MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 25TH SEPTEMBER 2024 - DAY 110

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THE INQUIRY RESUMED ON WEDNESDAY, 25TH SEPTEMBER 2025, AS FOLLOWS:

CHAIRPERSON: Good morning everybody. Just before Mr. McEvoy starts, can I mention tomorrow, when we've got one witness, Ms. Heaney, who may be quite a long witness. We're not sitting tomorrow afternoon, the Panel are unable to sit tomorrow afternoon, but for that reason we are going to have to have an early start because we want to make sure that we don't rush that evidence, and we will sit at 09:00, nine o'clock. I'm sorry to do that to everybody. We haven't had to do it very often, but we want to make sure that we have the right time with that witness. Okay. Mr. McEvoy. 10:04 10:04

INTRODUCTION TO ORGANISATIONAL MODULE 8 BY MR. McEVOY:

MR. McEVOY: Good morning, Panel. Today the Inquiry moves on to look at Organisational Module 8 on Professional Organisation and Oversight. The particular focus of this module is on the work and role of the Public Health Agency or PHA. 10:05

It will be recalled that evidence was provided during the Evidence Module phase for the purposes of Module 2 on Healthcare Structures and Governance by the Chief Executive of the PHA, Mr. Aidan Dawson, in the form of four statements, and just for recollection, for the purposes of recollection, those are the 16th March '23, 10:05

the 26th May '23, the 16th June '23, and 19th October '23. And it will also be recalled that he came to give oral evidence in two sessions to the Inquiry on the 3rd April '23 and the 26th June '23.

10:05

The purpose of this module, however, is to examine the adequacy and effectiveness of the PHA in responding to concerns and ensuring the safety of patients and best practice and service delivery at Muckamore Abbey Hospital. The period to be examined spans across the timeframe in the Inquiry's Terms of Reference.

10:06

The Inquiry has received four statements for the purpose of this module, as is the case, and has been the case in other modules, persons who made statements were asked to address specific questions put to them by the Inquiry. Three of those statements are from persons presently or previously employed by the PHA, and those persons are Ms. Mary Hinds, from whom the Inquiry will shortly hear; Mr. Rodney Morton, who will give evidence this afternoon, and from Pat Cullen. A fourth statement was then produced from Linda Kelly, who is the Chief Executive Officer of the Northern Ireland Practice and Education Council. All of those statements will be published on the Inquiry website.

10:06

10:06

10:07

Having considered those statements then the Panel wished to hear oral evidence from, as I've indicated, Ms. Hinds and Mr. Morton. It is important, however,

that I do say something at this juncture about the statement of Ms. Cullen for the Inquiry's record.

From approximately September 2009 to December 2012, Ms. Cullen was the Deputy Director of Nursing, Safety, Quality and Patient Experience within the PHA. From 2012 to 2015 she was the Executive Director of Nursing and Allied Health Professions within the Agency. From May '15 to '16, she was co-chair of the Unscheduled Care Regional Team of the HSCB. 10:07

After that she went on to hold various roles within the Royal College of Nursing, including as Chief Executive and Interim General Secretary, which is the role she held at the time she made her statement on 24th April of this year and, of course, then it's a matter of public record that on 4th July she became a member of Parliament for Fermanagh and South Tyrone. 10:08

The reason why I outline that is because within her statement at paragraph 7 she prefaces her evidence by saying that she has not had the benefit of accessing or reviewing any relevant documentation from her roles within the PHA, having left it in 2016. She makes the point that the questions that were asked of her date as far as back as 16 years ago and are answered to the best of her knowledge and recollection. 10:08

She then tells us that she contacted the Chief

Executive of the PHA to inform him that she had received her request for evidence, and due to her inability to access any information, her response to the Inquiry would be limited. She says that she sent that email on 11th March 2024 and didn't receive a response. 10:08

Now, having been provided with sight of that statement, the PHA wished to advise the Inquiry that it had a record of a response that it had provided to Ms. Cullen on 15th March, and it furnished that response to the Inquiry. The gist of the response is from the Senior Planning Manager for Public Inquiries within the Agency, and he indicates to Ms. Cullen that advice and support is available to her and that that service is on hand to any former member of staff who receives a request for information that relates specifically to their time within the Agency. And the Agency were, therefore, anxious to ensure that that was reflected in the Inquiry record. 10:09 10:09

The Inquiry subsequently provided that response to Ms. Cullen with the opportunity to comment upon it. Ms. Cullen availed of that opportunity and furnished a brief statement to the Inquiry yesterday. The material part of it and the gist of it is essentially that she does not recall having received the email. She does not dispute that it may have been sent, but that it may have been sent to her email address while still within 10:10

her role in the RCN, the Royal College of Nursing, of which she is no longer an employee.

So hopefully that clarifies the issue and that statement will also be published on the Inquiry website. 10:10

CHAIRPERSON: Okay. Thank you.

MR. McEVOY: Moving very briefly then to the evidence of Ms. Hinds, from whom the Inquiry is just about to hear. The Core Participants will be aware that the Inquiry was notified yesterday that an issue had arisen -- notified by the PHA that an issue had arisen with regard to the exhibits to Ms. Hinds' statement. Our attention was drawn to Exhibits 7 and 19, which are in error. The issue, we hope, has been cured by providing the proper exhibits to the Core Participants this morning. I'll obviously ask the witness to clarify the position when she comes in to give her evidence. 10:10 10:11 10:11

CHAIRPERSON: I think the right exhibits were referred to in the statement, but then they produced the wrong exhibits to us. 10:11

MR. McEVOY: That seems to have been what has happened. So I'll get her to give the correct title, and the Core Participants, and indeed the public, can be reassured then that the corrected exhibits will be published after today's evidence. But again to reassure everyone, it does not seem that the exhibits in question are going to trouble this session. 10:11

CHAIRPERSON: Okay. I mean if there is reference to

them, everybody has now got access to them via a slightly different route. Okay. Fine.

MR. McEVOY: So with that in mind, I think we can call Ms. Hinds.

10:12

MS. MARY HINDS, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

CHAIRPERSON: Ms. Hinds, thank you very much for coming to join us. As you know, we've already heard from 10:12
Aidan Dawson from the PHA, but this is a different module and a different focus. So thank you for your statement, which everybody in the room will have read, so we're not going to read that into the record, as it were, but counsel will ask you some questions about it, 10:13
and I'll hand you over to Mr. McEvoy. If you want a break - we normally take a break after about an hour and a bit, but if you want a break before that for any reason, just let me know.

A. Okay. Thank you. 10:13

CHAIRPERSON: Okay.

1 Q. MR. McEVOY: Thank you, Chair. Good morning, Ms. Hinds.

A. Morning.

2 Q. We met briefly a few moments ago. As you know, my name 10:13
is Mark McEvoy. I'm one of the Inquiry counsel team, and I'll take you through your evidence this morning. As a matter of formality you have provided a statement to the Inquiry, it's 27 pages in length, and it is

dated 17th April 2024. Might I ask whether you want to adopt that statement?

A. Yes, please.

3 Q. And 29 exhibits which came with it, as part of your evidence? 10:13

A. Mm hmm.

4 Q. There is one issue, however, in relation to the exhibits, or the naming of the exhibits, and we just need to clarify that for the record. Exhibit 7 should be the Terms of Reference QSE 2015; is that right? 10:14

A. Yes, that's correct.

5 Q. And Exhibit 19 then should be details of BASW website?

A. Yeah. Okay. Thank you.

6 Q. And having addressed that issue then we can move on to your statement. Now, to summarise your background, 10:14 you're a nurse by profession?

A. Yes.

7 Q. And from 2009 to 2019 then you were the Executive Director of Nursing and Allied Health Professions at the Public Health Agency? 10:14

A. That's correct.

8 Q. And you retired from that post then in September 2019?

A. Yes.

9 Q. You make a fair point in your statement that you have relied on memory and your personal review of 10:14 information available to you facilitated by the Agency. And you make the point also that there may be gaps in information that you're able to provide, for which you apologise. But the Inquiry can take it you will do

your best to assist today?

A. Absolutely, yeah.

Q. You'll see on the screen in front of you the content of your statement and some of the exhibits to which we might refer during the course of the session, so it's possibly the easiest thing to have regard to rather than the paper copy. 10:15

If we can pick up, at paragraph 9 you have - and 10 - you have helpfully provided some context to your role as Executive Director, and the integrated nature of the work that that role involved with the Health and Social Care Board to orientate us in understanding the role of the Agency and your role within it. But if we can look at paragraph 11 on page 3 then, you tell us that while you were the Executive Director of Nursing and Allied Health Professionals, part of the role of the Agency was to provide professional leadership and advice to the HSCB, which was required to publish a Commissioning Plan annually in response then to a Commissioning Plan Direction -- I think we'll come on to look at one of those examples later -- issued by the Department of Health. And in doing that then the HSCB was required, in statute, to consult you, to consult the Agency. And it couldn't publish the plan unless it was approved by the PHA. 10:15 10:15 10:16 10:16

Do you recall whether and, if so, how often the Agency would have challenged the HSCB's commissioning plans?

A. I can't recall when, but I do recall they were occasionally challenged, resulting I think on occasions with correspondence, you know. So it wasn't just a verbal challenge, it was challenged by correspondence. The process was, a draft plan came to the PHA Board for approval, as was required, and there would be a discussion, now there would also be a challenge to the professional directors around that table to ask us were we and our teams fully engaged in the process, and in the vast majority of occasions I would be happy to confirm that. But there were times, I think, when the Public Health Agency felt, Board members felt that there was perhaps a greater emphasis on illness prevention, public health, as opposed to always service response to illness. It didn't happen often, but I know it did happen. And that was right and proper, in my view, because that's why the organisations I think were created -- 10:17 10:17 10:17

CHAIRPERSON: And how far in advance of the plan actually being published -- 10:18

A. Yes, those conversations would have been held before the plan was published.

CHAIRPERSON: How far in advance?

A. Ehm, gosh.

CHAIRPERSON: Are we talking months or... 10:18

A. I think you're talking months in advance. And at times, therefore, amendments would have been made, you know. The Health and Social Care Board and Public Health Agency, I think I've said in my statement, were

created, I think, and designed, to create a bit of tension in the system. Now that's my perception of why they were created. So you had the Health and Social Care Board focusing very much on service delivery, service reform, but a Public Health Agency focusing very much on public health, you know surveillance prevention.

CHAIRPERSON: Yeah.

A. And I think it was created -- I didn't create the structures, but I think it was created to create that tension. 10:18

CHAIRPERSON: And the commissioning period would be what? If you're looking at something in Year X.

A. A year ahead.

CHAIRPERSON: It's X plus one? 10:19

A. Yeah.

CHAIRPERSON: Right.

A. You're always looking ahead with the commissioning plans, so you are.

CHAIRPERSON: Yes. 10:19

A. Now sometimes it was a year ahead with not much time between the year gone by. You were not constrained, you were required to wait until the Commissioning Plan Direction was published by the Department of Health -- and I think I have that in my statement, that has turned up in other statements -- which give you the direction of travel that the Department wished us to follow. But while there may well have been occasions where there were differences of emphasis rather than 10:19

differences of opinion, I think the two organisations worked well together, as did their teams.

DR. MAXWELL: So when HSCB were drafting a plan, before it got to the PHA Board...

A. Yeah. 10:19

DR. MAXWELL: Members of your team, would they have been having conversations with the people who were drafting?

A. Absolutely. I mean remember members of my team, Nurse Consultants, were part of commissioning teams. They 10:20 were there providing professional advice to the commissioning team, and the commissioning team was invariably multidisciplinary across both organisations, all working to the one end to meet the requirements of the Commissioning Plan Direction and the quality 10:20 indicators that came with it, but fundamentally to meet the needs of the population.

DR. MAXWELL: And then when the draft had been produced it was discussed at the PHA Board?

A. Yes. 10:20

DR. MAXWELL: And that would be minuted?

A. Yes. Also I think as -- like all of these things they changed and developed over time, and at a point in time I think - and, apologies, I can't remember when - but at a point in time to enable fuller discussion, because 10:20 a Board meeting is a very formal Board meeting and constrained by time. I remember workshops being held with the Health and Social Care Board and the Public Health Agency, which enabled even greater debate and

discussion to happen to ensure that the final product was one that everybody was happy to sign up to.

DR. MAXWELL: And you also attended the HSCB Board?

A. Yes.

DR. MAXWELL: I understand. Together with the Medical Director of PHA. 10:21

A. Yes. I think that's in paragraph 12 there. Yeah, they were unusual roles we held. So we attended -- we were full members and attended the PHA Board, the PHA Senior Management Team, but we also attended the Health and Social Care Board. We didn't have a vote, so we didn't, but we attended and gave advice and our advice was sought, so we did. And the same happened for the Director of Social Care. When the two organisations were originally created, the non-executive roles in the public health entity, one non-executive role, as I recall it, was for social care, and in the Board two non-executive roles were identified for somebody with a background in medicine and one with a background in nursing. Again, to try to create a balance but a degree of tension. 10:21 10:21 10:22

11 Q. MR. McEVOY: At paragraph 13 you have set out then the regional commissioning teams and you tell us that those were broadly based on programmes of care then, and you've listed them for us. Were specific staff within the Agency allocated to each of those areas? 10:22

A. Yeah. I mean, yes. So, for instance, Mental Health and Learning Disability were really a commissioning team together.

12 Q. Right.
A. They were broadly based on that, and a Nurse Consultant would be aligned to that, as would an allied health profession, and generally a consultant in public health.
13 Q. Okay. So there would have been the involvement then of Learning Disability professionals from the Trusts in addition to agency staff?
A. No, the commissioning team was an internal team made up of staff from the Board and the Agency. 10:23
14 Q. And I suppose in order to, if I can put a hypothesis to you, or a proposition to you, in order to improve services such as Learning Disability, you need to know what's going wrong in order to put it right.
A. Mm hmm. 10:23
15 Q. Who would you have expected to provide you with that information?
A. Right. So you're asking me how do I know what's going wrong to put it right?
16 Q. Yeah. 10:23
A. Okay. Well that information would come from a range of sources.
17 Q. Yes.
A. So there would be, through the process which is referred to in the statement, the Serious Adverse Incident process, Early Alert process. I chaired for many years the Quality and Safety Experience Groups, so you would pick it up from patient experience feedback. We had an initiative called "10,000 Voices", which 10:23

gathered the stories of individuals in our service. So there were some formal mechanisms by which you would pick that up. You would also perhaps pick up things through the commissioning team, because the commissioning team didn't work in isolation of Trusts. It is very -- Northern Ireland is a small place and people do work in partnership, so they do, and you might have picked up something from the Learning Disability nurse who works on that commissioning team. So from a range of sources. I've probably left something --

10:24

10:24

DR. MAXWELL: Were you involved in contract monitoring?

A. There was performance monitoring, which I assume is the same as what you're referring to.

DR. MAXWELL: Yeah.

10:24

A. There were regular performance meetings with Trusts, of which the relevant Nurse Consultant would have attended, so they would. There also would have been more regular informal meetings between the Trusts, because often the performance management meetings with Trusts focused on priorities as defined through the Commissioning Plan Directions, or priorities for action, or indeed some of the quality indicator work that came from the Department. Probably more detailed conversations were held in meetings between the commissioning team and the Trusts working in partnership.

10:24

10:25

DR. MAXWELL: But Nurse Consultants on your team would have been involved in comparing what had been

commissioned with what was being delivered?
A. Yes.
DR. MAXWELL: And the quality indicators.
A. Yes.
DR. MAXWELL: Associated with it. 10:25
A. Yes.
PROFESSOR MURPHY: And did you visit services?
A. Pardon?
PROFESSOR MURPHY: Did you visit services? I mean
obviously there were lots of Learning Disability 10:25
Services, but as MAH was such a big one, did you visit
MAH.
A. Yeah. It's many years since I visited Muckamore Abbey
Hospital, to be clear. My Nurse Consultant for
Learning Disability and Mental Health would have 10:25
visited regularly.
18 Q. MR. McEVOY: At 14 then you tell us something about
investment proposal templates, or IPTs, and the
importance of scrutiny of that process. But can you
tell us, explain a little bit more to us about what 10:26
that process was and what it entailed?
A. Okay. If a Trust was proposing to develop a new
service, often -- and very rarely in isolation in
conversations with the commissioners, as I say Northern
Ireland is a small place. Or they were proposing a new 10:26
investment to enhance a service or to transform a
service, they would be asked to complete this
particular template where they should outline what
service they're talking about, how it is going to

impact, how they expect it to be different, what would be the outcome? What would the cost? Quite often staffing numbers would be associated, and I think I appended sort of a template that is used. The templates I think are designed by the Department of Health and there are different templates for different scales of funding. So the Nurse Consultant would, I always hoped, be involved in the conversation about the development of the template from a Trust perspective, but would be involved in scrutinising it, bringing their expertise to the table to say does this fit with what her understanding patient need is? Does it prioritise the issues that have been identified by the Department of Health to the Commissioning Plan Direction? I would expect them to be able to challenge and support in equal measure the investment of funding, because at the end of the day it's public money and we have to ensure that it is put to best effect. So that would have been their role. And, sorry, quality indicators, you know, what was going to be the outcome of that investment for that population or that particular service group. 10:27 10:27 10:27 10:27

PROFESSOR MURPHY: So would CCTV proposal have been put in that way or did it fall below the financial criterion? 10:28

A. I wouldn't be appraised about how much CCTV would come in, so I honestly don't know that. And I have never seen a proposal for CCTV cameras coming in, nor has one ever been highlighted to me. The first I knew of any

CCTV cameras in relation to care was in the incidents in relation to Muckamore Abbey.

DR. MAXWELL: The Inquiry has heard that on more than one occasion proposals were put forward relating to staffing.

A. Mm hmm.

DR. MAXWELL: Both in terms of the number of nursing staff, but also professions that were not provided.

A. Mm hmm.

DR. MAXWELL: So we heard that occupational therapists only were funded at Muckamore very late. Do you recall seeing proposals about investment proposals for Muckamore?

A. No, because most of that would have been dealt with at Nurse Consultant level.

DR. MAXWELL: And then what would happen -- so if the Nurse Consultant -- and in fact we have heard Molly Kane was the Nurse Consultant who was involved in some of these -- if she approved them, what would she do with them? What's the route?

A. You have to remember the Public Health Agency didn't hold any of the funding for services. So if they were approved by the commissioning team, not just Molly, they would have gone into the system, into the financing and commissioning system within the Health and Social Care Board and allocations appropriately made.

CHAIRPERSON: But you are there to identify gaps in commissioning?

A. Mm hmm.

CHAIRPERSON: So one of the things that we heard yesterday, and maybe we're going to deal with this later, but one of the things we heard yesterday was because there was no regular GP service at Muckamore, the sort of health screening that went on for members of the public, cancer screening and the like, wasn't happening. Were you aware of that? 10:30

A. No, I wasn't aware of that. I was aware in conversations that there were challenges around the general practice cover, and in reading one of the transcripts or statements -- 10:30

CHAIRPERSON: Dr. Hughes yesterday.

A. -- relating to Muckamore, I mean I've tried to be fulsome in terms of preparing for coming today. I think it was Esther had said that she had submitted a paper to Molly and another colleague about GP access. I don't know any of the detail of that, but I assume, and perhaps it's a wrong assumption, but I would have expected that then to have been passed to the integrated care team. Molly's role would have been there to provide advice around nursing. Within the Health and Social Care Board there is a team that look after primary care, you know, and I think it's termed "integrated care" because it looks after pharmacy as well as general practice, and I would have anticipated that that bid would have gone into that team, but I don't know that for sure. 10:30 10:31 10:31

CHAIRPERSON: But then, if they wanted to do something

about that, would that have to come up to your level to raise it with the HSCB?

A. No, that -- if it's going through the commissioning team into a member of integrated care team of the Board, it would be addressed directly by the Health and Social Care Board, so it would.

CHAIRPERSON: Provided that it's brought to their attention.

A. Yes. Yeah.

CHAIRPERSON: Okay. 10:31

A. And that's what I say, I'm assuming, and I don't know that for sure.

DR. MAXWELL: So when PHA teams, whether they're Nurse Consultants or integrated care commissioning teams, identify a gap in the service, do they do any risk assessment? Because some gaps have more significance than others, and failure to screen part of the population for years would seem a very high risk? 10:32

A. Yeah. It would. And they may well have -- I'm not aware of any. 10:32

DR. MAXWELL: But there was no mechanism within the PHA Board to say these are the red risks?

A. Not for that level of detail, no.

DR. MAXWELL: Did the PHA have a Risk Register?

A. It did have a Risk Register, yes. 10:32

DR. MAXWELL: But it didn't cover the commissioning of services outside? It was an internal one.

A. Yeah. That's probably a good way of describing it, yeah.

19 Q. MR. McEVOY: Before we leave paragraph 14 then, in addition to the scrutiny of the IPTs, you also tell us that there was a role for the Agency in reviewing Trust delivery plans.

A. Mm hmm. 10:32

20 Q. How did Agency consultants review delivery plans?

A. The Department would have produced the Commissioning Plan Direction, the Board would have produced the Commissioning Plan. The Trust then in response would have produced, against the Commissioning Plan, detailed 10:33 information around how they were going to meet that particular Commissioning Plan target or issue. It didn't cover every element of every service, and tended to focus on those that were identified as part of the Commissioning Plan. A Nurse Consultant would have been 10:33 involved with the rest of the Commissioning Plan team scrutinising, going through those, raising any issues of concern, and a having a debate and discussion with the Trust as to whether they felt it was robust or achievable. 10:33

21 Q. Was there a means within that process for reviewing patient outcomes?

A. Probably not as robustly as it could or should have been. It was -- I mean I'm trying to recall what a Trust Delivery Plan looked like, but it was very much 10:34 about how they would expect to deliver the services, and there may well have been something around what we expect to see or change as a result of that service, but probably not a huge amount of detail. I would need

to see a TDP to be able to advise.

22 Q. At paragraph 15 then you discuss the Health and Social Care Act 2022, which provided for the dissolution of the Regional Health and Social Care Board and then its transfer of functions to the Department of Health, and then the creation of the SPPG within the Department of Health being accountable to the Minister. Why do you think that the HSCB was disbanded and the SPPG effectively brought under the Department's control in 2022? 10:34 10:35

A. Ehm, I'm not quite sure how to answer this. I think there was a feeling, Donaldson and other reports, about a lack of clarity about who is in charge. I don't know. I think, and it is entirely my opinion and nothing more, that perhaps the Department wanted to have some of those decision making closer to them. Because we had tiers in our service, and I think there was an anticipation if the change happened that would we reduce some of those tiers. I mean that's a large assumption on my part, so it is. 10:35 10:35

DR. MAXWELL: So you refer the Donaldson and that's Liam Donaldson's report that was the Commissioned by the Department of Health into all the services in Northern Ireland in health and social care.

A. Yeah. Yeah. 10:36

23 Q. MR. McEVOY: I appreciate you retired in 2019.

A. Yeah.

24 Q. But the extent to which you can help us maybe with the next question will have to carry that caveat.

A. Yeah.

25 Q. So, so far as perhaps your role, or your successor now in role would be concerned, do you know whether the advice provided to SPPG, or the SPPG, would be to the same degree, the same extent? Do you know, and again with the same caveat applying, do you know whether the relationship is different and, if so, how? 10:36

A. I think it would be unfair of me to comment on how things are now, in that I'm not part of that process.

26 Q. Yes. 10:36

A. The very fact that logistically you're not part of a combined, you know, integrated organisation makes it slightly different, I'm sure, but I think it would be unfair.

27 Q. All right. The Inquiry then asked you some questions about the issue of Serious Adverse Incidents or SAIs, and concerns a bit more specifically regarding Muckamore Abbey Hospital, and you then have addressed those questions, and if I can take your specific attention to what you tell us at paragraph 22 on page 5, and there you discuss what may or may not constitute an SAI. And here you say then: 10:37 10:37

"An adverse incident is defined in the guidance as "Any event or circumstance that could or did lead to harm, loss or damage to people, property, environment or reputation"." 10:37

And then you refer to the guidance and the criteria

within the guidance to be used to determine whether or not an adverse incident is a Serious Adverse Incident. The judgment then being made by the reporting organisation. And, indeed, you have provided exhibits to that extent or to illustrate that. 10:38

But if I could ask you the question more globally or ask you the point more globally in this way: I mean the Inquiry certainly has heard that the definition of an SAI is open to interpretation - you might have a 10:38 different view of that?

A. No, no.

28 Q. But in your view, and your experience, would harm to or damage to people include harm or damage to the quality of life of a learning disability patient or patients 10:38 through either single or indeed multiple acts of abuse or neglect?

A. Yes. I mean, you know, I think the simple answer to that is yes, absolutely. But I think your point that you made earlier that it is a bit of a subjective view, 10:38 you know, in terms of a list of things, but, yes.

29 Q. Yes. You're quite categorical in your answer.

A. Yes, absolutely.

30 Q. And then at 23 you have discussed then the three levels of review within the SAI procedures. Level 1 reviews 10:39 being the most common, that including then - the Inquiry has heard evidence about this, of course - but a Significant Event Audit to be immediately completed by the organisation reporting the incident, using a

template to access what has happened, why, what went wrong, what went well, and to identify learning at both local and regional level. You then go on to talk about Level 2 and Level 3 reviews?

DR. MAXWELL: Sorry. Before we go to Level 2. 10:39

MR. McEVOY: I beg pardon.

DR. MAXWELL: A Level 1 incident that produced a Significant Event Audit, would that be signed off within the Trust or would it have to be signed off by one of your DROs? 10:39

A. It's signed off within the Trust. Originally the Level 1s - and this is where I think I made the point - the SAI process changed over time, so it did.

DR. MAXWELL: Yes.

A. Originally it did come in to the PHA and was 10:40 scrutinised. But at one of the regular reviews of SAIs the decision was made that these were, the Trust should have sufficient governance arrangements in place to ensure that they can robustly complete a Significant Event Audit. There is criticism of the SAI process in 10:40 totality of it being quite a bureaucratic and quite a slow process. Now, the innovation of bringing in a serious or a Significant Incident Review was to attempt to get to the learning quickly. So a learning notification would have been sent in to the PHA as part 10:40 of this Significant Event Audit. DROs were entitled to ask for the entire audit, if they wished to, but it was signed off by directors, I understand, in Trusts.

DR. MAXWELL: And the learning review, was that sent

after they had signed off the audit?

A. Yes. Yeah. Yes.

DR. MAXWELL: So if the DRO had any concern about the quality of the audit or its conclusions...

A. They would go back to the Trust. They had the right to go back to the Trust, should they wish. 10:41

DR. MAXWELL: But the incident had been closed at this point?

A. Yes.

DR. MAXWELL: So they couldn't re-open the incident? 10:41

A. No, but what they could go back is with specific queries, you know.

DR. MAXWELL: Yes.

A. I think -- you know you've identified learning, but it's not clear where that learning has come from, you know. 10:41

DR. MAXWELL: But they couldn't go back and say: 'I'm not happy with this audit. It needs to be re-investigated'?

A. Well, ultimately if the DRO felt that strongly, the DRO had the right to come to any director in the Trust to say 'I'm really uncomfortable'. I don't know if that ever happened with an SAI. It could happen with a Level 2 or a Level 3, and I've been personally involved in a Level 3. The staff also could come to me should they not have a good hearing from the Trust. 10:41 10:42

CHAIRPERSON: Thank you.

31 Q. MR. McEVOY: Then at 24 and 25 you describe what a Level 2 and a Level 3 review would entail.

At 26, if I can take it up there then at the bottom of page 6, you also then touch on the role of the RQIA.

A. Yes.

32 Q. And specifically its statutory obligation to investigate specific incidents under the SAI procedure, to include all Mental Health and Learning Disability SAIs. And from your recollection, what did you understand that the RQIA's role was, from your perspective, and in the Agency? Was it to investigate or was it a review? 10:42 10:42

A. Well, we were to notify RQIA.

33 Q. Yeah.

A. And I think RQIA would probably be the best to answer what they did with it there. RQIA had a seat at our quality safety experience table to ensure that they heard the round of other things going on in the system, and there were clear procedures within the SAI Procedure Manuals, 2016 being the most recent, where RQIA were -- where information was shared, and apologies if I haven't got the detail quite right. For instance, when an SAI report came in, related to any of those areas, it would also have gone to RQIA and they were given a certain amount of time to comment on it, and I think if there was a learning letter or anything of that nature going out, it also would have gone to RQIA to comment. It's in the procedures, I just can't remember what page. 10:43 10:43 10:43

DR. MAXWELL: But that didn't stop the PHA from their

responsibilities?

A. No, absolutely not, no.

DR. MAXWELL: You weren't handing over responsibility.

A. No. No.

DR. MAXWELL: There were two agencies looking at it -- 10:44

A. No, it was a double check, I suppose.

DR. MAXWELL: Yes.

A. Yes. No, you're right.

34 Q. MR. McEVOY: And maybe just picking up on that point at the top of page 8, at paragraph 32 -- it'll just come 10:44 up on screen hopefully in a second. Thank you. You're talking about a situation where a Level 3 SAI review is completed and:

"...the DRO decides if they are satisfied with the 10:44 robustness of the review and that any appropriate learning has been identified. When a DRO informs an organisation that the SAI review can be closed, the organisation is advised that if additional information becomes available to the reporting organisation, for 10:44 example Coroner Reports which impact on the outcome of the SAI review, must be communicated."

Then in addition then:

10:44

"...a DRO might request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these

instances, monitoring will be followed up then via the HSCB Governance team."

I appreciate things might have changed now with the change in, statutory change in roles and responsibilities and authority, et cetera.

A. Yes.

35 Q. But taking into account that, and also the answer you've just given to Dr. Maxwell, your role with regard, or the Agency's role with regard to an SAI is or was to provide an overview, an assurance mechanism? 10:45

A. Mm hmm.

36 Q. So can you explain I suppose -- sorry?

A. No, you're okay.

37 Q. Can you help us understand then in simple terms what it is that you do that the RQIA doesn't do? I mean you may feel you've answered that? 10:45

A. No, no, happy to provide fuller detail. The SAI process, the management of the process is led by the Health and Social Care Board, and the PHA provides professional advice and guidance in relation to that and has a specific role in terms of learning. But we work those two organisations in partnership. So as an SAI -- the DRO, when assigned, could be a nurse, social worker, or allied health profession. They were assigned to become the DRO, they completed the DRO, which is detailed there, where they would, you know, immediately communicate with the Trust concerned, ensure people are safe, immediate action has been 10:46 10:46

taken, etc. For the different levels of each SAI, they would, for instance, discuss the Terms of Reference of the SAI Review Panel, they might discuss with the Trust concerned the level of independence of that panel, to ensure that it was appropriate to the particular set of circumstances, and that could be a HSCB member of staff or it could be a PHA member of staff. 10:46

They would then, through the HSCB Governance team, who were rigorous about following up on SAI notifications and the journey of a SAI through this process, they would have received, the DRO would have received a report from the Trust, or regular updates from the Trust if it was a particularly complex case and it required updates. The DRO was also responsible for ensuring that the Trust have actually thought about involvement of families and carers, because these were generally very difficult, quite stressful situations were people to be in, so they were. The DRO then, as I say, would have scrutinised the robustness of that report, did it meet the Terms of Reference that were actually set out? If they were concerned they had, and it is clear in the guidance, they had the right to go back to the Trust with queries. So at times there were queries going to and from the Trust and the DRO. If they remained unsatisfied, they had the right to go to directors within the Trust, or me as the Chair of QSE, to take any action that they felt appropriate. 10:47 10:47 10:47 10:48

The vast majority of cases, you know, they became satisfied with the robust report and identified any Regional Learning 'This is Trust responsibility'. If there's local learning, to actually get on with it, so it is. It was ours to identify any regional learning, and then there was a process by which the DRO could identify regional learning, and a range of things could happen, such as a reminder of best practice, a learning letter. 10:48

CHAIRPERSON: And that would go to all the other Trusts? Where would those go to? 10:48

A. Yes, all the other Trusts, and there's a circulation list I think in one of my exhibits. It also went, if appropriate, to universities, because we had to catch our professionals when they're young, and if there's learning that we get today, we need to ensure that they are prepared tomorrow. 10:49

I personally, you know, early warning scores, which is a system by which nurses can see if somebody's condition is deteriorating, we had quite a number of SAIs over a period in the very early days around early warning scores, and not only did we do learning letters, I personally went to the two universities to talk to nurses, because it was such an important thing and we really wanted to get to them, you know, before they picked up any bad habits, you know. So it was important we tried to catch the breadth of people who could influence change. 10:49 10:49

So it was -- I'm not quite sure what they did with the information in RQIA, but that's what we did with it.

CHAIRPERSON: And an SAI Investigation Report would presumably normally have an action plan? 10:50

A. Yes.

CHAIRPERSON: Attached to it. You would presumably review the action plan as well?

A. Yeah. Well...

CHAIRPERSON: Not you, but the DRO. 10:50

A. Yeah. If a DRO required that there were things -- if a learning was identified, so action was identified by the DRO as part of their scrutiny of a final plan, it would then go to -- one of two ways. The DRO could say, 'Right, I want the Trust to advise me when this is 10:50 done, when an action has been taken', and the team in the HSCB were diligent about following that up and advising the DRO. They were meticulous about how they did that. If there was a learning identified which required to be circulated, or there was a formal 10:50 learning for the Trusts, all Trusts in Northern Ireland to take forward, because we were interested particularly in regional learning, okay, that would come to -- and I think it's -- in terms of Terms of Reference, a group called the Safety Quality -- SQAT 10:51 Safety Quality Action Team. Apologies.

38 Q. MR. McEVOY: Alert team, possibly

A. Alert team. That's it. Sorry, apologies. It would go to -- and that group was chaired by the Director of

Public Health. That group looked at the learning or the actions that needed to be taken in relation to regional learning and it had a range of levels of assurance that it will look at, and that was based on risk and on impact. So the first level could be, 10:51
'There's regional learning, you should have sufficient resources', because all Trusts had resources, governance systems in place to ensure that learning was embedded. The next level might be that, 'Yes, we want to know when you have completed this piece of work'. 10:52
So proportionate to the issue. The third level could be, 'This is of such import and such significance we require you to provide us with regular updates'. And that appears to have worked very well, supported and administered by the Health and Social Care Board. 10:52
I know subsequent to my retirement some of those things have been further improved.

CHAIRPERSON: Could I just ask how this -- because the original question you were asked is what do you do that the RQIA doesn't do? How does this link with the RQIA? 10:52
Because they will go back and inspect where they've raised a serious concern, which may well arise from an SAI, they will go back and inspect. Do you then look at the RQIA report?

A. The RQIA -- a member of RQIA was always a member of QSE 10:53
invited member. RQIA also got copied into all the learning letters, reminders of best practice, as a matter of course. RQIA reports are invariably Trust focused, so there's a Trust action plan to them. At

QSE, if there were issues to do -- the Quality and Safety Experience Group attempted to bring together intelligence from different sources. So that was its role. So it looked at RQIA reports - are there themes coming out of RQIA reports that we really should be paying attention to? Are there similar themes coming out of complaints, or coming out of patient experience surveys, or coming out of SAIs? So the purpose of QSE was to bring all of that there together. 10:53

If there were specific alerts, departmental alerts, that would have gone to SQAT, so it would. QSE looked at RQIA reports, particularly in and around any regional recommendations. But mostly RQIA reports were also services in the Trust and Trust actions to be taken. 10:54

DR. MAXWELL: So would it be fair to say RQIA was drilling down on specific local issues and PHA was looking at generalised learning across the system rather than individual cases. 10:54

A. Yes. Yes, I think that would be fair. I think there were times, because each SAI is very personal and individual, and there were times when the PHA had to take a greater role than would have been anticipated, and Trusts knew they could come to us if they needed help, and that happened. On a few rare occasions the Trusts came and said 'This hasn't been going well and can you help?', and we were more than happy. The point of all of this was to learn and try and prevent this 10:54

happening again.

39 Q. MR. McEVOY: We'll come back to that precise point actually in a few moments.

A. Yeah.

40 Q. But just before we do, you have helped us with understanding the relationship between the QSE and the SQAT. But I think you told -- and you told us something in particular about the role of the QSE. There would have been a RQIA representative on it? 10:55

A. Yeah. 10:55

41 Q. And would there have been -- who else would have sat on the SQAT?

A. On SQAT was internal and more operational, so it was.

42 Q. So it was more PHA staff?

A. And Board. 10:55

43 Q. And Board.

A. Remember we were doing this together. The administrative and management function of all SAIs was through the Board. And we were working in partnership with them. 10:55

DR. MAXWELL: When you say you were working in partnership, did you have shared services doing this or were they two entirely separate organisations collaborating voluntarily?

A. I don't think the collaboration was voluntary, in that I think in the order, whenever we all created, it was clear that we will work together. The administrative -- I'll give you an example. The administrative function for the SAIs was housed and based in the 10:56

Health and Social Care Board, but as the Chair of QSE they were my colleagues, I depended on them entirely for information, they managed the whole process extremely well. So it's not as linear as we were two separate organisations. I think it is to the credit of the staff of the Board and the Agency, in a complex world, that actually most of the time -- no organisation in any shape or form is perfect -- most of the time they work very hard about working together. You know, I would have considered the team in the Health and Social Care Board Quality Safety Unit as much part of my team as my own Nurse Consultants. 10:56 10:57

DR. MAXWELL: So if I was employed in that team, regardless of who my contract sat with, I would have felt I was part of one team? 10:57

A. I would hope so, I mean it would be presumptuous of me to speak on their behalf, but we managed QSE together and we tried to learn together. As I say, not always perfect, but I do think there was a genuine attempt. And I include in that my colleagues at the Department. Northern Ireland is a small place, and we all know each other, and that has many strengths, some weaknesses, but many strengths, so it has. 10:57

PROFESSOR MURPHY: Were PHA and HSCB in the same building? 10:57

A. Yes.

PROFESSOR MURPHY: Yes..

A. Yeah.

44 Q. MR. McEVOY: You have also made reference then to, at

38, to a process of identification of learning, and I know you've talked about learning and what was done with it.

A. Mm hmm.

45 Q. But you've mentioned a group then at 38 called the SAI Review Subgroup, and you've helpfully indeed included some reports relating to that group, but can you help us understand who was involved on that group? Was that a PHA group or was the membership wider? 10:58

A. Again, it was a multidisciplinary group. The most recent version of the SAI Review Subgroup was chaired actually by a member of the Health and Social Care Board, one of the leads in the Quality Safety Team in the Health and Social Care Board, but it was made up of the multidisciplinary membership between Board and Agency. 10:58

46 Q. At 39 you talk about how then there was a -- the QSE Group to consider -- sorry, to consider issues identified by the SAIRSG and agreed actions on assurance arrangements. 10:59

A. Yeah.

47 Q. And you have exhibited some of that material, helpfully. A group which:

"...met on a monthly basis to consider learning, partners/trends, themes or areas of concern, and agreed appropriate actions to be taken, from a wide range of sources of safety and quality information received by the HSCB and the Agency." 10:59

Thinking back to something you told us just a few moments ago in response to Dr. Maxwell, you sort of agreed with the general proposition that the RQIA would have sort of drilled down into particular issues, whereas the Agency may have been more - it's my word "holistic", I suppose.

A. Yeah.

48 Q. -- in its examination of issues. But you did say that there were instances where you would have considered that it was open to the Trust to come to you if things weren't going well. I'm paraphrasing, but that's the essence of what you told us?

A. Yes.

10:59

10:59

49 Q. Did the QSE consider the fact that the, as the Inquiry has heard, that the Trust declined to assign what happened in the Ennis Ward in 2012 as a Serious Adverse Incident?

A. Unfortunately at that stage I was seconded out to do the Improvement Action Group, which was looking at unscheduled care. So the detail of that I would not have lived first hand. Occasionally you would have got Trusts when Early Alerts came in not submitting them as SAIs. In general, and it's a general observation, not of that particular time, when contact was made by the allocated DRO or lead officer, I don't think I recall a Trust not then submitting it as an SAI. Our advice to a Trust was always, "if in doubt, submit the SAI". You can de-escalate an SAI. Because remember at this stage

11:00

11:00

you're only looking at what's happening, so you are, and sometimes you don't know until you're in the middle of the review or the investigation. So that's always been our advice.

DR. MAXWELL: But the Inquiry has seen documentation where the PHA did request that Belfast Trust submit it as an SAI, and there was a protracted discussion about whether it met the criteria, and ultimately it never was an SAI. I understand you weren't there at the time, but in principle at the time did the PHA have the authority to require it being reported as an SAI or was it always at the discretion of the provider Trust? 11:01 11:01

A. I don't think anywhere in legislation or guidance there is the capacity of the Health and Social Care Board, because remember -- or the PHA to direct. Now I could be wrong, but I do not think there is anywhere where we can direct. As I said, there have been occasions, not particularly that one, where in my role as QSE Chair a DRO may come to me and say 'I think this should be an SAI. I'm not getting anywhere. Can you...', and generally in Trusts they have been extremely responsive, and when you lift the phone you can have the conversation. Because there's always the reassurance that you can de-escalate an SAI. You know, if, when you get into the middle of understanding what happened and it actually doesn't meet the criteria, and SAIs are there for learning, they're not there for blame, they're there for learning, so the attitude should always be to report and learn or report and 11:01 11:02 11:02

de-escalate.

DR. MAXWELL: I understand the principle.

A. Yeah.

DR. MAXWELL: But clearly, and we have documentation for this, that despite all that explanation it didn't happen. Would you have expected the DRO to have noted and raised this fact that there had been a disagreement with the Belfast Trust about whether this should have been reported? Even if you couldn't require the Trust to do it, would you have wanted to know that a Trust had not taken the advice as you've laid out? 11:03 11:03

A. In my experience, yes, because -- I'm only speaking from my own experience. I've had DROs come to me and say 'This really should be an SAI'. But it would -- to be fair, it would be an exception, because the Trust would generally work very well with you. 11:03

DR. MAXWELL: No, I understand that. I understand.

A. Yeah. So they would. And on the rare occasions where I have had to lift the phone call, I don't think I've ever had a refusal, that I can remember. 11:04

PROFESSOR MURPHY: But although they were supposed to see it as a learning opportunity, do you think they really felt it was a black mark against them?

A. If I speak in the general, I think -- this has been debated, I think, throughout the whole of the UK and beyond, because even the language of "Serious Adverse Incident" nearly assumes wrongdoing. I know in some parts of the United States they talk about preventible harm; could this have been prevented? Is there 11:04

anything to learn? I don't think any jurisdiction that I know of has got it quite right. You're trying on the one hand to encourage, you know. So I would never have seen multiple SAIs as always a bad thing, because it says that's a reporting organisation, that's an organisation that is open. And, indeed, whenever the SAIs came down to the Board and the Agency, I would have been more worried about the places that weren't reporting than the places that were. But it is, I suppose it's a reflection of how sometimes staff feel, and it's about how you do an SAI, and how you support, because nobody comes in -- I always hope, and live in hope -- nobody comes into these jobs to do any harm. So it's a language. You're right to say that some individuals, and I wouldn't like to comment on organisations, don't always see it as a learning exercise. But we don't always make it a learning exercise, and I have worked hard to try to turn it into a learning exercise.

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11:05

PROFESSOR MURPHY: Thank you.

11:05

50 Q. MR. McEVOY: On the point about learning, and you told us a little bit earlier on about how you would attempt to disseminate learning, learning letters.

A. Yeah.

51 Q. And going so far even as to go out to the universities and distribute learning in that way. Do you follow up beyond, or did you follow up beyond the learning that you would have taken sort of responsibility for, to see whether or not it had been disseminated beyond that

11:06

responsibility, and did you test it in any way?

A. That was the process for SQAT.

52 Q. Right.

A. And the alerts team would have followed up, as I said before, based on sort of an assurance, a system of risk based, you know, Level 1 being, you know, it's your responsibility, you have governance systems in place. Level 2 being, let us know when you've done it. Level 3 being a more detailed. The follow-up would have been around the more detailed, so it would. And beyond that it would have informed, I think, RQIA reviews in the future, so it would have, because RQIA would have been aware of that. And I think they would always have considered those sorts of things whenever they are going in to do inspections. 11:06 11:06 11:07

If we seen a theme starting to recur, imagine we had sent out a learning letter and everybody had signed off that they had done the bits that they were supposed to do in the timely way that they were supposed to do, and six months or a year later the same issue was coming up, often in those sorts of circumstances we might then attempt to do a thematic review to get under the detail of it a little bit more. So thematic reviews were where you look at SAIs, you look at AIs, which are Adverse Incidents, and if you think -- I think the proportion of SAIs to AIs, I think in the health service we might have in the region of 60 to 70,000 AIs a year and we have 300 to 400 SAIs. And I think as you 11:07 11:07

said earlier it's quite subjective when you look at the criteria for an SAI. So sometimes, if things were recurring at a point that we don't seem to be making a difference, we would then have undertaken a thematic review, trying to get under the skin of SAIs, AIs, looking at patient experience, is there anything out there in the system that could help inform? You know, looking at, you know, previous recommendations from RQIA, or learning from RQIA reports, and produced a thematic review with then learning beyond that there. 11:08

53 Q. Now at 44 then you pick up on three such SAIs with regard to Mental Health and Learning Disability Services in September and October of 2017. Two concerned Learning Disability Services, with the other in relation to the Mental Health Services. 11:08

"All had allegations of violence against patients in two Trusts, one in a mental health setting and two relating to learning disability setting..."

11:09

- being Muckamore Abbey. I appreciate it's 2017, but can you give us brief details in relation to each, from your recollection?

A. Well, I can't give you the exact details, so I can't, but what I can say is they came in quite closely together. There were features that caused me concern. They caused me concern because primarily they were allegations of abuse to patients, and I know "vulnerable" isn't the right word to use, but 11:09

particularly to vulnerable people who could not always speak for themselves. They were across two areas of practice. Not just learning disability, mental health. And they all involved CCTV cameras. And while it was all of those years ago, I can remember that as if it was yesterday, because it shocked me, so it did.

54 Q. What - and you may have perhaps answered this, but in case there's anything else you want to add - what was it that made you feel that additional action was needed over and above the SAI? 11:10

A. I suppose because -- I'm a nurse, and nursing is a profession that while we have clinical experts that are beyond anything that I ever was able to achieve, it's a profession that's built on compassion and care, and to see three SAIs come in that was an affront to the values that are nursing, shocked me. 11:10

DR. MAXWELL: Can I just asked you, you say that there were two different Trusts.

A. Yes.

DR. MAXWELL: So the mental health one was a different Trust? 11:11

A. Yes.

DR. MAXWELL: But it was using CCTV?

A. Yes.

DR. MAXWELL: So Muckamore wasn't the first NHS facility in Northern Ireland to use CCTV? 11:11

A. Apparently not, no.

55 Q. MR. McEVOY: What was it, therefore, that caused you to go so far as to contact the Chief Nursing Officer?

A. The Chief Nursing Officer is the most senior nurse in Northern Ireland, holds a significant role of responsibility and influence. I just felt -- these SAIs were going to go through the normal process and the rigour that goes with that, it would be assigned DROs, et cetera, so the urgent was being dealt with through that process. But I seen these three and thought -- actually my initial reaction is: "Where have we gone wrong that this has happened?". So I phoned the Chief Nurse and talked through what was coming through the door, and as you know in subsequent weeks and months more happened, and we had a long discussion about values and culture in nursing and what had happened that, you know, that this had happened, and the CNO then reflected and wrote to me and asked me to do a specific piece of work, a piece of scoping work basically. 11:11 11:12 11:12

56 Q. If I can pause you there.

A. Oh, yeah, sure.

57 Q. For your assistance -- no, it's okay we're going to it because -- 11:12

A. Okay.

58 Q. For your assistance we can bring it up at 304, I think, which is the letter?

DR. MAXWELL: Just before we get to that. 11:12

A. Yeah.

DR. MAXWELL: You said that obviously more events emerged at Muckamore. Did more events emerge in the other facility?

A. No. No. The other incident has been publicly -- it's in the public domain that an individual was prosecuted. That's in the public domain.

DR. MAXWELL: But nothing more was picked up on their CCTV? 11:13

A. No. Not --

DR. MAXWELL: That you are aware of.

A. Not that I was aware of, yes. Yeah. Not that I was aware of.

59 Q. MR. McEVOY: If you could bring up page 304, please? 11:13 If you could just scroll down. I'm sorry, Ms. Hinds, is that the letter you were referring to then?

A. Yes, that's right, that's the letter.

60 Q. In terms of the letter from the Chief Nursing Officer.

A. Yeah. Yeah. 11:13

61 Q. And it's a letter then of 24th November '17 asking you, as you indicate:

"...to provide a scoping report on the systems, professional structures, policy and procedures in 11:13 place..."

- to provide assurances to Executive Directors of Nursing in Trusts, and ultimately to their Chief Executive of the Quality of Nursing Care. 11:13

When you were requesting information from the Trusts in order to conduct that scoping review and to provide that report, did you triangulate the data from other

sources; in other words, any RQIA reports from Datix?

A. No, this report was a quick scoping report, so it was, to provide information to the Chief Nurse. So I had what amounted to eight weeks to get information in from Trusts and pull a report together, and I hope at least initially it provided some assurance to the Chief Nurse that the Directors of Nursing had returned to me and I was able to summarise in the report that they had systems in place. 11:14

DR. MAXWELL: And this was focusing on nursing practice, not the whole service? 11:14

A. Yes. Yeah. This was just -- this was I suppose a nursing response to a dreadful nursing situation. Accepting, you know, and I accept all these were allegations at a point in time, but sufficient to cause concern. 11:15

62 Q. MR. McEVOY: And, of course, the Inquiry then has your report and that's included in your exhibits and, of course, that's available to all to examine.

A. Yeah. 11:15

63 Q. But in particular the Inquiry would be interested to know, just at paragraph 52 there, about some of the outcomes the plan included, and in particular the commissioning of the Foundation of Nursing studies to complete two cohorts of "Creating Caring Cultures". 11:15

A. Yeah.

64 Q. Can you tell us a bit more about that? Were those intended to go into student nursing courses? What was anticipated?

A. Okay. Accepting we needed to do something, even though we had assurances that the systems and processes were in place, and when you read the report you'll see that some of those systems seemed to be well funded, some of them seemed to be not so well structured, some of them had lower grades, some of them had higher grade, you know, there was still a mix in there. The whole issue of culture was at the core of our concerns. So we - and the CNO in particular, through her extensive networks throughout the UK - knew that the Foundation of Nursing studies had completed a programme of this nature before, and it looked at values, and how we are with people, and the "Creating Caring Cultures" was commissioned, now it was commissioned as a bespoke, so they were briefed on the outcome of the report that I had written, the scoping exercise. Two cohorts were commissioned. The priority was given to learning disabilities, so they were the first to go through. Targeting, I think originally targeting Band 6 and 7s, but I know some Band 5s also participated. And I suppose it was a bit of a kick start to just trying to remind everybody why we're here. And the outcome of it has been very positive. I've read some of the outputs from that, and some of them are on the Foundation For Nursing studies website, and it did have an impact, and then it moved on to Mental Health Nursing, and fed into the work.

11:15 11:16 11:16 11:16 11:17

At the same time all of this was happening we had the

Strengthening the Commitment Group, chaired at that stage by Prof. Owen Barr, which was part of a UK-wide initiative to actually strengthen the role of Learning Disability Nursing, so, as you know, alongside the Creating Caring Cultures piece that was instigated.

I mean I know it might seem like it took us a while to do things, but sometimes it takes time to do the right thing, but the request for nominees went out in August 2018 for that particular programme. We also then in response, as you'll have seen, you know, commissioned other programmes for 8A nurses, which is sort of your middle tier manager programmes. We also commissioned some improvement training, and there was an enhancement to strengthen the commitment with the Director of Nursing co-chairing.

PROFESSOR MURPHY: So did it become an accepted part of nursing training in the longer term?

A. This is part -- this was post registration training. I think what has happened with student nurse training - I mean there are standards that they have to meet. I think nurses are -- my personal view is I think nurses are increasingly being trained to look at person-centred care. I know there's a wee bit of the sort of, you know, you can call it whatever you like in terms of giving it a label, but very much focusing on the person and the relationship that you have with someone, whether that is a therapeutic relationship or a relationship that is built on a clinical experience

that a patient has. I think we can never stop reminding all of our professional staff that our fundamental role is to care and treat from cradle to grave, including the family.

DR. MAXWELL: And it would be remiss not to mention that after the Mid Staff's Inquiry -- 11:19

A. Yes.

DR. MAXWELL: There was a big programme about compassion in nursing --

A. Yes, that's right. That's right. 11:19

DR. MAXWELL: So it was already in pre-registration nurse training.

A. Yeah. Yeah.

65 Q. MR. McEVOY: Before we move on then, Ms. Hinds, just at 54, if you can help us just with a kind of a bit of a technical question here, just at the top of paragraph 12. 11:19

"All serious adverse incidents are reported to the HSCB through a Datix system using a standard reporting form." 11:19

A. Yes.

66 Q. Was the SAI sent automatically to --

A. Yes. 11:20

67 Q. So it wasn't a human action?

A. No, no. It's sent electronically to Datix and, as I say, the Health and Social Care Board quality safety team were diligent in terms of their ability to track

and follow.

DR. MAXWELL: So does the HSCB team have the permissions to interrogate the Datix system for individual Trusts? So if I was working there and I got an SAI and I thought 'Oh, I wonder how many IR1s there have been in this topic?', could I do that? 11:20

A. I don't think they can interrogate IR1s, which is, you know, the adverse incidents. I think we have been doing that through thematic reviews. I think it's SAIs that they can interrogate. 11:20

68 Q. MR. McEVOY: Now, you told us a few moments ago that you were dealing with approximately 300 or thereabouts SAIs in a year.

A. Mm hmm. I think it was 3 to 4.

69 Q. I think you helpfully included an annual report for 2017/2018, and it's Exhibit 18. The statistics within that indeed show that there were indeed 361 for that year. I suppose the Inquiry would be interested to know, Ms. Hinds, whether that was typical? I think you've indicated that it was? 11:21

A. I think so.

70 Q. But in particular, did the numbers and types of SAI differ in any way between the different service areas?

A. Yes, they probably did. Thematically we would have picked up issues of concern, you know, where things were happening such as falls, is a good example of one, or indeed choking, and I included the thematic review on choking. And some covered all actually areas of practice. So choking you might associate with people 11:21

with swallowing difficulties say being admitted to a hospital for an acute intervention, but actually they were very relevant to people with learning disabilities.

71 Q. Yeah. 11:22

A. Extremely relevant to those with dementia. So sometimes the thematic reviews actually covered all programmes of care, and when we picked a thematic review to look at, we did try to make sure that we got all of the AIs and SAIs, regardless of where they 11:22 happened.

72 Q. Okay. If we can actually just open Exhibit 18, please, at page 383? If we can just zoom out so we can see the page, please? We're told in this page that there were various regional clinical networks to drive quality 11:22 improvement?

A. Yes.

73 Q. But there don't appear to be any specifically dealing with Learning Disability or Mental Health Services. There may be a reason for that? It would help the 11:23 Inquiry to know.

A. Those would be specifically things defined as clinical networks.

74 Q. Okay.

A. Mental Health and Learning Disability had an 11:23 improvement group, which all Trusts contribute to, and, you know, in terms of learning from SAIs could have been directed into that.

I should have said earlier, when you identify learning, one of the things we know, if you circulate everything to everybody then you've a good chance that nobody is going to pay too much attention to it, and I don't mean that in any derogatory sense, it's just volume, so it is. So if there was an SAI, or learning from a SAI about radiology services, what we would try to do is target it to those where it had significance, so say to the radiology network. So we would try also to do targeting. So that's where those clinical networks. But in Mentality Health and Learning Disability, there was an Improvement Board established, now I can't remember exactly when it was established, and learning would have gone in there as well. 11:23 11:24

75 Q. The Inquiry has obviously examined the exhibit in some detail, it's for 2017/'18, we know what was going on and emerging in that year, but we don't see anything specifically dealing with Learning Disability, despite the year of the report, indeed specifically around the theme of transforming the culture - I think that might be on the next page? Sorry, the previous page, I beg your pardon. Yes, the top of the previous page. Was the area of Learning Disability overshadowed by acute care issues in other service areas? 11:24 11:24

A. I think if you talk to those who work in Learning Disability they would say they've been overshadowed by more than acute for many years. I mean I think there is a feeling that Mental Health and Learning Disability have never had the same attention as acute, because

acute is the problem today, so it is. I think -- the reason it's probably not reflected in there, that was for 2017/'18, and while the numbers, and I don't want to turn any individual person into a number, while the numbers may well be reflected in there, the outcomes in terms of the report I think for all of those SAIs didn't come in until late on, until 2019. I'm not quite sure of the date. Even then for Creating Caring Cultures, the invitation to actually participate didn't go out until August 2018. 11:25

But I think if you go through that report, I'm nearly sure there is reference to Learning Disability, because the teams would always try to ensure that their areas were appropriately reflected. But the reality is probably more SAIs are reported in the acute sector than anywhere else. And I don't think that's unique to Northern Ireland, I think that would probably be material to the rest of the UK, if not beyond. 11:26

DR. MAXWELL: But that also reflects a larger number of people going through those services? 11:26

A. Yes. And the complexity of services where things can go wrong in a very practice sense, you know, such as, you know, the wrong patient, you know, for administration of medicines, for example. 11:26

DR. MAXWELL: So it's actually easier to identify something as an SAI? We talked earlier about the subjective nature, but if you've cut the wrong leg off that's not ambiguous?

A. Yes. No, you're absolutely right. Yeah, that's a very good way of describing it.

CHAIRPERSON: I'm just thinking of the timing.

MR. McEVOY: Yeah, I was just about to propose, Chair. I've two more themes to explore on SAIs before we leave it, but I'm in the Panel's hands. 11:26

CHAIRPERSON: I think we've been going quite a long time now for any witness, so we'll take a break there. About 15 minutes.

A. Lovely. 11:27

CHAIRPERSON: Thank you very much. Please don't speak about your evidence to anybody.

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:41

76 Q. MR. McEVOY: Thank you, Chair. Ms. Hinds, we were still on the topic of serious adverse incidents and the various processes that you have described. As these were going through those processes, as you have described, it would have been reported to the HSCB and then reported to you. Would you have expected them, that is the say SAIs, also be raised up to the Board level at the Trust involved? 11:42

A. I think I would reasonably expect reports to go on SAIs, not necessarily individual SAIs. 11:42

77 Q. Yes.

A. Although if an individual SAI was of particular importance, it would not surprise me if one had gone.

I think -- fair to say I think each Trust has different governance arrangements. So some of this information may well have gone to subcommittees of the Board. I don't know for sure. I'm sure each of them could account for what they do.

78 Q. And at the bottom of page 12, just at paragraph 58 then, you tell us that the process for managing the SAI process was ultimately led by the HSCB?

A. Mm hmm.

79 Q. The Agency Board would have received a report on incidents prepared by the HSCB governance team. And then at 59 you say that:

"Over time the reports and reporting arrangements were adapted and amended."

A. Mm hmm.

80 Q. The standalone SAI report was replaced by an annual Quality Report. You say that that was significantly more comprehensive than an SAI report?

A. Yes, because it covered a broader range of safety and quality issues. I think subsequent to that, and I'm not quite sure if it was related to SPPG being formed, I think that my understanding is some learning reports now do go to the PHA Board.

81 Q. The reason that there's a sort of a query, or certainly a querying tone there, is because I suppose at first blush an annual Quality Report could be interpreted as sounding less focused than a process of using an

individual SAI. Is that fair or unfair?

A. No, I think that's a fair reflection. But the annual Quality Report was defined by Quality 2020 and had specific sections that had to be completed. And, as I say, I think it provided a comprehensive and more -- quality and safety is more than SAIs, so it is. 11:45

82 Q. Mm hmm.

A. And I think it attempted to provide a more comprehensive picture of issues related to quality and safety. 11:45

83 Q. Okay. Question 5, which was posed to you, was whether you had concerns about safeguarding at Muckamore Abbey Hospital before September '17 and, if so, what was the nature of your concerns? What action, if any, was taken in relation to them? 11:45

A. Mm hmm.

84 Q. You begin your response to that by saying there were a number of ways that safeguarding concerns could be drawn to your attention through the SAI process, as discussed, or through the Early Alert process managed by the Department of Health? 11:45

A. Yeah.

85 Q. Your understanding then was that the majority of safeguarding concerns would not have been highlighted through either process but would have been managed at Trust level through Trust safeguarding procedures? 11:46

A. Yeah.

86 Q. We've touched on the Quality Report a moment ago. Can you help us understand where safeguarding fitted within

the Quality Report? Was it or was it not a quality indicator, for example, for the purpose of that report?

A. I think it's reasonable to say it was a quality indicator. Was it very visible in an annual Quality Report? Probably not. There was a separate safeguarding process where there was a regional adult safeguarding partnership forum, which was a pretty extensive and wide group, at which I would have had a Nurse Consultant. And then there were local area partnerships, sorry local adult safeguarding partnership groups, where Trust level information would have been shared and gleaned, and the two work together. In my time nothing was highlighted to me from either of those groups about issues of concern. There is no reason that an adult safeguarding referral cannot also be a SAI. Care has to be taken that if an adult safeguarding referral is made that is reported also as an SAI, care must be taken about how the arrangements and who is taking the lead. And in one of the exhibits there is a flowchart that will show you how that is managed, and it is managed in a conversation, generally if it is of such import with the police service involved, the Trust involved, and the indeed the Health and Social Care Board involved. The PHA's role is to provide the professional advice into that, as required. It can mean that the SAI process is paused and gets picked up when the safeguarding referral process has gone through, or it can mean that it can run in tandem, so it can.

11:46 11:46 11:47 11:47 11:47

87 Q. Okay. At 66 then we're told about the establishment of the Northern Ireland Safeguarding Partnership.
A. Yeah.
88 Q. And then the five Local Adult Safeguarding Partnerships, which was an outworking of guidance then from 2009. 11:48
A. Yeah.
89 Q. A document from the Department and the NIO reforming Northern Ireland's adult protection infrastructure, and then Adult Safeguarding prevention and protection and partnership? 11:48
A. Mm hmm.
90 Q. Do you recall when the NIASP came into being as an effective organisation?
A. No, I'm afraid I can't. The Regional Safeguarding Board I think was well established. I think it was established before the Board and the Agency were created, but I couldn't be absolutely sure, so I couldn't. The safeguarding partnerships at local level would have been established at the same time because it was part of the same restructuring. So, apologies, I can't remember. 11:49 11:49
91 Q. Okay. And had you -- I have -- I suppose I have some questions around these partnerships, but it might help then before I go down this road just of trying to gauge what your familiarity and role within those partnerships was, if you had one? 11:49
A. The PHA had, in the scheme of things, quite a small role in that I had a Nurse Consultant who would have

been part of the regional group.

92 Q. Right.

A. We would have had no role in the local group. The Nurse Consultant who, in her portfolio had some responsibilities for adult safeguarding, also would have contributed and led an informal network bringing all the adult Adult Safeguarding Nurses together to ensure that they were getting, you know, learning and opportunities to develop, and they also contributed to professional work led by NIPEC around, I think it was a Competency Framework for Adult Safeguarding. So it was -- I'd never say a nurse's role is minor, but in the scheme of things we were one member of a 24, I think, member organisation. 11:49 11:50

93 Q. Do you know whether, and you may not, but do you know whether the Chair of the Northern Ireland Adult Safeguarding Partnership would have been in a position to triangulate safeguarding data with Early Alerts and SAIs and whether they did so? 11:50

A. The regional group was chaired by the Director of Social Care or their nominee, and there was a member of the HSCB social care team as a member of the Quality Safety Experience Group. So I suppose my expectation is that there would have been a bit of triangulation through that member of staff. 11:50 11:51

94 Q. As my understanding just from 69, each member representative was accountable to their employing organisation, should have been of sufficient seniority to bring adult safeguarding issues to the attention of

the Northern Ireland Partnership, and to make decisions on behalf of their organisation, and each representative should have ensured that any actions and decisions taken were shared and implemented as appropriate within their organisation.

Then you tell us about the five LASPs located within and accountable to their respective Trusts. Can you help us understand the Accountability Framework there? Were the LASPs subdivisions of the Northern Ireland ASP but accountable to their own Trusts? 11:51

A. That sounds about right, so it does. It's not an area where I have a huge amount of expertise.

95 Q. Yeah.

A. But even just looking at the framework documents, that appears to be the case. 11:52

96 Q. Okay. And at 71 then you tell us that the NIASP was stood down by the Department of Health in '19/'20.

A. Yeah.

97 Q. And replaced then with an Interim Adult Protection Board. Do you know why it was stood down? 11:52

A. No, I don't know the detail. But I assume some of the outworkings perhaps of the Muckamore Inquiry, because we learn as we go along. I'm not sure. I suppose it would be probably fairer to ask departmental colleagues that question. 11:52

98 Q. Right. Okay. And we now then have, as you've touched on or as you've mentioned, the Interim Adult Protection Board. It's not yet on a statutory footing; is that

correct?

A. As far as I am aware, yes.

99 Q. Okay. And the Agency is represented on it?

A. As far as I'm aware, and, again, I'm happy to be corrected, that the -- I think the Director of Nursing is a member of that Board. 11:53

100 Q. Okay. If we could move across then to paragraph 79, which is towards to top of page 17. Here we're talking about you receiving a brief from the Deputy Director of Nursing within the Agency and the Regional Lead Nurse Consultant for Mental Health and Learning Disability on 15th November 2012, about allegations being managed through adult safeguarding procedures; was that in relation to the Ennis Ward? I know you had said earlier in your evidence that you were seconded? 11:53 11:54

A. Yes.

101 Q. At a point in time.

A. It was. I was seconded out doing the Improvement Action Group in relation to unscheduled care at the time, but I think quite rightly the individual who was leading nursing in my absence felt it important enough just to give me a quick briefing on what was going on. And as you'll see from exhibits, while I wasn't there and wasn't involved, I think the individuals within the PHA nursing team took action in terms of -- I've shared two sets of minutes that I managed to locate. 11:54 11:54

102 Q. So by virtue of your secondment you weren't in a position to take any personal action or intervene?

A. No.

103 Q. But you were briefed for your information as such?
A. Yeah. Yeah. Mm hmm.
104 Q. Okay. All right. Moving on then to paragraph 85 on page 18, which is an answer to a question of you around recommendations in relation to education and training of staff at Muckamore Abbey. In the foregoing paragraph 84 you have made the point that the identification of education and training needs is the responsibility of the Trust with the Executive Directors of Nursing working in partnership with service and other directors to identify need. 11:55 11:55

But at 85 you say:

"Executive Directors of Nursing access a significant level of education and training through the Clinical Education Centre, the HSC Leadership centre and through requests to the Education Commissioning Group..." 11:55

- which is funded by the Department of Health. Feeding into that process, did the PHA make any recommendations, in particular to the commissioning group, the Education Commissioning Group, relating to the changing needs of the population? For example, in relation to needs around Learning Disability in particular? 11:55 11:56
A. The request to the Education Commission Group primarily came through Trusts, because they're closer to the patient and the individuals concerned. Particularly

through thematic reviews and overviews of services, the Nurse Consultants in the PHA might have raised an issue, but they weren't members of the Education Commissioning Group because it was focused on Trusts, so it was. I chaired the Education Commissioning Group. The budget was held by our departmental colleagues. So, therefore, I was supported by the team and the Department. And a nursing officer was allocated to become part of the Education Commissioning Group. The process generally was that bids were submitted by the Trusts, they were collated, I had a duty to ensure that as many needs as possible were met, that the money that the Department allocated was used to best effect and as efficiently as possible, because like many things in life it was never enough, and we had a role to ensure, where we could, that all programmes of care were involved. 11:56 11:56 11:57

The Trust's representatives on ECG were generally the education leads for the Trusts. It was their responsibility to ensure that they collated all of the needs from their organisation to contribute to the plan. Some of that was done well, some of that was not done that well. And then probably post me coming back from my second bout of secondment to the Northern Trust, I paid significantly more attention to the Chief Nursing Officer, because I think things had changed over time, and she would have made requests, albeit it was Department money, but in terms of openness and the 11:57 11:58

transparency would have made requests for specific initiatives.

105 Q. And, indeed, just to pick up that particular point at 99 at the top of page 19.

A. Yeah. 11:58

106 Q. There you say in addition to core post registration commissioning the Chief Nursing Officer would request - this was you as the Chair, presumably, of the ECG.

A. Yeah.

107 Q. To action these initiatives or priorities, an example of which was the commissioning of Quality Improvement Training for nurses. And you have set an example out there in 91. 11:58

So an outcome of the Professional Governance Report in 2018, which was completed at the Chief Nursing Officer's request, a number of areas were identified for professional development for the Chief Nursing Officer and Executive Directors of Nursing to consider, and you listed three themes there by way of example. 11:58 11:59

On the first one, which relates to enhancing preparation and support for nursing staff moving into senior positions, can you recall whether that theme or that strand to the work would have included specific preparation for the management side being in a senior role, in other words staff management? 11:59

A. Yes.

108 Q. Disciplinary issues, regulatory issues, and so on?

A. Yes. I mean there were a range of programmes, you

know, starting with -- I think we started with the Ward Sister type level, team leader type level. We refer to the 8A Programme that was developed as part of the outcome of work.

109 Q. Yeah. 11:59

A. CNO has commissioned aspiring Director Nurse programmes. I mean there are a range of programmes to try to get people ready for roles that they move into, because historically we often put people in roles and then try and train them for them, as opposed to 12:00 preparing them for them.

110 Q. Yes.

A. So, yes, there would have been an extensive programme, and it was very much in partnership with the HSC Leadership centre, who provide very good leadership 12:00 development training. Some of it I think has to be uniquely nursing and some of it is of a more general nature.

111 Q. Yes.

CHAIRPERSON: And do you benchmark the competencies - 12:00 it's a horrible word, but do you benchmark the competencies that are required for each role?

A. Yes, in terms of some specific nursing roles, and the NIPEC have taken the lead in developing competency frameworks. In terms of senior roles where you become 12:00 as much a general manager as you do a nurse, the Leadership Centre would ensure that they are working against standards that are UK wide, particularly, you know, standards that have been developed say by the

King's Fund and other organisations of significance. So there's a lot of cross referencing there, so there is. So, yeah. You know the programmes are good and the programmes do help people get ready for the next role. I think in this process, and even in the small piece of work I did for CNO, I think like all of these things when you look at it with a different lens you see different gaps, which is why we specifically ask for an 8A programme. 12:01

112 Q. MR. McEVOY: Moving down to 93 then. 12:01

DR. MAXWELL: Can I just ask you a bit more about - you said as Chair of the ECG you were receiving training need analysis from each of the Trusts, but as I think you've already alluded to, Trusts are in the middle of the here and now. 12:02

A. Mm hmm.

DR. MAXWELL: So they will generally, and this isn't unique to Northern Ireland, ask for what they need today, not what they need tomorrow.

A. Yeah. 12:02

DR. MAXWELL: Given that following Bamford there was a major change in vision about how people with learning disability and autism would be supported, who was looking at the training needs of the staff, not the pre-register, of the current staff, who were going to be giving care in this new vision? 12:02

A. My expectation is that the Trusts should have been. But I think that's a fair point and something to reflect on. I think Mental Health and Learning

Disabilities, we often talk about hard to reach groups, or maybe a better description is we haven't reached far enough ourselves. So the issue of, and I am being honest, mental health in particular coming up. I mean there were programmes run, so there were, you know, CBT, you know, for Mental Health Nursing, and a range of others. But it always felt as if there were not as many requests coming through that I would have expected, the acute nurses were much quicker to put their hands up, and perhaps it is because specialities developed much quicker in the acute side than they did in Mental Health and Learning Disability. I think some of the work in Strengthening the Commitment helped, but how visible was that to the nurse education leads and Trusts, I'm not altogether sure, so I'm not. I think an example of where doing something can have an impact, my colleague, the Deputy Chief Nurse at the time secured the funding with the Chief Nurse for Mental Health Nurse Consultants. I could see a marked increase in the number of requests coming in following that, because there was an increased visibility and an increased profile. I think some of the challenges for Learning Disability is that that wasn't there in the same way.

12:03
12:03
12:03
12:04
12:04

DR. MAXWELL: So are you saying there wasn't the same professional leadership in the Trusts in Learning Disability Nursing that was making sure their voice was heard in the training plans?

A. Yeah. I mean I wouldn't want it to be seen as a

criticism, but I think the development of those professional roles probably would have been slower. I think my report references the fact that many senior nurses were actually holding dual roles, and that in itself is not necessarily a bad thing, but it is then the capacity to do the nursing piece alongside very complex operational roles I think was a challenge, so it was.

113 Q. MR. McEVOY: At the bottom of page 19, paragraph 93 then, you also mention the commissioning during your time as tenure as chair of the ECG, the commissioning of the Foundation of Nursing Studies to complete two cohorts of the Creating Caring Cultures programme on behalf of the Chief Nursing Officer, and that commenced in 2018 with the first cohort of 30 nurses from the Learning Disability Nursing. 12:04 12:05 12:05

A bit earlier in your evidence this morning, Dr. Maxwell picked up on the report of Sir Robert Francis into Mid Staffs and the problems there. This programme I suppose sounds like it touches on some of the themes there and the findings that emerged from that report. That report was in 2012, and this programme was put in place in 2018, was there nothing like it in the interim? 12:05 12:06

A. No, there would have been leadership development programmes. I know I commissioned quite an extensive number of programmes through the RCN, you know, staff nurse development programmes -- I can't remember over

that number of years how many. There was always a cohort of that type of development programme running, nothing specifically targeting Learning Disability Nursing, and I think what made this different was, you know, it came out of our thinking post my scoping report to CNO, and it was something that was developed, and the Foundation for Nursing Studies took the time to make it bespoke to Northern Ireland and our particular challenges.

DR. MAXWELL: Was it delivered in Northern Ireland? 12:06

A. Yes. Absolutely, yeah.

114 Q. MR. McEVOY: And --

CHAIRPERSON: Sorry, just so that I understand. You say it wasn't bespoke for Learning Disability Nurses, but then in your statement you say in 2018 there was 12:07 the first cohort of 30 nurses; so is that when it was focused on Learning Disability Nurses?

A. Yes. The Foundation for Nursing Studies I think delivered this programme primarily in England. I think through CNO's networks she knew of it, so she did. 12:07 Whenever I did the scoping paper, you know, her and I had regularly communicated with each other and she identified that this would probably be something that would be helpful, would need perhaps to be slightly bespoke to Northern Ireland and delivered in Northern 12:07 Ireland, and she ensured that that happened, and then it was commissioned as part of the normal commissioning process.

CHAIRPERSON: And can I just understand on a more

general basis, when an event like that happens in England, or there's a big report, or indeed there's a big report here in Northern Ireland, what are the formal systems to ensure that there's crossover between the two jurisdictions of learning? 12:08

A. I think our Chief Nurse in particular is very good at sharing information. I don't know about it being terribly formal, but we're very good about sharing information in terms of reports. Anything that impacts on the Nursing and Midwifery Council, of course gets 12:08 shared across Northern Ireland. Any changes in standards that the Nursing and Midwifery Council are adopting or are incorporating, would of course get shared across Northern Ireland.

DR. MAXWELL: I think I am right in saying there's a 12:08 five CNO network, which is the four countries of the UK and the Republic of Ireland.

A. And the Republic. Yeah, they meet on a regular basis to try to make sure -- you can't possibly know everything that's going on. 12:08

CHAIRPERSON: No.

A. But those professional networks, and I think the CNO in her role was really material to try to put us in contact with the right people.

CHAIRPERSON: But that's the route, it's through the 12:09 CNO.

A. The CNO, yeah.

CHAIRPERSON: Yeah. Okay. Thank you.

115 Q. MR. McEVOY: I appreciate this is 2018, and in respect

of its application to Learning Disability Nurses, and you retired the next year in 2019, but do you know whether the effectiveness of the Creating Caring Cultures programme was evaluated?

A. Yeah, I'm not quite sure about formal evaluation. I certainly know there's evaluative pieces on the Foundation for Nursing Studies website, one in particular that caught my eye in preparation for coming here today was that of a Band 5, so a young staff nurse, who really seemed to get something very positive. But creating cultures in itself can't be an end point, it has to be a point at which we continue to do pieces of work like this. 12:09 12:09

116 Q. And do you know about, well first of all, completion rates? Was it something -- 12:10

A. Well I think the attendance rates were excellent. I think once somebody was committed to taking part in this, they seen it the whole way through. And, you know, it took some nurses' personal time, because there were residentials and, you know,, it took a lot of personal time as well as professional work time, and people were committed to it, so they were. 12:10

117 Q. And did it become an established part of nursing training?

A. I don't know what has happened since, so I haven't, but I know there are programmes -- I think Learning Disability is certainly more visible now than it had been in the past. I think the chairing of ECG is now very competently led by the head of NIPEC. 12:10

118 Q. Okay. Overleaf then at the top of page 20, at 94, you talk about a further programme, which is the British Institute of Learning Disability Positive Coaches Support Training, and you give you a description then of what the training involved. And it was delivered in two cohorts and ti certainly seems to have been successful on the basis of what you have indicated. From the information it seems 12 nurses were trained in PBS in the BILD. Were the courses long enough, do you think? 12:11

A. Oh, the courses will be as long as required. I mean, you know, they have a curriculum, they have a set programme that they need to get through, and they go through it. I think subsequent to me retiring I think this has been repeated. I think it has been warmly welcomed by Trusts and nurses included. 12:11

119 Q. So when you say the course was as long as required, if it took more than four days?

A. If it took four days, it took four day. If it took five days. There was no restriction. It was what the standard would say it should be. 12:11

120 Q. And again I suppose do you know whether there was any way of evaluating whether participation in the programme led to differences in practice?

A. That I don't know, because it would have happened. But the informal feedback I have been given is that it was warmly received and impactful, you know. 12:12

121 Q. Again, I know you have been gone since '19, but do you know whether it continues as a project?

A. I think my colleagues could maybe elucidate further, but I would be surprised if it didn't.

122 Q. Okay. The next question you were asked then was whether you and your team were aware of serious adverse incidents relating to safeguarding for any persons resettled out of Muckamore Abbey Hospital from 2008 onwards and to provide any details if you were able. You told us that you reviewed the information available to you, facilitated by the Agency, from 2010 onwards. You weren't able to find any SAIs related to safeguarding for any resettled persons out of Muckamore for 2018 onwards. You make the point that it is important to note that while there may have been SAIs notified which related to someone who had been resettled from the hospital, if there was no reference to resettlement in the initial SAI notification, it would be difficult to determine if an SAI was related to that issue. 12:12 12:12 12:13

Do you know, or can you recall indeed, whether the Agency received any SAIs relating to any person with a learning disability resident in a community setting before or after 2017, regardless of how they got there? 12:13

A. No, I'm sorry, I can't. You know in preparation for this, you know, I did a search around resettlement, so I did, but I haven't done a search around the generalities, sorry. 12:13

123 Q. Right. The next topic then relates to that of commissioning, and at page 21 the question you were

asked was what advice the Agency provided about the commissioning of learning disability services? And at 99 and following you tell us essentially about how commissioning is a process for securing the provision of health and care assessment. The Inquiry has heard a lot about it. 12:14

But focusing on paragraph 101:

"The Department of Health set the strategic context for commissioning of health and social care services through the Commissioning Plan Direction." 12:14

That's at Exhibit 27.

"...and the Indicators of Performance Directions." 12:14

You say that:

"The plan translated the strategic objectives, priorities and standards set by the Department into a range of plans and associated investments for the delivery of high quality and accessible health and social care services." 12:14

If we could open Exhibit 27, please, at page 724? If you could just bring the page down, please? There is a target for Learning Disability discharges from the hospital in this example. It seems to be one of the 12:14

few targets, this target about discharges seems to be one of the few in relation to Learning Disability in the plan. I appreciate it wasn't your responsibility to set the Commissioning Plan, that was the responsibility of the Department, but would you agree that there seems to have been - there is a perception, looking back on it, that the acute care overshadowed Learning Disability needs?

A. I think as a general comment I think that's certainly how Learning Disability, and indeed Mental Health teams, yeah, would have felt.

124 Q. Yes. And what about you personally?

A. Yeah, you know, quite often in a system, don't we, we deal with the emergency or the urgent and it overtakes the important. So I think that's a fair comment to make.

125 Q. Yeah, okay. And at 104 then there's a discussion then about local commissioning groups, which were multidisciplinary, multiagency groups:

"...whose primary role was to ensure that local voices shaped the commissioning plan and the decisions made by the Board."

The Board stipulated the membership -- sorry, the Department, I beg your pardon:

"...stipulated the membership of the local commissioning groups. 17 members to include one

nurse."

Can you help us understand, if you're able to, the extent to which local commissioning groups were able to input on commissioners of Learning Disability Services? 12:17

A. I think central to that role would have been the other partners that were around the table as well as Trust partners, and I think the principle behind local commissioning group is to do just that, to ensure that people have a voice. How effective they are or were I think is probably not for me to comment, suffice to I think they've had several iterations since they were originally created, so I think there have been several different formats of local commissioning groups. They are I suppose subcommittees of the Board. They don't hold a budget, as far as I am aware. They can influence. So at that table would be the local lead commissioner, the person who reports to the Director of Commissioning and, therefore, can influence how things happen. 12:17 12:17 12:18

What I think is important is, and not everybody would agree with me, we also have local, or had local councillors around the table, and I'm not quite sure of the structures now, so I'm not, because local voices are important. And it is how you translate an overarching direction into something that is meaningful and sensitive to local need, and local need will -- need will vary. You know populations vary across 12:18

Northern Ireland in terms of their make up, in terms of age, and deprivation, etc. I suppose what influence they had on commissioning? I would like to think that they had influence on commissioning. The Chairs of those groups attended the Health and Social Care Board meetings and were given opportunity and invited to contribute to those meetings by the Chair of the Health and Social Care Board. So there were mechanisms to try to ensure that that voice was strong.

126 Q. Okay. Just to touch on something that arises from paragraph 105. You included a link to an example of a Commissioning Plan for '15/'16, telling us then of course the Chairs and Chief Executives signed it. 12:19

A. Yeah.

127 Q. I'm not sure about the extent to which you can help us with this, but certainly your view would be helpful if you're able to provide it. Looking at that plan, there's just a point that arises when one looks through it. It required the Trust to develop intensive support services available outside of working hours to reduce the risk of admissions to Muckamore. Do you know how HSCB responded to the fact that that doesn't appear to have been done? 12:19

A. No, personally I wouldn't, you know. My only involvement, and it is not in that direct area, at times -- I remember at times there being an issue with bed capacity. 12:20

128 Q. Yeah.

A. And the Health and Social Care Board, you know advised

by the PHA, would have done its best to help broker collaborative responses to that there, but beyond that I don't know, sorry.

CHAIRPERSON: Could I just understand a bit better?

A. Yeah. 12:20

CHAIRPERSON: I'm going back to the local commissioning groups.

A. Yeah, okay.

CHAIRPERSON: And the PHA influence on those, because you don't have a representative on each. 12:20

A. On the local commissioning groups, yes, I would have had the same nurse that would have been a DRO and would have been part of the --

CHAIRPERSON: Ah! I'm sorry, I had missed that.

A. No, no, you're okay. There were five, and there would 12:20 have been a nurse, an AHP, and a consultant of public health I think allocated. Now the ability to attend all of them wouldn't always have been easy. I think their role as a PHA was to bring the likes of population data to that table so that people better 12:21 understand their local need and, therefore, can respond to it by trying to ensure that services go in to prevent need happening in the first place.

CHAIRPERSON: And those groups would include, I think you said Trusts, representatives from the Trusts? 12:21

A. Yes. Yeah.

CHAIRPERSON: Certainly I think in England there used to be GPS.

A. Yes.

CHAIRPERSON: Quite commonly on these groups.
A. Yeah.
CHAIRPERSON: Is that the position here?
A. That would be the case. And quite commonly GPS would have chaired that group, or pharmacists, pharmacists were also involved in the groups. It was quite a wide expanse of members. And there was, if I recall it correctly, somebody from the voluntary community sector. The challenge with that is you potentially had one person representing all of the voluntary and community sector, and that's probably a bit of an onerous task. 12:21 12:22
DR. MAXWELL: But unlike England, your local commissioning groups don't hold a budget, they are advising the Board who will make the decision. 12:22
A. Yes. Yes.
DR. MAXWELL: Can I just go back to the point that Mr. McEvoy just raised with you, and I appreciate you don't know specifically why the intensive support services that were in the Commissioning Plan weren't enacted, but in principle when reviewing a commissioning intent, if it hasn't been delivered, how would that get discussed at the Board? 12:22
A. That should be picked up through formal performance meetings, which are led by the Board, and would have included PHA representatives. 12:22
DR. MAXWELL: So there would have been a quantum of money associated with this Commissioning Plan?
A. Mmm.

DR. MAXWELL: So if there was a requirement for the Belfast Trust to develop an intensive support service to be available outside normal working hours, and they hadn't done that, would the money have been recouped from the Trust? 12:23

A. That I couldn't answer, so I couldn't. It may have. It may have, with the Commissioner's agreement, been veered into another service that at a point in time was considered more significant. I don't know. Apologies.

DR. MAXWELL: Okay. Thank you. 12:23

129 Q. MR. McEVOY: Okay. And just -- now, I again appreciate that the example of the Commissioning Plan for '15/'16 is exactly that, it's an example.

A. Yeah.

130 Q. But there is one factual query which arises from it. 12:23 Within it we can see a planned additional spend on residential and nursing home care doesn't appear to have been increased at all, given the targets for resettlement?

A. Mm hmm. 12:24

131 Q. Can you throw any light on that?

A. No, I'm sorry, that amount of detail I wouldn't know, and not so far back.

132 Q. All right. Well, look, the next topic then, and we touched on it earlier in evidence, but it really 12:24 relates to the Agency's role in relation to the Ennis Investigation, and that's at the bottom of page 23. You can see there you were asked about whether the Agency was provided with the report and essentially

basically who received it and what was done with it?

Your recollection is that it wasn't sent to the Agency, but there is evidence that in November '19 a document entitled "Synopsis of the Ennis Report" was sent to the Agency through the Acting Director of Nursing, and it was circulated as a paper for the MDAG, the Muckamore Departmental Assurance Group.

A. Mmm.

133 Q. Now we know you weren't there on a day-to-day basis at the time, albeit that you were briefed or given some sort of information? 12:25

A. Yeah.

134 Q. But does it surprise you at this remove now, and knowing presumably what you must do about Ennis and what it was all about, that it didn't feature higher in the Agency's agenda at the time? I mean they knew something of it because you were able to be briefed, but... 12:25

A. Yeah. I'm not even -- I don't know whether it came into the Health and Social Care Board, so I don't. It was clearly a significant piece of work, so it was. The responsibility -- and if I try to think about who is responsible for doing what? I would be more surprised if it didn't go into the Health and Social Care Board. Absolutely the PHA, from a quality safety perspective, could have been appraised of it. The place where action should have been or could have been taken should it have been, at the end of that report it 12:25 12:26

being an SAI or whatever, would have been led then by the Health and Social Care Board. That's probably not a very good answer.

135 Q. No, no. No, no. You weren't there, so we understand that there's a limitation. 12:26

A. Yeah.

136 Q. But I mean if I can orientate you this way. The Inquiry has heard that the Health and Social Care Board asked the Trust in 2013 to report it as, that is the Ennis Safeguarding Investigation, as an SAI, and that 12:26 the Trust declined to do so. What's your reaction to that in the first instance?

A. Well, I think I covered it earlier. My advice is always to report it as an SAI and you can de-escalate. If the Ennis Report was a significant contribution to 12:27 why it was not an SAI, then it wouldn't seem unreasonable that it would be shared at the very least to explain why colleagues felt it wasn't. That's an entirely personal view.

137 Q. As an attendee at the HSCB Board meetings you would 12:27 have expected, would you, the Trusts refusal to do so to be escalated to professional and clinical leaders within your organisation and the Board?

A. As I say I wasn't there, so I don't know whether it was or wasn't escalated. Looking back it was significant 12:27 that it wasn't submitted as an SAI. As I said in my communications with Trusts, both the Belfast Trust and others, where there has been a query as to whether something should be an SAI, I have always found the

Trust to be cooperative and helpful.

138 Q. Question 14 just on down page 24 relates to correspondence which the Inquiry has seen from the RQIA to the Hospital Services Manager which is dated 3rd December 2012 about the Ennis Ward. It is stated that a review of staffing levels at Muckamore Abbey had been requested by Molly Kane, whose name was mentioned earlier this morning, Regional Lead Nurse Consultant at the Agency; you were asked was a review carried out and, if so, to provide details of and any evidence relating to it. You have been unable to locate a copy, you reviewed available information facilitated by the Agency, you can't put your hand to anything? 12:28 12:28

A. No.

139 Q. Notwithstanding that you were on secondment at the time would you have expected, even in your substantive role, would you have expected the Nurse Consultants to inform you of the work that was ongoing? 12:28

A. Yeah, the Nurse Consultants would have reported to the Deputy Director of Nursing who would have advised me if there was anything I needed to know. Knowing the Nurse Consultant concerned, I don't know for sure but I would have assumed and I would be reasonably confident, albeit that I can't find a piece of paper, that Molly would have stayed in regular contact with the Trust on this matter. I think that's exemplified in that, when the briefing I got, I think Molly and her colleague from the Board were out in the Trust very quickly thereafter and it is my understanding that they kept in 12:29 12:29

regular contact with the Trusts providing whatever support they could.

140 Q. Right. So, Ms. Hinds, a final small number of questions then just relate to the exhibits which you have helpfully provided, if we could bring up page 270, please, which is the Regional Choking Review Analysis, you had mentioned this earlier in your evidence. One of the points, I think we can put the points since you mentioned it earlier and you did make the point, one of the points raised in the review was that people with learning disability are at higher risk; did the Board or the Agency receive details of the incidents of choking at Muckamore or other in-patient learning disability facilities, do you recall? 12:30 12:30

A. The Board and Agency would have received through the SAI reports any episodes that were reported as SAIs. The thematic review looked at all adverse incidents plus SAIs and, therefore, would have reviewed the entirety. But on a regular reporting they would not have received anything that was reported as an AI, just SAIs. 12:30 12:31

DR. MAXWELL: But in this thematic review they would have looked at all the incidents, the IR1s on Datix.

A. Yes. Yes.

DR. MAXWELL: So had there been an unusual number of choking incidents at MAH reported through Datix you would have picked it up in this review? 12:31

A. In this review. The point of the review was to say, right, when you add it all together what are the things

that we need to do to make it safer and better.

DR. MAXWELL: If for whatever reason it hadn't been reported at MAH but the patient had been taken to Antrim Area Hospital, it would have been picked up through their incident reporting? 12:31

A. Yes, might have.

CHAIRPERSON: And, sorry, is this a review right across all in-patient facilities?

A. All Trusts in all settings.

CHAIRPERSON: Obviously not in the community, covering in-patient settings? 12:32

A. Nursing homes as well, I think they might have looked at nursing homes as well. Choking is, unfortunately, seems a very small thing but it causes death. Following this there was a hugely significant piece of work led by our allied health profession colleagues in partnership with others to actually improve awareness and training for all staff, that's been quite an extensive piece, and indeed information for families. Because if you're elderly and have dementia you are more prone to choking. That can be quite distressful for families. There are ways in which it can be managed safely to ensure people still have a good quality of life. 12:32 12:32

CHAIRPERSON: Thank you. 12:33

141 Q. MR. McEVOY: The last exhibit is exhibit 21 which begins at 578 and this is the Adult Safeguarding Operational Procedures. Specifically if we could just go to 584, please. If you can bring the page down to

just about half way, please. There is a definition of abuse, it covers physical abuse - and if we could just scroll on down, please - sexual violence and abuse - keep going please, thanks - psychological and emotional abuse, financial abuse and institutional abuse; did the Agency feed into this piece of work and in particular ascertaining a definition of what could be covered by the use of the term abuse? 12:33

A. I apologise, I don't know. I mean I am sure --- the working group that probably pulled this together was probably 2014/'15, because this was published in 2016. I certainly wasn't a member and I don't recall if anybody else was. 12:34

142 Q. Okay. Then if we move down to 611, please, if we can just move down the page, please. Sorry, just move back up, please. There are situations in terms of investigation by the Trust envisaged by this procedure which will also deal with multiple adults in need of protection. The document then also goes on to deal with the strategy where there are multiple agencies and professionals trying to work together; do you know whether these procedures have been reviewed in light of what happened in 2017? 12:34 12:35

A. That, I apologise, I don't know.

143 Q. Okay. 12:35

A. Colleagues probably in the social care team of the Board that could probably help you.

MR. McEVOY: Those are my questions for Ms. Hinds. Thank you very much, Ms. Hinds. The Panel may have

some questions.

CHAIRPERSON: No. Can I thank you very much. We've asked you a number of questions during the course of your evidence. It's been quite technical but you've answered very clearly and helpfully, so could I thank you very much for your evidence. The next witness due for two o'clock is here so we could start a bit early. We'll start at quarter to two, 1:45. Thank you very much indeed. Thank you. 12:35

12:36

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS. 13:35

CHAIRPERSON: Good afternoon. Thank you.

MS. BRIGGS: Afternoon, Panel. The witness this afternoon is Mr. Rodney Morton. The statement reference is 308. I should say at the outset there are some small amendments that the witness wishes to make to his statement, but we'll deal with those at the start of the oral evidence. 13:50

CHAIRPERSON: Okay. Let's get him in.

MR. RODNEY MORTON, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS: 13:51

CHAIRPERSON: Mr. Morton, can I just welcome you to the Inquiry. We've met very briefly this morning, I think.

So thank you for coming along to assist us. I think you know one of my colleagues, Dr. Maxwell.

A. Yes.

CHAIRPERSON: And you mention in your statement that you did a Post Graduate Certificate in Leadership in Healthcare in 2019 at London South Bank, and I think that was taught by Dr. Maxwell? 13:51

A. That's correct.

CHAIRPERSON: And you've had professional dealings with her since? 13:51

A. Indeed, I have, yes.

CHAIRPERSON: Okay. That's fine. Thank you very much indeed. Okay.

144 Q. MS. BRIGGS: Mr. Morton, good afternoon.

A. Afternoon. 13:51

145 Q. As you know, I'm going to be asking you questions about the statement you have submitted to the Inquiry and the reference is 308.

A. Yes.

146 Q. Your statement is dated 31st May 2024, and it's 49 pages long. It's then followed by 63 exhibits. Before I ask you to adopt that statement as the basis of your evidence, I understand that there are some amendments you would like to make to that statement? 13:52

A. That's correct. 13:52

147 Q. And I understand that the first of those is at paragraph 19 on page 9?

A. Yeah.

148 Q. We've got that on the screen there in front of you.

A. Yeah.

149 Q. Can you outline what it is you'd like to change about that paragraph?

A. Yeah. I'd just like to change the numbers. Where it says "paragraph 13", it should have read paragraph 25, and where it says "paragraph 15", it should read paragraph 31. 13:52

150 Q. So that's the last sentence of that paragraph?

A. That paragraph, yeah

CHAIRPERSON: Sorry, 13 should be 25? And where does it mention 15? Oh, yes, sorry. 13:53

151 Q. MS. BRIGGS: Then if we move on to paragraph 21 over the page on page 10. I understand that the subsection (a), 21(a) on page 10, the last sentence of that subparagraph, you also wish to change that "paragraph 13" to a different number; isn't that right? 13:53

A. To paragraph 23.

CHAIRPERSON: Yes.

152 Q. MS. BRIGGS: Then, finally, there are changes to be made to page 25, I understand, Mr. Morton? 13:54

A. Yes.

153 Q. And the first of those really relates to paragraphs 56 and 57 as they're currently numbered?

A. That's correct. So 56 and 57 should fall under Question 5. 13:54

CHAIRPERSON: Oh, I see.

154 Q. MS. BRIGGS: So those answers at 56 and 57 relate to the answer at Question 5 then?

A. Correct.

CHAIRPERSON: And Question 6 starts at 58?

155 Q. MS. BRIGGS: Well, I understand Mr. Morton, that there's a paragraph to be inserted now as 57A as the first paragraph in answer to Question 6; is that right?

A. That's correct. 13:54

CHAIRPERSON: Oh, I see. Okay.

156 Q. MS. BRIGGS: Can you outline or can you read out loud what it is that you're proposing to insert as paragraph 57A?

A. I'd like to insert: 13:54

"The PHA and my team would not ordinarily have responsibility for identifying the educational and/or training requirements of HSC Trusts. Since Belfast Trust was in charge of running and managing Muckamore 13:55
Abbey, it would have been their responsibility to determine their staff's educational and training needs."

CHAIRPERSON: All right. I think the best that we can 13:55
insert is "see transcript".

MS. BRIGGS: Yes, at this juncture I think so, Chair. We'll have to deal with that in due course.

CHAIRPERSON: Okay. Thank you.

157 Q. MS. BRIGGS: Mr. Morton, then with those amendments 13:55
made, so to speak, do you wish to adopt the contents of your statement and its exhibits as the basis of your evidence to the Inquiry?

A. Yes, I do.

158 Q. I've already explained to you when I met you earlier that your statement is very long and detailed and it answers questions put to you by the Inquiry, and I've explained that we certainly today won't go to every answer that you've given the Inquiry, because that stands now as your evidence. 13:55

A. Yes.

159 Q. And we've already heard from Ms. Hinds this morning, your predecessor. But there are some issues that I am going to go to today and you can assist the Inquiry with arising out of your statement. 13:56

So by way of background, Mr. Morton, your statement tells us that you were the Executive Director of Nursing, Midwifery and Allied Health Professions in the PHA from January 2020 until September 2022; is that right? 13:56

A. That's correct.

160 Q. And you start your statement, before you tell us even about your role, with an apology, and I just want to read that into the record at this point and give you an opportunity to expand upon that apology, if you want to? 13:56

A. Yes.

161 Q. Paragraph 4 then on page 2 you say this, you say: 13:56

"I would like to take this opportunity as a nurse to express my profound apologies to all those citizens and their families who have been impacted by the events at

MAH. As a nursing family, we did not protect you in the way that we should have. It is my sincere hope that the measures we have, and are, putting in place will prevent any reoccurrence and safeguard the most vulnerable in our society."

Is there anything, Mr. Morton, you'd like to add to that?

A. The context of this particular paragraph obviously is based on my knowledge of the events that unfolded out of Muckamore Abbey Hospital, and as a Registered Nurse our duty is to show people compassion, to protect them and to advocate for them. And when I read several of the reports, which are clearly very distressing, we did not live up to that obligation as a nursing family, and I felt it was important as a Registrant to acknowledge the pain and stress for many of those citizens and indeed for their families. 13:57 13:57

162 Q. All right. You go on in your statement to describe your role and responsibilities, and there are a couple of things that you raise in there that I'm going to ask you about. If we can go up to paragraph 6(c) on page 3, you're describing in that paragraph the PHA's establishment in 2009, and you also describe its role in providing input into the design and commissioning of services. Does the PHA also provide professional and clinical input into the monitoring of commission services? 13:57 13:58

A. So as part of the responsibilities of the Public Health

Agency, and particularly for Nurse Consultants who work in under my leadership in the Public Health Agency, they were part of commissioning teams. And so as part of commissioning teams they had responsibility for understanding the needs of the population for which they were commissioning services, for the development and design of services, and to support the performance management arrangements which was led by the Health and Social Care Board.

163 Q. Okay. At paragraph 6 (f) on page 4 then, you say there: 13:58 13:59

"My role and that of my team of nursing, midwifery, and the AHP consultants in the PHA was to provide professional nursing, midwifery and AHP leadership within and across programmes of care regionally."

Thinking about Muckamore Abbey Hospital specifically, were your team available to provide professional advice to nurses at Muckamore? 13:59 13:59

A. Not directly. But as part of their role they would have engaged with the service leads, service managers, for services in terms of learning disability and with Belfast Trust who had responsibility for Muckamore Abbey Hospital. So in that context there would have been an exchange of perspectives, views, and would have been involved in that context. I am aware that Nurse Consultants in my team, and previously, would have visited Muckamore Abbey Hospital on many, many

occasions, but would have done so with the representatives of Belfast Trust who had responsibility for those services.

164 Q. Okay. In your statement, Mr. Morton, you describe the importance of the Nursing and Midwifery Task Group Report? 14:00

A. Yes.

165 Q. Yes, or the NMTG for short, which you exhibit to your statement at Exhibit 4, and in particular you describe how that report and the reforms it envisaged were fundamental to your role really. You say this at paragraph 11, this is on page 7: 14:00

"The report incorporated much of the knowledge learned from care failures, and the recommendations were built on the best available evidence." 14:00

Did the report draw on learning from care failures in Learning Disability specifically?

A. So what I can say in relation to that particular paragraph, when this report was being drafted it took account of the learning that had emerged, for example out of the Hyponatraemia Inquiry, it took account of the learning that had emerged out of the investigation into Dunmurry. It also took account of the learning that had emerged out of the "Way to Go", and particularly drawing on the rapid review that my colleague Mary Hinds, the previous director, undertook on behalf of the CNO. So it reflected that range of 14:01 14:01

learning, but also more generalised knowledge around the issues that were facing nursing around safety and quality.

166 Q. Okay. The Inquiry asked you about the role of the PHA and more specifically Nurse Consultants in the investigation of SAIs? 14:01

A. Yes.

167 Q. And your answer starts at page 9. And Nurse Consultants, we've heard about this this morning, they can take the role of DRO in SAIs; isn't that right? 14:02

A. That's correct.

168 Q. Were clinical SAIs always assigned a DRO from the PHA?

A. So the mechanism for assigning a DRO, when an SAI report was notified to the Health and Social Care Board, the Health and Social Care Board have a 14:02 governance and quality team who oversee and coordinate the SAI processes. So they would have had a list of DROs, and they would have allocated, depending on the theme of that SAI, they would have allocated that to a specific DRO. 14:02

DR. MAXWELL: So could that mean that potentially you could have somebody with either no clinical background or not the relevant clinical background being the DRO for an SAI?

A. So in my statement I've indicated that in the vast 14:03 majority of circumstances the DRO would have usually had experience in the service area that it would have been allocated to. So, for example, Mental Health and Learning Disability, the DRO often came from those

backgrounds or had experience of the services in those backgrounds. But you'll appreciate because of the breadth and depth of SAIs that that may not have always been possible. But there was provision within the SAI policy that where someone did not have the appropriate levels of expertise they could, on request, seek additional professional support and advice whilst overseeing that SAI.

DR. MAXWELL: Thank you.

169 Q. MS. BRIGGS: At paragraph 21 on page 10, you refer to the SAI procedure and the 2010 circular, and you explain that those documents detail the respective roles of the HSCB, PHA, HSC Trusts and RQIA. You say that: 14:03

"While the HSCB had the lead role in the governance and administration of the SAI procedure..." 14:04

- that the PHA shared responsibilities with the HSCB in certain matters, and you go on to describe what they are. Whose responsibility was it to ensure that the various organisations who had roles in SAIs, and their staff and management, knew the respective roles of the organisations? 14:04

A. So as detailed in the circular and in the subsequent policy that underpinned that circular, and here I'm referencing the 2016 guidance, the various roles of each organisation is outlined. So that was a common Northern Ireland-wide document. So Health and Social 14:04

Care Trusts, RQIA, the Board - the Health and Social Care Board, I should say - and the Agency, all of their respective roles is detailed in that, including reporting arrangements to the Department of Health.

170 Q. Was there any confusion that you found within those organisations as to what their respective roles were? 14:05

A. I am not aware of any particular confusion about those roles. I think by the time I arrived in the Public Health Agency, there was a deep understanding of the SAI policy and procedure and how that worked out across respective organisations. 14:05

171 Q. You go on to describe the responsibilities that the PHA have together with the Board in SAIs, and at paragraph 21(b), this is on page 10, you say that one of the roles of the PHA was that: 14:06

"Upon submission of the completed SAI report to the HSCB by the reporting organisation, DROs scrutinise the findings to ensure the adequacy of the review and to identify any regional learning." 14:06

Do the DROs assess the quality of the SAI audit or the investigation report?

A. So I think my short answer to that is, yes, the role of a DRO is to determine that the SAI report that's been received matches the Terms of Reference that had been previously agreed. So before -- just to explain by way of context. Before an SAI is commenced in an organisation, there is a set of Terms of Reference 14:06

which govern that particular SAI, and it is in that context that the DRO would be part of signing off those Terms of Reference, or at least being satisfied. So it would be -- the report would be measured against those particular Terms of Reference by the DRO, and they would also check that any learning that is identified -- I think I referenced this in my statement -- that any learning matched -- any recommendation, sorry, matched the learning and the findings, and if they weren't satisfied they would have gone back to the respective organisation to resolve those matters.

DR. MAXWELL: That relates to the Level 3 SAIs.

A. That's right.

DR. MAXWELL: What role would they have in overseeing whether the Serious Event Audit or the Level 2 review was adequate?

A. So just on the Level 2, they would have applied the same rigour as to Level 3. In relation to Level 1 and the Significant Event Audit reports, the Public Health Agency, or if it was the Health and Social Care Board Officer, would have read that report. And it was in that context that if they weren't satisfied they could have gone back to the respective organisations. Mary Hinds referred to that this morning.

There was some opportunity in that context, that if they remained dissatisfied, that it would be escalated, and on occasions, but a very few occasions, that particular SAI might have been upgraded to a Level 2 or

a Level 3, depending on the findings of that report.

DR. MAXWELL: Okay.

172 Q. MS. BRIGGS: And thinking about that subparagraph. In terms of the PHA's role in identifying, formulating, and disseminating regional learning, and we've heard a bit about this this morning, how is that put into effect on a practical level? 14:08

A. So maybe what I'll do is just by way of context. So the report comes in, the DRO will review that report, covering off all the things that I have just said a few moments ago. But you'll notice later on in my evidence I talk about a professional group. And what we began to do a little bit more was to ensure that the findings of the SAI review was also shared with the multidisciplinary group. The reason for that, of course, was to make sure that we had a broader and more deeper perspective of the learning. So once the learning had been identified and agreed upon, under Mary's leadership it would have gone to SQAT, under my leadership it would have come to the weekly safety brief, and that weekly safety brief would have been, if you like, almost a third level of assurance ensuring that the learning that had been identified fitted with the context of the SAI. Then what would have happened, a learning letter would have been produced, would have been issued to health and social care organisations across the region, we would have got a response, that again would have been scrutinised by a multidisciplinary team to be satisfied that the 14:08 14:09 14:09 14:09

response from the organisation matched the requirements of the learning letter, and if we were satisfied, then that would have been closed off as a completed SAI.

173 Q. Okay. In the next paragraph, that's paragraph 22, you refer there to when you took up your role that there was an ever increasing backlog of SAIs. Can you tell the Inquiry a bit more about that backlog and how it arose? 14:10

A. So when I arrived in the Public Health Agency, and again you'll note from my statement, I did so at the time of the pandemic. And what was emerging as I became familiar with the internal arrangements within the Public Health Agency and the Board, it was clear that Trusts were grappling with being able to complete SAI reports on time, and they had generated a significant backlog across a number of areas. So obviously when you get that information you're concerned. Historically what had happened was the Chief Executive of the organisation would have written to the Chief Executive of Trusts asking him to make improvements, and later on in my evidence I detail some of the respective actions that we took. But principally, and in summary, why did that -- I think there was something about the increased complexity of the SAIs that required more independent panels, and we had a very small cohort of chairs who would, who were either willing or able to undertake the chairing of those more complex SAIs. 14:10 14:11 14:11 14:11

Obviously the pandemic didn't help and indeed added to the backlog as we went through 2020 and 2021.

PROFESSOR MURPHY: So if you're saying that you had more SAIs requiring independent review, does that mean you were getting more Level 3 SAIs? 14:12

A. I would need to go and check the data to be factual about that, but when we started to seek to understand why Trusts were generating these backlogs, one of the things that they told us during that process was that they were struggling to identify independent Chairs for 14:12 Level 3 SAIs. Small -- again it's been referenced early this morning by Mary, Northern Ireland is a small place, and indeed many families would have said they used to query and continue to query sometimes independence of the panel members. 14:12

PROFESSOR MURPHY: Yes.

A. And so it was not uncommon for us to go outside of Northern Ireland to seek independent panel members. So that naturally generates a delay in undertaking the appropriate SAI investigation. That issue around 14:13 independent Chairs also related to independent panel members, because sometimes an SAI, given its complexity, just required the entire panel to be independent.

PROFESSOR MURPHY: But it wasn't your impression that 14:13 proportionately you were getting more Level 3s?

A. I don't think so. I don't have that information with me today to give you a factual answer on that. I don't think so. In fact the bulk of SAIs that were somewhat

backlogs largely in Level 1, and I think Exhibit 9 of mine sort of details some information around what that backlog looked like and across what programmes of care.

PROFESSOR MURPHY: Okay. Thank you.

174 Q. MS. BRIGGS: At paragraph 23 you describe what was done as a result of the backlog, I think, in terms of strengthening the SAI procedures. Is that fair to say? 14:13

A. That's fair to say, yeah.

175 Q. And you detail what those are. I'm not going to go through each and every one of them. They're there for everyone to read online. But did the actions that were taken clear the backlog of SAIs? 14:14

A. The short answer to that is "no". But maybe I could contextualise some of the improvements? So whilst I reference the backlog, some of the changes that we made was in response to the pandemic. So you'll have noted that QSE, Quality Safety Experience Committee, and other committees, were stood down during the pandemic. So in order not to lose sight of the SAI process, I, and my colleagues, we introduced a number of additional measures to make sure we remained close to those. Previously when an SAI came in to the Health and Social Care Board it would have been distributed to a large distribution list, so we put in an additional measure that when SAIs came in, particularly during the pandemic, that they be scrutinised by a clinician. So we set up a system of daily triage, and that was to identify any specific issue that might need to be escalated as per the notification. We further enhanced 14:14 14:14 14:15

that obviously through the development of a weekly incident team meeting, which I detailed in my evidence.

176 Q. Okay. I am going to look at some of the actions that were taken now. The one I want to look at is 23D, it's page 14. This action that was taken was reconfiguring and strengthening SAI professional groups. I think you've touched on this earlier as well. You refer to SAIs having been previously overviewed by a single profession and the change was to have them reviewed by a multiprofessional group; why was that change deemed necessary? 14:15 14:16

A. So obviously when I took up my post in the Public Health Agency I sought to understand the internal mechanisms, and having understood those internal mechanisms, when an SAI came in it was allocated to DRO and then the DRO commenced the role in line with the procedures that have been outlined. But they didn't -- they could act fairly autonomously in terms of managing that particular SAI, and there wasn't always cross referencing with another discipline. So from my perspective when I came in, and obviously in discussion with others, I really wanted to endorse a more multiprofessional perspective from the very outset so there were a number of different people looking at an SAI. I felt that was supportive to the individual DRO. I also thought it was particularly important, particularly in terms of learning. I should say there was always provision for multiprofessional groups, but when I came in, just needed to do a bit more work to 14:16 14:16 14:16

strengthen their function and their role, and you'll see the Terms of Reference for those particular groups included in my exhibits. So the effort was really to support to DROs, and to support learning, and to bring a bit more rigour to that process. 14:17

177 Q. The other action you refer to, it's down at the bottom of this page 14, is the establishment of the bi-monthly Trust HSCB/PHA Quality and Safety Performance meetings, and you say there that: 14:17

"To improve HSC Trust performance in managing their SAIs, the PHA Quality and Safety Teams and the HSCB Governance Team formally established monthly performance improvement meetings with the HSC Trusts. The purpose of these meetings was to scrutinise HSC Trust's SAI improvement plans. These meetings were also used to ensure that HSC Trusts were also keeping their respective boards up to date with their compliance with SAI policy and procedures, including notifying them of any non-compliance." 14:17 14:18

Is this perhaps the type of work that RQIA might have been doing or at least been interested in? Was there any link-up with RQIA?

A. I certainly think probably RQIA would be interested in that. But perhaps I should explain the context? So earlier you asked me about the backlog, and I indicated that ordinarily when a Trust was not delivering SAIs in line with the guidance, the Chief Executive of the 14:18

Health and Social Care Board would have written to the Chief Executive of Trusts and asked for an improvement, and sometimes improvement was made. But in this context, whilst that letter did happen, I and my colleagues decided that actually what we needed to do was to talk to Trusts on a frequent basis in order to support and better understand their backlog and the actions that we were taking and, if you like, we were attempting to hold them more to account, but also to be supportive. So, for example, in this particular context we provided additional support to Trusts. So, for example, when they were struggling through the pandemic they had difficulties getting people to undertake their SAIs, so we went to the HSC Leadership Centre and we were able to call up their associate list and use those associates, obviously aligning with Trusts, to be able to support their work around SAIs. So that's the context of the establishment of those monthly meetings, which then became bi-monthly, and you'll see later in my evidence when I talk about the Leadership and Governance Review, specifically around checking that Trusts had fulfilled their obligations to make sure that their own Boards were informed of any breaches of the policy as it relates to SAIs.

14:18 14:19 14:19 14:19

178 Q. But what about RQIA? I mean is this something that really they should have been doing or interested in?

14:20

A. I think this sat within the responsibility of the Health and Social Care Board and the Public Health Agency, it was within our remit, particularly around

the management of SAIs. I think that's where it rightly sat.

179 Q. Okay. Did you consider speaking perhaps to CQC in England who have systems to analyse that type of data?

A. So the short answer to that is I didn't speak to CQC, but again you'll see later in my evidence where I allude to the development of a Safety Framework for Northern Ireland, and what sat behind that was a deeper desire to develop a more data-driven understanding of serious adverse incidents in Northern Ireland amongst other intelligence that perhaps existed within the system, so that we could be much better at detecting things at an earlier point and an earlier stage. 14:20 14:21

CHAIRPERSON: But there are sort of -- did you look internationally at all at other systems that are adopted in healthcare to analyse data? 14:21

A. So in the preparation for the work that's included in my exhibits around the safety brief, we looked at Scotland, we looked at Wales, we looked at what was going on in England, and also with our colleagues in the Republic of Ireland, and we identified some common features which then subsequently got recommended within our proposal around the Safety Framework, but internationally, no. 14:21

CHAIRPERSON: Thank you. 14:21

180 Q. MS. BRIGGS: At 23F then another action that was taken. That paragraph describes, amongst other things, the thought that went into creating a dashboard to enable the triangulation of data, and that's described in

detail in the paragraph. Is there now a single dashboard showing SAIs, safety and quality alerts, RQIA reports, complaints, NICE Guidelines, patient outcomes and deaths?

A. The short answer to that is, no, there's not, that I'm aware of, at this point in time. Just to explain the context. The reason that this is here is that when I took up my post I realised that we had sight of SAI data, we did not have sight of AI data. We did have data around complaints. We had data around citizen experience. We also had in another part of the system information coming back in, for example, around NICE guidelines, actions being taken around RQIA, but we did not have a place for those to be triangulated in data form. As you heard from Mary Hinds earlier today, those issues would have been discussed at QSE. 14:22 14:22 14:22

Where I was coming from here was seeking to try to nudge the system towards creating a dashboard that wasn't during the event but was proactively analysing that data in a way that would give people like me and others better information about the safety and quality of services in Northern Ireland, and you'll see in the exhibit that we recommended the development of a safety surveillance system, which in this case would have been a dashboard. 14:23 14:23

181 Q. And that dashboard hasn't been able to have been brought in at this stage?

A. As far as I'm aware, whilst there is still work going

on, I am not aware yet that Northern Ireland has a safety dashboard of the type that is described in my evidence today.

182 Q. Okay.

CHAIRPERSON: But can I just understand: Are you talking about the use of AI and a computer based dashboard? Something that analyses the information coming in, coding from hospitals, outcomes, benchmarks, is that sort of what you're describing? 14:23

A. Yeah. I mean at the time of this particular recommendation, what I was seeking to do was at least try and pull together the information we did have and to have it formatted in a way that would provide at least the level of intelligence. But you're absolutely right, where we are today we absolutely should be using, in my view, AI, to support analysis and to support critical decision making. 14:24

DR. MAXWELL: But when you're referring to "AI" at the time you meant adverse events, the IR1 reports.

A. So, sorry, I apologise. When you talked about AI, I thought you meant -- 14:24

DR. MAXWELL: I think you're perhaps both talking about different things.

A. We are.

DR. MAXWELL: So that's what I was trying to clarify. 14:24

A. I mean in the Public Health Agency and in the Health and Social Care Board we don't get adverse incident data, or AI data, we don't get it. It is recorded in Datix. So there is, there is a potential opportunity

for that AI, that adverse incident data to be analysed.

CHAIRPERSON: Exactly, yes.

A. It is just not -- in the Health and Social Care Board we just did not have access to it. Trust did. So you heard Mary describe how she undertook thematic analysis. What we had to do in that situation was go to Trusts and ask them for their AI data. We did not have automatic -- automatically have access to that. Do I support that? Yes, I do. I think that AI data is critical in understanding part of the picture around safety and quality. 14:25 14:25

CHAIRPERSON: But what is critical is what you then do with it? I mean, you know, it's one thing getting the data and then it is how it is analysed and how quickly your dashboard reacts to something going wrong somewhere in the system? 14:25

A. Yes. So the motivation of course behind this was really to support a more data driven understanding of safety and quality in Northern Ireland so we could triangulate different pieces of information in order to be proactive and address either emerging safety or quality issues or to learn from them. 14:26

CHAIRPERSON: But the reality is you haven't got to that point.

A. Not got to that point as far as I'm aware. 14:26

CHAIRPERSON: And you would need funding.

A. This would definitely need funding. There is, in previous iterations of the papers that you have before you, there was an attempt to consider this, I think

back around 2015/2016, it was called the "Real Project", and the idea was really again to try to triangulate it, but I think resources were an issue at that time. And so although I am not -- I wasn't resurrecting that proposal, what I was attempting to do with my team is to say, look, we need to have a better way of having data that's easier to consume, easier to identify particular critical issues so that we can be more proactive in responding to issues of concern.

PROFESSOR MURPHY: And wouldn't you need some other kinds of data as well as things like adverse incidents and SAIs? Wouldn't you also need, if you were really going to predict things, things like nursing turnover, percentage of agency staff, those kinds of things, because they may well predict a worsening quality of services?

A. Yeah.

PROFESSOR MURPHY: And presumably you didn't have that kind of data?

A. No. So in the context of my paragraph...

PROFESSOR MURPHY: F.

A. I've got many numbers here, just bear with me. 23F. It didn't -- at that stage it did not have visibility of workforce data, that is not to say, of course, that couldn't be a critical feature. Later on I'm sure I'll comment about critical findings within the nursing -- the task group report and our desire to develop a robust Nursing Assurance Framework, of which workforce data was seen as a critical dimension.

PROFESSOR MURPHY: Thank you.

183 Q. MS. BRIGGS: I'm going to move on to the second question you were asked, and it is really the post investigation role of PHA Nurse Consultants in SAIs, and this is at page 18. And you've described, and we've already touched on it, the DRO's role in ensuring learning is taken from SAIs. Was there any checking as to whether the learning letters were effective in producing change in the Trust? 14:28

A. So I think earlier I described that when a learning letter was issued we got a response back from individual Trusts. We had in the Public Health Agency, and in the Health and Social Care Board, a process where we would have scrutinised that, and we would have had an exchange with Trusts about perhaps some of the responses that they give, and we would not have signed off or closed off until we were satisfied that the evidence presented by the Trust to us met the requirements of the learning letter. However, did we go and check and validate that information with Trusts? We didn't have a role in that regard. That probably would be something that RQIA would certainly have a role in. 14:28 14:29

DR. MAXWELL: So were you checking processes or outcomes? Because normally in any part of the UK something adverse happens, people inspect, they make representations and people produce action plans which are processes, 'We will put in place this process', but they're not usually about 'And this is how we'll 14:29

measure whether the process was effective'.
A. Yeah. We did not -- if you're asking did we go out and check what Trusts had actually said? We didn't, the Public Health Agency or indeed the Health and Social Care Board, we wouldn't have done that type of audit with Trusts. We did seek assurances, we did interact with Trusts on the content of their improvement plan. We did check that -- we asked them on occasions, depending on the level, and Mary described that earlier, to sometimes give us evidence, documentary evidence that they had implemented it. So we absolutely did do that. But did we check in the longer term whether they were achieving the outcomes associated with that learning? I think the answer to that would probably be no. 14:30
DR. MAXWELL: Yeah, because most action plans, the number one thing is 'We'll send people for training'.
A. Yeah.
DR. MAXWELL: And there's very little evidence that training changes practice. 14:30
A. Yeah.
DR. MAXWELL: Did you ask them to demonstrate to you, even if they didn't give you data, how they would know that their action would have the desired effect?
A. So did we check did the action have the desired effect with Trusts? 14:30
DR. MAXWELL: Well did the Trusts -- were the Trusts going to measure whether the action had --
A. Yeah. So I think some of the action plans would have

included that on some of the evidence they would have generated. But just picking up your theme around training. So if there was training involved, they might have told us how many people were trained, and they would have provided evidence of that. Did we then check was that training subsequently effective? I think the answer to that is probably no.

DR. MAXWELL: Okay.

CHAIRPERSON: And is it right that most AI information that you would receive would be as a result of a patient incident?

A. So in the Public Health Agency and the Health and Social Care Board, we did not receive any adverse incident data whatsoever, unless we were doing a thematic review. We only received SAI data for Level 1, 2 and 3.

CHAIRPERSON: But, again, the SAI would normally be a patient?

A. It would always be related to a patient or an incident that may be related to a carer or someone who was availing of health and social care services in Northern Ireland.

CHAIRPERSON: Sure. But the sort of information that Professor Murphy has been talking about, so an over-preponderance of agency staff, actually wouldn't come into that at all, would it?

A. There may have been some SAIs that related to service and service failures, but usually that would have been expressed in the form of harm that occurred.

CHAIRPERSON: To a patient.
A. To a patient.
CHAIRPERSON: Yeah.
A. Yeah. I'm thinking of a number of occasions where, you know, a service might not be able to be delivered. That certainly would have been notified and there would have been actions taken by the Board and Agency to try to mitigate the impact of that.
DR. MAXWELL: Would you have expected -- if an admissions ward had had to close to admissions, would you expect that to have been reported in SAI?
A. It wasn't. That would not ordinarily have been reported as an SAI, simply because -- unless harm had been indicated in that closure.
DR. MAXWELL: So we have heard evidence that at a point in time the co-director in Belfast actually wrote to the HSCB to say that Cranfield admissions ward, which is the only admissions ward for people with mental health problems and LD in Northern Ireland, would not be able to take any more patients. So that's very high risk, and yet you're saying that wouldn't be an SAI?
A. I don't recall anything like that in my time being reported as an SAI. But I accept the serious implications of a ward closure and the implications that that has on people. It's my understanding that when those ward closures were happening there would have been a continuous dialogue between the Trust and the commissioning team, and that would have been -- it would have been planned in that context.

DR. MAXWELL: Well, it wasn't planned. What we heard was they just -- it was that the beds were all full, there weren't enough staff. It wasn't a planned closure, it was a crisis.

A. Yeah. 14:34

DR. MAXWELL: And you're saying that you wouldn't expect that to come up through an SAI, so how would it have got escalated through the system?

A. So that would have got escalated through the Early Alert process. So if there was a critical or 14:34 significant issue like that, it would have come in as an Early Alert particularly notified to the Department of Health. So -- and there's a specific criteria for that. What I can't answer for you today is: did we have, was that type of event reported as an SAI? 14:35 I don't know that, unfortunately.

DR. MAXWELL: Okay. So that would go through an Early Alert to the Department of Health, which is a completely different system from the SAI system you're discussing now? 14:35

A. Yeah. Yeah.

CHAIRPERSON: And --

A. Although we -- although the Board and the Agency would have been also copied in to those Early Alerts. So the Board and the Agency would have been aware of Early 14:35 Alerts that came in and would have responded to those. I do recall certainly in my time, and I know from talking to other colleagues, that where there was an issue with service continuity, service consistency,

there would have always been a very significant engagement between the Trust, and the Board or Agency staff, depending on that issue. So it wasn't that it wasn't addressed -- it wasn't that it was not addressed, it was addressed through a -- 14:35

DR. MAXWELL: Different --

A. Discussions. Yes.

CHAIRPERSON: And that would be the same, would it, if an accident and emergency had to close its doors at an acute hospital, that wouldn't produce an SAI? 14:36

A. So I think probably what would have happened in that situation, if there was, you know, if there was an incident like that it would have been managed as an incident and it would have been addressed and obviously very serious action taken in order to mitigate the 14:36 impact of that. Whether it would have got reported as an SAI I think would depend on the extent to which harm would occur and to what extent that was measured against the SAI criteria.

CHAIRPERSON: I suppose what I'm getting at is, would 14:36 mental health services be different, or be treated differently -- closing a ward on a mental health service, would it be treated differently to closing accident and emergency in a major hospital?

A. Personally I don't think it would. Personally I don't 14:36 think it should be. I don't have any specific, from my role in Northern Ireland I have no specific evidence that would suggest that Mental Health and Learning Disability would have been treated differently. In

that particular context I think it would have been taken very seriously by the commissioning team that had responsibility for that particular service area, and would have been discussed at various levels within the organisations.

CHAIRPERSON: Thank you.

184 Q. MS. BRIGGS: Just before we move on from the role of Nurse Consultants post investigation, if an SAI audit or investigation revealed issues that couldn't be addressed in the short term, would the DRO remain with oversight until those matters were resolved? 14:37

A. I think the DRO would have kept the case open until they were satisfied that all of the learning that had been identified had been applied and that evidence had been provided that the action was taken, and the DRO would have done that in the context of both the professional groups, but also the oversight that was provided by the safety quality alerts teams. 14:38

185 Q. If we can go on to paragraph 38 on page 20, here you're describing MDAG, and the MDAG HSC action plan, and you refer to MDAG being the primary mechanism to drive improvement and that it was established to monitor the effectiveness of the HSC systems actions in response to the "Way to Go" SAI report and the Leadership and Governance Review. Is that a fair way of summarising what you say? 14:38

A. Yes. Yeah.

186 Q. So was MDAG in a way acting as a DRO?

A. No. So in the context of the role of DROs, what I was

trying to indicate by this particular paragraph is that beyond the initial learning and the application of that learning, sometimes there were issues identified that required ongoing work, for example, the development of a new service model. So what I was trying to signal by this paragraph is that having reflected on the "Way to Go", having reflected on the learning that came out of that, there was a clear recognition that work needed to be done, in this case on a Northern Ireland-wide service model. But in this particular context, because of both the seriousness of the issues that surrounded Muckamore Abbey and a range of other recommendations and report, the Department took a lead role in providing oversight and holding the Board and Agency and other organisations to account for the delivery against that improvement plan. 14:39 14:39 14:39

187 Q. And it's a big --

A. That action plan, sorry.

188 Q. I am sorry, Mr. Morton. It's a big question, but how did MDAG relate to other parts of the governance system? 14:39

A. So I think in my statement I do allude to the fact that under MDAG, the Health and Social Care Board in particular had responsibility for the development, for example, of a service model. That was within their, completely within their span of accountability and responsibility. But I guess because of the seriousness of the issues that emerged out of Muckamore Abbey, the Department wanted a direct line of sight on the actions 14:40

that were being taken in order to assure themselves that the actions were starting to deliver improvements.

DR. MAXWELL: How did it relate to other things that were happening? So there seemed to be multiple committees and agencies trying to do something about Muckamore because the allegations were so horrific. I understand the Department of Health wanted an oversight, but we have heard that there were a group of people looking at the historic CCTV and changing the policy on safeguarding without any reference to the policy approvals mechanisms within Belfast Trust; you've got the Trust Board of Belfast, who were presumably ultimately responsible for the delivery; you've got safeguarding committees reporting right up to the chief social worker, how was governance joined up from the managers in Muckamore Abbey through the different agencies to the Department of Health? Did they all -- were they all supposed to funnel through MDAG? 14:40 14:41 14:41

A. Yeah. So my recollection and understanding is that when MDAG was set up it was an attempt to address the very issues that you have described, which is to bring together all of the various actions of the agency. So, you know, when you read the various agendas and the minutes of MDAG, all of the issues that you've just described were covered off there. So MDAG became the place for the Department to hold the various parts of the system to account for the various actions that needed to be taken, including those at Belfast Trust. 14:41 14:42

DR. MAXWELL: So was MDAG an oversight group or was it taking the responsibility away from Belfast Trust in making decisions about care?

A. It wasn't taking the decisions away from Belfast Trust because they had responsibility as an organisation in their own right to ensure safe and effective care, but what it was seeking to do, in terms of the various actions that were required, based on "Way to Go", based on leadership and governance and others, i.e. from RQIA, that there was a coordinated effort across all of the organisations to deliver the sorts of change that was expected. 14:42 14:42

DR. MAXWELL: So everything that MDAG had made recommendations for, Belfast Trust Board were responsible for implementing. 14:43

A. They were, yeah. They were. And also the Health and Social Care Board, because there were actions subscribed to the Health and Social Care Board.

DR. MAXWELL: Yes.

A. So we in the Health and Social Care Board and the PHA, we had our responsibility also to deliver those improvements that were outlined in the MDAG action plan, for which we were held to account obviously through the MDAG process. 14:43

DR. MAXWELL: Thank you. 14:43

189 Q. MS. BRIGGS: I'd like now to go to the MDAG action plan, it's Exhibit 26, and starts on page 594, if we can just show that on the screen, first of all. That's the covering page of the action plan. If we can then

go on to page 603, the action plan, and the Panel will be familiar with it, it sets out really a range of actions, and one of those is R5 there that I'd like to ask you about. R5 says:

"There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital."

And over in the fourth column there it says that by 30th June 2020, there should be a review of access and availability of meaningful activity in Muckamore and elsewhere:

14:44

"...including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices." 14:44

That review of day activities, and the review of activities in general, was that carried out?

A. I can't answer that question for you today because I just can't recall. I didn't look at that particular 14:45 area ahead of today's Inquiry. But we could very easily find that out.

190 Q. Okay. All right. And there is one other matter in the action plan that I am going to ask you about, and the

answer may well be the same, but just for completeness I'm going to ask the question anyway. It's page 612 and into page 613. That's a recommendation for the redraft of the community based assessment and treatment document. Are you aware as to whether that's been carried out? 14:45

A. Just give me a few moments to go through it.

191 Q. Take your time please, Mr. Morton. It's really the blue text. It goes on to the next page as well.

A. Again, I'm unable to answer that question. I don't know what the current status of that piece of work is. 14:46

192 Q. All right. I'm going to go back then to the main body of your statement at page 21, and you're asked here whether you're informed about the number and type of incidents, and you say there really that from 2017 onwards you became the Deputy Chief Nursing Officer and it is from then on really that you began to learn of the events at Muckamore, is that fair to say? 14:46

A. Is this paragraph 42?

193 Q. Yes. 14:46

A. Yeah. So what I was signalling there was that as Deputy Chief Nursing Officer in the Department of Health, as the issues around Muckamore became known that's when I became aware of the issues that were emerging at that facility. 14:46

194 Q. And prior to 2017 and before that role as Deputy Chief Nursing Officer, you weren't involved in a role that had oversight of LD services?

A. No, I didn't. No.

DR. MAXWELL: I think you were Deputy Chief Nursing Officer before 2017?

A. Yes, I was before. So what I was signalling in paragraph 42 is that in my role as Deputy Chief Nursing Officer in the Department of Health, I did begin to learn about the events from 2017.

DR. MAXWELL: Sorry. So would it be fair to say then that as the Deputy Chief Nursing Officer you weren't routinely getting quality indicators?

A. That would be fair to say, yeah. 14:47

195 Q. MS. BRIGGS: At paragraph 47 on page 22, this is before you took up your role in PHA, but you say that it's your understanding that:

"...in 2017 the HSCB Director of Social Care and the PHA Director of Nursing briefed the PHA Board regarding the emergence of serious adverse incidents at Muckamore." 14:47

At paragraph 48 you say that: 14:48

"The PHA Board is not usually notified of individual SAIs. The primary mechanism for informing the PHA Board of SAIs was through the provision of the PHA/HSCB annual Quality Report." 14:48

How did or how does the PHA Board become aware of Level 3 SAI investigations?

A. So what I was signalling here is that when I took up my

post, the way in which the Public Health Agency Board became aware of SAIs was through the annual Quality Report. I understand, both from Mary's evidence this morning, but previously, that there would have been -- a separate report would have gone to the Public Health Agency Board on SAIs. But that was replaced by the annual Quality Report, and Mary Hinds outlined earlier today the reason for that. However, later on in my evidence I do describe an internal audit, which absolutely recommended in the context in which that internal audit was done, that the PHA Board needed to have more visible sight of SAIs, and the actions of the staff within the Agency, and my understanding is that that action has been completed. 14:48 14:49

196 Q. Okay. Another question you're asked about by the Inquiry is whether your team made any recommendations about the education and training of staff at Muckamore, and your answer starts at page 25, and you've amended page 25 today. At paragraph 58, which is now really the second substantive paragraph, or second paragraph in response to Question 6, you say that: 14:49 14:49

"The PHA Assistant Director of Nursing for Mental Health and Learning Disability commissioned the British Institute of Learning Disability Positive Behavioural Support Coach Training in 2018/19 to assist staff working in learning disability services across the region, including MAH staff. This training was prioritised in acknowledgment of the need to improve 14:49

the scope of therapeutic nursing skills and contribute to the creation of practice models that decrease the need for or dependence on isolation and/or restrictive practices."

Did that training cover healthcare assistants as well as nursing or medical staff, or would HCAs not benefit from training in Positive Behavioural Support?

A. My understanding is, without the detail in front of me, that it was the Registrant nursing staff, but I would really need to come back to you to check if that also included healthcare assistant staff. I just couldn't be absolutely accurate about that today. 14:50

197 Q. The Inquiry has heard evidence that some staff, particularly perhaps HCAs, were reluctant to use Positive Behaviour Support as they felt it was more risky than containing behaviours. Would you agree with that? Was there any strategy of changing that culture that you know of? 14:51

A. I mean I'm unaware of that detail, but I wouldn't agree with that strategy, and I would love to know more about the rationale for why people felt that PBS would be less effective or less safe. Given the evidence base for it I would be surprised. 14:51

DR. MAXWELL: I don't think people were saying that it wasn't effective. I think -- so we have heard evidence from witnesses that some staff, particularly HCAs, were anxious about this, because we've also seen graphs of increasing assaults by patients on staff which, you 14:51

know, is not to criticise the patients, they were distressed, and it may have been because of what the staff were doing.

A. Yeah.

DR. MAXWELL: But we've heard that the healthcare assistants in particular felt that the fact that there was no consequence to this behaviour, that you were actually, rather than trying to do a behavioural response, would mean that they would be at risk, because rather than trying to contain that behaviour before an assault, you were then trying to look at route of it and distract. I don't think anybody is suggesting it is not the right way. The point is, if you're going to change your philosophical approach to this, how do you take the staff with you? 14:52

A. Yeah. Yeah.

DR. MAXWELL: Particularly the healthcare assistants, who are the ones who have the most direct contact time. So there seemed to be a lot of training going on with Registered Nurses, but the people who are actually there when a patient starts to become distressed, if they don't understand the philosophy, they're going to find that hard. 14:52

A. Yeah. Yeah.

DR. MAXWELL: So the question then is: when commissioning this training, was that just some training or was it part of a wider strategy to change the philosophy and approach? 14:52

A. Well, I think the motivation for that was to change the

philosophy and to do that through the individuals, obviously, who were trained. And you'll see later on in my evidence that the Public Health Agency and my team set up Project Echo, which was really a peer learning model, and that was regional, but it includes staff from Muckamore, and that was an attempt to try to embed the philosophy within practice. But I accept that PBS in its own right is a measure, it needs to be set in the context of the wider care improvements that were required, particularly in Muckamore Abbey. 14:53

DR. MAXWELL: And as part of that wider strategy how were healthcare assistants going to be engaged and change their view about the best ways to contain challenging behaviour, distressed behaviour.

A. Yeah. So you'll be aware of the work that was done through Strengthening the Commitment, and our colleagues in NIPEC did a huge amount of work particularly around hosting Strengthening the Commitment, but also provided and supported lots of learning, including those for healthcare assistants. And if I recall correctly, there was some work done for healthcare assistants - I can't name it for you today, but my understanding was that there was specific support provided through the Clinical Education Centre for healthcare assistants. 14:54 14:54

But I accept that in order to have an effective model of psychological and behavioural support, that needs to be set within a wider philosophy of care that includes

all of the multidisciplinary team.

198 Q. MS. BRIGGS: At paragraph 60 you say that:

"The goal of integrating PBS in nursing practice was to enable evidence-based, therapeutic, and ethical support for individuals with LD who present with behaviours of concern." 14:54

Would you say that the service was previously lacking in that regard? 14:55

A. I think the evidence before me in terms of the report in terms of "Way to Go", and the evidence that's contained within the Leadership and Governance Review, I think it's probably Section 5 or 6 of the Leadership and Governance Review, does outline some of the issues about the reliance on mandatory training. So I think I would accept from the evidence that was before me that further work needed to be done to develop the therapeutic regime within Muckamore Abbey, including wider multidisciplinary support, for example, from occupational therapy, et cetera, and psychology. 14:55 14:55

199 Q. You go on to describe MAPA training, and paragraph 66 over on page 27, you say that in October 2020 you contacted the CPI, that's the Crisis Prevention Institute: 14:56

"...which had previously delivered MAPA training in Northern Ireland."

And you go on to say that you did so because of the concerns which had surfaced about restrictive practices and how MAPA was being applied. What concerns had surfaced?

A. So obviously the evidence that came out of "Way to Go" indicated that MAPA may not have been appropriately applied in all situations, and I understand that there's been further evidence given in Inquiry about some of the concerns about how MAPA was utilised. So it was in that context that I began to make some enquiries from the authors of MAPA, just to explore their understanding and the approach. I have to say that was also driven by a deeper desire to develop a more therapeutic control and informed way of thinking and working, and so it was in that context that I had had this engagement with the Crisis Prevention Institute, and they had modified their programme quite significantly to include a lot greater emphasis on de-escalation, on human rights and trauma informed ways of thinking, and I felt that that was important. Starkly, within Northern Ireland MAPA training would have been provided by the Clinical Education Centre, and over time Trusts took on that responsibility, and you'll see in my evidence that I recommended the development of a community of practice and a restoration of that training and oversight by the Clinical Education Centre. 14:56 14:56 14:57 14:57 14:57

200 Q. Okay. So the training was really updated to reflect that new approach?

A. Absolutely. I should also say that training was mostly, the training in MAPA was mostly provided at postgraduate or post qualifying level. What I was seeking to do in this particular initiative was to begin to get that introduced at the earliest juncture of nurse training, and obviously you'll see from my evidence that we worked our academic institutions in order to build that into their programme of learning.

PROFESSOR MURPHY: So did the Crisis Prevention Institute say 'Oh, goodness me, we should have been telling all the people we trained ten years ago that we've changed our approach", and had they done any of that kind of updating?

A. I think -- I can't answer that question specifically, but my understanding is that for the people who applied MAPA they are registered with CPI, and as part of that they would have been sharing.

PROFESSOR MURPHY: Yes.

A. It's my understanding they would have been sharing information about that. I can't comment on how well that was responded to or taken up by respective organisations. So in my context, what I was seeking to do was to get it built into the undergraduate programmes, with a view then towards developing much more advanced practice in this area. Like all the learning that had emerged.

PROFESSOR MURPHY: But presumably what might have been happening is that as each person was trained their name was registered as trained with the CPI, but the CPI

didn't necessarily say 'Oh, we've got Version 2', or 'We've got Version 3', or whatever, and 'Your MAPA trainer needs to come for updating'?

A. Yeah. Yeah, I think that's correct, yeah.

DR. MAXWELL: And you seem to be saying that originally the training was delivered through the Clinical Education Centre, so one centre for Northern Ireland. 14:59

A. Yes.

DR. MAXWELL: And this had now been devolved to individual Trusts. And we've also heard it got devolved within Trusts. So the MAPA training unit at Muckamore was different from Mental Health. I can sort of understand how an individual who is registered might not notice an email, but are you suggesting that the training that was being actively delivered through Belfast Trust, or through any of the Trusts, wasn't compliant with the current best standards from the Crisis Prevention Institute? 14:59 15:00

A. I can't say that, because I obviously didn't examine the training that Trusts were providing under MAPA at this particular point in time. What I was focused on was attempting to get, if you like, MAPA or CPI training built into the undergraduate programme. But I was also seeking to restore a regional approach towards MAPA, and the reason for that is that I felt that that allowed for a community of practice, and I felt that that was safer and it gave an opportunity for excellence to emerge. So there was no sight of actually what happened when it was devolved to Trusts. 15:00 15:00

DR. MAXWELL: Okay. So we don't know what individual Trusts or units within Trusts were doing, which version of the Crisis Prevention Institute programme they were delivering?

A. I didn't know that at the time and I don't know it today either. 15:01

DR. MAXWELL: Okay.

CHAIRPERSON: But if well managed that should have been part of -- anybody who had to apply MAPA, it should have been part of their CPD? 15:01

A. I agree. I agree.

201 Q. MS. BRIGGS: And that old approach of the CPI, if I put it that way, there's the older and the new approach, is it fair to say that really it was deemed that the earlier approach was too interventionist, particularly physically? 15:01

A. I don't think CPI would say that. I think perhaps in practice that might have been the case. CPI always, from my understanding and dealings with them, always sought to promote a de-escalation approach. So I think that philosophy has always been there. However, they did update their curriculum. 15:02

202 Q. You've touched upon it there and it's about bringing the education to the undergraduate nurses, and that's something that you worked on, and you describe in your statement about the Prevention First and Safety Intervention Task and Finish Group that was established, and you describe at paragraph 71 how that group oversaw the development of a regional plan for 15:02

the implementation of Prevention First Training in undergraduate nurse education in Northern Ireland. Did the group consider development for healthcare assistants, given that the most direct contact time with patients is via healthcare assistants? 15:03

A. I can't answer you that question specifically about healthcare assistants, that being embedded in healthcare assistants. During my time it was definitely targeted at undergraduate Registered Nurses. But the general move, as you'll see, one of the reasons 15:03 why I set up that Task and Finish Group was to also develop a proposal around the wider training of staff towards developing a community of practice, and I would have envisaged that healthcare assistants would have been part of that. 15:03

203 Q. I'm thinking about undergraduate nursing qualifications, and Prevention First is embedded in undergraduate nursing training.

A. Yeah.

204 Q. What about Creating Caring Cultures, is it embedded as 15:03 well? We heard about that this morning?

A. No. As far as I know it's not. That said, I think many of the elements that are within the context of Creating Caring Cultures are part of the new future nurse, future midwifery curriculum programmes. So 15:04 I think you'd find, if you look at those curriculums, that there is quite a heavy reliance on person-centred ways of thinking, and practice, and obviously addressing the cultural context in which teams are

working in.

DR. MAXWELL: And those are the standards that the Nursing and Midwifery Council sets for registration.

A. That's right. That's right, yeah.

205 Q. MS. BRIGGS: Before we move on, do you know if PBS is part of the undergraduate nursing degree? 15:04

A. I don't think PBS is part of the undergraduate. I'm sure I can be corrected on that. I certainly know it is part of the postgraduate learning in nursing.

206 Q. If we can go on to paragraph 75, you say there that: 15:04

"More broadly, my recommendations on learning disability and mental health focused on the importance of developing psychological and behavioural skills as well as expanding the role of learning disability 15:05 nursing in physical and mental health. This was the direction I gave to my mental health and learning disability nursing staff."

What recommendations are you referring to there? 15:05

A. So I guess I'm speaking more generally at this particular point, in that I'm referring to what I consider to be the model for mental health nursing - mental health nursing. I've always been a very strong advocate of what often gets referred as the 15:05 biopsychosocial model, and the reason I believe in that is because obviously it's the right thing to do but, critically, nurses who provide a substantial part of the care need to have psychological and behavioural

skills in order to be able to work with citizens who have got behaviours of distress or distressing behaviours. But I also believe that the physical health needs of citizens, particularly vulnerable citizens, sometimes gets overlooked, and what I am seeking to do here is emphasise the importance of paying attention to the physical health and well-being. For example, for citizens with learning disability, we know lots of diagnostic overshadowing occurs, and sometimes their physical health needs are not given the same attention that they should be. So as part of addressing health and quality, really amplifying the role of nursing in championing and advocating for that, and you'll know from evidence that has been provided to the Inquiry, the Public Health Agency and our nursing consultants did a huge amount of work around developing a health passport for citizens with learning disability, but also in terms of providing support within a primary care context, particularly in promoting a health assessment model. 15:06

207 Q. Okay. Chair, I have two more topics to deal with; commissioning and then really the leadership and governance review?

CHAIRPERSON: Yeah, they're both quite big, biggish topics. 15:07

MS. BRIGGS: Fairly -- it shouldn't take too much longer, but I think it might be a good time now for a break.

CHAIRPERSON: Yeah. Certainly. Okay. Thank you very

much. We'll take a ten minute break or so and you'll be looked after. Don't speak to anybody about your evidence. We'll see you back in ten minutes. Thank you very much.

15:07

THE INQUIRY RESUMED AFTER THE SHORT ADJOURNMENT AS FOLLOWS.

CHAIRPERSON: Thank you very much. Ms. Briggs, yes.

208 Q. MS. BRIGGS: Thank you, Chair. If we can move to the topic of commissioning, Mr. Morton. You tell the Inquiry about it in your statement and you refer to the HSCB Commissioning Team, and you describe that at paragraph 90 page 33. You say that: 15:22 15:23

"The HSCB, operating under Bamford Structures, has a specific MDT learning disability planning and commissioning team for learning disabilities. PHA Nurse Consultants for learning disability and mental health were essential members of this team. The PHA provided recommendations on the commissioning of learning disability services primarily through this team." 15:23

I'd like to ask you about something a little bit technical now, it's called Implementation Science. Is that something you've heard of? 15:23

A. I am, yeah, I am familiar with that.

209 Q. Okay. To what extent did the HSCB team use

implementation science to manage the transition to the Bamford vision?

A. That is a difficult question. I am not aware that specifically Implementation Science model was used in the commissioning plan for Bamford. I'm not aware that 15:24
that model was specifically used. But I guess in terms of the way in which the commissioning team went about its business, there would have been elements of that Implementation Science model in play, but it would be inaccurate to say that that was the actual framework 15:24
that was used to support the implementation of the Bamford vision.

DR. MAXWELL: So was it assumed that if you just commissioned a new model, a new model would happen without anything thought about changing philosophies 15:24
and cultures?

A. I don't think it was assumed that just commissioning a new model would suddenly result in that new model delivering all of the outcomes. So, you know, when I speak about the Bamford work, and the Bamford 15:25
vision, obviously I wasn't the Director of Nursing in the Public Health Agency at that time, but clearly given my background I have knowledge of the Bamford processes, and I particularly led the Child and Adolescent Mental Health work around Bamford in 15:25
Northern Ireland. So I know that as part of the work that I did, I created a collective team, including providers, I worked with those teams in order to develop both the model and how we would go about

implementing some of the recommendations of that model, and that included paying attention to the sorts of things that were required in order to support delivery of that model. For example, psychological care, additional training, etc. So it wasn't just simply 15:25
'There's the service model, get on and do it', there was a programme of service improvement support provided. And particularly when I worked for the Health and Social Care Board I worked in the area of service improvement, and so we would have brought a 15:26
service improvement model to play. We didn't use Implementation Science per se, but we definitely used a quality improvement model in our approach.

PROFESSOR MURPHY: But did you say, or did I mishear you, that you were looking at it in relation to 15:26
adolescents?

A. So I'm referring to my previous role when I worked in the Health and Social Care Board, I had responsibility for leading the development of Child and Adolescent and Mental Health Services in Northern Ireland 15:26
when I worked for the Health and Social Care Board, but specifically using an improvement model of care. So I'm referring to that previous role that I played with the Health and Social Care Board.

PROFESSOR MURPHY: So am I understanding you right that 15:26
you were thinking about how to implement the Bamford vision with that age group?

A. That's correct, yeah.

PROFESSOR MURPHY: So who was thinking about it in

relation to adults?

A. So maybe I explain. In the Health and Social Care Board there was a number of -- there was a Bamford commissioning team, and the Bamford commissioning team was made up of a range of professional. But also because Bamford spoke across the age range, there would have been subgroups of that overarching Bamford commissioning group, and each one of those subgroups would have taken forward a programme of work, and they also sat on the Bamford commissioning team. So that was the place in which decisions around the models of care, the delivery of those models, attention was paid to those issues at that time. 15:27 15:27

PROFESSOR MURPHY: Okay.

DR. MAXWELL: And you may not know much about this, but after Equal Lives, the part of the Bamford report on learning disability was produced, Deloittes were commissioned to do a workforce review to support this vision. 15:27

A. Mm hmm. 15:28

DR. MAXWELL: Bamford had originally stated that there should be new roles and new teams to support this vision, but Deloittes concluded that actually that wasn't necessary and the existing workforce would be redeployed. In your various roles as Deputy CNO and then Director of Nursing for the PHA, you would have been aware of the number of times that staffing came up as an issue in SAIs. Are you aware that anybody ever went back and reviewed the Deloittes' assumption that 15:28

you just recycle the existing workforce.

A. I'm not aware of anybody going back and looking at that particular report.

DR. MAXWELL: Okay.

A. Or indeed the rationale for it. 15:28

DR. MAXWELL: Thank you.

210 Q. MS. BRIGGS: At paragraph 94 of your statement, Mr. Morton, you describe the changes to commissioning arrangements brought about by the formation of SPPG, and you say at the end of that paragraph, or the second 15:29 half of it that:

"The inception of SPPG altered the Executive Director of Nursing's role and PHA staff's involvement in service commissioning. This shift resulted in the PHA Board no longer signing off on the commissioning plan, and the PHA Directors no longer attended SPPG executive management meetings. Furthermore, the PHA (which was being reviewed at the time) was increasingly emphasising its public health contribution to the commissioning agenda."

Thinking about the changes brought in by the formation of SPPG and how that impacted PHA and its advice, is the advice provided to the same degree or extent as it 15:29 was before, or is the relationship different, would you say?

A. I think the first thing I would say is that the relationship obviously has changed. When I was in the

Public Health Agency there was a very collaborative approach between the Board and -- or between the Board and the Public Health Agency, and that culture had been well developed over many, many years.

15:30

As Mary indicated in her evidence earlier today, I and the Director of Public Health would have been in attendance at the Health and Social Care Board, and we also attended their senior executive team. So that did allow, to some extent, us the opportunity to influence 15:30
the direction of travel to influence discussions. Obviously with the formation of the SPPG, that executive role or that directorship role no longer existed within the context of that model.

15:30

So, for example, I'd have regularly attended and would have been discussing issues around SAIs. Obviously with that change I was no longer present. That is not to say that serious adverse incidents were not discussed by SPPG, they were, but I wouldn't have been 15:31
present in those conversations. So effectively the nurse commissioning team still continued to collaborate with SPPG colleagues, and still do to this day, in formulating commissioning plans. However, SPPG is a subdivision now of the Department of Health. So its, 15:31
the context for its commissioning processes has also changed.

CHAIRPERSON: And does that mean there's nobody on the PHA sitting on those committees which are making

decisions to the SPPG?

A. Sorry, could I ask you to ask me again?

CHAIRPERSON: Does that mean there's nobody from the PHA sitting on the SPPG committees?

A. So members of the Public Health Agency, in this case Nurse Consultants and allied health consultants, do sit on SPPG commissioning teams, they do support the work in there. But at executive decision-making levels, as far as I'm aware nobody from the PHA sits on SPPG Senior Management Team. However, I should point out that given the interfaces between the Public Health Agency and SPPG, I understand that they have a system set up where they have a joint assurance meeting where the Agency and the SPPG meet to discuss matters of mutual interest and areas of core business, for example around serious adverse incidents. 15:32 15:32 15:32

CHAIRPERSON: In simple terms does it mean less influence?

A. I believe so.

DR. MAXWELL: So for the decision making committee that approves, you know, there might be a lot of joint working to produce a draft plan for commissioning, and in previous iterations the HSCB could not go forward with the Commissioning Plan unless the PHA Board had approved it. 15:33 15:33

A. Yeah.

DR. MAXWELL: That no longer happens. You can contribute, but the final decision sits with the people who sit on SPPG.

A. Yes.

DR. MAXWELL: And in terms of managing SAIs and being confident that the investigations were thorough and complete, and the actions had been completed by the provider units, that isn't something people from the PHA are involved in making the final decision on? 15:33

A. No, I think the PHA are very actively involved.

DR. MAXWELL: Okay.

A. And certainly during the transition period we sought to make sure that those arrangements were robust. So at the level below Senior Management Team meetings, the teams of Nurse Consultants, PHA, the Safety and Governance Team in the Public Health Agency work very collaboratively with the Safety and Governance Team in SPPG, and some of the arrangements that I've outlined in my evidence remain to this very day. So obviously I can't speak for them, but I am very confident that that side of the work is robust, and has developed, and improvements continue to be made. 15:34 15:34

DR. MAXWELL: Okay. Thank you. 15:34

211 Q. MS. BRIGGS: Can I just clarify something: Is it the PHA nursing consultants then that provide the professional and clinical advice to SPPG?

A. That's correct.

212 Q. Okay. All right. You refer in subsequent paragraphs to Delivering Together 2026, and in particular at paragraph 96 you talk about that. Did Delivering Together specifically mention LD services? 15:34

A. I don't think I have a copy in my evidence today, but

I'm not sure that it did. I would need to go back and read the actual Delivering Together Strategy 2026 to see if it did reference learning disability.

213 Q. And you may not be able to assist with this, but you describe how the DoH initially established the Transformation Implementation Group. Do you know whether that group had a LD workstream? 15:35

A. Again, not to my recollection. The reason why I reference paragraph 96 was really just to signal that in Northern Ireland we started to move towards a more systems-based approach to service delivery and service design, and that was on the back of Rafael Bengoa's report, which really suggested a much more collaborative model, both of commissioning and service delivery, and so what you're seeing in this particular paragraph is the outworkings of that, and I think MDAG, to be fair, is an example of that in practice. 15:35 15:36

214 Q. Okay. You go on in your statement to describe commissioning advice given regarding LD, and you describe at paragraph 101 on page 35 the recommendations that you gave regarding the LD service. You mention in that paragraph recommending community based MDT crisis care. Was that in 2019 you gave those advices? 15:36

A. I think that probably was somewhere between -- I can't remember the pinpoint exact date, but it was somewhere between the formation of MDAG and the work programme of MDAG, so it would have been in the context of the work of MDAG, which started in November 2019. But I suspect 15:36

it was somewhere in 2021 that I would have given that advice. And the reason for that is that if you want to resettle people, if you want to create a support environment, you need to have robust crisis support and wraparound services for citizens with learning disability. So what I was emphasising here was the important part of that community architecture needed to be in place.

215 Q. And what was your -- what was the response to your suggestion? 15:37

A. Positively received.

216 Q. Has it been done?

A. I know that significant work was done on creating a crisis response and support service, so I understand that is now part of the service model, and I think I referenced somewhere in my evidence that this work was subsequently absorbed within the creation of the new service model for learning disability. I know that members of my team were heavily involved in its design. 15:37

DR. MAXWELL: It may have been accepted in the model, but is it actually in practice? 15:38

A. So my understanding is it's not in practice, but I could be wrong about that. It certainly was in the process of design as I was leaving Northern Ireland, and there was an intention that that would be part of the delivery of the new service model. But I understand work has continued on that service model, so I suspect this element has not yet been fully implemented. 15:38

DR. MAXWELL: So given the Equal Lives Report came out in 2005, we're nearly 20 years later, why has it -- why do you think it has taken so long and we still don't have a community crisis team for people with LD?

A. That's a very difficult question to answer. But I can understand why you ask that question. All I can say is that I endorse the development of a crisis support service and wraparound and enhance support, it's fundamental to both the service delivery but also it helps citizens enjoy the same access to service that other citizens do, for example, in mental health. So I strongly support it. I'm not sure whether it was, historically whether it was down to lack of resource, I'm just not 100% certain about that. From my recollection there was a suggestion in the days of early resettlement that you could release money from one system in order to support service development in another. I think that's -- in my experience, that's easier said than done. 15:38 15:39 15:39

DR. MAXWELL: Okay. 15:39

217 Q. MS. BRIGGS: And you describe it in detail in your statement, the recommendations that you made and how some of those were worked out, I suppose. One thing you tell us at paragraph 116 is that recommendations and advices led to investments in 20 Learning Disability Nursing posts, five Nurse Consultant positions, five Advance Nurse Practitioner roles, and 10 Learning Disability and Band 7 Specialist Nurse roles. Do you know, and you may not, whether priority 15:39

was given to Muckamore for those roles?

A. So if I could maybe set the context for this?

218 Q. Yes.

A. This particular commissioning objective is linked to the Nursing and Midwifery Task Group Report, which I've referenced in my statement, and I was part of the design group, but under the leadership of the previous CNO, Professor Charlotte McArdle. We were adamant about trying to create a context that modernised nursing and midwifery services in Northern Ireland. Clearly at the time of writing the Nursing and Midwifery Task Group Report, issues that related to Muckamore were very present in our minds, and we reflected the learning from that in much of the report. 15:40 15:40

You've heard from Mary Hinds, or the Inquiry heard from Mary Hinds earlier today about her report. It was very clear in the context of that report that we needed to invest in learning disability, clinical leadership, and to do so systemically. So the vision set by the Chief Nurse, Professor Charlotte McArdle at the time, was to begin to create a level of leadership across the region in Northern Ireland to support expert practice, promote quality and safety. And so what you're seeing here in my evidence is the outworking of that deep desire, and clearly when we had the opportunity of getting funding, which we did under the Nurse and Midwifery Task Group, we began to prioritise the development of Nurse Consultant roles in Northern Ireland, and here you see 15:41 15:41

the creation of these five Nurse Consultant roles in Learning Disability.

It was our vision, as I've tried to outline in the statement today, it was our vision that they would become a community, that they would work with other Nurse Consultants, for example, in public health, in terms of quality and safety, and again you'll see some evidence of that, in order to drive forward the sort of improvements that were articulated in the Nursing and Midwifery Task Group, and I think that work has been progressing, albeit delayed as a consequence of the pandemic, but I see that as a critical part of the infrastructure of the nursing development in Northern Ireland. 15:42

219 Q. Okay. You were asked to comment upon the recommendations of the Leadership and Governance Review, and your answer to that is at pages 44 and 45. I just want to read a very small part of the Leadership and Governance Report into the record, and everyone will know by this stage in the Inquiry that that document is available online. Paragraph 6.116 of the report says this. It says that: 15:43

"At corporate and clinical levels, the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems..." 15:43

It goes on to say:

"...monitoring, educational, and professional development processes and systems."

- I'm paraphrasing slightly: 15:43

"...capable of ensuring good governance at Muckamore."

Okay? Would you agree with that?

A. I mean obviously I've read the Leadership and Governance Review, and I think if my recollection is correct it wasn't that the structures didn't exist, it's just that they weren't always as effective as they could be. And so I think I can see why that might be the case. 15:43 15:44

220 Q. You were asked about actions that the PHA took in relation to the recommendations of the report, and you have outlined in your statement what those actions are, and I'm only going to go to one of these for today's purposes because your statement is online and everyone can read it there. But the one that I'm going to go to today is page 47. The recommendation is the second recommendation on that page, and it is that: 15:44

"Specific care sensitive indicators should be developed for inpatient learning disability and community care environments." 15:44

And your answer says that it was:

"...initially intended to respond to this recommendation by building on the LD Nursing Key Performance Indicator..."

15:44

- but this was unable to be progressed and you give reasons for that in paragraph 153. This is something that's in the MSC Action Plan as well, and I don't think we need to go there again at this time, but for everyone's reference it's back at Exhibit 26 on pages 634 to 635. Just thinking about the progressing of this, is that still a work in progress, do you know?

15:45

A. So if I could just set the context a little bit?

221 Q. Please.

A. Obviously we were unable to progress that in the way we would like to have at the time because of the pandemic, and that was largely due to the redeployment of members of my own team. However, during that period of time further discussions emerged around the service model. And, so, there was an increased recognition that there needed to be a relationship between care sensitive indicators and the development of the service model and, furthermore, they also needed to be multidisciplinary, not just nurse related.

15:45

15:45

15:46

But also in addition to that, at the time we were beginning to recruit these Nurse Consultants, and I had formed the view that this was an area of work that they should be intimately involved with, and particularly

providing clinical leadership, and particularly working with those who are leading the service model.

But also a link to this, the previous Chief Nurse, Professor Charlotte McArdle, had also commissioned a review of Learning Disability Nursing and its model. I understand her report was produced, and that report then further resulted in work being undertaken by NIPEC, which is in Linda Kelly's statement as part of this module. 15:46

So what I am trying to point out is that these are the factors that influenced how this work might be progressed.

15:47

In terms of where it is at today, it is my understanding is that work is still going on on the finalisation of that service model. But I have been reassured, just again because of colleagues telling me this, that the new model that Linda Kelly through NIPEC has produced, does contain (a) a nursing model and (b) sets out some standards that you would expect of Learning Disability Nurses across the life course. 15:47

PROFESSOR MURPHY: And it is also cognisant of the fact that on the whole community services are more likely to be social care led than nursing led? 15:47

A. So, the service model, I think from my recollection, seeks to recognise the contribution of social care nursing, medical, and allied health professions, as

well as the important role that is provided by the community and voluntary sectors, as well as promoting the voice of the citizen and their advocates and carers. The work that was led by Linda Kelly and by NIPEC was specifically relating to developing a nurse specific model for Learning Disability Nursing. But I can say to you the care sensitive indicators, because of previous discussions, there was a clear recognition that they needed to be multidisciplinary and multisectoral. 15:48

PROFESSOR MURPHY: Right. Lovely.

DR. MAXWELL: The recommendation talks about specific indicators for in-patient learning disability and community care environments.

A. Yeah. 15:48

DR. MAXWELL: And they are different environments.

A. Yes.

DR. MAXWELL: And I perfectly accept the move is to as much community care as possible. But it is now seven years since the first allegations arose at 15:48 Muckamore, which at the very best we might say showed poor practice; and given that these allegations of, at best, poor practice, at worst, abuse, are largely directed to nurses and healthcare assistants, how does a system wide multidisciplinary set of indicators 15:49 assure you that nursing care in in-patient facilities is safe?

A. So my understanding is that the current Chief Nurse did commission NIPEC to do a piece of work looking at a

number of indicators in Muckamore Abbey Hospital, and I understand a dashboard was produced. I can't comment on the detail of that today.

In terms of your wider point, the work that is and has been done around developing a specific model for nursing and learning disability should contribute to those broader set of indicators. However, just to answer your question about assurance in nursing and midwifery, one of the critical recommendations of the Nursing and Midwifery Task Group is the development of a statutory framework of assurance for nursing and midwifery. I personally support that recommendation, and the purpose of that was to develop a framework that would help and assist Executive Directors of Nursing to provide assurance to their Board of the contribution of nursing on the quality and safety of nursing care. And it was the intention that as that framework developed, which I understand again NIPEC has done some work on, that that would equally apply to Learning Disability services. 15:49 15:50 15:50 15:50

DR. MAXWELL: I understand all of that. But in the seven year interim, what measures are there to assure ourselves that the practice of nursing and the support of that practice by healthcare assistants is good? 15:51

A. I think they're limited. I think they're limited.

DR. MAXWELL: Okay.

A. They would be down to very basic data.

DR. MAXWELL: I'm not sure the number of pressure --

A. Ehm --

DR. MAXWELL: -- is particularly relevant.

A. No, I would agree with you. But I can say that the previous Chief Nurse did appoint a Learning Disability Nurse Specialist to take forward that work and, as I have indicated, a report was produced, but then further decisions were taken to further extend that work, so that might account for a bit of that time gap. 15:51

DR. MAXWELL: Okay. Thank you.

MS. BRIGGS: Mr. Morton, that's all the questions that I have for you. The Panel may have some further questions. 15:51

A. Thank you.

MR. MORTON WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS: 15:51

222 Q. CHAIRPERSON: Could I just ask this on sort of a similar topic: Do you think that if the PHA had received the Ennis Investigation report, which you have now read, and been more closely involved when that happened, that that would have made any difference to the PHA's approach? 15:52

A. So I think, I think the Health and Social Care Board and the Public Health Agency, had it received it at that time, I think they would have taken a different view, and I think there's some evidence again, as outlined in the Leadership and Governance, that there was quite a lot of dialogue, particularly with the Health and Social Care Board, about reporting Ennis as 15:52

an SAI. I think, had that happened, that might have led to further work, but I guess we won't know because it wasn't reported.

223 Q. CHAIRPERSON: We won't know. But just, I suppose it is speculating, but what sort of further work could have been done? 15:52

A. So I think, there would have been obviously an SAI investigation, and I think it would have probably warranted a Level 3. So that SAI report would then have made a series of recommendations. And, following our protocol and our processes, that would have resulted in learning, and that learning may have resulted in additional safeguards. And I have to use the word "may", because we genuinely don't know. 15:53

224 Q. CHAIRPERSON: Right. I'm just wondering if that happened now, you received that sort of report now, what the PHA could do? You would obviously engage now with the SPPG, presumably? 15:53

A. Yeah. So I think the Public Health Agency, if it received that report now, clearly that would be discussed with our colleagues in SPPG, because it would definitely have come up the social care lines, which fall under the SPPG. And I definitely think that, reflecting on my experience in the Public Health Agency, if I received something like that, I would have personally been taking action, and I think that action would have been looking for a thorough and rigorous investigation of the issues that eminently emerged. I mean, in my previous role in the Public Health Agency 15:53 15:54

there have been a number of times where reports have come in, and I, as director, and I know my previous directors in this role also took action in order to make sure that there was a rigorous approach to the SAI process and its investigation.

CHAIRPERSON: Mr. Morton, can I thank you very much for coming along to assist us. Despite appearing in front of you, effectively your ex-teacher, you got through it. So can I thank you for your very careful and frank answers.

A. Thank you very much.

CHAIRPERSON: Thank you very much indeed. Okay. We are going to sit early tomorrow morning, apologies to everybody, but you'll understand why. Nine o'clock. Thank you very much indeed.

THE INQUIRY ADJOURNED TO THURSDAY, 26TH SEPTEMBER 2024 AT 9:00 A.M.

15:54 15:55 15:55 15:59