ultimately it would require a new funding stream. 10:49

A. Yes.

DR. MAXWELL: Which wasn't within the gift of the Muckamore Hospital management. Do you know if it went up to the Department of Health, or the HSCB, or the Public Health Agency? 10:50

A. I'm not sure.

DR. MAXWELL: You don't know?

A. I'm not sure really.

22 Q. MS. BRIGGS: Dr. Hughes, I'd like to move on to something else now, and it's the pressures on your workload and it's something you've touched upon already. At paragraph 9, the second half of page 4, you're describing the pressures on your workload, and in particular the pressures that resulted from the retirement of two of the most senior consultant psychiatrists, and that was around 2007 to 2008 you say. You describe there that between 2006 to 2009, and this is towards the end of the paragraph, you say: 10:50 10:50

"I was effectively holding a position for which up to four consultants would have been recommended."

That's because you were looking after 35 patients on Cranfield Assessment Ward, which you say is twice the number recommended by the Royal College of Psychiatrists, and on top of that you were expected to retain your role in the community with a caseload of 300 patients. 10:51 10:51

You go on to say that your experience was by no means unique and you were aware of the plight of a number of senior colleagues with similarly onerous workloads.

10:51

When you refer to your other colleagues with the heavy workloads, was that an issue for psychiatry that was specific to Northern Ireland or were you aware that it was an issue across the United Kingdom?

A. I think it is an issue in many areas of the United Kingdom. It was particularly acute here. There were times in and around that time where it really did feel like the dearth of senior psychiatrists within the service in the region was potentially catastrophic, you know, it was at a time, those of us that were left sort of after those retirements. I mean I can remember all it took was for a colleague to go on extended leave, be that maternity leave, there were so few of us. I mean just to give you an example, I can -- at the minute our on-call rota is what we call a one in eight, so everybody is on every eighth night, or you're on every eighth night. There were times when there were three of us on that rota and you were on a one in three, so every third weekend, and that was on top of not just having to do your own work, which was already onerous, but then having to cover for colleagues and that. So there was a time in and around that where I can recall that striking a work/life balance was difficult. 10:52 10:52 10:53

23 Q. You say it was at times catastrophic. What do you mean by that? 10:53

A. Well, potentially so, in that you just didn't feel at times that you were able to keep up and, you know, we bumped into each other in corridors and at sort of Royal College meetings, if we could get away to them, and you did get a sense of a psychiatry service in crisis. And there were all the other things within the service, you know, that were, you know struggling, but just that particular spell I can recall it being very 10:54

difficult.

CHAIRPERSON: And, again, the spell is 2006 to 2009?

A. '09/'10 Chair, yes. Yes, in and around that. I can remember appointing -- well the Trust appointed a couple of consultants around 2010. 10:54

CHAIRPERSON: Right.

A. And that eased things.

CHAIRPERSON: I was going to ask --

A. Slightly.

CHAIRPERSON: -- alleviate it? 10:54

A. Yes. Yeah. You got a sense from that time on that things were a bit better. But, you know, even recent reports from the Department of Health have suggested that we're considerably under-resourced.

CHAIRPERSON: In Northern Ireland generally? 10:55

A. In Northern Ireland, yeah.

24 Q. MS. BRIGGS: And how did the catastrophe, as you've put it at that time, how did that impact patients?

A. It's very hard to measure that. We tried desperately to -- you're -- I suppose your working life became almost entirely an exercise in triage and about focusing your efforts to where you and other - obviously you were guided by other sort of senior members of multidisciplinary teams, but to try to focus your efforts on where they would be of most benefit to 10:55 10:56 patients. And I can't think of, you know, direct examples, but there's no doubt that across that time and at other pockets of time that, you know, patients might have been discharged sooner had there been more

resource in the hospital multidisciplinary team, and psychiatry was part of that.

25 Q. And you describe sitting on this Speciality Advisory Committee in Northern Ireland, and that workforce was a common topic between 2000 and 2010 you say. Were there any other mechanisms by which you escalated your concerns about the lack of consultant support or consultants in Muckamore? 10:57

A. Just through senior management. Just up -- I mean it was a situation that certainly the people within my sphere were all acutely aware of, you know. And then I'm -- you know the issue -- recruitment and retention obviously are multi-factorial, but we did also at that time struggle to recruit trainees into the speciality, and some of that may have been related to their impression of it, of what the speciality, and that it was quite beleaguered. So, yeah, I mean we -- basically any channel that we had, certainly at the level that I worked, it was mostly through Clinical Director and hospital management team and, as I say, we got a chance every year - now those SAC, Speciality Advisory Committee meetings were big, there was a large sort of collection of people there. There was, you know, a lengthy agenda. But I do recall that when we were asked to raise concerns about our practice and what mattered to us most, we did talk about workforce a lot. 10:57 10:58 10:58 10:58

26 Q. Okay. And just focusing back in 2006 to 2009 when you had your community consultant role alongside your role

in Muckamore, how was your time divided between those two?

A. There were certainly fixed points within the week where I had to be in one place or the other. So, for example, at ward rounds or multidisciplinary team meetings in the hospital, it would happen on a certain day, the same day every week, and I made every effort to be there for those, and was there for the vast majority of them. Clinics, likewise, in the community. So that probably accounted for around half my week, four or five sessions a week was fixed in the diary and you knew where you were. The rest was fluid, and as we've said a lot, as I've said a lot, subject to triage and crisis management and working out where your presence would be of most value. 10:59 10:59 11:00

27 Q. Do you think it was a roughly 50/50 split as between the community and Muckamore, or would that be unfair?

A. No, I think, I think that -- it wouldn't be far off, yeah.

28 Q. And you also tell the Inquiry about your heavy interest in your various roles and positions in education? 11:00

A. Yes.

29 Q. How did that time spent in education, how did that sit within your other time at Muckamore and as a community psychiatrist? 11:00

A. It was different in that it was possible to plan that. Certainly the role between, is it 2002? Whenever I was Training Programme Director for the Psychiatry of Intellectual Disability, that was quite a small role

and there were only a number of sessions in the year when you were needed around recruitment, annual review of trainees, those types of things. So, that was something that you could ring-fence, and it was often a case of, you know, asking the Senior Registrar to Chair the ward round or things like that.

DR. MAXWELL: How many sessions in your job plan were for education?

A. Throughout my time, never more than one and a half, which is six hours a week. 11:02

DR. MAXWELL: Yeah.

A. And often less than that. And certainly during that time it would probably have been a half a session for Training Programme Director, so that's two hours a week. 11:02

DR. MAXWELL: And you were on a maximum session contract, were you?

A. Yes. Yes.

30 Q. MS. BRIGGS: Dr. Hughes if we move on to paragraph 10 on page 5, you're describing there some changes to your role between 2009 and 2011, and to summarise you say you relinquished responsibility for the Belfast community sectors and you were able to focus on Cranfield. But you were also given the additional responsibility of Foybeg, which in 2011 was changed for Oldstone. Oldstone then closed in 2014, and then in 2015 Cranfield was re-profiled and you had responsibility for Cranfield 1 and Killead Ward, which are male and female admissions wards. And you worked

there until you left Muckamore in September 2018. Just thinking about the different wards there, did you notice a difference in atmosphere or culture on different wards or across different staff teams?

A. No, I don't recall having an impression like that. The experience I had in Oldstone was probably amongst the best that I had in my time in Muckamore. In short, it was a fantastic place. It was a number of houses across Oldstone Road, across the road from the main hospital, and half of them were in sort of public ownership and people lived there with their families, and the other half was set up at that time -- it had existed in a number of different guises over the years, none of which I was involved in, but at that time it was set up specifically as a rehabilitation ward, and it was essentially for patients who were in other wards who it was deemed would benefit from an extra layer of treatment before discharge. So, exposure -- you know there's quite a big jump between life on a hospital ward and, you know, in a community setting, virtually any community setting, and Oldstone acted as a bridge for a lot of patients. 11:03 11:04 11:04 11:05 11:05

DR. MAXWELL: So given that Oldstone -- and as I understand it, they had more autonomy, they were less closely supervised in making this transition.

A. Yes. Yes.

DR. MAXWELL: So given that seems to be quite a central approach to resettlement, why did it close?

A. I was told at the time that it was down to resources.

DR. MAXWELL: It seems an odd decision if there was a major drive towards resettlement and the one place that was preparing people for resettlement gets closed?

A. Yes. I can remember thinking that at the time.

31 Q. MS. BRIGGS: Thinking about Cranfield, because that's where you really spent the majority I think of your time, what was the mix of patients and their needs? 11:05

A. Broad. Both in terms of clinical presentation, which within Learning Disability Services is how it is. You know, Mental Health Services have a narrower range of presentation. With Learning Disability Services we do have to factor in people with not just mental illness, but people with neurodevelopmental disorders, with neuro-diversity, with - we've mentioned the term "challenging behaviour". So there was that whole range of people, of patients. And also then across the range of intellectual disability. So people who had mild to borderline, who had very, often very different needs, as you could imagine, to someone with severe or profound intellectual disability. And equally then, there was a broadening of the age range when compared to Mental Health Services. So there is no such thing as a specialist service for older people with intellectual disability, either in out-patient settings or in in-patient. So essentially to try to illustrate what that was like, you know, we would often have had 18-year-old patients with a condition like attention deficit hyperactivity disorder in the next room to an 80-year-old patient with Alzheimers. So you could

11:06 11:06 11:07 11:07

imagine the skill set that was required to manage those extremes and everything in between. We also then at a time would have had sporadic cases of children being admitted to Cranfield. I can't, I can't really recall the last, the date the last child was admitted? Probably around 2014. So for those first seven or eight years of the existence of Cranfield, we would have had a number of children admitted, obviously with a very significant level of risk assessment and risk management around that. 11:08 11:09

DR. MAXWELL: Is that because the Iveagh Centre didn't have any beds, or was it a conscious decision to admit them to Cranfield instead of Iveagh?

A. For some of it I'm not sure Iveagh existed. For the initial few years - I can't remember what date Iveagh opened, but I think it was after 2006. 11:09

DR. MAXWELL: Yeah, but before 2014?

A. Yes. So, yes, Iveagh also struggled undoubtedly with some of the issues that I've just spoken about in terms of - in relation to Cranfield. You know, the difference between a 5-year-old and a 17-year-old, and keeping everyone safe within that was difficult at times, and a decision was sometimes made that a 16 or 17-year-old could possibly have their needs better met in an adult ward, or simply by dint of risk management, collective risk management within the unit. You know if, for example, if a 16 or 17-year-old boy was behaving in such a way that a 5-year-old was at a particular risk. You know those sorts of things. So 11:10 11:10

there were -- now that stopped, there was a very conscious decision to stop the practice of having children in adult wards, but for a time during my spell in Cranfield we did look after. So I suppose in -- that's a longwinded answer -- we catered for the needs of a very broad range of patients.

32 Q. MS. BRIGGS: And on paragraph 17 on page 9, you're talking at that paragraph about treatments that were available for patients, and you talk about therapeutic day services, Positive Behavioural Support Services, pharmacological treatment, cognitive behavioural therapy and so on. You mention in that paragraph Positive Behaviour Support Plans, and you say that they were widely introduced during your latter years in Cranfield, having been around in slightly different guises before this. Can you help the Inquiry with this: when do you say that they were introduced, can you recall?

A. I can't, I can't really. You know we -- from the day we opened we had a behaviour service, as it was somewhat ham-fistedly called, and we would have had BNTs, Behaviour Nurse Therapists, whose job it was to assess and treat challenging behaviour in patients and develop bespoke plans around that. That did sort of crystallise a lot more sort of around about 2011/12 when -- I don't think we were much behind the curve with introducing Positive Behaviour Support, I think that's around about the time that the world cottoned on to this as being a good idea. So that was then

gradually introduced. But again, you know, resources were often a factor in how much of that and to what degree that could be provided to the patients.

33 Q. Thinking about -- I'll move on from that. Thinking about your visibility on the ward, seeing all this treatment being given, how often were you out on the wards spending time with patients? 11:13

A. Not often enough. And this is where workload obviously impacts. My role -- unfortunately there are a number of things that require a consultant and only a consultant can do. A lot of those relate to the Mental Health Order, and forums, and tribunals, but also at a -- and maybe this reflects on my practice, but I did always see it as my job to engage as much as I could with patient's families, and some of that came from me, but a lot of it actually came from the families themselves, where quite rightly they were keen to engage with the psychiatric lead within the team. So there were demands across the piece really that unfortunately limited the amount of time that I could spend in direct contact with patients. 11:13 11:14 11:15

34 Q. Could families make appointments to see you directly?

A. That was how I tried to work, yes.

35 Q. And thinking about the involvement of families in decision making, you say in your statement that you tried to do this when possible, and it was, you say - it's at paragraph 13 - you say: 11:15

"It was always our quest to involve families in

decision making as much as possible."

When was it not possible to involve patients or their relatives in decision making?

A. Usually, I have to say, when patients or their families chose not to be involved, and that, that happened a lot, where patients either came into hospital without much family involvement, or families took the view that whenever the patient was in hospital that we were the experts and we could crack on. 11:15 11:16

CHAIRPERSON: Presumably there were many who didn't take that view?

A. Yes, yes.

CHAIRPERSON: And are you saying that there was relatively open access to you? 11:16

A. Yes.

CHAIRPERSON: Provided you were the lead consultant for the particular patient?

A. Yes. I'd like to think that. And we did have very sort of touch points across an admission where we attempted to very actively engage with families, so around progress meetings. So I've mentioned in my statement that each patient had a post-admission meeting and families were always invited to those. Equally, on the cusp of discharge there was a predischarge meeting and, again, our social workers worked very hard. They were our sort of liaison officers, if you like, with families. So they would engage with families at those times and issue an 11:17 11:17

invite.

CHAIRPERSON: And how quickly would the post-admission meeting take place?

A. Our standard was within two weeks, but we always tried to have it within one. We had -- most of the time I was there the structure of the week was such that in order to ensure that the key people were around at the most important times for families, we would have had an all day agenda in each of the two wards. So I think off the top of my head Tuesdays was men's day and Thursday's was women's. And that was the ward round, the multidisciplinary meeting that was mostly the multidisciplinary team discussing and reviewing the patient, often with the patient there, or there for some of it, again if that was their choice. And then in the afternoon -- so that was a more business-like meeting, and then in the afternoon we would have had I think it was four 45 minute slots between 2:00 and 5:00 to have meetings about patients, and they were -- 11:18 11:18 11:18

CHAIRPERSON: Meetings with whom, with families? 11:19

A. Oh, that was with families. So these were the preadmission/post-discharge meetings.

CHAIRPERSON: Right. Okay.

A. Or if a patient was there long enough sometimes we felt it necessary to have a progress meeting or an update meeting. So if a patient was in hospital having treatment for say, you know, beyond three or four months, we would have had a meeting within that time to update everyone, and that was not just families, but 11:19

that would have been the community teams, because we had this model where it was the hospital team who looked after the patient during the admission and the community team before and after. So in order to facilitate transfer of information we would have had community teams, key people from the community teams at those meetings.

CHAIRPERSON: And in terms of post-admission meetings, just so that we deal with this quickly, we did hear from a number of witnesses that - or certainly more than one set of witnesses - that post-admission sometimes parents and relatives were told not to go and visit their patient relative for a number of weeks. Does that ring a bell with you? Is that part of the policy of the hospital or not? 11:20

A. Not at all. Well not at all in terms of it being policy of the hospital.

CHAIRPERSON: But might it have happened?

A. There may have been examples where on the basis of a risk assessment we felt as a team - I can remember having the very odd conversation with family members that it might not be a good idea. If people's safety was threatened.

CHAIRPERSON: Yes, I can understand that, but that would presumably be for a relatively short period? 11:21

A. Yes, that was -- yeah, as short a period as possible.

CHAIRPERSON: And not as long as something like six weeks? Or could it be? Or could it stretch to that?

A. It possibly could. I don't recall any examples, but it

possibly could. It did sometimes take us that length of time or longer to maybe get a patient's mental state settled enough that the risk diminished.

CHAIRPERSON: Okay. I'm just aware of the time. We're less than half way through the statement at the moment, and that's nobody's fault. Are you finished with this area as it were or... 11:21

MS. BRIGGS: I have one question arising out of this area, Chair, and then we can perhaps take a break and move on to something else. 11:22

CHAIRPERSON: Sure. Sure.

36 Q. MS. BRIGGS: Thank you, Chair. The Inquiry, Dr. Hughes, has heard evidence of really dissatisfaction from families regarding, some families, regarding the lack of information given to them about their loved one's care upon admission, and indeed thereafter, and the lack of ongoing involvement in their care. Was that ever something that was raised with you? 11:22

A. Genuinely I don't recall receiving complaints of that nature. 11:22

DR. MAXWELL: Can I just ask, you've talked about being available for families Tuesday afternoons and Wednesday afternoons, but we've also heard from some families that often siblings wanted to advocate and were perhaps more confident dealing with authorities, was there any capacity to talk to families at times when people wouldn't have been at work? 11:23

A. Yes. I would often have been on the ward in the

evenings doing that sort of thing.

DR. MAXWELL: So you would -- if required you would see families --

A. If it was possible, yes.

DR. MAXWELL: -- in the evenings. 11:23

A. Yes. Yes.

MS. BRIGGS: Chair, I wonder now if we take our break?

CHAIRPERSON: Yeah, certainly. All right. We normally take around a 15-minute break now, you'll be looked after. Don't speak to anybody about your evidence, and 11:23 we'll see you back in 15 minutes. So we'll try and stick - we'll try and come back in at about 25 to. Thank you very much.

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:24

CHAIRPERSON: Thank you.

37 Q. MS. BRIGGS: Dr. Hughes, I'm going to pick up on a couple of discrete issues, and one of those is the GP 11:40 services or lack thereof in Muckamore for a time, and this is paragraph 15, mainly on page 8. You're describing the physical health monitoring of patients, and you say that:

11:41

"Over many years the consultants at Muckamore raised our concerns to the hospital management team and beyond lobbying vociferously for a primary care service for our patients."

Then you go on to say:

"In the absence of any primary care services day to day clinical issues were addressed by one of the psychiatry team. More recently before I left Muckamore in 2018, a general practitioner was welcomed on to the medical team."

11:41

So really before 2018, did the hospital have to rely on the services of a GP in the community to attend the hospital if it was felt that a GP was needed to see a patient, or was it managed by the psychiatrists really?

11:41

A. Yeah, exactly the latter.

38 Q. Okay.

11:41

A. There was no routine access to general practice for the patients who lived there, to all intents and purposes, or for the patients who were there being treated for illness.

39 Q. When you say no routine access, was there access in other ways?

11:42

A. Very little. The reason I didn't say "none" was because for a number of years, certainly from I arrived in Muckamore, probably through the noughties, the out-of-hours cover, medical cover, was provided by a group of local general practitioners, which was unusual. Most, if not all other mental health facilities in the region would have had trainee doctors, psychiatrists, on a rota, but there was

11:42

out-of-hours GP cover. And occasionally those, the goodwill of those GPs was utilised to the maximum, in that the nurses would have said, "While you're here doctor, will you have a wee look at that?". But that was sort of unofficial and there wasn't any governance around it. But, no, essentially there was no GP medical service available to our patients.

DR. MAXWELL: Can I just clarify, because you've said before the break that you were on a one in eight rota. 11:43

A. Yes.

DR. MAXWELL: Meant that you were on-call every eighth night.

A. Yes.

DR. MAXWELL: Every eighth weekend.

A. Yes. 11:43

DR. MAXWELL: And now you're saying there was no cover for Muckamore out-of-hours?

A. Oh, no, there was no what we call first on-call cover, so cover for medical issues, or first on-call for psychiatry issues is usually provided by trainee doctors, they're on a rota. We didn't have that out-of-hours in Muckamore. 11:43

DR. MAXWELL: So there was no junior doctors at the weekend?

A. No. Well now that you mention it, the junior doctors were on site between 9:00 and 12:00 on a Saturday morning. 11:44

DR. MAXWELL: And that's all?

A. That's all out-of-hours.

DR. MAXWELL: So anything that happened between midday Saturday to 9:00am Monday --

A. And every evening after that.

DR. MAXWELL: And every night.

A. Yes. 11:44

DR. MAXWELL: The nurses had to make the decision 'Is this something I need to call the on-call GP for?'.

A. Yes. So things like admissions of patients out-of-hours, the clerking the admission process was undertaken by the GP. 11:44

DR. MAXWELL: Oh, really!

A. Yeah.

DR. MAXWELL: And the seclusion policy requires a doctor to be informed every hour that a patient is secluded. So if the patient was secluded out-of-hours, 11:45 were they informing the GP?

A. Yes. For that spell. Now things did change, I can't remember when, but in recent years there has been a first on-call rota that is covered by core trainees in psychiatry. But for I would say most of my time in 11:45 Muckamore it was that GP service that ran out-of-hours.

CHAIRPERSON: And given that an admission at the weekend would very often be a crisis admission.

A. Yeah.

CHAIRPERSON: You're saying there'd be no psychiatric 11:45 involvement until the Monday morning?

A. Well, there would have been psychiatry involvement in the accepting of the admission.

CHAIRPERSON: Right.

A. So -- and if the GP then felt it necessary to have -- there was a consultant on-call rota where the consultant could, and we often did go in, but there was no on-call psychiatry below consultant level.

CHAIRPERSON: No. Okay. Thank you. 11:46

40 Q. MS. BRIGGS: How did the lack of primary care services for patients affect patients in Muckamore?

A. Again, it's hard to capture the extent of that, but one -- you know, it was incredibly frustrating as a clinician to work with a big group of patients who 11:46 essentially weren't having their primary physical care needs met. Things like, for example, screening. Throughout that time there were a number of, you know, departmental initiatives around screening of patients and the onus for that - I'm thinking about breast 11:47 screening for women of a certain age, and mammograms and that kind of thing, our patients in Muckamore were often excluded from that because that was dictated by GP lists, so GPs were invited to be involved in that process and had maybe targets around it, but our 11:47 patients, the patients who lived there were no longer on GP lists so didn't have access to that.

41 Q. And when you raised your concerns about primary care services with the hospital management team, how was that received?: 11:47

A. Well, we were listened to. You know, it was acknowledged that it was a gap, but it just proved difficult to fill.

CHAIRPERSON: So you were listened to but nothing

happened.

A. Yes.

CHAIRPERSON: Until about 2018 I think you said.

A. Yes. Yes. And I suppose adding to our frustration, Chair, was the fact that there were other similar in-patient facilities where the patients did have a visiting GP. 11:48

CHAIRPERSON: And was this a funding issue or not?

A. I assume so.

CHAIRPERSON: Okay. But you don't know? I mean to be fair, you don't know. 11:48

A. I don't know. I don't know. I was never aware of anything going out to tender to invite, you know, a GP or a recruitment process around that, so I can only assume that the issue was before that, but possibly -- 11:48

CHAIRPERSON: And in terms of basic health things like screening services, does that mean that a patient would have to be referred by a psychiatrist to a GP for screening or was it just not happening?

A. For the most part it wasn't happening. There was no GP that we could refer to. 11:49

CHAIRPERSON: So learning disabled patients were being treated quite differently to the rest of the population in Northern Ireland in terms of health screening?

A. Yes. 11:49

MS. BRIGGS: If we can go on to paragraph 16, the second half of page 8. You're describing here the treatment needs of patients and how these were met, but you say about six or seven lines down:

"Unfortunately we were not always in a position to meet all the needs of a patient. There were sometimes gaps in the service which dictated this. At times, for example, I can recall periods when patients did not have access to a clinical psychologist or an occupational therapist due to staff shortages."

Thinking about the NICE Guidelines regarding challenging behaviour specifically, that they say that anti-psychotic medication shouldn't be used alone for the treatment of challenging behaviour, was practice falling short of those guidelines during the periods that there were no psychologists or occupational therapists? 11:49 11:50 11:50

A. Yes. Yes. Undoubtedly, that's exactly what I referred to, Chair, that there were times of feast and times of relative famine, and it was very noticeable in terms of the difference between the two. At various junctures we had a well staffed, almost complete multidisciplinary team, and at those times it felt like the ward functioned much better and, you know, patients recovered quicker and were -- and then at other times the opposite ensued where parents -- we didn't -- now, I have to say, you know, particularly with things like clinical psychology, there were recruitment issues. It wasn't that -- it didn't seem to be that these were about resources. So the resource was there, it was intermittent, and I think that related more to 11:50 11:51

recruitment than allocation of resource, and often it was only a matter of a few months and then we would get a new psychologist. But there were, over the period of my time there, there were gaps in a number of disciplines.

CHAIRPERSON: We also heard -- I'm sorry to intervene, but we also heard that there was effectively no OT service until pretty late in the day, again I think it was 2018. Were there OTs on the wards when you were there?

A. My impression is that it was possibly a couple of years before that.

CHAIRPERSON: Right.

A. Maybe from about 2015 or '16 we went from having no OT and never had OT, I think it was felt that Day Care filled the gap, you know that sort of vocational training stuff, but it wasn't, you know, anything like occupational therapy. But that did change around about 2015 or '16 where they did become very active members of the multidisciplinary team.

CHAIRPERSON: Right. Thank you. Sorry, Ms. Briggs.

42 Q. MS. BRIGGS: No problem, Chair. Thinking about then shortfalls in the multidisciplinary support or staff that were available to patients, did the times when it was lacking, did that perhaps lead to the use of what might have been otherwise unnecessary MAPA or seclusion?

A. I'm not sure it's possible to answer that. It would seem logical, but I can't, I can't think of specific

examples.

43 Q. And as a consultant with responsibility for the patients on the ward, was it your role to draw the inadequacy of the service in terms of a lack of psychologists or a lack of OTs to the hospital management's attention or was it somebody else's? 11:53

A. I saw it as part of my role to liaise with the hospital management team. I had the opportunity to do that. Mostly through meetings with the Clinical Director, be they consultant meetings, or as I've referred to in my statement, the medical staff meetings. So, yeah, there were opportunities, and I certainly took those opportunities to illustrate gaps in the service that we were providing to patients in Cranfield. 11:54

44 Q. And what was the response? 11:54

A. It varied. As I say, usually because both Clinical Directors that I worked with had responsibilities within the hospital. I would have engaged with them regularly in terms of things like patient handover and patient movement between wards. So they were as aware of issues like this in their ward. My job was to inform them of the situation in Cranfield, which I did regularly. 11:54

45 Q. Okay. Further on in paragraph 16 you give some statistics for the admissions to Cranfield during your time on the ward. You say that during the 12 years you worked there as a consultant there were approximately 1,500 admissions to wards that you had responsibility for, an average of two to three new admissions per 11:55

week. You say that you can recall evaluating length of stay figures for the service, probably around 2012/2013, and you believed that the average stay was approximately 13 weeks.

11:55

Where did you take those statistics from? Do you have a source document for those?

A. I'm sorry, I don't. And it's -- when it came to me making my statement, and obviously I attempted to, you know research my statement, and unfortunately things like audits, I didn't keep. A lot of them were led by trainees, trainee psychiatrists who worked with me. They would have been kind of a joint project. And ultimately they would have been, you know, PowerPoint presentations that were presented at, you know, medical staff meetings or things like that, and had I known what was ahead I certainly would have kept them.

11:56

11:56

46 Q. Where did you get the 1,500 admissions number from then?

A. Well that's just - any time we sat down to review admissions over the time I was there, we were roughly in the region of 100 to 120 or 30 a year. So that's just extrapolation.

11:56

47 Q. Okay. I'm thinking about the average stay of 13 weeks in the 2012/13 period. Was a move to a resettlement ward counted as finishing a length of stay?

11:57

A. I can't remember, but probably. We were focused on the length of time it took a patient to recover in Cranfield to a level that enabled them to move on. And

that either meant discharge, which wasn't in the vast majority of cases, or transferred to another ward for continuing treatment.

48 Q. Presumably also the range of a length of stay wasn't so good, because the Inquiry has heard quite a lot of evidence about patients that were in Muckamore for a very long period of time. 11:57

A. Which was why we sort of focused on Cranfield as an acute assessment and treatment ward.

49 Q. Right. 11:58

A. And our figures were based on the length of time we felt the patient needed to be in that setting, if that makes sense?

PROFESSOR MURPHY: So it was more an estimate of what you felt could be achieved than what was achieved in terms of the patient's experience of being in hospital. 11:58

A. Yes.

PROFESSOR MURPHY: Because lots of them just went to the resettlement ward and then were part of delayed discharge. 11:58

A. Yes.

PROFESSOR MURPHY: And then may have stayed there for years?

A. Yes. So this was an attempt to capture an outcome of our work in Cranfield. 11:58

50 Q. MS. BRIGGS: Dr. Hughes, I'm going to ask you about another statistic that's known to the Inquiry, and that's from the evidence of Mr. Hagan, the Medical Director in the Belfast Trust.

A. Yes.

51 Q. And that's an exhibit he has to his statement. The statement reference is STM-101, and it's an overview chart he exhibits at page 5490 of his statement. If we can pull up 5490 first of all? And I know, Dr. Hughes, you've had a chance to look at this as well. And Mr. Hagan's statement says that the graphs there were produced by the Risk and Governance Team at the Trust. 11:59

A. Mhm-mhm.

52 Q. 11:59

"...to assist the Inquiry."

And he says that the data was collected from Datix.

A. Mhm-mhm.

53 Q. And it's that graph on the left there that I'm going to look at. I think we can actually pull up, yeah, a bigger version of that. When looking at this graph, the green line represents inappropriate or aggressive behaviour towards staff by a patient, and this is behavioural incidents between January 2009 through to December 2022. And when you look at the green line there you can see that there's a steep increase in incidents of aggressive or inappropriate behaviour towards staff by a patient really from in and around 2014, and it goes up then to a height of about 2000 -- well, a height of 2,505 in 2018. And you can also see that there's a smaller rise from that graph in terms of inappropriate or aggressive behaviour by staff towards patients? 11:59 11:59 12:00

A. Mhm-mhm.

54 Q. Are you following all that okay as I've said it?

A. Yes. Yes.

55 Q. I'm just going to give you a chance to reflect on that. What do you think caused those increases? 12:00

A. Obviously this is something that I have reflected on and considered very carefully. Any insight that I can give is purely speculative.

DR. MAXWELL: Were you aware of this data? Because we see a stepwise change in 2014 going up to 2018. So 12:01 this was Datix incidents, and we've heard that Datix incidents were reviewed regularly in the hospital. Were you actually aware that there had been this steep rise?

A. I wasn't, but the information that I was supplied with 12:01 was specific to the wards that I worked on, and I'm not, I'm genuinely not sure how much of that affects the overall figures that we see.

DR. MAXWELL: So you were responsible for the admission wards for Cranfield? 12:02

A. Yes, at that time from 2014/15 for Cranfield 1 and Killead. The female admissions moved out of the Cranfield complex in 2015 I think.

DR. MAXWELL: Right. Were you responsible for the PICU? 12:02

A. Until 2015.

DR. MAXWELL: Because might one have expected these behavioural incidents to be more likely to happen in admission wards in Intensive Care Units than the

resettlement wards?

A. Yeah, I think so.

DR. MAXWELL: Those were the wards where you were more likely to see challenging behaviour?

A. Yes. Although what had also happened, and again I was peripheral to this, the resettlement agenda had limited success. A number of patients sort of between 2010 to 2015 or '16, had moved on to -- out of hospital. That led to at least a couple, if not more, re-profiling exercises where -- so the resettlement process, as far as I understood it, focused on one ward at a time, and the plan was to close wards in sequence. What happened in reality was when a ward was approaching closure, so it had shrunk from -- the population in it had shrunk from 15 or 20 patients to maybe five patients, it seemed to be that a decision was taken at that point to fast-track closure and move the remaining patients into other wards. Some of them were long stay wards, but some of them were, the moves were into the acute side, and this was something that frustrated us as a multidisciplinary team. But by definition, and I suppose one could maybe assume that the patients that were left in those wards as that happened were perhaps more difficult to discharge. 12:03 12:03 12:04 12:04

DR. MAXWELL: Distressed. 12:04

CHAIRPERSON: Oh, I'm so sorry, Dr. Maxwell.

DR. MAXWELL: Sorry. Can I just ask one other question? So I'm wondering if you had been aware of this what you might have done, because it seems to me

that if the staff were experiencing more assaults they might get distressed and burnt out and might be more likely to being potentially assaulting the patients who were assaulting them?

A. I did become aware of staff suffering more from stress at around that time. There's no doubt about that. A lot of senior staff seemed to seek alternative employment, or retire, those that could. 12:05

DR. MAXWELL: So if part of this stress was because, for whatever reason, the patients were becoming more distressed and there were more assaults on staff, what could or should have been done? 12:06

A. It's a very good question. I'm not sure I have any answer to -- I'm not a manager, I don't know. But certainly if these figures came to light and came to my attention, I would be raising concern and, you know, I did get a sense around that time that the hospital, and by that I mean the staff within it particularly, were struggling. I don't perhaps want to open up too much in terms of the direct impact on me, but suffice to say that around that time I began to consider what was best for me in terms of employment, and ultimately it took until 2018 for me to have an opportunity, but it was in my thinking from around this time. A lot of senior colleagues were leaving and left and... 12:06 12:07 12:07

CHAIRPERSON: Yeah.

A. Yeah.

CHAIRPERSON: Could I just ask this, I think we can all understand how you wouldn't necessarily be aware of

precise figures.

A. Yeah.

CHAIRPERSON: But in terms of a general increase of inappropriate behaviour towards staff by a patient, I don't quite understand how you wouldn't have been aware of that, because you were doing ward rounds. 12:08

A. Yeah.

CHAIRPERSON: You would have MDT meetings in relation to your patients, presumably?

A. Yeah. 12:08

CHAIRPERSON: You were having consultations with your patients. So if X had assaulted Y, wouldn't you be told about that?

A. Oh, yes, yes, and those incidents and figures were presented each week at the ward round relating... 12:08

CHAIRPERSON: Right.

A. But I --

CHAIRPERSON: But you weren't aware of an increase?

A. I didn't get a sense of this sort of an exponential increase in the two wards that I worked on. I genuinely didn't. 12:08

CHAIRPERSON: Okay. Okay. Thank you.

PROFESSOR MURPHY: Did you get a sense that there were increasing staff shortages as well? Because we've heard from a number of witnesses that from about 2012 onwards there were increasing difficulties with nursing staffing? 12:09

A. Yes. Yes, certainly. And that impacted on, you know, patient care. You know, we noticed that it was more

difficult for patients to spend time off the ward accompanied by nurses and, of course, that's therapeutic. So there were certainly examples of that. One other area where it I suppose affected practice was in response to risk of harm to self or others, we would 12:09
sometimes have had patients on levels of observation.
PROFESSOR MURPHY: Mhm-mhm.
A. There was a clear policy around that. And I did get a sense from nursing colleagues that our decisions in terms of that would impact on the care that was being 12:10
provided to other patients. So, for example, whenever we decided, for whatever reason, that a patient -- and it wasn't very usual for a patient to need two-to-one observations, we were told that that would significantly eat into staffing resources. There 12:10
weren't any extra staff coming along to do that for that individual patient, and that would undoubtedly lead to other patients not having access to the nursing team in the way that they did before.
PROFESSOR MURPHY: And presumably other consultants 12:10
covering other wards had similar worries about staffing?
A. Yes.
PROFESSOR MURPHY: And how was that escalated upwards?
A. Through the appropriate channels that we had, which was 12:11
up through Clinical Director. I can remember it being discussed often at consultant's meetings and medical staff meetings.
56 Q. MS. BRIGGS: If we can go on to paragraph 19, that's

page 10. You were asked, Dr. Hughes, to comment upon the evidence of some families that their relatives appeared "zombified" or "spaced out" or "not in the room" when they visited. You say that you do not recall this ever being the case with any patient under your care.

"It would, however, not be unusual for a patient to appear sedated having taken medication such as rapid tranquillisation where it had been required, a not uncommon occurrence in acute mental health wards."

Did any relatives ever raise that specific concern with you?

A. I can recall discussions taking place around this issue, and taking the time to explain to relatives, and sometimes patients themselves, that what we were trying to find was a balance between symptom control and the patient having enough energy and motivation to live a meaningful, active life. And at times of acute distress, finding that balance was a challenge for everyone, and is, in terms of psychiatric practice in acute wards. But in Cranfield it was always our focus, that balance, and we never accepted some of those things that have been referred to about being "zombie", that was so far removed from what we were about or who we were.

CHAIRPERSON: When you say you never accepted, what do you mean? Do you mean you never accepted allegations

that that was --

A. No, no, no, no, no, sorry, sorry, we never accepted it as a good outcome for the patient.

CHAIRPERSON: No. Right.

A. Sorry, I should have been clearer there. We did continually strive to work with patients and families in that regard. So, as I say, I don't recall a patient under my care being in that state or condition. 12:14

CHAIRPERSON: I mean we had some evidence of families sitting with their loved one, their patient, and the patient was out of it, or drooling, or didn't know where they were. Now if there had been a very recent sedation of that patient, I suppose one could understand that? 12:14

A. Yes. 12:14

CHAIRPERSON: But that ought to have been explained to the relatives, oughtn't it?

A. And I can only, only reiterate that instances like the one you describe, Chair, were as rare as we could make them, but it's impossible to not have any degree of sedation when you're using sedative medication. 12:15

CHAIRPERSON: No, of course.

A. But certainly at times where we were concerned, as sometimes we were about the levels of medication that were needed, we would, you know at any opportunity, try to engage with families and explain the nature of the treatment and what we were trying to achieve through it. 12:15

PROFESSOR MURPHY: But do you think that the

difficulties that resulted from the shortage of nursing staff on the wards had a knock-on effect on the levels of medication and PRN that you were having to use to keep things "calm"?

A. Again, it's -- there is evidence that that is the case. In the absence of other forms of treatment, often medication is used. The word "inappropriate" is, I think in cases ill-judged in that regard, because we have to accept that other treatments aren't there but the patient is still suffering, and it's our job to alleviate that. So I think there is perhaps a logical assumption that can be drawn that the absence of other forms of treatment do lead to increased use of medication. But I don't ever recall a situation where a patient came to direct harm as a result of that. 12:16 12:16 12:17

CHAIRPERSON: When you say "other forms of treatment", are you referring to things like Positive Behaviour Support or something else?

A. Yes, all forms, Chair. So, yes, those, you know, things that we've mentioned around psychology and that, but also -- I don't want to call them "softer", but those sort of therapeutic interventions that, you know, a well resourced nursing team can deliver. 12:17

CHAIRPERSON: Yes.

A. That don't fall under the umbrella of any particular form of psychotherapy. 12:17

CHAIRPERSON: No.

A. But they're just sort of more, more sort of psychosocial, you know, human interaction, exercise,

you know those sort of lifestyle issues that are very important for good psychological health.

DR. MAXWELL: So are you saying then that the shortages in ward staff, of both Registered Nurses and healthcare assistants, meant that there were less therapeutic interventions between the ward staff and the patient, and less activities, which resulted in patient's mental health and behaviour becoming more distressed? 12:18

A. Yes.

DR. MAXWELL: But that at the point at which the patient became distressed you had to do something which was some sedation? 12:18

A. Yes, if -- everything else we had was tried and failed. So, I mean, I saw, you know, daily examples of nurses using, you know, distraction, diversion, those sorts of things and, you know, in a huge proportion of cases that worked. 12:19

DR. MAXWELL: But if there weren't enough nurses to give enough time to each patient to do that...

A. Yes. Yes. 12:19

DR. MAXWELL: And the patient became distressed.

A. Yes.

DR. MAXWELL: You're saying that however they got there, that patient was distressed.

A. Yes. 12:19

DR. MAXWELL: And you had to treat that, which might have involved sedation?

A. Undoubtedly, yes.

PROFESSOR MURPHY: I think PRN wasn't monitored in

terms of trends, was it, the way that seclusion, and incidents, and physical intervention were treated - were analysed for trends?

A. Yes, I certainly have no evidence to contradict that. What I can say is that at an individual patient level in Cranfield we worked very hard to monitor the use of PRN medication. But I'm not aware of the same systems being in place for an overall review of use within the hospital, for example. 12:20

PROFESSOR MURPHY: Do you think they should have been analysed for trends in the same way that some of the other restrictive practices were analysed? 12:20

A. Yes.

57 Q. MS. BRIGGS: Dr. Hughes, Clozapine or Clozapine is a drug that the Inquiry has heard some evidence about. 12:20

A. Mhm-mhm.

58 Q. Can you explain its uses and effects first of all?

A. Clozapine is an antipsychotic drug that is licensed for use in patients with schizophrenia. It is considered -- it's not considered a drug of first choice. So it's -- guidelines for its use are very clear in that it is seen as an option when other forms of treatment have failed to control the patient's symptoms. So it's for those reasons, and reasons that relate to how it has to be monitored, which is, you know, regular blood samples and other things, it's not widely used. But in my experience it's a very effective drug at controlling symptoms in people with severe mental illness. 12:21 12:21

59 Q. Is it a drug that you prescribed at Muckamore?

A. Yes.

60 Q. And what -- you've said it's really a drug of last resort. Why is that? What are its effects on the patients? Is that due to the effects on the patient?

A. It's related to the effect it can have on blood cells, and ultimately it can leave patients prone to infection and some serious infection. So there are very clear boundaries around its prescription and monitoring. It's carefully controlled is what I mean. 12:22

61 Q. And can it have the effect of spacing out or "zombifying" a patient as well? 12:22

A. No more than any other antipsychotic drug.

62 Q. And if a patient disagreed with your prescription of a drug like Clozapine, how would you deal with that?

A. In the way that we would -- usually -- well I suppose what's slightly different about Clozapine, if there is patient objection we would need to think very carefully about proceeding. I can't remember a case where we did. Because essentially the monitoring that's involved where a patient has to have very regular blood checks, certainly in the early stages of prescription in the initiation period blood tests are very frequent, and patients more or less have to consent to a blood test being taken. So, yes, I can't remember a single case where we proceeded where there was patient objection. 12:23 12:23 12:24

63 Q. If we can move on then to paragraph 22, it's on the end of page 11 and into page 12, you're describing medical staff committee meetings and you say, and this is the

last line on page 11:

"During these meetings we reviewed Datix and other Serious Incident Summary Reports for patients and for the wards. It was a big part of the agenda of the meeting for around a decade. We had lists of incidents and enough detail to go through incidents individually. It was seen as part of the governance of the hospital in identifying safeguarding issues or concerns. Throughout this time I never had any indication which alerted me to the fact that patients were being abused by staff." 12:24 12:24

Were you ever at any time alarmed at the number of safeguarding incidents on the wards? 12:24

A. I don't recall being alarmed. I do recall being reassured. What happened was that at a point in the meeting -- so there was an agenda and this was a rolling agenda item, I think it was called "Incidents and Accidents", and each of us had a crib sheet with details of incidents, and it was everything that had happened in the hospital that was considered an event. Through from a stranger being seen in the carpark, and that was reported through as an incident by a concerned member of staff, to some of the issues on the wards where there were assaults, you know, across the people that were on the wards. And each, each incident was skimmed through. Time dictated that we couldn't focus on every one. So the Chair of the meeting would -- 12:25 12:25

everybody had their crib sheets, so the Chair would signal that we were on page 1, page 2, and anybody had the opportunity at any point in the meeting to ask a question about any of the incidents, and usually it was the consultant with responsibility for the ward who addressed whatever concerns. But occasionally those medical staff -- those staff meetings were a bit of misnomer because there were other senior members of the hospital management team there, so they would often chip in and say: 'Yes, I've heard of that incident' or 'I've investigated that incident and here's what' -- so, yes, it was -- it felt like a robust exercise. 12:26 12:26

As to whether or not all of the doctors in the hospital needed to take the time to do this, and I don't know if that was a factor ultimately in the decision to take that scrutiny away from that Committee and into the, I think it went into the hospital management team, at a time that I can't recall. 12:27

64 Q. Yes, you do say that in around 2012/2013 the role of scrutinising incidents in the hospital was transferred to the hospital management team? 12:27

A. Yeah.

65 Q. And was therefore no longer on the agenda of the Medical Staff Committee. Do you know why that was? 12:27

A. I don't.

66 Q. You don't?

A. I don't.

67 Q. Okay. And just taking it back to really the broader

question: At any time during your time in Muckamore, did you ever worry that there was institutional abuse happening?

A. No.

68 Q. What about around the time of the Ennis Investigation or again in 2017? 12:27

A. To be honest, the Ennis Investigation, I obviously was aware of it. We -- not so much the detail, but it was something that we were all made aware of, and all cognisant of and, you know, determined, in as much as we could, to take whatever steps we were able to, to prevent anything like that from happening again. But on the wards that I worked on, such was the honesty of the staff that I worked with, I honestly -- and maybe -- I mean I genuinely don't know as much as other people in this room about, you know, the level of abuse that patients suffered on each ward, but I would still be staggered to think if there was any, or certainly any significant abuse that took place on the wards that I worked on when I worked on them. 12:28 12:29 12:29

69 Q. And just thinking then about the Ennis Investigation. What learning was actually shared and utilised from the Ennis Investigation, can you recall?

A. Not specifically. I do recall receiving written communication, it was discussed at medical staff meetings, and beyond that I can't be specific. 12:30

70 Q. Just thinking about other avenues that concerns might have reached you. What about your trainees, your role in education, did any of your trainees ever raise

concerns about poor practice or abuse at Muckamore with you in supervisions, for example?

A. Never. Never.

71 Q. And what about your role then as a community consultant? I mean, had you come across former patients and their families who perhaps expressed concerns or even dissatisfaction about Muckamore? 12:30

A. Not that I recall. And actually what I experienced, continue to experience, is the opposite, where people, I suppose, share my disbelief and incredulity. You know patients themselves, families of patients, would often express - not often, would sometimes express to me in out-patient appointments their feelings about obviously what has been in the public domain now for a number of years, and still would stress their surprise, based on their experience. 12:31 12:31

72 Q. And I'm just going back to the transfer of responsibility really for scrutinising incidents. As you've said in your evidence it went from the hospital management team -- it went to the hospital management team from the Medical Staff Committee in 2012/2013. Was that a positive or a negative change in your view? 12:31

A. In hindsight a negative one, because the more scrutiny by senior people within the hospital the better, one would assume. But actually at the time I, I probably had mixed feelings about it, because medical staff meetings were lasting an inordinate amount of time, and I was sitting at most of them thinking about where else I could be and what other work I could be doing. 12:32

DR. MAXWELL: But at this time they were also being reviewed in other committees.

A. I think so, yes. Yes.

DR. MAXWELL: It wasn't that the medical staff were the only people reviewing it? 12:32

A. Yes. Yes.

DR. MAXWELL: It was just a decision was taken not to present it at the Medical Staff Committee?

A. Yes. Yes.

DR. MAXWELL: But would you have been looking at some 12:32
of these trends when you were doing the MDT meetings?

A. Yes, and a bit beyond. There would have been occasions where -- now not in any structured or formal way -- where we would have sat down with the Operations Manager, who was usually a nurse, I think maybe didn't 12:33
always have that title. So the nursing structure within Cranfield, which is all I can speak about, each ward had a Ward Manager or a Ward Sister, and then there was a more senior nurse overseeing the wards, and that person was key to a lot of this and we would have 12:33
discussed trends around seclusion and physical intervention, but, as I say, not in a formal way that was on an agenda in a meeting, it was just something where -- it was brought up.

DR. MAXWELL: Things that had come to your attention in 12:34
your review of patients.

A. Yes.

DR. MAXWELL: That suggested something unusual, a spike in a certain thing.

A. Yes. Yes.

DR. MAXWELL: And you had a route to raise that?

A. Yes.

73 Q. MS. BRIGGS: And just thinking about what you've said there about ward rounds and getting information in different ways. At paragraph 23 you're talking there about reviewing reported incidents involving patients at weekly ward rounds, and the information was prepared from the patient's care plan, and you say that those reports detailed the number and nature of incidents, including the use of physical intervention, PRN medication, and seclusion. Did those reports include peer-to-peer incidents and peer-on-staff incidents? 12:34 12:34

A. Yes.

74 Q. You go on to say, and it's in that paragraph I think, that as far as you were aware every incident was recorded in the patient's care plan. How did you satisfy yourself that that was the case? 12:35

A. I didn't go to any lengths to. I simply had to trust the senior people who were providing me with the information, and I did. 12:35

75 Q. Okay. If we can go on to paragraph 24 on page 12? You say there:

"I like to think that I always enjoyed good working relations with the hundreds of staff I worked with in Cranfield over the years. There were times when it felt like we were a beleaguered team working in extremely challenging circumstances and our ability to 12:35

function well as a team undoubtedly contributed to the excellent outcomes for the vast majority of our patients."

Why did your team feel beleaguered? Was that due to a lack of staff or other reasons? 12:36

A. Just simply that. As I said earlier, there were times of plenty and times of scarcity, and there's no doubt that during the latter there was that spirit that I've described there where we dug in and, you know, we stayed late and, you know, we did what we could. 12:36

76 Q. If we can go on to paragraph 25 on page 13. You say there that you recall only one situation potentially impacting on patient safety which you felt duty bound to report. You say: 12:36

"I was one of a small number of staff involved in raising awareness to the hospital management team, specifically on my part to the Clinical Director, raising concerns about the health and therefore the performance of a medical colleague in the hospital. Indeed, I raised these concerns on more than one occasion, some of which were brought to me by those less senior with less experience of such matters. With time, I did feel that my concerns were heard by those in senior management roles." 12:36 12:37

Perhaps it's difficult to separate the two, but was that a personal issue or a safeguarding issue about

that member of staff?

A. I was never made aware of any incidents that could have been regarded as safeguarding, but my concerns were that if the situation was allowed to develop it might reach that stage. 12:37

CHAIRPERSON: I don't think we need to spend more time on this. This was a member of staff who was unwell in some way.

A. I'm uncomfortable with this, yeah.

CHAIRPERSON: Let's move on. 12:38

77 Q. MS. BRIGGS: Thank you, Chair. If we go on to paragraph 26, you're providing the Inquiry with your view regarding what the strengths and weaknesses of care were during your time at Muckamore. You reflect on some positives. You talk about the treatment of 12:38 patient's mood disorder and schizophrenia, which you feel was an area of excellence, and you reflect upon many gifts and praise received from families. You tell the Inquiry about that as well. Regarding weaknesses, you refer to a sub-group of patients who you feel were 12:38 less well served, those with moderate or severe intellectual disabilities and autism. You say that it sometimes proved impossible to help those patients to achieve psychological well-being, such was their difficulty in adjusting to life on a busy hospital 12:39 admission ward. And you say that Cranfield was sub-optimal in several cases that you recall.
Can you explain what you mean by this, how the care at Cranfield was sub-optimal in several cases?

A. Most of it relates to the environment, and whilst it was carefully designed, it's well-documented that the admission wards do not meet the needs of people who struggle with the level of stimulation that is an inevitable consequence of bringing a number of sick people into the same environment.

CHAIRPERSON: Could you keep your voice up? Sorry, you've dropped your voice.

A. Sorry. Yeah, the plight of people with autism on the ward was a constant concern. They have very specific needs when it comes to sensory stimulation and the environment, and from the start it was clear that we weren't geared up to meet those needs.

78 Q. MS. BRIGGS: So for those patients, might it have been the case that admission to Muckamore decreased their mental health and well-being?

A. Yes. And that was acknowledged, and I can remember several conversations with -- often I was alerted to the possibility of an admission by a consultant colleague who worked in the community in advance of it happening. And I can remember a number of conversations where the consultant was already concerned about whether or not the patient would do well in Cranfield, but there often was no alternative. And it's been the long held view of many of us working in the speciality that the need for a specialist autism service is glaring. The gap -- the -- we simply don't cater well for the needs of, I have to say particularly young men, young men who leave school, and we had a

particular cohort of them who came through Cranfield during my time there and really struggled, 18, 19, 20-year-old young men who -- and, again, this was something that, you know, we regularly portrayed to people advocating on behalf of the patients, but were repeatedly told that there simply wasn't the resources to develop. And, you know, it certainly would have needed to go beyond Muckamore. This needed to be a bottom-up strategy, you know, for children with autism, for young, transitioning to adult services and all of that, and to this day we still don't have anything that resembles a strategy. 12:42 12:42

PROFESSOR MURPHY: So do you think it should have been more an issue of social care than health care for those particular individuals? 12:42

A. Yes, often. Often. I can recall visiting a unit in the north-east of England and being mightily impressed and thinking that it could be something that we could do here, and relaying it to a number of senior staff both at sort of hospital and maybe beyond level, but they had very creatively refurbished an old long stay ward, in a hospital that wasn't unlike Muckamore, and had turned it into a four-bedded assessment and treatment unit, but it was almost like four pods around a central hub, and it worked an absolute treat. And actually the thing that struck a cord with me particularly was because the environment felt very like Erne in Muckamore, and I beat the drum for as long as I could and said -- but was told that there just simply 12:43 12:43

wasn't... Now, I can understand that, because those four men, when I asked, there was a staff team of around 40 looking after, so it was very resource intensive, but... It's those sorts of things that are, you know, professionally very frustrating when you see them happening in other areas and not your own, and see then very directly the consequences, and when you're walking into work every day and having to, you know, do your best for the patients that are there, knowing that patients in other areas are receiving a much better service, that's tough. 12:44 12:44

PROFESSOR MURPHY: So you may be aware that in England, people with autism and severe learning disabilities are - or there's debate about whether they should be removed from the Mental Health Act for exactly the sorts of reasons that you're explaining. Has there been that kind of debate over here? 12:44

A. No.

PROFESSOR MURPHY: Do you think there should be?

A. Mhm-mhm. And I think even across the border they're miles ahead of us. I see they launched a new innovation strategy just last week or the week before. The Government - I think it was the Taoiseach maybe who launched it, you know, it's considered so serious. But, sadly, we don't have anything like it here. 12:45 12:45

79 Q. MS. BRIGGS: Before we move on to a part of your statement where you respond to criticisms that are put, I just want to go on to paragraph 29 very quickly, and you're reflecting on a number of matters there, and one

of those is something you've touched on earlier, the effects of austerity and government cuts, and how those were felt in Cranfield really from around 2012. How were they felt in Cranfield from 2012?

A. I think mostly in terms of the nature of the presentation of patients at the point of admission and their social circumstances and the number of - I think I've used the word "beleaguered" a couple of times, but it probably doesn't come close to describing how the condition that some carers and families were in at the point of admission, where the patients were so deprived of what they needed there was an inevitability about the circumstances, but also then the concern is that -- the concern always was that -- and some patients did, some families had reached a point of no return, and I saw a direct connection between the gaps in services in the community brought about by -- not -- I mean austerity made things considerable, they were never great, we never directed resources to the care of people with intellectual disabilities in a way that other areas did. It's the same for Mental Health Services here. Our spend, to put it bluntly, is much less than anywhere else on these islands, and certainly in Western Europe, and Learning Disability Services were at least as bad as that, if not worse. And then along comes austerity and, you know, simple things that patients who had a five day a week placement at an adult centre, which is kind of 9:30 to 3:00 o'clock, they're hardly full days, had that reduced to two, you

12:46 12:46 12:47 12:47 12:47

know overnight, and increasing the burden on, you know parental responsibility, family responsibility, and you know direct payments were introduced and it never really took hold. It was more stress for the family. So for all of those reasons we started to see patients whose starting point when it came to what we were tasked with was very different to what we had seen before.

80 Q. And what about on the ward itself, how was the ward itself affected? 12:48

A. Well just in the ways that we've discussed. Once, you know, the numbers of staff on the ward began to diminish, the seniority of the team members reduced and, you know, generally there was just a sense -- and I think it was reflected across -- I mean my work 12:49 within education, and other things where I would have gone to other hospitals to complete pieces of work, second opinions and things, I never had the impression - whilst things were bad where I worked, I never really got the impression that they were significantly worse 12:49 than any of the other facilities. You know in terms of things -- in as much as you can grasp morale, I think. But talking to other consultants, as I often did, and you know, equally they would come to Cranfield and have second opinions for me, and there was never a sense 12:49 that Cranfield was an outlier in terms of Mental Health and Learning Disability Services.

81 Q. And you finish off by saying that the service is really still under-resourced?

A. Yes.

82 Q. So, really would you say that for the last 12 years or so there has been a continued under-resourcing of LD adult care?

A. Yes. Yes. 12:50

83 Q. In Northern Ireland or across the UK, do you think?

A. Well, certainly in Northern Ireland. And, you know, the impact of restrictions on admissions to Muckamore and other places like, bed reductions in other in-patient facilities really have led to a considerable 12:50 deterioration in the level of care that we can provide.

84 Q. The last page or so of your statement, Dr. Hughes, is your response to criticisms that have been made about you by other witnesses who have given evidence to the Inquiry. For completeness I'm just going to read those 12:50 into the record and your response to them, and I'll give you an opportunity each time to add to your response, if you would like to, and by no means do you have to do so.

12:51

A Restriction Order applies to paragraph 31, so I'm going to start at paragraph 32 on page 16.

A criticism was made by P109's mother, and that was put to you, and she said this - the criticism that was put 12:51 to you was as follows, that, on the 4th July 2016, the patients from Cranfield Women's Ward, including P109, were transferred to Killead Ward. You were on leave when this transfer occurred. Before the transfer, P109

was doing well. After the transfer, P109's hygiene was being neglected and she was not being properly cared for or protected. There were 21 patients on the ward and there was a shortage of staff. There were a lot of incidents on the ward. P109 was pushed by a patient and fell hitting her head. She was bitten twice within days. P109's mother heard screaming on the ward when she visited and was told P109 was hitting out. There was no stimulation for P109. P109's mother complained about this and phoned the ward twice daily to ask if P109 had been taken off the ward and was told that there were not enough staff to facilitate this. P109 was a voluntary patient. P109's mother thought of bringing P109 home, however she believed that if she attempted to do so Muckamore would detain P109. P109's mother alleged that you had previously told her that if she attempted to remove P109 that she would be detained. 12:52 12:52 12:52

And your response is at paragraph 32, and you say that: 12:52

"I do not recall this specific conversation, but I would frequently have been asked by a patient or their relative/carer in relation to these matters of the legal status of a patient who had been voluntarily admitted to the hospital. In response, it was my practice to outline the range of potential eventualities in the event of a change in the patient's expressed view regarding continued admission." 12:53

Dr. Hughes, would you like to add to that response?

A. No, thank you.

85 Q. Okay. And then paragraphs 33 and 34 are your response to a criticism made by P77's mother. P77's mother alleged that P77 was taken to Antrim Area Hospital Accident & Emergency Department due to a very high heart rate. The A&E consultant advised that P77 needed to come off Haloperidol immediately. P77's mother was not aware that P77 was on Haloperidol. P77's mother phoned you four days in a row to discuss this. You returned her call from your car so she found it hard to make out what you were saying. P77's mother told you that the A&E consultant said that P77 needed to come off Haloperidol immediately. You seemed to be suggesting, she said, that the A&E consultant did not know what they were talking about. You told P77's mother that P77 could not come off Haloperidol immediately and had to be weaned off it. P77 was taken to the same A&E again due to a high heart rate. The A&E consultant told P77's mother that he had told MAH to take P77 off Haloperidol, but P77 was still on this medication. You ignored the advice of the A&E consultant. The A&E consultant told P77's mother that he would follow up directly with you and that he was unwilling to discharge P77 unless you confirm that P77 would be taken off Haloperidol, because he was concerned that P77 could have a heart attack. P77's mother told the A&E consultant that you said that P77

12:53 12:53 12:54 12:54 12:55

had to be weaned off Haloperidol. The A&E consultant reiterated to P77's mother that P77 would not be leaving A&E unless he had an assurance from Muckamore that P77 would be taken off Haloperidol immediately. The A&E consultant told P77's mother that he was going to call you immediately. 12:55

And your response at paragraphs 33 and 34:

"A concern has been raised by P77's mother, a patient at Muckamore, in respect of advice stated to have been given by A&E consultant that P77's Haloperidol medication should be ceased. It is stated that I refused to cease the medication and advised instead that P77 should be weaned off it. Given the specific clinical nature of this concern it would not be possible for me to comment on it without access to the relevant medical notes. 12:55 12:56

In the event, however, that there was any divergence of opinion as between myself and another clinician as to a patient's appropriate medication, it would have been my customary practice for me to have factored the opinion of a colleague into my decision-making." 12:56

Dr. Hughes, would you like to add to that response in any way?

A. No, thank you.

CHAIRPERSON: I mean it's a fair point you make that

you would have to review all of the notes, but is it also fair to say that there are divergences of opinion occasionally between consultants. In this instance who would have been the consultant managing the patient? In other words, whose ultimate decision is it to make about the use of Haloperidol?

A. It would be mine, but obviously it should be a joined decision.

CHAIRPERSON: It should be?

A. A joined up decision. 12:57

CHAIRPERSON: Yeah.

A. So if there is a consultant who has concerns about the effect of a medication that I prescribe on a patient's physical health, there will be a discussion.

DR. MAXWELL: Would it be fair to say it would be quite unusual for an A&E consultant to ring you to query medication? 12:57

A. Yeah. Yeah, but it wasn't unheard of. I mean usually the bulk of our patients who needed acute medical care went to Antrim, which is about four or five miles away, and over the time I spent I would have had very good working relationships with consultants who worked there in various specialties. So it wouldn't have been unheard of for me to receive a call from a consultant and a discussion like the one we're alluding to taking place. 12:58 12:58

DR. MAXWELL: If there was concern, as suggested, about cardiovascular function, so the high heart rate and the risk of - well, whatever the risk was perceived to be,

would you ever have thought of seeking a cardiology consultant's opinion?

A. Yes.

DR. MAXWELL: And that's why you need to see the notes.

A. I think that's what in this. I think that's what happened, but I can't state that in any categorical way because I haven't seen the notes, but that would usually have been what we would have done. 12:58

CHAIRPERSON: Thank you.

86 Q. MS. BRIGGS: The final response that we'll deal with is P34's sister. A criticism made by P34's sister who alleged as follows; you told P34's mother that P34 was allergic to Benzodiazepines. However, you later prescribed Benzodiazepines to P34 in January 2018. And your response at paragraph 35: 12:59 12:59

"A concern has been raised by P34's sister that I prescribed P34 Benzodiazepines despite having knowledge that he was allergic to them. It is not possible for me to address this concern without having access to the relevant medical notes." 12:59

Would you like to add to that response in any way?

A. No, thank you.

87 Q. Okay. I'm going to give the Panel an opportunity to ask any questions they might have arising out of this portion of the witness's evidence. 12:59

CHAIRPERSON: No, I think we've asked them all as we've gone along. I think we're going to need to move into

closed session.
MS. BRIGGS: We do, briefly, Chair.
CHAIRPERSON: It would be useful if we can keep going. I think it'll be a very short session. So what we'll do now is move into closed session. There is already a 13:00
Restriction Order in place. I think it is Restriction Order No. 9.
MS. BRIGGS: It is Restriction Order 9.
CHAIRPERSON: Which effectively covers this scenario, so I don't need to make any further Restriction Order. 13:00
All we will be doing is going into closed session. The feed please to B should be cut and the wider feed as well.

RESTRICTED SESSION 13:00

OPEN SESSION

CHAIRPERSON: But it only remains in fact for me to thank you - unless there is any other matter. 13:04
MS. BRIGGS: No, unless there's anything from the Panel.
CHAIRPERSON: No other matters from us. Dr. Hughes, can I thank you for attending and thank you for answering all of the questions with some care, and I 13:04
think this will be the last time that we see you, so thank you for your attendance.
A. Thank you.
CHAIRPERSON: Okay. Right. Good timing, Ms. Briggs,

if I may say so. 2:05 we'll meet again. Thank you.

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Ms. Tang.
MS. TANG: Thank you. Good afternoon, Chair and Panel. 14:11
This afternoon the Inquiry will hear from Ms. Monica Molloy, and she'll be giving evidence as part of Module 7, which considers Muckamore Operational Management.

The internal page for the statement is 285, and there 14:11
are several exhibits under a total of three tabs, which include some reports that the witness can speak to. I should say that the statement and the exhibits have been published on-line on the Inquiry website.
CHAIRPERSON: Excellent. And there's no ciphering and 14:11
no redaction?
MS. TANG: There's no ciphering and no redactions. If there's nothing further, the witness can be called.
CHAIRPERSON: Let's get the witness in. Thank you.
I think we all need to keep our voices up. 14:11
MS. TANG: Yes, yes. Thank you.

MS. MONICA MOLLOY, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:

CHAIRPERSON: Ms. Molloy, can I just thank you very much for coming to help us this afternoon. Welcome to the Inquiry. Thank you for taking the time to draft this statement, and I'm going to hand you over to Ms. Tang to take you through your evidence. 14:12

A. Thank you.

CHAIRPERSON: If you're still going in about an hour we'll take a break. 14:13

A. Okay.

CHAIRPERSON: But if you need a break before that, just let me know.

A. Okay. Thank you. 14:13

CHAIRPERSON: Okay.

88 Q. MS. TANG: Thank you. Hello again, Ms. Molloy. We met a short time ago, as you may remember. I'm Shirley Tang. I'm one of the barristers for the Inquiry. I'm going to be taking you through your evidence this afternoon, and I want to just check that you have a copy of your statement in front of you. 14:13

A. Yes, I do.

89 Q. You do. And you have your own handwritten notes, I understand, on your original statement? 14:13

A. Yes.

90 Q. Can I confirm did anyone assist with you those notes or are they purely your own?

A. No, they're my own notes and they're just on the border

of the statement.

91 Q. Okay. In view of that, can I ask you to confirm that you're content to adopt your statement as your evidence to the Inquiry?

A. I am. 14:13

92 Q. So you made your statement to the Inquiry. It's dated 17th June 2024, and you set out in that, that until you retired in December 2020, you were a Senior HR Manager in Belfast Trust?

A. I was, yeah. 14:14

93 Q. HR standing for Human Resources?

A. Yes.

94 Q. So in old money that would be personnel manager?

A. Yeah. Well I suppose in some regards. We had HR managers, but my role was a wee bit higher than that. 14:14

95 Q. I understand?

A. And sat under the Co-Director role. Okay?

96 Q. Okay. Thank you. And you say that you had been in that role since 2008, and that latterly from June 2016 you assumed responsibility to provide a Business Partner role to the Adult Social and Primary Care Directorate? 14:14

A. Can I just clarify that a wee bit?

97 Q. Yes.

A. I always had a Business Partner role from 2008, but I was aligned to the Children's Community Directorate. 14:14

98 Q. I see.

A. Initially. And then in 2016 there was a sort of reorganisation of HR structures a bit, and the HR --

the Co-Directors who would have been aligned to the Business Partner role stepped back from that. So some of the senior, other Senior Managers were given Business Partner roles as well, and as part of that I was moved from Children's to Adult Social and Primary Care.

99 Q. And that was 2016, is that correct?

A. Yeah. Yeah.

100 Q. Okay. So was that the point in time when you would have first had dealings with Muckamore or had you any dealings with Muckamore before that? 14:15

A. I've always, I've always known about Muckamore, and I've been up on the Muckamore site quite a lot even before that. My husband was the Director of HR and Corporate Affairs in North and West, so we would have gone up to Muckamore during their gala days and, you know, going round, and we bought their hanging baskets and things like that. I also, at the start of my time in the Belfast Trust, 2008, and I can't remember the exact date, but I did sit on a Disciplinary Panel and it was in relation to a Nursing Assistant who was accused or alleged to have abused a patient, and I did dismiss that individual. So I was always aware of Muckamore and how it was set up. 14:15 14:16

101 Q. And what year was that, do you think that -- 14:16

A. Of the?

102 Q. Of the disciplinary that you referred to?

A. I'm not sure. I'm really not sure. It could have been '09, or it could have been '10, I'm not sure. Because

as a HR Manager you do have to participate in disciplinaries and grievances and things like that, so I can't remember exactly. But there will be a file on it, there will be a file on the whole disciplinary case. 14:17

103 Q. So, what amount of your work would that type of HR work have been, because you mention later on that you were involved in workforce planning and modernisation. The Business Partner bit of it, what percentage of your time did that take up? 14:17

A. The Business Partner role I would say took up about 25% of my time. My main function was the modernisation and supporting the whole of the organisation through change, the management of change, and supporting staff as well through that. And later on, as you can see in 14:17 my statement, in 2013/14 I also resumed or undertook responsibility for the workforce planning, the workforce planning team.

104 Q. I want to ask you about workforce planning particularly. Do I understand correctly that that 14:18 process would be basically looking at what workforce we have, what are we going to need, where are the gaps, or is there more to it than that?

A. No, it's mainly that, and it's taken on board then in terms of what is proposed for the future and what 14:18 changes are going to be made, and working on that basis then to try and work out how much staff is required, what's the staff level to be, what's the skills required, you know, will people be working differently?

So all those things are in the pot and considered before they do their analysis on it.

105 Q. And would the fact that -- we've had evidence that there are, there have been staffing shortages and real difficulties attracting and retaining staff in Muckamore, would that have influenced your workforce planning role, or did you have any input to recruitment and retention issues? 14:18

A. Well, my role as the Business Partner is there to support the Adult, Social and Primary Care. So, yes, I would have been aware of staff shortages, and that would have been throughout, you know, the period of time that I was their Business Partner, there was always issues with staff. But in particular, I suppose you know from all the evidence that you've heard, that whenever the CCTV was discovered, that then meant that we were nearly haemorrhaging staff at that stage because staff were leaving. So in my role I -- in order to support the Trust I worked with my colleagues in the recruitment section to see if there was any innovative ways that we could maybe increase the numbers of staff coming to Muckamore. We also, because it was so, you know, the numbers were quite low, people were going and we couldn't replace them, so we needed to have something that we could actually retain the staff. So I don't know if you're aware, but in the terms and conditions, the Agenda For Change Terms and Conditions, there is a part where it talks about recruitment and retention premia, but in order to apply 14:19 14:19 14:19 14:20

that premia you have to get departmental approval.

106 Q. Can I just check so that everyone understands. A premia, do you mean by that an additional payment?

A. Yes, yes.

107 Q. Yes. 14:20

CHAIRPERSON: Was it 15%, the uplift you're talking about?

A. Yeah. To be honest, I can't actually remember the percentage, but, yes, it was applied to the individual salary. But I had to liaise with the Department to get 14:20 that approval.

CHAIRPERSON: Can I just ask something really basic about the Business Partner role. Why is it any different to just doing your job as a Human Resources Manager? What does the Business Partner bit of it 14:21 mean?

A. Well, I suppose it is like the conduit between the Directorate and HR. So in my role going to the senior manager meetings, I would have been asked various questions that weren't always necessarily within my 14:21 sphere of HR, so I would have advised managers on who they should be going to and what they should be looking at and stuff like that.

CHAIRPERSON: Oh, I see.

A. Rather than, you know, them flapping about. 14:21

CHAIRPERSON: Right. So was it almost as a consultant?

A. Yes. Yeah.

CHAIRPERSON: All right. Thank you.

A. It was, yeah. So, sorry, I was --

MS. TANG: That's okay. No, not to worry.

A. I was talking about the premia, yeah?

MS. TANG: Yes, yes, we had touched on that. So in terms of things that you did then, you've mentioned the premium to try and retain staff. Was there any other support that you were aware of that was being given to staff who were working on a site that had an increasing number of vacancies? 14:22

A. Yeah. Well, there was always a senior meeting, team meeting, and one of the -- because of the CCTV issue, a lot of that was moved up the organisation, if you like, to the Directors and the Chief Executives. So they were always aware that there was issues with staffing. But from my perspective, in terms of how I tried to help that, I also went to other Trusts, because I suppose you know that in Muckamore the clients weren't just all Belfast Trust clients, some were Northern, some were South Eastern. 14:22

108 Q. Mmm.

A. So I went to those Trusts to seek assistance from them to help us with managing, you know, the workload in the wards. Because they did have a responsibility as well, because those clients were their clients. 14:22

109 Q. So do you mean when you went to other Trusts that you perhaps asked to borrow staff or things like that? 14:23

A. Yeah. Yeah.

110 Q. And was that successful on occasion?

A. No, it wasn't hugely successful.

111 Q. Okay.

A. But we did get some staff, and then some of the staff as well would have maybe joined our bank and done sessions through the bank, but I suppose sometimes people were reluctant. But I think once you got the retention premia it sort of attracted people a wee bit more.

112 Q. So would you say that you noticed an improvement, a measurable improvement in terms of the turnover rate once the premia was in place?

A. Now I can't say hand on heart that that, you know, there was evidence to say that, but there certainly was - I think for staff on the ground it helped them, it helped them with their motivation, because a lot of staff would have voiced their concerns about the fact that the staff who were in, in block agency, were earning a lot more money than they were. So this in fact helped, helped them get over that a wee bit as well, the fact that they were getting extra money.

113 Q. Were there surveys done of staff satisfaction at the time that you recall?

A. Sorry?

114 Q. Were there any surveys done of staff satisfaction during this period?

A. Well, we had listening events, and I know you've had Jackie on here, Jacqui Austin, and Jacqui and her team actually conducted a number of those listening events. The modernisation, HR Modernisation Team, did conduct exit interviews, face-to-face exit interviews with staff. So, yes, there was a lot of things came up.

But satisfaction survey, around that time I would say it wasn't actually a satisfaction survey.

115 Q. Okay.

DR. MAXWELL: Is there not an annual staff survey? In Scotland, Wales and England there is an annual staff survey that can be drilled down to individual wards. Do you not have that in Northern Ireland? 14:25

A. Well, yes, we do actually, but if it was yearly, I'm not sure. But we did have staff satisfaction surveys conducted on a number of years.

DR. MAXWELL: And you can compare different Trusts' performance? 14:25

A. Yes, yes, yes.

DR. MAXWELL: So Belfast Trust does participate in that?

A. Yes. Well, we would have had staff surveys definitely. So they would be there if, you know, from the Trust, if you need to look at that. 14:25

DR. MAXWELL: So there will be staff satisfaction surveys that we can compare with other parts of the Trust.

A. Yeah, yeah. Absolutely. 14:25

DR. MAXWELL: And other Trusts in Northern Ireland and indeed the rest of the UK.

A. Yeah.

116 Q. MS. TANG: Thank you. I want to look in some detail at one of the, well some of the exhibits that you have provided. If we move to page 16, please? And this page, I should say, refers to part of the workforce 14:26

plan. It's a report that you and your team provided for the Adult Social and Primary Care Directorate,

A. Mhm-mhm.

117 Q. And that, as I understand it, is in response to a workforce plan that was put in place for the Directorate. So is this report a regular report that you would have prepared? 14:26

A. Well, the initial report was commissioned by Catherine McNicholl when she was Director, and I wasn't the Business Partner at that time. My actual Co-Director who I reported to was the Business Partner then, but because she also had responsibility for modernisation workforce planning she then instructed the staff to work with the Directorate and pull together a workforce plan, taking into consideration all of the modernisation that was being, you know, brought forward. 14:26 14:27

118 Q. So if we were looking down through that page we would see all of the different key areas in that ASPC Directorate, as I'll call it? 14:27

A. Yeah.

119 Q. A good number of projects on Older People's Services?

A. Yeah.

120 Q. Some on Mental Health, and three at the bottom in relation to Learning Disability. Did those projects come as a result of the Learning Disability service areas themselves, or were some of those Trust priorities that were then filtered down? 14:27

A. Well, obviously the resettlement project was something

-- it was actually nearly regional that, you know, Muckamore was heading for change. The other two I would say were from within the Learning Disability division, if you like.

121 Q. And would something like recruitment and retention have been seen as a potential modernisation project or a service improvement project? 14:28

A. Do you mean in terms of --

122 Q. The recruitment and retention issues that we talked about a short time ago, might that have been considered as a workforce project? 14:28

A. Yeah. Well, workforce was always an issue. So, yes, workforce should have been - I'm not saying, you know, it was an actual project, but within each of those staff, you know, you do look at staff, you do look at workforce, and you do look at retaining your workforce and, therefore, whenever we enter into a change programme, we have to make sure that staff are assured that there will be no redundancy, because we are such a massive Trust with 22,000 staff, it wouldn't seem right that we couldn't find an alternative position for staff. So, yeah -- sorry, I've lost my trail of thought now. Yes. Staff, workforce would have been part of all of these, yeah. 14:28 14:29

123 Q. I want to zoom in now if I can on some reports that you provided relating to the exit interviews and the pilot work that you did on that. 14:29

A. Yeah.

124 Q. If we can move to page 34, please? And what I should

set this up with -- you conducted two separate projects in terms of exit interviews, isn't that correct?

A. Mmm.

125 Q. The first one you tell us in August 2018, and then again in December 2019? 14:29

A. Mhm-mhm.

126 Q. Can I ask, you mentioned HRPTS, which am I correct that that's the IT system for HR?

A. Mhm-mhm.

127 Q. Were you getting any useful information from that about why people were leaving the Trust? 14:30

A. You would have gained some information, because people would have stated why they were putting in their resignation or why, you know, like retirement or whatever, and there was a section within HRPTS for staff to complete an exit form, you know, giving reasons why they were leaving, and there was a number of questions on that form. But to be fair, I don't think that that was used very widely at all. I think that staff either didn't really know about it or weren't directed to it whenever they put in their resignation or whatever. So because of what was happening in Muckamore it was the Director had asked specifically if we could do face-to-face exit interviews with the staff and that. I mean we gleaned a good bit of information from that. 14:30 14:30 14:31

128 Q. Well let's look at some of that information. Moving down page 34 towards the second half of the page. If we can stop there. Thank you. You noticed that there

were 45% of the staff within that survey who cited well-being and safety at work as their main reason for leaving?

CHAIRPERSON: Sorry, does "(5 headcount)" mean there were five people -- 14:31

A. Yeah.

CHAIRPERSON: -- interviewed.

A. Yeah.

CHAIRPERSON: So it was quite a small --

A. It is very small, yeah. Yeah. Because people, you know, didn't have to participate if they didn't want to. So it was, you know, it was difficult to get everybody on board with it. 14:31

CHAIRPERSON: No, sure, I understand. Sorry, Ms. Tang.

129 Q. MS. TANG: That's okay. Thank you. Yes, I should perhaps clarify, you've told us at the top of the report that you had 11 staff interviewed in total, seven of whom had resigned and four had retired. 14:32

A. Yeah.

130 Q. So the five that had cited, the 45%? 14:32

A. Yeah.

131 Q. That's what that number - it's five people. So in terms of well-being and safety at work, was there anything done by way of follow up of that, of those concerns that they raised? Were they asked to give more detail? 14:32

A. Yeah. Well in terms of the safety at work, staff had been raising the fact that because so many staff were suspended, and the permanent staff felt that they were

under a lot of pressure, and because agency staff weren't necessarily trained in MAPA or restraint, then they felt they had more to do and they felt less safe because of that. And there were incidents that took place, even after, you know, the suspensions and whatever and, you know, for staff it's a tough job and it is very challenging, and you can, you can be hurt and, you know. So it was the safety, they were a wee bit worried about their safety at work. So we, in terms of well-being and safety, the senior team, the Directors, made sure that there was staff briefings, and they had staff meetings on numerous occasions up on the Muckamore site, which also allowed staff to put forward their concerns to the highest level, because there were a number of directors sitting round the table at that time, and the HR Director would have been one of them. They also had put in place supports for staff in terms of counselling sessions or Occupational Health, and Occupational Health would have also been at those meetings. So, yes, they tried to address some of those. Whether it was done enough or not, I'm not sure. 14:33 14:33 14:33 14:34

132 Q. Were you surprised by these results?

A. No, not really.

133 Q. Not really. Were they fed back to the Muckamore senior management team itself as well as the Directorate and the -- 14:34

A. Oh, yeah.

134 Q. -- the senior team.

A. Yeah, it would have been fed back. Well, it would have gone to the senior team in the Directorate, but it certainly would have went to the management team within Muckamore.

135 Q. Do you know was it provided to any of the Director level team in the Trust? 14:34

A. In what way?

136 Q. What I mean is, would these results have been - or would your report have been fed back up through, for instance, the Director of HR? 14:35

A. Oh, yeah.

137 Q. Or to the Director of Nursing?

A. Yeah. She would have got a copy of that, as Marie Heaney too would have got a copy of that.

138 Q. Did you get any reaction from these individuals on the content? 14:35

A. Not that I can remember.

CHAIRPERSON: Could I just ask, you said you weren't surprised by these results.

A. Yeah. 14:35

CHAIRPERSON: Was your lack of surprise Muckamore specific or -- because you presumably see right across the Trust. Is that right?

A. Yeah.

CHAIRPERSON: And exit interviews for lots of other hospitals. 14:35

A. But we don't do face-to-face exit interviews.

CHAIRPERSON: No.

A. Normally people will either fill out that form, you

know, on the HRPTS system. But so for Muckamore this was the first time we did face-to-face interviews.

CHAIRPERSON: Oh, I see. So I just want to understand why you said it wasn't surprising. Did you not find it surprising because you knew what was going on at Muckamore? 14:36

A. Yeah. Yeah.

CHAIRPERSON: Right. It is Muckamore specific?

A. It's Muckamore specific, yeah.

CHAIRPERSON: Okay. Sorry. Thank you. 14:36

A. Yeah.

139 Q. MS. TANG: In relation to some of the things that the staff were saying, one of the other comments was that 64% of the people that you surveyed said they would not recommend Muckamore as place to work. Did they say why? What was it? 14:36

A. In some instances they would have said they didn't feel that they were supported by their Senior Managers, or like it says above, they didn't feel safe in some respects. And I think people, well staff at that time were very hurt and bruised by what had happened, and the fact that they, by association, were also looked upon as being, you know, "they're from Muckamore" and whatever. So there was a lot of that, and I think that I'm sure staff felt that they wouldn't want to recommend Muckamore -- if that's the way they felt they weren't going to recommend it to other people. But that's a sad reflection too, because Muckamore was an essential place, and I remember it used to be a really 14:36 14:37

buzzy, you know, happy sort of environment in Muckamore, way before I became Business Partner and whatever, because the clients would have been out around the grounds and they would have had - have gone to their workshops, or their day, you know, day activities. But then that all stopped with resettlement, and you could feel the change in the environment as well, even though I wasn't on the wards, but you could even feel it when you were up on the site. 14:38

140 Q. I want to move down to page 36 and pick up on some of the comments particularly --

A. Yeah.

141 Q. -- that were recorded. If we can go to page 36, please? And these are speech bubbles that are lifted, I guess, from the exit interviews? 14:38

A. Yes.

142 Q. Just picking out on some of them. One of them:

"Insufficient/dangerous staffing levels." 14:38

Another one:

"I submitted around 50 IR1 forms, never was there any follow up or de-brief or learning." 14:38

Another person observes that there were:

"Mental scars from violence."

They're quite alarming comments?

A. Absolutely.

143 Q. Any one of these things that would strike me could have been a prompt for some specific work, focused work, to try and address things like insufficient dangerous staffing levels, et cetera, were you aware of any specific pieces of work that were started as a result of these kinds of comments? 14:39

A. Other than what I've said about, you know, the support for staff that was put in place a wee bit more. There was the counselling. The things like they having submitted so many IR1 forms, I'm not sure if that was addressed, because that wouldn't have been anything that I would have been involved with. That was from management in a local perspective. They should have been told, you know, given some responses from, you know, putting complaints. 14:39 14:39

144 Q. Were you aware of an action plan or any kind of targeted follow-up on the basis of the findings of these reports? 14:40

A. Well, I know that with Mairead Mitchell, she had introduced a Task and Finish Group, and it was like - that was part of this as well. She had asked, you know, for this to be done. So, yes, I can't really remember exactly what it looked like, but there should be information in the Trust in relation to what came out of these and if there were actions tailored to individuals. 14:40

145 Q. We did see on page 37, if we can move down to that, that there were a list of recommendations?

A. Yes.

146 Q. Can I just be clear, was there any action plan that you're aware of developed in response to those recommendations? 14:40

A. Well, some of those would probably have incorporated the issues that were discussed at the Task and Finish Group. So I'm going to say, yeah, there should have been action points in relation to some of those, not maybe all of them. 14:41

147 Q. Did you see any follow up, or were you able to ask any follow up questions to find out how the division had got on with addressing those recommendations?

A. I can't really recall having voiced any opinion in that regard. But you see in 2019 then Covid hit and lots of things, you know, people were focused very much on Covid. So while there might have been follow up, I wasn't always aware of that. So I mean I think that's something maybe the Trust could answer. 14:41 14:42

148 Q. You've made reference to 2019 and that was the second exit interview pilot?

A. Yes. Yeah.

149 Q. And I noticed there on page 51 of your statement that there were a number of comments that were lifted from the different responses that were made at that point in time. 14:42

A. Mhm-mhm.

150 Q. And looking down through those, a lot of similar themes

coming out still. "Risk of physical harm", is one of them. "Mental scars from physical assault. Not enough staff." It would suggest that these big areas that staff were concerned about and that were actually compelling some of them to leave hadn't really moved on between those two years, is that a fair assessment? 14:42

A. Well the staffing levels probably didn't improve greatly during that time, but that didn't mean to say that people weren't trying their best to get more staff in or get funding or whatever. I mean I know the senior managers and the directors were all, you know, engaged with the Board and the Department and whatever to look at ways of supporting Muckamore. But it was, you know, it was a catch-22 situation. I mean you know you're not going to have a decline in violence against staff if your numbers are wrong in terms of the staffing numbers or even the skill mix, so it's hard to say, yeah. 14:43 14:43

MS. TANG: Chair, those are all my questions on the witness' evidence. Is there anything that the Panel wish to ask? 14:43

<u>MS. MOLLOY WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:</u>

151 Q. CHAIRPERSON: I've just got this. We've heard quite a lot about the effect on patients of the removal of activities, closing Day Care, fewer staff to help the patients keep busy and active, but you're saying this also had an effect on the staff, because you were 14:43

saying, you know, it used to be the position that staff could get out around the grounds and go off and do things with the patients. But the removal or the minimisation of those activities directly affected, do you think, the staff morale? 14:44

A. Absolutely, there is no doubt about that, because staff -- clients were constantly then on the ward, they weren't out, you know, using up their energy and whatever, so the staff were constantly there with them as well. So it did create stress for staff, absolutely 14:44 it did, because patients liked, or clients liked to go to their Day Care and liked to get involved in the wee workshops that they used to have. I mean they used to make, like I've said, hanging baskets, and it was the clients that did that. And they made a whole lot of 14:45 different things. But then, you know, whenever the resettlement came in, all of that stopped because it wasn't to be a home, if you like, it was to be a clinical place. So all of that stopped and it really did have an effect on both the staff and the patients. 14:45 Or the clients.

CHAIRPERSON: Yeah.

152 Q. PROFESSOR MURPHY: So can I clarify, in your workforce modernisation, tab 2, when it said "Day Opportunities Review", was that referring to day opportunities in the 14:46 community or in Muckamore? This is page 16 of tab 2.

A. I'm sorry, I'm not sure. I can't recall whether it was for the hospital itself or the community, but I do think they tried again to get the Day Care back up and

running in Muckamore, because it was having such an effect on clients and staff.

PROFESSOR MURPHY: Thank you.

153 Q. CHAIRPERSON: And one other thing that I just want to ask about, if we go back to page 36, which is the speech bubbles. So these are the direct quotes from the staff you interviewed, and on the left we see: 14:46

"I submitted around 50 IR1 forms."

14:47

Can you just help me, IR1 forms are what?

A. Incidents that would have taken place, yeah.

154 Q. CHAIRPERSON: An incident.

A. Yeah.

155 Q. CHAIRPERSON: But it says: 14:47

"...never was there any follow up or debrief or learning."

Now that's quite significant. 14:47

A. Yeah.

156 Q. CHAIRPERSON: Did you follow that up at all?

A. Well this went to the senior managers on the site, so it was really for them to put together an action plan based on the recommendations that were given by the 14:47 modernisation team, but also on the basis that these are their staff who are raising those issues and something should be done in relation to that. Whenever -- you see, whenever there was resettlement as

well, you'll probably see in my witness statement I refer to a framework called the "Management of Change" framework, and that framework clearly sets out the responsibilities for everyone involved in change, and that will be your senior managers, your directors, your trade unions, your staff. So any change, like for instance in terms of the resettlement, that should have been conducted in accordance with that framework, and that was a framework which was agreed in partnership with trade unions. So, whenever the modernisation team was up supporting change, they would have made sure that that framework was adhered to. So you would imagine some of those things should have been lifted from that and worked through on a change programme. 14:48 14:48

157 Q. CHAIRPERSON: But your position is, you make recommendations, as you did here, but you don't actually get to see either the action plan or whether the action plan is put into action? 14:49

A. Now to be fair, I'm not saying I didn't see it. I may have seen it, it may have been sent to me, or at least to the modernisation team, but it's not for me to ensure that they do that, it's more for the management within the division to ensure that they're followed up. 14:49

158 Q. CHAIRPERSON: And I should remember, are you still in post or not? 14:49

A. No, I've retired. In December it'll be four years, so it's hard to recall.

CHAIRPERSON: Okay. Yeah, well what we've seen has been useful. Can I thank you very much for coming to

assist the Inquiry in producing those exhibits, which are interesting and helpful. So thank you very much indeed.

A. Thank you.

CHAIRPERSON: All right. Well a much shorter day than yesterday, and we will sit tomorrow at 10:00 o'clock. Thank you very much indeed. 14:50

THE INQUIRY ADJOURNED TO WEDNESDAY, 25TH SEPTEMBER 2024 AT 10:00 A.M. 14:50