ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Elaine McCormill
Date: 20th September 2024

I, Elaine McCormill, make the following statement for the purpose of the Muckamore Abbey Hospital [MAH] Inquiry.

The statement is made on behalf of the PSNI in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I am a Detective Sergeant in the Police Service of Northern Ireland [PSNI]. I am currently on attachment, as a Permanent Official for the Police Federation for Northern Ireland, the staff association for officers within the PSNI.

2. My career history is as follows:
   1994 – Joining date to the Royal Ulster Constabulary GC (latterly PSNI)
   1994-1997 – Strand Road Beat & Patrol
   1997- 1998 – Strand Road Communications officer
   1998-1999 – Ballymoney Beat & Patrol & Assist CID
   1999 - 2000 - Bushmills Beat & Patrol
   2000- 2002 – Ballymena Beat & Patrol & Assist CID
   2002 – 2004 – Strand Road Detective Aide/Substantive
   2004 – 2008 – Lisburn CID/Intelligence office Detective Sergeant
   2008 -2011 – Staff Officer to District Commander Lisburn

2011 – 2022 – Public Protection Detective Sergeant incl. Safeguarding Vulnerable Adults, Public Protection Arrangements for NI and Child Sexual Exploitation – various locations
2022 – to date – Treasurer, Police Federation for Northern Ireland.

3. I joined the Public Protection Department in 2011, which, at that time, was part of District policing. In this department, I held the portfolios of Offender Management under Public Protection Arrangements for NI, Adult Safeguarding and Missing persons (which later developed into Child Sexual exploitation).

Module

4. I have been asked to provide a statement for the purpose of M4: Police role in safeguarding and responding to allegations.

5. My evidence relates to paragraph 13 of the Inquiry's Terms of Reference.

6. I have been asked to make a statement with regards to the policing role in relation to Muckamore Abbey Hospital ['MAH'] between 2011 and 2014.

7. In the correspondence, dated 22 February 2024 the MAHI provided the following question:

Q6. On the 31st July 2021, the report by the Muckamore Abbey Review Team, titled "A Review of leadership and Governance at Muckamore Abbey Hospital" concluded (with regard to investigative action taken by the Trust) that:

"the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards". [page 123]

Did PSNI consider conducting a wider police investigation into whether abuse was happening in other wards at MAH at that time? Please describe any decision making and/or action taken by PSNI in this regard.

8. From 2011, and at this relevant time, I supervised a team of six Constables: Four Public Protection Arrangements for Northern Ireland ['PPANI'] Offender Management officers, one Missing Person officer and one Adult Safeguarding officer.

9. During this era, we covered Antrim, Newtownabbey, Carrickfergus and Lisburn – known then as "D District".

10. The safeguarding officer was Constable Tracy Hawthorne [nee Gibson to clarify for any historical records] and I was her direct line manager.

11. Our area included many hospitals such MAH [Belfast HSCT], Holywell Hospital [Northern HSCT], Antrim Area Hospital [Northern HSCT], Lagan Valley Hospital [South Eastern HSCT].

12. Our area also included a high volume of other establishments including residential homes and community services for people with psychiatric and/ or learning disability, across the district.

13. The geographic position of MAH and Holywell Hospital meant that my team took ownership of the Police investigations, relating to those hospitals. However, whilst MAH and Holywell Hospital sat physically within the Northern Trust geographic area – the relevant Trust in respect of each patient/resident in those hospitals was dependant on the home address of the patient/resident.

14. This, at times, meant differing practices and that consistency of approach with regard to safeguarding, differed. We had good professional relationships with all Trust safeguarding teams.

15. A review of adult safeguarding, some years later, provided consistency of approach across all Trusts.

16. In 2014 I researched statistics with regards to police resourcing for all referrals from 2008 to 1st April 2014:

Year	Referrals	% increase (total of 8744%) from 2008-2012
2008	9	
2009	15	66.6
2010	73	38.6
2011	225	208.2
2012	507	125.3
2013	778	53.5
2014 (to 1.4.14)	199	N/a

17. These numbers increased to almost 1000 referrals per annum, in 2015.

18. Our highest number of referrals across the district were from MAH. A comparable hospital, Holywell Hospital, referred a very small number of incidents.

19. From these statistics it cannot be determined whether MAH had an increase in incidents occurring or whether staff became more confident in the safeguarding process and, as a result, reported more.

20. In my opinion, I felt confident that MAH staff were carrying out the safeguarding process as would be expected in so far as reporting the matters under the Joint Protocol Procedures. Whilst reports were made, there was an absence of witness evidence which made investigations difficult. It was practice for staff on

duty to be spoken to, to find out if there were witnesses. This was undertaken by the Trust Designated Officer as part of their internal investigation and that of the PSNI. It was practice to formulate this as part of the strategy discussion.

21. I found the Trust Designated officer both professional and proactive. We, particularly Constable Hawthorne, had an excellent relationship which involved daily contact with this officer.

22. I had less direct interaction than Constable Hawthorne, but I attended safeguarding meetings, both for individuals, wards and the hospital in general on occasions in my role as supervisor or as a deputy to Constable Hawthorne, if she was not available.

23. Every incident was reported to our team and the Adult Joint Protocol was followed.

24. The Adult Joint Protocol process was, as follows:
    - Trust Safeguarding Officer would make the referral to police.
    - Constable Hawthorne would commence a serial on PSNI Command & Control system.
    - She would commence a strategy meeting with the Trust Designated officer and ascertain the following as per Adult Joint Protocol procedures:
        - Details of the alleged incident
        - Does the alleged victim have capacity to make a statement?
        - Who was involved – was it Patient on patient or staff on patient?
        - Details of any witnesses
        - Medical Evidence
        - Safeguarding concerns
    - Police would take advice from the Designated officer and/or the Consultant if the alleged victim had capacity. If appropriate, a pre-interview assessment would be carried out to assess capacity, and if that was positive then the alleged victim would undergo a recorded interview [‘Achieving Best Evidence’ (‘ABE’) interview].

- In all cases – where the alleged victim had or had not capacity- it was always the case that other evidence would be sought, such as witnesses to the incident.
- In matters where the allegations were that one patient assaulted another patient, capacity was an obstacle to gathering evidence.

25. I recall times where it appeared that there were patterns forming of repeat assaults on specific patients. In response to this, Constable Hawthorne and I would meet with the Trust Designated officer, Barry Mills, (and, latterly, Michael Creaney) to ensure appropriate safeguarding was in place for that individual.

26. I know that Constable Hawthorne's practice was to seek to speak to the staff who were on duty at the time and the staff who had reported the matter, to ascertain if there was evidence of a crime.

27. Constable Hawthorne would update the NICHE records, the file management system within PSNI, for incidents reported. As her line manager, I would, in turn, review every incident to ensure that all relevant investigative actions were followed.

28. Our experience with regards to investigations was that they were difficult to get through the criminal justice process given that the victims either lacked capacity or were not able to give evidence in a court.

29. Where there were witnesses to assaults, statements were provided, particularly with patient-on-patient assaults/injuries. Witnesses to allegations of staff assaults were less common, despite the Trust policy of cooperation with safeguarding.

30. One example of the difficulties of criminal cases involving the ill-treatment of a patient arose in an incident where an external nurse was working within MAH, building a relationship with a patient who was moving to another establishment, in order to make his transition easier. This nurse observed a number of incidents of very concerning abuse by staff against patients (where a patient

was observed to have been pushed outside into the rain through a fire door with no means to get back inside, a patient being pulled over a sofa by their belt, staff members encouraging patients to physically fight). The nurse made a very detailed statement outlining the incidents she had witnessed. This became known as 'the Ennis Investigation'.

31. A full and thorough investigation was carried out and sufficient evidence presented. However, the court process was disappointing when the visiting nurse's evidence was in question, some years later, at a trial. In her statements, the witness stated that it had been raining hence, she believed putting a patient outside in bad weather conditions was concerning. The defence presented a weather report from the nearest meteorological station to MAH, some three miles away, for the relevant date, showing no rain. This led to the court dismissing the visiting nurse's evidence.

32. I recall both Constable Hawthorne and I being very disappointed in the outcome. I felt that the justice system and the judiciary had no appetite for prosecutions for the ill treatment of patients. I believed that this was due to their lack of knowledge around the complexities of safeguarding those with severe disabilities and unable to protect themselves or communicate in a way that supported what is already a protracted and difficult criminal justice process in NI.

33. The witness in this investigation had worked on other wards but she felt that the abuse that she witnessed on Ennis ward was not present across the hospital and she had experienced a positive environment in other wards.

34. Due to the concerning increase in number of referrals, I recall attending a meeting with the management team of MAH to consider whether the referrals and incidents amounted to institutional abuse within Ennis Ward. There was no evidence to indicate the abuse extended across the hospital. Constable Hawthorne and I looked at the referrals, the whistleblower's evidence and the evidence of other staff. Having considered all of this evidence, I did not believe that there was evidence that the abuse was hospital wide.

35. The use of CCTV was discussed in general, however, this had its own difficulties with the expectation of privacy meaning CCTV could only have been put in general areas and have to exclude bedrooms and bathrooms.

36. I also believe that the staff, many of whom were family members and close friends, felt it difficult to challenge behaviour of staff by reporting to police and supporting an investigation. This may have had an impact on our ability to collate evidence. It may also have developed a culture whereby staff felt they could not provide evidence of wrongdoing.

37. Due to the difficulties that I perceived that staff were having in reporting other staff and the potential impact that this may have on our ability to gather evidence, I considered the use of covert surveillance to identify any malpractice and criminal activity, without the need to depend on witnesses.

38. We had private verbal meetings with Áine Morrison on 13 November 2012 for the purpose of keeping this investigative method confidential and discreet. With covert surveillance, the fewer people that are aware of its presence, the more effective it is in capturing behaviours. If staff were aware of the presence of cameras, they would be more likely to behave differently.

39. Also, on 13 November 2012, I had emailed Superintendent Smyth, PSNI Authorised Officer for the Regulation of Investigative Powers Act ['RIPA'] about the feasibility of having approval for such an investigation using covert tactics [See Exhibit 1]. On 15 November 2012, I spoke with Supt Smyth and briefed her of the circumstances [as recorded in my policy notebook; page 3 – Exhibit 2]. Verbal approval was given at this time on the basis of ECHR, necessity and proportionality, pending the Trust cooperation in the installation of covert cameras. Once MAH authorities agreed to proceed, a formal application would be submitted and considered. I updated Supt Smyth, on 20 November 2012, that the Trust were still deliberating the consideration. [See Exhibit 3].

40. The use of covert tactics was never instigated on Ennis ward as the management of the Belfast Health & Social Care Trust decided against it [See

Exhibit 3] and did not provide the necessary authorisation for PSNI to install covert cameras in Ennis Ward. It is my recollection that the Trust communicated this decision to me during a telephone call, during which to was confirmed that the Trust did not wish to employ this tactic, preferring to utilise management, monitoring and additional resources to address the concerns. I updated Supt Smyth on 21st December 2012 of the BHSCT decision.

41. Covert surveillance is only ever authorised as the last resort to gather evidence that cannot be obtained by any other method. All other methods of gathering evidence must be exhausted. It must be an absolute necessity and proportionate to the outcome – in this case the abuse of vulnerable adults and the identification of any staff carrying out the abuse was our goal. The availability of CCTV evidence makes it much easier to present a case to the court that is likely to be successful.

42. RQIA were regular attendees at MAH to carry out their statutory role and they also attended safeguarding meetings. At this time 2012 the Trust employed an external professional who was to act in a "Matron" style role and have oversight of the staff and processes to ensure that safeguarding was carried out and appropriate supervision was in place. [See Exhibit 4].

43. The presence of the "Matron", in itself, would have been problematic to any covert tactics as the staff would know they had increased supervision and that there was a live investigation into abuse. This would, in turn, make the staff more likely to adhere to proper and professional care of their patient. The impact being that it would be unlikely, therefore, to capture any further abuse.

44. I attended a number of multi-agency strategy meetings at MAH which dealt specifically with the Ennis Investigation. Having consulted my work calendar, the dates of these meetings include 15/112012, 28/11/2012, 20/12/2012 and 9/01/2012. I believe that the Trust minuted these meetings and records of discussions from the meetings will have been recorded.

45. Every allegation reported to police had, under the Joint Protocol, a strategy meeting which could be escalated, where appropriate, to an investigation.

Q7. Does the PSNI wish to draw the attention of the Panel to any other matters relating to the PSNI investigation into incidents which took place in Ennis Ward and around November 2012?

46. The July 2020 report by the MAH review Team entitled, *'A Review of Leadership and Governance at Muckamore Abbey Hospital'*, at paragraph 8.45, states that there was a "significant delay" in police interviews with the two suspects in 'the Ennis investigation'. The interviews of these suspects were carried out in February 2013. I do not agree that this is an unreasonable passage of time, in a complex investigation, to collate relevant evidence from witnesses. Six patients were identified as having potentially witnessed the incidents of abuse. The witnesses who were patients required the assistance of a speech and language therapist to communicate and this delayed the gathering of information from them to assist the investigation case. This process took some time due to limitations on the availability of all concerned. [See Exhibit 5].

47. At this time, specialists, such as registered intermediaries, were not in existence and, therefore, police were heavily reliant on the abilities on one dedicated officer who, in turn, took their lead in relation to capacity from the medical teams. It was our experience that the MAH Consultant Psychiatrist would confirm whether capacity was an issue and from that, Police would decide whether a Pre-Interview Assessment ['PIA'] was appropriate or not.

48. MAH senior management team had asked us to have input into the disciplinary process. I did not consider that the Trust's disciplinary process was a matter in which the police had a role. I did emphasise at the meetings, and to the Designated Officer and Managers, that it was important that the criminal interviews took place first so as not to jeopardise any evidence gathering. The Trust - specifically, via the Designated Officer and generally, at the multi-agency meetings - were updated by Police when there was a relevant development in the criminal process and at the joint meetings. This is evidenced through

minutes recorded at the joint meetings. [See Exhibit 6 & Exhibit 7 as examples of email updates].

49. The protocol in place for safeguarding vulnerable adults is a joint protocol meaning that both police and Trust have their own responsibilities but there is a heavy importance on working together to ensure that relevant information is shared to allow both Police and Trust to progress their relevant tasks/priorities. Internal matters within the Trust are the responsibility of the Trust and undertaken in accordance with their organisational discipline and safeguarding policies. Police have no role to play in another organisation's staff discipline matters.

50. Aine Morrison from MAH was concerned around the staff being aware that there was an investigation into staff for abuse. HR representatives were present at some of 'the Ennis Investigation' meetings, and I recall their concern over staff being repositioned. Consideration was also given to how staff would feel, knowing there was a major investigation into abuse. Police investigations can take time, particularly once they are referred to the Public Prosecution Service for a decision as to whether to prosecute or not. Whilst the prosecution decision was awaited in respect of 'the Ennis investigation', MAH staff may have been suspended or repositioned under safeguarding, as a preventative precaution. Police were not involved in this safeguarding decision-making as this is a matter solely for the Trust.

51. RQIA are the Regulatory body in respect of MAH and it is their role to ensure that the welfare of patients/residents is being safeguarded. The police role is to investigate criminal offences. It is not for the police to sign off on safeguarding practices within Health care providers.

52. Police have no input into disciplinary processes for any Trust or other organisation.

53. As per paragraph 49, it is not the role of police to sign off on another organisation's safeguarding processes. Police would not have the suitable

credentials or resources to ensure a hospital trust is compliant with safeguarding. It is not their statutory role. This is the role of RQIA

54. The introduction of the “Matron” role was a BHSCT decision. Police would not have had any input into how The Trust managed and supervised their staff. It would not have been the role of police to inform supervisors of the Trust’s expectations.

55. With regards to the appeal in respect of the member of staff who was convicted following ‘the Ennis investigation’, it is incorrect that the primary witness/whistle-blower was out of the country. The appeal was only brought in respect of one of the charges against this staff member and so the running of the appeal did not require the reattendance of all the witnesses from the lower court but, rather, only the witnesses relevant to the charge being appealed. The Public Prosecution Service decide on who is required for a court hearing in this instance.

Q8. Does the PSNI wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel’s consideration of paragraph 13 of the Terms of Reference.

56. At this relevant time the country was experiencing an escalation in public disorder with the “Flag Protest” which directly impacted on availability of myself and my team.

57. I note commentary by A12 about police officers attending in riot gear and wish to explain the call allocation policy. At times when staff in MAH requested assistance with a violent patient, the PSNI Control room would send the available resource. Given the flag protests were ongoing, it was normal for officers to be in public order suits for that duty to deal with public disorder.

58. It was reiterated many times that police are trained in arrest and restraint for the purposes of arresting people, particularly violent people. Therefore, when MAH staff asked for assistance, this is the operational tactic they would use.

Some criticism was fed back about this. Both Constable Hawthorne and I would advise the Trust that this was an operational tactic and reiterate to the Trust that their staff were trained in MAPA restraint from a patient perspective and that police may not be the most suitable role to attend on these occasions. This fact is highlighted today in relation to the "Right People Right Care" forums between Police and HSCT where it is acknowledged that a uniformed response may aggravate matters. Police were used, at times, to support MAH staff with potentially violent, aggressive or challenging patients as a result of their disabilities.

59. As previously mentioned at paragraphs 16 and 17, the referrals from MAH alone were escalating. In order to manage Constable Hawthorne's workload and other demands from across the policing District, I invoked a 'clinic' whereby all non-urgent referrals were reported to Constable Hawthorne who would attend MAH and liaise directly with the Trust Designated officer to discuss all the referrals. Urgent or serious matters were reported as and when they occurred for the purposes of gathering evidence. The sheer quantity of referrals of alleged assaults from MAH affected the crime figures for that area and at one point Antrim was considered one of the most violent places to live.

60. I cannot recall when the Joint Protocol for Safeguarding Vulnerable Adults was adopted but at the start of my time 2008 – 2013 there were different but similar practices not only across policing areas but across Trusts. A review was carried out of the Joint Protocol to attempt to remedy these differences and provide a consistent approach regardless of geography.

61. When a matter is reported to police for investigation it is important to note that safeguarding will always be a priority for them and it is managed carefully around any investigation, firstly to ensure the appropriate safeguarding is in place and secondly to maintain the integrity of any evidence.

62. Regardless of the minimal resources, which was an obvious additional pressure, and the difficulty in gathering evidence to substantiate a crime, I believe that Constable Hawthorne and I did everything we could to bring

perpetrators to justice, expeditiously, and to protect those most vulnerable from abuse from those who were there to care and protect them.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 23 Sep 2024

List of Exhibits (Elaine McCormill)

Exhibit 1: ES2 Email to Superintendent Ruth Smyth 13/11/2012 re use of Covert Tactics

Exhibit 2: ES9 PSNI Policy Book in relation to decision and actions for MAH Ennis Investigation

Exhibit 3: ES3 Email to Superintendent Ruth Smyth 21/12/2012 re final decision of Trust not to employ covert tactics

Exhibit 4: ES 5 Email from Aine Morrison 30/11/2012 outlining resourcing concerns raised by RQIA and Trust plan to address

Exhibit 5: ES 4 Email to Aine Morrison 26/11/2012– sample of ongoing communication for investigation

Exhibit 6: ES6 Email from Aine Morrison 30/11/2012 regarding responsibility for updating victims' families

Exhibit 7: ES7 Email to Aine Morrison 31/01/2013 reflecting updating of progress of investigation

ES2

MCCORMILL Elaine

From: MCCORMILL Elaine
Sent: 13 November 2012 14:17
To: SMYTH Ruth
Subject: : APPLICATION FOR RIPA

Ma'am

I work within PPU D District and my role includes Safeguarding Vulnerable Adults (I spoke with Insp Emma Neil who pointed me your direction)

We are carrying out an investigation relating to institutional abuse of learning disabled patients within a Trust Hospital (Muckamore Abbey).
Three people are identified as offenders at this time but it is likely that others are involved and we were considering the possibility of
using covert surveillance to identify offenders.

It would be beneficial to discuss the scenario with you prior to any application to assess the difficulties that may arise and which may give us an indication as to reality of such authorisation being given.

Could you please let me know of a convenient time for me to ring or should you wish me to attend personally to discuss the matter with you.

Thank you for your time.

Elaine

SGT ELAINE McCORMILL, PPU [OFFENDER MANAGEMENT] 'D' DISTRICT. Ext 36609 DIRECT LINE: RO1

NOTEBOOK REF NO: 237791

EXHIBIT NO: _____

Form 38/67
PB 6/02

POLICE SERVICE OF NORTHERN IRELAND

D DISTRICT PPU. DCU/Department

ANTRIM Station/Branch

11/2/14 Date

SUBJECT: Copy of notebook entry made by ~~Inspector/Sergeant~~/Constable/~~R/Constable~~ TRACY HAWTHORNE No: PW2299.

MAHI - STM - 330 - 17

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M. Long
Name

Const
Rank

21351
Number

NOTEBOOK REF NO: 237791 EXHIBIT NO: _____ Form 38/67 PB 6/02

POLICE SERVICE OF NORTHERN IRELAND

D DISTRICT PPU. DCU/Department

ANTRIM. Station/Branch

11/2/14. Date

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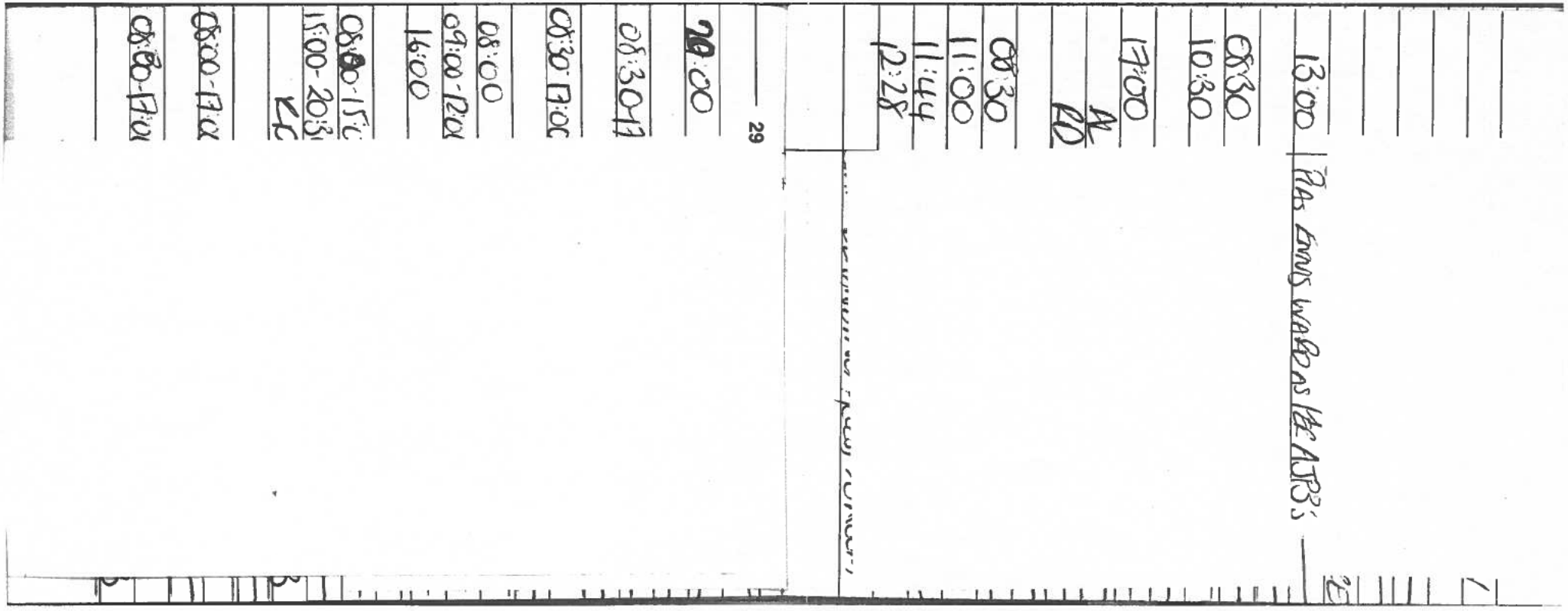

Certified a true copy of original M. Long Name Const Rank 21351 Number

NOTEBOOK REF NO: 237791 EXHIBIT NO: _____ Form 38/67 PB 6/02

POLICE SERVICE OF NORTHERN IRELAND

ANTRIM Station/Branch

D DISTRICT PPU DCU/Department

11/2/14 Date

SUBJECT: Copy of notebook entry made by Inspector/Sergeant/Constable/R/Constable TRACY HAWTHORNE No: R2299

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Serial No. 237791

Page No: 3

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M. Long Name

Const Rank

21551 Number

Making Northern Ireland Safer For Everyone Through Professional, Progressive Policing

NOTEBOOK REF NO: 237759

EXHIBIT NO:

PPU — DCU/Department

Antrim - PPU — Station/Branch

11/2/14 — Date

SUBJECT: Copy of notebook entry made by ~~Inspector~~/Sergeant/~~Constable/R/Constable~~ ELAINE MCCORMICK No: PW1602

MAHI - STM - 330 - 20

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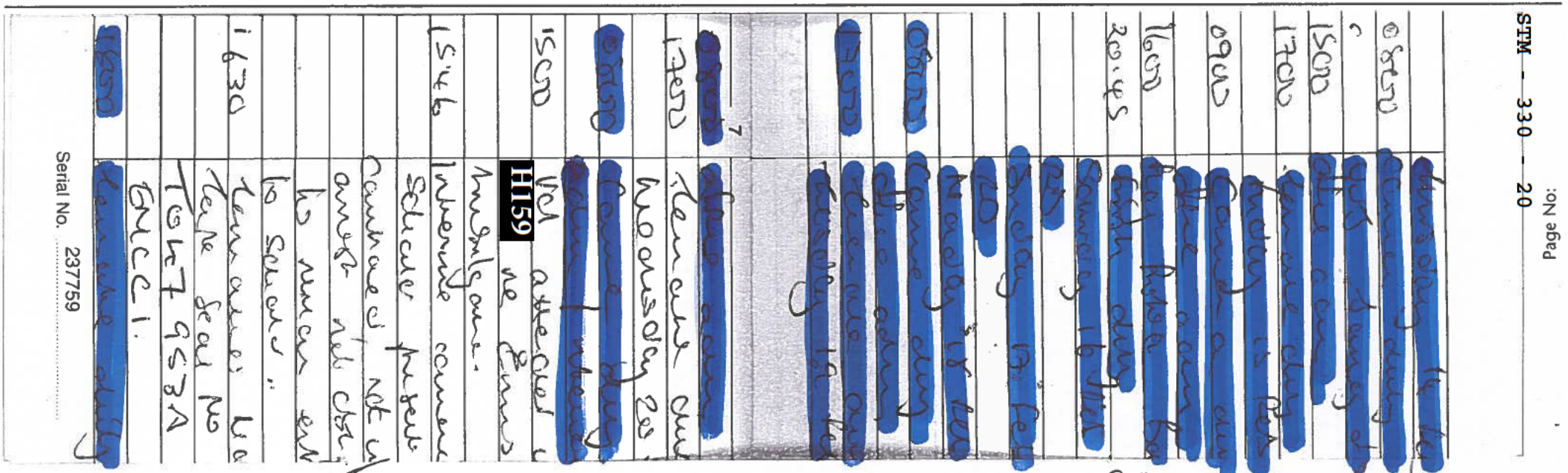
Serial No. 237759



Certified a true copy of original

Elaine McCormick
Name

Sgt
Rank

PW1602
Number

Form 38/67
PB 11/03

Making Northern Ireland Safer For Everyone Through Professional, Progressive Policing

NOTEBOOK REF NO: 237759

EXHIBIT NO:

D District PPU DCU/Department

PPU Station/Branch

Date

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POLICE SERVICE OF NORTHERN IRELAND

D DISTRICT PPU DCU/Department

ANTRM Station/Branch 11/2/14 Date

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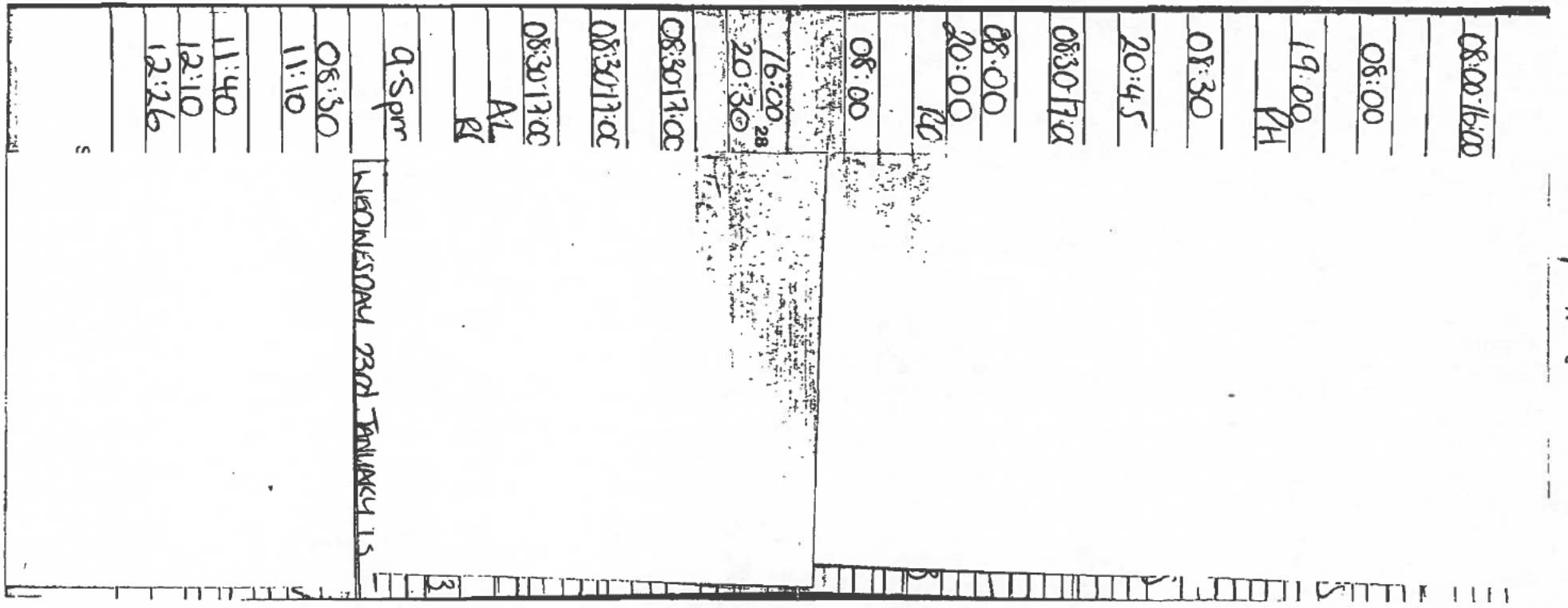

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POLICE SERVICE OF NORTHERN IRELAND

D DISTRICT PPU. DCU/Department

ANTRIM. Station/Branch

11/2/14. Date

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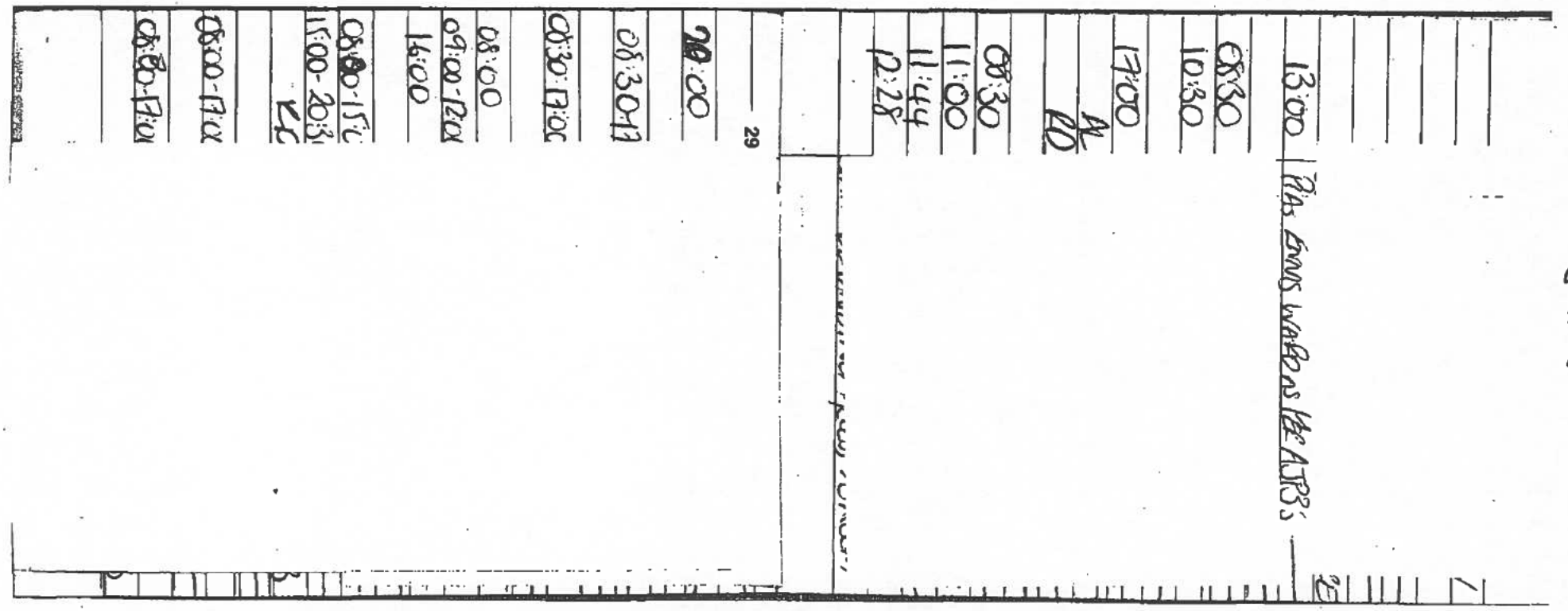

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M. Long
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POLICE SERVICE OF NORTHERN IRELAND

ANTRIM Station/Branch

D DISTRICT PPU DCU/Department

11/2/14 Date

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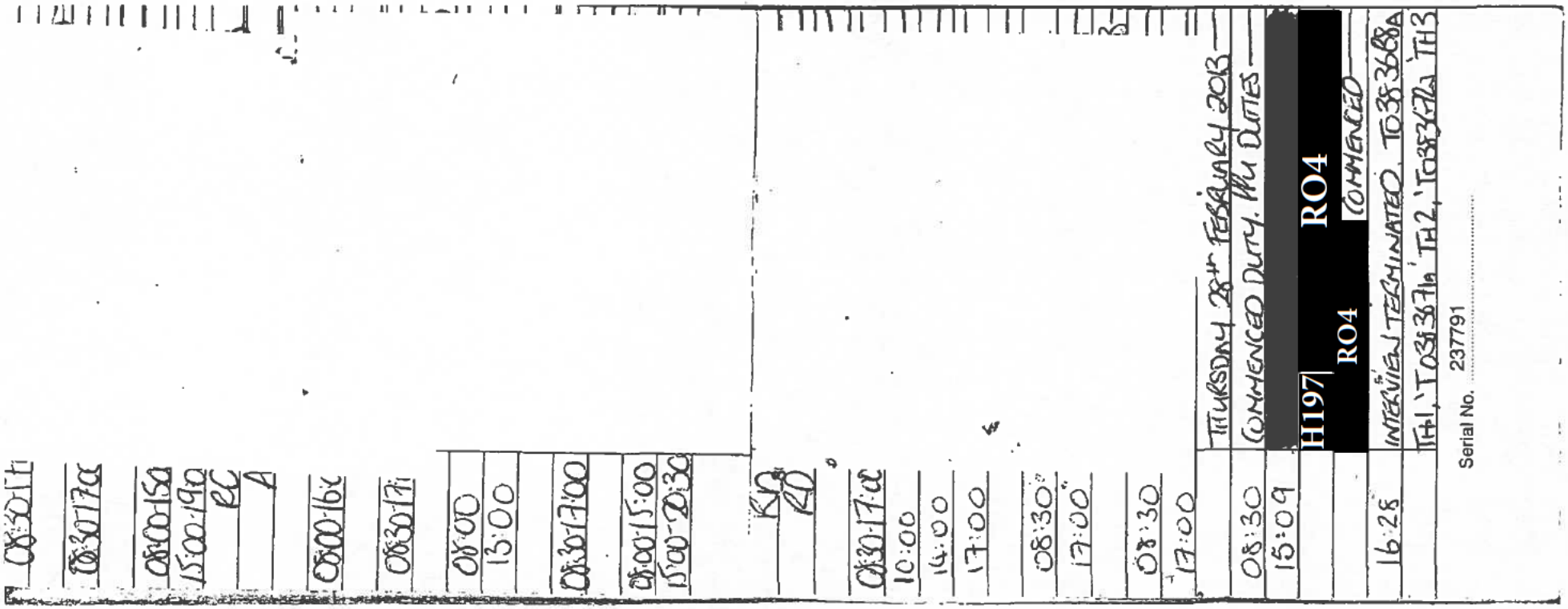

Certified a true copy of original M. Long Name Const Rank 21551 Number

MAHI - STM - 330 - 25

Personal, Professional, Protective Policing

INVESTIGATOR'S NOTEBOOK (Large)

CRIME OPERATIONS DEPARTMENT

Name E McCORMICK Rank SGT No [illegible]

District/Department 'D' PPJ

ISSUE NUMBER

LNB 16584

Date of Issue _____ Date of Completion _____

Form LNB 1
PB 2/11

Date/Time	Details
	Summary of na[redacted] B15
8/11/12	Reported by [redacted] B15 Manager @ Bohill/Priory Residential Home to [redacted] H92, Designated officer @ Muckamore.
	See email dated 8/11/12 from [redacted] B15 to [redacted] B1 [redacted] B1
	Email sent to Esther Rafferty Muckamore Deborah [illegible]-Campbell.
	RQIA informed by Priory Group.
	Allegations are that a member of Bohill staff who was working @ Muckamore on 7/11/12 witnessed incidents which were not conducive of safeguarding/care for the patients within Ennis Ward
	Brief details received as per spreadsheet [redacted] RO4
9/11/12 11.30	Meeting @ Muckamore. Strategy Discussion re reports of alleged abuse.
	See minutes dated 9/11/12.
14.30	attend Bohill Residential home with Const Hawthorne. Statement recorded from [redacted] B2 who was visibly upset when recalling the incidents witnessed.
	See SOE [redacted] B2

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Date/Time	Details
9/11/12	FMO - Dr Gallagher tasked in the evening of 8/11/12 and examined the Li patients. Photography tasked to attend and photograph 4 victims however the victim **P41** had already gone home for the weekend. D/I & team appraised of situ. Report and actions taken thus far.
14/11/12	Court Hamburg made contact with FMO - reports will not be ready until next week.
15/11/12	further briefing regarding Strategy & investigation carried out. Minutes not typed. Notes taken. See Notes dated 15/11/12 made by Sgt McGinnis. Actions:
1	Charge Nurse **H198** to be suspended.
2	**RO4** to be interviewed but Supervised during conduct.
3	Statements to be taken from further ward staff regarding further incidents
4	Band 7 to be on ward supernumerary to required staff ensuring the monitoring role during the day
5	Band 6 to work shifts for monitoring again supernumerary to staffing level.
6	AHP, Dr & Speech therapist to

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Date/Time	Details
	converse and talk to patients in Emmy to attempt to ascertain other reports/concerns of abuse/ internal issues.
7	Ana Manson to evaluate staffing schedules
8	Ana Manson to obtain via her staff debriefs of incident reports to try to ameliorate bullying to encounters and establish non reporting if any.
9.	Ana Manson to speak with her SMT regarding level of resources as stipulated by RQIA. 5 + 1 per person a obs 3 := 7 staff.
15/11/12	RETROSPECTIVE ENTRY ——— Consenvation for RRA in Ward has been discussed 15/11/12 Rationale: Detect further allegations Detect further allegations Establish whether patients reported are isolated incidents or a cultural problem within ward Protect the most VA within the setting Advice sought from Supt Ruth Smith (CARE) and full brief given. She is happy to authorise with the hospitals consent.

Date/Time	Details
	Collateral witness discussed. Management of Information discussed Evidential information discussed. Liaised with D/I Stanbridge - of devices if RRA application is progressed. Discussed with Anne Mamson who will discuss with her Director. Informed of confidentiality and the need to know basis of involving others in the decision making process Anne Mamson spoke with her Director Kathryn ? who wishes a meeting to discuss queries they have. Meeting to take place early next week in order to progress asap D/I St Jam appraised.
16/11/12	Policy from RQIA - Review of Ralphs Close Residential Grandma Care Home need to ensure learning from similar incident is carried forward with this investigation. Summary of recommendations considered. None specific to PSNI investigation. Most already considered and implemented to this investigation.

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Date/Time	Details
16/11/12	Any information request to Muckamore should be made via Esther Rafferty or Aine Morrison. All other hospital staff will step back from investigation/strategy discussion to ensure impartiality and independence.
22/11/12	Spoke with Aine Morrison for any further direction re RQIA. Director is not yet ready to make the decision and seeking advice from Legal Services. As it stands they feel the mandatory role and current investigation is sufficient to cover this dealing and feels we would get no product out of it. They also feel it would affect relationships between managers & staff. To be further discussed on 28th Nov. 12.
21/11/12	Retrospective entry. Medical statements received from Drs Dr Gallagher in respect of 4 victims.
22/11/12	[redacted] contacted re arrangements for further statements to be taken. Awaiting return call
28/11/12	Const Hawthorne attended Muckamore re interviewing patients & their capabilities (Action 6)

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Date/Time	Details
28/11/12	Meeting re progress. Chair Anne Harrison
	Packe received with amended minutes from first meeting minutes from last meeting + other information. Placed in file.
Action	SOE to be progressed from rest of staff @ Bohill. Co-ordinated through B15.
	Staff monitoring in place via Independent Mentor Maria Harrison, she will also carry out a nursing records review. Ongoing protection + care plan. Daily monitors will report weekly to Ms Harrison.
	Monitoring reports discussed. Main issue staffing levels/more resourcing. Staffing Action Plan enclosed.
	Meeting with Dr Milliken & Speech Therapist & Cast Hawthorne Dr Ling + Ward Manager.
	Patients discussed - capacity/evidential value P39, P43 & P22 - nothing. P42 may be able to give patient experience re SOE. P41 possible but doubtful as to patient experience. 12 other patients in ward. 4 would not be able to give anything. 6 patients

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Date/Time	Details
	possible with right preparation
	1 patient no SA but very good
	patient experience.
Action	RPS to be spoken to. re
	advice about information being
	evidential.
Action.	Photos - identification from
	work passes;
	Changes started with patterns
	of work.
Action	Counterpart notices for staff
	notice doctors.
	Advocate required for updating
	of victims without NOK.
	Update of families - protection
	plan and further enquiries. include
	Independent investigation outside
	hospital staff.
Action	Police update on day of Trust -
	among families at update of
	investigation.
17/12/12	Statements received from hosp
	witness @ Mary Bohmi

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Date/Time	Details
20/12/2	Meeting @ Ems ward char Ane Hanson
	Summary of allegations under investigation.
	Issue of Social worker questions to Ward staff - issue raised as to the questions being leading
	No concerns raised by Char or myself as witnesses give eye witness accounts of their statements.
	No general comments was recorded in statements that they drew witness themselves.
1	Advocates discussed - to be progressed with Esther re parents who are isolated or no NOK - discussion with ward staff re police input
2	Relatives - to be updated by phone followed up by letter.
	Belfast Trust expressed concern matter now discussion. Police contact details remain to be passed.
	Pont of Contact revealed a potential assault see Pont 40 Summary of Allegations under investigation. Clarification required Ane attempt to contact her

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Date/Time	Details
	Police contact details to be made available. Learners 'Case Progress' to be delivered today. Esther had informed all staff to make contact with police & management if they have concerns.
3	Analysis of information. - Any checked information no significance except for October 2012 & September 2012 low resources.
	VA referrals examined - Avie Manor appropriate but further analysis to carried out ongoing.
5	Staff Rotas - analysis of staff named up with Bolton staff carried out & information passed to police. Ongoing
6 ACTION	PIA - agreed further assessment of **P41** & **P40** carried out further information. **P41** (NURSE) no verbal communication - not at picture level - can vocalise likes/dislikes. No progress with **P41** **P40** assessment in progress. Carried Drysdale Walsh with Tracy Hawthorne. **Brother of P40** HJ to make a statement. Police contacts to be passed.

Date/Time	Details
Action	PPS to be discussed as to information gleaned during investigation but not a SOE how it can be used evidentially.
Act. as	Brother of P42 to be spoken to. re statement. Allegation no 40 refers - Carmel Drysdale to facilitate timeline to be clarified.
No 33	P44 NVT annual Trust to Carmel to investigation.
7	PSNI statements summonsed. to meeting. Future criminal offences. Aine will attempt to identify members of staff described in statements.
	Thursday 3rd January 2013
10:05	met with Aine Marnson (Designated officer) to go through witness statements and check through all allegations being made of criminal nature and relating to care/practice Aine also advised that she had spoken to Brother of P42 who had stated that P42 had disclosed that H198 had grabbed her by her clothes and brought her to her room. However there was some indication that this may have been in jest. Carmel Drysdale (ABE trained Social Worker) to be asked to make contact with me Early

Date/Time	Details
	next week to make arrangements to speak with [redacted] and [redacted]

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ES3

2012

MCCORMILL Elaine

From: MCCORMILL Elaine
Sent: 21 December 2012 20:47
To: SMYTH Ruth
Subject: 1.NOT PROTECTIVELY MARKED-All Networks:: RE: Investigation at Muckamore Abbey - OP DEVOIRS

Ma'am

Just a wee quick note to update you - the Trust decided not to provide the authorisation for the covert cameras and are dealing with it by way of managemnet monitoring and extra resources.
Thank you for your help and advice

Merry Christmas

Elaine

From: SMYTH Ruth
Sent: 20 November 2012 16:20
To: MCCORMILL Elaine
Cc: STANBRIDGE Gary
Subject: : RE: Investigation at Muckamore Abbey - OP DEVOIRS

Thanks Elaine

Here's hoping..... Maybe a way to help persuade her is for a deployment for a short period, say two weeks, which could be reviewed in conjunction with her ie if nothing untoward occurs the deployment ceases. If there are matters of concern we continue. Obviously if there is blatant criminality causing risk to the residents we would intervene. Hope this makes sense, but happy to discuss further, if necessary.

Kind regards

Ruth Smyth D/Superintendent

RIPA Cadre

Ext 23044

From: MCCORMILL Elaine
Sent: 20 November 2012 13:23
To: SMYTH Ruth
Cc: STANBRIDGE Gary
Subject: : Investigation at Muckamore Abbey - OP DEVOIRS

Ma'am

Just a wee note to update you - the Director of the Trust is still deliberating on giving permission with regards to placing covert cameras within the ward.

I will keep you updated as to the outcome.

ES3

MCCORMILL Elaine

From: MCCORMILL Elaine
Sent: 20 November 2012 13:23
To: SMYTH Ruth
Cc: STANBRIDGE Gary
Subject: : Investigation at Muckamore Abbey - OP DEVOIRS

Ma'am

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Thank you

Elaine

SGT ELAINE McCORMILL, PPU [OFFENDER MANAGEMENT] 'D' DISTRICT, Ext 36609 DIRECT
RO1

ES5

MCCORMILL Elaine

From: Morrison, Aine < RO1

Sent: 30 November 2012 15:37

To: 'Wilson, Greer'; 'Margaret.Cullen RO1 ; 'Siobhan.Rogan RO1
Hegarty, Deirdre; HAWTHORNE Tracy; MCCORMILL Elaine; Veitch, John;
'lesley.jones RO1

Subject: Staffing E Ward

Hi all,
Following our meeting on Wednesday, I met with Esther Rafferty again and confirmed that the current staffing levels on the ward are 6. This includes the 2 staff assigned to one to one obs. This level of staffing has been in place since the RQIA's unannounced inspections.
Esther informed me that the Telford assessment shows that the ward should have 6 staff. Esther informs me that it is practice to include the first on to one obs on a ward as part of the routine staffing complement and not requiring extra staff.
Given the discussion about staffing at Wednesday's meeting, the concern expressed by RQIA and the comments about staffing made by some monitoring staff, I have asked Moira Mannion, Co Director, Corporate Nursing, to review the assessments carried out to date and give us her own professional assessment of what the appropriate staffing should be. Moira is going to prioritise this bit of work.
I will inform you all of the outcome as soon as it is available,
Aine

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No RO1

ES4

MCCORMILL Elaine

From: Morrison, Aine <[RO1]
Sent: 26 November 2012 13:28
To: HAWTHORNE Tracy; MCCORMILL Elaine
Subject: Meeting MAH

Tracy/Elaine,
I can get everyone else together to discuss communication/capacity issues for patients in Ennis tomorrow at 11.30.
Could you by any chance attend ?
Aine

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No [RO1]

ESb

MCCORMILL Elaine

From: Morrison, Aine <RO1>
Sent: 30 November 2012 16:26
To: HAWTHORNE Tracy; MCCORMILL Elaine
Subject: RE: MAH investigation

Tracy,
I believed it to be the responsibility of the Trust. I will confirm this with Moira Mannion and let you know,
Aine

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
RO1

From: TRACY.HAWTHORNE RO1 [mailto: RO1
Sent: 30 November 2012 16:17
To: Morrison, Aine; ELAINE.MCCORMILL RO1
Cc: hilda.williams RO1
Subject: 1.NOT PROTECTIVELY MARKED-All Networks:: MAH investigation

Sgt,Aine,

I received a call this date from Hilda Williams of the Nursing and Midwifery Council with regards to H197 and the allegations at MAH. I informed her of the current status of the investigation. She asked if I could keep her up to date with the progress in the investigation. I explained that I would normally updated the D/O and where necessary the victim and/or NOK and have not previously been asked to update the NMC.

I would just like to clarify whose responsibility it is to keep the NMC updated regards this matter?

Tracy

ES7

MCCORMILL Elaine

From: MCCORMILL Elaine
Sent: 31 January 2013 10:32
To: 'Morrison, Aine'
Subject: : RE: Strategy Meeting E Ward

certainly will do

Unfortunately the protests are impacting us on desperately

Will update asap

Thanks

Elaine

SGT ELAINE McCORMILL, PPU [OFFENDER MANAGEMENT, & ADULT PROTECTION (SAFEGUARDING)] 'D' DISTRICT, Ext 36609 DIRECT LINE: RO1

From: Morrison, Aine [RO1
Sent: 30 January 2013 17:48
To: HAWTHORNE Tracy; MCCORMILL Elaine
Subject: Strategy Meeting E Ward

Tracy/Elaine,
As discussed I'm going to postpone the meeting planned for Friday 1st until you have completed your suspect interviews as I don't think we'll be able to progress much further with planning the next steps until then.
Would you let me know when you have dates arranged so I can start trying to get everyone gathered together again,
Thanks,
Aine

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
RO1