MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 18TH SEPTEMBER 2024 - DAY 106

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

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THE INQUIRY RESUMED ON WEDNESDAY, 18TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you.

MS. TANG: Good morning, Chair. 10:01

CHAIRPERSON: Yes.

MS. TANG: Good morning, Panel. This morning's witness is Ms. Jacqui Austin, who is a former Belfast Health and Social Care Trust employee, and she's giving evidence as part of the Operational Management Module 10:01 7. The statement reference is page 248, and there are 13 tabs to exhibits to her statement.

And if there are no other restrictions? There are no restrictions. If there are no other issues, the 10:02 witness can now be called.

CHAIRPERSON: Yes, certainly. Can we get her in.

MS. JACQUI AUSTIN, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS: 10:02

CHAIRPERSON: Good morning, Ms. Austin. Thank you very much for your statement.

A. Good morning.

CHAIRPERSON: And thank you for coming to assist the 10:02 Inquiry. And I'll hand you over to Ms. Tang. I should say, if you want a break, we normally break after about an hour, a bit longer than that, if you need a break before that just let me know.

A. Okay. Thank you.

CHAIRPERSON: Okay.

1 Q. MS. TANG: Thank you. Hello again, Ms. Austin. We met a shorn time ago, but just to remind you, I'm Shirley Tang, and I'm going to be taking you through your evidence this morning. Can I check you have a copy of the statement in front of you? 10:03

A. I do have a copy in front of me, yes.

2 Q. You do. And I understand that you have made some of your own notes on that statement? 10:03

A. I have, indeed, just some notes in the margins just as aide-memoirs.

3 Q. Can I confirm with you that those are only your notes, that there's no one else who assisted you with it?

A. They are my notes, yes. 10:03

4 Q. Thank you.

CHAIRPERSON: Ms. Tang, you might just need to keep your voice up a little bit, because remember it's going out on a feed as well.

MS. TANG: Okay. Yes, of course. I'll pull this a bit closer. 10:03

CHAIRPERSON: Thank you.

5 Q. MS. TANG: Can I ask you to confirm that you're content to adopt your statement as your evidence to the Inquiry? 10:03

A. I am.

6 Q. Thank you. I want to turn to paragraph 7, first of all. If that could be brought up on the screen, please? What I should say, you'll see the statement in

front of you as well, if it assists you, you're welcome to follow it there too. And this picks up on the fact that you were appointed in the Service Improvement, Governance and Modernisation role, and you tell us in your statement that that covered the whole of the Adult Social Care, and Primary Care, and included Intellectual Disabilities. Would it be fair to say that's a pretty broad remit? 10:04

A. It was a very broad remit.

7 Q. Would you have any sense of how much of your commitment was to Intellectual Disability in particular? What proportion of your time might you have spent on it? 10:04

A. I would say it varied. In the beginning Intellectual Disability and Mental Health were fairly new to me. I would have been familiar with the older person's section - division - because I worked there previously. So I had to spend a lot of time getting to know the services initially, getting to know the people who were there. So I would say in the beginning I spent most of my time between Mental Health and Intellectual Disability, and a smaller amount of time maybe in Older People Services. They were the three divisions. 10:04

8 Q. Mmm. Okay. So that I understand it directly, whenever we talk about the Adult Social Care and Primary Care, what was that bit of it? 10:05

A. Adult Social and Primary Care incorporated three divisions: Intellectual Disability, both in-patient and the community; Mental Health, in-patient and community; and then Older People Services, or ACOPS as

it became known then, was the Adult Care, so domiciliary Care, district nursing, and some in-patient older people's wards. So it was a very, very big remit.

9 Q. Very big remit. 10:05

A. And Physical and Sensory Disability.

10 Q. So Muckamore was one small bit of that?

A. It was, yes.

11 Q. Yes. In terms of the amount of your time you were able to focus on Intellectual Disability particularly, it 10:05 sounds like a sixth of your remit at most?

A. It would have been at most a sixth of my remit, yes.

12 Q. And is that reflected in the amount of your time commitment you could put into it as well?

A. It would be reflected in the time in a broad sense. 10:06 When something was going wrong, perhaps I spent more time up there or, you know, there might have been different meetings in a particular week which meant I spent a bit more time up there. But in the broad sense I would say I tried to divide my time as equally 10:06 as I could.

13 Q. Mm hmm. Okay. You made reference to attending some meetings regularly. There was an Intellectual Disability senior management team meeting and Ward Sister meetings. Can you tell us, were those meetings 10:06 at Muckamore or were they held elsewhere?

A. Occasionally the senior management team meeting would have been held in the Fairview, which was where my office was based, and the Co-Director was based in

Fairview too. But they did move up to Muckamore and were more frequently held in Muckamore. The Ward Sisters meeting always happened in Muckamore.

14 Q. And the Ward Sisters meeting, is that one that you always went to, or just sporadically? 10:06

A. No, I would have gone to the Ward Sisters meeting, I would have asked to be invited maybe to explain a specific piece of governance, an assessment tool, looking at data on incidents, explaining to people how they could interrogate the system themselves, trying to 10:07 bring governance to that level.

15 Q. Okay. So if you had to think back over the number of Ward Sister meetings that you would have went to in the course of your job at Muckamore, have you any...

A. It would be very small. It would be... 10:07

16 Q. Really.

A. I would say somewhere between five and ten. It wouldn't be any more than that.

17 Q. Okay. Okay. And was that at their request on occasions, or was it typically you that would have 10:07 said: 'I want to go and tell you about something'?

A. No, it would have been both.

18 Q. Both. Okay.

A. Occasionally they would have invited me as well.

19 Q. Okay. So you mentioned being at those meetings which 10:07 would have been on the Muckamore site maybe between five and ten times. Would you have had other occasions to be at the Muckamore site in the course of your job?

A. I had one member of staff that I line managed and

provided professional management, professional supervision for, a resource nurse.

20 Q. Mm hmm.

A. So in the early days - well I would have met her once a month for supervision. And in the early days we did a bit of work looking at her role, her job, so that I could get a feel for what it involved. And looking at did the job description match what she was actually doing, and it didn't. So we spent a bit of time amending that job description, and I had sent that through to HR for matching. It hadn't concluded by the time I retired. 10:08 10:08

21 Q. Okay. So what I'm hearing is that the bulk of your contact with Muckamore, if I'm understanding you correct, and please tell me if I'm not, would have been either supervising your Resource Nurse or attending the Ward Sister meetings? 10:08

A. Not the Ward Sister meetings. Well, meetings in general, yes.

22 Q. Oh, right, so other meetings? 10:09

A. So maybe the SMT might have been up there as well. The senior management team.

23 Q. Because of, yes, the IDS --

A. Sometimes it was in Fairview and sometimes it was up there. 10:09

24 Q. Yes. Okay. You have mentioned in your statement that you didn't consider yourself part of the operational team in Muckamore because of your governance role, and that your focus was very much service improvement and

modernisation. Can you tell me about any service improvement or modernisation work specific to Muckamore that you were involved in or that you initiated?

A. Ehm, one of the first things that I did was look at the gap, look at the team up there, and because of the remoteness of Muckamore, I requested that we put a Quality and Governance Manager in there, which would give me two members of staff up there to bring governance on the ground, if you like. And I saw that as a service improvement. I spoke to the Director about it. We got funding and advertised, and were successful in doing that. 10:09 10:10

CHAIRPERSON: Could I just ask about that. Would you have had - would there have been a Quality and Governance Manager always, for instance, in an acute hospital setting? 10:10

A. Can I go back just a wee step? There is a Quality and Governance Manager in each Directorate. In Adult Social and Primary Care, the post that I held, Service Improvement Governance and Modernisation, was a unique post. So that post was very unique. There was a Quality and Governance Manager in the division of Older People Services, but there wasn't in Mental Health or Learning Disability. 10:10

CHAIRPERSON: No, I understand that, but I'm trying to compare that to how Mental Health and Learning Disability was treated, as it were, as compared to the other divisions. Would there have always been a governance, a Quality and Governance Manager locally in 10:10

other hospitals or not?

A. No. No.

MS. TANG: In other directorates.

CHAIRPERSON: No.

A. The Quality and Governance Manager in other Directorates was a Directorate post. 10:11

CHAIRPERSON: Right.

DR. MAXWELL: And they didn't have one in each division?

A. No. 10:11

DR. MAXWELL: In other directorates?

A. No, they didn't.

DR. MAXWELL: So Older People's was quite unusual in having a dedicated person at the division level?

A. Yes, yes. Yeah. And that was because the post of Service Improvement, Governance and Modernisation was a unique post in the Trust. I wasn't the only person who held it. But it was a unique post. That post didn't exist in other directorates. 10:11

CHAIRPERSON: I see. Thank you. 10:11

25 Q. MS. TANG: So when you refer to that post and you link that with service improvement, what kind of service improvements then would you have expected to have come about because of that post when it was established at Muckamore? 10:11

A. The service improvements would be things like implementing BRAAT risk assessment tools. Looking at implementing, you know, encouraging people to join in with Safety Quality Belfast, so that people were

putting safety and quality on the agenda. And looking at -- the data that came out maybe highlighted areas of concern. Not concern but, you know, highlighted incident reporting, needed a bit more training, and I would have seen those as service improvement/governance.

26 Q. So if there was something coming out, for instance, via the incident reporting, like elsewhere in your statement you make reference to high levels of reporting of violence and aggression? 10:12

A. Yes.

27 Q. Is that something that would have filtered through to a service improvement agenda, a work plan?

A. It would have, yes. So it would have then looked at - I would have discussed, that would be the kind of thing that I would discuss with Ward Sisters as well, and with the Resource Nurse, and we would have looked at reasons perhaps for that. I wouldn't have been directly involved, but I know that Positive Behavioural Support was implemented, and I would have been aware of that as well. 10:12 10:13

28 Q. Mm hmm. Okay. I'm going to come back on to that a wee bit further on because I know that you deal with it a little more later on. You mentioned that the newly established post, the Governance and Quality Manager, am I right in understanding it hadn't existed in any form before? 10:13

A. No.

29 Q. At that point. It's just the way you had worded your

statement it sounded like the post had been vacant rather than that...

A. Apologies. No, it didn't exist.

30 Q. It didn't exist.

A. It didn't exist. 10:13

31 Q. So whenever it was funded, this was funded as a newly established post?

A. It was funded as a newly established post. There was funding available because a person who held a business support post hadn't, was moving into an 8B post, so 10:13 that was where the funding came from.

32 Q. Okay. You also tell us that it took three years to recruit the post in effect, because you took up post, and presumably did you identify the need for it fairly early on? 10:14

A. Fairly early on, but not in a, you know, it took me a while to look around and see what was available to get a feel for the division. And it then had to be discussed with the Director and the Co-Director, and they both were in agreement. It did take some time 10:14 then from that to actually having someone on the ground.

33 Q. I used the word "recruit", and I think I probably should have said to get the post established?

A. Yes. 10:14

34 Q. So from the point in time when you identified when you needed, can you remember roughly when that was?

A. I can't. I think it may have been around the end of 2017.

35 Q. So not that long after you went into.
A. Beginning of '18. Yes.
36 Q. Yes.
A. About a year or a year and a half afterwards.
37 Q. And it wasn't until December 2019 that the post was actually filled? 10:15
A. Yes, there was somebody filled in the post, yeah.
38 Q. So how did that work get covered in the meantime if there was a need for it?
A. The work was covered between myself and the Resource Nurse. 10:15
39 Q. Mm hmm.
A. Who was based at Muckamore. She was based at Muckamore. She - while her responsibilities weren't just for Muckamore, she spent most of her time there, and that would have been doing a lot of the governance work. 10:15
40 Q. Was there any sense that the scandal around the abuse that was becoming apparent in Muckamore was influential in getting that post filled? 10:15
A. No, I think we had identified that before then. I had thought about it before then and maybe spoke about it with the Director. I won't be 100% sure. But it wasn't my reason for doing it. I felt that we had a model in Older People's Services which worked very well and that we should replicate it in the other two divisions. 10:16
41 Q. Did you get the sense that your Directorate was supportive of the concept of establishing this new post

or was it an uphill struggle for you to get the funding?

A. No, they were supportive.

PROFESSOR MURPHY: Can I just clarify one thing, sorry. You say that before the post came in, the Resource Nurse did governance tasks, but wasn't she producing data but not actually doing governance? In that we understand she was reporting incident data and seclusion data and so on and so forth. But that's not necessarily changing anything in the system, is it? 10:16

A. No, it certainly wasn't doing the whole, she wasn't fulfilling the whole role, but she was doing aspects of it, and I was trying to fill in to do other aspects of it as well.

PROFESSOR MURPHY: Okay. Thanks. 10:17

42 Q. MS. TANG: Would you say when you reflect back on that, that there were bits of the role that weren't done, that couldn't be done because of the fact that you were both trying to cover other things?

A. I'm going to say no, because I think we covered it very well. It was tiring and hard work, but I think we did cover it as well as we could. I don't recall feeling 'if only I had someone here that might make that, that would have done that better'. 10:17

43 Q. Okay. I want to move down to paragraph 25, please? 10:17

A. Okay.

44 Q. And that is where we start to focus in a little more on the Resource Nurse role that you've discussed. You set out the main areas of responsibility at that point for

that Resource Nurse.

A. Yes.

45 Q. Can I ask, what kind of support would the Resource Nurse have provided when it came to SAIs, Serious Adverse Incidents? 10:18

A. At that point in time, so I'm going to say between -- I'm going to go from 2016, when I first took up post, and 2017. She would not have provided a lot of support at all. And, indeed, that was one of the things that I would have encouraged her to get training in to 10:18 provide support to SAIs, and that maybe happened around about 2018.

46 Q. So whenever that changed, what kind of practical support would that nurse then have been giving around an SAI? 10:18

A. Well, she may have created a timeline to help the Chair to go through the timeline. She may have provided support at the meetings, the significant event audit meetings, she may have provided support in documenting the discussion. But the timeline and supporting the 10:19 meeting would have probably been the most thing that she would have done.

47 Q. So would it be fair to say she wasn't necessarily advising on how things could be handled?

A. Yes. 10:19

48 Q. It was more a support --

A. Support.

49 Q. -- what was being done by others.

A. Very much so. Very much supportive.

50 Q. I want to ask you about RQIA in particular. The Inquiry has heard some evidence about, you know, some issues that RQIA have picked up in the course of their inspections of Muckamore. Would you or the Resource Nurse have been involved in the response to RQIA recommendations?

A. Yes. So the RQIA, when they did visit, they would have had a meeting to conclude their visit and highlighting areas of concern or areas of good practice. So we would have had a sense of those before the report came in. And when the report came in, an action plan would have been created from the report, and the Resource Nurse would have I suppose coordinated people to make a response to that action plan.

10:19

10:19

CHAIRPERSON: And would you have been at those meetings?

10:20

A. Yes. Not all of them. Depending on my timetable. I would have tried always to go to the close-out meeting for the RQIA visits.

CHAIRPERSON: And you'd get an idea from those meetings.

10:20

A. Yes.

CHAIRPERSON: The sort of issues that might be coming in up in an Improvement Notice or something like that.

A. Absolutely. Yes, absolutely.

10:20

51 Q. MS. TANG: So where an RQIA Improvement Notice, for instance, was issued, would you or the Resource Nurse have been involved in coordinating the response to that particular, you know, to fix things?

A. An Improvement Notice would have been escalated more to Co-Director level, and the Co-Director would have been responsible then, but with support from the Resource Nurse and myself. But a Co-Director would have been responsible for ensuring that Improvement Notices were actioned. 10:21

52 Q. Mm hmm. Can I go down to paragraph 30 now, please. And I want to pick up on the quality -- the Governance and Quality Manager's role, three of whom ultimately reported to you; isn't that right? 10:21

A. That's right.

53 Q. Yeah. You've mentioned that they had responsibility for integrated governance and patient safety. Can you tell me what integrated governance means, just for the purposes of these roles? What was that, in your understanding? 10:21

A. So integrating governance, from -- my understanding of that would be that I think sometimes people think of governance as a thing set aside, integrating governance to every aspect of the care, and making sure that governance is on the agenda, is everybody's responsibility. So integrating the governance agenda into all aspects of care, all aspects of the day to day running of the division. 10:21

54 Q. Okay. So in terms of what the managers would have been looking after, did they have any links into the function of safeguarding, for instance, in their governance role? 10:22

A. I have to be honest and say that I felt certainly that

safeguarding set aside. It didn't -- I didn't feel that I linked very closely with adult safeguarding. I knew it happened, I knew it was there, but it was very much led by the social work team. And it didn't sit in the governance, in with the wider governance agenda, I didn't feel, that's a personal opinion, but I didn't feel that it did.

55 Q. Did you have concerns at the time that from a governance perspective your team should have been involved much more in the safeguarding side of things, particularly given the stories that were emerging about safeguarding issues? 10:22 10:23

A. I did feel that there should be more integration, but I think I took assurance that it was professional people dealing with this and they had a process in place to deal with it. There was a local Adult Safeguarding partnership meeting that I would have attended. It was very, very big. It was very big. It was attended by many, many external organisations as well as people within the Trust. And that was the only time that there was sort of a meeting of the two. But in a division, I think it sat slightly to the side of the governance team. 10:23 10:23

56 Q. I think - on one hand I'm thinking about what you said elsewhere in your statement, and we'll come to it shortly, about the increased incidents of violence and aggression within Learning Disability? 10:24

A. Mm hmm.

57 Q. And then we have separate to that the safeguarding

function, and I just would like your thoughts on - for a clinical area that had, we've acknowledged, higher than elsewhere levels of those sorts of things.

A. Yes.

58 Q. Was that not a safeguarding issue in itself when you see that data come through? 10:24

A. Yes, it was a safeguarding issue in itself. And I suppose I took assurance that the Safeguarding Team were looking at those incidents, because there was -- the incidents would have been referred, and reading patient's notes you will see refer to safeguarding, and they provided the screenout process or the investigation. I don't think I ever saw an Adult Safeguarding investigation. 10:24

DR. MAXWELL: Can I just ask you, I understand that safeguard -- incidents were referred on an individual basis for safeguarding. 10:25

A. Mm hmm.

DR. MAXWELL: But what you were collecting was data across the whole service, and you could see not just the individual case, but the volume. 10:25

A. Yes.

DR. MAXWELL: Was there ever a discussion about: 'This is a high volume of incidents and maybe we need to look at this beyond individual case management in safeguarding'? 10:25

A. Yes. Ehm, that would have happened in two places. It would have happened, you know, at corporate teams, we would have been given data and it would have shown that

obviously Adult Social and Primary Care had the higher incidents of violence and aggression, and then that would have been broken down into the divisions.
I would have then taken that to governance meetings and discussed that openly, and the divisional social worker would have been at the governance meeting. So we would have had discussions then about the increased, or the high level of incidents of violence and aggression. We also -- I would have received reports from the corporate team, and then if there was a spike I would have maybe sent those to Service Managers to give me an explanation for them. So, yes, there would have been discussions about spikes or high levels at different places. 10:26 10:26

DR. MAXWELL: Was there ever any discussion about the baseline? Because the data we've seen, there seemed to have been quite a lot of incidents as your baseline. Did you ever consider benchmarking with other Learning Disability in-patient units to see whether the baseline number was high and of concern, let alone spikes. 10:26 10:27

A. In my time that didn't happen. But I do recall some benchmarking going on previous to my time. I honestly don't know the detail of it, but I can look it up and get back to you, if that would be helpful.

DR. MAXWELL: So in the discussion about the number of incidents, particularly around violence and aggression, was there ever a discussion about: 'Well, this is a problem, this is too high', even if it's consistent month to month? 10:27

A. Yes, we would have acknowledged that it was very high, and we would have expected to get maybe an explanation, you know, or people to investigate why it was like that if there was a particular. But baseline, I don't think we talked about baseline, no. 10:27

DR. MAXWELL: Okay.

59 Q. MS. TANG: You've made reference to the Resource Nurse, and we've talked a little bit about the reporting and the data capture role that was part of the Resource Nurse's job. Did the Resource Nurse provide the 10:28 seclusion figures that you refer to?

A. Yes. The Resource Nurse provided a physical intervention and seclusion report for all areas that used physical intervention and seclusion, all wards that used that. 10:28

60 Q. And would the Resource Nurse have audited the use of seclusion across the wards?

A. She did at a time. I don't know -- well seclusion isn't used now. But she did, she did.

61 Q. And how was that fed back to the ward staff? 10:28

A. Through governance, you know. And seclusion would have also been discussed at the weekly governance meeting, seclusion and physical intervention would have been discussed. But now that happened later on, that didn't start until 2019. But we would have talked about it 10:29 then. But the Resource Nurse would have provided those physical interventions and seclusion reports because of audits that she carried out on seclusion.

62 Q. Do you recall any trends or any particular differences

in the figures that the Resource Nurse was generating?

A. No.

63 Q. No contrast between ward areas?

A. No, I don't recall. It's a while ago and I don't recall. You would have focussed on something unusual that came up in the report. You know, again, it would have been a trend analysis. So if one ward had no seclusion one month and the next month there was evidence of five or six, then you would want to know what the difference was, and you would get that explanation from the service area itself. 10:29 10:29

64 Q. So whenever you talk about getting that explanation, is that the case that you would have noticed figures? Would you have challenged the service area and said: 'Why is this going up?, or 'what was that?'? 10:30

A. Yes.

65 Q. What was the nature of that?

A. The person chairing the governance meeting would have challenged the service area to explain that.

66 Q. I noted as well, I think it was paragraph 40 that we're on at this stage, from then onwards you talk about other figures. So there would have been physical interventions, complaints, and safeguarding issues, figures on those. Was that -- was all of that information part of what your team generated as well? 10:30 10:30

A. We wouldn't have put the safeguarding figures together. We would have put physical intervention, complaints came from the corporate complaints team, and we also looked at local -- we did some local analysis as well,

but the main complaints report came from the Corporate Complaints Department. Sorry, what was the other one you were asking me?

67 Q. The other one was safeguarding?

A. Safeguarding. We didn't provide that report, the Safeguarding Team would have provided, and the divisional social worker at the governance meeting would have spoke to that. 10:31

68 Q. So at the meetings where these reports were tabled, am I right in thinking the Intellectual Disability SMT would have been the main one where those were discussed? 10:31

A. The Intellectual Disability Governance meeting.

69 Q. Governance meeting.

A. Quarterly governance meeting 10:31

70 Q. So were they fed on through then to the SMT, the Intellectual Disability one, from that Governance Committee or Governance Group?

A. No, not necessarily. No, it would have been the same people attending both, usually. So they wouldn't have necessarily gone, unless there was a specific issue that needed to be addressed by SMT. 10:31

71 Q. Do you recall at the governance meeting that these figures would have been tabled at, any discussion or concerns about some of the figures and what they were showing and what could be done about them? 10:32

A. Yes. The reports generated discussion at the governance meeting, and that's the purpose of having them at the governance meeting.

72 Q. So would there have been an action plan or anything generated as a result of that governance meeting to say: 'Okay, there's an issue. We need to do something. Task an individual to do it', or...

A. Not an action plan per se, but the governance meeting minutes would have said, you know, would have sort of documented the discussion and then said "action", and who was going to take that action. 10:32

73 Q. I think what I'm trying to get at is, and I hear what you're saying, is whether or not did this group actually resolve these issues, or was it a case of they were monitoring the numbers and what appeared to be the problems, but do you recall movement on issues, you know, for instance, some of the violence and aggression issues or staffing shortages that came about as a result of the governance overview of it? 10:32 10:32

A. Do I recall reduction in incidents?

74 Q. Yes, improvement, yes.

A. Or improvement in staffing.

75 Q. Yes. Yes. 10:33

A. I recall discussions about reduction and how do we reduce incidents, and the Positive Behavioural Support Plan being an example of that. I recall discussion about staffing and what was going to be happening to try and improve staffing through recruitment, and specific recruitment. I suppose that's what would have happened. 10:33

76 Q. Mm hmm. Can I ask, are you familiar with the Restraint Reduction Network? Have you heard of that?

A. No.

77 Q. You haven't?

A. No.

78 Q. Okay. I want to move down to paragraph 43, please, and I want to zoom in there on complaints? 10:33

A. Okay.

79 Q. Can I ask you, would you have responded -- if a family member had made a complaint, would you have been personally involved in the response to that on occasions, or what was your input? 10:34

A. I would have on occasions. My input into complaints was, I sort of led the complaints response for the Directorate. But the complaints response, and providing a response, would have been delegated to the particular person in that service area, a Service 10:34 Manager perhaps, sometimes a Ward Sister. When that response was drafted, it would have come through my department. I would have quality assured it to make sure that it was answering the actual complaint. Sometimes that meant a bit of going backwards and 10:34 forwards with the Service Manager. I also would have made sure that I kept in touch with the Complaints Department, letting them know if it was going to be delayed, and asking them could they involve the family member and let them know that it was going to be 10:34 delayed. Sometimes there was a bit more involvement with families around complaints, and I would have been asked to do a significant event audit to look at, you know, a complaint. The example that I can think of is

a failed discharge that I think I provided that in my...

80 Q. Yes.

A. And that would have been, I'm going to say -- it wasn't unusual, but it wouldn't have been an every day occurrence. Mostly I monitored complaints, monitored response times, quality assured the responses before they went to the Complaints Department, kept the Complaints Department informed if I was anticipating delays to make sure that the family were kept informed of delays. 10:35 10:35

81 Q. So would it be the case that you saw the detail of every complaint that was then sent on to a clinical area for investigation?

A. Yes. Yes. 10:35

82 Q. And you saw their response?

A. Yes.

83 Q. And when you had all of that information, did you then do your own analysis or your own trend review of that kind of material? 10:36

A. I did do some trend analysis on that. I don't have anything in my papers, but I would have done some trend analysis on that. Because it made it easier at governance meetings to talk about the kinds of things that were coming through as complaints. 10:36

84 Q. So when you had some details of the trends, for instance if there were more families complaining, or staff complaining about a particular issue, can you remember what you did with that? I mean did you feed

that back through?

A. Yes.

85 Q. And how was that taken on board?

A. It would have been discussed, just generally. I didn't meet resistance or anything, you know. I would have discussed it. So I would have discussed trend analysis at complaints. If there was a very specific complaint that was unresolved, I would have discussed that with the Director on my one-to-one supervision. 10:36

DR. MAXWELL: Can you recall what the most common causes for complaint were? 10:37

A. Within the whole Directorate or within Learning Disability.

DR. MAXWELL: Within Muckamore or within Learning Disabilities. 10:37

A. To be honest, Muckamore didn't have a huge number of complaints, and it would have been about care, you know. Maybe laundry going missing, maybe not referring on to hospital, you know, patients with physical disabilities, and the family's perception was that they weren't referred to hospital quick enough. I can't recall a massive number of complaints in any one particular area. 10:37

PROFESSOR MURPHY: Did you worry that that might be because the patients themselves on the whole couldn't complain? 10:37

A. That probably had an impact on it. But they had a very strong family and carer's group in Muckamore, and they also had a service user group, the TILII Group, I don't

know if you've heard of that.

PROFESSOR MURPHY: Yes, we have.

A. That would have supported that. And key workers. We had a lot of Easyread leaflets and helping people to make complaints if they felt that they needed to do that. 10:38

PROFESSOR MURPHY: Okay. Thank you.

CHAIRPERSON: Can I just understand in relation to your role in complaints. I understand that you would quality check the response and make sure that it was all in order as it should be. 10:38

A. Yes.

CHAIRPERSON: And then it doesn't get sent out by you. The response isn't sent by you?

A. No. Now. 10:38

CHAIRPERSON: You would say you would either pick a tick in the box or you would say, no, you haven't dealt with this part of the complaint.

A. Yes.

CHAIRPERSON: Yes. 10:38

A. Yes.

CHAIRPERSON: And you would advise on how to respond to complaints or not?

A. Well, I wouldn't advise how. I would say to them the complainant has asked why this didn't happen and you haven't addressed that in your response. 10:39

CHAIRPERSON: Right. Yeah. I understand that. Okay. Is there then any sort of feedback loop? The response to the complaint goes out, but very often the response

will say: 'We're going to do X, Y and Z. We put an action plan into place', that's something you must have come across quite often, presumably?

A. Yes. Yes.

CHAIRPERSON: Yes. Does that ever come back to you to see if actually what the nurse manager, or whoever it is who is responding has said is going to happen, did happen? 10:39

A. I can't think of an example where it did. But I understand what you're saying. I can't think of an example where they'd have come back to me directly to say -- well, I can think of one. For example, there was a complaint about an area outside one of the Mental Health wards, and it was discussed -- the complainant was responded to. We discussed it. And then that was -- it was a swing that was broken, and the swing was fixed, and I was told that the swing was fixed. So there were mechanisms to do that. I don't recall getting it a lot of the time. 10:39 10:40

CHAIRPERSON: It doesn't sound - and this isn't critical of you because it may not have been your role. 10:40

A. No.

CHAIRPERSON: But it doesn't sound as though there was a lot of enquiry. Once the response has been ticked off, as it were, it doesn't sound as if there was a lot of enquiry thereafter as to whether in fact the resolution has resolved the issue? 10:40

A. Yeah. No.

CHAIRPERSON: Is that fair?

A. That's fair. That's fair.

CHAIRPERSON: Okay.

A. That's fair. And you probably would have known that it wasn't resolved if you got another complaint and then you would have -- about same thing. 10:40

CHAIRPERSON: And then you start again.

A. And then you start all over again.

CHAIRPERSON: Yes.

86 Q. MS. TANG: Can I move down to paragraph 44, please. I noted at the start of your statement that you had 10:41 started your career as a nurse. Can I ask you with your nurse head on, that I guess you never really take off when you start in that profession.

A. Okay. No.

87 Q. Did you have any specific concerns about the care? 10:41

MS. ANYADIKE-DANES: Sorry, there's a problem on the link.

CHAIRPERSON: Oh, thank you very much. Okay. Let's just stop for a second. Thank you. [Short pause]. Have you just had a message from one of your clients? 10:41 Yeah, fine. Thank you. It may be that the voices -- both voices are quite soft this morning.

MS. TANG: We need to be louder maybe.

INQUIRY SECRETARY: It is working, so it could be that it's just a volume thing. 10:42

CHAIRPERSON: Yeah. If you could (a) speak a little bit slower and a little bit louder.

A. Okay.

CHAIRPERSON: And you as well, Ms. Tang.

MS. TANG: I will of course.
CHAIRPERSON: Right.
MS. TANG: I've tilted my microphone a little as well. I hope that may help.
INQUIRY SECRETARY: Chair, we've turned the microphones up as well, but the link is working. 10:42
CHAIRPERSON: Okay. Thank you. I'm sure we'll be told, okay, if there's still a problem. Thank you, Ms. Anyadike-Danes.
MS. TANG: Yes. Yes, we'll certainly -- we'll try that. Thank you. 10:42

88 Q. Yes. I was just asking you, with your nurse head on, which I guess you never really set aside, would you have had any specific concerns or worries about the type of care at Muckamore in the course of your job? 10:42

A. I wouldn't have been - I'm not a Learning Disability nurse, and I'll say that at the outset, so I wouldn't have been familiar with the type of care that would have been given. I didn't spend a lot of time in the wards observing care. There was nothing coming to me that was making me believe that there was any lapse in care. 10:42

89 Q. So what you were seeing in terms of complaints, or looking at the incidents, did you have concerns about the standard of care based on those? 10:43

A. No, no, no. I knew that there was a high level of violence and aggression incidents, and I refer to that - I've referred to that already. That is incumbent in the type of patient that is being looked after in

Muckamore. Sometimes it went up - patients were very unwell, and it does seem to be a daily occurrence that there's incidents of violence and aggression.

90 Q. I want to move down to paragraph 48, please. This picks up the issue of implementing Belfast Trust policies, and the Inquiry has heard evidence that there are large numbers of Trust policies at any given time, and I can imagine it was quite a challenge to keep people up to speed with all of those? 10:43

A. It was. 10:44

91 Q. Can you tell me how your team went about making sure that for anything that was appropriate to Muckamore that the staff on the ground there actually did have all of the policy information they needed?

A. That would have been the kind of thing firstly that we would have discussed at the quarterly governance meeting, it would have been discussed at a senior management team meeting, and that would have been the kind of thing that I may have asked to go to a Ward Sister's meeting to discuss to bring it there. The papers that were provided for the quarterly governance meeting, my expectation would have been that they were shared with the wards and they would have documented the policies. I sat on Trust Policy Committees, so I was - a lot of them did not apply to Muckamore. You'll understand it was a very specific niche hospital. 10:44 10:44 10:45

92 Q. Sure.

A. So a lot of them didn't apply. But I suppose that was what we did to try and make sure the policies were

discussed and talked about, and then each individual has a responsibility to keep themselves updated on Trust policies.

93 Q. Mm hmm. So would your team have conducted any follow-up audits, for instance, for policies that you knew did apply to Muckamore, to assess the level of staff understanding and the extent of their application of those policies? 10:45

A. No. Not unless there was a specific need to. For example, a hand hygiene policy, you would have had to conduct monthly hand hygiene audits, and the Resource Nurse may have done that for me. But not unless there was a specific need to follow up with documentation. 10:45

94 Q. Mm hmm.

A. So not for every policy would I have gone out to check that every member of staff knew about the policy. 10:46

DR. MAXWELL: Can I ask, in some places there is a system where staff are asked to initial to say that they have read a new policy.

A. Yes. 10:46

DR. MAXWELL: Have you come across that scheme?

A. Yes. Yes.

DR. MAXWELL: Was that operating in Muckamore?

A. It was initially. What happened was Trust policies, we got the intranet system, and new policies were announced and advertised, if you like, for want of a better word, on the Trust intranet system. So that people stopped printing them off and signing them. That used to happen. 10:46

DR. MAXWELL: So people were initialling them when they were paper versions.

A. Yes. Yes.

DR. MAXWELL: So you would have had a complete record, somebody would have initialled to say they had read it. 10:46

A. That's right.

DR. MAXWELL: And then it moved to the internet

A. To electronic.

DR. MAXWELL: And you had to just hope people had read it. 10:47

A. Yes.

DR. MAXWELL: What happened with agency staff who don't have a password for the intranet?

A. Agency staff would have had a specific induction to the ward. There was a ward induction programme so that 10:47 they knew basically what, you know, what to do on a daily basis.

DR. MAXWELL: But they didn't have access to the intranet?

A. No, they didn't. They didn't. 10:47

DR. MAXWELL: So how would they have known what the policies were?

A. They wouldn't.

DR. MAXWELL: So there would have been at least some staff who weren't aware of the policies? 10:47

A. Yeah.

CHAIRPERSON: And there was no system of checking whether - once it had moved to the internet, there was no system of checking that staff, not agency staff, but

staff, had actually undertaken the training or read the policy?

A. No. No, system of checking that individuals had done it. It may have been discussed at ward staff meetings and through the tiered meetings. 10:48

CHAIRPERSON: And at ward level, or hospital level, whose responsibility would it be to ensure that all members of staff did know what the policy was? Where would that responsibility lie?

A. Because this policy would have been discussed at governance meeting, and senior management team meetings, that responsibility then would have been delegated down to the people who attended those meetings, to bring the policy down to the ward or the area of concern. 10:48 10:48

CHAIRPERSON: Right. Okay. Thank you.

95 Q. MS. TANG: Just a final question on that particular topic: You've mentioned that a certain amount of this material would initially have been paper copy and then everything shifted online. So for staff, busy nurses working on a ward who maybe didn't have access to a screen, how would they have known what those policies were if there was a new policy, for instance, on something that was pertinent to them? 10:48

A. They may have been discussed at - I didn't ever attend a ward staff meeting, but there were staff meetings on the ward, and possibly that would have been an opportunity for the Ward Sister or Charge Nurse to discuss it. And then they -- sorry, can you repeat 10:49

your question?

96 Q. I will, of course. I think what I'm trying to understand is, if not everybody had access to a screen, or couldn't spend a certain amount of their day at a computer screen, is there a risk that they might not have actually been familiar with at least some of the policies that were relevant to their area? 10:49

A. Yeah. I would say most - everybody had access to a screen. Your point about not having allocated time during the day to read them is probably valid. But it is incumbent on each member of staff to make sure that they keep themselves up to date with policies. But I can't think of a check-in mechanism. 10:50

97 Q. No check-in mechanism.

DR. MAXWELL: Is there the facility to print the policies from the internet? 10:50

A. There is. There is, yes.

DR. MAXWELL: So if I was a Ward Sister and I was concerned that my staff didn't know the policy, I could print it off for them? 10:50

A. You could.

98 Q. MS. TANG: I want to move down now to paragraph 61. 61 and 62, please. And we're talking about data analysis and trying to understand what various different reports are showing us. We've talked already to some extent about the analysis of violence and aggression and the reporting that would have been done; can I ask did you or your team take part in any exercises or training with ward staff to ensure that there was a good 10:51

understanding of what kind of things needed to be documented, and when to do it, and that whole process?

A. Yes, there would have been training provided again by the Resource Nurse, and by myself on occasions, on how to work with the Datix system for incident recording. Am I answering you correctly? Is that what you mean? 10:51

99 Q. Yes.

A. So we would have worked with ward staff on how to use the Datix system to record incidents, adverse incidents, and trained them on how to get their own reports back for their own specific area. 10:51

100 Q. Thinking back to what we had mentioned previously about access to screens, Datix, as I understand it, is as an online reporting tool?

A. It is. 10:52

101 Q. So is there a risk in your view that if somebody is on a busy ward, maybe can't get sitting down in front of a screen to actually complete a Datix report, that there might be underreporting of incidents because of that?

A. I would have had no sense that that happened. 10:52

102 Q. Okay.

DR. MAXWELL: Sorry, can I just ask, would the healthcare assistants have been able to enter an incident on Datix or was it only the registered nurses?

A. I'm not 100% sure, but I know that the healthcare assistant will go to a registered nurse to report an incident, and then they will be named as the witness on the incident. 10:52

DR. MAXWELL: Yes, but the data entry may only be by

registered nurses.

A. I'm not 100% sure, and I don't want to give you the wrong answer.

PROFESSOR MURPHY: Given that there are a lot of agency staff, and we've heard that at times there were something like 50% agency staff, I'm presuming that they couldn't enter stuff on Datix, or is that wrong? 10:53

A. That's wrong. They do enter data on to Datix.

PROFESSOR MURPHY: Thank you.

103 Q. MS. TANG: I know - I want to move down to paragraph 69 now, and I know that there was something you wanted to draw to the Panel's attention in relation to that. 10:53

A. Yes. Sorry. So I have written that on 21st August 2017, I became aware of abuse of patients at Muckamore Abbey Hospital. It didn't happen on that date. I got the phone call - I would like to amend that to read: 10:53

"In September 2017, I received a phone call from the Divisional Nurse who told me that she had viewed CCTV footage of the 21/8/17 in the presence of the Business and Service Improvement Manager and had witnessed abuse by a member of staff." 10:53

So it didn't happen on that day. It couldn't have happened on that day, because they didn't view it on that day. 10:54

104 Q. Okay.

A. So I had just got confused with the dates. Apologies.

105 Q. Thank you. Thank you for clarifying that. Did you

have any ongoing involvement in the follow-up response to what had been discovered?

A. My involvement was, as I've stated here, the first thing I wanted to do was to make sure that the information had been escalated appropriately. So I asked the Divisional Nurse had she escalated it. She assured me that she had phoned the Director of Nursing and the Acting Director of Adult Social and Primary Care. My involvement then would have been to ensure that the escalation appropriate to the Department of Health happened in the form of an Early Alert, which came through our Department. The Early Alert would have been after the Director of Adult Social and Primary Care made a phone call to the Department, and we did that Early Alert and updated it as it went along. It stayed open for a very long time because of things that were developing and ongoing. So that Early Alert stayed open for a very long time. We just kept updating it with new events. 10:54 10:54 10:55

106 Q. You told us earlier that the Adult Safeguarding arrangements were very much within the social care team's remit. Was there any review of that once these revelations came to light? Was there any change to how the safeguarding role was - within governance? 10:55

A. It didn't change for me. In my role it didn't change for me. I can't answer whether for the relationship between other senior managers in the Directorate did change, but it didn't change within my team. 10:55

107 Q. Were you conscious of any changes within your team

particularly because of these revelations around that time in September/October of 2017?

A. No. No.

108 Q. No changes?

A. I don't know. Our role would have been simply to create the Early Alert. The processing of it as a Serious Adverse Incident would have been the responsibility of the Co-Director, and we would have been - because it was a Level 3, it was completely independent. So, no changes within my Department nor within my team, no. 10:56 10:56

MS. TANG: Okay. Thank you. Those are all my questions, but I'm going to hand over to the Panel in case they may have some questions for you.

A. Thank you. 10:56

MS. TANG: Thank you.

MS. AUSTIN WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

109 Q. DR. MAXWELL: Can I ask you about the BRAAT tool? 10:56

A. Yes.

110 Q. DR. MAXWELL: You talk in, I think it's paragraph 8, about you attended Ward Sister meetings to discuss the Belfast Risk Assessment and Audit Tool?

A. Yes. 10:57

111 Q. DR. MAXWELL: Can you tell me what that is and what it covers?

A. It's an audit tool. It's sometimes a misconception that it's a risk assessment, it's an audit tool, and it

is a Trust-wide document, only certain aspects of it will apply to particularly Learning Disability. There will be generic sections of it that everyone has to fill in, and then there will be sections that will have to be completed by ward staff, sections that will maybe have to be completed by administration staff. It's just getting a sense of where you are with risk and governance.

112 Q. DR. MAXWELL: So what are the generic sections? What would they cover? What are they auditing? 10:57

A. The generic sections would have looked at things like staff training. It would have looked at have you carried out - are there general risk assessments available in your particular Department? I'm having to challenge my memory a bit at the minute, but it would be the things that would apply to everyone. 10:58

113 Q. DR. MAXWELL: So the staff training would be the mandatory training via health and safety...

A. Definitely, yes. Yes.

114 Q. DR. MAXWELL: Equality and Diversity. Those sort of things. 10:58

A. Yeah.

115 Q. DR. MAXWELL: It wouldn't be the service specific clinical skills?

A. They would have come into the sections that were specific to the clinical area. So BRAAT in itself had -- I'm really challenging my memory, but I think the first ten sections were applicable to everyone, and then there were maybe 45, in and around 45 sections, 10:58

and you chose the sections that were applicable to your area. So if you were a ward-based area, then that might ask are staff trained in specific things to do with that ward or... It wouldn't have been specifically for a Learning Disability ward, it would have been a clinical.

116 Q. DR. MAXWELL: And who chose? So there's a core section that everybody in the Belfast Trust has to do.

A. Yes. Yes.

10:58

117 Q. DR. MAXWELL: Then there are optional modules. Who chooses which of those modules a given area uses?

A. From memory it was quite clear, you know, which areas that you needed to complete. You knew you had to do your core and then you would look -- so, for example, if you were working in administration offices you wouldn't be talking about medical devices. There would have been a section on medical devices, so you would have known not to do that.

10:59

118 Q. DR. MAXWELL: But it sounds as though you're using some discretion yourself, rather than corporate governance team at Trust-wide level saying --

10:59

A. It was the health and safety.

119 Q. DR. MAXWELL: 'This is what the Learning Disability Department need to do'.

A. That would be fair. There was a lot of training went on prior to the introduction of BRAAT from the health and safety team, the corporate health and safety team, and they carried out a lot of training.

10:59

120 Q. DR. MAXWELL: So this was largely to do with complying

with health and safety laws?
A. It was, yes. Yes.
121 Q. DR. MAXWELL: So it would have been manual handling, lifting, medical devices, those sort of things?
A. Yes, yes, yes. 11:00
122 Q. DR. MAXWELL: Not actually the care of the patients?
A. No, no. Definitely not. It was a health and safety tool.
DR. MAXWELL: Okay. Thank you.
CHAIRPERSON: Just give me a second. 11:00
MS. TANG: I wonder if I could assist with that, Chair? I'm sorry, I should have mentioned it. What we're referring to is the table of data that was sent to you.
A. Yes.
MS. TANG: The statement reference for that is 29342. 11:00
CHAIRPERSON: Can we get that up on the screen?
MS. TANG: Yes. Yes, the team have that.
CHAIRPERSON: This is a document that we were looking at yesterday as well I think.
MS. TANG: Yes. 11:00
A. Yes.
MS. TANG: That's correct.
CHAIRPERSON: I just think we ought to resolve some potential issues.
MS. TANG: Yes. We had a short discussion with 11:00
Ms. Austin's legal team beforehand and they confirmed that they had looked back to see what the issue was and that that 46 number was in fact a typo.
CHAIRPERSON: Is Ms. Austin in a position to be able to

assist us with this or not?

THE WITNESS: Yes.

CHAIRPERSON: Yes. Good.

PROFESSOR MURPHY: So should it have been 246 when you say it was a typo? 11:01

CHAIRPERSON: Well, let's see where this goes.

MS. AUSTIN WAS THEN FURTHER EXAMINED BY MS. TANG AS FOLLOWS:

11:01

123 Q. MS. TANG: Can you the figures in front of you there, Ms. Austin.

A. I can, yes.

124 Q. The one that we're talking about, as you will know, is the middle box, and it's at the very end of the row, 11:01 "Average 2015/16", and you'll see that all along that top row of abusive violence --

CHAIRPERSON: Sorry, let's just describe it a bit better for people who are listening. We're looking at an ASPC Governance Dashboard, and it's a table of 11:01 incidents. The heading is "April 2016 to March 2017", and then specifically under "LD 2016 to 2017", there is a heading "Incidents Within Learning Disability Services", the first line of which reads:

11:02

"Abusive, violent, disruptive or self-harming behaviour."

And then we've got figures for each month from April of

'16 to March of '17, and then we get to an average, and that's what you're about to ask her about.

MS. TANG: That's correct.

DR. MAXWELL: -- average for the previous year.

CHAIRPERSON: You're quite right. It's the average for '15 to '16. Right. 11:02

MS. TANG: Thank you. Thank you, Chair.

CHAIRPERSON: Just so that people who are listening can follow what we're doing..

MS. TANG: Yes, I appreciate that. Thank you. 11:02

125 Q. So we come to the very end column there, and you'll see that the average per month up along there in that row had been somewhere in the 200s or 300s, and then at the very end the suggestion that the average for 2015/16 was 46. So as you might appreciate, that drew our attention. Can you clarify -- 11:02

DR. MAXWELL: It wasn't a suggestion, it's a statement that that was the average.

126 Q. MS. TANG: Yes. Yes. So can you clarify anything around that number of 46 as an average. 11:03

A. I can. I can just say that that is a typo, because we've looked back over the data, similar data for the same period in time, and the average is actually 279. And that's documented in previous reports.

MS. TANG: Thank you. 11:03

MS. AUSTIN WAS FURTHER QUESTIONED BY THE PANEL AS FOLLOWS:

DR. MAXWELL: So can I ask, who does the quality assurance of these reports? I mean this is the summary report to the Governance Committee I presume? 11:03

A. It did, yes.

127 Q. DR. MAXWELL: And -- well, firstly, who produces this table and who double-checks it before it goes out?

A. So this report, the Adult Social and Primary Care Governance Dashboard came from the Corporate Risk and Governance team. It came into my Department and would have gone to the governance meeting. 11:03

128 Q. DR. MAXWELL: And did anybody notice the typo at the time? 11:04

A. I don't remember this specific report, but it should have been me quality assuring it. So I don't remember seeing that particular typo, and I don't have the minutes of the meeting to see whether we discussed that or not. 11:04

129 Q. DR. MAXWELL: Okay. So what we see through - if that was the average, was there a trend within the year of 2015/16? You've been back through the data. Was it on an upward trajectory, or a downward trajectory, or constant? 11:04

A. I didn't come into post until 2016, so, apologies, I can't answer for the previous years. But there wouldn't... That definitely is a typo.

130 Q. DR. MAXWELL: Yes. I mean that does sense, and

actually, as my colleague Prof. Murphy has pointed out, if you look down at the numbers, the totals don't add up.

A. No, they don't.

131 Q. DR. MAXWELL: So that is clear. But we have heard from other witnesses that over time incidents went up as the case mix changed, as the patients admitted changed in their needs. 11:05

A. Yes.

132 Q. DR. MAXWELL: Over a period of time there were more patients with mental health problems and challenging behaviours, and I'm wondering if that was something that was ever discussed at the governance meetings? 11:05

A. It would have been. If there was an increase noted in incidents, the kinds of things we would have discussed are, like you've just said, are there new patients with particular challenges? We would have also discussed has there been a recent training session in how to record adverse incidents? Because sometimes after you deliver training you do see an increase in people recording, they get more confidence to record it, or we've demonstrated the importance of recording it. So sometimes you do see an increase in that. So those are the kind of things we would have discussed when we saw an increase. 11:05 11:06

133 Q. DR. MAXWELL: We've also heard from other witnesses that when wards were merged and one ward was closed.

A. Yes.

134 Q. DR. MAXWELL: This was very difficult for some

patients.

A. That's right.

135 Q. DR. MAXWELL: And their challenging behaviours went up.

A. Yes.

136 Q. DR. MAXWELL: Did you discuss whether any of these fluctuations were related to any ward closures? 11:06

A. On this particular report?

137 Q. DR. MAXWELL: Well any time in your...

A. On any report? Yes, that would have been the kinds of thing, whenever we discussed peaks or increases in incidents, we would have had asked -- that's what I mean when I say we were asking does anyone have an explanation for this? We would have looked at have we delivered training, were there specific things that happened, such as ward closures? That would have been discussed at governance. 11:06 11:06

138 Q. DR. MAXWELL: Did that then influence future decisions about ward closures? Because we've heard that they were sometimes quite sudden, so no preparation for staff or patients, and some people have suggested the incidence of aggressive and violent behaviour increased after this, was that something that the Governance Committee discussed and made recommendations about? 11:07

A. It would have been discussed and the discussion would have centred around more planning, more preparation for the patient to move to new wards, or making sure that the communication was good with families and carers and patients. 11:07

139 Q. DR. MAXWELL: But some people have suggested that

actually a lot of people with some of this behaviour are people with autism, who find it very difficult to move to an environment with more stimulus, more close contact with other patients.

A. Yes. 11:07

140 Q. DR. MAXWELL: Was it ever considered that actually merging the wards wasn't in the patient's best interest and that was evidenced by the increase in violent and aggressive behaviour?

A. I wouldn't have been at those discussions. 11:08

141 Q. DR. MAXWELL: Sorry?

A. I wouldn't have been at those discussions, but I'm not saying that they didn't happen.

142 Q. DR. MAXWELL: So you don't recall those happening in the governance meeting? 11:08

A. No. No. No.

143 Q. PROFESSOR MURPHY: Can I just ask you about these Learning Disability figures. They cover all Learning Disability services, not just MAH?

A. Yes. Yes, that's correct. 11:08

144 Q. PROFESSOR MURPHY: So did you also have figures that split MAH from other services?

A. Yes.

145 Q. PROFESSOR MURPHY: Because, obviously, that's a bit crucial? 11:08

A. Yes. This would have been the high level figures here. Datix is a system that allows you to put filters in to see for specific areas.

146 Q. PROFESSOR MURPHY: Can you tell us anything about how

those figures compared? MAH versus, for example, community services? Obviously there were lots more people in community services, so really you need a per head calculation, don't you?

A. I don't have a per head calculation. But what I will say is the figures for abusive, violence and aggression, were higher within Muckamore than they would have been in community. 11:09

147 Q. PROFESSOR MURPHY: So that suggests they were in a sense very much higher, had you been able to do a per head calculation? 11:09

A. Sorry, repeat that for me again?

148 Q. PROFESSOR MURPHY: Well, given there weren't very many people in Muckamore and yet they had this very high level of incidents, and it was higher than the numbers in community services where there are a lot more people? 11:09

A. Yes. That's correct.

149 Q. PROFESSOR MURPHY: Then had you done a per head calculation that would have been really startling, I imagine? 11:09

A. I didn't do it, but I imagine it would be, yes.

150 Q. CHAIRPERSON: Can we just come back to this table and I just need a bit more help, I'm afraid.

A. Okay. 11:10

151 Q. CHAIRPERSON: Could we highlight the whole section of LD 2016/17? Yeah. Thank you very much. That was very clever. Right, thank you. When would this table have been discussed, at which meeting?

A. The governance meeting.

152 Q. CHAIRPERSON: When? I don't want an exact date.

A. A quarterly governance meeting. Quarterly governance meeting.

153 Q. CHAIRPERSON: So some time after March of 2017, presumably? 11:10

A. Yes. Yes.

154 Q. CHAIRPERSON: And who would be present at the quarterly governance meeting?

A. So there were different quarterly governance meetings. There was a Directorate quarterly governance meeting, which I presume this is for. 11:10

155 Q. CHAIRPERSON: Right.

A. Because the three divisions are named on it.

156 Q. CHAIRPERSON: So each Divisional Director would be there. 11:10

A. Each Divisional Co-Director would be there and it would have been chaired by the Director.

157 Q. CHAIRPERSON: Right. So is that the sum total of who would be at this meeting? 11:11

A. No. We would have had the Divisional Social Worker, Divisional Nurse, Chair of Division.

158 Q. CHAIRPERSON: Right.

A. HR colleagues, health and safety colleagues.

159 Q. CHAIRPERSON: So quite a lot of people actually at the meeting. 11:11

A. Yeah.

160 Q. CHAIRPERSON: And this dashboard presumably would have been the focus of some of that discussion?

A. It would have been, yes.

161 Q. CHAIRPERSON: So if in fact the figures had been correct, which we now are told they're not, a leap from 46 to the sort of figures that we're seeing across the rest of the months, should have been a red flag, shouldn't it. 11:11

A. It would have been, yes.

162 Q. CHAIRPERSON: So somebody should have said: 'Hang on, is that actually right?' Because if it is right, it would have been a real problem. 11:12

A. And that's probably what happened. I don't have the minutes, so I would presume that someone looked at that figure and said 'that can't be right'.

163 Q. CHAIRPERSON: All right. Then I suppose you would expect this to be updated and corrected. 11:12

A. Yes, and there are other reports with the correct number.

164 Q. CHAIRPERSON: Could we just look three lines down at the line which reads "Accident that may result in personal injury", and we can see that the average for 11:12 April of '16 was 36; then May, 44; June, 56; and then if we look at the average for '15/'16, it's 3.

A. So that's incorrect as well.

165 Q. CHAIRPERSON: That's also incorrect.

A. That is. I think the whole table, the calculations 11:12 have gone wrong in the whole table.

166 Q. CHAIRPERSON: And the bottom line, average per month for '15/'16 is 312 throughout.

A. Yes.

167 Q. CHAIRPERSON: Is that correct?
A. No, it -- no.
168 Q. CHAIRPERSON: No. So nobody in this meeting has actually looked at this table properly?
A. No, I'm not saying that. I don't recall the discussion about this particular report. I don't know... 11:13
169 Q. CHAIRPERSON: So it may have been spotted and it may be in the minutes.
A. It would be surprised if it wasn't spotted.
170 Q. CHAIRPERSON: Well I think many people would be. 11:13
A. I would be surprised if it wasn't spotted.
171 Q. CHAIRPERSON: But we may want to discover if it was.
A. Okay.
172 Q. DR. MAXWELL: But it would have been minuted if it had been discovered that the figures were wrong? 11:13
A. Yes, it would have been minuted.
CHAIRPERSON: Right. Okay.
173 Q. DR. MAXWELL: So it will be in the minutes if somebody raised concerns about any of these figures?
A. Yes. 11:13
CHAIRPERSON: All right. Well, that's very helpful. I think that that completes our --
174 Q. DR. MAXWELL: Sorry, just to clarify that. So do you think this would have been presented at an April '17 Directorate governance meeting? 11:13
A. So the quarterly meetings happened January, March, just before summer, September and December.
175 Q. DR. MAXWELL: So it's probably the September.
A. Yes.

CHAIRPERSON: And, actually, I hate to say it, but it looks like the figures above for Mental Health CAMHS are wrong as well, because the average per month is the same. All right. Well we'll no doubt be able to examine the minutes and see if this was picked up. 11:14

MS. TANG: Thank you.

CHAIRPERSON: Can I thank you very much for giving us your time this morning, you're finished before we even had to have a break. So thank you for your statement and thank you for your time. 11:14

THE WITNESS: Thank you.

CHAIRPERSON: Well this afternoon, could we start early or is the witness... Okay. Two o'clock. All right, two o'clock. Thank you very much indeed.

11:14

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

11:17

CHAIRPERSON: Ms. Bergin.

MS. BERGIN: Good afternoon, Chair and Panel.

CHAIRPERSON: Good afternoon.

MS. BERGIN: This afternoon's witness is Marie Curran. The internal statement reference is STM-315 and Chair, 14:03 just one matter. You have grand a Restriction Order, RO86 in relation to one paragraph on page 43 of the witness statement that there should be no reporting in relation to that.

CHAIRPERSON: I mean there's probably no need for you specifically to refer to it in any event, is there?
MS. BERGIN: No.
CHAIRPERSON: But there is a Restriction Order so that people know. 14:03
MS. BERGIN: Yes.
CHAIRPERSON: All right. Thank you.
MS. BERGIN: The witness can be called.

MS. MARIE CURRAN, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS: 14:04

CHAIRPERSON: Can I just welcome you to the Inquiry. Thank you for your statement. Thank you for coming along to help us this afternoon. I'm going to hand you straight over to Ms. Bergin. 14:04
A. Thanks very much.
MS. BERGIN: Thank you. Good afternoon, Ms. Curran. As you know, my name is Rachel Bergin. I am one of the counsel Inquiry team, and we met briefly this afternoon, and I'll be taking you through your evidence. 14:04

You have been asked to give evidence to the Inquiry in relation to Organisational Module 7, which is about the Operational Management of Muckamore, and you were asked a series of questions by the Inquiry and you have addressed those in a statement to the Inquiry; isn't that correct? 14:05

A. Yes. That's correct, yes.

176 Q. And you should have a copy of your statement in front of you and it's dated 26th August 2024?

A. Yes.

177 Q. And there are also some exhibits attached to your statement. I'll be referring you to particular paragraphs of your statement and you'll be able to follow along with your statement in front of you and also on the screen. Now, before I ask you to adopt your statement, can I just confirm, do you have any notes on your statement? 14:05 14:05

A. I do.

178 Q. And have those notes been made by you? Are they your personal notes?

A. They are. 14:05

179 Q. With that in mind, are you content to adopt your statement as your evidence to the Inquiry?

A. I am, yes.

180 Q. And one final note before we start then is, you may have some ciphers used on your statement to deal with the names of some patients and staff, and where those have been applied if you could also refer to staff, or relatives or patients by the same ciphers. 14:05

A. Okay.

181 Q. And, if in doubt, if you can write down a name and the secretary will be able to assist you. Okay? 14:06

A. Okay. No problem.

182 Q. So if we now turn to your evidence, and we have up on screen your statement. And we see then at page 1,

paragraph 6, you refer to your professional background, and you commenced your career in 2002 as a Human Resources Assistant with the South Eastern Belfast Health and Social Services Trust, one of the legacy Trusts that then merged into the Belfast Trust; is that correct? 14:06

A. Yes.

183 Q. South and East Belfast Trust, yes. If I could just ask you to speak as slowly and as loudly into the microphone as you can. 14:06

A. No problem.

184 Q. Just in aid of everyone listening and the stenographer. So moving on to paragraph 7 then, in terms of your employment with the Belfast Trust, you began working for the newly formed Trust in April 2007, and at Question 1 then, if we can go to page 3, please, you were asked about your role and responsibilities in respect of Muckamore, and you answered that between paragraphs 8 and 13, and you say that your role and responsibilities in relation to Muckamore have changed over time. Before the allegations of abuse came to light in 2017, you had no role in Muckamore; is that correct? 14:06 14:07

A. No dedicated role within Muckamore Abbey Hospital.

185 Q. Yes. 14:07

A. But in my corporate role within Human Resources would have managed any concerns or issues or provided any advice as was required in relation to Muckamore Abbey staffing.

186 Q. Yes. And in 2017 you were appointed as the HR Senior Manager Employment Law and Medical HR, and that's the role in which you became initially involved with Muckamore?

A. That's correct, yes. 14:07

187 Q. Is that correct?

A. Yes.

188 Q. And you say in your statement that between May 2017 and December 2018, your role involved providing support to managers dealing with the issues that were emerging 14:08 from Muckamore in respect of disciplinary procedures and suspension processes?

A. Mm hmm.

189 Q. Then you say that in December 2018 you then became the Interim HR Service Manager for the HR Muckamore Abbey 14:08 Hospital Investigation team?

A. Yes.

190 Q. And that was a specific HR function to support dealing with the significant problems emerging from Muckamore at that time. You say that you were initially involved 14:08 in setting up the dedicated HR support team for the Muckamore Investigation?

A. Mm hmm.

191 Q. And the initial view was that HR would be required to manage the internal disciplinary investigations for 14:08 staff identified during CCTV viewing, and at that time you were reporting to the then HR Director, Jacqui Kennedy. And you say that you were in that role until very recently, May 2023, when you were appointed as

Head of Employee Relations, and in that role you're responsible for the full employee relations service within the Belfast Trust HR Department, and that also includes the HR investigation support team for Muckamore?

A. That's correct, yes.

192 Q. Now I just want to pause there for a moment, and we're jumping around somewhat, but just to understand the HR role generally and also at Muckamore, and we're going to come to some of the specific aspects of the HR role that you played at Muckamore in due course. But if we look at page 6, paragraph 19, please, and in terms of the broad role of HR, you say that: 14:09

"HR is a support service which is there to assist operational directorates. The nature of performance issues in question determine whether or not line managers sought HR advice." 14:09

And then: 14:09

"If line managers considered that they could deal with the performance issues informally, there was no requirement to inform HR or seek advice." 14:10

But as you go on to say then you actually fulfilled quite specific roles at Muckamore in respect of the CCTV investigation. So if we pick up again at paragraph 13 then, please?

And here you say that by December 2018, you had over a dozen cases where you felt there was sufficient information to commence disciplinary proceedings in relation to the CCTV matters, but there were prolonged discussions with PSNI about whether accused staff could be shown CCTV footage of incidents grounding the disciplinary proceedings, and you discuss the tension or the concerns on the one hand between the PSNI about potentially prejudicing criminal matters, but on the other hand the Belfast Trust concerns about not being able to progress disciplinary proceedings internally. 14:10 14:10

And you say that the Trust considered whether there were other ways to progress disciplinary proceedings without using access to CCTV footage, but concluded that it wouldn't be possible to operate a fair process. 14:11

Now, we're going to come on to deal with CCTV specifically, because you're asked about that at Question 9 of your statement. 14:11

A. Mm hmm.

193 Q. But for now, in terms of the specific questions about this, the Inquiry has heard that it was very stressful for staff to be on these lengthy, often lengthy precautionary suspensions, and often not knowing why. Could staff not have been given a gist or a brief explanation of what was shown on the CCTV, rather than seeing it to progress the disciplinary proceedings? 14:11

A. Well that was certainly one of the options posed around progressing disciplinary matters with staff and trying to give them a level of information that led to the significant decisions around precautionary suspension. But it was the view of the PSNI that in doing that and providing even a description of the concerns, even in the broadest sense, had the potential to prejudice the criminal investigation.

194 Q. You go on then to say that it wasn't until March 2020 that PSNI agreed that CCTV could be shown for disciplinary proceedings, but that was where criminal interviews had already been completed? 14:12

A. Yes.

195 Q. And we're going to come to disciplinary procedures in some detail in a moment. But between 2017 and March 2020 then, was there any disciplinary action being concluded in relation to CCTV? 14:12

A. In terms of formal disciplinary investigations?

196 Q. Yes.

A. None. No. 14:12

CHAIRPERSON: Could I just ask this: You obviously felt that you had to follow what the PSNI were asking you to do?

A. Yes.

CHAIRPERSON: I don't want to know what the advice was, but did you take legal advice? 14:12

A. We did.

CHAIRPERSON: Fine. Thank you.

197 Q. MS. BERGIN: So between 2017 and 2020, the role of HR

then in dealing broadly with the disciplinary procedures was what?

A. It was somewhat different to what HR's role would normally be in employment investigations, and when we set up the dedicated team, we essentially became a depository for the information that was flowing from the safeguarding referral process through, and we were trying to capture as much information as possible. So there were examples that we were receiving information from Muckamore management to advise that a number of staff were identified in footage and as a result there was a decision to place on precautionary suspension. So we were initially receiving names, but we weren't receiving the information or the detail of the concerns that was leading to the suspension decisions. So we almost came in behind that process to try and capture that and work closely with our safeguarding colleagues to collate all of that information as best as possible. 14:13 14:13 14:14 14:14

198 Q. And we previously discussed how earlier in your career at the Belfast Trust in your HR role, you were initially involved with Muckamore as the HR Senior Manager dealing with Muckamore issues as they arose? 14:14

A. Yes.

199 Q. So is your evidence then that in your initial role you were dealing with Muckamore matters, and then more periodically in terms of as and when they arose, but then in your subsequent role when you took over the HR role for the HR investigation team, there was a specific dedicated team on site at Muckamore, so it was 14:14

a very different role?

A. No. So the team was never on site in Muckamore, it was always based within the HR Department. So it just became a specific function of the HR team to manage the investigations.

200 Q. And in terms of the role that HR would have had with Muckamore prior to the setting up of the investigation team, could you tell us a little bit about the volume? Obviously the events came to light in 2017, where I think you've described them as being entirely different to what had come before in many ways, but could you tell us a little bit about the volume of engagement that HR were having before the 2017 allegations came to light with Muckamore in relation to HR issues? 14:15

A. Well, I suppose to help answer that question, it would be useful to set out how the employee relations team is set up. So within that core employee relations team they will deal with matters around grievances, disciplinaries, employment investigations, bullying and harassment concerns, and the management of industrial and employment tribunals, and within that team it is - there are case managers aligned to specific Directorates. So at that time, prior to 2017, there would have been a Senior HR Officer and a HR Officer, and one of their Directorates would have included Muckamore Abbey Hospital. So they would have case-managed any concerns that were coming through. So they would have received email or telephone contacts

from managers within Muckamore. I can't talk to specifics of the volume prior to 2017, but it certainly will be available in terms of some of the information held within the human resources teams. But I do recall there being some activity and some concerns, and I suppose because of the nature of the patient and client group within Muckamore Abbey, there routinely would be concerns raised. 14:16

CHAIRPERSON: Could you just remember that somebody is trying to write down what you're saying. 14:17

THE WITNESS: Sorry. Yes.

CHAIRPERSON: So just slow down a little bit. They're very fast, but you also speak quite quickly.

PROFESSOR MURPHY: Can I clarify: Those two HR people then were then covering other places than Muckamore? They weren't just -- 14:17

A. Yes, they could have had two or three large Directorates. Belfast Trust is significant in size, and our employee relations team is relatively small, you know, less than ten staff within the employee relations team, so you are covering large areas of the organisation. 14:17

PROFESSOR MURPHY: Yes. Thank you.

201 Q. MS. BERGIN: You then go on to say that in your role as HR Senior Manager between December 2018 and July 2020, at times at the beginning of that process you were involved and actually attended when CCTV was viewed by the Adult Safeguarding Team or others, other senior managers, and you say that you provided HR advice at 14:17

meetings where staff were being informed of decisions then made off the back of that. Following the appointment of two Senior Nurse Advisors in July 2020, you then weren't required to be present for the CCTV viewing. Now, as I've said, we are going to come to the CCTV viewing in just a moment.

A. Yes.

202 Q. But for now, why were you no longer required to be present during the CCTV viewing when the Senior Nurse Advisors were appointed? 14:18

A. Well, I suppose in relation to the availability of CCTV - so just to discuss a little bit about how the process was working prior to the appointment of the Senior Nurse Advisors. The Safeguarding Team were viewing the footage when it was in Muckamore Abbey Hospital, and there were a number of DAPOs who were responsible to view any incidents, and the incidents were also viewed by Muckamore senior management. 14:18

I know you're going to come to it, but at the point when that CCTV was removed from Muckamore, that process was no longer operational. So when I talk about my access to viewing the footage, it was in very, what was described as more serious incidents because the police had the footage and the Belfast Trust did not have the footage. So we were being guided by the police at that point to say that: 'We have reviewed an incident and we are concerned. It involves staff members that are potentially still at work', and so there would have 14:19 14:19

been an agreement that I would have supported the Senior Nurse Manager or Service Manager in Muckamore and we would have actually went to the police station to view that footage. And I suppose what I was trying to do there, it was, you know, streamline the decision-making process. So normally if a decision is taken by a Senior Manager to suspend a staff member, you would routinely make contact with HR to go through the motions, in terms of having a letter prepared, having your guidance, making arrangements to meet the staff member. But by me being present, I was - it was streamlining that. So the footage was reviewed by the Service Managers in Muckamore, and the Senior Nurse, and then decisions were taken and communicated up through to Co-Director and Director level. 14:19 14:20 14:20

203 Q. So during the time that you were attending during the CCTV viewing, would it be correct that you're saying it's not that you were involved in the decision making per se that was being made by safeguarding, but rather that you were there to, as you've said in your own words, to streamline how quickly the decisions were made, because they didn't have to come to you after the meeting, it was all rolled up together? 14:20

A. Yes. And I suppose because we had moved to that model where I was seen as the dedicated support for the Muckamore Abbey Investigation, and because of the continuity and my involvement from the beginning, I was just a core member of those involved with the concerns. 14:20

204 Q. Okay. If we could go to paragraph 14 then, please.

And here you say that during the period before being able to commence the disciplinary proceedings:

"...the HR MAH Investigation Support Team worked closely with the relevant Adult Safeguarding staff and with Service Managers viewing the incidents." 14:21

And you describe then further down the support that was given to the overall investigation process, including capturing safeguarding referrals sent across to HR, and capturing the decisions that were taken by management about any actions relating to staff, including suspensions or training. 14:21

Did you keep, and we're going to come to the decisions and the mechanism by which those were dealt with and processed later, but in terms of capturing the data at that stage, did you keep a comprehensive record, HR, of all of the safeguarding referrals? 14:21

A. We did, yes. 14:22

205 Q. Okay. If the Inquiry wanted to obtain a sample of that, is that something that could be provided?

A. Yes, very easily, yes.

206 Q. You say then that you liaised - further down - you liaised with PSNI and RQIA, and in March 2020 when internal disciplinary processes then eventually began for some staff, your role was: 14:22

"...to ensure that staff were investigated properly and

fairly, and managed in accordance with the applicable disciplinary procedures."

And you also say then that due to the additional workload, you secured a number of investigating officers from the HSC Leadership Centre to commence the internal disciplinary investigations. 14:22

Now, earlier on in the previous paragraph of your statement, paragraph 13, you had said that the initial view on bringing the HR team on board in this specific role, the initial view was that HR would manage the internal disciplinary procedures, and here you're saying that investigating officers were brought in from the HSC Leadership Centre. So can you explain to us how that process worked in terms of managing the procedures? 14:22 14:23

A. Yes, certainly. So it would never be a charge role to undertake the investigation. We case manage and we advise and provide guidance on the relevant policy. So in this case it was the application of the Trust disciplinary policy. So the mechanisms to follow, the processes to follow, and the timeframes within that. And when it was -- when we got to that position of being able to commence employment investigations, the formal disciplinary investigations, it was agreed that it would be more appropriate to use what we refer to as independent investigators. So within the Leadership Centre they have a number of associates, a number of 14:23 14:23

which could be former HSC senior staff or other associates that are trained to undertake employment investigations. So when I refer to the management of the employment investigations, it's the practical management of it. It's the assigning a case to an investigation team, ensuring they have the Terms of Reference. My team, because they were a dedicated resource, they were also able to support those investigation teams, so they could gather on their behalf any relevant evidence that would be required for their investigation process and manage the correspondence with staff members as well on their behalf. 14:24 14:24

CHAIRPERSON: Could I just go back to the period when you were watching the CCTV? 14:24

A. Yes.

CHAIRPERSON: What did you regard your role to be? What was the purpose of you watching the CCTV, when you weren't trained in MAPA or you hadn't work on a ward?

A. My role at that time was purely advisory. So the senior staff who were the decision-makers, they would be the appropriate individuals to make the decision and to assess the need to suspend a staff member. And I suppose I was there to say: 'Okay, well can we understand is that a current employee? Are they still in Muckamore today? Are they working today? Can we get some information? What is the level of potential risk?', and working that through, and then trying to arrange meetings as quickly as possible and having 14:25 14:25

letters prepared to hand deliver to the staff members.
CHAIRPERSON: I understand that side of your role.
A. Okay.
CHAIRPERSON: Which is obviously an important one, but why did you need to watch the CCTV for that? 14:25
A. I think possibly at the beginning there was a level of just consistency, because decisions were being taken about suspensions for various staff members for various reasons, and because I had been there, been in receipt of some of the information from the outset, there was 14:26 possibly a view that I had oversight of some of the decisions, and the decision-makers were changing.
CHAIRPERSON: Well that's what I wanted to get to. Did you have any oversight of a decision as to whether something ought to be referred or not? 14:26
A. Referred?
CHAIRPERSON: As a safeguarding incident.
A. No.
CHAIRPERSON: So what was your oversight?
A. Well, there was two -- there was different parts of the 14:26 process I suppose. So the safeguarding -- so at the point I'm talking about when I was present for any of the footage, safeguarding weren't involved. So safeguarding hadn't reviewed the incident for the purposes of referral because it was already sitting 14:26 with the police. So the police had viewed it and had determined that it was a serious incident. So they wanted to flag it with Operational Management to say: 'We have a staff member, or we have identified staff

members in this particular piece of footage, we believe you need to review it', and it was for a very, very short period of time that I was present. I mean I could - probably less than, you know, half a dozen times maybe being present in Antrim Road Police Station to view some of that footage. But it was more of a supportive role than an assessment, from my perspective.

CHAIRPERSON: Okay. All right. Thank you.

14:27

207 Q. MS. BERGIN: Do you think you would have been able to do the same job without having seen the CCTV though?

14:27

A. Well, at the early stage of the process, decisions to place staff on precautionary suspension or other management actions were taken without the footage. So the very early process involved safeguarding on site. So as I explained, you might have had a review of the footage by local management on site, and they would have identified the staff member, and they would have looked at the concerns. DAPOs then would have came in to look at it from a safeguarding perspective and whether it required a referral. And then at that point when we were the dedicated team, you know, it was the paperwork that was used to make an assessment. So it was really based on the language and the description of the incident provided by safeguarding. And that was again for a short period of time until we had the full access to the footage that we do today, in the format that we do today.

14:27

14:28

14:28

208 Q. You've indicated that when you were initially involved

in the CCTV viewing the police hadn't yet viewed the footage, or the Adult Safeguarding hadn't yet viewed the footage?

A. Adult Safeguarding, yes.

209 Q. But the police had? 14:28

A. Yes.

210 Q. And the Adult Safeguarding Team were then making decisions following the police having viewed it and then with you supporting them. Is that correct?

A. Well, safeguarding -- at that point I wasn't supporting 14:28 Adult Safeguarding, because the police had the footage, the police were identifying potential safeguarding concerns, and then they were flagging with management and I was supporting management.

211 Q. And to what extent, if at all, do you think that the 14:29 decisions that management then made around disciplinary action, or around whether a matter was something that warranted referral in terms of being either an Adult Safeguarding matter for disciplinary procedures, to what extent do you think those were influenced by the 14:29 police already having made decisions in respect of whether or not something perhaps met a criminal threshold?

A. Well, the process was different throughout, you know, various stages of it. I believe safeguarding applied 14:29 due process in terms of their own safeguarding policies and procedures, you know, they were the experts in safeguarding. So there was crossover in terms of viewing the footage. Both organisations were viewing

the same footage at different times.

212 Q. So would there though have been examples or instances that you can perhaps recall where the police might have said: 'This doesn't meet the threshold for a criminal prosecution', but where the management and Adult Safeguarding then had made a decision that in fact under the Trust procedures it was something that the Trust would have to follow the disciplinary procedures for? 14:30

A. Yes, and that would be normal, you know, conduct versus criminality, you know. So our thresholds are completely different. 14:30

213 Q. At Question 7 then, if we can move to the top of page 7, please, and on to page 8. You were asked then about the Muckamore (Safeguarding) Operations Group, and your response at paragraph 25 outlines that there were actually two multiagency groups at that time. Both of them were established in September 2019. The first is the Muckamore Operational Working Group, and the second is the Muckamore Safeguarding Governance Group; is that correct? 14:30 14:31

A. That's correct, yes.

214 Q. And it's the Operational Working Group that I'd like to focus on. Now at paragraphs 25 and 26 you say that the group was set up to ensure that there were regular operational multiagency meetings to provide regular updates on the CCTV investigation in respect of HR, Nursing, Safeguarding and PSNI actions. Now, I'm going to be referring to two of your - the two exhibits to 14:31

your statement, and so we're going to be jumping back and forth somewhat. So if we can now go to page 38, please? And here we have a copy that you've provided of the Terms of Reference of the Operational Working Group. And you're named further down -- that's fine, 14:31
thank you, at the top -- you're named further down as the Chair of the Group in the minutes.

A. Yes.

215 Q. And in the Terms of Reference. And you say elsewhere in your statement that in your capacity as Senior HR 14:32
Manager you've been the Chair of this Group since December 2019.

A. Yes, that's correct.

216 Q. Yes. And to date. Is that still the position?

A. Yes. Yes. 14:32

217 Q. Now at the top of the document, the group is called the Muckamore Abbey Hospital Operational Working Group.

A. Mm hmm.

218 Q. And then in the box immediately below it's called the Muckamore Abbey Hospital Safeguarding Operational 14:32
Working Group. So they're presumably the same group, but it appears they are referred to in various documents, not only their own Terms of Reference, but also before the Inquiry, by two different titles?

A. Yes, it appears that way, yes. 14:32

219 Q. Yes. Was there ever confusion about that in terms of with which group was being referred to as regards this group or the other Safeguarding Group?

A. No.

220 Q. No.
A. No confusion, no.
221 Q. Now in the first row under "Purpose" it states that the purpose of the group is:

"...to note all actions and decisions taken in relation to staff implicated in the investigation. To provide assurance of safe management of all alleged safeguarding concerns." 14:33

So were the Operational Group, and then the Safeguarding Group, only focused on investigations arising from the historical CCTV, or did the work continue after the viewing of the 2017 footage?
A. So the purposes of this group was solely around the CCTV 2017 investigation. 14:33
222 Q. And you come on later in your statement to say - we'll just stay with the Terms of Reference for now - but you come on later in your statement for the - I'll find the reference in a moment - but to say that the meeting purpose and in fact the attendees of the meeting changed over time? 14:33
A. Yes.
223 Q. And as incident referrals reduced and there were no longer referrals being received, that the meeting then moved on and morphed slightly, if I could put it in those terms, to being a forum for updates on any new issues arising? 14:34
A. Mm hmm.

224 Q. So if there was a new incident that arose from a contemporaneous CCTV review, is that not something then, according to this, that would be referred into this group or reported into this group also?

A. No. So when I refer, or when it says around any new or emerging issues, they're new and emerging about the 2017 investigation. So, you know, the process evolves and continues to evolve, and we find ourselves dealing with different scenarios now today. We're not solely focussed on the review of the raw footage and any identified staff members and subsequent management actions, that was very much our purpose for a considerable amount of time, just given the volume of footage. But now we're moving into a different phase where we can talk about the outcomes of disciplinary investigations. And to give an example I suppose of a new or an emerging issue, we may have a staff member that has been criminally interviewed, recommended for prosecution, their name released to the Trust for an internal disciplinary investigation, and that may result in, for example, a final warning. So we now have a staff member in our employment who essentially has concluded their internal investigation and should naturally return to work, but we now have a number of factors to consider around the pending prosecution decisions, potentially NMC restriction orders or other regulatory processes. So that's - when I talk about new and emerging issues, it is still about the 2017 investigation, but I understand in Belfast there would

14:34 14:34 14:35 14:35 14:35

be other mechanisms to deal with current issues.

I suppose it would be important to say that if there was a contemporaneous safeguarding issue that related to a staff known to the 2017 investigation, then we will absolutely be made aware of that by Operational Management in order to I suppose triangulate that information and make a decision and support management. 14:36

225 Q. So - apologies for cutting across you.

A. Okay. 14:36

226 Q. So I think we understand now that this group solely relates to the 2017 matters. You said that there would be other processes within the Trust to deal with contemporaneous matters. Are you aware if there was any type of a similar group? 14:36

A. No. I think it would just follow normal process. So if there was footage or a contemporaneous issue that arose today, the Safeguarding Team would be looking at that, the Safeguarding Team would undertake their own process around referral to PSNI and then their own internal Safeguarding investigation, and it's normally only after that where, you know, a process around disciplinary or conduct may be required. So that would all follow its own process. 14:37

14:37

Now -- and there are contacts throughout HR where senior management in Muckamore can come to for advice and guidance on that. Me being one of them anyway generally because of my role in HR.

227 Q. Further on down then at page 39 on the role relating to duties, you say that - or, apologies, you don't say - the Terms of Reference state that the group are to support the Governance Group Agenda:

14:37

"Members are responsible for sharing all information with the group that is relevant to and will assist other organisations in ensuring the protection of patients."

14:38

And:

"Where there is any dissent on any issue..."

- within the Operational Working Group, it should be escalated to the Safeguarding Governance Group, which is the other group we've referred to. 14:38

In the row titled "Authority", it states that the group works under the authority of the Safeguarding Governance Group. And in relation to "Reporting" then: 14:38

"Any issues that cannot be resolved are presented to the Governance Group for directions."

14:38

Now, if we could go back to page 8, please, and you were asked for the purposes of you statement who the group reported to and where the group sat in the governance structure?

A. Mm hmm.

228 Q. And at paragraphs 27 and 28, you say that this was not an internal Belfast Trust meeting it's a multiagency group, and it reports to the Safeguarding Governance Group. So are you saying that as a multiagency group it wasn't accountable through the Trust's governance system? 14:38

A. No, I'm not saying that. I suppose I'm just trying to describe how it's slightly different, that it wasn't solely an internal meeting or group, but it was attended by a number of representatives from other agencies. But certainly there was a level of governance. And as that, you know, the Terms of Reference outline, that it did feed into the governance group, where required. 14:39

DR. MAXWELL: It fed into the MAH Safeguarding Governance Group, but where did that fit into? We've had organisational structures of governance that all come up eventually through the Assurance Committee to the Board. 14:39

A. Mm hmm.

DR. MAXWELL: And I understand you're saying that individual Directors attended, but in terms of governance, how did the MAH Safeguarding Governance Group report through to the Assurance Committee? 14:39

A. Well, I'm not a part of the Governance Group, so I'm not sure how they reported through to the Assurance Committee in Belfast. But certainly given that there was a number of Directors on the Governance Group.

DR. MAXWELL: Well that's not quite the same as a governance structure. That's relying on individuals rather than systems, isn't it?

A. Yes. Yes. Yes.

DR. MAXWELL: So any decisions made by the group that you attended, you had delegated authority from the MAH Safeguarding Governance Group to make those decisions? 14:40

A. Yes.

DR. MAXWELL: Okay.

229 Q. MS. BERGIN: You say at paragraph 30 that one of the functions of the group was to ensure that: 14:40

"...all referrals generated as part of the CCTV viewing by either Adult Safeguarding or PSNI were accurately recorded." 14:40

A. Mm hmm.

230 Q. How did the group ensure that referrals were accurately recorded and where?

A. So in terms of the representatives of that particular group, you will have your safeguarding lead for the Muckamore Investigation, and then myself as the HR lead for the investigation, and we will have our respective records around the recording of those. And, of course, the PSNI representative would attend those meetings as well. So I know the minutes have been shared, and you will see within the minutes one of the standing agenda items will be new incidents or incidents to be discussed by the PSNI or Trust, and that is what is 14:40 14:41

intended there when I say that, that that opportunity every three weeks to discuss the incidents received by either PSNI, or sent to PSNI from ASG, are clearly documented and everybody has oversight.

231 Q. And if we go to those minutes now then, please, at page 42. And these are minutes of the Operational Working Group from Wednesday, 13th May 2020. And if we scroll down to page 45, please, and at point No. 9. And this is in relation to: 14:41

"Progress update regarding viewing completed/work yet to be viewed." 14:42

And the final paragraph in that box states:

"PSNI colleagues confirmed that approximately 70% viewing has been completed on Six Mile, no significant volume of incidents raised." 14:42

Did this position change after May 2020?

A. The position around the volume of incidents?

232 Q. Yes. And also the viewing in terms of 70% of the viewing?

A. Yes. I mean we provided - the update was provided around viewing from both PSNI and Safeguarding at those meetings, so we both knew each other's progress around that. Yes, it will have changed, and I'm sure if you review any of the minutes you'll where that percentage does change as time goes by, and it is impacted at 14:42

1 various times through maybe resource issues, or the
2 police would have paused viewing in order to focus on
3 criminal interviews. And, yes, it absolutely will have
4 changed as it goes on, yes.
5 233 Q. Was there ever any -- 14:43
6 DR. MAXWELL: Sorry.
7 MS. BERGIN: Apologies.
8 DR. MAXWELL: I suppose another way of phrasing the
9 question is; when PSNI had viewed 100% on Six Mile,
10 were they still saying "no significant volume of 14:43
11 incidents raised", or is that not information you have
12 to hand?
13 A. No, I am aware in my role that Six Mile was the area
14 where there were the least amount of safeguarding
15 incidents identified. 14:43
16 234 Q. MS. BERGIN: If we could go to page 11, please, at
17 question 9 - and we will be returning to the minutes
18 later.
19 A. Okay.
20 235 Q. And at question 9 you were asked about your role in 14:44
21 relation to the CCTV viewing process?
22 A. Mm hmm.
23 236 Q. And you have addressed this already in your answers to
24 the Chair. And then at Question 10, you were asked
25 about setting the procedures for viewing CCTV, and you 14:44
26 say that you weren't involved in setting the procedures
27 for CCTV viewing. Now you've already given some
28 evidence in relation to CCTV viewing, but did you feel
29 that HR should have been involved in setting the

procedures around CCTV viewing?

A. No. No. I believe the responsibility for viewing the footage was with Safeguarding, and they would set their own procedures around the viewing of that.

237 Q. The Operational Working Group you've said came into existence around September 2019? 14:44

A. Mm hmm.

238 Q. And we know that the allegations at Muckamore began to emerge in 2017, and you've described in your statement the work in terms of multiagency work and information sharing that was done in relation to that by the Operational Group. Do you think that the existence of the group came somewhat late given that it was two years after the allegations came to light? 14:45

A. Well, that was a more formal structure, the Operational Group. Absolutely before that there were regular meetings with PSNI and Safeguarding that were probably happening on a weekly or fortnightly basis. So to go back to the initial stage, it very much was what is normal process? The police will deal with their investigation and the Trust will wait any outcomes of that. And clearly as matters escalated and there were more incidents and more footage being reviewed, clearly we needed stronger links with the PSNI to build those in. So, yes, I would have been party to a number of meetings with PSNI colleagues at a constable level, you know, that we're sharing incidents and ensuring that we had access to all of that information. 14:45 14:45

239 Q. If we could move to page 13 then, please, and at 14:46

question --

DR. MAXWELL: Just before you move on, can we come back to this issue about different people viewing the CCTV, and there was no particular protocol. We've had conversations with other witnesses about what is the definition of abuse versus poor practice. 14:46

A. Mm hmm.

DR. MAXWELL: Was there any way of quality assuring that the same standard was being applied through all the viewings? 14:46

A. Not in a prescriptive way to quality assure I suppose. The concerns and incidents that have been identified do span lots of different areas of concern. You know, we will have very direct and overt incidents, and then we will have, as you describe, practice or conduct matters that need to be addressed, and I suppose, yes, it's dependent on the person and their assessment of that, and possibly some of their own experience and skills. 14:47

DR. MAXWELL: So there may have been some variability on how people viewed things? 14:47

A. Possibly, yes.

DR. MAXWELL: And on your -- you were keeping this list of all the incidents in anticipation of disciplinary action.

A. Yes. 14:47

DR. MAXWELL: Were they just recorded as incidents or were they given any categorisation? As you've said, there was a wide range of things seen. Did you use different categories for different types of incident?

A. So Safeguarding would have captured the detail around categorisation. So they will have incidents categorised by safeguarding referral so that it met the threshold for referral to PSNI, and then they will probably have a description, or they will have a description around the nature of the incident around physical, psychological, verbal, seclusion, that sort of categorisation. Then you will also have categories of other types of incident around conduct. We also have categories around weighted blanket, the use of weighted blanket, and then just other areas. 14:48 14:48

DR. MAXWELL: So on this comprehensive database that you said would easily be made available to us, would that have those categories listed on them?

A. It will. 14:48

DR. MAXWELL: Thank you.

240 Q. MS. BERGIN: And so just to confirm, there was no formal written protocol in place in relation to the process for watching CCTV or for the CCTV Safeguarding investigations? 14:49

A. So I suppose the way in which I have answered that is I am not aware if Safeguarding have their own protocol. There certainly is not a policy around how we were viewing the 2017 footage, but it is very probable that the Safeguarding Team have operating procedures on how and what footage is required to be viewed, and in what format they would view it. 14:49

241 Q. At paragraph 40 then you say that in any of the subsequent disciplinary processes, the HR Investigation

Support Team prepared and prepare the CCTV to be used in the disciplinary process, and in relation to providing it to staff, investigating officers and disciplinary panels, but there's no policy for the HR preparation work. So the HR team that you refer to, presumably they're all HR staff, yes?

A. Yes.

242 Q. And in terms of how they know which clips to provide then, if there's no formal policy for how this is managed, how did that work in practice? 14:50

A. Well, it was very straightforward, because the incidents that are being referred for disciplinary were on the basis of the safeguarding referral. So the information that was captured on our records would have been very specific in terms of the date, the time, the location, and the relevant cameras. So Safeguarding capture a lot of that information on their referral form, and then HR will come in and capture that footage. And we have a mechanism to do that on our viewing platform where we can go in and prepare the incidents for the purposes of the disciplinary investigation. 14:50

243 Q. At Question 12 then, if we could move to page 14, please? You were asked about any quality assurance procedures in relation to the CCTV viewing process, and Professor Maxwell has already asked you about this. 14:51

Now, at paragraphs 41 to 45 you describe some of the steps which were taken in the CCTV process, and you've

already indicated that there was no written policy in terms of how the process worked, the management of the process; isn't that correct?

A. That's correct, yes.

244 Q. So you outline here that the Adult Safeguarding Team first identified incidents and had their own ASG referral process, with referrals to PSNI through the APP1 Forms. 14:51

A. Mm hmm.

245 Q. And at the same time, as we've heard, PSNI were also viewing CCTV and were making referrals back into the Trust to the Adult Safeguarding Team. Then the APP1 Forms were shared with the HR Investigation Support Team. Your team then recorded the details on an Incident Ward Database that you maintained. So are all APP1s from the 2017 historic viewing listed on the Incident Ward Database? 14:51 14:52

A. They are, yes.

246 Q. How are those categorised? Is it by - do they each have a unique reference number, for example, in terms of searching those 14:52

A. They do, yes.

247 Q. And you then say that the HR Support Team then referred the incident to Senior Nurse Advisors.

A. Mm hmm. 14:52

248 Q. Who then reviewed the CCTV and completed IMR - Incident Management Review Forms - to record their decisions about staff involved in incidents, and that form was then returned to the HR Investigation Support Team, and

your team then recorded those decisions in the HR Incident Ward Database.

So the first question I have about that is: were the Senior Nurse Advisor decisions recorded on the Incident Ward Database in detail, or at all, in terms of their decisions? 14:52

A. Their decision would be captured, yes, against the database, yes.

249 Q. And in terms of there not being a written procedure, and I appreciate that these were the HR Support Team, and this process emerged from an extraordinary event, you've earlier in your evidence said this was different from the ordinary HR procedures prior to this, do you think that it would have been helpful for such a process to have been developed at the time, a written process? 14:53 14:53

A. Possibly, but very challenging to do that when you're in process. So to stop -- and the process changed, the flow of information changed, the CCTV viewers changed. So it was never going to be a static written process. And I suppose from my perspective, as long as we were following our HR policies and procedures around the management of the staff, and Safeguarding were following their policies and procedures around the safeguarding concerns, then we were fulfilling our requirements. But, yes, we have - I wouldn't describe it as policies, but we do routinely capture the process flow of what we are doing, and how we are, how we are 14:53 14:54

made up, and we will update that if something changes or we decide to do something differently, and we'll capture that and change that in a process flow so everyone is clear on their roles and responsibilities throughout the process.

PROFESSOR MURPHY: So do you have a flowchart that shows the whole thing? Because personally if I was working in this system I might find it a bit confusing, and I'm just aching to see a flowchart with it all on there. 14:54

A. We have a number of flowcharts, yes, throughout the period of time that we're discussing, and, yes, we could absolutely share those in terms of the flow of information and who looks at what and at what time.

PROFESSOR MURPHY: That would be great. 14:55

CHAIRPERSON: And those were provided to everybody involved in the process?

A. We developed them, you know, in terms of the safeguarding. We work like a multidisciplinary team. So we have our Safeguarding lead, our two Senior Nurse Advisors, and myself as the HR rep, and we meet every week and if there's any issues emerging like that, or we need to capture a new way of working or a new process, we will do that. 14:55

CHAIRPERSON: Sorry, I understand that. That's my fault. Who gets the flowchart? 14:55

A. Well, the team, the team that are supporting me and the team that are the supporting the Safeguarding lead presumably will have sight of them. I can't talk for

the Safeguarding and who they share it with, but my team certainly.

CHAIRPERSON: And those watching the CCTV?

A. And what, sorry?

CHAIRPERSON: And those watching CCTV -- 14:55

A. Well I suppose their role is distinct to viewing the footage to identify incidents.

CHAIRPERSON: Right.

A. And I suppose they don't necessarily need to know where that goes and what database it's put on. So presumably 14:56 Safeguarding will have their own operating procedures around viewing of the footage.

DR. MAXWELL: But you haven't seen them?

A. I haven't seen them, no. And I suppose to put some context to that. In terms of viewing that footage and 14:56 how challenging that was when it was initially returned to Belfast, you know, it was really, really, really difficult, because of the way in which it was returned, and how they needed to view in it little pieces to put it together to get a shift, for example, covered. But 14:56 now with our new system, you know, I know Safeguarding will, you know, they have a number of viewers that were coming or working on that, and they would have assigned days, times, wards or shifts to view.

250 Q. MS. BERGIN: Picking up again then in relation to the 14:56 database and the data that was held by HR - we don't need to go to it for now - but later on in your statement at paragraph 61, for the record, you say that Adult Safeguarding and HR maintained separate databases

to record the information that was generated, and that from 2020 there were data analysts appointed for HR and for Adult Safeguarding, and that those were shared and cross-referenced by the data analysts for quality assurance purposes? 14:57

A. Yes.

251 Q. So just to be clear, was it data, one data analyst for HR and one for Adult Safeguarding, they were separate?

A. They were separate, but work together. So one had a focus on the HR data for the purposes of the 14:57 investigation, and the other in terms of the Safeguarding referral data. But I suppose it was one of the same, just had different focus.

252 Q. And those analysts were brought in in 2020?

A. Mm hmm. 14:57

253 Q. So from 2017 onwards, was there any form of data capture and analysis and cross-referencing between the Departments at all?

A. There was certainly data capturing, because that was really important that we captured all of the 14:58 information that was provided to us. Analysis from a HR perspective, no, we were certainly just capturing the information and there was no cross reference in any great detail. At a point there was some cross reference between HR and PSNI just to ensure that we 14:58 had the correct details against each of the incidents received. And, you know, and I do talk to it in my statement, but there were times where there were duplicate referrals received because of the dual

viewing process between PSNI and Trust, we were maybe receiving the same incident on two different referrals, and potentially in some cases different staff members being cited within the referral documentation with different reference numbers, because the police generated their own reference number and Safeguarding generated their own. So it took a period of time to cross reference and quality assure those records. 14:58

254 Q. And was that happening during the lifetime of the operational investigation, or Operational Working Group rather? 14:59

A. Yes, it's part of our core business in terms of ensuring we have all of the correct detail. It's less of a requirement now. But that would, that would have been one of the key reasons why we wanted dedicated staff whose responsibility that was to ensure the records were accurate. 14:59

DR. MAXWELL: Can I just ask, you said you would get duplicate referrals, one from PSNI and one from Safeguarding identifying different staff, and we've also heard that there was some difficulties sometimes in identifying staff. Were there ever occasions when staff were misidentified? 14:59

A. On a couple of occasions that happened, yes.

DR. MAXWELL: So the database had to be changed because somebody had been misidentified? 14:59

A. Yes. Yes.

255 Q. MS. BERGIN: Yes, and in fact at Question 13 you were asked - if we could move to page 15, please? At

Question 13 you were asked if HR took any steps to ensure that DAPOs were able to identify those appearing on CCTV, and you outline at paragraph 46 that HR did provide assistance in respect of identifying staff, but in the early stages of the investigation it was Senior Management who identified staff during the CCTV investigation and, you then say that a master file was created by management with staff photographs and ID from HR records. 15:00

Now, the Inquiry has heard evidence that there were difficulties at times for some staff being able to identify those on CCTV and being able to get information to be able to ascertain who they were. Do you know when that master ID file that you've referred to was made available to the DAPO or the Adult Safeguarding Team? 15:00

A. I don't have the specific date, but it was relatively early on in the process, so probably 2018/19.

256 Q. And when you say "HR then", I presume you mean chronologically HR then afterwards took over in terms of assisting with identification? After the Senior Managers had fulfilled that role, HR then began to assist? 15:01

A. Yes. So initially management within Muckamore, because they were most familiar with their workforce, would have identified the staff members. And then as the referrals were being received we would have had more instances where staff were recorded as TBIs, so "To Be 15:01

Identified", and we would have supported in terms of trying to fill those gaps. So we may have spoken with the Nurse Bank Office to see if there were any bank staff that were assigned to Muckamore on those dates or times. We would have maybe had queries, it may be this person, and HR could have reviewed some of the personnel records to try and verify IDs through maybe the IDs held on file, around driving licences or passports. And then, Safeguarding, yes, they took ownership of the ID file and trying to ensure we had everyone identified that needed to be. 15:01 15:02

PROFESSOR MURPHY: So presumably that got really complicated when you were also possibly looking for agency staff, of whom we understand there were a jolly large number. 15:02

A. Yes, but there was less of an issue for agency staff identification. From my understanding there wasn't a lot of agency staff in Muckamore at that point at 2017, you know, the agency work force increased.

PROFESSOR MURPHY: After. 15:02

A. -- in response to the concerns. But Muckamore was well, you know, staffed with core staff members. But I suppose there were issues around In-Reach staff, so where patients were being resettled and they were maybe on trial, you had individuals from other facilities external to Belfast coming in. 15:03

PROFESSOR MURPHY: Yes. Yes.

257 Q. MS. BERGIN: If we could go to page 16 then, please, and at Question 14 you were asked about the

relationship between the HR team and the three successive teams working on the historical CCTV viewing, and this is something the Inquiry has heard evidence about already. And you answer this question from paragraph 50 onwards in respect of the three teams, and specifically you were asked by the Inquiry in relation to any tensions between HR and each of those teams. So to just summarise very briefly what you've already said in your statement, and you can confirm if this is correct. 15:03

During the first phase there was initially no specific HR Investigation Team during the initial period of the investigation, and then the HR Investigation Support Team was formed in late 2018. 15:03

And so during that first phase, you describe the relationships between HR and the Safeguarding Team as being broadly positive and a learning phase when both teams were learning from each other, would that be correct? 15:04

A. That's correct, yes.

258 Q. Then in the second phase from April 2019 to March 2020, you say that there were definitely difficulties between the teams, and you outline that there were a significant increase in the number of incidents identified on CCTV. 15:04

And at paragraph 54 you say that it is difficult to convey the extent of the difficulties faced by the

teams during this second period. So could you perhaps tell us a bit more about those difficulties? You mentioned some of them, and you've already referred I think in your evidence to the issues - I presume you were referring to the hard discs being corrupted when returned, and having to seek IT assistance. So could you describe to us the difficulties that the two teams were facing in that second phase?

A. Well, I suppose, yeah, the context at that time with the footage having been removed from Belfast just created obvious difficulties in order to progress safeguarding reviews and respond to any concerns about staff in alleged incidents. So that new Safeguarding Team was appointed, I believe on the 1st April 2019, and it was the very same day that PSNI returned some of our footage on the hard drives, as you describe. And that Safeguarding Team were very well experienced DAPOs within the world of safeguarding, and were immediately faced with this new way of working, or very modified approach to safeguarding investigations. And by that I mean that Safeguarding were not undertaking safeguarding investigations, they were essentially there as a dedicated team to view the referrals, and generate referrals to PSNI, and then liaise with HR or management, and that was unusual in terms of an approach when it comes to safeguarding investigations. So initially there were I suppose challenges in agreeing working practices, and the sharing of information, and the processes to support that work.

15:04 15:05 15:05 15:05 15:06

Safeguarding, in a normal sense, are independent and undertake their own process, and HR come in at a much later stage after an investigation has either taken place from a criminal perspective, then maybe a Safeguarding investigation, and then potentially only at that stage you would be looking at a conduct investigation, and there's very few times where Safeguarding are talking directly to HR in the midst of a process. So that was some of the difficulties in terms of new ways of working. 15:06 15:07

259 Q. Yes. And later in fact at paragraph 55 you refer to HR and Adult Safeguarding trying to improve how they work together by having weekly meetings, but that these meetings could still be difficult.

15:07

And at paragraph 57 and 58 you explain a bit more about how this was an unprecedented situation, and certainly investigation facing HR management and Adult Safeguarding, and you refer to this as being high pressured work, with professional tensions between Safeguarding and HR, and there were rapidly evolving workstreams, and you say in paragraph at paragraph 58 that HR had problems at times about the efficiency and effectiveness of the Adult Safeguarding referrals, or process rather, particularly in respect of delays in referrals, which had the potential to delay the implementation of then the management actions relating to the relevant staff. 15:07 15:07

And you then refer to changes to the Adult Safeguarding referral process, which you say were not effectively communicated, and that duplicate or differing information was being sent to HR, and you've already referred to that? 15:08

A. Mm hmm.

260 Q. Picking up on the meetings. It seems from your statement that they were a way of trying to work together through some of these issues. Could you tell us the types of formats that the meetings took and 15:08 whether they were successful in improving relationships between the teams?

A. Yes, absolutely. Well we met every week and we would have met with the Service Managers. So the Service Lead for Safeguarding and her two or three DAPO 15:08 colleagues would have met with myself and my HR Manager, and I suppose the purpose of that was really very operational in terms of what has flowed through to HR, going through the records, clarifying in cases where there were potential misidentifications of staff, 15:09 where there was a use of very - what I would describe as quite loose language in some of the referral documentation. So, for example, in some of the referrals we received from Safeguarding, there was language along the lines of "without having viewed the 15:09 footage we believe this may be", and they would have named a staff member. And I found that challenging, because as the custodian of the HR process, where potentially there was going to be a decision taken by

Senior Nurse Management around suspension or other action, I found that unsafe and a risk. So those were the types of discussions we were working through. And, again, a core focus in those meetings would have been around our TBIs, because they were a critical category for us, so we didn't know who they were, and they were involved in incidents, and we needed to identify them to take appropriate action.

261 Q. One of the other difficulties you've referred to that I've already mentioned is changes to the Adult Safeguarding referral process and those not being effectively communicated. Was it the communication of the changes or was it the changes themselves? And can you tell us a bit more about what those changes were, please? 15:10

A. There was different forms being used at different times. We had APPs, and ASPs, and different versions of documents. We had referrals that contained five or six incidents, because they were in a similar timeframe or within a shift, and we found that really difficult, because within that body of the referral we potentially could have had 20 staff named, but we couldn't determine if those staff were involved in every aspect of all of the concerns within the referral, or in only a part of it, and we found that somewhat of a challenge. So those were the types of scenarios we had, and we tried to work with Safeguarding to discuss maybe a different way to process the referrals to us, because we needed that clear documentation around the

staff members involved to record accurately.

262 Q. Do you think that the changes in those processes affected then how different staff processes were dealt with? If some members of staff were dealt with by ASG and HR following some system that was following some forms... 15:11

A. Mm hmm.

263 Q. And then there were changes, as you've said, and HR sometimes weren't clear about those.

A. Mm hmm. 15:11

264 Q. Do you think that affected the overall treatment of staff as they were engaging through these processes?

A. No, because that was part of the discussion was trying to clarify. So we were never making those types of critical decisions without being absolutely clear on 15:12 the staff members' involvement. So that's the purpose of those weekly meetings. And we would have referred some of that documentation back to ask them to be specific around the details so that we could make and refer those on to the Senior Nurse Advisors or Senior 15:12 Managers for decision making.

265 Q. In relation to Phase 2, you've referred to tensions arising from the PSNI and HR views that Adult Safeguarding was slow or there were delays in progressing or passing on these referrals to 15:12 management, and you've already referred to the technical problems in relation to the hard drives.

A. Yes.

266 Q. Were you aware that there was a request that initially

the CCTV viewing was to view a 25% sample?

A. Mm hmm.

267 Q. And that then moved to viewing 100% - all of the CCTV footage?

A. Yes, I'm aware of that, yes. 15:12

268 Q. Do you think that that process which was adopted had a, or caused difficulties in terms of how the staff disciplinary matters progressed? So, for example, when the initial sample was done and maybe incidents were picked up about specific staff and they were referred 15:13 onwards, and then at a later stage all of the footage was checked, there could have been incidents maybe which predated those, or further incidents which were then having to be dealt with when there were already existing matters with HR and the Adult Safeguarding. 15:13 Can you tell us a bit about how that impacted the process?

A. Yes. So we would, initially, you're correct in terms of the viewing. So there was a query over whether we could even, as an organisation, rely on this footage 15:13 because it had been running in test mode, as we know, and then the decision to look at a 10% sample. Because I suppose nobody anticipated that there were going to be more issues of concern. And as we were viewing, or as the Trust was viewing that footage and identifying 15:14 concerns, decisions were taken in response to those. But, absolutely, as you move through the wider viewing process, more incidents relating to the same staff were being identified. But ultimately all we were in a

position to do, our response as an organisation was to put in place a management action, so that would either have been the precautionary suspension, supervision and training, or some other modified arrangement.

15:14

So if someone had an incident identified within that first 10% viewing stage, and then there were subsequent incidents of a similar nature, didn't change anything. I suppose the dates and times and order of the incidents didn't affect anything. But where we had staff members, and we did, that were initially placed on a supervision and training plan, and then following further viewing of footage we would have needed to invite them back in to advise that due to the incidents now being viewed that they were being placed on precautionary suspension. So it was challenging in that way, you know. It's always preferential to know everything you're dealing with before decisions are made, but with this particular scenario we only completed the footage in the early part of this year, so we can only confidently say from 2024 that we know everything that there is to know about the incidents of concern within that footage.

15:14

15:15

15:15

269 Q. You then, at paragraph 56, go on to describe Phase 3 of the viewing?

15:15

A. Yes.

270 Q. And you say in summary that from March 2020, during this phase, there was a change in the Adult Safeguarding leadership, followed by a further change

in August '22, and you don't recall any significant tensions between the teams in this period. And as you've referred to in your evidence more recently, and certainly around this stage, operating systems and processes were then well established, and you describe the current team and HR as working successfully together. Were you aware during any of the three phases - we've discussed tensions between HR and Adult Safeguarding - were you aware of any tensions with the nursing team between Adult Safeguarding and the nursing team? 15:16 15:16

A. None, no, not that I'm aware of, no.

MS. BERGIN: I wonder, Chair, is that an appropriate time?

CHAIRPERSON: Yeah. How much further do you think you've got? 15:16

MS. BERGIN: I think half an hour.

CHAIRPERSON: Yeah. Okay. We'll take a short break and give you a bit of a rest, and we'll be back in about 15 minutes. Thank you. 15:16

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS

CHAIRPERSON: Thank you. 15:33

271 Q. MS. BERGIN: If we could pick up at page 23, please? Thank you. At question 18 you were asked about the thresholds for supervision and suspension of staff identified on CCTV. Now we're going to come to the

PSNI referral threshold in just a moment, but just focussing on the internal Trust threshold for suspension and supervision; you answer this at paragraph 67 saying:

15:34

"There are no prescribed thresholds for supervision or suspension of staff. Decisions were and are based on the level of potential or actual risk to patients and each decision was taken on its merits based on the available evidence."

15:35

And at paragraph 68 you say that:

"Broadly speaking, a staff member suggested to be involved in direct mistreatment of a patient was

15:35

suspended. Staff who may have witnessed or failed to intervene or report an incident were placed on supervision and training, but this was not a hard and fast rule."

15:35

Do you think that there ought to have been a more prescriptive threshold in respect of providing clarity for when suspensions or supervision ought to have been considered?

A. In the context of this investigation or generally?

15:35

272 Q. Well, generally.

A. No, I think it's really challenging. Because a decision to suspend is based on a number of factors and, you know, you have to consider the employment

arrangement, what is the job that the person undertakes, what are their responsibilities, what is the level of actual or potential risk to either themselves, others, the process of the organisation? So it is - it would be really, really challenging to have a list of prescribed actions, or incidents, or scenarios where a suspension -- now there's clearly obvious incidents, you know, of a very serious nature, where it would result in precautionary suspension decisions. But in these cases I believe all the suspension decisions were appropriate. And given the availability of the CCTV, which is highly unusual, where you would have actual footage of the concerns, the decisions were sound in that respect. 15:36 15:36

273 Q. One of the matters that the Inquiry has heard about in relation to the CCTV viewing, is the fact that the CCTV footage lacked any audio, which may have been something that would assist. In addition to that, in your evidence you've said that you considered that the suspensions that were made were sound, in your view. Given that there was no prescribed threshold, first of all how are you able to say that they were sound and, second of all, was there any type of auditing or assurance that was done to look at suspensions that were being made to make sure they were consistently applied? 15:36 15:37 15:37

A. I suppose it's hard to say whether or not something was consistent, because nothing is exactly the same. So every scenario, every incident, every staff member may

have had varying degrees of involvement. But in terms of my comment about them being sound, the footage is exceptionally clear, and a decision to suspend is a precautionary one. So there is no presumption of guilt or that facts have been established, but if there is significant information to give management or the organisation concern about that particular staff member, then the safest and most appropriate response would be to precautionary suspend that staff member.

274 Q. And when -- 15:38

DR. MAXWELL: But actually this wasn't just a single patient and a single member of staff, this was a whole hospital, at least a significant number of wards within it. And as you say, precautionary suspension does not say that the case has been proved against somebody. We have heard a lot of testimony that the number of staff who were suspended, or put on supervision and they weren't quite clear what they were being supervised for, led to significant staffing shortages, which had significant consequences for patients. So was there any consideration given to the fact that in normal circumstances suspending somebody during an investigation is the safest thing to do for the patients, but suspending a large number of people involved in a range of different categories of incident may not be quite as straightforward as if it was just suspending one person,

A. Mmm. Yeah, I really agree with that sentiment around the large number of staff members being suspended, and

I suppose that is reflective of how unprecedented this investigation was. In my normal employee relations role you're dealing with one-off isolated incidents maybe involving one or two staff members. That is and can be effectively managed. You don't necessarily need 15:39
to move to suspend in some of those cases, you can modify, you can restrict, and you can transfer the individual to make the situation safe. But within the context of Muckamore, that was really challenging, and we didn't know what was ahead of us. You know, we made 15:40
decisions at that early stage based on the footage, and the concerns, and the referrals received, and I don't think anyone involved in that process anticipated the number of staff. And, so, it's really difficult to say at what point do you say it's too much and it's going 15:40
to have this overarching negative impact on the hospital or the patients. But ultimately if the decisions are safe and appropriate, because of the level of risk, then that's what we had to do.

DR. MAXWELL: But I suppose the point I am making; the 15:40
level of risk identified from CCTV, was that ever compared against the level of risk to providing a service without any staff? Was there ever a balancing of the different risks? We've heard a lot of people saying: 'Of course, you must always suspend these 15:41
people. There's no other option', but they don't seem to have taken into consideration other risks, i.e. the risk of not having enough staff, or not having staff who know the patients, or not having staff with

learning disability training. Was there ever any discussion in your group about balancing those two risks?

A. And I suppose that was the challenge between having the two separate processes, because we weren't managing the hospital and we didn't know the needs of particular patients or their relationships with certain staff members. So ultimately we were looking at it from purely an alleged conduct perspective, and the severity of the incidents that were being viewed on footage, it felt that there was very little option. 15:41 15:41

DR. MAXWELL: So you're saying there wasn't a forum to discuss both risks, they were managed entirely separately without any consideration of the other risks? 15:42

A. Yeah, they were managed separately. I wouldn't say that there wasn't a consideration. Obviously we knew any decision to remove staff was going to impact the operations of the hospital. But the decision to remove the staff member did take precedence because of the level of risk and because of the severity of the incidents that they may have been involved. 15:42

DR. MAXWELL: So that level of risk was always considered to trump the lack of availability of staff in terms of keeping patients safe? 15:42

A. I would say, yes, because the decisions to suspend were usually taken as a result of very overt serious incidents.

DR. MAXWELL: And in your database, can we identify

this category that you're calling very overt? Because you seem to be identifying a category of incident that was so obvious that it needed suspension, and is that clearly identified within your database that you talked about earlier? 15:43

A. Between the databases held between HR and Safeguarding you will find a level of detail that would describe the severity of the incidents. So you will have categorisation around physical, emotional, psychological, and then you will have other matters like seclusion, management of seclusion, MAPA, physical intervention. 15:43

DR. MAXWELL: And are you saying that one of those is more serious than the others or that within each category there are different levels of behaviour? I'm just wondering how you get to define this so overtly obvious? Is that across all those categories, or is it just one category, or are there gradations of physical incident that go from an acceptable practice to overtly abuse? 15:43

A. There would be the broad categories. They wouldn't have each category then broken down into a scale of category.

DR. MAXWELL: Right.

A. So we wouldn't have that level of detail. But, yes, I agree with that, that a physical assault or a physical intervention with a patient can vary significantly in some of the footage. 15:44

PROFESSOR MURPHY: We've heard from some staff that

they didn't understand what they were suspended for and that that uncertainty for them lasted for months and months. That seems surprising, given you felt it was all very cut and dried?

A. Well, I suppose my access to that information was for the purposes of the investigation process, and the Safeguarding process, and there were very clear restrictions on HR and management in sharing any detail with the staff members. So, yes, absolutely I could have, and I would have information at the point of suspension, that that staff member was being placed on precautionary suspension because of a number of incidents, a category or type of incident, but I was unable to share that with that staff member. 15:44 15:44

PROFESSOR MURPHY: Do you regret that in retrospect? 15:45

A. Absolutely. I mean in terms of the core principles of a fair process from a HR perspective, I really struggled with that from the very beginning about not being able to adequately share information with staff members. A decision to suspend is incredibly significant around a staff member's profession, their personal life, their reputational, you know, all of that. It's so significant. 15:45

PROFESSOR MURPHY: Yes.

A. And obviously around generally their welfare, because it was the unknown, and we couldn't provide any timeframes, and we couldn't provide detail, and then I suppose the point around staff on site hearing about all of these suspensions and not having a full sense of 15:45

why their colleagues were being removed, and if their practise was something that they needed to be concerned about or were they going to be next to be met with and suspended. So it was really, really challenging.

15:46

But I did, and I would want to say that from the beginning I was always trying to engage with PSNI at those various meetings about the level of disclosure that we could provide to staff. It was always something I felt was so important, but was always told 15:46 that we couldn't do it because of the potential prejudice to the ongoing criminal investigation.

PROFESSOR MURPHY: I mean were this all to happen again, which God forbid, do you think it would be any different next time, or does PSNI always have the last 15:46 word?

A. Well in our disciplinary procedures it does say where there is a criminal, a parallel criminal process, it will normally take precedence. And I believe, just given the scale of this particular investigation, that 15:47 was the case, that the PSNI investigation took precedence. If this was to happen again, I believe we have learned significantly from this process and the impact on the staff, the organisation, and the patients, that we would want to respond differently and 15:47 ensure that we complied with our obligations to inform staff and progress matters as quickly as possible.

PROFESSOR MURPHY: Are there other things you'd do differently as well?

A. I think we have -- the process has evolved. So we've always taken the opportunity to do things differently where we can. But, yes, I do think we would do things differently now, with knowing what we know, I think we would maybe adopt a slightly different approach with the management of some of these certain concerns. 15:47

PROFESSOR MURPHY: In what sorts of way?

A. Well, there is the option around the use of the modified dismissal procedure under disciplinary proceedings, which we would very rarely - and in my time I have never known it to occur within Belfast Trust - but it is there as a process that can be adopted where there are such significant concerns known to the organisation, that you can do the modified dismissal process and you can put those concerns to the individual with the decision to dismiss with immediate effect. And I'm not suggesting that we would do that for all staff, just to reassure, I would absolutely not be suggesting that. But for some of the very serious incidents involving a number of staff, I believe we would have had suitable grounds to do that. A number of those staff were placed on paid precautionary suspension for years. 15:48 15:48 15:48

PROFESSOR MURPHY: Yes.

A. And were facing criminal process, and we had the footage that clearly showed some of the very obvious incidents. 15:49

PROFESSOR MURPHY: Yes.

A. So I think we would absolutely have done things

differently, and may still do.

PROFESSOR MURPHY: Thank you very much.

DR. MAXWELL: Can I just ask you about people who are put on supervision?

A. Yes. 15:49

DR. MAXWELL: Because we've heard from various witnesses it was quite hard to supervise colleagues who were on supervision, if you didn't know what you were supervising, and I perfectly understand and I can hear your frustration in this that you were constrained. 15:49 But how was that supposed to work? If nobody knew what they were being supervised for, how did it make the patients any safer?

A. That was certainly a challenge for us in terms of placing those staff members on supervision and 15:49 training. So, similarly we could not tell them anything about the incidents or the concerns they were involved in. So when they were placed on supervision and training, at a point in time it would have been a very generic support plan with a range of training 15:50 objectives and regular supervision, and that's the way it was for a period of time. Then again there was ongoing engagement with PSNI about being able to share a level of information with staff in Muckamore who were in those roles to undertake supervision for the staff, 15:50 and for the staff on supervision and training to understand what it is they were supposed to be being supervised for, and what they were training, and what they should be learning from. So we got to a point in,

I think it was '21, March 21 - we started conversations in 2020 about this with the police about being able to share themes. So we agreed themes. So rather than share specifics of the incident, we were able to give them themes. So, for example, their supervision and training plan may have been as a result of one or two incidents, and the nature of those incidents may have revolved around, you know, seclusion, the policy not being applied, maybe mealtime breaks not being adhered to, or mealtime observations, or failing to intervene, report, or escalate concerns. So that would have led to a theme of Adult Safeguarding. 15:51 15:51

DR. MAXWELL: But if I was a member of staff and you said to me "You're on supervision and training because something has been identified", and for four years you wouldn't even have told me what. 15:51

A. Yeah.

DR. MAXWELL: There are some people who are abusive and know they're doing it and are intentional, but there will be some people who are doing things because that's how it was done around here, and don't necessarily know that it is wrong. If I don't know what I've done wrong, and neither does my supervisor, how does that stop me doing it again? 15:51

A. Well, it won't. 15:52

DR. MAXWELL: So that was -- so --

A. It's very difficult.

DR. MAXWELL: So the extent to which that actually safeguarded patients was limited, even though it was

protecting a criminal process, it may not have been protecting patients.

A. Well, I wouldn't have the information to support that view either way.

DR. MAXWELL: Potentially.

A. But, yes, I can see the difficulty with that. And we have always voiced our concerns about that, to make it more meaningful for the staff and for the process.

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: Could I just ask about the role of the NMC in all of this. I think we've had evidence that if somebody was suspended, that would always be reported to the NMC? 15:52

A. Yes.

CHAIRPERSON: Is that right? 15:52

A. Yes.

CHAIRPERSON: But people put on supervision, would some people put on supervision also be reported to the NMC or not?

A. Up to recently, no, the process was for referral. It was only at the point where the threshold of suspension had been reached. 15:52

CHAIRPERSON: Right.

A. So I don't believe staff on supervision and training were referred to the NMC. But that was managed by the Senior Nurse Advisors and our Central Nursing Team. 15:53

CHAIRPERSON: Although somebody on supervision would be able to leave your Trust and work for another Trust, and provided that hadn't been reported to the NMC,

nobody would be necessarily the wiser.

A. Well, we built in processes to engage with other Trusts, because the protracted nature of this particular process did mean that that did occur, and obviously the decision to close Muckamore resulted in a number of staff seeking employment elsewhere, and they have been employed in a number of other Trusts in the region. So when we are notified that a staff member is leaving, we do try and follow that up. So if we know they're on supervision and training, we do ask them to inform us where they are working. And we have now established links within each of the other employee organisations and Trusts within Northern Ireland, from the - there's the Safeguarding Lead, the Nursing Lead, and the HR Lead that we engage with to inform that the individual is on -- when they were working in Belfast Trust they were on a supervision and training plan.

CHAIRPERSON: And you are legally allowed to do that?

A. We are doing that. But, again, very similarly, they were unable to adequately apply their own safeguarding provisions because they didn't have the detail.

CHAIRPERSON: Yes.

A. So we went back again, and as part of further negotiations and discussions with PSNI colleagues, we did get approval in March '22 to share a level of detail with the other organisations, but only a limited number of senior staff we would share the detail with, and that detail does actually provide a detailed description of the incidents that they're involved in,

and their role within that, and we also have provided the opportunity for those individuals within those other Trusts to come to Belfast to view the footage, if they require that.

15:55

So, again, it's another shift in the process. Still a difficult one, given now the new employer knows more than the staff member who has moved into their employment.

DR. MAXWELL: But actually staff aren't obliged to tell you where they're moving to, are they? I mean if they went to work in Scotland or... 15:55

A. No, but if they are a Registrant with the NMC, we are able to see where they are working, or if they are registered with NISCC, for example, there might be a trace of where they're working. But, yes, we have individuals that may - for example, a healthcare worker, a non-Registrant, might leave the Belfast Trust and go and work in a care home and not tell us about it. But I suppose that's when we were looking with RQIA in our Operational Group that they had that ability to engage with care homes in their regulatory role, and we have been able to, in the majority of cases, track where our staff have moved to. 15:55 15:56

CHAIRPERSON: And inform the employer? 15:56

A. And inform the employer.

CHAIRPERSON: Because I know that used to happen, and I thought that had actually been stopped, but I'm obviously wrong?

A. No, we would still update the employer. So we would -- initially we would tell the staff member that it is their contractual obligation to ensure that their new employer is fully aware.

CHAIRPERSON: Right. That's how it's done. Thank you. 15:56

A. And, clearly, if that is not followed up, we would then follow that up with a generic style letter to that organisation, we wouldn't disclose anything, but we would ask them to make contact just to provide the assurance that they have. 15:56

DR. MAXWELL: And how is that different from - is it the Chief Nursing Officer used to issue alerts about staff and following legal conversations had to stop doing that.

A. The CNO alerts? 15:57

DR. MAXWELL: Yeah.

A. The nursing alerts? That's --

DR. MAXWELL: Yes. And they had to stop.

A. They did, stop, yes.

DR. MAXWELL: So presumably there was a feeling that 15:57 those weren't within the legal framework, but you informing a specific employer is within the legal framework?

A. I suppose somewhat different because we asked the staff member to inform the employer, and when we check in 15:57 with the employer at a period of time after that, if they are not aware, we would be going back to the staff member to say, or we would encourage the employer to have a discussion with the staff member to ensure that

they were aware.

CHAIRPERSON: That sounds like a workaround.

A. But it's important because it's safeguarding.

CHAIRPERSON: I'm not challenging you --

A. Yes. No, it is, it is somewhat of a workaround, but it absolutely feels that it's the right thing to do. 15:57

CHAIRPERSON: Okay. Just at the very beginning of this very long period of questioning you said between the databases held by HR and Safeguarding you will find a level of detail that would describe the severity of the incident. So are there two databases that we need look at - that we would need to look at to make sense of it all? 15:58

A. Yes, there is not one composite database, because we hold information for different purposes. 15:58

CHAIRPERSON: I understand that. So HR will have one and Safeguarding will have one?

A. Yes. Yes. So in the HR database, the information contained is more about the response to the concerns. So what is the management action regarding the staff member? And the incidents, the number of incidents. And then the Safeguarding will clearly have the type and categorisation of the safeguarding incident or conduct incident. 15:58

DR. MAXWELL: But not necessarily the management action? 15:58

A. I don't know if they record that against it, but I can -- but we have that, so it can be cross referenced.

DR. MAXWELL: You have that. Yeah.
CHAIRPERSON: Okay. Thank you.
PROFESSOR MURPHY: But am I right in thinking there are actually three, because there's also the PSNI one?
A. Presumably, yes, PSNI will have their own. 15:59
CHAIRPERSON: Sorry, Ms. Bergin.
275 Q. MS. BERGIN: No, not at all. Thank you. If I could just return. You indicated in your evidence there that one of the changes, you've talked about changes that have been made in response to the question by 15:59
Professor Murphy, and one of the points that you made was that this workaround essentially described by the Chair in relation to contacting subsequent employers of Trust employees who have since left Muckamore, you've said that that process is relatively -- or you've 15:59
described, rather, from 2022, that that process is quite detailed in terms of the PSNI allowing specific details to be shared with former - or of former employees with their new employers. How recently did that I suppose process come into being? Is that 16:00
something that was occurring before the allegations of Muckamore and the HR Investigation Support Team started working at Muckamore, or has that always been the case that if there were ongoing disciplinary matters with Trust employees at Muckamore, or more broadly within 16:00
the Trust, and they left with those matters still hanging over them, so to speak, is that something the Trust would previously have followed up with?
A. So if this was a single incident, so non-Muckamore

related, and we had a staff member who was within a process and then they subsequently left, we would write to the staff member to advise that if they were to seek a reference from the Belfast Trust it would detail that they were part of a formal disciplinary process at the point that they resigned or left the organisation. But, no, we wouldn't follow up routinely with other organisations. We wouldn't be tracking staff in the same way as we are doing with the Muckamore cohort of staff. And I suppose the difference really is because of the volume of staff who are working within that regulated activity type of work, they're either Registrants or non-Registrants, and are then likely to take up employment in that type of work and, therefore, safeguarding is critical. 16:00 16:01 16:01

276 Q. So is this process of following up - just to be clear about your evidence - is this really only happening in respect of Muckamore employees, or past employees? Are the Trust not doing this on a wider scale?

A. No. 16:01

277 Q. No. Okay. One of the alternative options that you've referred to in the disciplinary procedures, in addition to suspension or supervision and training, is that there is an ability to consider alternative working arrangements, if feasible, and subject to various considerations that you've set out in your statement at paragraph 70. Were any Muckamore staff offered alternative working arrangements as part of the ongoing investigations? 16:02

A. Yes, a number of staff have been placed in what we would refer to as non-clinical roles. So where there is an opportunity to put a staff member in like an office based role so they're not on the ward and not providing any direct care, we have been able to do that in a very small number of cases.

278 Q. You've referred previously in your evidence to the different types of database, and also the data analysts in respect of the HR and ASG. Is the Trust - if you're not able to say now - is the Trust able to provide, or has the Trust already carried out an exercise of analysing how many staff were suspended during each of the three phases, how many staff were placed on supervision, and how many staff were placed into alternative working arrangements? 16:02 16:02 16:03

A. Yes, we have all of that information, yes.

279 Q. Okay. If we can then go to page 24, please? Here you were asked about the threshold for referral of incidents to PSNI, and at paragraph 74 you say that this was managed by the ASG team. And then at Question 19 below you were asked about whether there were tensions or disagreements between Adult Safeguarding and others in respect of whether an incident should be referred to PSNI? And you say in response at paragraph 75 that you weren't aware of tensions about the threshold, but you recall discussions between ASG and PSNI at the Operational Group meetings about this. And if we could look then again to the minutes of the Operational Group meeting, please, and that's at page 16:03 16:03

43, and at No. 4 states:

"Yvonne highlighted that since coming into this post she had noted that the threshold for referral to PSNI was very low and queried whether all the referrals being sent by the team were appropriate. Neil Harrison advised that there is no issue with the referrals being made by the Trust and these are considered to be appropriate. It was acknowledged that the threshold is low and that police are content that they have the opportunity to screen all queries. As discussed above, the PSNI commented they have no issue in relation to the information being received and feel this should continue." 16:04 16:04

And the Inquiry has heard evidence in relation to concerns about the threshold for Adult Safeguarding referrals from Muckamore being lower than referrals for other places within the Trust.

A. Yes. 16:05

280 Q. What was your understanding of the thresholds for referral of information to PSNI?

A. Well, I suppose as I say in my statement, I wasn't responsible for the referral process to PSNI, so never would have seen the incident at that early stage, it was already referred before it got to HR. But, yes, being present at some of those meetings where there was a discussion around a lower threshold, and I suppose going back to some of the change of process that we 16:05

talked about earlier between safeguarding, that was, I feel, a bit of a shift in terms of how they were used to referring incidents. And when the police had access to the footage themselves, they were referring in incidents that I believe the Trust may not have naturally referred out, and that's where then the query came up about it appears lower and, therefore, our Safeguarding Team, I believe, adapted in terms of how they were referring incidents and there became a much lower -- 16:06

DR. MAXWELL: So you think this was driven by the PSNI, the change in the threshold for referral to them?

A. I do, yes.

DR. MAXWELL: And as an HR professional, is it fair to staff to have one threshold in one workplace and another in another? 16:06

A. No, it wouldn't normally be fair in that way. But I suppose the safeguarding thresholds was not my area of expertise, and I suppose I was accepting it.

DR. MAXWELL: Did you know whether this decision to do this went through any governance process in the Trust? Because it's all very well for the PSNI to say 'We're happy to have whatever you send', it's quite a different matter for the Trust to say 'Okay, we're going to lower the threshold'. Did it ever get formally ratified through any governance process? 16:06 16:07

A. Well, I know that in terms of safeguarding in Muckamore, maybe outside of the 2017 process, there was an agreement where, you know, there was a modified

approach.

DR. MAXWELL: And do you know where that was agreed?

A. I understood that that was agreed at the governance group, the Muckamore Governance Group, with the Directors. 16:07

DR. MAXWELL: The one that we previously agreed didn't go through any formal Governance Committee process?

A. [WITNESS NODS].

CHAIRPERSON: Sorry, you're nodding. Is that an agreement? 16:07

A. Sorry. Yes, I believe that that's where the discussions would have taken place, because that's where the representatives were from each of the organisations. And given the number of concerns being identified, I believe there was a level of anxiety 16:07 around the number of issues within Muckamore Abbey Hospital, and that's where that modified staff-on-patient incidents were bypassing local management and going straight into the Safeguarding Team in Muckamore. But in respect of the thresholds 16:08 for the CCTV, I don't know exactly where that decision was agreed, whether it was the governance group or just local arrangements between Safeguarding colleagues and PSNI colleagues.

CHAIRPERSON: And just to make sense of the question 16:08 that you were asked originally. We can see, but the transcript won't show, that "Yvonne" referred to - and this hasn't been redacted, has it - is Yvonne McKnight, and Neil Harrison was a PSNI officer?

A. Yes.

CHAIRPERSON: Thank you.

281 Q. MS. BERGIN: If we could then look at page 45, please, and it's No. 10 in these minutes. At the bottom of the page under "Any Other Business", if we could go down to the second paragraph on page 46, please, and here it states: 16:09

"Concerns raised were in relation to the misinterpretation from staff with one staff previously making contact understanding the matter had been dealt with. It also raised concerns as there is no record of a sanction in place against those staff who could go on to seek further employment." 16:09

16:09

That's touching really upon the issue that we just dealt with in respect of staff moving on from Muckamore. Could you explain, without referring to any specific names, if you can recall what that refers to exactly, please? 16:09

A. Yes. I can recall the specific incident or scenario as well. So where a staff member was placed on precautionary suspension, we initiated a referral to the Disclosure and Barring Service, and HR would be responsible for those initial referrals to the DBS, and at a point in time, so presumably around the date of this particular meeting, I had received a phone call from a healthcare worker who had advised that they had received a formal letter from DBS advising that their 16:10

case was closed, and then there was a number of questions about: 'Have you concluded my case? Is there nothing here you haven't told me? The DBS are saying the case is closed'. So the issue that I was raising in this particular meeting, having had a conversation with DBS, was that because of the lack of information provided to the Disclosure and Barring Service in the initial referral, because we were unable to share any level of detail, they couldn't act on the referral in any meaningful way. So the letter that was I believe misinterpreted by the staff member was that they were paused for a point in time. So DBS confirmed with the Trust that as matters progressed internally, once they are notified or provided with further information they would essentially re-open the case. So that was where there was a bit of a breakdown. 16:10 16:10 16:11

Now following on from that, I clarified with the trade union colleagues, because they would have been receiving the same queries from their members, and clarified the position and have spoken with DBS, and we have engaged with them around how that has created this difficulty for staff, mixed messages. 16:11

282 Q. Okay. If we could then scroll down, please, to the heading "Medical Staff Member"? Thank you. And here it states: 16:11

"RQIA colleagues queried if any further developments had took place in relation to the reviewing of the

incidents relating to the consultant. Mrs. Diffin committed to follow up with the Medical Director and/or the Chief Executive."

Now, I also just want to bring you to the paragraph in your statement also which deals with this. 16:11

A. Okay.

283 Q. So if we could go to page 26, please? And at Question 20 you were asked whether doctors were treated differently to other members of staff in relation to suspensions? And how and why they were treated differently? 16:12

So if we pick up first of all in the minutes that we've just dealt with, which refer there to a medical staff member, a consultant, and follow-up in relation to incidents they were involved in, or reviewing incidents about them with the Medical Director. How did the Operational Working Group deal with medical staff disciplinary matters? Did they deal with it differently to other staff? 16:12

A. Yes. So following the identification of medics, within the footage a separate MAH Operational Working Group for medics was established that only discussed the medics, and the reason for that was because it required a different group of individuals to discuss that, and because medical staff need to be managed and we need to engage - under the MHPS Framework - and we did need to engage with the Medical Director as opposed to Senior 16:13

Nurses.

284 Q. If I can just get you to pause there just to explain? So at paragraph 76 you said "H" - were you referring to the HPSS?

A. Sorry, the Maintaining High. 16:13

285 Q. Yes. So just to put that in context. So you say in your statement here the procedure is mandated for doctors by the Maintaining High Professional Standards in the Modern HPSS Framework?

A. Yes. 16:13

286 Q. Yes. So just to clarify, there were two operational working groups; the Operational Working Group we've just referred to that feeds into the Safeguarding Group?

A. Mm hmm. 16:13

287 Q. And there's a separate Medical Operational Working Group, and does it feed into the Safeguarding Group also?

A. Yes. It's just we use a different forum to discuss the medics, just to maintain that level of confidentiality 16:14 around the medics.

288 Q. And are there also Terms of Reference for that group like we've seen for --

A. There should be, yes.

289 Q. Yes. Okay. 16:14

DR. MAXWELL: And are the medics included on your database that we've referred to?

A. Yes.

DR. MAXWELL: So that would include all staff?

A. Yes.
DR. MAXWELL: Including different professions, including medicine, but also including cleaners, porters?
A. We didn't have any support services staff identified. There was a decision taken at a very early stage of the process because of the - I suppose the support staff were routinely in and out of wards just undertaking their respective duties, and I believe at an early stage it was agreed that we would not be focussing on the PCSS support services staff, because they would not have had the same level of, you know, involvement or obligation, and they would have been in and out of the ward and it wouldn't have been providing any direct care or treatment. 16:14 16:14 16:15
DR. MAXWELL: But all other staff, all professional staff and healthcare assistants would be on one database?
A. Yes, your daycare staff.
DR. MAXWELL: There wasn't a separate database for medical staff? 16:15
A. No. Oh, I have a separate, I keep a separate list. So we have - on the main database that you're referring to, everyone is on that, but for the purposes of the Operational Group for medics, there is a standalone database that just talks about the medics. 16:15
DR. MAXWELL: Okay. And I understand - because they're very special, they have a special arrangement in their contract that isn't discretionary, you have to do that.

What about AHPs? Did they have special arrangements?

A. No, I don't believe we have any AHPs identified as part of the process.

DR. MAXWELL: But if there had been, would there have been a separate process for them? 16:16

A. Yes, we would -- so in the scenario of having a social worker identified, there is a slightly modified process. So it wouldn't be the Senior Nurse Advisors that would be reviewing the concerns, it would be someone from a social work profession. 16:16

So, yes, to answer your question, if there was an AHP identified, we would be seeking input from someone of that profession.

DR. MAXWELL: Would there have been a separate group to look at them? So I understand that you need different expertise to review their practice. 16:16

A. Yes.

DR. MAXWELL: But we now know that there was the Operational Group that we've been discussing which was looking at nurses and healthcare assistants, a separate group to look at medics. Is there a separate group for AHPs? 16:16

A. No. There's no other separate group. So what we would have done in those situations, we would have invited in -- so if we needed to discuss the social worker or the psychologist, we would have invited in the relevant person to discuss and provide the assurance around the management of that staff member. 16:16

DR. MAXWELL: In this group that's variously called Safeguarding Operational Working Group or the Operational Working Group?

A. Yes, into the general Operational Group.

DR. MAXWELL: Okay. 16:17

A. And the medics were the only group that had their distinct separate meeting.

290 Q. MS. BERGIN: So as part of the safeguarding and then subsequent disciplinary processes, is it correct that the process would remain the same? So Adult 16:17 Safeguarding would make an initial determination based on the CCTV viewing, based on what they saw, and at that point then either matters would be referred to the Senior Nurse Advisors, or in the case of a medic it would be referred to the Medical Director; is that 16:17 correct?

A. That's correct. Yes.

291 Q. And then at the stage where, or however often, I think it was three-weekly, was it, that the Operational Group met? 16:17

A. Yes.

292 Q. Yes. So say three-weekly when those groups met, those matters would then be dealt with separately. The other staff, if I can put it in those terms, and then the medical staff separately? 16:18

A. Yes.

293 Q. And did the medical staff, the group that met in respect of them, did they also meet every three weeks?

A. No, because the numbers were so much smaller. So we

only meet maybe quarterly for the medics. I think we've now moved to even less frequency because of the decisions and the outworkings from PSNI that we won't need to meet.

294 Q. Are you also the Chair of that group? 16:18

A. Yes.

295 Q. Yes. In terms of the role of the Operational Working Group, or in the case of medics, the Medic Operational Working Group, what is the actual title of that group?

A. It's the same. So it's MAH Operational Group, and then 16:18 in brackets it just says "medics".

296 Q. Thank you. Were there any specific actions that were taken that were different to the other group because it involved medics, in terms of any specific types of meetings that flowed from that, or reviews that took 16:19 place because it was in relation to medics?

A. Yes. So there is a structure within Belfast Trust for medical staff, where there are any concerns around medical staff that they're discussed at what we refer to as DDDRC, and it's really like our Doctors in 16:19 Difficulty forum, and that would be attended to by the Deputy Medical Director, the Medical Director, if available, and members of staff from the relevant service area, the Clinical Director or Chair of Division, to discuss the management arrangements around 16:19 those individuals. So there's a series of DDDRC meetings for different divisions and, so, where we have one that is for our Learning Disability or Intellectual Disability and Mental Health Directorate, that's where

we would discuss any doctors that were identified within the viewing of the footage and how they are being managed.

297 Q. In the minutes that I first referred you to before I brought you back to your statement, and if you can bring it up in front of you perhaps, or we can bring it up on the screen again, it's at page 46, but what I want to ask you about that is; the notes there refer to reviewing incidents relating to a consultant and follow-up with the Medical Director. 16:20

A. Mm hmm.

298 Q. Without saying the number of that consultant, and you could perhaps write it down to assist the Inquiry, can you recall what that related to?

A. Yes. So the incident identified involved a medic as part of the incident and the staff group, and at that particular time you'll see that it was the Director, the Social Work Director who was involved in reviewing some of those incidents, and in order to for a decision to be made around an appropriate management action, she would not have been appropriately qualified to make that assessment, so she needed to engage with the Medical Director. So that was probably one of our first - that was before the medic operations meetings where we were just uncovering incidents involving medics, and so that was, I suppose, that interim approach to managing them. 16:20 16:21 16:21

299 Q. And thereafter then medics wouldn't routinely be mentioned or dealt with then at the general meeting?

A. No. Absolutely not, no.

300 Q. Okay. And if we return to page 26 then, please? And at paragraph 76 you say that some doctors working at Muckamore have had other management actions applied. Can you give examples of the types of management actions that would have been applied to doctors at Muckamore?

A. Yes. So we applied a very similar approach. So of the medics identified, a number of them were placed on supervision and training with themes provided to them.. 16:22

301 Q. If we can then move to page 30, please? And at Question 26 you were asked about any other matters that you felt might assist the Inquiry, and you address that, and if we can look at paragraph 87, please? And here you say that in relation to the evidence that Professor Owen Barr provided to the Inquiry in June 2024 about the 19th September 2018 Independent Assurance Report, that:

"...it does not appear that anyone from HR was spoken to as part of that process, which took place at a relatively early stage."

And you say there may have been some misunderstanding of the HR process in terms of decision-making and reviewing decision-making about staff. And you then say that:

"...it was possible to develop the approach to managing

supervision and training over time, which may not have been something which Professor Barr was aware of."

Do you want to elaborate on that in terms of what you'd like to clarify? 16:23

A. Well, I suppose, ehm, yeah, I was not met with around that review that was undertaken, and within that I think there was clearly some criticism around the inability, or the lack of communication, or providing any detail or clarity to the staff members, and I fully 16:23 accept that. And I suppose what I don't feel it reflected was the limitations on us to do that. It wasn't through choice of not sharing it, it was because we were advised that we couldn't because of the criminal process. And there was also some discussion 16:23 or some reference within that around the apparent lack of review of suspensions, or meaningful review of suspensions. And, again, going back to what we talked about earlier on, when we were viewing a small percentage of the footage we didn't know what we didn't 16:24 know until we started to view more of the footage, and there was a point in time that we did go back and review the initial decisions to suspend, just to provide just some assurance that the decisions were appropriate, and I think that probably came about 16:24 because we then had the footage, so we could do that in greater detail. And we were assured that all of those decisions were appropriate and did warrant a precautionary suspension.

Within our disciplinary policies and procedures it clearly does say that we should review suspensions every four weeks, and under very normal circumstances around employment investigations we can act quickly around those processes and we can establish facts quickly. We might suspend someone on a Friday, and by Monday we might have clarified a particular piece of information that would, therefore, change the decision to suspend the individual. 16:24 16:25

But in this particular investigation it was probably the opposite. We were placing individuals on precautionary suspension on the basis of a limited access to incidents and footage, but then as we progressed through the process we were uncovering more. So we did routinely write out to every staff member every four weeks to advise that the precautionary suspension remained. 16:25 16:25

The process hadn't moved on. The criminal process clearly has been very, very long, a very long process, and been very difficult for everyone involved, so there has been no significant change that has required a meaningful review of suspension. If anything, the decision has been further confirmed that individuals should be placed on suspension. 16:25

In terms of the point around supervision and training

and about how we would manage that, yes, at the very beginning staff were placed on what was being referred to as "restricted duties", and we very quickly moved away from that phrase, because when we're talking about our nursing professionals we believe that the NMC are the only body that can restrict a nurse's practice. So we tried to move away from that language. And initially nurses or healthcare workers might have been moved wards, they might have been advised that they couldn't undertake additional shifts in other wards other than their core wards, they might not have been able to work night shifts. So there were modified arrangements around some of them. But that again evolved and we moved into what we refer to now as the supervision and training arrangement, where we have the themes, and we have training objectives, and we have the regular meetings with staff with their supervisor, and it has evolved over time, and clearly through some negotiation we have been able to share greater detail. It's not ideal, we still aren't telling them the specifics, but we're sharing greater detail around the themes to support their learning and reflection. 16:26 16:26 16:26 16:27

And I suppose in terms of that supervision and training approach, you know, we are now in a position where we're taking a number of those cases to conclusion, and whilst you can criticise that process because it didn't give them all of the information and maybe necessarily didn't provide a safer environment for patients or 16:27

that, we are able now to bring them to a meeting, share some of the footage, and undertake a really robust reflective discussion so that there is learning around the incidents. And I suppose the passage of time, some of these staff were involved in incidents seven years ago, so they have naturally developed and improved over time.

MS. BERGIN: I have no further questions.

PROFESSOR MURPHY: I've just got one.

THE WITNESS: Okay. 16:27 16:28

MS. CURRAN WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

302 Q. PROFESSOR MURPHY: Before we broke for tea at sort of half past three or whenever it was, we asked you about whether there were tensions between the ASG team and the nursing team. You had been talking about the tensions between HR and the ASG team during Phase 2, and I just wanted to check that we were on the same page: Because we've heard quite a lot of witnesses from both sides of the fence, the ASG team and the nursing team at all sorts of seniority levels, saying there were major tensions between them. But am I right in thinking that you, in HR, didn't see those tensions playing out in any of the meetings, for example? 16:28 16:28 16:29

A. Not that I can recall, no. I suppose when I have answered that question I am thinking about the nursing staff and the ASG staff within that investigation framework, you know the multidisciplinary team, and I,

I can't recall any instances where there have been any tension or difficulty. Now whether or not there has been wider discussions with more senior nursing representatives, or more senior safeguarding or social work colleagues, I can't answer that.

303 Q. DR. MAXWELL: Can I just clarify: You said you were referring to the nurses within the Investigation Framework, so you mean the Senior Nurse Advisors?

A. Yes.

304 Q. DR. MAXWELL: Not the staff on the wards? 16:29

A. No, no.

305 Q. DR. MAXWELL: Because you didn't observe them interacting with...

A. No, is that the question? Is it about the nursing staff in Muckamore? 16:29

306 Q. PROFESSOR MURPHY: Yes. Yes, it is?

A. And the Safeguarding Team? Was I aware of that tension? I was aware of difficulties in managing contemporaneous safeguarding incidents in Muckamore Abbey Hospital, yes, because the thresholds, the change 16:30 of process, and the difficulties between Management and Safeguarding in those processes. So, yes, I was aware of these.

307 Q. PROFESSOR MURPHY: But not about the historical CCTV?

A. No, not about the historical. There was no tensions 16:30 that I'm aware of within that.

308 Q. DR. MAXWELL: With your Senior Nurse Advisors?

A. With my -- no, no.

PROFESSOR MURPHY: Okay. Thank you.

THE WITNESS: Thank you.

309 Q. CHAIRPERSON: Was there any -- did you in Human Resources lay any importance on there being a clear division, or Chinese Wall, or whatever you want to call it, between those who were viewing CCTV and referring cases, and what was then happening on the disciplinary side so you didn't -- you wanted there to be a line between the two? Does that ring any bells with you or not? 16:30

A. Yes, that there was the decision taken at a point in time to separate the decision-makers from Muckamore to a standalone team. I do recall that happening. 16:31
I can't recall the specific date and time, but I know that it was felt that just with the emerging situation and the number of concerns being raised, and the difficulty in managing the hospital and having to make those critical decisions, Muckamore is a very close-knit working community, and a number of those Senior Managers have worked alongside some of those nursing staff for very many years, and I suppose what we know now today is around some of the family links within Muckamore and localised relationships, you know, it was really difficult to ensure that there was that clear robust decision-making taking place, because we didn't know who was making decisions and what were the links in the relationships between them, and I suppose, yes, the impact on service and on the patients and keeping wards open where there was at times decisions to suspend 10 to 12 people at once, and that could 16:31 16:31 16:32

completely close down a ward.

310 Q. CHAIRPERSON: So would it be fair to say that you as a department were holding your cards fairly close to your chest in terms of what was happening to staff who were being referred? 16:32

A. No, I think we were communicating very well with the service when we needed to, but we were managing a process that was external to Muckamore Hospital site. The footage had come back, we then had a system to view the footage, we had a dedicated Safeguarding Team, we 16:33 weren't reliant on the DAPOs on site. We had the dedicated HR and Senior Nurse Management oversight, and where there were decisions that were taken that impacted service, we absolutely ensured that they were communicated. We weren't seeking approval to do it, we 16:33 were informing that these decisions have been taken, and albeit very, very challenging and difficult for Muckamore, these were decisions that were critical and really important to keep the hospital safe.

311 Q. CHAIRPERSON: And just finally this from me: It sounds 16:33 very much as though when PSNI asked you to do something, you did it?

A. Well, it was...

312 Q. CHAIRPERSON: Was there any pushback? Was there anybody at the Trust saying: 'Look, we realise you've 16:33 got to undertake this investigation, but if you don't tell us within six months what you're going to do about this member of staff, we're going to take our own disciplinary action'?

A. I don't believe anyone felt in a position to pushback in that way, but there were a number of meetings with senior individuals in the PSNI and the Trust to try and find a way forward, and we did find a way, it's maybe not perfect, but it took us time, and I suppose providing the assurance that we were, or the reassurance that we would work within the confines of a fair and reasonable disciplinary process, but not prejudicing the criminal process.

313 Q. CHAIRPERSON: Sure. But some members of staff who were suspended for years might not agree with that, would that be fair? 16:34

A. Sorry?

314 Q. CHAIRPERSON: Some members of staff who found themselves suspended for years might not agree that process was very fair? 16:34

A. No, I wouldn't think that they would, but we tried our best in the situation we had.

CHAIRPERSON: No, I understand.

A. And faced. 16:34

CHAIRPERSON: All right. You've answered quite a series of questions, particularly those from the Panel, very fully, and so can I thank you very much for coming along to do your very best to assist the Panel. Thank you very much indeed for your time. 16:35

THE WITNESS: Thank you.

CHAIRPERSON: Okay. Tomorrow I think we can sit a little bit later, eleven o'clock. Mr. Veitch is going to be here at eleven, so we'll start at eleven. Thank

you very much everybody.

THE INQUIRY ADJOURNED TO THURSDAY, 11TH SEPTEMBER 2024 AT 11:00 A.M.

16:36