MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 26TH SEPTEMBER 2024 - DAY 111

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

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THE INQUIRY RESUMED ON THURSDAY, 26TH SEPTEMBER 2024, AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you.

MS. KILEY: Good morning, Chair and Panel. This morning we move back to Organisational Module 7, Operational Management, and our witness is Marie Heaney and she's ready to be called when the Panel are ready. 09:05

CHAIRPERSON: Thank you.

09:07

MS. MARIE HEANEY, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Ms. Heaney, good morning.

A. Good morning. 09:07

CHAIRPERSON: Thank you for coming to assist the Inquiry. Thank you for your statement and thank you for your attendance. You have quite a soft voice, which I can tell straight away from the way you took the oath. Because this is streaming and there are 09:07 people watching and listening, and also in Room B, it's very important you keep your voice up. So could I ask you just to be aware of that.

A. Yes, I will.

CHAIRPERSON: We normally take a break after about an 09:07 hour. We make take two shorter breaks this morning, but we'll see how we do. But if you need a break at any stage will you just let me know.

A. Yes, I will. Thank you.

CHAIRPERSON: All right. Thank you. Ms. Kiley.

1 Q. MS. KILEY: Good morning, Ms. Heaney.

A. Good morning.

2 Q. As you know my name is Denise Kiley, I'm a member of the Inquiry counsel team and I'm going to take through your evidence this morning. 09:08

A. Okay.

3 Q. I can see that you have in front of you a copy of your statement?

A. I do. 09:08

4 Q. And I can see that you've also written some notes on that.

A. Yes, a few notes here and there.

5 Q. And can you confirm that those are your own notes?

A. They are. 09:08

6 Q. And they're as an aide-mémoire for your evidence; is that right?

A. Yes.

7 Q. And for everyone's else reference, the Inquiry reference for your statement is STM-301, and as we go through your evidence today, although you have a copy in front of you, I'm also going to be calling up particular aspects of your statement on the screen in front of you. Okay? So you will see particular paragraphs and exhibits come up there. 09:08

The first question that I need to ask you, Ms. Heaney, is, having read your statement and had it in front of you again, are you content to adopt it as your evidence

to the Inquiry?

A. Yes, I am.

8 Q. And I think -- thank you. Our secretary is just giving you a list of ciphers that may be mentioned in your statement, so you may wish to refer to those. As you know from your earlier evidence giving, if in doubt you can pause, if you're unsure as to whether you can refer to - you should refer to a name, you can pause and check with the Secretary to the Inquiry and myself and we'll keep you right. 09:09

A. Okay.

9 Q. But turning then to your statement, you detail your professional background at paragraphs 5 to 20 of your statement, and I won't go through all of those, but it's right that you're a qualified social worker? 09:09

A. That's correct, yes.

10 Q. And in the course of your career did you ever receive specific training in respect of learning disability?

A. I would have -- in my very early social work course there would have been, you know, some information about disability, including learning disabilities, but it wasn't my area of expertise throughout my career. 09:09

11 Q. Yes. What would you say your area of expertise was?

A. Well, most of my career I worked in various parts of organisations concerning Older People's Services. So older people in need, so older people with mental illness, dementia, you know, various other cognitive impairments, physical illnesses, stroke and so on. So most of my experience would have been with Older People 09:10

Services, both in direct practitioner services as well as in my various managerial and service development and commissioning roles.

12 Q. Yes. And you've had a number of roles in the Belfast Trust; isn't that right? 09:10

A. Yes. I mean obviously the organisation changed and I went with it.

13 Q. Yes.

A. So it started out quite small units of management and then moved into bigger organisations, until finally the 09:10 Belfast Trust was an amalgamation of six former Trusts, including two large Community Trusts.

14 Q. Yes. And I want to turn to paragraph 16 of your statement, this is where you describe your role whenever the Belfast Trust was first created, and you 09:11 say:

"In 2006 I was appointed to the post of Service Manager for intermediate care and mental health services for older people." 09:11

A. Yes.

15 Q. Did you have responsibilities for Muckamore Abbey Hospital as part of that role?

A. No. 09:11

16 Q. No.

A. No, I would have had responsibilities for dementia ward on the Knockbracken site for Frail Older People Services in Meadowlands, rehabilitation wards, and

responsibility for stroke services. So I was familiar with having responsibility for hospital services, but not Muckamore.

17 Q. Okay. Then if we look down to paragraph 17, we can see there that in 2012 you were appointed Co-Director for Older People Physical Disability within the Directorate for Adult Social and Primary Care. Did that involve any specific responsibilities for Muckamore Abbey Hospital? 09:11

A. No. 09:12

18 Q. Okay. And then if we turn over the page to paragraph 18, we can see then on 1st September 2017 you were appointed as the Director of Adult Social and Primary Care in the Belfast Trust, and you took over from Cecil Worthington in that role; isn't that right? 09:12

A. Yes, that's correct.

19 Q. I think you had a phased entry and you ultimately started substantively on 1st October 2017?

A. That's correct.

20 Q. That's right. And that obviously was a role that brought you into contact with Muckamore Abbey Hospital? 09:12

A. Very much so.

21 Q. And prior to that time had you ever visited the hospital?

A. I did visit as part of my social work course as, you know a visit, a professional visit as a student. 09:12

22 Q. Yes.

A. But it was a long time ago. It was the '80s.

23 Q. Okay.

A. It was very much a village feel to it then.

24 Q. Yes.

A. It was living, you know, it was a long-term living option.

25 Q. And presumably very different then whenever you encountered it in 2017? 09:13

A. Yeah, very different.

26 Q. I'll come on to ask you about that. One thing I just want to pick on then, if we move down to paragraph 20, please, is, you took over this post from Cecil Worthington. 09:13

A. Yes.

27 Q. And you said that Cecil Worthington conducted a review into whether the directorates should be combined. So it looks like was he acting -- he was acting at that time as the Director of Adult Social and Primary Care, Director of Children's Services, and the Executive Director of social work. So what directorates was he looking at combining? 09:13

A. When Catherine retired, the Chief Executive asked Cecil to take responsibility for Adult Social and Primary Care, there were three major divisions in that; Learning Disability, Older People, and Adult Mental Health, as well as his Executive Director of Social Work role, and his children's, the Community Children Services role, so it was quite a large, you know, spread of community and hospital services. I mean he concluded that it should remain -- I think the brief was: Do we need two Directors here or will one 09:13 09:14

director do? He concluded that two directors needed to remain.

28 Q. Yes. Okay.

DR. MAXWELL: So he was looking at whether children's services should be combined with ASPC? 09:14

A. Yeah.

DR. MAXWELL: And decided, no, they should remain separate.

A. Absolutely, yeah.

29 Q. MS. KILEY: You refer to a report, is there a formal written report authored by Mr. Worthington? 09:14

A. Yes, there was a report. He produced a report before we retired. I think I recall seeing it.

30 Q. So that would have been just roughly around autumn 2017 then, is that right? 09:14

A. Yeah, yeah.

31 Q. Just before --

A. September '17.

32 Q. Okay. Thank you. And if we move down then to your own experience, and you start describing this at paragraph 21 of your statement, so if we scroll down there. We can see at the -- that's it, just pause there, please, at the second sentence at paragraph 21. As you have already explained: 09:14

09:15

"The Director of Adult Social and Primary Care is responsible for a broad range of different services and is not under normal circumstances involved in the day-to-day operational management of MAH."

I've left out that second "not", presumably it shouldn't be there.

A. That's right.

33 Q. Yeah. 09:15

A. Yeah.

34 Q. So what you're saying is ordinarily that director is not responsible for operational management of Muckamore?

A. Yeah. 09:15

35 Q. But it was different whenever you took up post, isn't that right?

A. Yeah.

36 Q. And that was because of the unfolding crisis at the hospital? 09:15

A. Absolutely. I mean in many ways I never really had the opportunity to develop -- to be in the role that I was appointed for, because it was an evolving and enlarging crisis from really September on.

37 Q. Yeah. 09:16

A. And a very short space of time practically all of my time was devoted to various aspects of the issues in Muckamore.

38 Q. And you refer to the crisis evolving, but as it evolved your role evolved too. 09:16

A. Yes.

39 Q. Yeah.

A. Yeah.

40 Q. And you have described that with reference to three

periods of time in your statement, so I just want to look at those in summary first of all.

A. Yeah.

41 Q. If we could look at paragraph 24, please? And you say that your role was best described by reference to three periods of time. Firstly, September 2017 to March 2019. Second, April 2019 to October 2019, and October 2019 to June 2020, and you describe later on in your statement how your time changed in those three phases. So if we take the first one first of all, September 2017 to March 2019, you the describe this at paragraph 31 of your statement, please. If we could turn that up? 09:16 09:16

The documents that IT are working with today are quite large, so it often takes quite a bit of time to bring them up. 09:17

CHAIRPERSON: I know.

MS. KILEY: Okay. Thank you. You should see that on the screen in front of you now. So you say that your role during this time was to work with the Director's Oversight Group and the CLT, Collective Leadership Team, isn't that right? 09:17

A. Yes.

42 Q. 09:17

"...to ensure patient protection after the allegations of mistreatment of patients had been raised and subsequently viewed on CCTV and to provide assurances about MAH patient safety to the Trust Board. This

included reviewing the effectiveness of the systems which were in place, changing or replacing those systems as appropriate, coordinating effective working arrangements and communication across the different teams within the Belfast Trust and between Belfast Trust and external agencies."

And then at paragraph 32 you say:

"On a practical level this meant establishing working groups and meetings, creating and monitoring the progress of action plans, developing, progressing and monitoring the progress of resettlement, looking at data and trend analysis, providing briefings and update reports for meetings and committees (including the Trust Boards) and commissioning, coordinating and/or overseeing audits and reviews. Despite retaining overall responsibility for the entire Directorate, my diary was dominated by Learning Disability Services." 09:18

So those practical things that you have described, you've summarised them there and you give us more detail in your statement, so I will come on to look at those, but just to be sure what your role was at this period of time. You did have responsibility overall still for the Directorate, but in reality you were dominated by the issues that were taking place at Muckamore, is that fair? 09:18

A. Well, during that early period from September, you

know, September/October 2017, I mean I was heavily involved in actually, you know, reporting around the CCTV, you know, getting involved in all of that. I think that first six months or so was very much about discovery. I mean we had a team looking at -- a team of existing staff whose responsibility, part of their responsibility was to continue to do the viewing, and to do the sampling, and sense checking of the CCTV, so that we could start to get a sense of, you know, how, you know, the frequency of incidents. I mean then there was a decision taken to view about 25% of -- in order to undertake the sense checking. So a lot of that during those first few months was around that particular work. I was based in the City Hospital, I still had responsibility for Adult Mental Health and Older People's Services. We were trying to implement collective leadership teams. 09:19 09:19 09:20

43 Q. I'm going to pause you there, if you don't mind, Ms. Heaney?

A. Okay. 09:20

44 Q. Because I am going to come on to ask you about all of them.

A. Okay. That's fine.

45 Q. But what I just want to do at this stage is just orientate us as to how - what your role was at the different periods before we go into it. 09:20

A. Yeah.

46 Q. So at this stage you're Director of the entire Directorate still, you're based at City Hospital, but

in reality you were dealing with Muckamore nearly all of the time?

A. Yeah. Yes. I mean obviously the Collective Leadership Team were responsible for Learning Disability, they were responsible for the hospital, and they were responsible for a whole range of Community Learning Disability Services. The management structure within Muckamore was quite light. I mean there was -- you know, before the Collective Leadership Team there was one Service Manager and a number of Assistant Service Managers. There was no Governance Manager. It was quite a light -- and it surprised me that it was such a light, given the high level of risk evident within that hospital. So those first few months were very much with putting investigative processes in place, the Adult Safeguarding Investigation, talking to the police, setting up the multiagency groups that are required under the Adult Safeguarding Policy, as well as a Memorandum of Understanding. You know, starting to looking at the issues within the hospital in terms of what is governance like in this hospital? 09:20 09:20 09:21 09:21

47 Q. Yes.

A. What are the systems and processes in place? So that was the type of work that the collective leadership were doing and reporting to me, but one of the very first things we did as a Directorate was to get ourselves together and set up a Directorate oversight meeting. 09:21

48 Q. Yes.

A. Obviously everything was new to me, I had no history in Muckamore, I didn't know any of the staff. I knew some of the managers from other forums. So it was very much a steep learning curve for me, and it just got steeper from that point onwards. 09:22

49 Q. Yes.

A. So those were really the tasks, and I found myself -- as I say, there was so many gaps in the management structures at that stage that I was filling in for interview panels and, you know, various other pieces of 09:22 work. So that was that first phase. I mean obviously we didn't -- the viewing that was going on at that time to try and sense check was done by senior staff, it was done in a fragmented way because they could only do it maybe at certain times when they got a chance with 09:22 their other duties.

CHAIRPERSON: Can I just ask what you mean by sense check?

A. Just to see, you know, what the type of practice was from the CCTV viewing. I mean there was a view of 09:22 maybe some staff that these were isolated incidents.

CHAIRPERSON: So to get an overview?

A. Just to get an overview of...

CHAIRPERSON: Yes.

A. But I think we did... 09:22

50 Q. MS. KILEY: I think in fairness to you, Ms. Heaney, you describe this in detail later on in your statement, and you've mentioned important things about the CCTV viewing and governance, and I want to give you an

opportunity to describe those in more detail.

A. Yeah. Okay.

51 Q. But if we stick just with what you're saying here about your various points in time. Your role -- if we park what happened in September '17 to March '19, and I'll come to ask you about that in detail, but just so we understand what happened then in March '19. Your role changed, and you describe it from paragraph 34 onwards, and you say there that you returned at -- yes, if we look at paragraph 34, you have in front of the screen there. 09:23 09:23

A. Yes.

52 Q.

"By March 2019, notwithstanding the considerable efforts that had gone in by many people, it was apparent that in order to support the stabilisation of management structures in MAH and Community Services, it would be best for other Directors to cover the normal functions of the Director of ASPC to allow me to spend 6 months focusing solely on MAH."

So by this time your other responsibilities were taken away so that you could focus solely on Muckamore for six months.

A. That's correct, yeah. 09:24

53 Q. And then that takes you to your third phase of time, which is October 2019 to June 2020. You mention this at paragraph 39. And it was at that time that you returned to lead Older People and Community Services,

isn't that right?

A. That's correct.

54 Q. And I just wanted to clarify with you then, are you saying that at that stage, October '19, your role in the day-to-day operational management of Muckamore ended? 09:24

A. That's correct.

55 Q. Okay. So really the time period that we're looking at for your Operational Management experience is September 2017 to October 2019? 09:24

A. That's correct.

56 Q. So I want to go back then to that first period, and you described your steep learning curve, you've already mentioned CCTV and governance issues. But you were joining the hospital at the time when the crisis was just unfolding, and you described not being familiar with the staff or the environment. Can you give the Panel a sense of your first impressions of Muckamore whenever you first visited it? 09:25

A. Well the first time I visited it, you know, during that period, I suppose the first thing that struck me what a restricted environment it was, you know, and we went around all the wards, you know, and into Cranfield 1 and 2, and the Intensive Care Unit, Six Mile, the Day Centre. I mean clearly the environments had been a lot of new buildings, but very restrictive. I mean a lot of keys, you know. It was definitely a very -- it was a bit like a prison really, and that was my first impression. Quite stark. I mean it was a lovely - 09:25 09:25

lovely grounds and nice -- great Day Centre. The Therapeutic Day Centre. Some good facilities. But some really old buildings, you know, that were no longer fit for purpose, it was very clear. Highly restricted. Just not really a homely place. I mean I learned that there was about - at that stage there were still about 95 patients on the site. Only a small number of them were in active treatment. So, in essence, it was a long-term living environment. So that didn't really sit well with me because all of my career has been about de-institutionalisation. I mean I was a manager of a care home back in the '80s and managed care homes quite a lot, and I was very acutely aware how the complex job it is to run a successful institution. You know, there is hypervigilance required all the time. And I was involved in, you know, a number of Adult Safeguarding Investigations in relation to nursing homes. So I was quite tuned in to all of that and I was picking up just red flags on my first visit, you know. 09:26 09:26 09:27 09:27

57 Q. What do you mean by red flags?

A. Well, the fact that there was over 90 patients there and most of them not in need of assessment and treatment, who were de facto detained, you know, going by case law, and I was reasonably familiar with that. Discharges were glacially slow. I mean you were there for months, if not years. So very concerned about deprivation of liberty, and the lack of responsiveness of the wider system to support discharge. I mean those 09:27

are my early thoughts. I was taken aback by the culture. I mean the issues in Adult Mental Health and Older People's Services at a high level are similar, you know, the issues around the quality of community services, the range of community services that's 09:28
available across seven days or even after hours, you know, and there's huge pressure in Older People's Services on delayed discharges. I mean there's no way you would be permitted or the system would have the tolerance to leave older people, you know, languishing 09:28
in hospital - though it did happen, you know, there was delays, significant delays there too, but not to the extent. So it was those human rights issues, delayed discharges, people missing out on their lives. I could see that there was gaps in governance, you know, when 09:28
I was talking to the Director of Nursing and other staff there. I learned of the chronic staffing shortages in all areas, but particularly -- now I mean obviously it was a hospital. The majority of the workforce was nurses, and the concerns around the 09:29
ratios of qualified to unqualified.

I noticed that, you know, it was quite siloed. The nurses, the doctors, the AHPs, you know, everybody had -- I didn't get any sense or didn't see any much 09:29
evidence of integration, very much it was a hospital in retraction with very unsafe populations at times in each of the wards, high levels of aggression, violent incidents. I mean it is quite shocking when you don't

know that particular area and the high tolerance of it. I mean that's the thing that really gripped me was the fact that, you know, there was thousands of patient-on-patient incidents and staff injuries. Some of them quite serious. So I found it quite alarming and quite scary, you know.

CHAIRPERSON: Can I just ask, had you had any heads-up about any of these issues? 09:29

A. Well, not really.

CHAIRPERSON: From your predecessor? 09:30

A. Yeah, I mean you would -- I would be at directorate level meetings, governance meetings, and you could see there was all these incidents. But I didn't really understand the reality of it, because I was focusing on my own area in Older People Services. 09:30

CHAIRPERSON: No, I understand.

A. So I didn't really take it on board. But when you actually see it, I just, you know, I found it quite disturbing, that's the honest truth. I remember talking to families, you know, and they were so -- they 09:30 were just so -- it's hard to find the words for it. They were just exhausted and they just -- I was really taken aback that these individuals were locked up and here their families were past themselves with worry, and I just, I found it hard to believe that we had a 09:30 service like this. It was so difficult. And that it was so hidden, or at least it was hidden to me. So that was my first impression. I mean I garnered that over a period of months, I would during those first few

months I learned quite a bit. I did a lot of research as well myself, I did a lot of reading, talking to staff, you know, and there was a learned helplessness about the staff group, you know, there was a culture there that "nobody understands us, they don't know what we have to deal with, there's no appreciation of it", so the culture slapped me in the face straight away. 09:31

DR. MAXWELL: Can I just ask, so Cecil Worthington had been managing in the interim while there was a vacancy.

A. Yeah. 09:31

DR. MAXWELL: And he was the Executive Director of Social Work, so an executive member of the Trust Board, had he not shared these findings with you?

A. No. No, I mean I had conversations. I think the thing -- I mean Cecil was a very, you know, a very positive person and he did -- I think there was issues going on with Muckamore that he shared with me, but not the actual clinical side of it. It was more, you know, what are the issues? We talked about delayed discharges and staff shortages. But I think the reality of -- 09:32 09:32

DR. MAXWELL: And in the report -- did you read the report that he did that we referred to earlier, where he concluded the two directorates shouldn't be merged?

A. Yes, I read it at the time, but I don't have much memory of it. I think it was very much not about services but about the role of the Director, you know, with all these environments, it was impossible to deliver. 09:32

DR. MAXWELL: So when you did the sense checking and were so shocked by what you found, did you go back and discuss that with him?

A. This was after he left. I mean he retired 30th September.

DR. MAXWELL: Okay.

A. So it was very much after that.

DR. MAXWELL: Did you discuss it with his replacement, the new Executive Director of Social Work.

A. Well, that post was vacant, the Executive Director of Social Work when I joined the team, and it wasn't filled substantively I think maybe for another year.

DR. MAXWELL: So who was your line manager at the time?

A. The Chief Executive.

DR. MAXWELL: So did you discuss it with the Chief Exec?

A. Yes, I think -- yes. I mean as -- obviously once the information became clear, there was the extensive discussions about it at Executive Team every week and at every Trust Board meeting.

DR. MAXWELL: So how early do you think the Chief Executive knew that you had major concerns about the culture and the practice?

A. Yeah, I think that was more or less, you know.

DR. MAXWELL: So October '17.

A. Probably between October and March, you know, the information was the filtering through. Mr. Martin Dunne would have visited the site itself himself. I think everybody on the executive team got a clear idea

of the challenges within Muckamore.

DR. MAXWELL: Okay.

58 Q. MS. KILEY: One of the other major challenges that was unfolding on top of what you have described was dealing with the CCTV, and you have described that in detail in your statement, so I want to turn to that now, please, at paragraph 154. And here you describe the immediate actions and response to the CCTV incident. I know you have it in front of you, Ms. Heaney, so we'll continue while we wait for that to be brought up on screen. 09:34

A. Okay.

59 Q. But you say there at paragraph 154 that:

"On 12th August 2017, an adult safeguarding incident occurred in the psychiatric intensive care unit (PICU). 09:35 While internal reporting occurred within the ward, it wasn't until the 21st of August 2017 that the incident was reported to the hospital management team."

A. Mm hmm. 09:35

60 Q. When you refer to "hospital management team" there are you talking about directorate management at directorate level or at hospital level?

A. No, at hospital level.

61 Q. Okay. And then -- are you aware then of why it took 11 days for it to get to that management report? 09:35

A. Yes. My recollection is from the detail is that the Ward Manager or the Charge Nurse was on leave. The staff nurse who made the observation and the report had

contacted, had let his line manager know, which was the Deputy Charge Nurse in PICU. I think he wasn't quite sure, he wanted to get more information, so there was a delay until their manager, their Charge Nurse came back from leave, but as soon as he came back. So it was reported but within the ward, it wasn't escalated to the hospital management team, and once the Charge Nurse returned from leave, learned about this, he immediately went to the hospital management team, and then all the usual processes kicked in, you know, referral to the police, to the adult safeguarding team for investigation, notification to RQIA. So the reporting systems kicked in at that point. 09:36 09:36

62 Q. Can you recall when --

CHAIRPERSON: Just to be absolutely accurate, it is nine days. 09:36

63 Q. MS. KILEY: Nine days. Oh, well my maths has let me down then. Can you recall whenever you first became aware personally?

A. Yes, I was in that phase of moving into the role of Director in September. I was -- a Co-Director colleague, Barney McNeaney phoned me and said that this incident had been reported to him and he wanted to let me know because he was concerned about it. So we agreed that we would meet that day, we would just pull an urgent meeting together, you know, with Esther and the DAPOs, Amanda. So we all met that day. I can't remember exactly who was there, but certainly Esther and Amanda. I forget her last name at the moment. And 09:36 09:37

we -- I asked Esther to do a timeline from the 12th August so that we could have contemporaneous information about what steps were taken, what gaps there were, and I immediately asked the staff to do an SAI notification and update the Early Alert, which had already occurred, and we started to organise -- it was a Friday, actually, so we had to organise amongst ourselves leadership visits, monitoring visits, to make sure that the senior nurses on site were aware of this, and one of the early steps was they needed to move out. So there was enhanced monitoring put in place over the weekend to give us a chance, you know, to think about this and regroup on Monday and make some decisions on Monday. 09:37 09:38

64 Q. And how quickly did viewing of the CCTV footage start? 09:38

A. Well, Esther had -- I learned then on the Monday then, I think at that meeting we all regrouped and there was more people. I mean Dr. Milliken was there and I think the Associate Medical Director was there. There was a bigger group of us there. We just tried to, what information do we have about this, you know, and what decisions do we need to make? Protection. You know, the senior social workers were there. I mean the key decisions were, I think Esther had already established that she had contacted DLS to determine if we could -- this test footage, which obviously was new to us, we weren't aware that there was test footage available. I had been told that the CCTV was due to go live some time in September. So it was Esther and a few other 09:38 09:39

staff, Colin Milliken, Dr. Milliken, some of the senior clinical staff within Learning Disability undertook to do some viewing, view the incident that had been reported, and then it became clear that there was more incidents and there was underreporting. 09:39

65 Q. Yes.

A. So that was another --

66 Q. I want to just take you to paragraph 161, because you describe there:

09:39

"As the initial viewing continued, it demonstrated that behaviour from staff in this ward..."

- that's PICU that you referred to earlier:

09:40

"...reached criminal and safeguarding thresholds, with some evidence that most incidents occurred at weekends and evenings, suggesting covert behaviours."

I just wondered what the significance that you attach to the weekends were? You describe that as covert behaviours. Can you tell us a bit more about that? 09:40

A. Well, the people who were viewing, you know, those sessions, I mean I think they would have viewed a sample of shifts, you know, day shifts, evening shifts, overnight shifts, and weekend shifts when there's less. And those early times of viewing, they were reporting that most of the incidents appeared to be occurring when there was less supervision around, evening and 09:40

weekends.

67 Q. The process of viewing CCTV then grew ultimately, and DAPOs were viewing CCTV. Were you in charge of that overall process? Did you have operational oversight of that? 09:41

A. Of the viewing?

68 Q. Yes.

A. I mean the first decision was made that there would be an Adult Safeguarding Investigation, and the divisional social worker would have been taking that forward with 09:41 Amanda, with the DAPO, who was the Designated Adult Protection Officer. So, no, I wouldn't have been directly involved. But they would have been, you know, of the viewing, I mean they would have been -- I mean obviously very early on there needed to be guidance 09:41 provided, and protocols were drawn up, they were amended and developed over time. But obviously we had to put in place a system to take forward the viewing. It had to be downloaded and, you know, there's a lot of technical work to be done initially in a room, a secure 09:41 room identified, screens set up. So there was all those practical -- and then a rota of staff to do viewing and make sure that it was recorded and forms were drawn up. So all of that work was undertaken by the Collective Leadership Team and shared with the -- 09:42 particularly Brenda Creaney and myself as, you know, the --

DR. MAXWELL: Who line managed the social work team that were doing the viewing?

A. Who managed them?
DR. MAXWELL: Who line managed them?
A. Oh, who line managed? Let me think now. The social workers in Muckamore -- no, sorry, the social workers who were doing the viewing initially would have been the DAPOs in the community. 09:42
DR. MAXWELL: So who line managed the DAPOs in the community?
A. I just can't quite recall. I mean certainly Amanda was one of the Assistant Service Managers, and she would have -- there were community -- the way it worked was that the community teams were largely multidisciplinary and they would have had a professional manager and a Service Manager. So there was a Service Manager for the community. 09:42 09:43
DR. MAXWELL: And so they were being managed operationally through the Service Manager in the community.
A. Yes. Yes.
DR. MAXWELL: And -- 09:43
A. And professionally by --
DR. MAXWELL: Do you remember who that was, without naming them? Perhaps write it down for the Secretary.
A. Yeah, I'll need to think about it for a moment.
DR. MAXWELL: Sorry? 09:43
A. I'll need to think about it for a moment.
DR. MAXWELL: Okay.
A. But it will come back to me.
DR. MAXWELL: Okay.

MS. KILEY: Well we can maybe come back to that then.

A. Yeah, I've taken a blank.

69 Q. But you were Director at the time. So whilst you might not have had line management responsibility, is it fair to say that you would have had overall responsibility for the process that was going on at the time, or is that not -- 09:43

A. Yes.

70 Q. That is right. Okay.

A. Yeah. Yeah. 09:43

71 Q. The Inquiry has heard from DAPOs whose task it was to view the CCTV, and they have described challenges in the process, including challenges in terms of lack of facilities for their viewing, the volume of referrals, lack of support for them in viewing upsetting footage, were you aware of challenges like that? 09:44

A. Well, certainly not initially. Initially they would have been -- are you talking about the staff or the team who were appointed?

72 Q. The DAPOs who were viewing footage? 09:44

A. Yes. Oh, yeah. Yeah.

73 Q. Were you aware that they were facing those sorts of challenges?

A. It certainly filtered through to me I think possibly around Christmas '18 or January '19 , around that period. The issue was that -- I'm trying to think of a timeline. I mean certainly there was, there was a couple of DAPOs involved from the community in the major part of the viewing alongside a Learning 09:44

Disability Nurse, she was experienced in MAPA, who was a MAPA trainer as well. So, yes, I became aware. I can't quite pinpoint when I became aware of that. I think it was really around Christmas '18. But certainly I mean there was -- it became clear that some of the incidents were upsetting for them, and over time, you know, more support was provided to the viewing teams. But certainly it was emotionally, you know, it was laborious, or emotionally challenging, and a lot of staff, viewing staff, would have turned over. 09:45

74 Q. Mm hmm. There was the viewing of the historic CCTV and there was also viewing then that commenced of contemporaneous CCTV; isn't that right?

A. Yes.

75 Q. And you describe that at paragraph 163. So just to orientate us in time: The contemporaneous viewing started in 2018; is that right? 09:45

A. Yeah.

76 Q. Can you recall roughly the month?

A. Paragraph 163? 09:46

77 Q. Yes.

A. I think that started to happen -- I mean obviously -- i mean what we were dealing with here, you know, if you take it, you know, to a higher level, you know, the Adult Safeguarding Policy and Procedures provided no guidance for large scale viewing, nor did the Joint Protocol. I mean there was absolutely no guidance, so this was an unprecedented and novel situation to be in. There was no CCTV policy in terms of the analysis of it 09:46

and the interpretation or protocols, everything had to be done, you know, as you went along day by day. So it was -- everybody was in this together, learning together, trying to make it work. There was no detailed guidance anywhere in the system, and there was no really help forthcoming, you know. I mean I did try to see from other jurisdictions that this was a situation that other local authorities in England and Scotland had encountered, and I couldn't come across anything. Normally when something like this happens in learning disability care settings, from what I was hearing and reading, the facility was closed pretty sharpish once the residents or the patients had found suitable placements elsewhere in the country. We had 95 patients on site. There was CCTV that by the time probably a six to nine months after we started viewing, it was -- I mean the volume and the seriousness of some of the incidents was, you know, very -- you know, you were in an emergency or a crisis management situation every single day. So it's not surprising that staff at all levels, particularly those viewing, did become burnt out and stressed. 09:47 09:47 09:47 09:48

78 Q. And being aware of that situation and being in it...

A. Yes.

79 Q. Did you take any steps to try and alleviate those pressures? 09:48

A. Well, the steps that were taken for the viewers, I mean obviously there was training and protocols provided, and mutual support I think was provided. But I mean I

would certainly say it was insufficient, you know, there's no doubt about that. I wasn't close to the team. It maybe came to the Director level, you know, weeks and weeks maybe after, and I certainly did two exit interviews with two DAPOs at one point who were leaving, who had done a sterling job, but felt they just couldn't continue anymore. So I think that was the first time I really, this is really, really difficult for these staff and, you know, I think that, you know, the staff counselling and things like that were made available, occupational health, you know the usual mechanisms to try and support staff. 09:48 09:49

80 Q. But they weren't sufficient for this type of task, is that what you're saying?

A. No, I don't think the were. No, definitely not. It was a major learning point. 09:49

81 Q. And you described a lack of guidance in terms of the level and the scale of this investigation.

A. Yeah. Yeah.

82 Q. Having considered that there was a lack of guidance, did you seek external assistance or guidance from the Department, for example, or from anyone? 09:49

A. Oh, yes. I mean I had extensive conversations, both within the healthcare system at home, here, as well as England. I contacted -- I had contacts in emergency care in other places, you know, just to find out. So there was really nothing forthcoming. It was novel for the police as well, you know. The initial response from the police was that we needed to view this and 09:49

identify incidents of concern, have a joint agency conversation and decide if it, you know, met a certain threshold. So all those processes were new. I mean the policies and procedures were designed for individual cases. It was completely inadequate. The Adult Safeguarding Policy and Procedures were very new. They were only published, you know, probably the year before, 2015. 09:50

83 Q. Are these the regional policy that you're referring to?

A. Yes. Yes. It was a regional policy. There was a lot of dissatisfaction with it. It was felt to be quite inadequate. 09:50

84 Q. Can you tell us a bit about that? The dissatisfaction in respect of the policy, was that something that had arisen before the CCTV revelations? 09:50

A. Yes. Yes.

85 Q. And in what ways was it considered to be inadequate?

A. Well, this policy and its procedures were in development for two or three years. I mean it had been flagged probably in 2014/2015 that they needed to be upgraded. But it took the Department a few years to publish these updated adult safeguarding procedures. Those of us who were close to adult safeguarding, although I was not an adult safeguarding practitioner, you know, a middle manager, if you like, with multidisciplinary responsibilities, but certainly staff who I worked with reported that it took a long time for the new policies and procedures to come out, that staff on the ground, and certainly at my level, were pushing 09:51 09:51

for legislation in line with other jurisdictions. We were looking for detailed guidance, including large scale investigations, because in practice most of the referrals we had in Adult Safeguarding and Older People Services were from nursing homes, and they were very much related to quality of care issues, and there was a lack -- there was a distinction there that was difficult -- you know the new policy conflated prevention and protection, and that, in my opinion, was a mistake, because we were overwhelmed then with the -- the care homes felt they had to report everything. So the whole system became overwhelmed. Nobody understood the policy. I think it was introduced -- in my opinion not much in the way of understanding of the governance implications, the training implications, I mean the recommendations for gateway, adult gateway service for external and internal referrals, it didn't take account of the implementation challenge. But particularly the conflation of safeguarding and protection confused everybody. 09:52 09:52 09:52 09:53

86 Q. And you're placing that at a point of time before even the CCTV --

A. Yes.

87 Q. -- incidents emerged. So there was a confusion between the guidance being put in place, which I think was 2016? 09:53

A. Yes.

88 Q. And you're saying there was a period of confusion where Belfast Trust staff were unclear as to what --

A. Completely.

89 Q. What was going on.

DR. MAXWELL: Can I just ask you, because there had been -- you mentioned nursing homes, there had been a big concern in Dunmurry care home. 09:53

A. Yes.

DR. MAXWELL: And quite a few investigations. Had they also found the policy to be inadequate at Dunmurry.

A. Absolutely. I mean I think it was common across every Trust, you know. At regional meetings. I mean there 09:53 was, it was a well written document, and good values and principles, and so on. But the procedures were very much -- there was no IT system to deliver the forms, so it was laborious, there was endless forms to fill in, and staff felt that their social work skills 09:54 were being eroded, they were being disempowered, you know, everything had to be reported, and that kind of clogged up the system, and I think it took us back, you know, it was regressive.

DR. MAXWELL: So can I ask you, Dunmurry happened 09:54 before the CCTV at Muckamore, and I think the report was issued before that. Was there any regional or Belfast Trust learning or reflection from the Dunmurry investigations?

A. In my recollection the Dunmurry thing happened during 09:54 the Muckamore.

DR. MAXWELL: Did it? Okay.

A. Yeah, because I do remember I'd asked Margaret Flynn to do - who was the author of a "Way to Go" - to help me

with a workshop with social workers around the whole area. So I think it happened at the same time.

DR. MAXWELL: Okay.

A. You know, during the same period.

90 Q. MS. KILEY: But regardless of Dunmurry, you were forming a view on the implementation of the regional advice that there were issues with it. So were you or anyone else in the Belfast Trust escalating those issues and communicating them to the Department? 09:55

A. Yes. I mean the mechanism we had was the delegated statutory functions, you know, reporting system, where all of the programmes -- really in adults or a social care performance system really, where we reported all our activities and measurements, such as, you know, where they were, to the HSCB, the Regional Commissioning Board, to the Executive Director of social work and her team or his team. I was -- I looked over them recently, and the whole -- the business of the Adult Safeguarding Policy and Procedures was raised consistently, and it needed more resources, it needed more time for implementation, it needed to be phased, and Belfast in particular flagged that, you know, every year since its introduction. So there was a process to feed back to the Regional Board, who presumably would have fed that up to the Department. So, yes, that's really all we could do. 09:55 09:56 09:56 09:56

I mean as far as I'm aware, the policy came out, there was limited training budget - Belfast Trust had 22,000

staff - and a very small team of staff were available to provide training for the entire Trust, as well as specialist advice, perhaps in a situation in a hospital, like an incident, you know a general hospital where an incident occurred. 09:57

So overall I think we had to try and adapt, the social workers working with the viewing had to look at the procedures they had and adapt it as best they could to the situation that they found themselves in. 09:57

91 Q. And who was making those decisions in real time? You --

A. Largely those operational decisions were being made by the Collective Leadership Team and shared with the Directors Oversight Meeting. So there was, you know, a collective response to that. 09:57

92 Q. We have digressed a little bit from paragraph 163, so I just want to bring you back there, because I was asking you about the contemporaneous viewing.

A. Oh, yeah. 09:57

93 Q. And I had asked you roughly which month in 2018 the contemporaneous viewing started. Can you recall?

A. I can't recall precisely, but I think it was mid -- it would maybe have been May, June, you know around that period. 09:58

94 Q. Yes.

A. I mean obviously we had to recruit a separate team.

95 Q. Well, I wanted to ask you about that.

A. Yes.

96 Q. So what was that separate team made up of? What were their professional background?

A. Social work. I mean I think we wanted to include social work and nursing. But it was easier to recruit social workers, retired social workers and so on. 09:58

97 Q. And how many were people in that team?

A. It varied. It was quite small. And we could only do the contemporaneous viewing related to the capacity of the team to carry it out. So we were always trying to recruit more people to that team so that we could 09:58 get -- I mean this was a key mitigation for us that we could demonstrate -- I mean I do recall that the PSNI, who also did some of the viewing, that the behaviours changed quite noticeably once it became known across the site and then we decided we would -- or a 09:59 contemporaneous team would be set up.

98 Q. Do you mean once it became known that contemporaneous viewing was going to happen?

A. No, that the CCTV had been running since March to September and that there was, you know, close to 09:59 500,000 hours -- but that reduced because of the sensors. And staff were then immediately aware, I mean because that was shared with them, you know, as quickly as possible. So they were aware. I was told that the behaviours changed. We had the contemporaneous TV, we 09:59 improved governance. So it took us a while to build up a series of mitigations so that we could demonstrate that learning had occurred on the site, and that behaviours that may have been part of a culture, or may

have been criminal, were unacceptable, and behaviours changed, and we were able to demonstrate that through this mechanism.

99 Q. Is there a reason why that mechanism, and implemented for the reasons that you've outlined, wasn't in place sooner? Either before mid-2018, but also even before the CCTV revelations, as a precautionary measure in a high risk environment? 10:00

A. Well, that's a good point.

100 Q. But is there a reason that you know of as to why that didn't happen? 10:00

A. The only reason is that, you know there was no -- I mean the whole CCTV in a high risk care setting was controversial. I mean it didn't occur, as far as I'm aware in any -- I mean sometimes families would have done covert recordings maybe in a nursing home, and I was aware that sometimes that happened, but that had to be very much the families made that decision as opposed to the Trust. So there was a period when we had to have the CCTV policy for a particular - it was to help in adult safeguarding investigations, not, you know, viewing staff practice. I would suspect that that would have taken - would have been quite controversial with staff and with unions. So it wasn't for that purpose. We had to amend the CCTV policy when we decided to introduce contemporaneous CCTV. I can't remember whose idea it was, it certainly wasn't mine, but it was a very useful -- and over time, whilst staff were uncomfortable with it, we did speak to the unions 10:00 10:00 10:01

and staff, and then, you know, over time they became more comfortable with it. But it was a major issue, and we feel it was a factor in the turnover of staff. I mean the other thing that struck me about Muckamore was the haemorrhaging of staff.

CHAIRPERSON: So the controversial side of it, the pushback, certainly as far as you know, wasn't from families or patients; it was all from --

A. Staff.

CHAIRPERSON: Staff and unions. 10:02

A. Yeah. Yeah.

CHAIRPERSON: Yes.

A. Yeah.

DR. MAXWELL: But was that based on data protection concerns? 10:02

A. No, I don't think it was, you know, data protection in particular. I just think it was -- they felt it was scrutiny of their practice, a lack of trust, and would be used to, you know, if they weren't wearing the right uniform, or they were out smoking, you know, that it was an unacceptable level of scrutiny that no other staff group were exposed to, district nurses or social workers in the communities weren't being. I think it was more that dimension. 10:02

101 Q. MS. KILEY: In terms of volume of viewing in this contemporaneous phase, in the second sentence there you say: 10:02

"Initially, this consisted of viewing one shift a week

per ward, including night shifts."

And then the frequency increased later as more personnel became available. So what level did the viewing increase to? How much was being viewed? 10:03

A. I can't remember the specific detail, but I think, you know, we were aiming to have every ward, you know, a shift per week in every ward.

102 Q. So this was a dip sampling type approach?

A. Yes. You know it wasn't continuous, so I mean the viewers would have come in and picked say Cranfield 1 and looked at several shifts over a period of time and then the next time it would be another. But I mean there was a pro forma, they were submitted, they became part of the safety metrics and, you know, we fed back to them and wanted more detail, for example. So it was very useful and reassuring, and eventually, you know, we -- it became part of a feedback loop to staff, you know, that good practice occurred and, you know, in some of the communications, you know, the speech bubble would have been put out so that staff were aware that all of these good practice, sometimes very sophisticated practice in diffusing and de-escalating quite difficult situations, and that was captured. So I mean I think some staff eventually came to see that that the CCTV was extremely useful for debriefing on a particular incident, because everybody in the team could look at the incident and see and analyse the triggers and then devise better psychological

formulations, pod arrangements, to try and reduce the number of incidents and safety for patients.

103 Q. And as the usefulness of the viewing and the product of it became known and embedded, did that change staff views? Was it less controversial? 10:04

A. Yes. I mean it certainly reduced that anxiety. We had a critical friend in East London Foundation Trust, and their team were over, and they did a workshop with staff on, you know, practising under CCTV with confidence, you know, because obviously there's a lot 10:05 of physical and emotional labour with supporting patients in some of the wards in Muckamore. So I think that was helpful. I don't think, you know, some staff ever got used to it. But after a while I think they forgot it was there. I mean like human beings, you 10:05 just forget, you know.

104 Q. Well, CCTV viewing was one of the immediate responses. There are a number that you also refer to in your statement and I'm going to move to those. Chair, I'm in your hands, we've been going for an hour. I'm going 10:05 to move on to some different responses? I can continue or take a break, if you like?

CHAIRPERSON: Are you okay for another 15 minutes or so? Let's try and do another 15 minutes and then we'll break. 10:06

105 Q. MS. KILEY: Can I ask you then to go back to paragraph 162, Ms. Heaney, because this is where you set out all the emergency actions that took place in the immediate period from September 2017? I'm not going to go

through all of those. CCTV viewing, both historic and contemporaneous, was a major workstream. Another one that I want to ask you about is, if we scroll down to (f), please, you describe here:

"Rapid review of crucial patient safety systems was undertaken by the CLT, discharge delays, patient activities, seclusion policy and restrictive practices." 10:06

Who undertook the rapid review? That was part of CLT work, was it?

A. Yes.

106 Q. And why was the seclusion policy particularly singled out for review? 10:07

A. Because some of the earlier CCTV viewing had clearly shown unauthorised use of seclusion, and poor practice in relation to seclusion, and lack of recording, and lack of matching between what we saw on Datix and what was on the CCTV. So clearly there was a lack of compliance and adherence to the seclusion policy, as well as poor practice in some of the incidents at that stage. So that was number one policy for review. 10:07

I mean there was also -- we'd asked -- or Brenda Creaney had asked an Independent Assurance Team, it was called, I mean there was a Professor from the University of Ulster, yeah, Frances Cannon, to have a look at some policies as well as staffing models -- 10:07

there was a number -- a number of tasks were set then, and they certainly came back to say that the policies were out of date and were more appropriate for Mental Health and Learning Disability, you know, they appeared to be a lift from Adult Mental Health. So that concerned us. So obviously the key safety policies were the ones we looked at; admission and discharge, restrictive practices, all of those policies, and seclusion was number one, and we contacted Mersey Care because they had, you know, had done good work in this area, and spoke to an officer there and they shared a lot of their material. 10:08 10:08

107 Q. Mmm.

A. So a process was then started to develop our new seclusion policy, and that was widely consulted on and implemented. 10:08

108 Q. Can you describe the changes that were made, in summary?

A. Look I can't remember the specifics, but certainly the monitoring of seclusion, you know. I mean the overall aim was to reduce or eliminate the use of seclusion. I mean there was an analysis done on why so much seclusion and what measures were put in place to reduce seclusion? I mean we talked about some patients who wanted voluntary confinement to self-soothe. It was very much around compliance of observation, the use of it, the reasons for it, who signed it off, you know, who authorised it? The senior nurse? The doctor? And then the monitoring of it afterwards, to make sure that 10:08 10:09

it was in line with guidelines. But the overall aim was to eliminate seclusion.

I mean just to say, I mean this was a hospital full of people who shouldn't have been there, and my number one priority from my task list was making sure people were discharged from this institution and had good accommodation and good support in the community so that they were liberated from this environment. So I mean you wouldn't need seclusion if you hadn't so many patients who were triggering each other and causing lots of incidents. So from a high level it was 'We need to get some flow through this hospital'. However slow it was, we needed to start moving that process on. And obviously this hospital had reduced from I would say 350, when the Trust took it over, and it was now down to around, well 90, and then gradually -- I think by the time I moved on it was in the 50s. So there was good success, but it was slow, very complex, labour intensive. There was lack of overall structures in the system regional meetings, interdepartmental meetings, none of that existed, but it had in the past, you know.

10:09
10:09
10:10
10:10
10:10

109 Q. Well, I'm going to come on to ask you about resettlement specifically. But presumably there was a balance there too, Ms. Heaney, because whilst there might have been a desire to move patients on, there was also a need, presumably, to make the environment safe and to provide for the needs of those who remained in hospital?

10:10

A. Absolutely. Yeah. Absolutely.

110 Q. And I think some of the measures that you describe in the immediate aftermath were with a view to that. For example, if we look at paragraph 164, you describe the introduction of a team of positive behaviour therapists? 10:11

A. Yeah.

111 Q. And that was in late 2017. Can you describe the appointment of that team, the number who were appointed and what their role was? 10:11

A. Well, at the outset I would say that the nursing workforce and the psychology workforce were not my area of expertise, and I mean what my role was in that was to meet with PHA staff and secure as much resource so that we could -- there was some positive behaviour staff in Muckamore, but they were a very small number, and clearly that was an issue because, you know, the psychology input needed to expand and deepen, and that culture of, you know, understanding the behaviours and responding to them appropriately and therapeutically was a priority. So I mean the recruitment of PBS staff was the responsibility of Sarah Meekin, you know the Head of Psychology. So I think there was about seven or eight were appointed and integrated into the system at Muckamore. 10:11 10:12 10:12

112 Q. And was their introduction at that time as a result of -- was it accepted that prior to that there hadn't been sufficient Positive Behaviour Support?

A. Yes. Yes. Absolutely.

113 Q. And it might be thought that Positive Behaviour Support in a long-stay learning disability hospital is a straightforward requirement?

A. Yeah.

114 Q. Is there a reason why this team wasn't in place until late 2017 and was introduced only as a result of a crisis? 10:12

A. Well, I don't think it was introduced just because of the crisis. I think there was some staff there. I mean Learning Disability Nurses themselves consider themselves, and they are highly skilled in Positive Behaviour Support, you know, it's not -- but there was a lot of -- the skill mix in Muckamore, you know, very often dipped, you know, the ratio of Learning Disability Nurses and healthcare assistants would have dipped from time to time, so there was concern. But you're absolutely right. 10:13 10:13

But my impression in talking to colleagues, there was a sense that Muckamore was a retracting hospital, that there wasn't sufficient understanding across the system, that as the hospital retracted the needs grew more complex and actually you needed to focus much more on maintaining a safe and therapeutic environment in Muckamore. But that's -- there was a number of factors appeared to diminish that. So you're absolutely right. I mean -- 10:13 10:13

115 Q. And are you saying that focus hadn't been there before 2017?

A. Well, I'm sure the staff in Muckamore were doing everything they could to utilise their skills and knowledge, but they were faced with a situation where patients were being admitted, continually admitted, re-admitted because of the lack of the right, you know, the lack of home treatment and crisis support in the community wasn't there. So this created unsafe populations. I mean it was fairly straightforward. And I think that, you know, took away from their ability to provide a therapeutic environment, because they were dealing with unsafe groupings of staff and it really was, the priority was just to keep everybody safe as opposed to being a therapeutic hospital. 10:14 10:14

PROFESSOR MURPHY: So are you saying that because it was known that Muckamore was retracting and trying to resettle people, that generally speaking it was thought by those probably not on site that they could do with less services, less day activities, less PBS, less this, less that, because actually everybody was moving out. 10:14 10:15

A. Yes. Yeah. Yeah. I think that was a mind-set, you know, maybe subconscious. But I do recall colleagues saying that, you know, all of the funding was for resettlement. Resettlement was the number one agenda item, if you like, for the Board. Now I think the Board, the Commissioning Board, you know, people would have used the money more flexibly at times in discussion with the Regional Board, and I think everybody was trying to support Muckamore. But 10:15

ultimately, you know, the culture and the feel of the place was neglected as a hospital, if you know what I mean? Neglected in terms of its clinical purpose.

PROFESSOR MURPHY: So did it take something like this major safeguarding issue and all the CCTV viewing for HSCB, for example, to realise that actually it needed to put more funding in, rather than withdrawing funding because it was in theory closing? 10:16

A. Well, yes, that was certainly my impression. I mean Ms. Hinds at the Board, you know, immediately provided the funding for PBS, and immediately made all of the training for PBS that year available to Muckamore as a priority. So there was an emerging recognition: 'Oh, look, we need to do something about this'. So there was -- and I mean money was no object after that, in terms of non-recurrent funding anyway. So I think that the realisation, you know, that this had been missed, you know, the needs of Muckamore, were actually more as it was retracting, rather than less. And I think staff nursing -- there was a lot of loss of skill over a period of time. I certainly learned that from colleagues. You know, highly qualified and skilled staff were leaving. And there was a confluence of factors I think that led to that. Certainly the slowdown of Supporting People and housing options put a great depression into the system because, you know, there was a lot of projects at that time were stalled or it was cancelled. So, yes, I think there was an overall sense of 'Nobody cares about us, don't 10:16 10:16 10:17 10:17

understand the problems we have to face, don't realise the severity of stuff, you know of incidents'. Parents were despairing that they would ever see their young people come out into the right support system. So, yes, it was -- I think it was subconsciously neglected because -- resettlement had been going on for decades and decades, and the hospital had gone through so many phases of history, but this was felt to be the last one, and I think that culture or that mind-set contributed greatly. 10:18

PROFESSOR MURPHY: Thank you.

116 Q. MS. KILEY: You mentioned pressures there in respect of resettlement and the Supporting People funding, and you have an exhibit that refers to that, so I just want to turn it up now. If we can look at page 240, please? 10:18
If we can just scroll up to the page before perhaps? Yes. So this is a presentation that was made to the CEO on 6th September 2016 entitled "Potential impact of SP Budget Freeze" - SP being Supporting People; isn't that right? 10:19

A. Yes.

117 Q. And Supporting People was the programme that provided funding?

A. Yes.

118 Q. And this is a very high level summary, but funding for supported and community living, isn't that right? 10:19

A. Yes, it provided capital and revenue for housing projects.

119 Q. So it was a necessary --

A. It was critical. It was -- you couldn't do it -- I mean there was a model of private funding that we looked at, but it was very new and people shied away from it, you know, getting Trust staff who were enough, you know, accountants getting involved in, you know, private funding efforts.

120 Q. And you mentioned in answer to a question there, the pressures on the Supporting People Budget, and it appears here that there was a freeze on the budget then in 2016, and this presentation looks at the potential impact of that. 10:19 10:20

If we scroll down to the next page, please, we can see some of the statistics. Just pause there. This table is entitled "Summary of completed S housing" - supported housing presumably - "tenancies @ September 2016", and then you can see then on the left-hand column it's broken down by services. So if we can focus on the Learning Disability. Number of schemes delivered at September 2016 were 11; number of new tenancies delivered, 79. So schemes presumably could have more than one tenant, so that's why there's the increase in numbers in tenancies. But then on the right-hand column there's "Planned tenancies at risk", 38. Can you describe what effect that had for patients at Muckamore? 10:20 10:20 10:21

A. Well I mean obviously I didn't work in Learning Disability at this time. I would have been, you know, looking at Older People. Yes, it was a definite chill

factor, you know, particularly for Learning Disability. For Older People we had done well out of Supporting People in Belfast, and we had, you know, maybe five supported housing schemes for people with dementia, and we were very proud of them, but it was very much a collaborative with housing and other agencies. Learning Disability were much smaller units and most of them would have been targeted at Muckamore because it was the prior -- resettlement was the policy priority. So it did have a definite chill factor and schemes were abandoned. 10:21 10:21

121 Q. But what does that actually mean, "Planned tenancies at risk"? Does that mean that there were 38 patients?

A. 38 patients, yes.

122 Q. And would they all have been Muckamore patients? 10:22

A. They probably weren't all Muckamore patients. I mean I wasn't involved in this particular slide. But in my experience working in the Community Learning Disability Team, there may have been people returning from England, from placements in England, ECRs, or extra contractual referrals, you know. So it would have been the most -- the people ready for discharge from Muckamore, and maybe one or two other high risk people in the community or coming from ECRs. 10:22

123 Q. And so was the effect of this then to further delay the discharge of patients from Muckamore? 10:22

A. Yes. Yes. Yes, it was a big delay factor, because there would have been so much work gone in to find -- to match patients or clients with particular schemes.

So finding locations, identifying a housing provider or a care provider. So the care manager in the community or the social worker in the community would have done intensive work to do all of that identification and managing and matching, and then for that all to stop and for the discharge or the planned discharge not to go ahead, it would have had a significant impact. Not just -- sorry, Chair.

CHAIRPERSON: No, I just want to understand what this really means. This is looking at a four year period, and the number of new tenancies delivered within that period for Learning Disability is 79. 10:23

A. Mm hmm.

CHAIRPERSON: But the 38, the planned tenancies at risk, is that looking forward? 10:23

A. Yes.

CHAIRPERSON: Right. So it's not saying that of the 79, 38 of those are at risk?

A. No.

CHAIRPERSON: It's saying looking forward there are 38 tenancies that you expected to have that are at risk because of a lack of funding. 10:23

A. Yeah. Yes. Those were the ones which were in the process.

DR. MAXWELL: But as they were planned, are those 38 named individuals? 10:24

A. Yes.

DR. MAXWELL: So it was people who had thought they were going to have a placement?

A. Yeah. Now, I couldn't be clear on whether they had been informed yet.

DR. MAXWELL: But they had their name on a place?

A. Yes. Yes. They were ready --

DR. MAXWELL: So there was an expectation they were going and suddenly that was no longer there. 10:24

A. Yeah. That's correct.

DR. MAXWELL: Can I also ask if it would be reasonable to say that the other three categories had a larger number of people in them, so there were more people with mental health problems, more older people and more people with complex and physical disabilities. 10:24

A. Yeah.

DR. MAXWELL: And yet the tenancies at risk is the highest in the Learning Disability group, which is the smallest population of people? So the impact would have been greater in Learning Disability than the other areas? 10:24

A. Yes, yes, yes.

DR. MAXWELL: And you may not be able to answer this, but do you know how it was decided which schemes and therefore tenancies would be frozen? 10:24

A. In the planned tenancies?

DR. MAXWELL: Yes.

A. I don't know the detail of those 38 planned tenancies. They tended to be maybe single houses or group houses. 10:25

DR. MAXWELL: No, I'm just wondering, in the overall budget somebody must have decided, 'We can't afford all of this. We'll cancel this one, this one, and this

one'.

A. Yes. Yes.

DR. MAXWELL: Do you know how that process was conducted? Because it seems to have disproportionately affected Learning Disability. 10:25

A. Well, from my recollection from the discussions at these inter-agency -- I mean obviously Supporting People took a decision to review their policy, and review value for money, and the Learning Disability packages were extremely expensive, you know, compared 10:25 to the Mental Health and Older People, who were much lower cost. So that - I assume that would have been a significant factor. And there was a dispute, I mean the housing people, Supporting People, I often heard this conversation that they felt some of the clients 10:26 should have been funded by health they were so complex, particularly maybe forensic, who had a forensic background, and I mean you're talking eye-watering sums of money. So I have no doubt that that was a factor in Learning Disability. I mean the cost of those 38 may 10:26 have been four times what it would have been for an older person.

DR. MAXWELL: Thank you.

CHAIRPERSON: And do we know what proportion that is of planned tenancies? So presumably there were a number 10:26 of planned tenancies that were not at risk, do we know what percentage this is or what --

A. No, I don't have that information just off the top of my head. I could try and find out.

CHAIRPERSON: And 38 in a small jurisdiction seems to be a quite a high number.

A. Yes.

124 Q. MS. KILEY: That, Ms. Heaney is the bricks and mortar, as it were, the schemes that were available for patients to go to. 10:26

A. Yes.

125 Q. But you also describe other challenges with resettlement in your statement, one of which is transition planning for patients in the hospital to enable them to successfully transition; isn't that right? 10:27

A. Yes.

126 Q. Can we bring up paragraph 212, please, of Ms. Heaney's statement, page 51? 10:27

CHAIRPERSON: As soon as we've done this we'll take a break.

127 Q. MS. KILEY: You just describe there, Ms. Heaney, trial placements and you say: 10:27

"The concept of 'trial discharge' seemed out of date and the inappropriate. A proposal to strengthen transition planning was developed but insufficient resources were dedicated to this complex, intensive process." 10:27

And that time period you're discussing there is 2019. So even at that stage transition planning and work with patients was still a challenge in Muckamore; is that

right?

A. Very much so.

128 Q. And was that a funding issue or were there other issues there too?

A. I mean my impression -- I mean we had -- one of the workstreams was looking at admission and prevention of admission, and the other workstream was around what is happening at the back door of Muckamore, because it was very difficult from where I was sitting to understand the processes. So I did ask Fiona Rowan, you know, a colleague from Mental Health to look at this, and she produced a report which broke down for us what the key challenges were. 10:28 10:28

129 Q. The Inquiry has heard from Ms. Rowan?

A. Yeah, okay. 10:28

DR. MAXWELL: Can I just follow on from that. We've heard from other witnesses that when a patient was resettled into a care home, a private care home, there would be a call on ward staff in that transition period to go out and support the patient, or if there was a crisis the care home could call on them. 10:28

A. Yeah.

DR. MAXWELL: Was that reflected in the staffing funding for Muckamore?

A. No. 10:29

DR. MAXWELL: So if they were trying to support transitions, that was taking staff off the ward.

A. Yeah.

DR. MAXWELL: And did that ever get -- was that one of

the problems that was identified in the transition plan?

A. Yes. I mean some of the nursing staff in Muckamore were heavily invested in making the placement succeed for their patient, and if they had the capacity and willing to do, to provide outreach for a very short period of time to prevent a re-admission, then some staff were quite motivated to do that, and it was -- 10:29

DR. MAXWELL: So that's a funding pressure. They weren't doing it for love. 10:29

A. Absolutely.

DR. MAXWELL: They were being paid, presumably.

A. I mean in my experience it didn't happen that often because obviously they just didn't have the capacity, staffing was chronically, you know, it was always a problem, but it did happen for one or two people that I am aware of. So, yes, have I answered your question? 10:29

130 Q. MS. KILEY: Yes, I had asked whether funding was the only challenge there, but you were referring to Ms. Rowan's report? 10:30

A. Yes.

131 Q. And are you saying that that demonstrates the other challenges to resettlement?

A. I mean I noted when I visited Muckamore that there was one individual nurse who was, I think she was called Community Integration Officer, you know the title, and she was responsible for the liaison with all of the other Trusts who had patients in Muckamore to provide that link to support halfway planning and discharge, 10:30

which really should have been much, much more intense. I mean Fiona's work demonstrated, you know, that the actual process of getting a person ready for discharge took many, many months, and there was so many types of things to do. I mean I put a note here for myself, you know, the essential lifestyle plan, the detailed care plan, carer's needs assessment, the discharge plan, you know declaratory orders were needed for many patients and they had to be completed, you know all of the - the house had to be identified, the business case. It was an incredibly complex process to arrive at a successful placement, it often took maybe a year, and the communication required was very intense with the patient, with their family, with the Trust, with all of the other agencies, and very often we failed to complete that task because there was also a bit of a rift, not a rift, but I mean the community staff and the hospital staff had different outlooks, you know, they had different agendas. So that was a problem. That's one of the reasons I brought the two teams together in March '19, you know, to try and support integrated thinking about discharge planning.

10:31

10:31

10:31

10:31

132 Q. MS. KILEY: Yes. And I think you brought them together in one of your meetings.

A. Yeah.

10:32

133 Q. I'm going to come on to that, but I think now is an appropriate time for a break?

A. Okay.

CHAIRPERSON: Yeah. All right. Thank you. We'll take

a 15-minute break. Thank you very much. You'll be looked after. Please don't speak to anybody about your evidence, thank you.

THE INQUIRY RESUMED AS FOLLOWS AFTER A SHORT ADJOURNMENT AS FOLLOWS: 10:45

CHAIRPERSON: Thank you.

134 Q. MS. KILEY: Ms. Heaney, just before the break we were talking about resettlement. 10:48

A. Yes.

135 Q. But at the other end of the scale, as it were, are admissions, and you've already described in answer to some questions the challenges that admissions faced. You deal with this in your statement and I want to turn 10:48 to that now if we can look at paragraph 169. This is -- we're still on the list of actions that were implemented in the immediate aftermath of the September '17 revelations, and management of admissions is noted here as one of the issues that was looked at. We can 10:49 see you say there:

"Admissions to Muckamore Abbey Hospital were consistently high. The data showed that most admissions were at weekends or out of hours. There was a widely held view within the hospital that most admissions did not meet the hospital's clinical criteria and that the hospital was historically used as a behaviour management backstop. Further there was evidence of

repeat admissions. This practice reflected the lack of adequate community infrastructure in assessment and treatment and long-term living options that could meet complex needs, including episodes of behaviours that community services could not effectively address. Adult Mental Health inpatient units did not accept admissions, even for those with a mild learning disability."

So you then go on to say that there was no regionally agreed admission criteria or out-of-hours regional pathway for admission - this is just at paragraph 170. But ultimately you say: 10:50

"The Trust provided leadership in securing regional agreement regarding admission criteria for in-patient learning disability units." 10:50

When was that regional agreement?

A. It would have been 2019. 10:50

136 Q. And earlier on you said that often admissions didn't meet the Trust's clinical criteria or the hospital's clinical criteria?

A. Yes.

137 Q. Can you give the Inquiry any insight as to why, if patients weren't meeting those clinical admissions criteria, they were nonetheless being accepted and admitted to Muckamore Abbey Hospital? 10:50

A. Well, I mean it's a good question. I think it was

custom and practice, and there was a particular model of care here in Northern Ireland that wasn't elsewhere. Now obviously I'm not a doctor and, you know, it's not really my area of expertise, but I did work closely with the Clinical Director and the Medical Director to try and understand, you know, what the position was, and obviously Dr. Milliken as well. And their view was that, you know, there were clinical criteria -- maybe there was three elements to them. I mean obviously if somebody was having, you know, an acute mental illness episode, I mean there was something about severe behavioural disturbance or severe behaviour episodes. But I mean the consistent view that I heard from the staff in Muckamore was that there was a lot of repeat admissions, that it was usually provider breakdown, maybe some staff in the supported housing scheme or at home, you know, could not deal with the behaviours that were presenting, they were afraid, you know, and they would have contacted the GP out-of-hours and maybe the Mental Health Order would have been deployed to, you know, get somebody admitted to Muckamore. And there was no system of challenge prior to admission, it was just -- you know there was no regional bed manager, you know, for Learning Disability. So the night coordinators and the night staff didn't have a lot of power in a scenario, you know, so they were just - they had to take them, they had to find a place for them. Sometimes the information didn't come through in a timely way. So I mean certainly Dr. Doherty was

10:51 10:51 10:52 10:52 10:52

concerned about this, as was Dr. Jack, and we started to engage, as did Dr. Milliken, started to engage with the Learning Disability consultants and the Mental Health consultants, you know, in the local Trusts, particularly South Eastern Trust and the Northern Trust, who would have been, along with the Belfast Trust, would have been the primary users of Muckamore. So there was a number of meetings that Dr. Jack chaired, and a number of us attended with Directors and Medical Directors of other Trusts, and ultimately an agreed medical criteria was agreed and then applied quite rigorously. 10:53 10:53

138 Q. So that was something that was agreed between all the Trusts; is that right?

A. Yes. Well, not all the Trusts, but the Trusts that used Muckamore, you know, which are the three. 10:53

139 Q. Yes.

DR. MAXWELL: Can I just ask, you said that often it was a re-admission because of a provider breakdown. So it sounds as though Muckamore was being used as a place of safety. 10:53

A. Yes.

DR. MAXWELL: Rather than a clinical setting.

A. Yes.

DR. MAXWELL: But doesn't that also indicate that the resettlement programme wasn't working effectively if there were a significant number of resettlement breakdowns leading to re-admission? 10:53

A. Yeah.

DR. MAXWELL: And was that failure of the resettlement programme for at least some of the patients ever investigated?

A. Well, I am sure it was, but in the period that I was there we set up -- if there was a re-admission, an SEA, a Significant Event Audit, really to examine the reasons, get the appropriate people in the room, the families, if they wished to attend, to participate in that. I mean the key reasons seemed to be, you know, the gaps in the community service, particularly home treatment. 10:54 10:54

I mean in Mental Health, as you know, they gate-keep the admissions to their hospitals, and I think we collectively wanted to try and move to that model. But it wasn't -- I don't think it was particularly well -- and obviously we were influenced by Dr. Roya -- he did the SAI -- and from ELF, you know, East London, you know, who were just blown away by the number of people in Muckamore, and even in the Republic of Ireland, we spoke to a team in the Republic of Ireland who didn't have beds in the west of Ireland. So I mean it had to be. So there was a number of actions. I mean we were negotiating with Adult Mental Health. 10:54 10:55

DR. MAXWELL: Before we go back to the actions, you said a Serious Event Audit would be done if somebody who had been resettled got re-admitted. 10:55

A. Yes. Yes.

DR. MAXWELL: Was that something that was in practice

before you started or something that you started?

A. Well, I honestly can't answer that question. But I became concerned -- we all became concerned, it was very much a collective thing -- about readmissions or, for example, I remember one individual, a young man, you know, he was out literally six hours and he was back in, you know. So we decided then that this group have to understand the reasons for this, and then every time that happened -- and then it was actually quite a helpful process because it highlighted key issues, and was one of the reasons the nursing staff volunteered to go out and support people. Now it didn't always work.

DR. MAXWELL: And it wasn't funded?

A. And it wasn't funded, yeah.

140 Q. MS. KILEY: You describe your concerns, Ms. Heaney. So you arrive at Muckamore in September 2017 and you're noticing these things, but the challenges and the problems with re-admission didn't just happen in September 2017; isn't that right? They were historic problems.

A. Yes.

141 Q. And so was no one noticing these things before and trying to take the steps to agree the regional criteria that ultimately you were able to do?

A. I'm pretty sure they did. I just think the reasons was that there wasn't enough focus on Muckamore, and there was a kind of a learned helplessness that the system couldn't be changed. I mean after all I do think it would be difficult for the staff in Muckamore to start

to, you know, go out and, you know, escalate this, because there was so much dependence. I mean I certainly observed the degree of dependence the other Trusts, and Belfast Trust, Belfast community, depended on Muckamore. There was great anxiety, you know, if we close the beds or we restricted admissions, and I can understand that because of the other bits of the menu weren't in place. I mean at times we had to do that, you know, and we instituted the blue light meetings in line with the care reviews that were happening in other parts of England, and presumably Scotland and Wales as well. 10:57 10:57

142 Q. So is it the case that it took the crisis that emerged to bring a focus on Muckamore?

A. Yes. I do, I do believe that. Because obviously there was several directors now, more staff, governance staff was appointed, there was meetings with the various stakeholders, the Department was being kept informed, the Board, we were talking to the Board. We were talking to colleagues, whereas -- and that was a lot of directors and a lot of senior staff and senior clinical staff, you know, creating this agenda, 'We have to do something about this', and I suspect that resource or that focus wasn't there before because it took the crisis, as you say. 10:57 10:58 10:58

143 Q. I do want to turn now actually to look at the structures and the governance that was in place at Muckamore when you arrive. You describe various meetings in your statement and I want to look at those.

If we turn first to the structures then at paragraph 59, please, if you can turn there? You describe the structures that were in place at Muckamore whenever you came into post in 2017.

A. Yes.

144 Q. And so you can see you list them there (a) to (h), Director of -- this is paragraph 59 for our IT team. So Director of ASPC, so that's you whenever you came in then in 2017.

A. Yeah.

145 Q. Then you had:

"Senior Management Team within ASPC
Collective Leadership Team (in progress)."

I'll come back to that.

"Service Manager
Assistant Service Managers
Ward Sisters/Charge Nurses
Deputy Ward Sisters/Charge Nurses."

And the "Night Coordination Team", and then at paragraph 60 you say there were other teams of professional groups who supported the delivery of care.

At point (c) you refer to the Collective Leadership Team as being in progress, so this was something - there were changes going on to the Collective

Leadership Team across the Directorate whenever you came into post in September 2017; isn't that right?

A. Yes.

146 Q. And what was it that existed before the Collective Leadership Team as it became called then? 10:59

A. Before that there would have been a Co-Director. For example, I was a Co-Director in Older People's Services and, you know, you were the Senior Manager for that group of services and you would have a team below you of Service Managers. You would have had an Associate 11:00 Director of Social Work, and an Associate Medical Director, and an Associate Nurse, but they were -- that was like 30% of their role. I mean they were still - they had huge areas of responsibility of their own. So the professional element of it was quite limited, but 11:00 that 30% of their role was to advise on professional issues.

147 Q. And so what was the purpose then of bringing in these Collective Leadership Teams in 2017?

A. Well, from my memory, I mean the genesis of it was that 11:00 it was to try and engage medical staff within the acute hospital system, because I think there had been audits or studies to show that there was significant disengagement with management. I'm sure it wasn't across all of the acute hospitals, but that was the 11:01 driver for it.

148 Q. So this was across the Trust, it wasn't just Muckamore focused?

A. Yes, across the whole Trust. It originated in the

Acute Hospital Trusts, the idea of collective leadership, and there was -- it was fashionable at the time, collective leadership. There was -- we had some conferences, you know Belfast Trust Conferences and was, you know, I think a university professor was talking about the research related to collective leadership. But the Belfast Trust decided to go on a structures basis, you know, and created this triumvirate of a Chair, who had to be a consultant, a Divisional Nurse. Well, the teams varied slightly depending on the area. I mean in community it was a Divisional Social Worker, Divisional Nurse. In Learning Disability they had added in psychology as well, and a carer's consultant later on. So the Collective Leadership Team differed slightly, but the core of the triumvirate was the nurse, the social worker, and the doctor. 11:01 11:01 11:02

149 Q. And was it the Collective Leadership Team then that was responsible for the day-to-day operations of the hospital? 11:02

A. Yes. The Collective Leadership Team was responsible for Learning Disability, including Muckamore. So they had wider responsibilities. I mean Muckamore would have been one small like part of Learning Disability. Important, but small, yeah. 11:02

150 Q. Yes. Whenever you come into post then in September '17, the Collective Leadership Team is fledgling but is in place, is that right?

A. Yes, I think it was fully in place by the end of 2017.

I mean it was a very new team. They were recently appointed. Some were appointed before I came in, I think, but they were all in post I'd say by the end of 2017.

151 Q. Were you able to observe how they worked then in respect of Muckamore? 11:02

A. Not straight away. I mean the whole idea of the Collective Leadership Team was Trust's attempt to devolve responsibility, and decision making, and governance and to push it down the organisation to increase ownership, to increase the resources, not just to have one co-director responsible for everything, but to engage with the professions so that there was that team work across the key professions for that service area, and it made sense. I think in the community we had sort of different, slightly different partners we would have chosen, but that was the decision and there needed to be uniformity across the Trust. But they were very new, they were only in post when this crisis occurred. So there wasn't really an opportunity for that team to jell, to team build, you know, all the forming storming, you know. I mean I know they did have some team building, you know, at the Leadership Centre. But probably realistically, you know, the crisis just -- it was just like a tsunami of concerns and workstreams, and everybody was working, you know, seven days a week almost, you know, it was really a tsunami of work and concern, particularly during that first year or two. 11:03 11:03 11:03 11:04

152 Q. So are you saying that the crisis affected the ability of the Collective Leadership Team to function properly?

A. Yes, I don't think they had sufficient time and space. I think, you know, the crisis produced just endless work, people were stressed. I mean what I observed really was dedicated individuals with all their own personalities, as we all have, working extremely hard. Tensions certainly arose. But what I saw was professionals working extremely hard and being as responsive as they could. 11:04

153 Q. The Inquiry has heard that the Collective Leadership Team, which others have referred to as the Divisional Leadership Team, but it is the same team that was in place at that time, described as dysfunctional. Was that your observation? 11:05

A. I think that might be a bit harsh when it was so early into the process. The team hadn't really had the opportunity to jell, develop their roles, think through what their shared values, their principles, you know, to engage with their staff. Usually people have an opportunity, you know, when a new team is formed, to do that. This team didn't. 11:05

What I would say was Muckamore operated in a very dysfunctional system of care, for the reasons I have described earlier, you know, because there was enormous pressures building up due to gaps and difficulties that I have outlined earlier. So I would go higher and say the system was dysfunctional and perhaps produced 11:05

behaviours. I mean I know I was stressed out many, many times, and everybody exhibited stress and anxiety, because obviously we were trying to deal with this crisis, and the magnitude of it was just increasing exponentially. We didn't have the resources. We didn't have the expertise at times. We never had the opportunity to sit down and reflect: Are we doing the right thing here? And I'm sure plenty -- and I personally would have made plenty of missteps and mistakes along the way, because I had quite -- I had to do a lot of learning very quickly. 11:06 11:06

Alongside -- to try and deliver a safe hospital in those circumstances was extremely challenging, and people were really stressed out at times. But also, you know, our number one priority was keeping patients safe. So we had to rapidly put in scrutiny systems, you know, that I have listed. 11:06

154 Q. Yes. And I think we can turn to those. If we turn to paragraph 66. First of all you say: 11:06

"After September 2017, there was a rapid review of key aspects of governance in the hospital."

Is that what you're referring to? 11:07

A. Yeah. Yeah.

155 Q.

"...many of which needed updating and improvement."

What was that rapid review? Who conducted it?

A. Really all of us. We did a collective exercise. We wanted to look at all the policies, particularly the key policies, you know, the governance policy. There was no Governance Manager in place, usually you'd have had that resource to go to. I described earlier the key safety policies, admission, discharge, resettlement, restrictive practices, seclusion, there's probably others. So those were all reviewed and analysed. We looked at all the data, you know, the safety metrics, you know, admissions and discharges again. All the medication issues. 11:07 11:07

156 Q. Yes.

A. Physical intervention.

157 Q. So this wasn't a formal review that was documented in a report? 11:07

A. No. No.

158 Q. It was an ongoing action plan essentially; is that right?

A. There was action plans everywhere, but I mean certainly there was an action plan around that, around, you know: 'What are the safety metrics? What are they telling us? Let's dig beneath these. Is the information right?", and what we discovered was in many cases it wasn't and there wasn't sufficient follow-up. So, for example, Datix, there was a significant challenge in getting incidents approved and to make sure that they were accurate and that they were followed up if they were serious. 11:08 11:08

159 Q. What do you mean by that? What was the issue in getting them specifically approved?

A. Well, the Ward Sister/Charge Nurse has to, you know, look at the incident, assure herself of its veracity that any steps were taken to make sure that it was accurate, that there was follow-up or that it represented an incident. I mean Datix, as you know, is a risk management tool. But, again, it's always the Sister has to -- the issues of two weeks leave, for example, and the deputy hadn't got around to it, so there was practices like that where they really weren't followed up, and maybe there wasn't a ward clerk on duty. Maybe wards didn't have a ward clerk. So there was, if you like, a casualness about it. 11:08 11:09

160 Q. So just to be clear, the issue you're describing is ward staff making entries on Datix. 11:09

A. Yes.

161 Q. But the specific issue that you're describing is the delay then between that entry and a Ward Sister approving the entry essentially? 11:09

A. Yes.

162 Q. And was the issue with that then that the data relied on those formal entries having been made and approved?

A. Yes.

163 Q. So the data that was being extracted and analysed was insufficient, is that the case, because of that? 11:09

A. If I could just maybe give the context. I mean the Trust, for many years, the system of governance was retrospective, so data would have been collected and

then analysed and presented in reports for quarterly governance meetings. Now I know Muckamore or Learning Disability did have monthly governance meetings and they were trying to develop their metrics and have, you know, a dashboard of key metrics that they could interrogate. I mean they had a brilliant resource on the site. We had a nurse -- she really was a data analyst, but her title was, you know, Resource Nurse.

164 Q. Was she there whenever you arrived?

A. Yes. 11:10

165 Q. Okay.

A. I mean she was a tremendous resource. But she was very -- I mean I think she was a Learning Disability Nurse herself. She would have went around all the wards providing training, gathering the data, flagging things up. So there was an embryonic system there. But the Trust were gradually moving towards a live governance system which meant that the data had to be accurate. I mean it had to be gathered very quickly, it had to be quality assured, if there was a discrepancy or it looked wrong, somebody had to go and find out. Say there was ten safeguarding incidents in Cranfield 1, 'Well that's a big jump, what's going on?', you know, so that type of thing. 11:10

166 Q. When you describe -- you said there the Trust was moving towards live data, was that something that was in place before September '17? 11:11

A. No. No.

167 Q. That was as a result of September '17 revelations?

A. Well certainly it accelerated 100 miles an hour, you know, around that time, it accelerated the section analysis of that, but the Trust as a corporate entity was moving towards -- the Chief Executive had introduced, you know, elements of the Charles Vincent model, and these systems, you know, they're very designed towards acute hospitals as opposed to a learning disability hospital or community, so it was a struggle sometimes to, you know, apply it in different settings. 11:11

DR. MAXWELL: Are you saying that before this you didn't have the permission to interrogate the Datix system as a Senior Manager, that you had to wait for the Trust to introduce live reports? Because Datix has allowed you to look at realtime data for ten years or more. 11:12

A. Yes. I mean I think, you know, managers could have looked at the data, and I am sure they did, the Governance Manager in particular. I mean we had one Governance Manager for the whole of, you know, the Directorate. She would have looked at the Datix and tried to identify any issues. But what I'm saying was it was a slower time. She would have done that and presented it at a quarterly meeting, whereas now we were moving to a system where it had to be analysed on a weekly basis. 11:12

DR. MAXWELL: So the capacity had always been there.

A. Yeah.

DR. MAXWELL: Belfast Trust Policy about how often you

looked at it, it changed.

A. Yeah. Yeah.

DR. MAXWELL: So there was always the capacity.

A. Yes.

DR. MAXWELL: There just wasn't a requirement to do it. 11:12

A. Yes. The corporate system was retrospective as opposed to live, that's my understanding.

168 Q. MS. KILEY: Whenever the live system was introduced then, and you've referred to working towards the Charles Vincent Framework also, whenever that was 11:13 introduced, were the issues with Datix that you've described still ongoing, the issues with having incidents approved and the impact on data analysis then?

A. Yes. Yes, I mean they were certainly there. So there 11:13 was work required to support the Ward Sisters do it in a timely way, you know, because backlogs would have built up for various reasons. So that was essential to get that streamlined to provide the Ward Sister with any support she needed. 11:13

169 Q. What was the issue there? Was it a lack of training or was it a resource issue? Lack of time?

A. Lack of time.

170 Q. This, however, was, even before 2017, a high risk environment, I think it is fair to say. So is there a 11:13 reason why the live governance model was not introduced sooner?

A. I mean it's a good question. I mean I can't really speak for what happened in Muckamore before I came, but

all I was describing was the corporate system of governance. Now I mean it would have been the role of the Service Manager, I mean any of them at any time could have examined Datix, and they possibly did, it's just that I don't know because I wasn't there at that time. 11:14

171 Q. So are you unable to say then whether, if Datix was examined, how it was examined and what trend analysis took place beforehand?

A. What I described earlier was that the Governance Manager and other managers certainly examined it and produced reports for their monthly governance meeting, and then the directorate governance meetings were quarterly. So there was a system in place to examine it. It's just that it was much faster when we introduced the live, it had to be done every week. 11:14

172 Q. Yes.

DR. MAXWELL: So you were getting the data, it was just a couple of months out of date.

A. Yeah. 11:14

DR. MAXWELL: So there was no gap, there was just a delay in meeting the data.

A. Yeah. Yes.

DR. MAXWELL: So in January you'd had the full data up to the previous September, you just didn't have the data from September to January? 11:15

A. Yes.

173 Q. MS. KILEY: And I think did you say there was no Governance Manager in Muckamore?

A. No.

174 Q. What was the effect of that?

A. Well, governance managers, you know, they really -- I mean their role is really to keep a daily watch over all things governance, you know complaints on behalf of the Collective Leadership Team, for example. So their role would be very much about process for alerting, for training in all of the areas of governance, whether it was complaints, or incidents, or SAIs. She would have been linked into the Corporate Governance Team. So there was that link. So she was an essential part of the, or he or she would have been a very important part. 11:15 11:15

175 Q. And was that a role that was created then post September 2017? 11:16

A. Yes. Well we decided, I can't remember exactly when, but we decided we really needed to have a full-time Governance Manager for Muckamore alone and another one for the community. Because obviously in the community there's high risk care environments in supported housing and nursing homes, so that needed to be -- we just wanted to increase governance support. 11:16

DR. MAXWELL: Can I just go back a little bit? So there was always a Governance Manager for the Directorate. 11:16

A. Yes.

DR. MAXWELL: And I think we might have had heard before there was somebody for Mental Health as well.

A. Yes. And when I was in Older People's Services and

I got myself an additional member of staff.

DR. MAXWELL: So there's three parts of the Directorate - well, four. There's Community, there's Older People, there's Mental Health and there's Learning Disability.

A. Yes. Older People, Learning Disability and Mental Health. 11:16

DR. MAXWELL: So are you saying -- you're saying that there was a dedicated Governance Manager for Mental Health, a dedicated Governance Manager for Older People, and one for the Directorate as a whole. 11:17

A. Yeah.

DR. MAXWELL: But not one dedicated to Muckamore.

A. No.

DR. MAXWELL: But Muckamore had -- when we've heard before about this role of resourceness. 11:17

A. Yeah.

DR. MAXWELL: How was the resourceness role different to the Governance Manager's?

A. Well, my understanding was the Resource Nurse was largely about data and training. I mean it was a part-time post. It probably wasn't as senior as the Governance Manager. 11:17

DR. MAXWELL: Okay.

A. You know, it was a resource for the ward in terms of anything they might need in the way of training or... 11:17

DR. MAXWELL: So was it more input than analysis?

A. Yes. Yes.

DR. MAXWELL: Okay.

176 Q. MS. KILEY: Can you say when the Governance Manager was

introduced to Muckamore?

A. It probably would have been 2019.

177 Q. One of the other things that you describe in detail in your statement are the various meetings that then started taking place post September '17, and I want to turn to look at those now. If we can look at paragraph 87 onwards, and at paragraph 87 to 88 you describe what was happening before, so pre September '17, but then I think it is fair to say there were significant amounts of new meetings that were introduced in specific response and you were responsible for introducing those; is that right? 11:17 11:18

A. Some of them, yes. I mean collectively the Directorate -- I mean the levels of meetings and the focus of them evolved over time and they became, you know, Dr. Jack had an assurance meeting at a later stage. I mean initially it was a Directors oversight. 11:18

178 Q. Yes. Well, let's look at that. Let's go there first then. So you're saying that's initially. So that was the first new meeting that was introduced at Directorate level in response to this crisis; is that right? 11:18

A. Yes.

179 Q. So if we look at page 93, please? Just while we're waiting for that to turn up, you describe it there -- it was page 93, please. Sorry, paragraph 93. Paragraph 93, sorry. Can you describe why that was put in place at that time? What was it hoped that that would do? 11:19

A. Well, that was set up, yes, from 27th November - that was in recognition that what was emerging from the CCTV should not be the responsibility of one director, that clearly it was a nursing workforce, so the Director of Nursing needed to be closely involved, there were going to be HR issues, so, you know, HR needed to be involved, as well as the Operational Director, which was me. So that was, the genesis of it was that we met weekly and then fortnightly. I mean we met all the staff in Muckamore, you know, we met with the Collective Leadership Team. We did a round of kind of meetings. But the core director's oversight was really just that, it was to share information, to triangulate information from various parts, various responsibilities for Muckamore and Learning Disability -- 11:19 11:20 11:20

180 Q. So did it have --

A. And the Medical Director too was involved, sorry.

181 Q. Okay. And did it have a role then in looking at the CCTV and doing protocol investigation that was ongoing? 11:20

A. No.

182 Q. No.

A. No, no.

183 Q. It was just looking at the operational management of the hospital? 11:20

A. It was really supervising and supporting the Collective Leadership Team, you know, and supporting the team and developing action plans across key areas. So it really was to make sure there was very close scrutiny, close

communication, escalation being made clear, you know, just that housekeeping, you know, when a crisis occurs. I mean obviously at that point we didn't really have a sense how big this was going to become, but that was the early genesis of that. And the meeting had to change. By January '19 it became the Directors Coordination Meeting.

184 Q. Yes. You do describe this meeting goes through some changes.

A. Yes. 11:21

185 Q. So if we just look at that. You describe it starting as the Directors Oversight Meeting on 27th November 2017, and you describe the various workstreams at paragraph 94?

A. Yeah. 11:21

186 Q. But then if you look to paragraph 98 you say:

"In January 2019, this was renamed the Directors Oversight Senior Coordination Group to reflect the growing number of workstreams arising." 11:21

So that was a change in name, but not a change in practice; is that right?

A. It was a change of name and it was really to reflect there was many people joined the meeting, you know, we had a Comms Officer, HR, more HR officers. 11:21

187 Q. And as a result of this meeting did it mean that directors were attending Muckamore for the meetings, did they take place there?

A. There was a mix. Most of the Directors Oversight Meetings were held in Muckamore. The Coordination Meeting mainly met in the City Hospital, and that was to facilitate better attendance, because a lot of the staff didn't work in Muckamore. So those are the two locations of the meetings, they flipped between them. 11:22

188 Q. Just on the director's presence generally, the Inquiry has heard that before the crisis that directors and senior management were rarely seen at Muckamore. Was that something that you were aware of coming into post? 11:22

A. No. I mean my information was that, you know, the directors, maybe not all of the directors, but that there were director walkabouts and director visits, and the board meeting was held there a couple of times. But I mean certainly that was one of the - leadership walkarounds were one of the mitigation elements, so there was a much greater frequency of leadership walkarounds, from various parts of the organisation, you know, from Mental Health, from Acute Services, you know, they would have visited various wards and recorded that they had been, and what they had seen, and who they talked to, that type of thing. 11:23 11:23

189 Q. And this group then, the Directors Oversight Meeting, went through another change, didn't it, I think in April 2019? The assurance element was taken out, is that right? 11:23

A. Well, I mean the Directors Oversight Coordination Group I think continued. Dr. Jack put in an assurance meeting, because I mean just some of the issues that

were arising were quite complex and difficult, and she needed to provide assurance to the Chief Executive and to the Trust Board.

190 Q. Yes. And just for your ease, you describe this at paragraph 102. That was in April 2019. 11:24

"...the assurance element of this group was separated into a bespoke assurance group, the MAH Assurance Group..."

11:24

So the Directors Oversight Meeting remained; is that right, but there was an offshoot of that, which was then the assurance group, and it was specifically to look at assurance?

A. Yes. Yes. 11:24

191 Q. You describe that in more detail at paragraph 107, and at 108 you say that:

"It was agreed that as an extra layer of assurance, Dr. Cathy Jack would Chair a new group to provide 11:24 assurance to the Chief Executive, Martin Dillon, and the Chairman Peter McNaney, on the delivery of the action plan, progress with the Belfast Trust Investigation, and progress with delivering the regional plan." 11:24

A. Yes.

192 Q. Did you sit on that assurance group?

A. Yes.

193 Q. Okay. And the other group then that was operating at Directorate level at this time was the task force, isn't that right? The MAH internal task force group?

A. Yes. Yes. And that group, you know, was a group that I had chaired for the six months that I was sort of seconded to Muckamore, and that was really a combination of all the community senior managers and the hospital senior managers and other individuals, or relevant individuals. 11:25

194 Q. What was the purpose of that group? What was it doing that the Directors Oversight Meeting wasn't? 11:25

A. That meeting was really there for two main reasons. One, to put in a new -- to create a new management team because there was gaps had appeared in the management structure and we needed to put in a new team. 11:25

195 Q. Can you just elaborate on that? What gaps were apparent in the management structure?

A. Well, Mairéad Mitchell had retired. So the Collective Leadership Team itself had been depleted. We didn't have a Divisional Nurse at that stage. So there only was a couple of staff left. So I mean there was an urgent need to stabilise management structures, and it was, in the workstream, that we didn't just want to have a Service Manager, we needed to have much more support around that Service Manager, so a deeper management structure, probably consisting of a dedicated Co-Director, a Service Manager, you know, a Divisional Nurse, and divisional -- well we already had a Divisional Social Worker there, and Governance 11:26 11:26

Manager, just to deepen the whole management structure in Muckamore.

196 Q. And prior to that --

A. Below the Collective Leadership Team.

197 Q. Yes. So that's what I'm trying to understand. Prior to that time there was the Core Group, isn't that right? 11:26

A. Yeah.

198 Q. And so was this internal task force, how did it relate to the Core Group of Muckamore? 11:27

A. Well the Core Group was an earlier sort of iteration of the Collective Leadership Team.

199 Q. Okay.

A. Okay.

200 Q. And so this was - the internal task force was, as you say, kind of a level underneath, but it also had Directorate membership; isn't that right? 11:27

A. Yes. Yes. Well, I chaired it. It was really an attempt to stabilise the management structure at Muckamore, oversight of the governance workstreams, and push, really put a huge focus on resettlement and trying to address the barriers to resettlement. 11:27

201 Q. You have provided a minute of the first meeting of the internal task force, which we can look at. This is at page 93 of the exhibits. So this was the first meeting of the internal task force on 1st May 2019, and it starts at page 93, but if we can turn to page 94, please? 11:27

A. Yes.

202 Q. And if we can just move down then and we can see the sorts of things that this group was looking at. One of the first substantive things it looked at is the Adult Safeguarding Team, and you can see there that it's recorded at that first meeting that work was under way in recent months to separate the work associated with the CCTV investigation and the day to day service delivery in the hospital. 11:28

"A new Adult Safeguarding Team is in place." 11:28

So was it the case then that this task force was noting what was happening with the safeguarding, but its role was to do something else and was to deal with the service delivery of the hospital? 11:29

A. Yes. I mean the Adult Safeguarding Team, a new team were put in place around March/April 2019.

203 Q. Why was that at that time?

A. Because the volume -- I mean there was evidence, as you mentioned earlier about stress and burnout of some staff who were involved. I mean it was extremely stressful work. So we put in a new team, you know, of senior staff. So it was -- there was quite a senior social worker. Can I -- I'm not sure if I can say her name -- 11:29

204 Q. Well perhaps just refer by role?

A. Yes. She was in charge of the Adult Safeguarding Team for the historic investigations, and she had -- had many more staff under her, I think three or four, maybe

more, and the team grew over time, of specialist DAPOs to support the viewing of the CCTV.

205 Q. And it's noted there in fact at the last sentence of the second paragraph that you highlighted that:

11:30

"...the CCTV protocol which required the hospital management team to determine the appropriate protect plan is being amended."

Can you recall why that was being amended at that time? 11:30
So this is May 2019. Was there a particular reason that you can recall?

A. What I think that refers to is that initially of the three stages, you know, there was the initial viewing, the identification of incidents for discussion, then 11:30
the team of DAPOs and MAPA, you know, would have analysed it. It was quite a difficult and extended process, because there was various camera angles. And at that stage the PSNI had seized the CCTV hard drives from Muckamore and we didn't get them back for several 11:31
months, and they came back in a much different, you know, in an inferior -- they didn't work on the Trust computers. So that significantly delayed and we had a big backlog.

11:31

The protocol, the third part of the protocol was that the hospital management team would have seen the evidence in written form and had to make a decision about whether the individual member of staff required

enhanced supervision, retraining, or in fact it was such a level that it would have required precautionary suspension. I think that was changed and taken away from the management team at Muckamore because there was problems, you know, with that, because they were managing the hospital as well.

206 Q. So from your recollection the change introduced at this time was to take that responsibility away from the hospital management?

A. Yes. Yes. 11:31

207 Q. And that was -- this was May 2019?

A. Yeah.

208 Q. And who was responsible for the amendment of the protocol?

A. It was in conjunction with the PSNI, as I recall. 11:32
I mean if I could just maybe add: I mean one of the major challenges in this project, or this crisis, was working with the PSNI. I mean they made it clear that we -- they weren't operating under the Joint Protocol. And in effect in many ways we were. But they 11:32
considered the historic material on the CCTV as live. So even though we had puts lots of mitigations in, and we were able to demonstrate as far as was possible that the hospital was safe today, care is safe today was the mantra, although there was many challenges in that, but 11:32
it was definitely much safer than it was pre-October '17, and I found that quite challenging that we were expected to run this hospital safely, but we were in many ways a corporate suspect, and that if we -- if a

background developed anywhere in the process, the police became concerned that we weren't doing it fast enough, or whatever, you know, and they would have raised that concern with the Department of Health or RQIA, and we had to then, you know, panic stations, 11:33
'How are we going to get this viewing up to date?', and I personally would hope the Panel would look at that circumstance of running a hospital, a fragile hospital, keeping patients safe, at the same time like every month -- I mean I remember one occasion 34 staff had to 11:33
be suspended and, you know, it brought it home to me there's something wrong with this. Now the police are right, they were following the process, I'm not criticising that, but it was -- there was something I think difficult about it, or it was extremely 11:34
difficult and provided many more challenges, and I think it increased the non-safety of the hospital.

DR. MAXWELL: So are you saying that because of all of the processes and safeguards you had put in from October, that it was now a safer place, and even if 11:34
somebody had been viewed on CCTV, that couldn't have happened again because of the new safeguards you put in place?

A. Yes.

DR. MAXWELL: And, therefore, a suspension wasn't 11:34
necessarily in the best interests of the patients?

A. Yes. Yes. Now that wasn't a popular view.

DR. MAXWELL: No. But it's -- I can see --

A. Yeah.

DR. MAXWELL: And I -- this has been discussed in the Inquiry before, that safeguarding is about primarily protecting the patient.

A. Yes.

DR. MAXWELL: And if you're suspending all the staff, the patients might be less safe than if you kept them and put in better safeguards. 11:35

A. Yeah.

DR. MAXWELL: Which you say you had already done.

A. Well, I am sure the safeguards continued to develop, you know, because it takes time for things to bed in. But I was very convinced that it was a much safer hospital because of the safeguards we put in, compared to pre-October '17 when, you know, there was lots of -- RQIA were visiting, there was leadership walkarounds, and yet all this was going on. So it was a dilemma and a source of great anxiety I think for the Trust, because we were always being held for account for 'Why have you got 158 incidents not sorted out yet?', you know. 11:35 11:35

209 Q. MS. KILEY: Ms. Heaney, I'm going to come to ask you about safeguarding specifically.

A. Yeah.

210 Q. But just to keep us orientated as to the meetings that you have described and the relationships to them. The next meeting that I want to ask you about is the Intellectual Disability Directors Oversight Group? 11:36

A. Yes.

211 Q. If we can turn to paragraph 113, please. Now, this is

another meeting that you described. It was created in October 2019. It has a very similar name to the Directors Oversight Meeting, but are you saying this is something different?

A. It's not something different, it's just a different name and a different phase. 11:36

212 Q. Okay. So it was the same, same personnel, same aims?

A. Yeah. Yes.

213 Q. Okay. So it was still looking at service delivery in the hospital and how that could be delivered. 11:36

A. It was, yes.

214 Q. Okay. Then finally to complete the picture of new groups, you refer to the Muckamore Safeguarding Assurance Group, we see that at paragraph 116, if we can move down, please? This was a group that was 11:37 created on 6th September 2019, and the safeguarding -- it's given two names there. So in the heading it's "Safeguarding Assurance Group", but at paragraph 116 it's described as the "Safeguarding Governance Group", are they one and the same thing? 11:37

A. They are.

215 Q. And it was:

"...established between the Belfast Trust, the PSNI, the RQIA, the Department, and HSCB." 11:37

And as I've said, the first meeting occurred on 6th September 2019. You do say that it was similar to a multiagency strategy group and its Terms of Reference

were similar to that. So does that mean essentially its focus was the investigation arising from CCTV?

A. Yes. Yes.

216 Q. But that date seems quite late in the day, 6th September 2019. 11:37

A. Yeah.

217 Q. Why was that sort of meeting bringing those people together only taking place at that time?

A. Well, in fact there was three or four multiagency strategy meetings in early 2018, because I convened 11:38 them under the Adult Safeguarding Policy, and RQIA, and the Department of Health, the key agencies, the other Trusts who had patients, and it was following that process of bringing the key agencies together to make sure that there was transparency, that the issues were 11:38 discussed and agreed, the actions and strategies were known to the key partners, and the police were there obviously as well. I mean at that stage I mean we certainly knew there was 5,000 hours of CCTV that we had to view. The police knew that. Everybody around 11:38 the table knew that, that it was going to take a long time and we didn't know what we were going to find. So that meeting was under the Joint Protocol. But somewhere in 2019, the police changed their approach and they didn't think it was appropriate for them to 11:39 operate the Joint Protocol because the Trust had employees that were under criminal investigation, you know, as far as I am aware that was the rationale. So those meetings stopped. Now, I mean I had set up

meetings with some police officers just to make sure that, you know, there was a shared understanding, because by that stage issues were arising. I mean I'm sure you're aware of the Form 80s that the police use to gather information. So they were bringing us or 11:39
sending lots of Form 80s, there was really quite a lot requesting, say, that the records of this member of staff, or the patient notes for this patient, and staff had raised with me that they were quite, sometimes they were quite generic, in one form there was maybe more 11:40
than one patient, or they were asking for all the patient notes going back, you know, and some patients were in the hospital for 20 years. And, you know, in those scenarios the doctors had to go through that and sign them off, and then they had to go to the Data 11:40
Protection Office.

I remember going into the Clinical Director's office and there was a pile of files going up to the ceiling that he had to work his way through, as well as his 11:40
clinical duties and his leadership duties. So I did raise it with the police and they said 'Look, we don't even have to do Form 80s, Form 80s set out the legal authority for' -- so I took legal advice and got, spoke to the senior officer in DLS, and he provided a letter 11:40
and advice. His advice basically was, 'look, they do have, they can get records, but it is best practice that they set out their legal authority and it has to be for a specific reason and a specific person', so --

but during that time issues like that were arising, you know.

218 Q. Ms. Heaney, just to be clear on the time.

A. Sorry.

219 Q. Are you saying that there was a time period in 2018 where the usual strategy meetings, joint strategy meetings occurred, that stopped -- 11:41

A. Yes.

220 Q. -- some time in 2019, and it was during that time when those meetings weren't occurring that these sorts of issues were arising? 11:41

A. Yes, and I set up some liaison meetings, just to clear -- talk these issues through with the PSNI to see how we could work, you know, how we could address their needs in terms of information, the CCTV. 11:41

221 Q. And so the purpose then of the creation of the Safeguarding Assurance Group in September '19 was to formalise that information sharing; is that right?

A. Well, not quite. That liaison meeting, I think we had three or four meetings, it was really just to clarify what the PSNI needed. Because I had felt, you know, the relationship had changed, and we had been working on a plan to move the hard drives from Muckamore Abbey Hospital to -- well one option was to have a joint team of police officers and adult safeguarding social workers, DAPOs, in Seapark, you know the forensic, it's the police's forensic unit for CCTV. Now I don't know whether it would have been feasible, but we thought it seemed like a good move, you know, to get it out of 11:42 11:42

Muckamore and have that close joint working under the Joint Protocol. It was then I realised they weren't working under the Joint Protocol. So there was a definite shift in attitude. They were treating I think the Trust very loosely as a suspect because we had employed these staff. So that was a shift in the relationship.

So this meeting was set up in response to the fact that there was quite a backlog had developed in terms of viewing. So, for example, there may have been, you know, 100 or 150 incidents that had been first viewed, but because they had, the DAPOs, there was a delay in getting all the analysis done of the incident, because the DAPOs had to, you know, obviously get a MAPA view, they had to gather the care plans, they had to identify staff, they had to write comprehensive report, they had to create a file for the police. We had staff leaving, burned out, fed up. So this list, this backlog created, that was considered unacceptable, in my view, by the police. So they I think raised it with RQIA that they were concerned these live incidents were not being addressed, and they were certainly following the Joint Protocol processes and recommendations. So that's why that meeting was created, to provide assurance to the key stakeholders of what we were doing with the backlog. That was my understanding.

CHAIRPERSON: Did you think it was purely the backlog or was there an issue in relation to the thresholds

that were being applied.

A. There was no specific discussion about the thresholds, but I mean certainly I was hearing that -- now that both organisations had the CCTV and they had decided, the police had decided that they were going to view everything 100%, they were going to satisfy themselves independently that we had identified the right number of incidents -- and there was always going to be gaps. I mean I think it's acceptable to say 'Well, we missed that one'. They were sending us back referrals for safeguarding, which I found a bit odd, but at a lower --

11:44

11:44

CHAIRPERSON: In relation to incidents that had already been viewed?

A. Yes. Yes. We had already viewed them and dismissed them or, you know, whatever the word is, as a non-issue, or a practice issue or, you know, something like that. But they came back to it then. So there was clearly different thresholds operating between the two agencies. The backlog was being dealt with as a serious issue by the PSNI, a serious risk issue. They said they were victim centric, and that's why that principle drove them, which is understandable, but it created this -- I'm trying to explain the reason for that meeting, that was to provide assurance to various agencies, RQIA and so on, that we had a plan to deal with the backlog.

11:45

11:45

11:45

222 Q. MS. KILEY: And as a result of all these meetings that were taking place either to deal with service delivery

and operational issues in Muckamore, or to look at the investigation, is it fair to say then that as a result of those there was significant management oversight at a Directorate level of what was happening at Muckamore at this time? 11:46

A. Absolutely.

223 Q. Is it also fair to say that there was -- a significant focus of that was on safeguarding?

A. Yes.

224 Q. But despite all that, RQIA had an unannounced inspection at the end of February 2019; isn't that right? 11:46

A. That's correct.

225 Q. And as a result of that they issued notices, Improvement Notices, in August 2019, one of which related to safeguarding; isn't that right? 11:46

A. I think it was March, was it?

226 Q. Well, let me take you to it, because you address this in your statement. So if we go to paragraph 34 and 35 first, please. You give a summary of the issue here and then you deal with it in more detail. But at paragraph 34 you say: 11:46

"RQIA had carried out an unannounced inspection of MAH between 26 and 28 February 2019 and had requested a meeting to discuss their notice of intention to serve six improvement notices. That meeting was organised for 6 March 2019, at which the Belfast Trust presented a detailed Action Plan on a range of actions being taken

forward in MAH to address the issues that RQIA were Concerned about."

So that's the first part, and then you complete the picture really later on in your statement at paragraph 187 onwards, if we can turn there, please? I won't go through all of these paragraphs, but in summary, RQIA indicated after that February inspection that you've described that they were considering applying six Improvement Notices. They weren't served at that time because of the action plan that was created. 11:47 11:48

A. Yeah.

227 Q. There was a further inspection by RQIA on 15th to 17th April 2019, and a third inspection then on 1st July 2019, and then Improvement Notices were served on the 16th August 2019, three Improvement Notices, and you summarise them there at paragraph 189. 11:48

"The Improvement Notices that were issued concerned ward staffing models, safeguarding and patient finances." 11:48

A. Yes.

228 Q. Now the Inquiry has heard from Bernie Owens, and she came in to the deal with the latter issues relating to the RQIA inspections. 11:48

A. Yes.

229 Q. And she has exhibited some later versions of the notice to her statement. So I think we can call those up now

if we can, please. This is statement STM-279, and if we could go to page 89 first of all, please?

So this first Improvement Notice, the issue date is 16th August 2019, but in fact the version that is exhibited to Ms. Owens' statement is a later amended version, because what happens is, RQIA issue an Improvement Notice and then they continue to come out and check, as it were, to see if it has been complied with, and then they give updates; isn't that right? 11:49

A. Yeah. That's correct.

230 Q. So if we can just scroll out on this one, please, just so we can see that whole page. And we can see there that the standard there is:

11:49

"The health provider is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability." 11:50

If we scroll down to the next page, please, we can see in the body of this...

A. Sorry, could that be a wee bit bigger? 11:50

231 Q. Yes. Can we zoom in? The second box that says "Specific Findings", if we could zoom in on that, please. So this is the notice that was issued in respect of financial governance?

CHAIRPERSON: Can you read that?

A. Sorry?

CHAIRPERSON: Can you read it?

A. Yes, I can now.

232 Q. MS. KILEY: You can see there in the second line it says: 11:50

"The Improvement Notice was issued as a result of the Trust failing to ensure a robust financial governance framework was in place for the effective management of patient finances within Muckamore Abbey Hospital as identified during inspections to MAH in February, April and July 19." 11:50

The notice then goes on to discuss the later observations in later inspections. But I just want to stick with thinking about the position from February to August '19. So if we can move on to the next page, please? Page 92. And this is the notice that was issued in respect of safeguarding. And I think if we can zoom in at that bottom paragraph under "Specific Findings" first of all, please? This just summarises the notice: 11:51 11:51

"An Improvement Notice was issued to the Belfast Trust on 16th August 2019. The Improvement Notice was issued as a result of the Trust failing to ensure and evidence effective safeguarding arrangements are implemented and assured within Muckamore Abbey Hospital, as 11:51

identified..."

And then the next page says:

"...during inspections in February and April '19." 11:52

Despite the intense focus on safeguarding between September 2017 and August 2019, the RQIA still felt it necessary to serve a notice in respect of safeguarding at that time. Was that a surprise to you, Ms. Heaney? 11:52

A. Not really.

233 Q. Does that mean you were aware that there were continued issues with safeguarding?

A. No, sorry, maybe just to qualify that. I mean I think from memory the RQIA were very much focusing on 11:52 referral processes, you know the Adult Safeguarding procedures and how they were interpreted, or how they were utilised by staff ward by ward. I was aware there was a significant turnover of staff, a lot of agency - new agency staff. 11:53

234 Q. And one of the other Improvement Notices, which I don't think we need to turn up, but the third one related to staffing; isn't that right?

A. Yes. Yes. But I think from my perspective at the time there was a clear need to ramp up the way we train 11:53 staff, particularly staff who were, you know, turning -- new staff coming in, a lot of them had a different approach to training. It had to be rolling training, it had to focus on patients, and we increased

the ability of those staff, or those residents or patients who could access that training, keeping me safe. That was part of it. I mean there was all sorts of flowcharts and guidance issued to staff on ward by ward training for individual staff members and group staff members.

But I think what I had picked up was the staff were incredibly confused by the safeguarding policy, and there was a number of cultural issues. One, there was a bit of a social work/nursing divide. The nursing staff were experts in many ways, from my perspective, in safeguarding, because, you know, I saw some tremendously positive examples of the use of MAPA, you know, things like using the contemporaneous CCTV to analyse incidents, create pods and safe areas, you know, they were using incidents, possibly safeguarding incidents, but applying an alternative approach through changing the environment, their de-escalation. All of that, in my view, was safeguarding. There was incidents that occurred that were clearly into the protection bracket, and that is when the actual procedures needed to be used. The procedures weren't understood. The difference between incidents and safeguarding incidents, you know, we were dealing with different staff groups all the time. I'm sure it's still an ongoing challenge.

11:54 11:54 11:54 11:55 11:55

235 Q. That's what I wanted to ask you, because you have said that there's confusion and that the procedures weren't

understood. But you have described earlier in your evidence a number of actions that were implemented whenever you came into post in September 2017, and we have seen the various meetings that were taking place. But this RQIA notice is August 2019, so is it the case that, even two years later, despite those interventions, the various action plans and meetings that were taking place, the Trust couldn't get a hold of this issue, is that fair to say? 11:55

A. Partly. I mean I would be very confident that the actions, that mitigations we put in place were keeping patients safe; and incidents, if and when they occurred, were under CCTV and were then analysed and protection plans put in place. What was difficult for staff was the procedures and understanding what represented an actual safeguarding incident, a protection. I mean, all of the patients were at risk all the time, particularly from each other and treating each other. My understanding was, a criticism that RQIA were levelling was about staff's understanding, appropriate use of the procedures, so we really had to address that and we had missed that. I mean, there had been refreshed Adult Safeguarding training but it wasn't effective, that's the key issue; that it wasn't effective in terms of understanding what was a protection incident, how you reported it, what information you provided and what time, accessing the CCTV to analyse the incident. So those procedures needed to be repeated and repeated and repeated. That 11:56 11:56 11:56 11:57

was my understanding of where RQIA were with it, that when they went out to talk to staff they weren't able to tell them in language that was understood.

236 Q. So is it the case then that the mechanisms that were being implemented post September 2017 didn't have enough of a focus on the safeguarding policies and training staff and ensuring their understanding, is that fair? 11:57

A. Yes, and repeat the training. It almost has to be, you can't stop it. 11:57

DR. MAXWELL: A couple of things there: Firstly, are you saying that RQIA was concerned about the processes but not that patients weren't safe? Did they have any evidence that patients were unsafe?

A. No they didn't. There was one incident, one case they raised with me, but I was able to clarify. No, it was process. 11:58

DR. MAXWELL: Process. The second thing then is: You had processes in place to keep patients safe and the evidence seemed to be that they were safe, but you have also alluded to the loss of staff and the very high use of agency staff, so whatever training you put in place was bound to have challenges if you were increasing the number of agency staff who didn't have an LD background so wouldn't necessarily understand how safeguarding occurred in LD; and back to your point earlier about the number of suspensions, is that directly linked to this finding that the staff didn't understand the processes? 11:58 11:58

A. Well, I haven't thought of it that way, but that's absolutely right. I think one of the challenges and criticisms we faced was the same staff were in place and so on, that we should have replaced everybody in Muckamore almost; (a) that would have been impossible and (b) not necessarily in the patient's best interests who valued familiarity and consistency. I mean, highly autistic patients, they had relationships. 11:59

DR. MAXWELL: And understand the processes.

A. Yes. So I think that was part of the problem and it really was insoluble, it was always going to be a problem. But having said that, the intensity of training and attention to detail and follow-up occurred over the next few months and then that was lifted. But it would have inevitably taken quite a bit of time to get around to all of those wards and then go back and check people's understanding. That's, I think, what's put in place. 11:59 12:00

237 Q. MS. KILEY: As Director at the time were you responsible for the levels of staffing and the skill mix that was on the wards in Muckamore between that time that we're really looking at, September '17 and the issue of the notices in '19? 12:00

A. Yes, as the Operational Director I had definite responsibility. I mean, the Director of Nursing would have taken the lead in terms of the workforce analysis and trying to build a model of nursing that was appropriate. It was a major struggle all the time because of the turnover and the lack of -- there is a 12:00

serious lack of Learning Disability Nurses, a shortage of Learning Disability Nurses. So that was a problem. Then reputational issues, we weren't getting a lot of issue for any posts in Muckamore.

238 Q. That was an issue, as you say the lack of Learning Disability Nurses was an issue, that wasn't something that had just emerged in September '17; isn't that right? 12:01

A. No.

239 Q. But perhaps the latter issue was the reputational issues that perhaps meant that you weren't getting a lot of interest. But that was, I think it's fair to say, a foreseeable outcome of the level of this crisis and the media attention that was happening, so what was being done then at Directorate level to try and mitigate those impacts and try and mitigate the loss of staff and the loss of skill mix? 12:01 12:01

A. Well, we were definitely trying to do as much as we could possibly do. I mean, obviously the nursing office and the senior nursing staff were at this day and daily to recruit -- (a) to recruit staff, healthcare assistants, nurses and increase the agency, the agency nurses in particular, and build a particular relationship with a particular agency. I mean, obviously there was long-term agency staff over time who were highly skilled and became better integrated. The uniform issue, I think they started to wear the Trust uniforms, eventually they were allowed to staff a ward. I mean, we escalated the issue regularly to the 12:01 12:02

Department of Health who put out a call for other Trusts to ask their staff to "don't come and work in Muckamore", the Permanent Secretary had sent out a letter. We didn't get much back from that at all.

240 Q. You didn't get much back from the Permanent Secretary or all those measures? 12:02

A. Well, no, I mean I think there was success. I'm not the best person to talk to this, it's Brenda Creaney and Maura Mannion who were close to this day to day. I was hearing the information but not actually engaged in doing things about it. But I mean day and daily, there was strenuous efforts made all the time to recruit and retain agency staff. There was continual advertisements, there were searches for Learning Disability Nurses maybe to move out or wherever they had gone. There was premiums offered. I mean we thought we could -- we couldn't think of anything else, frankly. 12:03 12:03

241 Q. So did it continue to be a problem throughout your tenure? 12:03

A. Yes. I mean, obviously my focus and my responsibilities was reducing the numbers of patients on wards through successful discharges, so there was less -- the pressure on staff was a bit relieved. But, obviously, as you know, the amount of observation requirements are for some staff and the model of staffing was...and the use of e-rostering helped a bit. But it took a long time for e-rostering to bed in which gave you better transparency as to what your next four 12:03

weeks is going to look like, associated with the observations prescribed by the doctor and try and collect that. I mean, some wards did struggle with providing that information because it changed so much.

242 Q. Moving forward in time a little bit then. There were some changes to the Directorate management structures in October 2019 and that's what caused you to move away from Operational Management; isn't that right? 12:04

A. Yes.

243 Q. So you have already said that from that time, October 2019, you weren't involved in Operational Management day to day of Muckamore, why were changes made at that particular time? 12:04

A. Well, I think it was a combination of additional pressures, particularly around -- well, obviously we all felt there needed to be much more, I mean I had come to the end of the six months. 12:04

244 Q. The six month period that you had been released from your wider directorate role to focus on Muckamore?

A. Yes. I had put in place a new management team. It was topped off then by Gillian Traub, who came out of Cancer Services to be Co-Director for Muckamore alone. The team that I had put in place just before that and work had been allocated to them. So there was quite a new -- I mean, the staff I had recruited were from Mental Health they were seconded from Mental Health who were very experienced, a strong association. So they had a lot of relevant knowledge and experience in managing hospitals. We felt we had a good team in 12:05 12:05

Muckamore to pick up the work. There was a view that I should be released to focus on community learning disability because there was gaps there.

245 Q. But didn't that result in a loss of your expertise because you had been immersed in Muckamore for nearly two years? 12:06

A. I mean, I remained on all of the meetings. There needed to be a scrutiny in terms of the community learning disability to see what issues -- because during all this time, community learning disability, they didn't get much attention. 12:06

246 Q. Whenever you say you remained on the meetings, so you didn't have operational responsibility but you remained as a director sitting on those meetings that we have discussed? 12:06

A. Yes.

247 Q. Okay. I want to turn to, towards the end of your statement you outline a number of additional challenges that you would like to bring to the attention of the Inquiry Panel. Some of those we have talked about already, resettlement, issues with departmental or regional safeguarding policies. There was one I wanted to pick up on that we haven't looked at yet, if we turn to paragraph 184, please. 12:07

12:07

One of the things that you describe as being an issue was the absence of an agreed co-produced model of care. You say there:

"The need for a shared model of care was evident with an absence of the assessment of need data, the difficulties in transitions, conflicting professional views on the role (if any) of hospital provision, the lack of community-based assessment and treatment as well as insufficient specialist housing, and respite services."

You are listing these as additional challenges that were faced, what do you mean there by the need for a new shared model of care, what was happening and what was missing? 12:08

A. Well, a couple of us had been over visiting in London, went around all their services and talked to their teams, so we picked up a lot of knowledge. It became clear to me that Northern Ireland had a very outdated model of care particularly when it came to in-patient assessment and treatment, home treatment and crisis response and intensive support services, behavioural services at home. I had been involved in a couple of cases that were really very, very complex. But what I found was that the professional staff, there was disagreement nearly on every, 'should we have a tertiary level hospital or should everybody do their own assessments, should psychology lead intensive behavioural support or should that be a multidisciplinary team?' There was no forensic, there was hardly any forensic community support, 'should it be integrated with mental health, no it shouldn't'. 12:08 12:08 12:09

248 Q. So this was a wider, not just looking at Muckamore, this was a wider Learning Disability Services issue?

A. Yes. It seemed to me that it would have been beneficial if there was a document that says 'this is the evidence, this is best practice, all trusts should follow these models rather than having different models'. 12:09

249 Q. Did you try to make progress on that whenever you were in post?

A. Well, I mean the Board recognised this and they appointed staff to consult on a new model of care. In fact one of our senior nurses was seconded out to help with that, because obviously she had tremendous knowledge from her years in Muckamore. There was a whole process of consulting in that and there was a review of acute services. Because I think that would have reduced a lot of the arguments, 'this is the way we're going for the next five years'. 12:09 12:10

CHAIRPERSON: When you say you had been to London, was that the East London Trust which was your critical friend trust? 12:10

A. Yes.

250 Q. MS. KILEY: So --

A. Just on that point, I mean the East London Foundation, they didn't have any in-patient learning disability beds, but they had a very deep range of providers who were very, very skilled, who did the assessments. Whereas our providers were at arm's length, were social care driven as opposed to multidisciplinary. So they 12:10

were much more advanced. I think there was a lack of development on the provider side of the house. So I think an agreed model of care which was evidence based and had one document which provided a template for every trust to follow would have reduced that issue, out of hours support, out of hours pathways for behavioural issues and stuff.

251 Q. MS. KILEY: The regional agreement on admissions that you referred to earlier, did that in some way -- was that a part response to what was required? 12:11

A. Yes, I personally felt that that was quite an achievement for the medical staff because it reduced admissions from 10 a month to one a month which made a significant difference, which kind of encouraged -- and also access to adult mental health beds for people with mild learning disability and what consultant's name was providing the in-reach learning disability support. I mean, teasing out those sorts of operational fine details took some time, but it was a good outcome, I think, for everybody. So certainly in Belfast the Adult Mental Health Team became much closer, CAMHS became much closer to Iveagh, you know there was positive benefits to that close collaboration between adult mental health and learning disability. 12:12

252 Q. Ms. Heaney, I don't have any other questions arising from your statement. I know before you gave evidence you had mentioned that you saw the transcript of Moira Mannion's evidence on Monday and there was something you wanted an opportunity to comment on, so I'll give 12:12

you that opportunity now.

A. Yes, just very briefly. I mean, I did read Moira's text. Sorry, I'll just get my note here on it. Yes, I just would like the opportunity to address a couple of comments made by Moira in her oral session on Tuesday the 24/9. There was a couple of inaccurate pieces of information which I would like to clarify, if you don't mind. 12:13

The meetings she referred to on 21st August '18 was a Directors Oversight meeting. It wasn't a Collective Leadership Team meeting, it was Directors Oversight meeting. It was co-chaired by myself and Brenda Creaney. At that meeting Moira's role was described and elaborated on by Brenda Creaney, the Director of Nursing. 12:13

MS. KILEY: And, Ms. Heaney, in ease of you, I think we can bring that minute up on screen now.

CHAIRPERSON: Do you have a reference for it?

253 Q. MS. KILEY: The IT team have it, but they did make me aware that it's a bit slow this morning. This is the second page, if we can move up just to see the first box on the first page. So this is the minute of the meeting, the Hospital Directors Oversight Meeting on 21st August 2018. It's a four-page minute, if there are any particular parts that you want to refer to you can do that. You can continue, Ms. Heaney? 12:14 12:14

A. There was a discussion at that meeting in Moira's role in Muckamore. Obviously there was a gap at Divisional

Nurse. Ms. Creaney, Brenda, had deployed Moira to Muckamore, not full time, I can't remember the exact number of hours, but she had other duties so it was a part-time role. And her role, she continued to be the Deputy Director of Nursing. It was made clear that she was not the Divisional Nurse, she was a Deputy Director of Nursing. Her role was going to be almost entirely focussed on nursing workforce issues. So she would have responsibility particularly around the provision of ongoing analysis of the nurse workforce ward by ward, numbers, grade bank, agency, that was a critical task that had to be completed every day or every week. The provision of supervision appraisals and provide alerts and assurances to the Directors, who then had to provide those same assurances to the CNO. So her role was very clear to me, she was Deputy Director of Nursing providing that function within Muckamore on a part-time basis. She wasn't replacing the Divisional Nurse, though there was some overlap in the roles. I mean, she went on to become part of the viewing for the management part of the CCTV protocol. She directly reported to Brenda, to the Director of Nursing, she didn't report to me. I mean obviously we would have had a close and productive working relationship. But I didn't have a management role with her. So I was surprised that she had that confusion. 12:15 12:15 12:16 12:16 12:16

I think she conflated that meeting with the Divisional Team meetings which I did not chair at any time.

I think I attended one of two of those for specific parts of the agenda. Those meetings were chaired by the chair and the Co-Director, Mairéad Mitchell. So I think she conflated those meetings or she may have been thinking of my task force meeting which she attended. Obviously Moira was an essential part of the coordination. And her role then, when I checked the minutes, were about reporting on workforce issues, nursing workforce issues. So I just wanted to make that... 12:17

MS. KILEY: Thank you, Ms. Heaney, I have no further questions, Chair. The Panel may.

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

254 Q. PROFESSOR MURPHY: I've just got one extra question. When you were talking earlier on in your statement about realising that the size of the task for CCTV viewing, you were talking about needing to expand the team to do the viewing, you said that you decided to appoint more social workers to the DAPO roles, did it worry you at all that you might be setting up professions to feel that they were in some way operating against each other? We've heard nursing saying they felt social workers were against them, we've heard social workers saying they felt nurses were against them, I just wonder what you thought about that and whether you thought in retrospect it could have been done differently? 12:18

A. Yes, I think we were very aware that it created division between social workers involved in this and the nursing staff at Muckamore. If it could have been done differently, I mean in retrospect I think it should have been done or could have been done differently. I think it was difficult to identify the forum where you could think through these issues in more detail. I suppose looking back, I mean the police should have just taken the hard drive, did the analysis and contacted us for a discussion about actions as opposed to us engaging in this major viewing and identifying, it was outwith our experience and created, I think, unintended consequences. We were following the Adult Safeguarding policy as was the police, but it was insufficient for this task, for this major institutional investigation. So it wasn't fit for purpose in retrospect. 12:19 12:19 12:19

But what I would say was, we all felt at the time just in an eye of a storm. In retrospect one of the mistakes was we didn't take time out maybe to reflect. The PSNI were very, very strong that this was a live investigation and we had to take action. So I think we were slightly overwhelmed by that attitude. It seemed to me that RQIA and the Department had the same view. So, therefore, I think we were very much on the back foot. We were already deeply ashamed of what happened in Muckamore and, you know, it was a major profound impact, I think, on everybody who was close to it. 12:20 12:20

255 Q. PROFESSOR MURPHY: So you felt you were beleaguered on all sides really?

A. Yes. So I think a lot of mistakes and missteps definitely occurred, I know I certainly made several.

PROFESSOR MURPHY: Thank you. 12:21

CHAIRPERSON: Can I thank you very much for your evidence, we've asked quite a lot of questions as we've gone along, but your evidence has been very informative and helpful. So can I thank you for the care with which you have answered. 12:21

All right, thank you. We next sit on Tuesday, 8th October at ten o'clock. There will be one further staff witness and then we're moving on to PSNI, dealing with OM4, and that will be dealt with in one day. All 12:21 right. Thank you very much. We'll see everybody in October.

THE INQUIRY ADJOURNED TO TUESDAY, 8TH OCTOBER 2024 AT 10:00 A.M. 12:22