ORGANISATIONAL MODULES 2024 STATEMENT

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Sean Holland
Date: 28 June 2024

I, Sean Holland, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made by me as a witness for the Department of Health (DoH) in response to a request for evidence for the M10:Department of Health module 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 qualified as a Social Worker from Ulster University in 1986. I am a qualified Social Work practice teacher and I have a LLM in medical law. I worked in a variety of residential and childcare posts post qualification, including as a senior social worker, practice teacher, planning manager and manager of a long stay neurodisability hospital Thompson House Hospital. . In 2001 I was seconded to the Department of Health, Social Services and Public Safety to work on the development of a 20 year public health strategy *A Healthier Future* which set out the vision for health and wellbeing in Northern Ireland. In 2022 I was made visiting Professor of Social Work at Ulster University. I am currently a trustee of the Social Care Institute of Excellence and I sit on the Board of TUSLA, the national Child and Family Agency for the Republic of Ireland chairing their Quality and Services Committee. Over the past twenty years I have undertaken a number of short term projects in the field of social services working with UNICEF, LUMOS (a charity

supporting de-institutionalisation) and the EU as well as being involved in longer term projects in Bulgaria, Croatia and Jordan. I am currently the Director for Access to Justice in the Department of Justice where my responsibilities include policy responsibility for victims of crime and tackling sexual and domestic abuse.

2. I moved to the Department's Social Services Inspectorate in 2008 taking up the post of Assistant Chief Social Services Officer. I was appointed Chief Social Services Officer in July 2010. The Office of Social Services (OSS) which includes the Professional Social Work Group is located within the Social Services Policy Group in the Department of Health. OSS provides professional social work advice and expertise to the Minister, the Deputy Secretary/Chief Social Work Officer, the Department and social care and criminal justice agencies in the arena of social work and social care and children's function. OSS works with others to ensure that social work and social care services are responsive to the needs of people living and working in Northern Ireland and are of the highest possible standard in keeping with the resources available. The titles 'Chief Social Services Officer' and 'Chief Social Work Officer' are used interchangeably for the same role and for the purposes of consistency in my statement I will use the title 'Chief Social Work Officer.' I subsequently became Deputy Secretary of the Social Services Policy Group in January 2012 in addition to my responsibilities as Chief Social Work Officer, a position I held until I moved to the Department of Justice in October 2022. Upon my appointment to Deputy Secretary I also became responsible for the Mental Health, Disability and Elderly and Community Care Directorate, which moved into the Social Services Policy Group following internal Departmental reorganisation at that time.

Module

3. I have been asked to provide a statement for the purpose of M10: Department of Health - the evidence of persons in positions of responsibility for MAH and relevant professional standards, systems and processes, past and present, at Department level. In making this statement I have received assistance from former Departmental colleagues who have provided me with information and documentation relevant to the questions posed by the Inquiry. I can indicate their

identity to the Inquiry should it require this information. I have tried to indicate in this statement where information is within my own knowledge and recollection and where I have been alerted to it. I have appended relevant documentation or referred to where it is to be found in the evidence already before the Inquiry.

4. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Q1. Please explain the professional reporting lines that existed from MAH to the Chief Social Work Officer.

5. I held the position of Chief Social Work Officer from 2010 to 2022. As Chief Social Work Officer I was responsible for leading a team of professional officers at the Office of Social Services to support ministers, the Department of Health, and other government departments and agencies to ensure that local social work and social care services were responsive to the needs of the population in Northern Ireland, and were of the highest standard.

6. The Office of Social Services provides professional advice and input to the formulation and implementation of Northern Ireland government departments' policies on social care services and related social and professional practice matters. These matters include safeguarding children; looked after children; sponsorship of the Northern Ireland Social Care Council and regulation of the social care workforce; adult social care; older people and carers; mental health, dementia and disability, including learning disability; social work and social care training policy.

7. There is no direct professional reporting line between social work staff employed by the Belfast Trust at MAH and the Chief Social Work Officer. There are reporting arrangements in place on Delegated Statutory Functions which are described in Mark McGuicken's statement of 13 February 2023 at paras 15.14 – 15.18. These arrangements were reviewed as part of the programme of work to migrate the functions of the HSCB to SPPG, and the new reporting arrangements are set out in 3 revised OSS circulars, which were issued in 2022 and are

exhibited to Mark McGuicken's statement of 12 April 2024 at para 1.2, exhibits MMcG/313, MMcG/314 and MMcG/315. As part of these arrangements, I received annually a year-end overview report on Delegated Statutory Functions from the HSCB (now SPPG) which identified any issues requiring escalation or appropriate action by my office.

8. I also held regular meetings with all of the Trusts' Directors of Social Work, both collectively and individually, where a wide range of issues relating to professional social work practice were discussed. These meetings usually took place every 2 months, and provided a forum for consideration at a strategic level of issues relating to professional social work practice. While the focus of the meetings was primarily at a systems level rather than an operational one, the issues at Muckamore were discussed on occasions after the allegations of abuse emerged in 2017. I exhibit as an example of this a copy of the agenda and minutes of the meeting held on 22 January 2020 where Muckamore was discussed under AOB, at Exhibit 1 and Exhibit 2 respectively. Minutes of all the meetings held during my time in post are available and can be provided if that would be helpful to the Inquiry.

Q2. How often was MAH discussed within the Office of Social Services? Please explain what regular information your Office received about MAH. How often was any such information received and who provided it?

9. During the period I held the post of Chief Social Work Officer up until August 2017, my Office did not receive regular information or communication about MAH nor was the operation of MAH regularly discussed in my Office. In the main, issues raised with my Office would have been at a strategic level involving emerging professional and strategic matters rather than operational issues. The annual report from the HSCB occasionally mentioned issues in MAH with regard to resettlement of patients to the community and also provided data on safeguarding referrals across the region.

10. Operational responsibility for the services provided at MAH rested with the Belfast Health and Social Care Trust, and I would not have expected any direct

involvement by my Office in this, unless any professional social work issues had arisen at the hospital which were of sufficient gravity to require escalation to my Office.

11. During this period prior to August 2017, I do not recall any MAH related issues being raised at my regular meetings with Trust Executive Directors of Social Work, and I had no information which caused me to believe that there were any systematic issues at the hospital. The follow up work undertaken by the HSCB into the allegations of peer-on-peer abuse at MAH which first emerged in 2005 would have been discussed with me on occasion in these meetings, albeit I do not recollect this being on a regular basis. I also corresponded on this matter on a number of occasions with the then Director of Social Care and Children in the Health and Social Care Board, and as an example of this I exhibit correspondence at Exhibit 3 and Exhibit 4.

12. I also attended Belfast Trust mid and end-year assurance and accountability meetings with Departmental colleagues up until around 2014, when new arrangements for these meetings were introduced. I exhibit at Exhibit 5 a Departmental memo setting out the new arrangements for mid and end year accountability meetings. Copies of all Belfast Trust accountability meetings which included references to Muckamore or Learning Disability services are exhibited to Mark McGuicken's statement of 26 May 2023 at MMcG/293 – MMcG/303.

13. After I became aware of the allegation of abuse by staff on patients in August 2017 and subsequently the existence of CCTV evidence which raised systematic concerns about safeguarding arrangements at the hospital, I took a number of steps which I will detail in paras 127-141 in my statement to ensure that information on a range of metrics at MAH was provided on a regular basis to the Department for assurance purposes.

Q3. Did you receive any intelligence about MAH from your professional reporting lines? If so, what information did you receive, and what action(s) did you take, if any, in relation to that information?

14. Again, I did not receive any information or intelligence through my professional reporting lines on services at MAH prior to August 2017 which caused me to have any concerns about systematic professional social work or safeguarding practice at MAH. After August 2017 when it became clear there were serious concerns about safeguarding practice at the hospital, I took the steps I describe in more detail at paras 120 - 131 below.

Q4. RQIA frequently reported staff shortages at MAH from 2010 onwards, meaning that the prescribed levels of supervision for distressed patients were not achieved. Were you or your professional group aware of these RQIA reports? What action(s), if any, were taken arising from the information provided by those reports?

15. Reports of RQIA inspections at MAH were routinely circulated to the relevant policy lead within the Department, who would in turn share these with relevant Departmental professional officers either for information purposes, or to seek professional advice on issues that may have been identified through inspection reports. As Chief Social Worker I would not have led on considering any findings from inspections relating to nurse staffing levels. I was aware however that RQIA raised concerns about staffing at MAH after 2017, which culminated in the issue of two Article 4 letters to the Department in the first half of 2019. I provide more detail on these letters in para 16 below. In general terms, where inspections find staffing levels in any service to be consistently inadequate, responsibility for addressing these in the first instance rests with the provider organization. If the provider is unable to do so within their existing resource allocation, then they have a responsibility to raise these with the service commissioner through a bid for the necessary additional funding through the established HSC commissioning arrangements. Where staffing concerns arise from workforce supply issues, these should again be raised with the service commissioner and through them if appropriate with the relevant Departmental Chief Professional Officer to consider any necessary regional action.

16. Where RQIA inspections identify very serious concerns relating to a particular service which is not regulated under Part III of the Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003

("the 2003 Order") they can report these to the Department, and may under Articles 4 and 35(5) of the 2003 Order recommend that the Department takes special measures in relation to the service. As I indicate above, I am aware the Department received two such Article 4 letters from RQIA in 2019 in relation to inspections they had carried out at MAH, as set out in Mark McGuicken's statement of 26 May 2023 at paras 1.1-1.5. (MAHI – STM – 118 – 1 to MAHI – STM – 118 - 2) Copies of these letters have been exhibited to that statement at MMcG/176 and MMcG/177.

Q5. Are you in a position to express a view on whether the immediate suspension of staff identified following review of CCTV at MAH made patients at MAH safer?

17. The decision to suspend a member of staff rests with the employer and should be taken in accordance with the terms of the contract of employment between employer and employee. It should not be a knee jerk response to the raising of a concern or an allegation being made. Each case should be dealt with on an individual basis taking account of the risks of the particular situation and alternatives to suspension should always be actively considered. Where suspension is deemed appropriate it should be kept under review and should only last for the minimum period necessary. Contact should be maintained between the employer and employee during the period of suspension. Where viewing of CCTV identifies potentially abusive behaviour by a member of staff towards a vulnerable patient, placing the staff member involved on precautionary suspension has the benefit of ensuring that no further potential harm can occur while the incident is being investigated including ongoing trauma arising from vulnerable person continuing to being cared for by a person whom they may be fearful of. This is reflective of normal practice across a range of care settings where children or vulnerable adults receive services.

18. However in Muckamore the sheer number of staff who were placed on suspension following the viewing of CCTV recordings when the allegations of abuse emerged in 2017 was in my professional experience unprecedented.

19. Furthermore the situation in Muckamore was widely reported in the media and as a result the Belfast Trust indicated that they were having difficulty in recruiting sufficient staff to cover the gaps created by staff suspensions. In order to address this, the Department made significant additional funds available to the Belfast Trust which allowed the Trust to avail of high cost agency staffing including staff sourced from outside of Northern Ireland. I attach at Exhibit 6 an example of a funding allocation letter showing (at para 10) the additional in-year funding made available in 2021-22 to the Belfast Trust to meet these additional costs.

20. The Department also agreed to the introduction of a time-limited financial incentive to existing HSC staff in other services to encourage them to take up posts in MAH. I provide further detail on this later in my statement at para 151.

21. Inevitably the difficulties experienced by the hospital in covering rotas coupled with the high use of temporary staff was disruptive for patient - staff relationships and had the potential to undermine the quality of care. However these detriments had to be balanced against the potential risk of harm being done by a member of staff about whom concerns had been identified through the viewing of CCTV. The decision to suspend in each case was an operational one and it is my understanding that where concerns arose about a member of staff were identified through the viewing of CCTV, but where action short of suspension was deemed appropriate, that action was taken.

Q6. Were the consequences of staff suspensions, both intended and unintended, discussed at MDAG? If so, please explain.

22. MDAG, which I co-chaired with the Chief Nursing Officer, had four objectives, two of which (‘*The services being delivered at Muckamore continue to be safe, effective and fully Human Rights compliant’;* and *‘The team on site at Muckamore is given the support and resources necessary to achieve their goals’)* related to ensuring the maintenance of safe staffing levels on site.

23. In this context, reports on hospital staffing levels and the stability of services on the site were provided and discussed at meetings of MDAG from the first meeting which was held on 31 August 2019. This included information on the numbers of staff placed on suspension as well as the level of agency staff deployed on site. With effect from the third meeting of MDAG held on 30th October 2019, the staffing position at the hospital was included as a standing agenda item at the meetings.

24. Unsurprisingly given its Terms of Reference, the discussions at MDAG had a clear focus on providing assurances on patient safety, and in this context the precautionary suspension of some hospital staff as a result of viewing of CCTV footage was considered to be an important protective factor for patients. However the Group was also aware that suspensions at the levels involved inevitably contributed to a less stable environment in the hospital, and the introduction of new staff with the attendant disruption to the continuity of staff providing care was less than optimal in meeting the particular needs of the in-patient population.

25. Minutes from all MDAG meetings up until February 2023 have been exhibited to Mark McGuicken's statement of 26 May 2023, at MMcG/209 – MMcG/228. Minutes from meetings held after February 2023 can be provided to the Inquiry on request.

Q7. The Inquiry has received data demonstrating a rise in incident reports from 2011-2018 regarding inappropriate or aggressive behaviour by patients towards staff (see MAHI-STM-101-005490). In relation to this data:

i. Were you aware of it?

ii. What action(s), if any, were taken arising from this data, in the context of changes to and closures of wards at MAH over the same period?

iii. What action(s) should have been taken?

iv. Was this data significant in relation to the staff shortages reported by RQIA across the same timeframe?

26. I have reviewed the Inquiry exhibit MAHI-STM-101-005490 and note that this is an exhibit to Chris Hagan's statement of 20 March 2023 and forms part of his statement which describes Belfast Trust policies for management of violence and aggression. I also note that para 63 of this statement indicates that the Trust's Risk and Governance team has collated this data to assist the Inquiry from information recorded in the Trust's DATIX record system since the system was established.

27. I have no recollection of this information being previously made available in this format to the Department, and a search of Departmental records has not identified this being provided to the Department. I am not therefore able to comment on question ii.

28. In general terms however in relation to questions iii and iv, I would expect the Trust to have analysed this information with a view to identifying any trends, including any potential impact this may have had on any reported staffing shortages, and taking necessary steps to implement appropriate remedial action.

29. I would note however that assurance reports provided by the Trust to MDAG since its establishment in 2019 have included information on rates of Adult Safeguarding (ASG) referrals in the hospital. The information, which is provided by the Trust to MDAG to enable it to discharge its assurance function, remains under continuous review and has evolved over the lifetime of MDAG to improve the level of assurance provided through MDAG to the Department. As an example, I exhibit at Exhibit 7 a copy of the assurance report provided to the MDAG meeting held on 17 April 2024, which includes trend data on ASG referrals and includes sources of referrals and categories of abuse.

Questions for Departmental witnesses

Q1. Please explain what your role was and when you held that role. Please also detail any particular responsibilities you held in relation to MAH and identify any groups relating to MAH which you were a member of.

30. I joined the Department in 2001 and became Assistant Chief Social Work Officer in 2008, before being appointed Chief Social Work Officer (CSWO) in July 2010. In this role I provided professional leadership for Social Work and Social Care, including the promotion of professional standards, education, training and workforce regulation.

31. As part of departmental reorganisation I assumed the additional responsibilities of the Deputy Secretary of the Social Services Policy Group in 2012, which included policy responsibility for adult and children's social care and mental health services. It was at this point that I assumed policy responsibility for the services provided at MAH. I include at Exhibit 8 a diagram showing my responsibilities at this time.

32. I held this role until 30 September 2022. In this role I was responsible for leading, managing and co-ordinating social care policy and legislation across the Department, identifying and monitoring strategic priorities and supporting the decision making and accountability processes associated with the effective operation of the Department.

33. Following the allegations of abuse in 2017, the Muckamore Departmental Assurance Group (MDAG) was established in 2019 to provide further oversight and assurance of the hospital. I was Co-Chair of this Group alongside the Chief Nursing Officer, Charlotte McArdle.

Q2. Please explain your understanding of the structures and processes that were in place at Departmental level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Departmental level?

34. A summary of the evolution of HSC structures over the 20-year time period being examined by the Inquiry from 1999-2021, along with the associated oversight and accountability arrangements, is set out in Mark McGuicken's statement of 13

February 2023 at paras 2.10 – 2.33. [MAHI - STM - 089 – 4 to MAHI - STM - 089 - 8] This summary covers the establishment of Health and Social Services (HSS) Trusts and HSS Boards in the 1990's, the changes to HSC structures resulting from the Review of Public Administration in Northern Ireland in the 2000's which saw the amalgamation of 18 HSS Trusts into 6 HSC Trusts and the replacement of the 4 HSS Boards by a single regional Health and Social Care Board, and the subsequent dissolution of the HSCB in 2022.

35. These general oversight arrangements were/are applicable to all HSC services, including those provided at MAH. The statement goes on to describe specific arrangements for oversight of learning disability services at paras 4.1 – 4.6. [MAHI - STM - 089 - 16 to MAHI - STM - 089 – 18] This includes a summary of the relevant reviews and reforms which have informed the development of oversight structures.

36. Paras 4.4 – 4.6 make reference to the HSC Framework document as the overarching summary of HSC governance and accountability arrangements.

37. In addition, at para 4.7, it also identifies a number of additional time-limited oversight arrangements for learning disability services which would also likely have related to MAH, either peripherally or in total. These were the Bamford governance structures (paras 4.8 – 4.10), the Learning Disability Service Framework oversight arrangements, the establishment of MDAG (para 4.12) and commissioning arrangements (para 4.13).

38. As evidenced in Mark McGuicken's statement which I refer to at para 34 above, arrangements for oversight of HSC services have evolved considerably over the last 25 years. This evolution partly reflects the organisational changes in the structures of government of Northern Ireland over this period through the Review of Public Administration, but also the Department's commitment to continuous review and improvement in governance arrangements which takes account of learning emerging from, for example, public inquiries, emerging best practice in safety and quality of health and social care services, risk management and any other relevant developments. This commitment was evidenced for example by the

programme of work initiated by the Department in response to the recommendations which arose from the 'A Way To Go' report in 2018 and the report of the Leadership and Governance Review in 2020, which I have described in paragraphs 141 - 143 of my statement.

39. The HSC governance arrangements as they were structured during my time in post were in line with the relevant requirements for public sector bodies in Northern Ireland. However the risk of abuse of vulnerable individuals by way of neglect incompetence or malign act is persistent all care settings, and efforts to eradicate or minimise this risk are continuously evolving. It remains the responsibility of the relevant Arms Length Body to escalate any concerns appropriately through the established structures and the effectiveness of the extant governance arrangements is dependent on all stakeholders recognising their obligations and taking the appropriate steps to assure themselves that they have appropriate and proportionate measures in place to meet these obligations. However those who provide such care should always remain alert to the possibility of abuse regardless of any governance or safeguarding arrangements in place.

Q3. Did the Department rely on incident reporting in respect of MAH?

40. There are a range of reporting mechanisms which provide the Department with information on front-line service delivery (which includes those services provided at MAH), and the Department does not rely solely on incident reporting to become aware of issues emerging in front line services.

41. These mechanisms range from the formal reporting arrangements outlined in Qu 2 above through to other specific reporting requirements associated with various statutory requirements as well as safety and quality functions.

42. Examples of specific reporting arrangements relevant to all HSC services (which again included MAH) include information on compliments and complaints (as outlined in Mark McGuicken's statement of 26 May 2023 at paras 50.1 - 50.2 (MAHI – STM – 118 – 47 to MAHI – STM – 118 – 48) and 51.1 – 51.4 (MAHI – STM – 118

- 47 to MAHI – STM – 118 - 48), reports on the discharge of Delegated Statutory Functions (outlined in Mark McGuicken's statement of 26 May at paras 66.1 - 66.2 (MAHI – STM – 118 – 54), adverse incident reporting and the Early Alert system (Mark McGuicken's statement of 13 February at paragraphs 13.1 – 13.21 (MAHI – STM – 089 – 57 to MAHI – STM – 089 - 63).

43. After the emergence of the abuse allegations in 2017, from January 2018 onwards the Belfast Trust provided regular update reports to the Department on the actions taken by the Trust to address the allegations. The reports included updates on the Adult Safeguarding investigation, the PSNI investigation, RQIA inspection findings and the enhanced assurance arrangements established by the Trust. These were initially monthly until May 2018, then every other month after that. All reports provided were scrutinised by policy and professional officers and further information or clarity was sought if required. I exhibit a copy of the first update report provided in January 2018 at Exhibit 9. Copies of further reports can be provided if the Inquiry considers this would be helpful.

44. Face to face monthly update meetings between policy and professional leads in the Department with senior staff from the Belfast Trust and HSCB were introduced from April 2019. These were to provide relevant assurances in relation to the various strands of work involved in ensuring the ongoing safe operation of the hospital and successfully delivering on the 'A Way To Go' report recommendations and the Permanent Secretary's subsequent commitments to families. Action points from these meetings were provided to the Inquiry as part of the Department's Schedule 1 return, and I exhibit the action points from the first meeting in April 2019 at Exhibit 10.

45. These monthly meetings were subsequently stood down following the establishment of MDAG in August 2019, that I co-chaired with my colleague Charlotte McArdle. The Department commissioned update reports from the Belfast Trust on ASG/patient safety at MAH in advance of each meeting of MDAG which informed the assurance reports prepared by the Department for each meeting. The information provided for MDAG to support its assurance

function is subject to continuous review, and the format and content of this has evolved over the lifetime of MDAG.

Q4. How would concerns at MAH trigger a notification to the Department? Who decided that a notification ought to be made and what guidance was there to identify when that ought to happen?

46. Depending on the nature of the concern, the Department may be made aware of this through various channels such as, for example, a complaint being made or a whistleblower raising issues. However the official system in operation in the HSC for notification of concerns is through the Department’s Early Alert System. This was introduced in June 2010 when responsibility for oversight of Serious Adverse Incident reporting transferred from the Department to the HSCB/PHA.

47. The operation of the Early Alert system is outlined in Mark McGuicken’s statement of 13 February at paras 13.17- 13.21. [MAHI - STM - 089 – 61 to MAHI - STM - 089 – 63], this includes the various updated circulars issued by the Department on the Early Alert process and steps taken when an incident occurs.

48. This system was put in place to ensure that the Department and the Minister were made aware in a timely manner of any significant events occurring within the HSC system. The criteria for reporting incidents through the Early Alert system are as follows:

    1. Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

    2. The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

3. The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

4. The event may attract media interest;

5. The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that an HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:

   i. there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or

   ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or

   iii. the Coroner's inquest is likely to attract media interest.

6. The following should always be notified:

   i. the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;

   ii. the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;

   iv. allegations that a child accommodated in a children's home has committed a serious offence; and

v. any serious complaint about a children's home or persons working there.

7. There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

49. I exhibit the full guidance on the arrangements for the Early Alert reporting system at Exhibit 11.

50. In addition, the RQIA is also required to keep the Department informed about the provision of services and their availability and quality, and I refer in para 16 of my statement to concerns about services at MAH which were notified to the Department by RQIA.

Q5. Did the Department receive regular data or other reports in respect of MAH? If so, please provide details, including how often they were received and who provided them.

51. The Department receives data and reports in relation to its range of responsibilities on an ongoing and continual basis and these may include information about services provided at Muckamore Abbey Hospital. This may include direct information regarding the operation of the hospital which has been commissioned for a specific reason, for example information required for MDAG; or be of a more general nature as part of updates or information being sought on the wider Belfast Trust as part of performance or financial management oversight arrangements. A number of examples of the types of data and reports by way of illustration are set out in the following paragraphs.

Performance Management

52. During the operation of the Department's Service Delivery Unit, from around 2006 until 2009, the Business Services Organisation (BSO) provided weekly reports on hospital activity which were used to track progress on the achievement of the

Departmental targets, including resettlement from long stay hospitals such as Muckamore. This function was absorbed into the information function of the HSCB when it became established in 2009.

53. As part of the Commissioning Plan monitoring processes which were in place from 2009 the Department received performance reports on progress against targets within the Commissioning Plan from the HSCB, including those with relevance to Muckamore (which related in the main to learning disability and mental health discharges). The HSCB received updates from Trusts on a regular basis and provided reports based on these to the Department for performance monitoring purposes, including an annual report on outcomes. Following the dissolution of HSCB the SPPG, through its Performance Safety and Service Improvement Directorate, continues to collate detail on HSC system performance.

54. Also as part of HSC commissioning processes, the HSCB submitted copies of Trust Delivery Plans (TDPs) to the Department for formal approval. The TDPs set out how each HSC Trust planned to deliver its commissioning commitments, including in relation to resettlement. The Belfast Trust TDP would cover services provided at Muckamore Abbey Hospital. TDPs were submitted to the Department annually as part of the commissioning plan process.

Accountability Processes

55. The Department's HSC Trust sponsorship branch receives information related to governance from the Belfast Trust including sponsorship checklists, copies of the Trust's Board minutes, a mid-year Assurance Statement and an end-year Governance Statement. This process is replicated across all Trusts. These would be shared as appropriate with relevant policy branches within the Department to consider any specific issues raised that require Departmental intervention. Trusts complete sponsorship checklists throughout the course of the financial year. Board minutes are shared with the Department following meetings

of the Trust Board, which are usually monthly or bi-monthly depending on scheduling by the Trust.

Delegated Statutory Functions

56. As I mentioned at para 7 above, in line with the requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions there are arrangements in place for ongoing professional oversight to deal with any issues as raised. In addition, I received a yearly overview report on the Discharge of Statutory Functions, provided by the HSCB during its existence. SPPG continue to collate and provide the report.

Information Analysis Directorate

57. The Department's statistical function, the Information Analysis Directorate, requests and receives updates from Trusts on a range of Mental Health and Learning Disability patient activity, which includes Muckamore Abbey, as outlined below on a quarterly or annual basis.

58. Information includes detail on:

- Admissions under Mental Health (NI) Order 1986: Legal Status (quarterly) (Returns: K15 & KH15b);

- Admissions under Mental Health (NI) Order 1986: Change in Legal Status (quarterly) (Return: KH16);

- Electro-Convulsive Therapy (quarterly) (Return: KH17);

- A summary of available bed days, occupied bed days, discharges and deaths, and day cases (quarterly) (Return: KH03a); and

- Mental Illness and Learning Disability (MILD) Census (annually).

System Audit/Accountability Reports

59. The Department received copies of HSC related Northern Ireland Audit Office (NIAO) reports once published, such as the NIAO General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland that ran roughly annually from 2003/04 to around 2018. These reports would have at times contained references to audits of specific services, such as the administration and safeguarding of clients' monies in mental health and learning disability wards in the Belfast HSC Trust.

60. Reports in relation to mental health and learning disability services would also be received from the RQIA. Examples of these include:

    - Review of the Safeguards in Place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in HSC Trusts, 2008;

    - Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, 2013;

    - A Baseline Assessment and Review of Community Services for Adults with a Learning Disability, 2013

    - RQIA Mental Health and Learning Disability Directorate Annual Report produced 2013/14.

    - Review of Adult Learning Disability Community Services – Phase II, 2016; and

    - Review of Emergency Mental Health Service Provision across Northern Ireland, 2019.

61. Relevant reports were also received from the NI Assembly's Public Accounts Committee. Examples include:

- PAC Report on the Resettlement of Long Stay Patients from Learning Disability Hospitals, 2010; and

- PAC Report on the Safety of Services Provided by Health and Social Care Trusts, 2013.

62. Following the allegations of abuse in MAH came to light in 2017, the Department requested regular reports from the Belfast Trust from January 2018 to provide assurances and an update on the actions and progress on matters relating to Muckamore Abbey Hospital. I have attached a copy of the report from January 2018 at para 43 of my statement. Other copies of these monthly reports have been provided to the Inquiry as part of the Department's Schedule 1 request.

MDAG

63. As part of the operation of the Muckamore Departmental Assurance Group (MDAG) over its lifetime, from August 2019 to date, the Department commissions a range of information to help inform reporting to the Group at each meeting. This has included at various points:

- Update reports from action owners on implementation of the recommendations in the HSC Action Plan;

- Update reports from the Belfast Trust on progress with the identification and review of material in relation to the historical CCTV viewing and ASG referrals;

- Highlight reports from the Belfast Trust on key aspects of the operational of the hospital such as staffing, current ASG activity, communication/engagement with patients' families, RQIA inspections;

- Resettlement progress dashboards from the then HSCB (latterly SPPG); and

- Ad-hoc ASG process maps from the Belfast Trust.

The information provided to MDAG is used to prepare an Assurance Report which is used to support MDAG in its assurance and oversight role for the services provided at MAH.

64. Following concerns raised at MDAG over the number and nature of safeguarding referrals at MAH, the Department commissioned an independent safeguarding audit file review in July 2021. This was discussed at MDAG on 30 June 2021, the minutes of which were exhibited with Mark McGuicken's statement dated 26 May 2023, MMcG/220 refers.

65. The audit was carried out by an independent team of four auditors; three from a social work background; and a fourth member from a learning disability background. The file review focused on two key areas; the appropriateness of the thresholds in operation for initial referral and screening outcomes (based on the Northern Ireland Safeguarding Operational Procedures, 2016); and the levels of actual and/or potential harm caused to patients by the incidents that had been reported. The review team was also asked to comment on any positive or negative aspects of the safeguarding process that they considered noteworthy, as evidenced within the reviewed files. The audit was completed on site at Muckamore on 19, 21 – 23 and 30 July 2021 and examined a sample of 60 staff on patients' referrals from the period 1 January 2020 to 30 April 2021, as selected by the team.

66. Following completion of the audit, the Department was provided with a summary of the team's findings in advance of the formal report being submitted. In response to the summary findings from the audit, the Department asked the Belfast Trust to immediately follow up in three areas:

    i) Review any cases where there had been some actions taken in relation to an agency member of staff because there were concerns about their behaviour towards patients. This was to ensure that all necessary protective actions were taken in respect of staff, including referrals to professional regulatory bodies as appropriate.

    ii) Immediately review all cases where there has been more than two adult safeguarding referrals involving the same patient. This was to ensure that incidents had not been considered in isolation.

    iii) Review the referrals to identify what had been the outcome of each investigation adult safeguarding documentation in response to auditors' comments that the records lacked any conclusion in a large number of cases.

This was outlined under Agenda Item 5 at the MDAG meeting on 25 August 2021, per exhibit MMcG/221 to Mark McGuicken's statement of May 2023.

67. The final report from the audit was received by the Department on 17 September 2021 and shared with the Belfast Trust and the RQIA on 20 September for consideration of any action required. Updates on the report were provided to MDAG, although the report itself was not circulated to MDAG members for reasons of confidentiality. A copy of the report was exhibited at MMcG/308 to Mark McGuicken's statement of 26 May 2023.

68. Following completion of the audit, the Department continued to engage with the Trust on follow-up actions, including the development by the Trust of an action plan to address the recommendations. An additional agenda item 'Outcome of the Safeguarding Audit', was added to the agenda for the MDAG meetings held between August 2021 and April 2023 (Exhibits MMcG/221, MMcG/222, MMcG/223, MMcG/224, MMcG/225, MMcG/226, MMcG/227, MMcG/228, and Exhibit 12).

69. At the April 2023 MDAG meeting, members agreed that this work should be signed off as complete by the Department, with the Trust action plan remaining a live document for implementation by the Belfast Trust. The Trust also confirmed that RQIA inspection arrangements would include an assessment of the Trusts' performance against the action plan.

70. I also considered it important that the findings from this review should inform the work the Department is progressing to introduce the new Adult Protection Bill, and this was noted at the meeting of the Adult Safeguarding Transformation Board held on 26 July 2021. I exhibit a copy of the minutes from the meeting at Exhibit 13.

Q6. Was soft intelligence triangulated with data? How were different data sources integrated (for example, staff shortages and patient outcomes)?

71. I would understand soft intelligence to refer to information which arises outside the formal HSC reporting metrics and does not lend itself to straightforward classification or quantification. Typically such information may become known to me from a number of potential sources, for example, correspondence to the Minister's Private Office from MPs or MLA's, letters or calls from relatives/carers of patients, members of the public, or staff whistleblowers. Important or significant intelligence may also have been provided to me through interactions at meetings, conferences, visits to HSC front-line services or my professional reporting lines such as from Executive Directors of Social Work.

72. Depending on the nature of the intelligence, as normal process I would ask my direct report policy or professional staff to triangulate this with advice or data from a range of sources, for example, advice from other Departmental professional officers where relevant, information from the sponsorship branch for the relevant Trust including sponsorship checklists, minutes from Trust Board meetings and accountability meetings with the Department, and relevant RQIA reports. I would also ask them to approach any relevant organisations, such as the HSCB and the Trust involved to share the information with them and seek their perspectives.

73. Information gathered through these channels would initially be reviewed by the policy lead to identify any emerging trends or learning and to inform any direct intervention that may be required by the Department.

74. I have no recollection of becoming aware of any soft intelligence in relation to MAH prior to 2017, however I do recall after this I attended a number of meetings with relatives of patients in MAH. An issue was raised with me where families reported feeling pressured to accept resettlement options for their family members. Following this I issued a letter to Trust Chief Executives reminding them of the importance of taking account of the views of patients, family members and carers in developing resettlement options. I attach a copy of this at Exhibit 14.

75. I do not recall any specific work carried out while I was in post to examine the impact of staff shortages on patient outcomes at MAH. Since it was established, MDAG has kept the impact of staff shortages on services at MAH under continuous review, though this has primarily been through the lens of patient safety.

Q7. Did the Department have any role in the decision to install and operate CCTV at MAH? If so, please give details.

76. The decision to install and operate CCTV at MAH was an operational one for the Trust as the service provider and we have no records of the Department being directly involved in this process.

77. The Department issues regular finance circulars to its Arm's Length Bodies setting out Delegated Limits for approval of all areas of expenditure, which includes capital items such as the installation of CCTV. I exhibit at Exhibit 15 a copy of the Departmental circular from 2012 setting a Delegated Limit of £500,000 for capital expenditure by Trusts.

78. This meant that authority for any expenditure of less than £500,000 had been delegated to Trusts and this would therefore have been the responsibility of the HSC Trust to consider within its own allocated budget.

79. As part of finance monitoring processes to ensure adherence to guidance on business cases, yearly monitoring was carried out on Below Delegated Limit (BDL) business cases by Trusts. Trusts were asked to provide details of any business cases each year that were below the BDL and a number of these were then selected for test drilling to gauge compliance or identify any areas for learning or improvement.

80. As part of this process I am informed that the Belfast Trust notified the Department of a business case for the installation of CCTV on Cranfield and Sixmile wards in Muckamore in 2014/15 at a cost of £127k. I would not have expected to have had sight of this. The selection of cases for test drilling is by random sample and it does not appear this case was selected for test drilling by the Department.

81. From a search of Departmental records, it appears the Department was informally advised by the Belfast Trust in January 2016 that the Trust was exploring the possibility of piloting the use of CCTV technology in a small number of wards in MAH later that year. This was in the context of correspondence from Gordon Lyons, MLA, to the Minister on behalf of a constituent who had made

allegations of inappropriate behaviour towards him while he was a patient in MAH. In line with established practice for responding to such correspondence, policy officials contacted the Belfast Trust to inform them of the correspondence and to seek an update from the Trust to inform the Minister's response to Mr Lyons. In their response to the allegations raised the Trust also advised that they was trialling the introduction of CCTV in some of the hospital wards. I exhibit a copy of the Trust response at Exhibit 16.

82. The Department became aware that CCTV was operational at the hospital through an updated Early Alert from the Belfast Trust in relation to the allegations of abuse from August 2017, which I have exhibited at Exhibit 17.

83. The report of the Review of Leadership and Governance at MAH notes that a Belfast Trust business case for the installation of CCTV was developed and approved in 2014 and cameras were first installed in MAH in 2015 (p124 – 131).

Q8. When did the Department first become aware of allegations of the abuse of patients at MAH? What action did it take in response?

84. The Department was made aware of allegations of abuse at Muckamore Abbey Hospital on a number of occasions during the period covered by the ToRs of the Inquiry, and I have set out below the detail I am aware of for those allegations which fell within my time in the Department.

Historic abuse allegations

85. The first of these was in the autumn of 2005 when the then Eastern Health and Social Services Board (EHSSB) alerted the Department to allegations of historic abuse dating back to the 1960's and 1970s which arose from a legal case taken by an ex-patient of Muckamore Abbey Hospital against the then North and West Belfast HSS Trust.

86. I have been informed by the Department that records still held on this are partial, as a number of these were previously disposed of in line with the retention and disposal schedule for management of HSC records. The records held by the Department relating to this matter have been provided to the Inquiry as part of the Department's Schedule 1 request.

Preliminary Fact Gathering Review (Phase 1)

87. To investigate the allegations, the EHSSB and North and West Trust conducted a review of 64 patient files dating back to the 1960's which revealed a number of concerns in relation to possible sexual abuse of other patients in the 1960s, 1970s and early 1980s.

88. This initial Review was limited to an examination of the files of inpatients identified in the ex- patient's file and related contacts, and was completed in December 2005. Although the ex - patient had originally alleged staff involvement in these events, no evidence of any such involvement was found by the Review Team as part of this exercise.

89. The EHSSB and North and West Belfast Trust Chief Executives also commissioned a Review of current practice and care within Muckamore. The Review Report was completed in December 2005 and confirmed that relevant policies and procedures in relation to safeguarding children and the protection of vulnerable adults were in place.

90. The results of the preliminary fact gathering review (Phase 1) were presented to the PSNI in December 2005.

91. In order to co-ordinate and take forward the investigation, the PSNI and Health and Social Services formed a Strategic Management Group in May 2006, chaired by the Chief Executive of the former EHSSB, Paula Kilbane.

92. The then DHSSPS Permanent Secretary, Dr Andrew McCormick wrote in September 2006 to all Chief Executives of the Trusts responsible for mental health and learning disability inpatient facilities seeking assurance from them that appropriate procedures were in place to prevent abuse of children and vulnerable adults and to ensure that any incidents that may arise are dealt with properly and effectively. He also asked that Chief Executives consider the need for a retrospective review of patient notes. I attach copy of this letter at Exhibit 18.

Phase 2

93. In or around 2006, a further 296 Muckamore Hospital case files were retrieved and reviewed in line with police requirements. Concerns raised as a result of that review of files were shared with PSNI in August 2007; and for the group of cases where there was a primary indication of concern, the Strategic Management Group put forward two options to be considered to take forward the remainder of the investigation: Option 1 - to fully investigate all complaints elicited from the file search and, Option 2 - to investigate only the most serious offences.

94. Following consultation with the Chief Executives of the Belfast Trust, PSNI, the Chief Executive of EHSSB, and in keeping with the recommendation of SMG, it was agreed with the Department (at a meeting in June 2008) that Option 2 would be accepted.

95. As a consequence, interviews were carried out with a number of patients, which resulted in a number of allegations including rape, general homosexual activity and minor sexualised behaviour. These were investigated by police but this did not result in any convictions, which was confirmed by the Public Prosecution Service when they announced in April 2011 that, following the extensive police investigation, they had ruled out prosecutions.

96. The Strategic Management Group did, however, produce a series of five recommendations arising from this historical investigation into Muckamore which were as follows:

- Accountable Officers of commissioning, providing and regulatory bodies, under the Governance duties, were to ensure that best practice in relation to the protection of children and vulnerable adults was evidenced in learning disability services.

- A position should be reached as quickly as possible that enabled adolescent services to be commissioned in separate facilities from adult services.

- Until this position could be reached, Trusts were asked to undertake a review of current arrangements to satisfy themselves that they had taken all reasonable steps to protect children.

- Trusts should reference the Vulnerable Adults policy and its implications for practice in situations such as these.

- All organisations were required to produce an action plan following receipt of the RQIA report on the protection of children and vulnerable adults in mental health and learning disability services (June 2008, see paragraph 60).

97. The Department fully endorsed these recommendations and the then Permanent Secretary, Dr Andrew McCormick issued them to the Service for immediate action in October 2008.

Assurances from RQIA

98. Dr McCormick also wrote to RQIA in September 2006 seeking an independent assurance that appropriate procedures were in place to prevent abuse of children and vulnerable adults in mental health and learning disability hospitals on these matters.

99. Work to deliver this request took place during 2007 and the RQIA Overview Report of the Review of the "Safeguards In Place For Children and Vulnerable Adults In Mental Health and Learning Disability Hospitals" in HSC Trusts dated June 2008 was received by the Department in August 2008.

100. Whilst the report identified a number of examples of good practice, there were concerns about the work which remained outstanding, especially in relation to staff training and the number of children and young people being treated in adult wards.

101. In light of this report Dr McCormick wrote in October 2008 to Trust Chief Executives conveying the recommendations arising from the work of SMG and requesting production of Trust action plans in response to the RQIA report.

102. In January 2009 he again wrote to RQIA seeking assurance that the Trust action plans were appropriate. This assurance was received from RQIA in November 2009.

103. I understand assurances as to extant procedures from each relevant Trust were received in the Department between 2nd October 2006 and 3rd November 2006, although it has not been possible to locate copies of these.

Retrospective sampling exercise

104. In May 2007 the DHSSPS Deputy Secretary responsible for mental health and learning disability policy wrote to the five new Trust Chief Executives reiterating the need for a retrospective sampling exercise and calling a meeting with Trusts on 28 June 2007. At this meeting it was agreed that a 10% record sampling exercise would be performed in each Mental Health and Learning Disability Hospital throughout Northern Ireland for the period 1985 - 2005.

105. The Trust reports of the sampling exercise were received by the Department between September 2008 and December 2009.

106. The Department's medical, nursing and social services professional advisors reviewed the retrospective sampling reports from Trusts. My recollection is that I was involved in this discussion with professional colleagues and we concluded that the exercise had not been executed in a uniform or robust manner and options on a way forward were provided.

107. Following a meeting with the PSNI in June 2011 all material obtained from the retrospective sampling exercise was shared with the police to consider and request their advice on how to progress.

108. The PSNI confirmed in August 2011 after a preliminary consideration that in their view there were instances which would merit further investigation. As a first step, the PSNI and the HSC Board agreed to reconstitute the Strategy Management Group between the HSC and the PSNI which had been in operation during the earlier phases of this exercise in 2006-2008.

109. The Strategy Management Group was re-established in March 2012 by the HSCB and the PSNI to identify gaps or issues arising from the reports conducted by the EHSSB into Lissue and Forster Green Hospitals and from the wider review of Mental Health and Learning Disability hospitals. All cases in which abuse was suspected were referred to PSNI for criminal investigation. The final Strategy Management Group report into the review of the retrospective sampling exercise was sent to the Department on 17 December 2013. I include a copy of this report at Exhibit 19.

110. The key findings of the SMG report were as follows:

- 77 incidents were referred to the PSNI for consideration. Where it was possible to identify either the victim or the alleged perpetrator, criminal concerns / issues were passed to the PSNI for investigation;

- PSNI identified a number of challenges including: de-criminalisation of some offences since that time; absence of identifiers, including names, of alleged victims or perpetrators in records; a number of incidents are statute barred; and some patient records have been destroyed;

- There were no prosecutions as a result of the retrospective sampling exercise or the review of the exercise, for the reasons set out above.

111. By September 2014, the HSCB and PSNI agreed that the retrospective sampling exercise was concluded and that all incidents had been investigated as far as possible.

112. The SMG was stood down following PSNI confirmation that the aims and objectives of the retrospective sampling process have been achieved, and that the Strategic Management Group has achieved its function and could be formally closed. A copy of the letter from the PSNI is at Exhibit 20.

Ennis Ward abuse allegations

113. The Department was notified on 9 November 2012 by way of an Early Alert about another alleged case of abuse involving four patients at Ennis Ward in Muckamore Abbey Hospital.

114. The Department sought and received assurances from the Trust that an investigation was carried out by the Belfast Trust with the PSNI under Adult Safeguarding Joint Protocol arrangements. Two members of staff were referred to PSNI and their investigation into the allegations resulted in the prosecution of two members of hospital staff in 2014, one of whom was convicted of assault on a patient, while the other was acquitted. I attach at Exhibit 21 advice provided to the then Minister in May 2013 which provides an update on the investigation into the allegations. I also attach at Exhibit 22 a further update from RQIA which was requested by the Department in February 2014.

115. The RQIA also sought assurances from the Trust and conducted a number of unannounced inspections on the ward following the allegations. I include a copy of correspondence between Theresa Nixon, Director of Mental Health, Learning Disability and Social Work in RQIA and Esther Rafferty, MAH Hospital Services Resettlement Manager at Exhibit 23.

116. Following the RQIA unannounced inspections I refer to in para 115, I wrote to RQIA in April 2014 to confirm the Department's position on the outcome of their inspection of Ennis Ward. A copy of this correspondence is exhibited at Exhibit 24.

117. I also wrote at the same time to the HSCB to draw their attention to the findings from a number of RQIA inspections of mental health and learning disability wards carried out in 2013, including Ennis Ward, and asking them to consider whether the themes emerging from these inspections were more widespread and might require a regional response. I exhibit a copy of this correspondence at Exhibit 25.

118. I understand the report of the Adult Safeguarding investigation was completed in October 2013. The report identified and investigated a total of 22 incidents. These included concerns over the physical treatment of patients, the verbal treatment of patients and the lack of supervision of patients. I do not believe the report was provided to the Department at that time, as it was a report of an ASG investigation carried out by the Trust under the Adult Safeguarding arrangements in place at that time. The Department would not routinely have had sight of such reports.

119. I do not recall the exact time I became aware of the report, however, the Department became aware of the existence of the ASG report on the allegations of abuse in the Ennis Ward following media reports in October 2019, and on becoming aware requested a copy of the report from the Belfast Trust. This was provided to the Department by the Trust on 17 October 2019, and a synopsis of the Report prepared by the Belfast Trust was considered at the MDAG meeting

held on 27 November 2019. The minutes of this meeting are exhibited to Mark McGuicken's statement of 26 May 2023 at MMcG/211.

2017 abuse allegations

120. On 30 August 2017, Gavin Robinson MP contacted Chris Matthews, then Director of Mental Health, Disability and Older People and a member of my senior staff team by telephone, about an allegation of abuse by staff of a current in-patient in Muckamore. This allegation had been brought to his attention by the in-patient's father, who was a constituent of Mr Robinson.

121. The father advised that his son had been assaulted by a member of staff in the ward on 22 August 2017, although it subsequently emerged that the assault had actually taken place on 12 August 2017. He was concerned that there was a gap of 10 days in reporting the incident and that Trust staff would not provide him with any details about the incident.

122. Following inquiries from Chris Matthews to Barney McNeaney, the then co-Director for Mental Health at the Belfast Trust about the circumstances of the alleged incident, it was established that there had been a delay in reporting the incident due to the leave commitments of some of the Trust staff involved. The Belfast Trust provided Early Alert notifications on 7 and 26 September 2017 about the incident and the related precautionary suspension of staff involved.

123. I exhibit copies of Chris Matthew's initial query to Barney McNeaney and the subsequent Early Alerts at Exhibit 26, Exhibit 16 and Exhibit 27.

124. Chris Matthews wrote to Gavin Robinson MP on 20 September to update him on the actions taken following his telephone call. I exhibit a copy of this letter at Exhibit 28.

125. Further updates on this Early Alert were subsequently provided by the Trust on 20 and 27 October 2017 advising that more safeguarding concerns had emerged following viewing of CCTV footage.

126. A copy of these updates is exhibited at Exhibit 29.

127. The Departmental policy lead for learning disability services immediately followed these up with the Trust and, as a result of concerns the Department had about the Trust's reporting and handling of the allegations, I wrote jointly with the Chief Nursing Officer (CNO) to the Trust on 20 October to seek assurances that effective arrangements would be put in place to address the issues. A copy of this letter is at Exhibit 30. The Department also requested monthly updates to be provided to allow progress to be monitored. The Trust began providing these regular updates from January 2018.

128. The Trust provided a response to my letter on 3rd November setting out a timeline of the incidents and actions taken by the Trust, as well as the additional structures and actions the Trust had put in place to address the allegations and provide the necessary assurances about patient safety. Professional colleagues met with senior Trust staff on 17th November to discuss the detail of the letter of 3rd November, and also a subsequent briefing report which was prepared for the Trust's Quality Assurance Committee.

129. Following that meeting, I again wrote jointly with the Chief Nursing Officer to the Trust on 30th November to seek further written assurances on a range of issues which were raised during the 17th November meeting, and also on related matters which had emerged in parallel, including the status of a proposed 'turnaround' team, the state of play regarding the adult safeguarding investigations, allegations made on social media and the Trust's proposal to review only 25% of the available CCTV footage. The Trust were also formally requested to provide the Department with a copy of the Terms of Reference for the Level 3 SAI investigation into the incidents as well as fortnightly progress updates. I exhibit a copy of this letter at Exhibit 31.

130. The Trust responded on 22nd December providing the written assurances sought, along with further details of the governance structures put in place; and confirmation that the SAI would include a review of all allegations of abuse over the last 5 years and also the difficulties the Department faced in securing details and timely information from the Trust in relation to the incidents in August and October. I exhibit a copy of the correspondence at Exhibit 32.

131. An independent Level 3 SAI review was commissioned by the Belfast Trust in January 2018 into the allegations of physical abuse of patients by staff at Muckamore Abbey Hospital. My expectation, given the gravity of the allegations, was that the SAI process would be handled without any unnecessary delay, and I wrote to the HSCB on 4 December 2018 to signal my concerns about the length of time it took for the report to be signed off. A copy of this letter is at Exhibit 33.

132. The Department received a copy of the SAI report on 6 December 2018, and along with the then Permanent Secretary, Richard Pengelly and the Chief Nursing Officer, I met with the families on 17 December 2018 to share the report. The Permanent Secretary apologised to the families for the failings in their relatives care. He also accepted the recommendations in the SAI report, and renewed the policy commitment to expediting the resettlement of patients resident in Muckamore. I exhibit a copy of the statement issued by the Department after this meeting at Exhibit 34.

133. On 30th January 2019, I attended an HSC Summit meeting chaired by the Permanent Secretary to plan and expedite a robust and co-ordinated response to delivering on the recommendations in the review. I exhibit a copy of the note of this meeting at Exhibit 35.

134. During the HSC Summit, the Permanent Secretary set out his expectations in relation to an Action Plan, and an initial draft of the Action Plan was submitted by the then HSCB on 13th February 2019. I exhibit this at Exhibit 36.

135. The Belfast Trust submitted a monthly report for February 2019 which raised some concerns about the protection and safeguarding arrangements for patients in MAH on which the Department required urgent assurance. The Deputy Chief Social Work Officer Jackie McIlroy wrote on my behalf to the Belfast Trust seeking this assurance. A copy of her letter is exhibited at Exhibit 37.

136. In their response the Belfast Trust proposed formal monthly meetings between the Trust and Department to provide assurances on the Trust's arrangements for safeguarding MAH patients, and these meetings were subsequently instigated. I attach as an example a copy of the note from the first meeting in April 2019 at Exhibit 38.

137. On 5 April 2019, I met with Gavin Robinson MP and his constituent who had raised the concerns in August 2017 about the treatment of his son. Representatives from the Belfast Trust, including the then Chair Peter McNaney and the then Chief Executive Martin Dillon, also attended the meeting. Following the meeting the Trust Chief Executive wrote to Mr Robinson's constituent to follow up the actions agreed at the meeting. I have exhibited a copy of this letter at Exhibit 39.

138. In light of the findings from two unannounced RQIA inspections at MAH (26- 28 February 2019 [MAHI - STM - 118 – 64] and 15-17 April 2019 [MAHI - STM - 118 – 116]) on staffing at the hospital and the subsequent Article 4 letters to the Department, I wrote jointly with the Chief Nursing Officer to the HSCB on 17 May 2019 to request an additional resource to work with Trusts to stabilise services at the hospital, contingency planning work and expediting the resettlement of the delayed discharge patients. I exhibit a copy of the letter at Exhibit 40.

139. Mark McGuicken's statement of 26 May 2023 at paras 1.1 – 1.5 (MAHI – STM – 118 – 1 to MAHI – STM – 118 - 2) described the setting up of MDAG in response to the findings of these RQIA inspections, and I co-chaired MDAG along with the Chief Nursing Officer.

140. In response to ongoing concerns about the safety and sustainability of services at MAH, I met with senior Departmental and Belfast Trust colleagues in a series of meetings on 6th, 13th and 25th September 2019 to consider measures to strengthen assurance arrangements for the hospital and also options for the future of services being provided at MAH. A note of these meetings can be provided to the Inquiry on request.

141. Having considered the findings of the 'A Way to Go' report of the SAI investigation into the allegations of abuse and the views of the Belfast Trust, the Department took the view that further analysis of the Trust's leadership and governance arrangements was required. I wrote jointly with the Deputy Chief Nursing Officer on 5 July 2019 to formally ask the HSCB, as the commissioning body and overseer of the SAI process, to commission a review to critically examine the effectiveness of the Trust's leadership, management and governance arrangements in relation to the hospital for the five-year period preceding the allegations that came to light in late August 2017. I exhibit a copy of this letter at Exhibit 41.

142. The Review commenced in January 2020 and the final report was provided to the Department in August 2020. Minister Swann accepted the Review's recommendations, and these were incorporated into the MAH HSC Action Plan, with implementation overseen by MDAG.

143. In September 2020, having considered the findings of the Leadership and Governance Review, Minister Swann made his decision to call a Public Inquiry into the abuse at MAHI. This was to ensure a full and rigorous investigation into what happened at Muckamore and what lessons need to be learned to ensure there was no repeat of the events.

Q9. What arrangements were in place at Departmental level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by the Department to ensure that MAH staff skills matched MAH patient needs.

144. A summary of Departmental arrangements for Workforce planning for disability care services is provided in Mark McGuicken's statement of 13 February 2023 (paragraphs 17.1 – 17.14) [MAHI-STM-089-74 to MAHI-STM-089- 77]. This outlines the Department's role in strategic long-term planning across the HSC, and makes clear that immediate workforce planning to deliver commissioned services is the responsibility of the Trusts. A history and overview of the related Frameworks, Strategies and reports published by the Department in this area is also included. I have nothing further to add to this.

Q10. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Department? If so, please describe any actions taken by the Department to address those concerns.

145. Responsibility for day-to-day operational workforce planning at MAH is the responsibility of the Belfast Trust as the employer. This workforce planning addresses issues such as service delivery, safe staffing levels, operational vacancy management and recruitment. As an example, Mark McGuicken's statement of 26 May (paragraphs 14.1 – 14.4, MAHI – STM – 118 – 13) set out reasons for an underspend on staffing at MAH linked to the reduction in staffing levels associated with resettlement.

146. If the Trust in its role as the provider of the commissioned service at MAH identified a significant shortfall in its workforce skill mix and or staffing levels which it was unable to manage in the context of the overall Trust workforce, it had a responsibility to develop a business case to address this, which would be considered by the HSCB as commissioner of the service in the first instance. The relevant policy lead in the Department would also be sighted on such business cases to ensure any proposed additional resource allocation was consistent with the wider regional policy imperatives and strategy for services. I do not recall any such business case during my time in post.

147. The Department has responsibility for longer-term strategic workforce planning and oversees a rolling programme of long-term, regional workforce reviews for this purpose. For learning disability services, this has included the

Review of the Learning Disability Nursing Workforce referenced in Mark McGuicken's statement of 13 February (para 6.15, MAHI – STM – 089 - 26) and the Regional Workforce Review across Adult Learning Disability Teams and Services referenced in the same statement (para 17.14, MAHI – STM – 089 - 77).

148. The Department has been made aware of issues in relation to staffing levels at Muckamore on a number of occasions as part the ongoing systems of assurance that have operated within the HSC system. Issues have been flagged through the Early Alert system, and also through RQIA inspections. I exhibit an example of an Early Alert relating to nursing staff levels at Exhibit 42.

149. On receipt of such information, the Department will alert the Minister to the issue, and will also seek assurance that from the service provider that they are providing services in line with all extant legislative and best practice requirements. Depending on the nature of the alert, the Department may also seek similar assurances about the service in question from RQIA in its role as the independent regulator for health and social care.

150. Where RQIA inspections identify concerns about an individual service which they consider are sufficiently serious to warrant intervention by the Department, they can make recommendations to the Department. Following concerns identified by RQIA during two unannounced inspections at Muckamore in 2019 I referred to in para 115 above, the RQIA raised these concerns, which included staffing levels, with the Department. In response to the issues raised in these inspections around nursing staffing levels, I am aware the then Chief Nursing Officer instigated follow up work to address these concerns, including commissioning an independent nursing expert to provide professional assistance to stabilise the nursing workforce. The former Chief Nursing Officer is best placed to advise the Inquiry on this work.

151. To address staffing shortages at Muckamore, the Department agreed in November 2019 that an enhanced salary uplift of 15% should be offered for a limited period to encourage registered nursing staff from other Trusts to relocate

to work in Muckamore. In the interests of equity this enhancement was also offered to registered nurses and healthcare assistants in Muckamore. Travel cost for those willing to relocate was also agreed for reimbursement in line with existing terms and conditions of employment. I understand this enhancement remained in place until the end of September 2023 when the Belfast Trust made the decision to cease the payments.

152. Action 37 in the MAH HSC Action Plan required the Department to develop an evidence-based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce for learning disability services, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services.

153. To address this action the Department commenced a Regional Workforce Review across Adult Learning Disability Teams and Services in late 2021. Following initial work to understand the make-up of the workforce a number of baseline reports were issued in June 2023. I understand this work is currently paused pending progress with the work on the Learning Disability Strategic Action Plan.

154. The HSC Action Plan also included an action for the Department (A30) to complete a review of Learning Disability Nursing. Charlotte McArdle would be best placed to advise the Inquiry about this work.

155. Information on staffing levels at MAH is routinely provided to MDAG as part of its oversight role, along with updates on RQIA inspection activity at the hospital.

156. More generally, issues in relation to workforce problems and challenges faced by health and social care in Northern Ireland were recognised in the report ‘Health and Wellbeing 2026: Delivering Together’ from Professor Rafael Bengoa in 2016. The Report found that the workforce arrangements within the HSC were not set up to meet the needs of twenty first century care. The challenges identified included delays in accessing services and long waiting lists for patients.

The Report also noted that at times, and despite resources being made available for staff recruitment, posts cannot be filled placing further pressure on the current workforce.

157. In response the Department published the ‘Health and Social Care Workforce Strategy 2026: Delivering for our People’ in 2018. Mark McGuicken’s statement of 13 February 2023 provides more detail on this (paras 17.8 – 17.12, MAHI – STM – 089 – 76 to MAHI – STM – 089 – 77); exhibits MMcG/173 and 174).

158. The Strategy includes detailed analysis of the workforce problems and challenges facing health and social care in Northern Ireland. Amongst other things, the Strategy addressed the need to tackle the serious challenges with supply, recruitment and retention of staff, including on page 56, Learning Disability Nursing. The Strategy aims by 2026 to meet workforce demands and the needs of the health and social care workforce.

Q11. The Inquiry has heard evidence regarding the Chief Nursing Officer’s programme “Delivering Care: Nurse Staffing in Northern Ireland” (2014). The Inquiry has heard that Phase 9 of the programme was in relation to Learning Disability nursing. Did the Department consider accelerating this phase when concerns at MAH arose in 2017? If not, why not? If it did, what action, if any, was taken?

159. This programme fell within the professional responsibilities of the Chief Nursing Officer, and I had no direct role in this. This question would be best addressed by the Department’s former Chief Nursing Officer, Charlotte McArdle.

Q12. How did the Department assure itself that Trusts had properly checked the current registration of clinical professions with the NMC, HCPC and GMC?

160. The Department has no role in checking the current registration of individual clinical professionals with the relevant professional bodies. This is an issue for the employer, and this would therefore be the responsibility of the Belfast Trust in relation to employees of MAH. Each individual professional also has a personal responsibility to maintain their registration with their professional body, and the

employer has a duty to check an individual's registration status before making an appointment to a professional post. The Quality Standards for Health and Social Care, which are used by RQIA to assess compliance with the statutory duty of quality placed on all HSC bodies, require robust pre-employment checks to be carried out including that individuals are registered with the appropriate professional or occupational body, and also that organisations have in place appraisal and supervision systems for staff which facilitate professional and regulatory requirements (Standard 4.3(k) and (l)). A copy of the Quality Standards was exhibited to Mark McGuicken's statement of 13 February 2023 (MMcG/81).

Q13. What systems were in place at Departmental level to ensure adherence to relevant professional standards by MAH staff? What actions were available to the Department if it had any concerns in relation to the adherence to professional standards?

161. The Department operates no such systems, as it was, and remains, the responsibility of the Belfast HSC Trust as the employer of MAH staff, to ensure effective Human Resource policies are in place for recruitment and employment of staff (including agency staff), including ongoing Access NI and continuing professional regulatory checking processes. It is also the role of the Belfast HSC Trust to ensure effective clinical and professional governance processes are in place. The Belfast Trust are required to report individual staff members to their relevant professional body in the event of concerns being identified in relation to their professional conduct.

162. The Department is responsible for setting guidance and frameworks on professional standards. The operational day-to-day oversight of individual employees' professional standards is the responsibility of the employer, namely the HSC Trust. HSC Trusts employ professional staff in specific clinical governance roles with an emphasis on quality and safety of care. The HSC Trust's Board, made up of Executive and Non-Executive Directors, has an overarching responsibility for clinical and corporate governance and must provide assurance to the Department through established channels.

163. Prior to the introduction of the Health and Social Care Act (NI) 2022, Trusts were accountable to the HSCB for the availability, quality and efficiency of the services they provide against agreed resource allocations.

164. Issues of concern can be escalated formally as part of Departmental Arm's Length Body (ALB) Accountability arrangements. The Department may, and often does, also act in response to concerns raised, whistleblowing or other intelligences received as necessary.

165. An important aspect of ensuring adherence to professional standards is through the role of professional regulators. A regulator has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate.

166. Professional regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective professions. They maintain registers of workers who meet those standards and this information is publicly available.

167. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

168. There are a variety of standards and best practice guidelines depending on the clinical service area or professional practice and these will be used at regional and organisational level to inform and underpin service delivery, improvement and transformation. Those with the responsibility of ensuring that effective governance arrangements are in place within their areas of responsibility is set out in the Belfast Trust's Assurance Framework (p59-62).

169. From a professional Social Work perspective, the post of Executive Director of Social Work in the Trust is responsible for ensuring the effective discharge of statutory functions across all social care services and reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce. I recognise that social workers did not have a direct front line caring role in MAH.

170. Since 1994, Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards. Arrangements for professional oversight are designed to ensure that statutory functions are discharged in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions.

171. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the then HSCB (current SPPG) to me as the Chief Social Work Officer and then to the Health Minister, as set out in Circular HSS (Statutory Functions) 1/2006.

172. However, I would wish to make clear the distinction between my professional accountability role and the line management function. In practice this means that while the Trust is ultimately accountable to me via the Trust's Executive Director of Social Work for the professional practice of social work staff employed by the Trust, I do not have direct line management responsibility for individual social work staff employed by the Trust.

173. Responsibility for the professional oversight of the system for the performance management and quality assurance arrangements for the discharge of certain specified Delegated Statutory Functions in Social Care rests with the Office of

Social Services (OSS) within the Department. To manage the performance management and quality assurance arrangements for these functions, the OSS issue circulars providing frameworks, guidance and detail on legislative and structural arrangements. The extant OSS circulars are exhibited to Mark McGuicken's statement of 12 April 2024 at MMcG/313, MMcG/314 and MMcG/315.

174. In my role as Chief Social Work Officer, I was ultimately responsible for issuing and keeping under review all relevant circulars, professional standards, guidance or directions in respect of arrangements for the discharge of relevant functions.

175. In terms of reporting, professional oversight is an ongoing process and takes place throughout the year with arrangements in place for any issues raised to be dealt with. As Chief Social Work Officer, I also received a year end overview report on the Discharge of Statutory Functions from the HSCB (and latterly SPPG), to identify any issues requiring escalation. DSF reports which refer to MAH after 2017 have been exhibited to Mark McGuicken's statement of 26 May 2023 at para 66.1 (MAHI – STM – 118 - 54), and copies of all DSF reports from 2007 onwards which include references to MAH have been uploaded to the Inquiry record management platform (para 66.2, MAHI – STM – 188 - 54).

176. The end year overview report should reflect both operational performance and strategic issues and assist the HSCB Board and Department in their respective governance, accountability and strategic planning roles including: overview and analysis of Trusts' performance in respect of DSFs, including good practice and performance gaps; level of compliance with the law, professional standards and targets; outcomes of in-year audit and improvement activity; emerging pressures and/or concerns; and regional comparison and trends.

177. The Leadership and Governance Review was critical of the DSF reporting arrangements and I understand the Department is currently carrying out a review of the DSF accountability arrangements.

178. The responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs.

179. There is also an option for ALBs to escalate issues to the Department through this reporting line, where these are judged to be of sufficient gravity or have potential regional implications. In this scenario, the Department would initially ask the ALB to provide proposals on how they plan to address the issue in question, and to develop an accompanying remedial action plan and provide regular progress reports on this. The expectation is that each ALB as an autonomous body will take the necessary action in the first instance to resolve the issue from their own resource, and provide the Department with assurance that this has been done. Depending on the nature of the issue, for example where the Department considers it may have wider policy or legislative implications for other ALBs, the Department will also take any broader action it deems necessary. This may involve for example seeking assurances from other ALBs, issuing regional guidance or potentially reviewing relevant extant policy or legislation.

180. Should the ALB prove unable to address the issue to the satisfaction of the Department then this will be addressed through the established HSC accountability arrangements, that is through the relevant sponsorship branch in the Department in the first instance, who will raise with the relevant policy and professional leads and if further intervention is required to the Permanent Secretary to raise through the ALB's annual accountability meeting. If the issue still cannot be resolved, then ultimately Ministerial intervention will be sought, and in an extreme scenario the Department can by use of a Direction transfer responsibility for the issue from the ALB in question to another ALB.

181. The Northern Ireland Social Care Council (NISCC) was established in October 2002 as the body for accrediting, regulating and monitoring the social care workforce in Northern Ireland and for the development of professional

standards and training arrangements. NISCC also deal with issues of professional malpractice in the social care workforce.

182. If I had become aware of concerns in relation to adherence to professional social work standards by any individual staff members, I would have raised those in the first instance with the employing Trust. As Chief Social Work Officer, I also had the option of bringing the concern directly to NISCC as the relevant professional regulator. If there were more widespread concerns about a Trust's discharge of their responsibilities in this regard, I also had the option of commissioning RQIA to inspect and report on the Trust's compliance with the relevant Quality Standards I identified in para 160 of my statement. I did not have any cause to take this action during my time in the Chief Social Work Officer post.

Q14. Equal Lives (Bamford, 2005) recommended improved community services and stated that all people with a learning disability living in a hospital should be relocated to the community by June 2011. Transforming Your Care (2012) recommended the resettlement of all people with a learning disability from hospital to community living options with appropriate support by March 2015. What did the Department do to promote that pledge? What were the barriers to achieving it?

183. Departmental policy on resettlement, along with associated Departmental actions to deliver the policy, is set out in Mark McGuicken's statement of 13 February 2023 (section 11, MAHI – STM – 089 – 46 to MAHI – STM – 089 - 51). This outlines the overarching policy on resettlement from the early 1990s when the concept of betterment was introduced, and provides an overview of subsequent work to progress resettlement, in particular the publication of the Bamford Report 'Equal Lives' in 2005.

184. Resettlement has also been a priority for the Executive since 2007 as evidenced, for example by the 2008 PfG target that : *"By 2013, anyone with a learning disability is promptly and suitably treated in the community and no one remains unnecessarily in hospital"*

185. Resettlement planning depends upon the availability of appropriate accommodation and continuing care and support (and the associated funding) for former hospital patients.

186. In relation to funding, additional resources of £54m (£27 recurrent) for mental health services and £33m (£17m recurrent) for learning disability services were secured by the Department under the Comprehensive Spending Review (CSR) for the period 2008-2011 to provide a range of additional services for people with a mental health and a learning disability, including the resettlement of long stay patients from mental health and learning disability hospitals.

187. However, a barrier to progressing resettlements was a misalignment of budgets between the then DHSSPS (who had responsibility for providing the care package) and the then Department for Social Development (DSD) (who had responsibility for housing provision) for the Comprehensive Spending Review (CSR) period 2008-11, where DSD revenue monies were baselined and those for DHSSPS were not. Progressing the resettlement of some individual patients with complex needs was dependent on the availability of bespoke placements, which in some cases required new build facilities. The funding for building these facilities was provided by DSD, who were reluctant to commit to new builds without a guarantee that DHSSPS funding was available to support the individual in their community placement.

188. For the CSR period 2011-15, the drive to increase resettlements meant the misalignment of the respective Departmental budgets became acute. This in turn meant DHSSPS and the HSC could not commit to such schemes and DSD (and the NIHE) could not invest the capital monies to build them.

189. To address this, DSD and DHSSPS agreed to the principle of transferring resources from the Supported Living budget which was administered by DSD to that of Resettlement, which was administered by DHSSPS, specifically for patients moving to supported living accommodation to permit the delayed schemes to progress. The increasing need profile of the remaining in-patient

population, including an increasing prevalence of individuals with a dual diagnosis, also impacted on the rate of progress.

190. As a result of this, it was subsequently agreed that the DSD would transfer £2m in 2012/13, increasing to £4m in 2013/14 and £6m in 2014/15.

191. Following a review of the Supporting People programme in 2015, DSD and DHSSPS agreed to work together to clarify the relationships and funding responsibilities of the various statutory partners in the Supporting People programme to ensure costs and risks were shared appropriately (Recommendation 7). I exhibit a copy of correspondence from the DSD Minister and the action plan for implementation of the review at Exhibit 43 and Exhibit 44.

192. Although very significant progress has been made on resettling long stay patients since the Bamford Report, I am aware that there were a number of barriers to fully meeting the various resettlement targets that have been set since that Report. These have included a reluctance on the part of some patients and their families to relocate from a hospital setting, a lack of appropriate community placements to meet the needs of complex individuals and difficulties in recruiting appropriately skilled staff, and a reluctance by some hospital staff to fully support the resettlement concept. Some of these barriers were identified in the 2014 report commissioned by the NI Housing Executive, 'The Hospital Resettlement Programme in Northern Ireland after the Bamford Review' which I understand has been provided to the Inquiry as an exhibit to Fiona Boyle's statement (MAHI – STM – 110 – 19)

193. In recognition of this, the then Permanent Secretary renewed in 2018 the Department's commitment to completing the resettlement programme and as part of work to address this, the Regional Learning Disability Operational Delivery Group (RLDODG) was established in 2019 to oversee the effectiveness of resettlement and expedite discharges. The Group was responsible to MDAG, which monitored progress on resettlement for all LD patients.

194. Paras 11.23 – 11.27 (MAHI – STM – 089 – 50 to MAHI – STM – 089 - 51) of Mark McGuicken's statement of 13 February 2023 set out the oversight arrangements for monitoring the renewed commitments on resettlement which were made by the Permanent Secretary.

195. At the MDAG meeting on 27 November 2019 (MMcG/211) the Group was advised that the Permanent Secretary commitments on resettlement were unlikely to be met. In response, members agreed (Action point - 27/11/AP10) that proposals to address barriers to resettlement should be tabled by the Belfast Trust for consideration by MDAG.

196. The Belfast Trust subsequently presented proposals at the MDAG meeting held on 19 February 2020 (MMcG/213), and members agreed (Action point – 19/2/AP6) that the Department and the Health and Social Care Board should jointly review the effectiveness of the regional resettlement process and structures, with a view to making recommendations for improvement.

197. While progress on this work was delayed by the Covid 19 pandemic, the Department asked the HSCB in October 2021 to commission an independent review of the LD Resettlement Programme.

198. The review was carried out by Bria Mongan, a retired Executive Director of Social Work in South-Easten Trust and Ian Sutherland, who was previously the Director of Adults and Children's services in Medway Local Authority. Their report was completed in July 2022 and made a number of recommendations for the Department and Trusts. This report also identified barriers to the resettlement programme which I detail at paras 204-206 in my statement.

199. Minister Swann accepted the recommendations of the Independent Review of the LD Resettlement programme in September 2022, referred to in Mark McGuicken's statement of 13 February 2023 (para 11.27, MAHI – STM – 089 - 51), and confirmed he was considering options for the future of MAH.

200. I understand that he subsequently announced on 24 October 2022 that signalling a clear intention to close MAH would help to support and accelerate the delivery of the long-standing policy aim on the resettlement of long-stay patients. The Department simultaneously launched a public consultation on the Minister's proposal which closed on 24 January 2023.

201. In light of the consultation findings, and also the clear direction of travel for the future of the hospital, the Permanent Secretary decided to use the powers available to him under the Northern Ireland (Executive Formation etc) Act 2022 to confirm the Minister's proposal to close the hospital. I am aware that work is continuing to resettle all remaining in patients in MAH before the hospital closes.

202. Following the publication of this review in September 2022, I understand the Department established the Regional Resettlement Oversight Board led by Dr Patricia Donnelly to expedite resettlement arrangements for the remaining patients in MAH.

203. The Board commenced work in October 2022, and reports directly to the DoH Permanent Secretary on progress on achieving resettlement for all patients in Muckamore. I am advised that to date the Board has achieved 14 resettlements from a baseline of 36 patients in Muckamore in August 2022. Currently there are 22 patients remaining in Muckamore with placements identified for 19 of these patients. Planning continues to expedite all remaining delayed discharges from MAH.

204. The Independent Review also identified a number of barriers to the resettlement programme.

205. Para 5.2.11 (p28) notes that *'The review team felt that this balance* (between improving quality and safety of care and progressing resettlement) *wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and*

consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes.'

206. Workforce issues were also identified as a barrier, as outlined in paragraph 8.2.1 of the review, *'The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.'*

207. The ongoing work to agree a Learning Disability Service Model will seek to address these barriers and provide guidance for the future infrastructure of Learning Disability Services.

Q15. In seeking to deliver the Bamford Vision, how did the Department consider the impact of bed and budget reductions on the operational running of MAH?

208. The Department has no direct role in the operational running of MAH. This was the role of the HSCB as the service commissioner and the Trust as service provider.

209. The Department, under the 1972 Order, is responsible for providing funding for mental health and learning disability services within the overall funding available for HSC services. This funding is allocated through the HSC commissioning process to fund the delivery of services to meet assessed need.

210. The commissioning process included the management of performance and resources and was overseen by the Department through a commissioning plan. The Health and Social Care (NI) Act 2022, in excluding Section 8 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, removed the statutory requirement for a Commissioning Plan. A new planning process for the HSC is currently being developed through the Integrated Care System, and pending this

SPPG continue to be actively engaged in planning for resettling the remaining in-patient population.

211. In general terms, throughout my time as Chief Social Worker, I viewed the reduction in long stay patient beds for people with a learning disability which was a consequence of the resettlement programme as a development to be welcomed. The operational day to day management of the implications of that were for Trusts to manage as the service providers, with assurance provided by RQIA. I was and remain clear that the overall policy intent and direction of travel of the resettlement programme was to improve the lives of people with learning disabilities. Of course, as the focus shifted away from a single regional long stay institution and towards community based living, the HSC system had to adjust to reflect that. This adjustment was driven through the commissioning process, for example the opening in 2014 of the Dorsy Unit, a new LD inpatient ward in the Southern Trust.

212. One of the actions arising from both the Bamford Action Plans 2009-2011 and 2012-2015 was to implement a regional bed management protocol for those with a learning disability. This action was to be taken forward by the HSC Board to lead in collaboration with the HSC Trusts as set out in action 58 (page 56) of the 2012-2015 Action plan, which was exhibited to Mark McGuicken's statement of 13 February at MMcG/40.

213. The evaluation of the second Bamford Action Plan 2012-15, exhibited to Mark McGuicken's statement of 26 May 2023 at MMcG/196 (Page 58), confirmed that, '*The HSC Board also completed a learning disability bed management protocol to govern how beds are allocated in the event of a bed shortage,.'*

214. Further work was undertaken as part of the MAH HSC Action Plan to progress work on a regional bed management protocol (Action 39). This involved the recruitment of a Regional Bed manager who I understand was appointed in October 2022.

Q16. Did the Department monitor the effectiveness of the resettlement strategy? If so, please provide details.

215. Departmental policy on resettlement, along with associated Departmental actions to deliver and monitor the policy, is set out in Mark McGuicken's statement of 13 February (section 11, MAHI – STM – 089 – 45 to MAHI – STM – 089 - 51), and I provided an overview of this at paras 183 – 207 of my statement.

216. Progress on resettlement was monitored through the Bamford governance structures. The evaluation of the Bamford Action plan 2012-15 (p12) '*found that there had been many achievements in the development of learning disability services since the Bamford Review, including the resettlement of the majority of people living in long-stay hospitals into the community.'* It went on to note that a total of 347 long stay patients had been resettled into the community and the quality of life for those who had been resettled had much improved.

217. In addition, resettlement targets have also been included in the Executive's Programme for Government, and in Commissioning Plan directions, for example the 2008 PfG target I referenced at para 184 above.

218. As I mentioned at para 193 of my statement the Regional Learning Disability Operational Delivery Group was established in 2019 to oversee the effectiveness of resettlement and expedite discharges. The Group was responsible to MDAG, which monitored progress on resettlement for all LD patients.

219. The Independent Review of the LD Resettlement Programme found that the pace of resettling patients out of Muckamore was too slow, and recommended the establishment of a Regional Resettlement Oversight Board. The overarching aim of the Oversight Board was to ensure a consistent approach to resettlement across the system.

220. As part of the work of this Board a resettlement tracker tool was developed to monitor resettlement options for each individual patient. Work to complete the resettlement programme is continuing, with MAH set to close upon its completion.

221. The Department is continuing to work with SPPG and Trusts, and other partner organisations such as DfC and the NIHE, on enhancing the current resettlement process.

Q17. Were concerns about the resettlement programme ever raised with the Department, either by the Trust Board or other stakeholders? Please describe any actions taken by the Department to address those concerns.

222. It is important to re-emphasise that the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey to community living facilities has been the overarching policy direction of the Department since the early 1990's. This has been progressed in line with the ethos of betterment; i.e. resettlement would only be where there was betterment for the patient in a community setting and they would not be moved to a placement against their will.

223. The Departmental policy direction of resettlement into community settings is consistent with the rest of the UK in seeking to move away from large scale institutional settings where Learning Disabled patients are cohorted together, often giving rise to perceptions of an 'out of sight, out of mind' approach. The Bamford Review through the Equal Lives report emphasised the need to achieve this aim and for the Department to increase its focus on its implementation without further undue delay.

224. Throughout the lifespan of the resettlement programme, concerns have been raised on occasion with the Department on its operation. These have in the main originated from families of patients in Muckamore who do not agree with the resettlement programme, and from patient representative groups associated with Muckamore Abbey Hospital. In addition, concerns have also been raised by patients/families on the length of time that their resettlement is taking. These

have been raised via a number of avenues, including correspondence received from families or elected representatives to the Minister/Department, Judicial Reviews or Pre-Action Protocol letters, representations to MDAG, and the Departmental ALB Accountability processes.

Correspondence

225. Correspondence received has included representations from interest groups such as the Society of Parents and Friends of Muckamore, citing concerns with the resettlement process being prioritised over the well-being of the patients in Muckamore, with the patients being resettled against their will, and inadequate resettlement planning having been done in advance of resettlements. The Department sought assurances from the Trusts involved on planning and implementation of resettlement for individual patients. In some instances, meetings were offered with the Health Minister or Departmental officials to hear these concerns firsthand. As an example, along with the CNO I attended a meeting the Minister held with patients and families at MAH on 22 January 2020 to hear their concerns first-hand.

Judicial Reviews/Pre-Action Protocol Letters

226. The Department has also been named in a number of JRs on MAH resettlement cases, on the basis of an alleged failure to provide adequate resources to enable resettlement to be progressed in a timely manner. As an example I attach a copy of correspondence from the Permanent Secretary in relation to a JR judgement at Exhibit 45.

MDAG

227. MDAG was established in recognition of the particular concerns at MAH, and issues in relation to resettlement have also been raised at MDAG. Examples have included concerns about pressure being put on resettled individuals to

move from their current community placements to new supported living developments.

228. In response to these concerns, I wrote to the Independent Providers and Directors of Adult Services in HSC Trusts on 15 September 2020 to emphasise the need to ensure that community placements were to be treated as forever homes, people should not be being pressured to move and should any moves be required these were on basis of the Betterment principle with appropriately planning and implementation. A copy of my letter is exhibited at Exhibit 46.

229. The continuing reluctance of some remaining patients at Muckamore to be resettled out of Muckamore has also been raised. In response to these concerns, I wrote to the Chief Executive of the Belfast Trust on 15 September 2020 to ask that the Trust to explore the potential for an onsite option for the resettlement of those considered suitable for such provision. A copy of this letter is exhibited at Exhibit 47.

230. Other general issues raised at various points included the slow progress overall of the resettlement programme, concerns over the services provided by the community or private sector, specifically around the availability of suitable accommodation and/or staffing, communication with patients and families around resettlement planning and the need for an understanding of individual patients needs to be central to the planning process.

231. To address these concerns, the Department asked the HSCB in October 2021 to commission the independent review of resettlement I refer to in para 197 above.

232. The final report of the review, including its recommendations, was endorsed by Minister Swann on 29 September 2022, and published on the Department’s website. I exhibit a copy of the Report at Exhibit 48.

233. At an operational level the Regional Learning Disability Operational Delivery Group (RLDODG) I mention in paragraph 193 above, established in 2019 and chaired by the then HSCB, also provided a forum to progress the resettlement programme, and updates from this Group were provided to MDAG. However, following the publication of the Independent Review into Resettlement in September 2022, this group was replaced in October 2022 by the Regional Resettlement Oversight Board.

234. During its lifetime, issues raised with RLDODG included the need for increased provider development and issues with housing, including caps on housing benefit and how this and universal credit were impacting on placements.

235. The provision of housing is a key interdependency to the Resettlement programme. This requires sufficient housing units, housing support services and health and social care to enable a person with learning disabilities to be adequately supported in the community.

236. Across learning disability services, there is a growing need to provide more bespoke accommodation solutions for individuals with very complex needs and to expedite discharge from inpatient settings, this is underpinned with more specialised health and social care support. In terms of costs, care packages can range from £500k to £1.5 million per annum for a single service user, dependent on assessed need. However, the provision of housing and associated support services falls within the remit of the Department for Communities and the NI Housing Executive.

237. At the end of 2022, the Permanent Secretary of DfC approved an uplift to the Supporting People budget, matching recent DoH uplifts to residential care, domiciliary services and supported living.

238. The Department of Health and DfC engage frequently at a senior official level to develop policy and ensure that, where possible, there is parity in financial support for the sector. A joint policy forum involving DoH, DfC, DoJ, and the NI

Housing Executive has been established and meets quarterly to consider funding options for the continued collaboration between health and housing services.

239. In addition, DoH colleagues and Trusts work closely with the NIHE through the established Supporting People cross – Departmental management structures to ensure effective planning and commissioning to expedite the Muckamore Resettlement programme.

Trust Board

240. As part of the Accountability arrangements between the Department and the Belfast Trust, Trust Board members have at various times between 2008/09 and most recently 2022/23 provided high level updates on resettlement progress at meetings as part of the in-year and end-year accountability processes.

241. With the exception of 2009/10 and 2013/14 when positive updates where provided on progress against resettlement targets, generally these updates have advised in the main of the difficulties in achieving resettlement targets. An example of a Belfast Trust accountability meeting where an update on difficulties on achieving a PfA target on resettlement was raised is exhibited to Mark McGuicken's statement of 26 May 2023 at MMcG/293 (para 33).

242. Updates provided since the allegations of abuse in Muckamore came to light in 2017 have also highlighted issues including pressures on the hospital, lack of suitable community infrastructure and the need for a regional approach.

243. Before the allegations of abuse at Muckamore came to light in 2017, any items raised in these meetings would have been passed to the relevant Departmental policy branch for consideration of any actions available to help improve performance.

244. Since the allegations of abuse came to light, the Department has been working with the Trust at senior staff level in order to better understand the issues

raised and seek to improve the resettlement landscape to enable well planned and effective resettlements to take place. These arrangements are taken forward through groups such as MDAG and also through the work of the Regional Resettlement Oversight Board which has brought a continuing focus on the planning for resettlement of each patient in Muckamore.

Q18. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Department consider whether similar initiatives should be applied in Northern Ireland, and was any action taken in this regard? If not, why not?

245. I became aware of Winterbourne View from media coverage following the BBC Panorama programme which aired on the 31 May 2011 and which highlighted serious and systematic maltreatment of residents with learning difficulties.

246. I am aware that following the broadcast the Chief Medical Officer sought assurance from RQIA with regard to regulated services for people with a learning disability in Northern Ireland, and he is best placed to advise the Inquiry of the outcome of this.

247. I was aware that the Department of Health (DH), England led a review to investigate the failings surrounding Winterbourne View, to understand what lessons should be learned to prevent similar abuse; and explore and recommend wider actions to improve quality of care for vulnerable groups. I was also aware that the Care Quality Commission carried out inspections at similar units and the findings contributed to the interim report.

248. I wrote on 22 April 2013 to Departmental policy and professional leads drawing their attention to the DH response, *Transforming Care,* which was published in 2012. A copy of my memo is at Exhibit 49.

249. While recognising that the recommendations in Transforming Care were for England and health and social care services are structured differently in Northern Ireland, I considered that in view of the seriousness of the events at Winterbourne, it was important for the Department to review the recommendations to consider whether there were any lessons arising which might have applicability in Northern Ireland. Tab 2 to this e-mail provides an assessment by Departmental colleagues of the actions in the DH Transforming Care report, and how these were being addressed locally.

250. In the main, this assessment indicated that many of the actions were already being addressed in Northern Ireland through existing policies such as Transforming Your Care (TYC), the Bamford Review of mental health and learning disability services, and existing regulations and standards, the development of the Mental Capacity Bill and the Paediatric Care Strategy.

251. In addition, work being progressed in Northern Ireland on enhancing adult safeguarding arrangements, developing professional regulation of the social care workforce, work on developing guidance on the use of restraint and seclusion and strengthening regulation and inspection arrangements were all considered to contribute to the aims set out in Transforming Care. I provide a brief summary of some of this work below.

252. The Department, in conjunction with other agencies, developed measures aimed at safeguarding all vulnerable adults including older people in hospitals and care homes and people with a learning disability. This included ‘Adult Safeguarding - Prevention and Protection in Partnership’ (2015) and ‘Protocol for Joint Investigation of Adult Safeguarding Cases’ (2016). Copies of these have been exhibited in Mark McGuicken’s statement of 13 February at MMcG/72 and MMcG/73 respectively.

253. Following a review in 2010 of the Vetting and Barring Scheme, a change to the disclosure and barring arrangements for preventing unsuitable individuals from working with vulnerable groups was implemented. A service framework for learning disability services was developed and published in 2012. The service framework set standards of care, specific timeframes and expected outcomes designed to improve the health and wellbeing of people with learning disabilities and their carers in Northern Ireland, promoting social inclusion, reducing inequalities in health and improving quality of care. Mark McGuicken's statement of 13 February 2023 provides a summary of the Learning Disability Service Framework at paras 5.14 - 5.17 (MAHI – STM – 089 – 23), and the Service Framework is exhibited at MMcG/33.

254. A safeguarding vulnerable adult training programme targeted at the voluntary, community and independent sectors was developed. The training programme was commissioned from Volunteer Now and was based on the guidance and standards that the Department commissioned the Volunteer Development Agency to develop, called 'Safeguarding Vulnerable Adults – A Shared Responsibility'. The aim of the Guidance was to improve safeguarding outcomes for some of the most vulnerable adults in Northern Ireland by establishing standards of acceptable practice across a range of organisational activities, including the recruitment, selection, management and supervision of staff.

255. The Department published minimum standards for day care settings in January 2012 to enhance protection arrangements for vulnerable individuals accessing care services outside of a hospital setting.

256. The STOMP and STAMP initiatives are referenced in the Department's new ten-year mental health strategy launched in 2021, 'Mental Health Strategy 2021-2031' at para 137, p 58, and the associated action is Action 18 (p 59) of the Strategy, as follows '*Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that*

involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.'

257. The Health and Social Care Board also produced advice on medicines use within mental health conditions which I include at Exhibit 50.

Q19. Do you 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 the Terms of Reference?

258. I have nothing further to add.

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: 28 June 2024

List of Exhibits (Sean Holland)

Exhibit 1: Draft Minutes of CSWO's Meeting with executive director of social work - Dated 22 Jan 2020

Exhibit 2: Agenda CSWO Meetings- Dated 22 Jan 2020

Exhibit 3: Letter from Sean Holland to Fionnuala McAndrew re Retrospective Sampling meeting - Dated 20 July 2012

Exhibit 4: Letter from Fionnuala McAndrew to Sean Holland re Retrospective Sampling Report/Strategic Management Report - Dated 02 April 2014

Exhibit 5: Memo from Julie Thompson re Accountability review meetings - Dated 01 Oct 2014

Exhibit 6: Letter to Sharon Gallagher from Annette Palmer re Revenue Resource Limit 21/22 - Dated 16 July 2021

Exhibit 7: MDAG Assurance Report Dated - April 2024

Exhibit 8: Social Services Policy Group/Chief Social Work Offiver Group Structure - Dated 2014

Exhibit 9: MAH update for DoH - Dated 19 Jan 2018

Exhibit 10: MAH - BHSCT Monthly Update Meeting - Dated 10 April 2019

Exhibit 11: Early Alert System Guidance - Dated 28 Nov 2016

Exhibit 12: Minutes MDAG Meeting – Dated 26 April 2023

Exhibit 13: Minutes - Adult Safeguarding Transformation Board - Dated 26 July 2021

Exhibit 14: Letter from Sean Holland to Chief Execs of HSC Trusts re Resettlement Concerns - Dated 24 Jan 2020

Exhibit 15: Delegated Limits Circular - Dated 21 Dec 2012

Exhibit 16: Email from Gordon Lyons to Graeme Crawford re Allegations of abuse - Dated 07 Jan 2016

Exhibit 17: Early alert Updated re Safeguarding concern and alerting to use of CCTV - Update dated 22 Sep 2017

Exhibit 18: Letter from Andrew McCormick to Chief Executives of HSC Trusts re Safeguarding/Abuse allegations - Dated 22 Sep 2006

Exhibit 19: Strategy Management Group report into the review of the retrospective sampling - Dated Dec 2013 exercise

Exhibit 20: Letter from PSNI to Fionnuala McAndrew, Joyce McKee & Martin Quinn re meeting outcomes - Dated 08 Sep 2014

Exhibit 21: Submission to Minister re Update on Ennis Ward Investigation - Dated 21 May 2013

Exhibit 22: Email from Rosaline Kelly to Julie Stewart re Ennis Ward Inspection - Dated 26 Feb 2014

Exhibit 23: Letter from Theresa nixon to Esther Rafferty re Outcome of Inspection - Dated 03 Dec 2012

Exhibit 24: Letter from Sean Holland to Theresa Nixon Re RQIA Reports - Dated 15 April 2014

Exhibit 25: Letter from Sean Holland to Tony Rodgers re RQIA reviews - Dated 15 April 2014

Exhibit 26: Early alert re Safeguarding concern - Dated 07/09/2017

Exhibit 27: Email from Chris Matthews to Barney McNeaney re Incident at Muckamore - Dated 30 Aug 2017

Exhibit 28: Letter from Chris Matthews to Gavin Robinson re allegations of assault - Dated 20 Sep 2017

Exhibit 29: Early alert Updated re Safeguarding concern - Update dated 20 Oct 2017

Exhibit 30: Letter from Sean Holland and Charlotte McArdle to Martin Dillon re Allegations of abuse and staff suspensions - Dated 20 Oct 2017

Exhibit 31: Letter from Sean Holland and Charlotte McArdle to Martin Dillon re Requesting assurance on range of issues - Dated 30 Nov 2017

Exhibit 32: Letter from Martin Dillon to Sean Holland and Charlotte McArdle re Assurance and details of governance structures - Dated 22 Dec 2017

Exhibit 33: Letter from Sean Holland to Valeria Watts re MAH SAI report - Dated 04 Dec 2018

Exhibit 34: Apology from Permanent Secretary to Muckamore Families - Dated 17 Dec 2018

Exhibit 35: Note of HSC Summit meeting on MAH SAI Report - Dated 30 Jan 2019

Exhibit 36: Action Plan for Muckamore - dated 13 Feb 2019

Exhibit 37: Letter from Jackie McIlroy to Marie Heaney re Seeking assurance re protection and safeguarding arrangements at MAH - Dated 22 Feb 2019

Exhibit 38: Action points from MAH BHSCT Monthly Update Meeting - Dated 10 Apr 2019

Exhibit 39: Letter from Martin Dillon to Mr Father of P96 re Actions agreed at meeting on 5 April 2019 Dated - 15 Apr 2019

Exhibit 40: Letter from Sean Holland and Charlotte McArdle to Valerie Watts re MAH Inspection concerns - Dated 17 May 2019

Exhibit 41: Letter from Sean Holland and Charlotte McArdle to Valerie Watts re MAH Leadership and Governance Review - Dated 05 Jul 2019

Exhibit 42: Early alert re staffing levels at MAH - Dated 19 Mar 2021

Exhibit 43: Action plan for the implementation of the supporting people review - Dated March 2016

Exhibit 44: Letter from Lord Morrow to Simon Hamilton re Correspondence regarding Supporting people review implementation - Dated 25 Mar 2016

Exhibit 45: Letter from Andrew McCormick to Chief Executives of HSC Trusts re Judicial Review Outcome - Dated 29 May 2013

Exhibit 46: Letter from Sean Holland to Resttlement Providers and Trust Directors of Adult Servies re Resettlement expectations - Dated 15 Sep 2020

Exhibit 47: Letter from Sean Holland to Cathy Jack re Regional Resettlement Process - Dated 15 Sep 2020

Exhibit 48: Independent Review of the Learning Disability Resettle Programme Report - Dated Jul 2022

Exhibit 49: Letter from Sean Holland to Departmental policy and professional leads re Transforming care report - Dated 22 Apr 2013

Exhibit 50: HSCB Advice on Medications Portal - Dated 27 Jun 2024

CSWO's MEETING WITH EXECUTIVE DIRECTOR'S OF SOCIAL WORK

22 January 2020 – 10am

Clotworthy House, Antrim

Present:	Seán Holland	CSW/Deputy Secretary, D0H
	Jackie McIlroy	DCSW, DOH
	Christine Smyth	Strategy Director(SW), DOH
	Eilis McDaniel	CCPD, DOH
	Marie Roulston	HSCB
	Paul Morgan	SHSCT
	Carol Diffin	BHSCT
	Marie Heaney	BHSCT
	Melanie Philips	NHSCT
	Maura Dargan	NHSCT
	Bria Mongan	SEHSCT
	Karen O'Brien	WHSCT
	Deirdre Mahon	WHSCT
	Maxine Gibson	HSCB
	Brendan Whittle	HSCB
In Attendance:	Edel Irvine	DOH
	Ainé Morrison	DOH
	Michael Burns	DOH

1. **Apologies**

Apologies received from Barney McNeany,SHSCT and Phil Hughes, NHSCT.

2. **Minutes and Matters arising from 11 September 2019 Meeting**

Minutes of the previous meeting were accepted as a true and accurate record.

Marie Roulston confirmed that the Social Care Delegation Framework (point (vi) of previous minutes) had been raised at a meeting held on 20th January and a further workshop was to be held on 25th January 2020.
Action: Marie and Paul to provide an update to Jackie McIlroy.

3. **Primary Care Social Work**

Ainé provided an update on the Primary Care Teams which are now expanding - Causeway was well progressed, also Mourne, West Belfast had been slightly delayed and two other areas were not yet decided. The Social Workers and Social

Work Assistants in the Multi-Disciplinary Teams were doing superb yet challenging work. Unexpected Issues such as families struggling with childhood behaviours, autism, homelessness and poverty are being experienced. Clarifying roles is an ongoing process and managing the different voices has been challenging. Also GPs as a group do not have a group management structure. The interface with the community and voluntary sector has also improved.

Ainé explained the Social Worker Assistant's role was to support the Social Worker, they cannot do assessments and they would not be used in all multi-disciplinary teams. The banding of the roles within the MDTs are different (SW Band 8A, Mental Health Band 8B and Physiotherapist (Manager of Team) Band 8B) and this is difficult to challenge due to having different employers but will need to be considered by the Departmental Recruitment Board as the job descriptions appear similar.

Jackie confirmed that cases that previously may have gone to the Adult Safeguarding Team in the Trusts were able to be dealt with by the SWs in these teams. Deirdre advised that they had noticed an increase in referrals to Gateway. Seán Holland added that the job description was to improve the wellbeing of anyone that needs it. The role was generalist with a high degree of autonomy.

Handouts:
Operational Guidance for the Social Worker and Social Worker Assistants in Primary Care Multi-Disciplinary Teams
Professional Development Workshops
General Practice Social Work Leaflet
Action: Directors asked to provide education and information within Trusts on the Primary Care Social Work.

4. Article 15 Payments

Ainé advised that from the Delegated Statutory Functions it could be seen that the use of Article 15 was very low in Adult Care. Belfast Trust used it the most. These small sums of money could be a most effective intervention as it is often small things that put people into debt. Trust Social Workers should make judgements on these as there is legal provision. She also felt these payments could possibly be used within the MDT teams but knew there was resistance to this.

Paul mentioned that SMT had approved a paper for the setting up of a group to look at poverty with the councils in the Southern Area and he would keep everyone updated as this was developed.
Action: Directors to discuss these payments with their Accounting Officers.

5. Recruitment of Newly Qualified Social Workers and Safe Staffing

Michael provided an informative paper on Recruitment to Social Work Posts in HSC and this was discussed in detail.

Michael advised a new approach was needed as demand was exceeding supply and options now needed explored on how best to carry out recruitment, operating within Employment Law.
Action: AD'S Governance, BSO and Michael Burns to form a Working Group to explore and develop approach to form a Regional Recruitment for newly qualified Social Workers and report back.

6. Issue with HSCTs providing information on Junior ISAs and Child Trust Funds

Eilis provided handout on the current position. The Trusts had agreed to provide information to ensure the timely access to these monies but this was not happening. Bria Mongan advised they were restructuring to make a more sustainable approach and Paul Morgan confirmed his ADs had been promoting this.
Action: Directors to ensure Trusts leads are providing information to The Share Foundation and that contact details provided were kept up to date.

7. Update on Regional Facilities for Children and Young People

Eilis advised that Phase 1 of the draft service design proposals for the new campus had been completed. It would now go to the Minister with consultation on 6 April 2020. This is a positive programme with Youth Justice Agency now becoming involved with Gateway services in bringing two facilities together in Bangor. Seán thanked Eilis for being the driving force from DOH.
Action: Eilis will issue information regarding this. Seán asked for his thanks to be passed on to all staff involved.

8. Update on Senior Leadership Network

Brendan advised that the network was now established, supported by Patricia and Paul as the Chairperson. They had held a meeting to discuss Terms of Reference. It was recognised that this group would be independent of the Department.

9. Workforce Review – multi-disciplinary teams, mental capacity and workforce plan

Marie advised that both Don Bradley and Oscar Donnelly were retiring and a Senior team would be completing this work. She wanted to flag up that the mental capacity work was causing stress in the system.

Melanie said she had found the BASWA sessions on Mental Capacity Act very helpful.
Action: Seán asked Director's to contact him directly if they had any specific MCA issues.
Seán requested that a letter issue to BASW thanking them for their support in coping with difficult change.

10. Transformation

Director's raised their concerns due to the uncertainty around the Transformation Project and the challenges in moving forward. It was recognised that the most significant initiative was the Multi-Disciplinary Teams. Eilis confirmed priorities within children services had been identified.

11. NICE Guidelines

Marie requested a steer from DOH. They had a presentation from NICE but there are resource implications. Jackie advised that any Clinical Guidance provided by NICE had to be implemented. The Public Health Social Care Guidance issued was for guidance only. Jackie confirmed that due to a depleted medical team the guidance was not scrutinised but simply issued. Michael added that NICE social care guidance only began issuing guidance two years ago but it was not always a good fit with the position in Northern Ireland. It was likely that we would take the approach of public health and issue as guidance to be considered within services.

Michael due to meet NICE Chief Executive tomorrow and asked if anyone had any key messages to provide them by lunchtime.
Action: DOH to provide written clarification to Trusts.

12. Newly appointed Health Committee

This was discussed and Paul felt it was important for the Trusts to engage with the Health Committee to create their own platform.

13. Key pressures within the system

The following were identified as key pressures: Autism, children with disabilities, separated and unaccompanied children, ADHD and parental alienation.

14. AOB

DOH Booklets - Ainé requested Directors' help in the dissemination of Reflections Mental Health and Homelessness Booklets to ensure their information was passed out throughout Trusts and offered to hold talks in Trusts.
Seán and Jackie congratulated Ainé on producing these booklets.

It was mentioned that these booklets do not have to be written solely by OSS and if anyone wished to do be involved in developing one, they should contact OSS who would work with them.

Dunmurry Manor - The Department has received the Dunmurry report, completed its audit and this will now go to the Minister. As a result radical reshaping of Adult Safeguarding is necessary – there is currently blurring of social work and police roles. There is also inconsistency between Trusts and it is difficult to collect meaningful data. New interim arrangements will be needed that Managers will then manage, monitor etc. Sean advised that he will be publicly saying it has not worked.

Muckamore – Police investigation ongoing. Muckamore continues to present challenges. Families have reported that resettlement has sometimes been a negative experience as they have felt bullyed, harassed and not listened to.

Seán will be engaging with Marie to discuss a regional approach.

Unallocated Cases – Seán advised a longer term view was needed to get stability.

Action: Ainé to issue link to the Directors for the booklets.
Action: Seán to further discuss the roles of the ASWs and the roles in the different teams in the Mental Health directorates.
Action: Directors will be kept updated as DOH may be moving to legislation for Adult Safeguarding.

15. Date of Next Meeting – Wednesday 4 March 2020

16.

CHIEF SOCIAL WORKERS MEETING WITH
EXECUTIVE DIRECTORS OF SOCIAL WORK
CLOTWORTHY HOUSE, ANTRIM CASTLE GARDENS

22 JANUARY 2020 - 10.00 a.m.

AGENDA

ITEM	REQUESTED BY
1. Apologies	
2. Minutes and Matters arising from meeting held on 11 September 2019	
3. Primary Care Social Work	*Aine Morrison*
4. Article 15 Payments	*Aine Morrison*
5. Recruitment of Newly Qualified Social Workers and Safe Staffing	*Michael Burns* *Jackie McIlroy*
6. Issue with HSCTs providing information on Junior ISAs and Child Trust Funds	*Eilis McDaniel*
7. Update on Regional Facilities for Children and Young People	*Eilis McDaniel*
8. Update on Senior Leadership Network	*Directors*
9. Workforce Review – multi-disciplinary teams, mental capacity and workforce plan	*Directors*
10. Transformation	*Directors*
11. NICE Guidelines	*Directors*
12. Newly appointed Health Committee	*Directors*
13. Key pressures within the system	*Directors*
14. AOB	
15. Date of Next Meeting – Wednesday 4 March 2020	

From the Deputy Secretary, Social Services Policy Group
Mr Sean Holland

Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0561
Fax: 028 9052 0574
Email: sean.holland@dhsspsni.gov.uk

Ms Fionnuala McAndrew
Director, Social Care and Children
Health and Social Care Board Headquarters
12-22 Linenhall Street
BELFAST
BT2 8BS

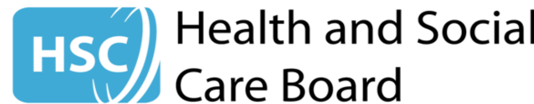
Our Ref:
Date: 20 July 2012

Dear Fionnuala

At our most recent meeting re retrospective sampling you agreed that you would report back from the Strategic Management Group following its next meeting in August. I would be grateful if you could advise when we might expect to receive this report.

Yours Sincerely

SEAN HOLLAND
Deputy Secretary



Health & Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Tel : 028 90321313
Fax : 028 90 553625
Web Site : www.hscboard.hscni.net

Mr Sean Holland
DHSSPS
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

2 April 2014

Dear Sean

Re: Retrospective Sampling Report/Strategic Management Group Report

Following our meeting of 10 March 2014 I would like to provide you with some updated information as follows:

- **Para 7.1.2 (page 22) – PSNI analysis of the adult sample from the Western Health and Social Care Trust:**
  I can confirm that all relevant matters involving the sample of adult in-patients within the Western Health and Social Care Trust have been reviewed by the PSNI and no further action will be taken.

  The case involving a child noted in this section has also been considered by the PSNI and no further action will be taken.

- **Para 7.2.3 (page 24) – PSNI analysis of the children's sample from the Southern Health and Social Care Trust:**
  I can confirm that the 4 incidents referenced in this section of the report which are not yet resolved all relate to one individual. These matters have been forwarded to PSNI for further investigation. No information on the outcome of this referral is yet available from the PSNI.

I trust this helps to keep you informed.

Yours sincerely

Fionnuala McAndrew
Interim Chief Executive

cc Martin Quinn

Exhibit 5

MEMO

From: Julie Thompson

Date: 1October 2014

To: SMT/TMG
Sponsor Branches

cc: Linda Devlin
Wendy Patterson
Ian McFaul
Karen Jeffrey

ACCOUNTABILITY REVIEW MEETINGS

1. As discussed at TMG and with sponsor branches, the purpose of this memo is to advise colleagues of changes being made to the accountability review cycle which will need to be implemented immediately for the mid-year accountability meetings which are planned for October/November 2014.

2. For all 17 ALBs, the mid-year meetings will be led by the Permanent Secretary, supported by the sponsor Executive Board Member (EBM) and a note-taker. Sponsor Branches should ensure that the meetings are booked into Mr Pengelly's and the relevant EBMs' diaries.

3. The meetings will be attended by only the Chair and Chief Executive of the ALB. It is the responsibility of all sponsor branches to inform each of their ALBs that only the Chair and Chief Executive are required to attend.

4. A draft Agenda has been attached at **Annex A**. There will no longer be Part A and B to these meetings. The meetings will focus on strategic issues affecting the ALB grouped around the four domains; corporate; quality; resources; and service delivery.

5. EBM's will be required three weeks before the meeting to provide Permanent Secretary with a note outlining the issues which they feel need to be escalated to the Accountability meeting and enclosing a proposed agenda, which is not to be shared with the ALB at that stage.

6. Permanent Secretary will consider the draft agenda and decide on the issues he wishes to raise at the meeting. His office will issue an invitation to the Chair and Chief Executive setting out the date, time and place of the meeting, along with the agenda and a request for the Chair and/or Chief Executive to advise if they wish to add any other items for discussion. The intention will be to issue the letter two weeks before the meeting.

7. Once the final agenda has been agreed the sponsor branch should prepare briefing and return it to Permanent Secretary 3 days before the meeting.

Identifying Strategic Issues

8. Strategic Issues which could be considered for escalation to the Permanent Secretary's meeting include;
   - issues which can not be resolved through other avenues including the 'ground-clearing' meeting (paragraph 9);
   - issues which are not being adequately addressed or responded to by the ALB;
   - issues which could have serious consequences for the Department if not addressed;
   - repeated underperformance in relation to key objectives;
   - issues which involve more than one organisation;
   - issues which will have a significant impact well into the future;
   - issues which require action by the Minister;
   - issues which have an impact on the regularity of the Department's expenditure;

- issues which have implications on the Department’s Governance Statement; and/or
- issues which may prevent the ALB from achieving their statutory roles and functions.

This list is not exhaustive or definitive and it is the responsibility of the EBM to use some judgement on whether an issue should be escalated.

9. It is envisaged that it will become normal practice for Sponsor branches, Policy Leads and Professionals (as appropriate) to hold a ‘ground-clearing’ meeting with their ALB prior to the Permanent Secretary’s meeting. It is expected that these meetings would be attended by relevant members of the senior team of each ALB. At these meetings colleagues should be seeking assurances from the ALBs around issues grouped under the four domains (see Annex B for a more detailed explanation against each domain). These meetings will help to inform the Permanent Secretary’s accountability meeting.

10. I understand that sponsor branches may not be able to hold a meeting prior to this round of mid-year accountability meetings however Sponsor Branches should still have informal discussions with their ALBs to ensure the EBM is up-to-date with all current issues.

11. In addition sponsor branches should issue memos to TMG members, Policy Leads, Professionals, Finance, Investment, Information Governance and Human Resources, requesting proposed agenda items. This memo should reiterate that only issues that can not be resolved through other avenues should be escalated to the Permanent Secretary’s meeting.

Mid-year Assurance Statement

12. As you are aware all DHSSPS ALBs are required to submit a Mid-year assurance statement every October. For 2014/15 the 17 ALBs are

required to submit their Mid-year Assurance Statements to the Department on or before 17 October 2014.

13. The statements should be reviewed by EBMs, Sponsor Branches, Policy and Professional areas and by FMD and CAGU. Issues identified within the Mid-year statement should first be forwarded to the relevant Policy or Professional lead for action. It is the Policy or Professional leads decision on whether or not issues identified within the statement should be escalated to the Permanent Secretary's meeting.

Action Required

14. EBM sponsors and their sponsor branches should take a number of immediate steps :

    a) ensure that Permanent Secretary's accountability meeting has been tabled in his and the EBM's diary and that the Chair and Chief Executive have been advised that only they need to attend;

    b) request possible agenda items and an explanation as to why they should be included in the Permanent Secretary's meeting from Policy leads, Professionals, Finance, Investment, Information Governance and Human Resources;

    c) review the Mid-year assurance statement and highlight any issues/concerns to the relevant Policy or Professional lead; and

    d) three weeks prior to the meeting forward a note from the EBM outlining the issues and a draft agenda to the Permanent Secretary.

15. The introduction of a more focused and streamlined approach to the Permanent Secretary's accountability meeting should allow for the Permanent Secretary to focus on the main strategic issues affecting ALBs. The EBM's role is to provide assurance to the Permanent Secretary by

ensuring that the ALB has an effective system of internal control and delivers on its functions, other statutory responsibilities, and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department.

16. In the meantime, if you have any queries relating to this memo please get in touch with Wendy Patterson (ext 23112) or Karen Jeffrey (ext 28662).

JULIE THOMPSON
Deputy Secretary
Resources and Performance Management Group

ANNEX A

Draft Agenda

Name of ALB

Mid-Year Assurance and Accountability Meeting

Day, Date, Time

Location

1. Minutes and action points from Previous Meeting (dd mmm yyyy)

2. Strategic Direction (Communicating information about relevant developments in policy, legislation, strategy and Ministerial priorities and issues)

3. Strategic Issues (to be grouped around the four domains)
    - **Corporate**
    - **Quality**
    - **Resources** (Finance, Estate, Human Resources)
    - **Service Delivery/Performance**

4. AOB - Issues raised by ALB

ANNEX B

Domains

Corporate

1. This Domain encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the ALB is fulfilling its essential obligations as a public body.

2. Specifically the Department will seek assurance from all ALBs on the existence of effective corporate control arrangements e.g. existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance thereon.

Quality

8.1 The 'Quality' domain covers the duty of each ALB to put and keep in place arrangements for the purpose of monitoring and improving the quality of programmes/services provided by and for that ALB.

8.2 The safety of services being provided is implicitly addressed under the quality domain as is the quality of professional practice and the personal responsibility of every individual for the quality services they provide.

8.3 The Department will seek assurance from ALBs on their ability;

- to understand the relative quality of services they provide;
- to ensure that practice is safe and the safety of clients;
- to identify and manage risks to quality;
- to act against poor performance; and
- to implement plans to drive continuous improvement.

Resources

8.4 The 'Resources' domain refers to the arrangements ALBs have in place for ensuring that resources, e.g. finance, allocated by the Minister/Department are deployed fully in achievement of agreed outcomes and for ensuring value for money and that other resources e.g. Human Resources and Estate, are managed effectively.

8.5 Specifically the Department will ensure that appropriate resource accountability mechanisms are in place to:

- ensure that the optimum resources are secured from the Executive for Health and Social Care;
- ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;
- deliver and maintain workforce and financial stability
- facilitate the delivery of economic, effective and efficient services; and
- facilitate the development of innovative and effective models of care.

Service/Programme Delivery

8.6 The domain of 'Service/Programme Delivery' refers to the arrangements the ALB has in place for ensuring the delivery of programmes and services with particular reference to meeting PfG commitments, Ministerial targets, Departmental priorities, required service improvements and any other relevant objectives/ targets/ commitments/ policies/ strategies developed by the Department.

Exhibit 6

Via Email

Sharon Gallagher
Interim Chief Executive
Health and Social Care Board
12-22 Linenhall Street
BELFAST
BT2 8BS

Room D3.14
Castle Buildings
Stormont BELFAST
BT4 3SQ
Tel: 028 9076 5605
Email: annette.palmer@health-ni.gov.uk

Our Ref: **HSCB 07 – 21/22**
TRIM Ref: HE1/21/376230
Date: 16 July 2021

Dear Mrs Gallagher

REVENUE RESOURCE LIMIT 2021/22

Further to the Department's allocation letter of 15 July 2021 (HSCB 06) I write to advise you that the revenue allocation for the HSC Board has increased from **£6,181,855,245** to **£6,206,526,273**. A summary of the allocations to date is attached at **Annex A.**

This represents **a net increase of £24,671,028** as follows:

1. **£67,000 non-recurrent (assumed recurrent) allocation** to Southern HSC Trust in relation to the Framework for Integrated Therapeutic Care Regional Implementation Lead (FAO Ivor Crothers – SHSCT/Deirdre Coyle). (**Traffacs ref 4234**). This should be classified as Commissioning of HSC Services.

2. **£80,000 non-recurrent (assumed recurrent) allocation** to South Eastern HSC Trust in relation to the Regional Facilities for Children and Young People Clinical Lead (FAO Elaine Somerville – SEHSCT/Deirdre Coyle). (**Traffacs ref 4235**). This should be classified as Commissioning of HSC Services.

3. **£150,000 non-recurrent (assumed recurrent) allocation** in relation to the Framework for Integrated Therapeutic Care Associate Psychologists Posts to cover the period of 9 months (FYE 22/23 £200,000) (FAO Deirdre Coyle). (**Traffacs ref 4236**). This should be classified as Commissioning of HSC Services.

   Note, **non-recurrent (assumed recurrent)** funding (para 1-3 above) is provided in-year from a non-recurrent source however for financial planning purposes it can be assumed that a source of recurrent funding will be secured in 2022/23 and beyond.

4. **£3,100 non-recurrent allocation** in relation to the Framework for Integrated Therapeutic Care Licence Fee for 'Removed' Film and Workshop (FAO Deirdre Coyle). (**Traffacs ref 4237**). This should be classified as Commissioning of HSC Services.

5. **£100,000 non-recurrent allocation** in relation to HSCB Contract for Advocacy for LAC (VOYPIC Contract) (FAO Deirdre Coyle). (**Traffacs ref 4238**). This should be classified as Commissioning of HSC Services.

6. **£1,200,000 non-recurrent allocation** in relation to Primary Care Elective Care – Integrated Care (FAO Roger Kennedy). (**Traffacs ref 4267**). This should be classified as Commissioning of HSC Services.

7. **£10,000,000 non-recurrent allocation** in relation to Increasing Price Pressures on Pharmaceutical Budget for Medicines (FAO Joe Brogan). (**Traffacs ref 4269**). This should be classified as Commissioning of HSC Services.

8. **£7,000,000 non-recurrent allocation** in relation to Pharmaceutical Price Reduction Scheme (PPRS) (FAO Joe Brogan). (**Traffacs ref 4270**). This should be classified as Commissioning of HSC Services.

9. **£1,344,000 non-recurrent allocation** to Belfast HSC Trust in relation to Muckamore Abbey Hospital – Acute Inpatient Unit for Adults with Learning Disabilities (FAO Lorna Conn). (**Traffacs ref 4271**). This should be classified as Commissioning of HSC Services.

10. **£3,000,000 non-recurrent allocation** to Belfast HSC Trust in relation to Muckamore Abbey Hospital (FAO Lorna Conn). (**Traffacs ref 4272**). This should be classified as Commissioning of HSC Services.

11. **£66,962 non-recurrent allocation** to 5 HSC Trusts in relation to Clinical Physiology as shown in the table below. (**Traffacs ref 4276**). This should be classified as Commissioning of HSC Services.

Trust	Amount £	FAO
BHSCT	25,788	Kerry Corey
NHSCT	10,556	Beverley Houston
SEHSCT	12,222	Naomi Mitchell
SHSCT	8,876	Leor Ovadia
WHSCT	9,520	Tom Flanagan
TOTAL	**66,962**	

12. **£300,000 non-recurrent allocation** in relation to Mental Health Pressures (FAO Frances McGreevy). (**Traffacs ref 4280**). This should be classified as Commissioning of HSC Services.

13. **£1,052,000 non-recurrent allocation** in relation to Bright Start (FAO Una Lernihan and Christine McAllister). (**Traffacs ref 4281**).

Note, Bright Start scheme funding is part of the **Executive's Delivering Social Change Fund** and is a separate **ring-fenced** allocation; this funding should be assigned to **Executive Funding** and cannot be used to fund any other projects.

14. **£82,000 non-recurrent allocation** in relation to Educational Attainment of Children in Foster Care (FAO Fiona Gunn). (**Traffacs ref 4282**). This should be classified as Commissioning of HSC Services.

15. **£33,000 non-recurrent allocation** in relation to Mentoring Support to Looked After Children (FAO Deirdre Coyle). (**Traffacs ref 4283**). This should be classified as Commissioning of HSC Services.

16. **£15,000 non-recurrent allocation** to 5 HSC Trusts in relation to Allied Health Professions (AHP) Education Commissioning Budget to support education programmes selected by the AHP Lead as shown in the table below. (**Traffacs ref 4284**). This should be classified as Commissioning of HSC Services.

Trust	Amount £	FAO
BHSCT	3,000	Paula Calahan
NHSCT	3,000	Jill Bradley
SEHSCT	3,000	Margaret Moorehead
SHSCT	3,000	Carmel Harney
WHSCT	3,000	Paul Rafferty
TOTAL	**15,000**	

17. **£11,678 non-recurrent allocation** to Southern HSC Trust to support work in relation to the Social Work Strategy. Further details are provided by Jocelyn McAvera in the attached table at **Annex B**. **(Traffacs ref 4288).** This should be classified as Commissioning of HSC Services.

18. **£166,288 non-recurrent allocation** to Belfast HSC Trust in relation to the Infected Blood Inquiry Legal and Admin Support (FAO Caroline Leonard – BHSCT). (**Traffacs ref 4294**). This should be classified as Commissioning of HSC Services.

Addendum to HSCB 02 dated 21 June 2021:

£1,453,000 recurrent retraction from Transformation Funds for 2021/22 to support the development and implementation of the Future Planning Model (**Traffacs ref 4203**) which was allocated in error in the opening allocation letter as part of the Northern Prototype (TF 150) allocation.
This should be treated as a **non-recurrent (assumed recurrent) retraction**.

Yours sincerely

Annette Palmer

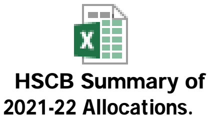
Annette Palmer

cc: Christine Frazer, HSCB
Stephen Bailie, HSCB
Jacqui Cairns, HSCB
Tracey McCaig, HSCB
Colin Bradley, HSCB
Lindsay Stead, HSCB
Anne Brownlee, HSCB
Andrea Henderson, HSCB
Brigitte Worth, DoH
Annette Palmer, DoH
Nodlaig Keenan, DoH
Nicola McKnight, DoH
William Scott, DoH
Graeme Houston, DoH
Dean Russell, DoH
Christine Scallan, DoH
David Keenan, DoH
Nicola Shields, DoH
Catherine Fitzpatrick, DoH
Jenny Wilson, DoH
Isobel Scott, DoH
Joan O'Hara, DoH
Shona Graham, DoH
Pauline Coulter, DoH
Chris Matthews, DoH
Mark Lee, DoH
Maire Redmond, DoH
Jerome Dawson, DoH
Mark Browne, DoH
Michelle Graham, DoH
Melanie McClurg, DoH
Tomas Adell, DoH
Peter Toogood, DoH
Peter Beattie, DoH
Jill Hawthorne, DoH
Marc Bailie, DoH
Leah Kelly, DoH
Annette Irvine, DoH
Jennifer Mooney, DoH
Elizabeth Kayaalp, DoH
Karen Brown, DoH
Roisin Madine, DoH
Charlotte McArdle, DoH

Gerard Gilhooly, DoH
Denise Nixon, DoH
Jenny Keane, DoH
Jackie McIlroy, DoH
Jocelyn McAvera, DoH
Edel Irvine, DoH
Lesley Heaney, DoH
Eddie Dillon, DoH
Gareth Reilly, DoH
Alasdair MacInnes, DoH
Liz Redmond, DoH
Alison Marley, DoH

traffacs.updates@hscni.net

Annex A



HSCB Summary of 2021-22 Allocations.

Annex B

SOCIAL WORK STRATEGY FUNDING ALLOCATION – July 2021

Amount: £11,678
Cost Centre: 13241
Budget Code: 055483
Approved by: Jackie McIlroy, Director of Social Work Strategy and Social Care Workforce Strategy

Amount	Trust / Organisation	Project	Attention of:
£11,678	Southern Health and Social Care Trust	Salary costs for Chris Millar iro work on SWB Tool App for the period 01 April 2021– 31 March 2022	Francesca Leyden

Muckamore Departmental Assurance Group (MDAG) April 2024

Assurance Report

Ref: MDAG/03/24

MDAG Assurance Report	
MDAG Objectives	i. The services being delivered at Muckamore continue to be safe, effective and fully Human Rights compliant; ii. The commitment given by the Permanent Secretary to resettle patients is met, and the issue of delayed discharges is addressed; iii. The team on site at Muckamore is given the support and resources necessary to achieve their goals; and iv. The lessons learned from Muckamore (including the Serious Adverse Incident report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

1. <u>Safeguarding</u>

2017 CCTV Footage/ASG aspect of investigation

1.1 The viewing of all the raw footage across the 5 wards is now complete. The footage in relation to the shifts still to view outlined in the table at paragraph 1.6 is corrupted and unable to be viewed.

1.2 The 4 Designated Adult Protection Officers (DAPOs) and 2 Investigating Officers (IOs) are focusing on processing the outstanding referrals in Cranfield 1.

1.3 Two Family Liaison Social Workers (FLSWs) continue to provide support to affected families and engage in cross-Trust work.

1.4 The other core elements of the work of the historical Adult Safeguarding Team are continuing, as follows:

- Respond to any urgent safeguarding issues raised by the PSNI through the ongoing police-led investigation;

- Review referrals received from the Police regarding Cranfield 2 Ward, to consider and address any immediate Adult Safeguarding concerns;
- The Safety Intervention assessor (historically known as MAPA) is continuing to complete MAPA assessments and support requests for information from disciplinary investigators. These requests fluctuate and therefore the Safety Intervention assessor has returned to work in the Corporate Team 3 days per week;
- Ongoing review of Interim Protection Planning processes and consideration of Interim Protection Plans based on new incidents;
- Data analyst continues to maintain and quality assure the database;
- The team continue to provide information when requested by the external disciplinary investigators or the PSNI in respect of their criminal proceedings;
- Continued attendance at the Operational Meeting (3 weekly); and
- Work alongside the Trust HR investigation team.

Additional Work Streams

1.5 The Adult Safeguarding Team are also currently commissioned to undertake two additional pieces of work:

a) Identifying a communication mechanism to update families in relation to the progression of the investigation (proposal has been submitted and awaiting approval); and

b) Reflection upon any additional learning emerging from the raw footage viewing to support improvement within LD Division and across the organisation.

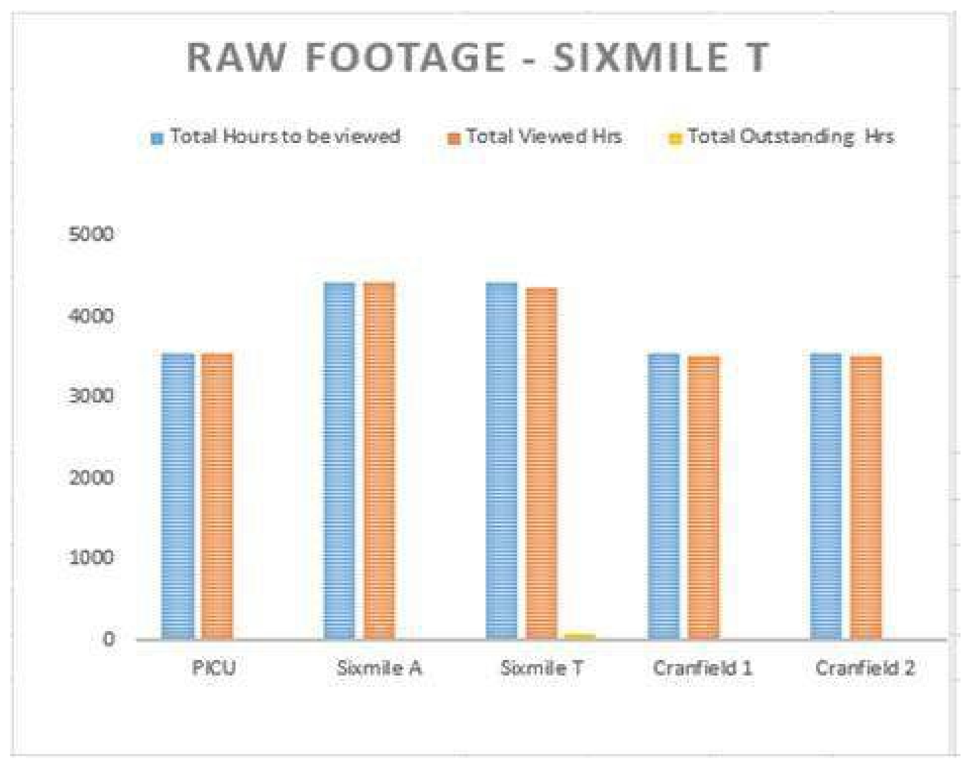
Viewing of CCTV footage

1.6 The timeframe for the review of footage is from March 2017 to September 2017. The raw footage viewing is now complete, the files in relation to the 13 shifts still to view as outlined in the table below are corrupted and unable to be viewed.

WARD	TOTAL HRS TO BE VIEWED	TOTAL HRS VIEWED	TOTAL % VIEWED	TOTAL HRS OUTSTANDING	TOTAL 5 OUTSTANDING	No of AM shifts still to view	No of PM shifts still to view	No of Night shifts still to view
PICU	3552	3552	100%	-	-	-	-	-
SIXMILE A	4440	4440	100%	-	-	-	-	-
SIXMILE T	4440	4368	98.38%	72	1.62%*	3	3	3
CRANFIELD 1	3552	3534.5	99.51%	17.5	0.49%*	-	1	1
CRANFIELD 2	3552	3534.5	99.51%	17.5	0.49%*	-	1	1
TOTAL	**19,536*** **	**19429.00**	**99.45%**	**107**	**0.55%**	**3**	**5**	**5**

*corrupted files.

**19536 denotes the hours in total of shifts to be viewed. This total needs to be multiplied by the number of cameras to be viewed per shift to understand the true figure. The total number of cameras varies from Ward to Ward.



PICU - SHIFTS LEFT TO VIEW		
AM	PM	NIGHT
0	**0**	**0**

CR- SHIFTS LEFT TO VIEW		
AM	PM	NIGHT
0	**0**	**1**

Corrupt footage

Processing Identified Incidents

Overall Incident Totals identified by PSNI and Adult Safeguarding as at 10th March 2024

OVERALL INCIDENT TOTALS	
Total Incidents Identified	1938
Total Incidents Completed	1906
Total Outstanding (Still to be processed)	**32**

Breakdown of 'Outstanding (Still to be processed total = 32)

Ward	10.03.2024
PICU	0
Sixmile Assessment	0
Sixmile Treatment	0
Cranfield 1	32
Cranfield 2	0
Total	32

Other Core Statistics

To Be Identified (TBI) Employees as at week ending 10.03.2024

The team continue to work to identify all employees that are involved in incidents using the following available mechanisms:-

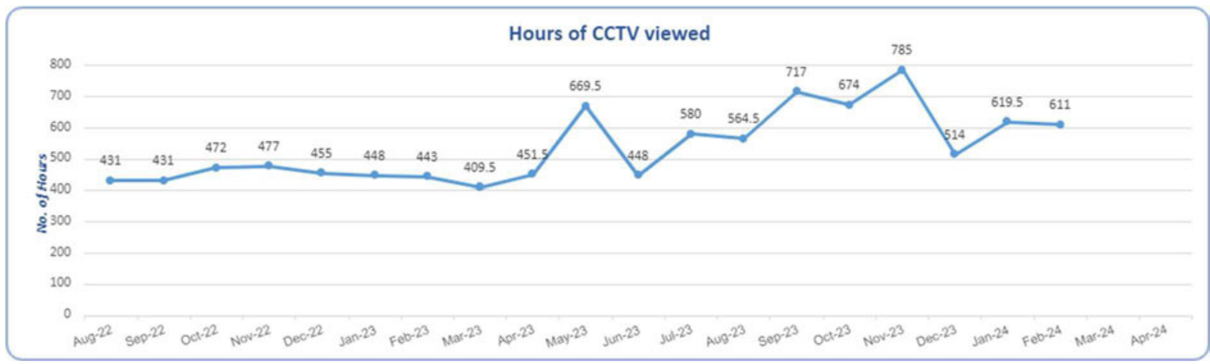
- Reviewing footage
- Clipping images
- Review staff ID images
- Consulting HR records
- Consulting with MAH
- Reviewing visitor log books
- Reviewing rotas/allocation sheets
- Cross referencing PARIS records
- Cross referencing datix incidents

	10.03.24	**Comment**
Outstanding TBIs- alleged perpetrators	1	This relates to a non-Trust staff member observing an incident
Outstanding TBIs – Possible Witnesses to an incident	13	All 13 are being actively reviewed by a DAPO
Total	**14**	

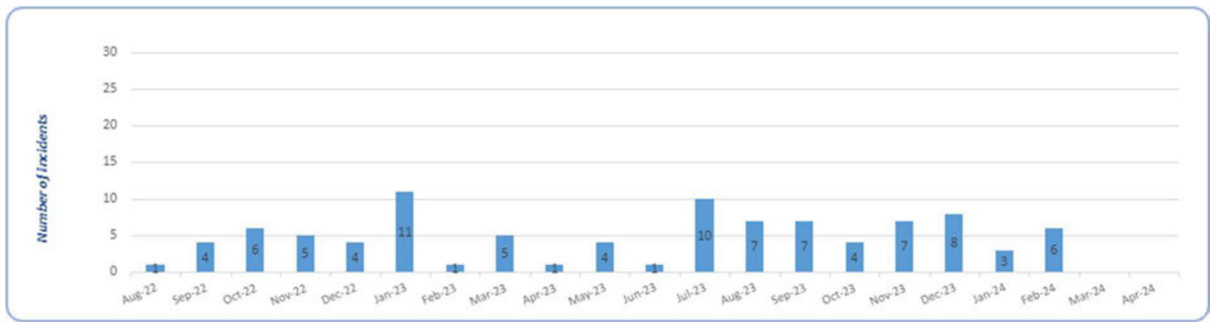
Current CCTV viewing

1.7 CCTV contemporaneous viewing continues on a daily basis to a set schedule. Shifts are selected randomly across all wards and daycare. Between 400 and 600 hours are viewed per month. A proforma is completed for each viewing, reporting general observations in relation to interactions, recognising and responding to the needs of patients, restrictive practices, safeguarding concerns, practice concerns, positive care or practice.

1.8 The recordings are then quality assured each Monday by a Lead Nurse and a Designated Adult Protection Officer (DAPO) to ascertain if there have been any practice or ASG issues highlighted. If this is the case, the CCTV footage is viewed again by the ASM and the DAPO.

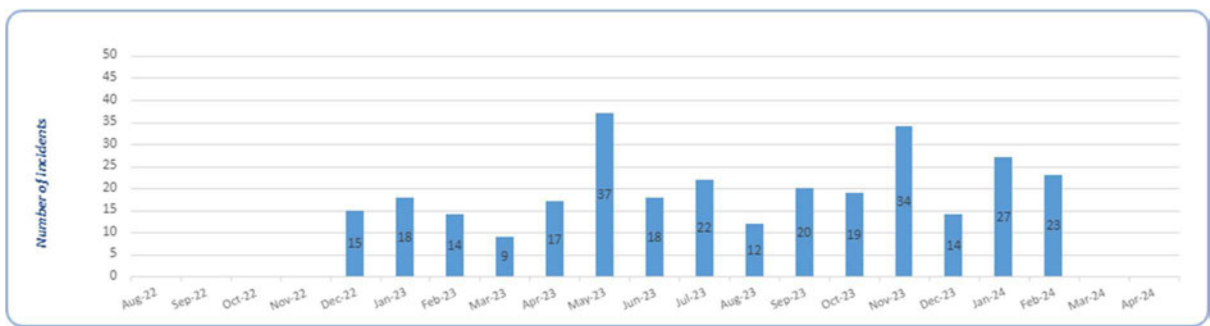


Incidents escalated from CCTV for further review



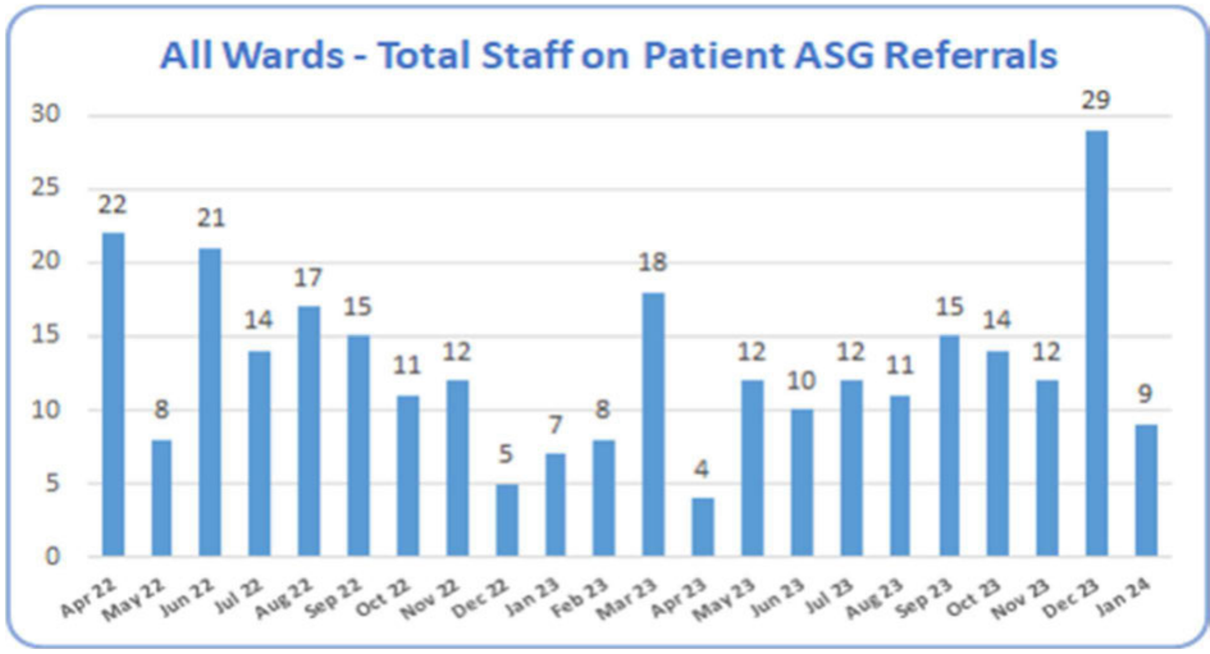
Incidents for further review are viewed by DAPO and Lead Nurse for appropriate action.

Incidents of good practice noted via CCTV review

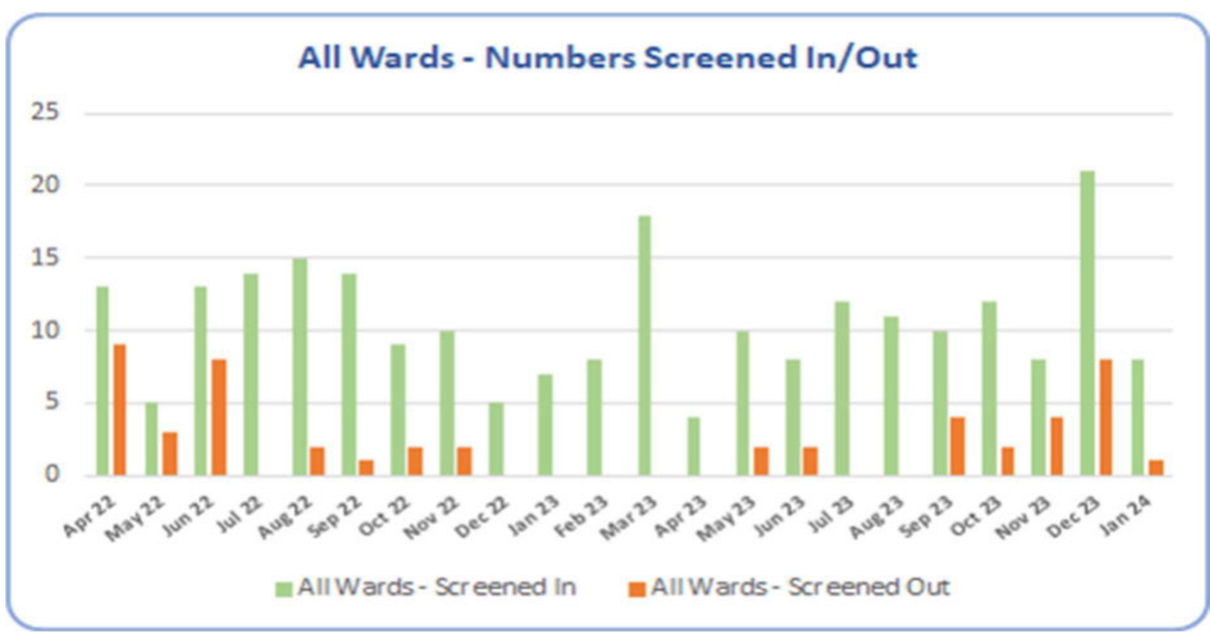


Incidents of good practice are shared with relevant teams by the Lead Nurses.

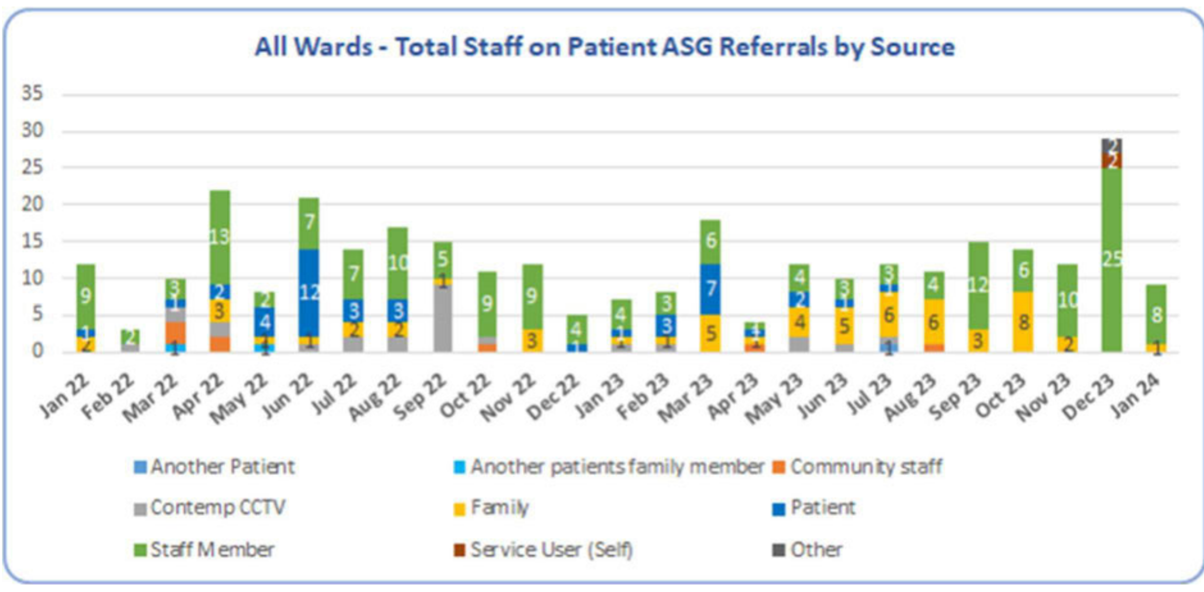
Trend data on ASG referrals



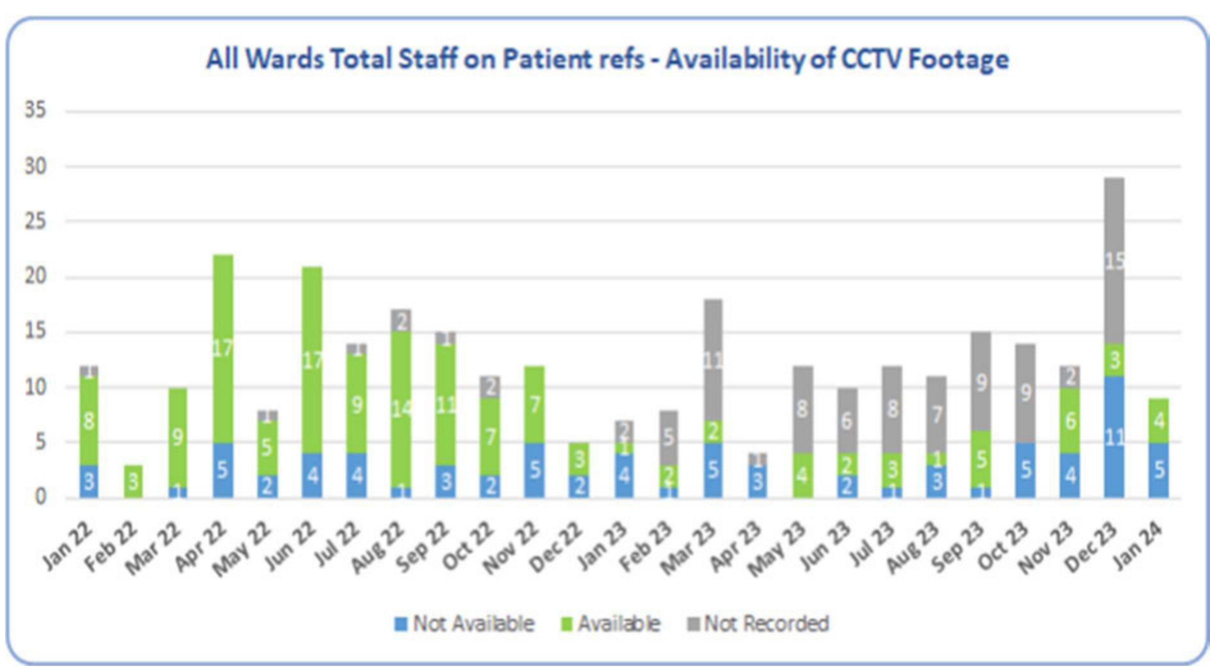
1.9 The Safeguarding team at MAH complete daily screening of Duty desk, attend safety briefs, with the ASG dashboard informed by referrals, numbers screened in and those that require an alternative response. Each ward has an Adult Safeguarding assurance review which is presented monthly to the ASG oversight group chaired by the Divisional Social Worker. A number of the staff on patient referrals relate to one individual, and the Trust have agreed to provide a separate report on this to the Chief Social Work Officer. In the last three months 50 – 70% of staff on patient allegations have been in relation to one individual. Strategy meetings are held with the NHSCT and the individual's family, and all allegations are investigated. The family meet regularly with the senior management team.



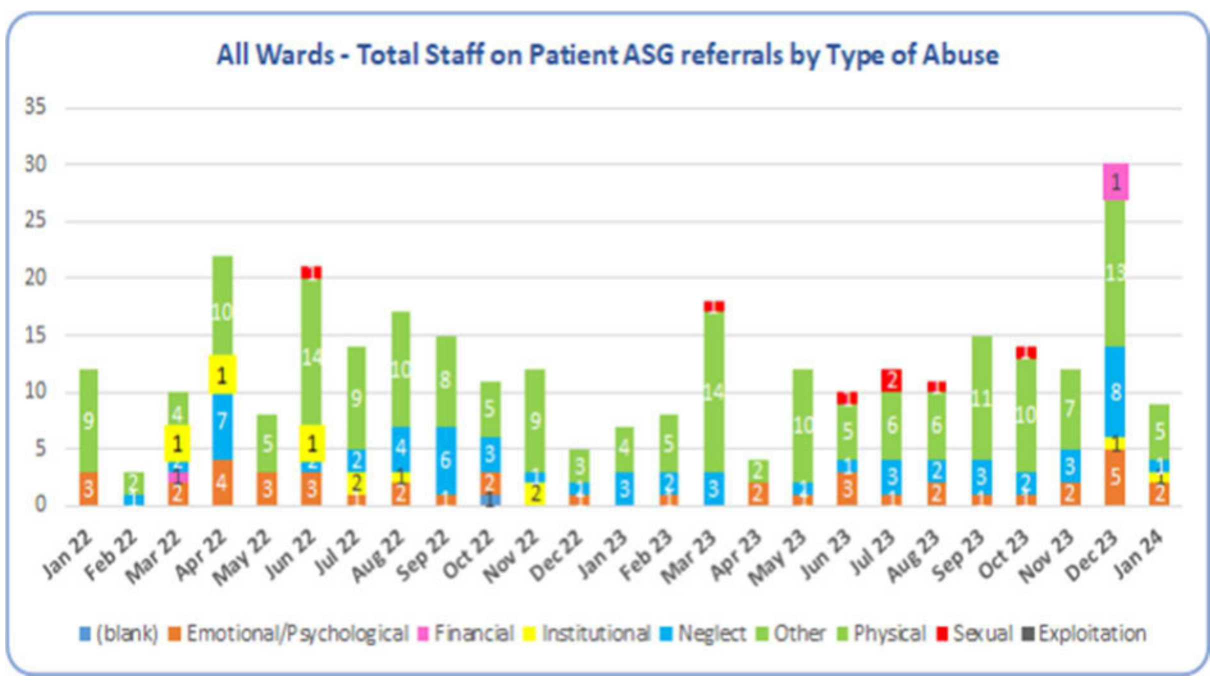
1.10 The ASG dashboard charts referrals by source and time. The data demonstrates that CCTV is not the main source of referral and that staff, patients and family are reporting concerns for investigation.



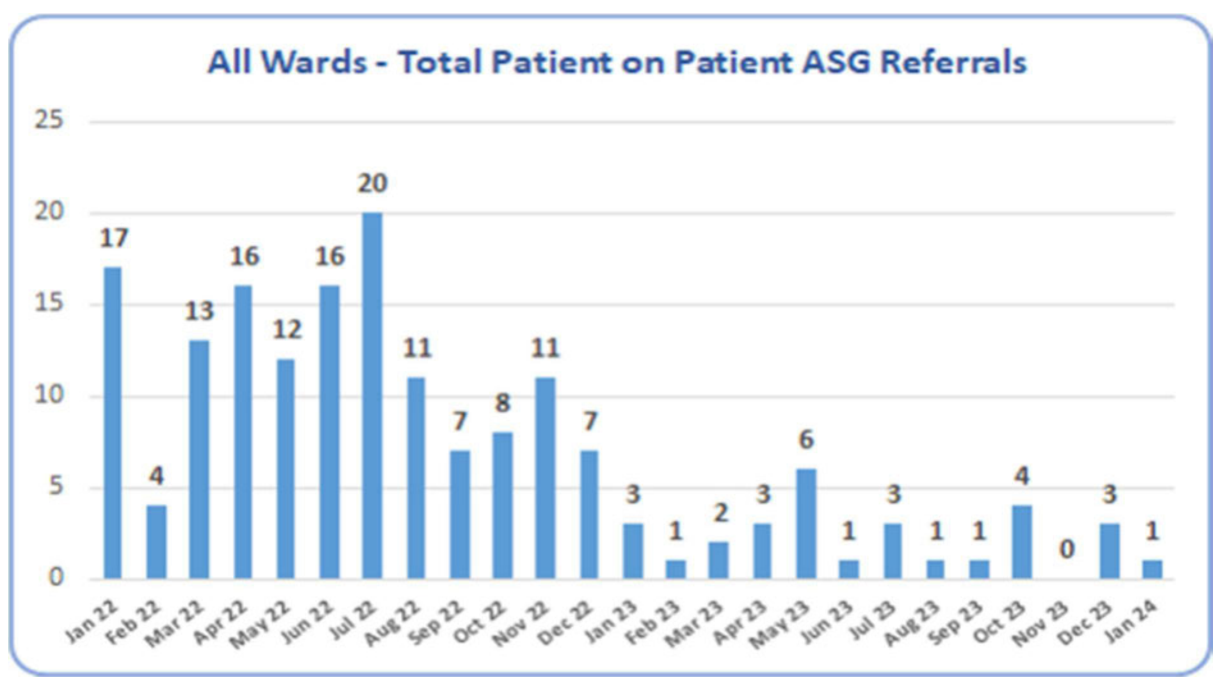
Staff member as source records where a member of staff is the referrer. A manual review would be required to identify whether this was the result of staff concern or an onward report.



Delays to viewing will be highlighted in Red in future versions of this chart. Currently only one case has had delayed viewing, in response the Trust have added additional viewing time referrals where footage is available. Capacity is monitored on a weekly basis.



The Trust have advised that the colour changes for 'Other' and 'Physical' have not been able to be changed for this update.



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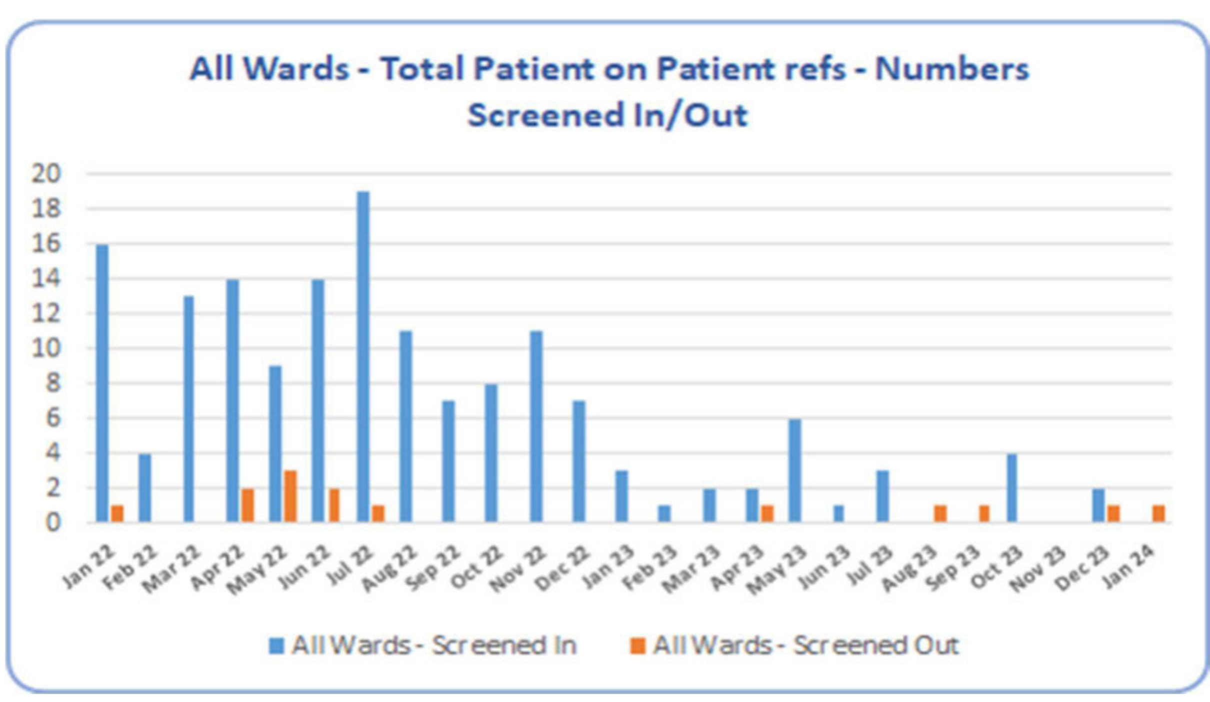


Patient on patient ASG concerns have reduced as numbers have reduced so less people are living together.

Family Liaison Role

1.11 In addition to the above, the Trust Team provide a Family Liaison Social Work (FLSW) role to 41 families whose relatives have been identified through the raw footage viewing.

1.12 The core role of the FLSW is to share summary of identified incidents, provide emotional support, to signpost to other support services, assess carer needs and provide emotional support during the on-going criminal processes.

1.13 The FLSWs have also maintained on-going and regular contact with families and professionals by telephone calls, emails, text messages, home visits and attendance at relevant meetings.

Operational Management Group

1.14 The Operational Group comprising of representatives from Adult Safeguarding MAH 2017 CCTV team, HR, Senior Nurse Advisors, RQIA and the PSNI continue to take place every three weeks to review the management decisions in relation to the safeguarding referrals made. An additional meeting has been held to consider the position in respect of a small number of the medical staff.

Safeguarding Governance Group

1.15 The last Safeguarding Governance Group meeting took place on 26 February 2024.

2. MAH Inpatient Numbers and resettlement

2.1 As of 1 April 2024, the number of patients in the hospital is **25.** This total includes the patient admitted in January 2024 following a Judicial Review.

2.2 The Resettlement Oversight Board continues to meet every two weeks, with the most recent meeting taking place on 19 March. The Board have been focussing on the expedited resettlement of delayed discharge Learning Disability patients, and twelve patients have been resettled since the Board was established in August 2022.

2.3 The Belfast Trust continues to hold weekly meetings to review progress on resettlement and any risks or delay. These meetings involve the Deputy Chief Executive, along with the Interim Director, Collective Leadership Team and Directors from the Northern, South-Eastern and Southern Trusts. Each patient in residence is discussed by the team in order to ensure active resettlement continues at the accelerated pace, and in and outreach provision is ongoing.

2.4 The tables below provide a summary of the current assessment of readiness for resettlement by Trust patient.

Key	
Green	Good to go
Potential Green	Minor obstacles but easily achievable
Amber	Moderate Risk or Delay
RED	Significant Risk or delay

Table 1*

	BT	NT	SET	ST	Total
Green	2	1	0	0	**3**
Potential Green	3	2	4	0	**9**
Amber	6	1	0	0	**7**
Red	1	1	2	1	**5**
Total	**12**	**5**	**6**	**1**	**24**

**detail from Resettlement Plan Tracker – 19 March 2024.; Note – does not include Jan 24 JR admission.*

2.5 Resettlement plans have all been reviewed in light of the change to some of the schemes (Table 2). The individuals in the red category have complex needs

and need specific planning. There are now two individuals in active treatment with the new admission in January 2024 as outlined in paragraph 2.1.

2.6 All Trusts are working with providers across the province to source suitable community options.

2.7 A summary of the various resettlement schemes currently being progressed, along with the anticipated patient numbers, timescales and issues is provided in Table 2 below.

Table 2

Patient Numbers for schemes	No of individuals identified	Timeframe/issues
Braefields (NHSCT Locality)	6	this facility is operational
Mallusk (NHSCT locality)	4	1 patient moved May. The Trusts met with Inspire 9th February to look at the remaining 3 voids new referrals have been forwarded but no response as yet.
Mullan Mews (BHSCT locality)	4	Resolution with Housing re ongoing funding and supporting people is progressing. RQIA registration is being updated given the change in numbers registered manager post and all staffing model will be shared as part of organisational change.
Corrywood bungalow (s)		Church Road Completion on track for end April. Manse Road Completion date to be confirmed.

2.8 Since the update circulated for the February MDAG meeting, there have been no further patients resettled from Muckamore. This means that, including the admission of a further patient in January 2024, there are currently **24** patients in the hospital. Against the August 22 baseline of **36** patients to be resettled, this means that the number of resettlements having taken place remains at **12**. The current position in respect of successful resettlements and a breakdown of remaining patients by Trust is outlined in Table 3 below.

Table 3 *

Discharge Summary (Baseline at August 22)	**36**
No residents discharged in week	0
No residents discharged since Aug 22	12
No residents remaining on site	**24**

** detail from Resettlement Plan Tracker – 19 March 2024; Note – does not include Jan 24 JR admission.*

2.9 As of 19 March, there are a total of 16 resettlements with potential timeframes for completion (with the latest of these being forecast for June 2024). The number of patients who are still to have their resettlement timeframes confirmed is 8. A summary of the current potential timeframes is provided in Table 4 below.

Table 4*

Summary Potential Resettlement Timeframes

	Mar-24	**Apr-24**	**May-24**	**Jun-24**				**TBC**	**Total**
BT	0	1	4	4				3	**12**
NT			2	1				2	**5**
SET	1	2	1					2	**6**
ST								1	**1**
Total	**1**	**3**	**7**	**5**	**0**	**0**	**0**	**8**	**24**

** detail from Resettlement Plan Tracker – 19 March 2024; Note – does not include Jan 24 JR admission.*

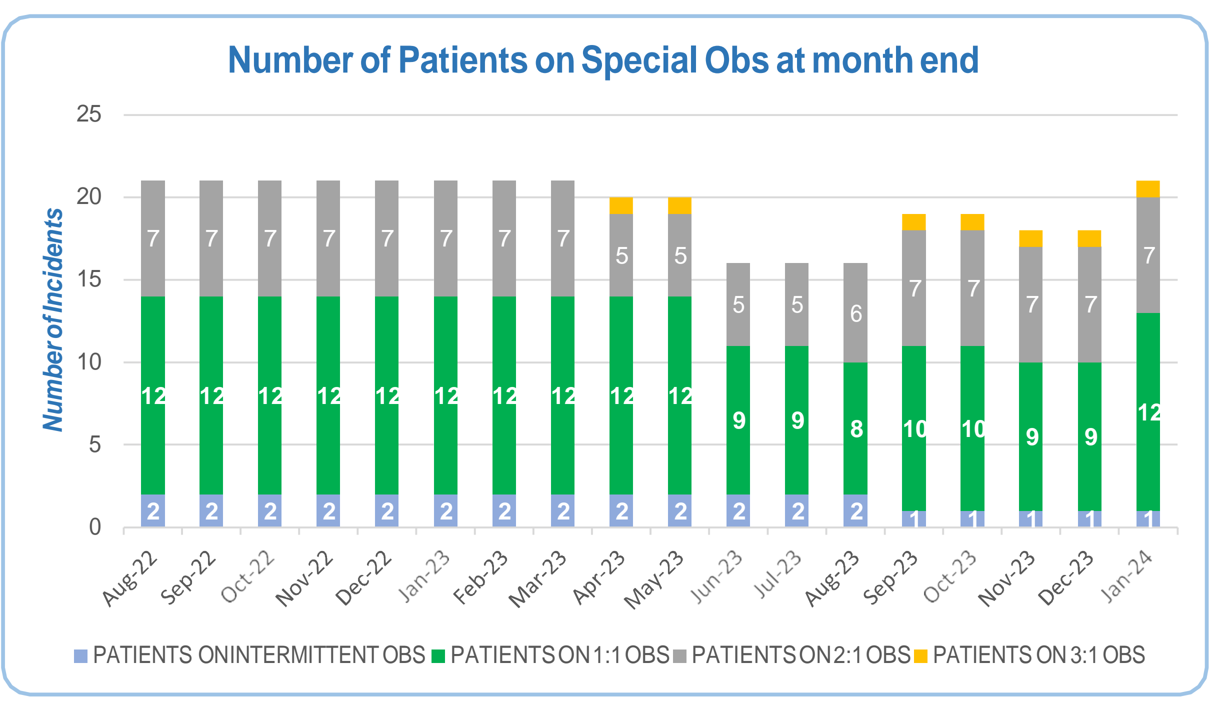
3. Patient Safety

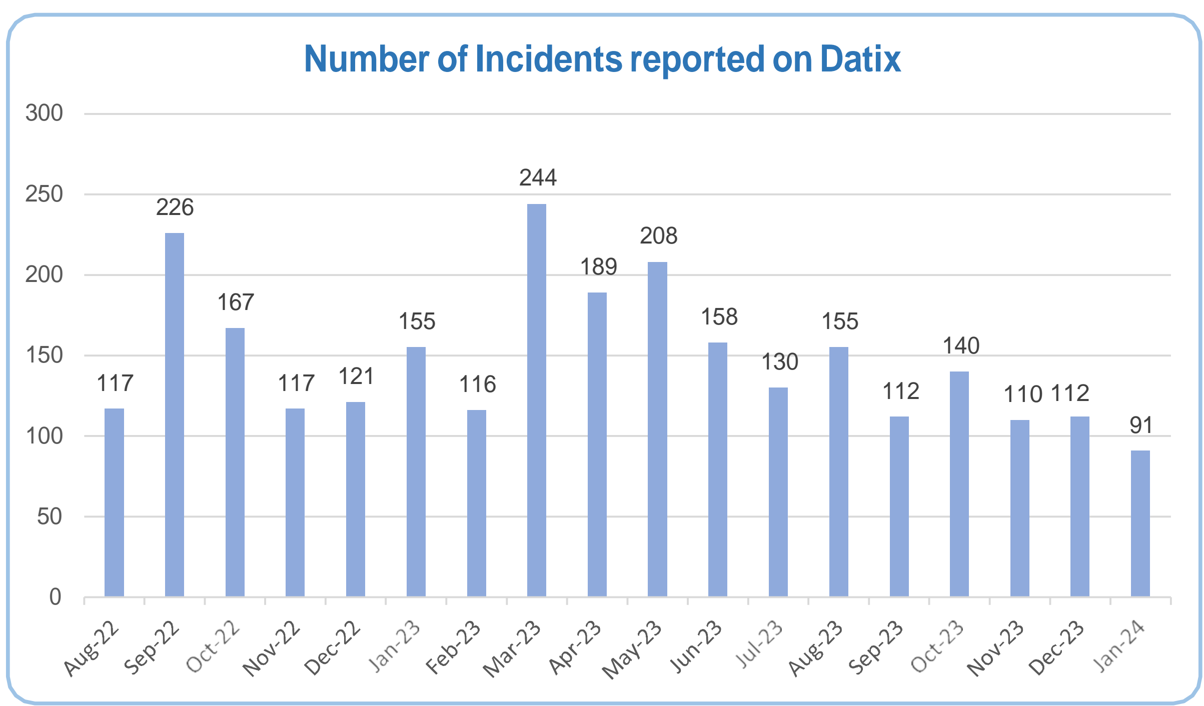
3.1 A daily safety huddle takes place across the MAH site to review day to day risks and patient safety. This informs daily schedule changes required and feeds into the overall ID safety huddle. Issues requiring escalation are shared to the Senior Leadership Group Charles Vincent safety huddle for the Belfast Trust.

3.2 The weekly Safety Report continues to provide assurance on patient safety metrics, and is reviewed by the senior management team in MAH and collated and reviewed with the multi-disciplinary team. This is part of a weekly Live Governance meeting for all clinical areas to feedback on the previous week's incidents within a governance framework. This reports into monthly divisional governance oversight and review of safety dashboard.

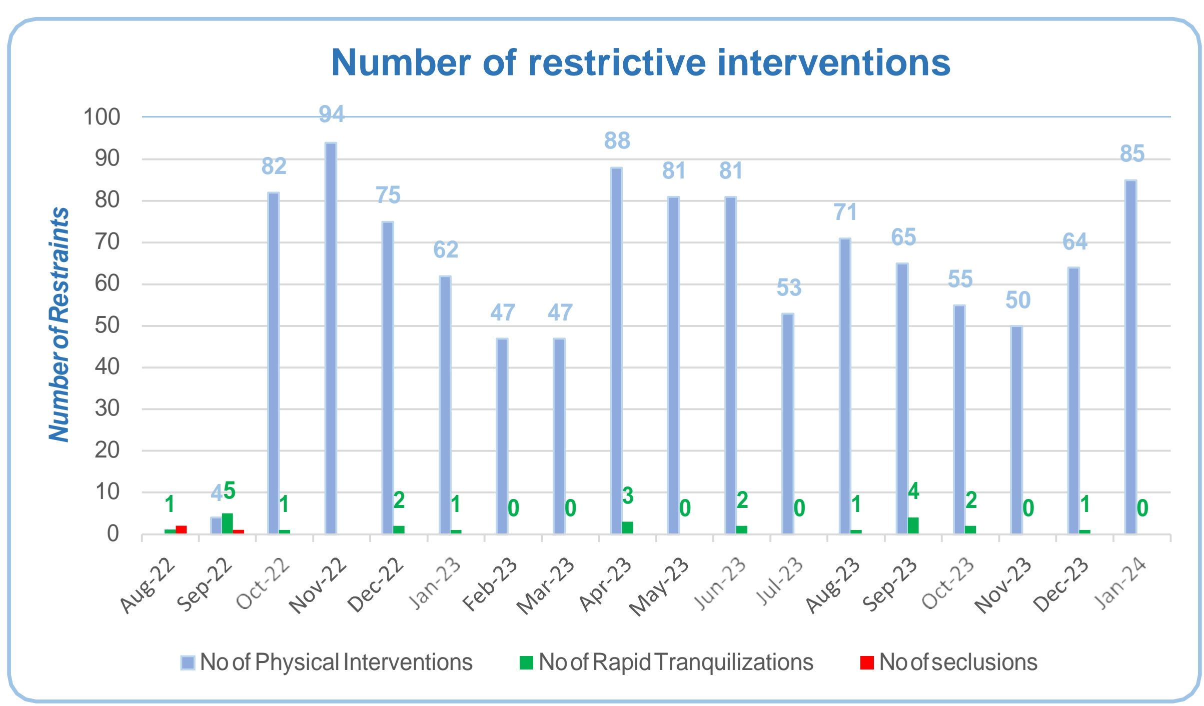
3.3 The Trust have provided a number of charts and graphs from the safety dashboard to aid the assurance provided to MDAG and these have been included for information below.

Safety Dashboard graphs are used for all reports





The number of incidents has been steady in the last two-month period. Incidents are monitored and reviewed to identify any recurrent themes or learning at Clinical Improvement meetings. Ongoing incidents are related to a small number of individuals experiencing periods of dysregulation.



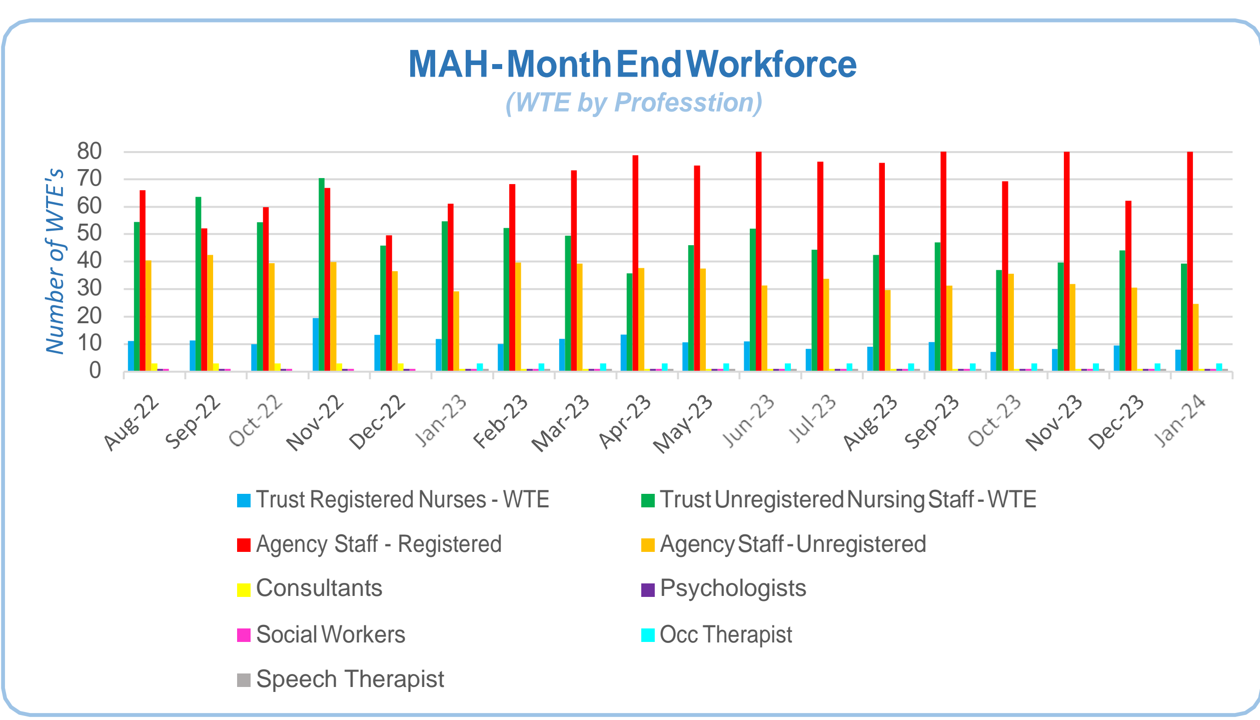
The Trust have advised that the increase in Restrictive (physical) interventions has been due to a new acute admission.

4. Staffing Levels

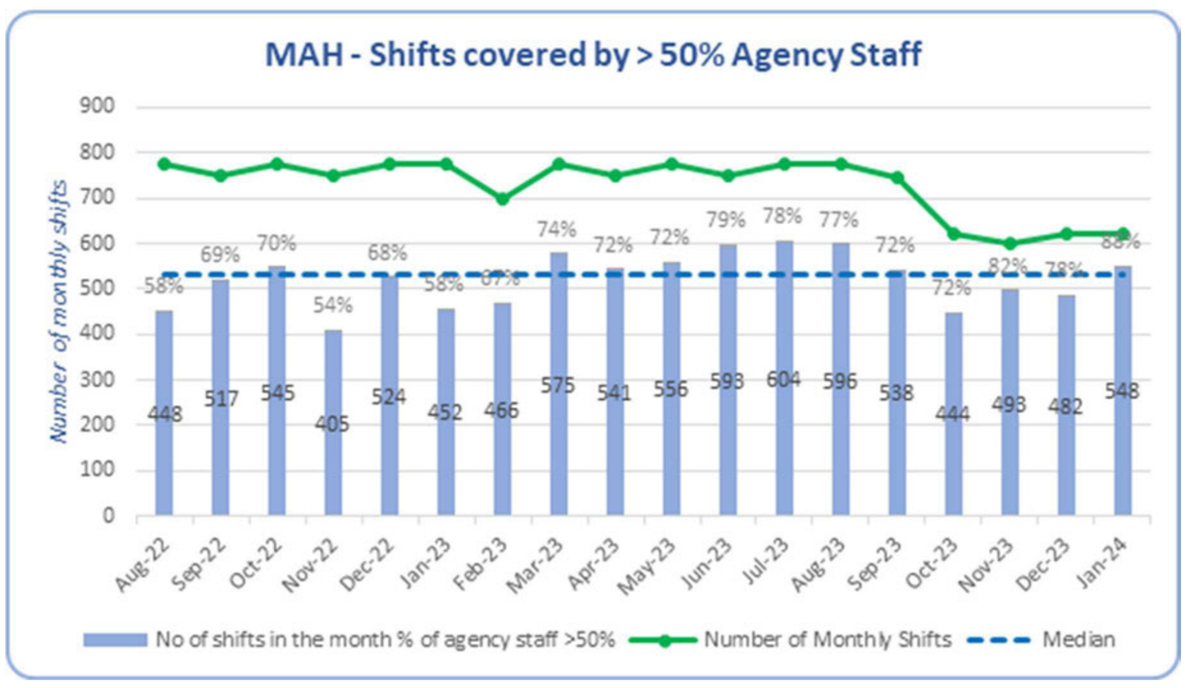
Nurse staff

4.1 The Trust have advised that there are four lead Nurses in post, and an out of hours Site Coordinator Senior Nurse is on site at the hospital with an on-call Senior Nurse Manager available.

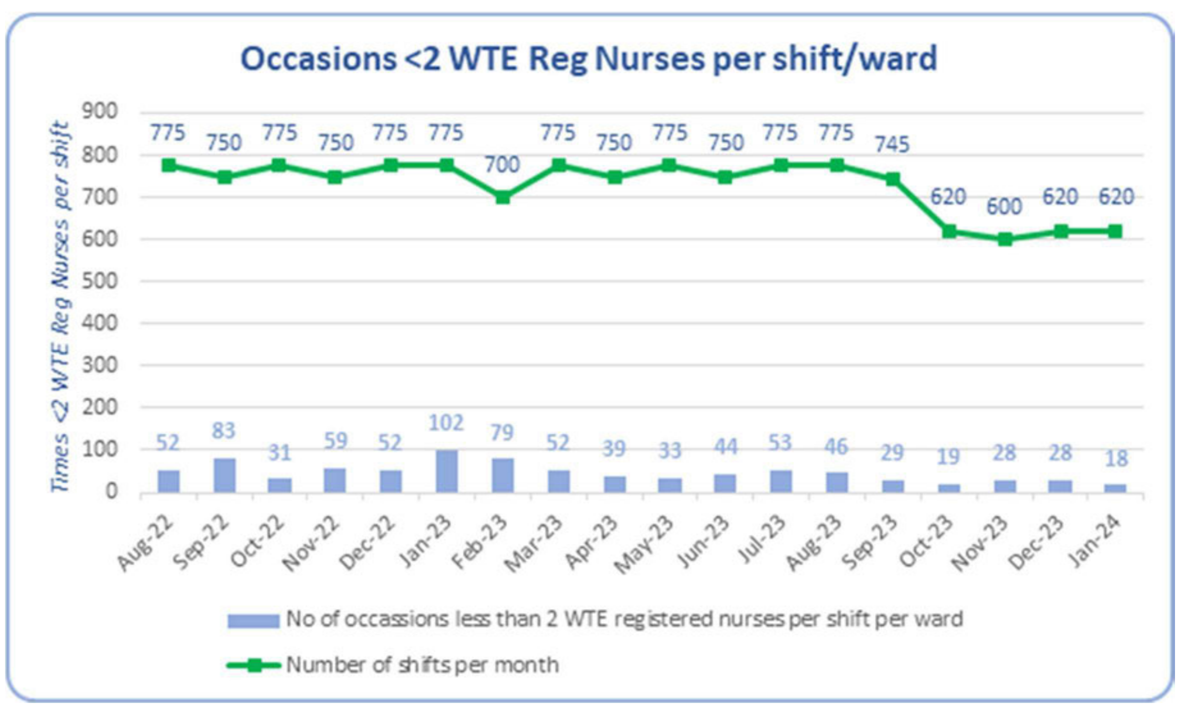
4.2 Month end workforce statistics demonstrate a slight reduction in the number of agency registrants and a reduction in the number of substantive senior nursing assistants, which is in line with the reduced patient population in MAH. The number of substantive BHSCT registrants has remained stable. All other disciplines have remained consistent. Daily and weekly monitoring is inplace.



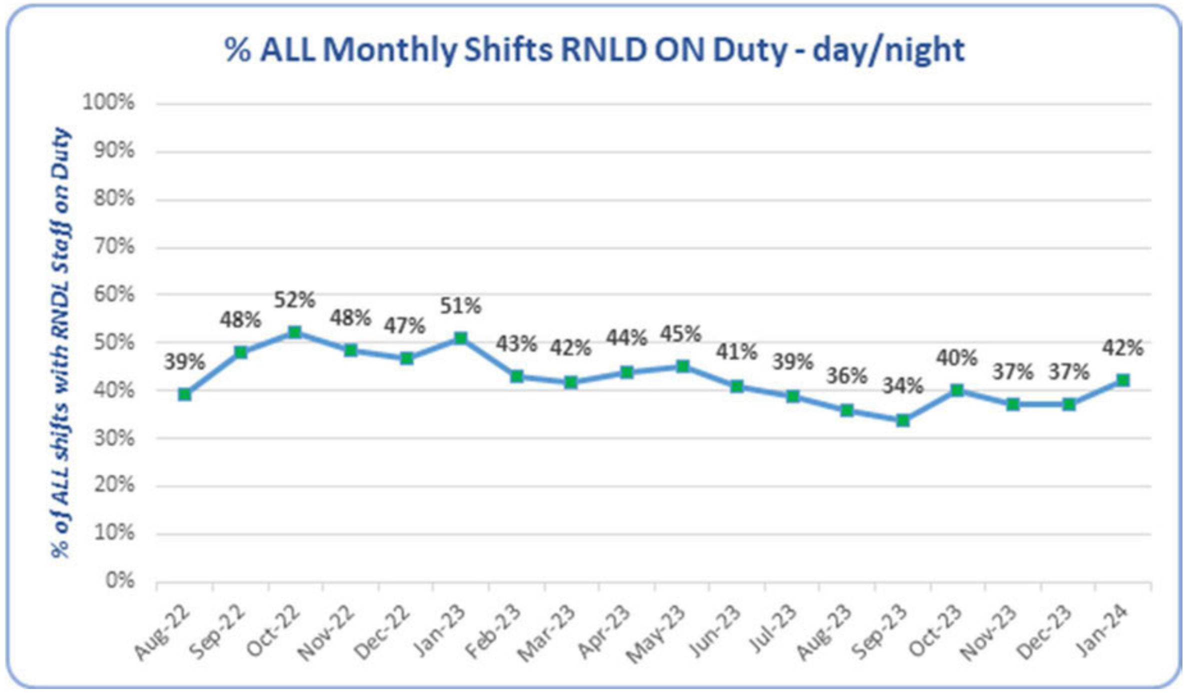
4.3 The number of shifts where there is more than 50% agency staff is currently over 70% of shifts in month, as set out in the table below.



4.4 The number of shifts with less than 2 RNs has continued to reduce. These instances are monitored through site wide staffing review and support from other wards.

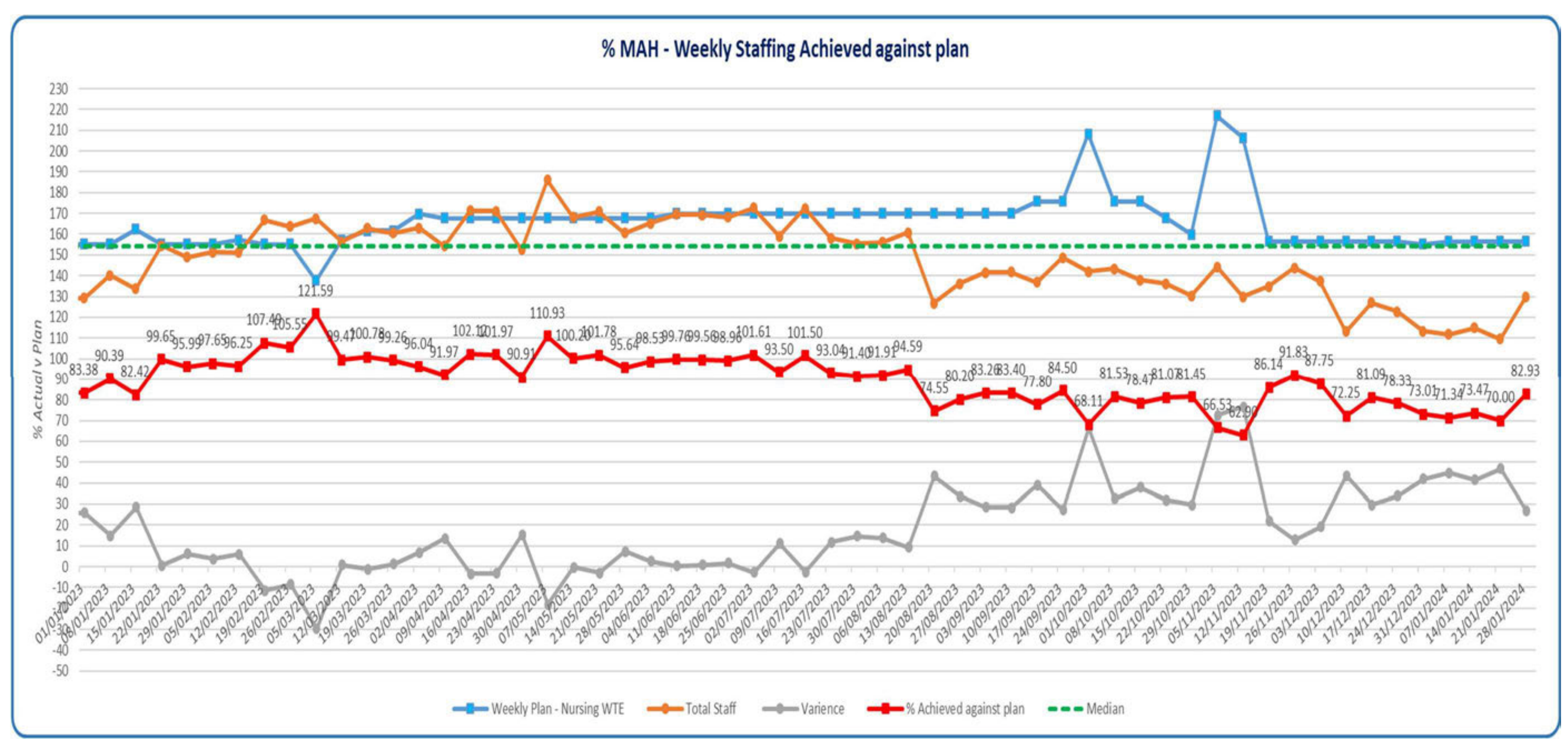


4.5 The number of shifts where an RNLD is on duty is currently approximately 34 - 40%, which is consistent with the number of RNLDs at Muckamore.



4.6 The Trust have advised that January staffing levels were 60 – 70% of safe staffing due to the impacts of the time of year, sickness and new admissions. For February and March staffing has stabilised and for these months between 98 – 120% of safe staff is being achieved (over 100% is to continue to facilitate outreach for resettlement). The corresponding chart is provided on the next page in order to enable the detail to be read.

Exhibit 7
MDAG/03/24



5. RQIA

5.1 The RQIA inspection which focused on incident management commenced on 19 July 2023 and concluded 29 March 2024 with verbal feedback provided to the Trust.

5.2 The purpose of the inspection was to assess the Trust's processes for learning from incidents at MAH and determine if the Trust have been compliant with the Regional Procedure for Reporting and Follow up of SAI's and the criteria for Early Alerts.

5.3 The inspection methodology included an audit and analysis of 398 out of 2,765 incidents and an onsite visit.

5.4 The inspection findings identified that the majority of incidents were managed appropriately, although some areas for improvement were identified. It is RQIA's view that these areas for improvement will support the Trust to strengthen the current processes.

5.5 The Trust have an action plan in place which is updated monthly.

5.6 In terms of next steps, RQIA will share the inspection findings with SPPG to consider scope for disseminating the learning regionally, and arrangements are underway to convene a meeting with SPPG. The inspection report will be issued to the Belfast Trust for a factual accuracy check, and once this is complete the Inspection Report will be published on RQIA's website.

6 Other Developments

MAH Closure

6.1 The Trust have advised that an organisational change process is in place in line with the organisational change policy, and drop-in sessions and 1:1 meetings for staff have been available throughout with Trade Unions. A formal process for redeployment of staff and decommissioning of the site is drafted and in progress.

6.2 The Belfast Trust have completed an Equality Impact Assessment (EQIA) on the process of the closure of the hospital. This has been published for consultation, with an easy read version, with a closing date for comments by the end of March 2024. The Trust have since extended the date for responses to the end of April 2024.

7 Communication with families

7.1 The Trust have provided an update on activity in relation to communication with families since the last MDAG outlining:

- The MAH Carer and Patient forum continues to take place bi-monthly with all Trust Assistant Directors to attend future meetings;

- Individualised resettlement meetings are in place and each individual will have a plan on a page from the responsible Trust that will outline the contingency for each patient in a personalised manner; and

- A visit to Muckamore is to be arranged for DoH staff.

8 MAH HSC Action Plan Update

8.1 Pending completion of the work being taken forward by the Learning Disability Task and Finish Group to develop the LD Strategic Action Plan, and the further development work on the Assurance Framework which is being progressed by NIPEC, this section of the Assurance Report continues to provide thematic updates on actions from the previous MAH HSC Action Plan. As previously advised, this remains under review with comments welcome from members.

8.2 Further to the open action point from the December 2022 meeting on the circulation of an overarching action plan for the Learning Disability Strategic Action Plan, monitoring of progress on all the remaining open actions in the HSC Action Plan is continuing with updates being sought from action owners in advance of MDAG meetings. Updates will be brought to MDAG for agreement where there are proposals to close any of the remaining open actions, or where the update provided by the action owner merits consideration by MDAG.

LD Strategic Action Plan Update

8.3 Throughout 2023/24, the Department has led on an exercise to finalise a service model for adult Learning Disability (LD), by establishing a Task & Finish group to develop an evidence base to inform how services would be delivered in the future. Draft outcomes, measures and actions were shared with Trusts and the independent sector in December 2023 for feedback to inform the next phase of this work and wider consideration.

8.4 A revised draft of the LDSM was endorsed by Trust Directors on 11 March 2024 and the Department is now moving to wider engagement around the Service Model (LDSM). It is critical that the LDSM is supported both by those who use and those who deliver LD services. An implementation plan will be developed throughout this Spring.

8.5 In parallel to this work, the Department's Strategic Planning and Performance Group are working closely with Trusts to undertake a financial review of adult learning disability services. The outputs of this work will inform decisions on the service model and long-term planning for adult learning disability services.

Independent Review of Acute Care services

8.6 The development of the CART will be progressed through the LD Service Model to enhance the continuum of Mental Health Services available for people learning disabilities and reduce pressure on acute beds.

8.7 Following further regional discussion at Learning Disability Director level, it has been agreed that a separate Regional Bed Management Protocol is required in respect of Specialist Learning Disability Beds. The Department, through SPPG, will progress this work at pace in conjunction with HSCT Learning Disability Assistant Directors.

8.8 SPPG have worked with HSCTs to develop a Learning Disability Dashboard for Specialist Learning Disability Beds. A pilot of the Learning Disability Dashboard is ongoing in one Trust at present. It is anticipated that pilot findings will inform next steps to support regional roll out of the Learning Disability Dashboard.

MAH Action Plan Update

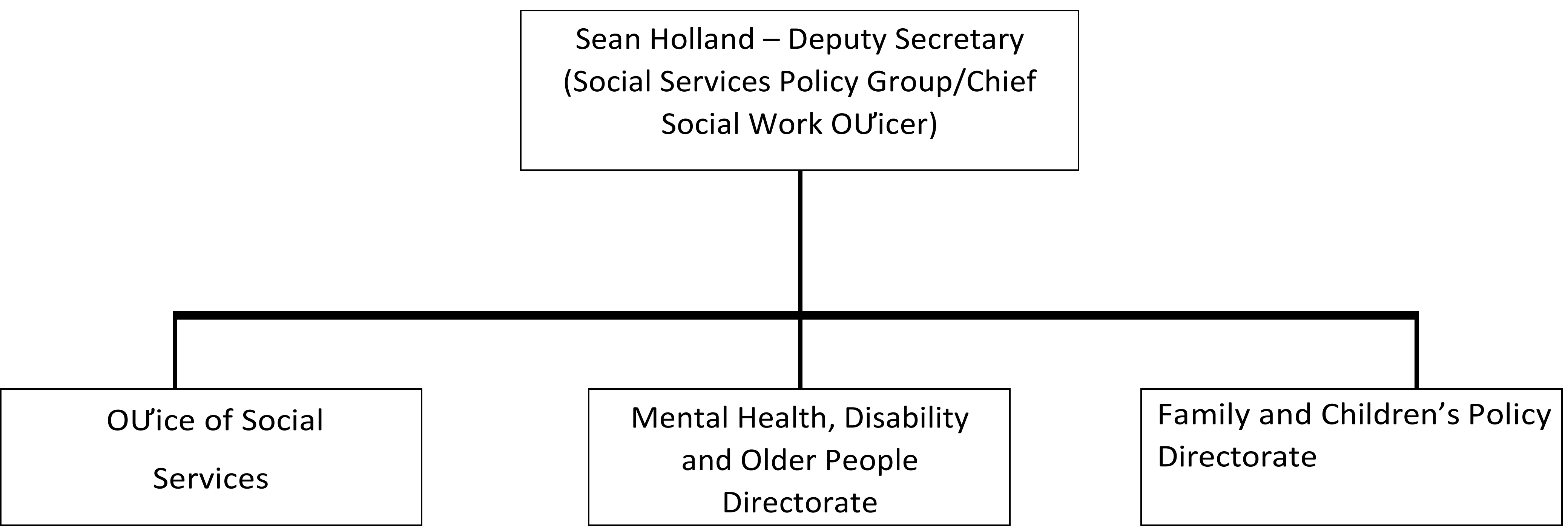
8.9 No further actions have been identified for closure since the last MDAG meeting. The position therefore remains as outlined in the Assurance Report circulated in February, i.e **14** of the **54** actions contained within the HSC Action Plan still remain open with **10** of these to be progressed as part of the wider work being taken forward by the Learning Disability Task and Finish Group. Progress reports on the open actions are commissioned from action owners in advance of MDAG meetings, and these will continue to be monitored and reported to MDAG.

Summary

8.10 MDAG members are asked to:

i) Note the updates provided in this report; and
ii) Provide any further comments on this revised assurance reporting format.

Social Services Policy Group/Chief Social Work OƯicer Group Structure (2014)



Strictly Private and Confidential

Muckamore Abbey Hospital
Update for Department of Health
19th January 2018

Background

This paper provides a further update on the actions and progress on matters relating to Muckamore Abbey Hospital.

It is important to highlight that there has been no further Adult Safeguarding (AS) incidents in Muckamore Abbey Hospital following examination of 25% of the CCTV footage, which focused on the period from August 2017 to October 2017 and all the contemporaneous CCTV footage.

Adult Safeguarding (AS)

The second multi-agency meeting took place on the 8th January.
The purpose of this meeting is to review and co-ordinate the relevant agencies actions in line with the multi-agency Memorandum of Understanding (2013) and the Adult Safeguarding Policy and Procedures (2016).

In attendance:

Belfast Trust Representatives
Detective Inspector, PSNI
Lead Inspector for Muckamore Abbey Hospital, RQIA
Deputy Chief Social Services Officer Department of Health
Deputy Chief Nursing Officer Department of Health
Public Health Agency
Health and Social Care Board
Head of Service Northern Trust

PSNI

The PSNI reported that they are progressing the staff interviews relating to the incidents previously reported from 12th August 15th August and 2nd October 2017, which meet PSNI thresholds The Officer advised that all incidents are likely to be progressed under ill treatment and neglect

rather than common assault. It is planned to complete police interviews by the end of January 2018.

BHSCT Adult Safeguarding Investigation

The Trust Adult Safeguarding Investigation consists of 2 categories.

- Members of staff alleged to have caused harm
- Members of staff who have failed to report incidents on 12/8/17, 15/8/17 and 2/10/17.

H425 who is leading The Adult Safeguarding investigation outlined all Joint Protocol and Trust Adult Safeguarding Incidents that are being investigated relating to:

- Incidents which occurred in August 2017 and October 2017
- Whistleblowing historical allegations, six of these relate to alleged incidents in the MAH swimming pool of which three have been "screened out" as it has not been possible to identify patients.
- The other three are subject to Adult Safeguarding investigations
- Social Media Posts-109 posts were placed on Belfast Live platform. They have been carefully and extensively examined with all possible leads followed up as far as is possible.

It is unlikely that these can be pursued due to lack of sufficient information.

The Trust has reviewed and improved information about how to access the Trusts Gateway Adult and Children's Safeguarding Service through the trusts Facebook page .In addition, work is underway to improve access to Adult and Children's Safeguarding on the Trusts website.

These investigations are being conducted by Adult Safeguarding staff from Belfast Northern and South Eastern Trusts. It was clarified that all of these incidents highlighted above will be included in investigative processes under one SAI and one PSNI category.

Time Line for Adult Safeguarding investigation

The Adult Safeguarding Investigation will require a further 6-8 months to complete and report on.

This includes a further stage that will involve interviewing all patients and relatives in the psychiatric intensive care unit and Six Mile ward to explore if they have any concerns about the care of their loved ones, which warrants further investigation. This may be extended to all wards.

Serious Adverse Incident Review

The panel for this fully independent review has now been appointed(carer appointment pending) and the Designated Review Officer at the HSCB has agreed the Terms of Reference. Work is now underway to organise the meetings and work of the panel. The panel have been asked to complete this work within six months. A final report will be produced as well as regular bulletins to ensure learning is highlighted in a continuous process

Chair/ Social Work

- Margaret Flynn Adult Safeguarding Expert .Margaret Flynn served as independent Chair of Lancashire's Safeguarding Adults Board and is a joint editor of the Journal of Adult Protection .She chaired the Steven Hoskins Serious Case Review and has chaired and written several influential reviews including Winterbourne.

- Professor Michael Brown /Nursing Professor of Learning Disability Queens University Belfast

- Dr Ashok Roy Consultant Psychiatrist Coventry and Warwickshire Trust Chair of Faculty of Intellectual Disability Royal College of Psychiatry

- Mr Bryce Mc Murray /Retired Director of Mental Health and Learning Disability Southern HSC Trust

- Identification of a carer for the panel is being pursued

It is planned that the team will commence in early February and will complete their work within six months

A teleconference meeting has taken placed with the HSCB Designated Review officer, the Chair of panel and Trust Corporate Lead and the Service Director.

Implementation of/and reviewing CCTV

Work is now underway to install CCTV in remaining wards and the swimming pool area of the Hospital Site.

The team have viewed 25% footage as previously advised to the Department and with the exception of the concerns reported there have been no further adult safeguarding concerns identified.

Contemporaneous viewing remains in place for all areas where CCTV is in place, reports are collated by the Senior Nursing Team and provided to the Co-Director and Service Managers. There have been no further Adult Safeguarding concerns.

The Trust intend to ensure viewing of all the CCTV footage from March 2017 as recommended by DOH colleagues. The Trust are currently in the process of identifying individuals who can view the CCTV footage who are independent of Muckamore MENCAP were initially approached however they were unable to support this.

The Trust wish to complete this CCTV in the shortest timescale possible. Individuals undertaking the viewing will be provided with guidance and protocols in terms of the viewing process, recording requirements and reporting and escalation processes.

RQIA

Previous Whistle-blower complaint received by RQIA

Patrick Convery Lead Inspector reported that RQIA had investigated concerns raised by a mother of a patient in the psychiatric intensive care unit. These concerns related to staffing levels, shift patterns and breaks. Patrick indicated that most of the issues were historical and that the mother was satisfied with the responses provided.

Both the Department of Health and Regional Health and Social Care Board colleagues present confirmed that they were assured by the comprehensive nature of the investigative processes.

Assurance

The Trust has now completed its appointment of an External Assurance/Support team which consists of the Trust Adult Safeguarding Specialist, Yvonne Mc Knight, Professor Owen Barr (Ulster University) and Frances Cannon (NIPEC).

The purpose of the Senior Project team is to provide an independent assurance to the Trust Director level Governance and Improvement Board in relation to the Learning Disability service area response to the serious safeguarding concerns in Muckamore Abbey Hospital.

This team will work with the senior management team in relation to specific areas of work agreed by the Directors Governance and Improvement Board.

Proposed priority areas

- Review of model of service delivery
- Review of advocacy arrangements
- Nursing staffing levels , skill mix ,training and education
- Review of enhanced monitoring
- Review of AS processes
- Review of viewing of CCTV

Directors Oversight Group

This group continues to meet weekly to review the Action Plan for Protection of Patients with the service management team, provide support and offer an “open door” to any staff member who wishes to speak to the Directors. Directors have also visited clinical areas.

The current action plan contains actions under the following headings

- Enhanced Monitoring
- Improving Staffing
- Communication
- Reflection and Learning
- Adult Safeguarding and Disciplinary Investigations.

All actions are reviewed and significant progress has been made with the majority of actions amber or green.

Many staff from all disciplines have taken the opportunity to speak to Directors and have shared their passion for the service as well as the frustrations and the complex issues they face daily. These issues are responded to where possible and others will feed into the wider debate on the reform needed in learning disability services particularly for those with significant challenging behaviours and severe autism.

The service has been in discussions with the HSCB and they have signalled their intention to re-establish the regional directors group to review the current commissioning framework.

Weekly Director Oversight meetings will continue until the end of January 2018 when this will be reviewed.

Trust Board

The service have provided reports to the Trust Board and the Trust Assurance Committee on the following dates

- Thursday 2nd November (verbal report)
- Written Report 14th November to the Trust Assurance Committee
- Written Report to Trust Board 7th December
- Written Report to Trust Board 11th January 2018.

A visit to Muckamore Abbey Hospital is being organised for Non - Executive Trust Board members. We would still wish to arrange a date for a visit to Muckamore Abbey Hospital by senior Department of Health officials.

Trust Officers continue to brief the Executive Team on weekly basis

Conclusion

All of the actions described in this paper and from our interactions with the clinical and managerial teams, the Executive Team are satisfied with the safety and quality of care of all patients currently residing in Muckamore Abbey Hospital.

MUCKAMORE ABBEY HOSPITAL – BHSCT MONTHLY UPDATE MEETING

KEY ACTION POINTS

10 APRIL 2019

DoH Attendees:
Jerome Dawson
Rodney Morton
Siobhan Rogan
Alison McCaffrey
Darren McCaw

BHSCT Attendees:
Marie Heaney

HSCB Attendees:
Valerie McConnell

Apologies:
Marie Roulston (HSCB)
Brenda Creaney (BHSCT)

Subject	Update	Person Responsible
Introduction	Jerome welcomed everyone to the first monthly update meeting of the group and commenced a round of introductions. Rodney introduced Siobhan Rogan, who has recently joined the Department and will be leading on the LD Nursing Review.	
RQIA Inspection – follow up/update/additional support requirements	Jerome advised that a further letter from the Department had been drafted following a meeting between Richard and the RQIA, but is still under consideration. Jerome also advised that a response to BHSCT would issue once the Department had responded to the RQIA. **AP1** Next MLA briefing due in May. It was noted that this may be affected by elections/purdah.	**J Dawson**
Governance Arrangements	To inform future advice to Richard on options for further scrutiny, it was agreed that earlier correspondence/commitments would be reviewed – in particular leadership and governance was highlighted as an	**J Dawson**

	outstanding issue during discussion. Jerome also indicated that he intended to discuss with PSNI. **AP2**	
Staffing Issues	Marie clarified recent Early Alert updates regarding further precautionary suspensions arising from CCTV viewing of Sixmile (one due to retire, others on sick leave bar one on mental health training who is now on enhanced supervision in Mater). She also advised that staffing remains a very difficult risk management task. Monthly written reports from BHSCT to continue. **AP3**	**M Heaney – to submit written report prior to monthly meetings**
PSNI Investigation	Marie advised that BHSCT is in the process of appointing a Project Manager to coordinate requests from PSNI relating to current and historical allegations, and continues to cooperate fully with the PSNI investigation.	
CCTV Viewing	Marie provided an update on CCTV viewing advising: • Less than 50% of the footage for Sixmile has currently been viewed; and • Contemporaneous viewing of footage continues each week.	
Disciplinary Processes (Trust and Professional Bodies)	Marie provided an update advising: • Material on all those on suspension have been referred to PSNI; • BHSCT keen to progress disciplinary processes for those who were bystanders, however PSNI consider them as potential witnesses and do not want BHSCT to progress until they complete their investigations; and • BHSCT are taking legal advice on potential options to proceed.	

Exhibit 10

Engagement with Families	Marie advised that: • BHSCT have appointed a Band 8A Trust liaison officer to support affected families who will work closely with the PSNI liaison officer. • A Carers consultant has also been appointed to work with all families (75 invited to recent meeting) to develop a new model of advocacy in Muckamore; • A Carers Oversight Committee, comprising 8 carers, was established 2 weeks ago and receive weekly governance reports; and • All affected families have been offered access to psychological/counselling support services. Alison referred to recent discussions with Counsel during which he emphasised the critical importance of support for/engagement with families and patients at this time, and going into the future. The role of PCC was discussed. BHSCT to follow up with PCC. **AP4** Valerie advised that the HSCB have a regional contract with the Law Centre (NI) and there was potential to make use of this as required. **AP5** Rodney referred to the Inquiry into Hyponatraemia Related Deaths (IHRD) advocacy workstream. Siobhan referred to recent research around the impact of trauma on LD population – seen as a major gap following Winterbourne. Valerie mentioned recent discussions with	**M Heaney** **V McConnell to circulate details** **HSCB to consider further**

	colleagues working on the Regional Trauma Network around this. This was considered important to reflect in the Muckamore Action Plan. **AP6**	
Meeting with Gavin Robinson – update and actions arising	Marie confirmed that a bespoke arrangement is to be put in place between the BHSCT families' liaison officer and Mr Father of P96 The Chair of the Trust would be writing to Mr Father of P96 with details. BHSCT to share a copy of the letter to Mr Father of P96 with the Department. **AP7** Any future FOI requests from Mr Father of P96 are to be redirected to Marie to be picked up and actioned directly.	**M Heaney**
Action Plans	Valerie circulated a 'to do list' of issues relating to the current delayed discharge population, and indicated that a draft paper was currently with Marie Roulston for consideration. It was agreed that this should be forwarded to the Department, quickly, to inform advice to Richard. **AP8** The potential for additional capital funding in 2019/20 was raised, and whether this could be channelled to the voluntary sector.	**V McConnell**
Iveagh – follow up	Notes of meeting to discuss RQIA letter to be checked to ensure all relevant actions were captured, and updates to be provided to Department as soon as possible to inform response to RQIA. **AP9** Marie advised that the mindset that people automatically move from Iveagh to Muckamore once they turn 18 needs to be addressed.	**R Morton** **HSCB/BHSCT**
AOB	Valerie advised that, further to recent discussions with Trust ADs, she had advised them that there was no more time available for workshops on the LD acute care and treatment review and that this work needed to proceed in order to meet the timetable set for completion.	

	Jerome provided an update on recent meetings with Mrs Blake, and referred to the draft ToRs for SAI Level 3 investigation sent recently by Richard Dixon (Mrs Blake's advocate). Marie to consider the detail and respond to Rodney, copied to Jerome. **AP10**	**M Heaney**
Date of Next Meeting	The next meeting will take place on 8 May 2019 in Marie Heaney's office, BHSCT.	

MUCKAMORE ABBEY HOSPITAL – BHSCT MONTHLY UPDATE MEETING

TABLE OF ACTION POINTS

AP No.	Meeting Date	Action	Person Responsible	Comments
AP1	10/04/19	A response to issue to BHSCT once the Department had responded to the RQIA.	J Dawson	
AP2	10/04/19	Discussion with PSNI to help inform detail on future options for scrutiny.	J Dawson	
AP3	10/04/19	Monthly written reports from BHSCT to be received in advance of update meeting.	M Heaney	
AP4	10/04/19	BHSCT to engage with PCC re role of PCC.	M Heaney	
AP5	10/04/19	Detail of HSCB contract with Law Centre (NI) to be circulated.	V McConnell	**Complete.** Received 10/04/19
AP6	10/04/19	Consideration re detail on Regional Trauma Network to be reflected in Muckamore Action Plan.	HSCB	
AP7	10/04/19	BHSCT to share copy of letter to Mr Father of P96 with the Department.	M Heaney	
AP8	10/04/19	Draft paper re delayed discharge 'to do list' to be shared with Department asap.	V McConnell	**Complete.** Received 10/04/19
AP9	10/04/19	Note of meeting to discuss RQIA letter to be checked for completeness and updates to be provided to the Department asap.	R Morton HSCB/BHSCT	
AP10	10/04/19	BHSCT to consider detail re SAI Level 3 investigation recently provided by PCC advocate and respond to the Department.	M Heaney	

Exhibit 11

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

For Information:
Distribution as listed at the end of this Circular.

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

   i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
   ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
   iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

   i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
   ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
   iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
   iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 3775
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

Exhibit 11

ANNEX A

☐ **Initial call made to** [ ] **(DoH) on** [ ] **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: [ ]

Contact details:

Email address (work or home) ……………………………………………………………………………

Mobile (work or home) ……………………………… Telephone (work or home) ……………………………

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ………………………………………… Office: ……………………………

Forwarded for consideration and appropriate action to: ……………………………… Date: …………………………

Detail of follow-up action (if applicable) ……………………………………………………………………

Exhibit 12
MDAG/06/23

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 26 April 2023

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Peter Toogood	DoH (Chair)	Maria McIlgorm	DoH
Mark McGuicken	DoH	Lynn Woolsey	DoH
Sean Scullion	DoH	Mary Emerson	PHA
Darren Strawbridge	DoH	Brendan Whittle	DoH (SPPG)
Darren McCaw	DoH (Note)	Aine Morrison	DoH
David Petticrew	DoH (SPPG)	Brother of P90	Family rep
Brenda Creaney	BHSCT	Margaret McNally	Family rep
Peter Sloan	Belfast Trust	Randal McHugh	DoH (SPPG)
Billie Hughes	Belfast Trust		
Tracy Reid	Belfast Trust		
Rachel Gibbs	South Eastern Trust		
Christine McLaughlin	Western Trust		
Jan McGall	Southern Trust		
Gareth Farmer	Northern Trust (agenda items 7 – 11)		
Mother of P77	Family rep		
Sister of P90	Family rep		
Siobhan Rogan	PHA		
Lynn Long	RQIA		
Meadhbha Monaghan	PCC		
Grainne Close	Mencap		
Elaine Armstrong	Cedar Foundation		
Mandy Irvine	NI British Psychological Society		
Gavin Davidson	QUB		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Peter Toogood welcomed everyone to the meeting and specifically Rachel Gibbs and Meadhbha Monaghan who were both attending their first MDAG meeting. Attendees were advised that Rachel was the new Director of Adult Services for the SEHSCT and that Meadhbha had replaced Vivian McConvey

as the Chief Executive of the PCC and as the PCC representative on MDAG.

2. Members were advised that apologies had been received from Maria McIlgorm, Lynn Woolsey, Mary Emerson, Brendan Whittle, Aine Morrison and Randal McHugh.

Agenda Item 2 – Minute of Previous Meeting

3. Peter Toogood noted that the draft minutes of the meeting held on 22 February had been circulated to members for consideration on 10 March. Following receipt of a number of comments, an updated version of the minutes had been published on the Departmental website on 6 April. There were no further comments on the minutes.

Agenda Item 3 - Update on Action Points

4. Peter provided an update on the open action points from previous meetings, starting with the actions from the February meeting. In relation to 22/02/AP1, attendees were advised that a total of six requests were received for an extension to submit a response to the MAH consultation. Short extension periods were agreed for the six and, from those six requests, five responses were then received as the RQIA decided not to submit a response. Of the five responses received, three of those were returned within a week of the initial consultation closing date of 24 January. The final response received was the engagement report from the PCC with this being received on 20 February, not 21 February as noted in MDAG/04/23. As a result of this update this action was now closed.

5. Regarding 22/02/AP2 and 22/02AP3, the Belfast Trust advised that additional detail had been added to their reporting material as requested. In response to 22/02/AP2, the total number of CCTV viewing shifts viewed each week now included in the Highlight report and the Trust added that it was hoped that this number of shifts would increase each week. This action was now closed. In relation to the detail in the 'Overall Incidents Totals identified by PSNI and Adult

Safeguarding' table, per 22/02/AP3, Tracy Reid confirmed that the 100% figure used related to the total number of incidents for review, and advised that this figure may change should more incidents be identified whilst the review was being carried out. The figures in the rows then underneath in the table provided a breakdown of the percentage and related numbers at each stage of the process. Tracy advised that the Trust was testing different options for the presentation of this information and would provide this for the next meeting of MDAG. Peter thanked Tracy and noted the content of the highlight report continued to evolve in support of the Group's assurance role.

6. In relation to 22/02/AP4, Peter confirmed that Mark McGuicken and David Petticrew had met with a number of current Muckamore inpatients, facilitated by TILII at the hospital on 27 March to hear their views on the future of the hospital. Mark McGuicken advised members that two of the patients they met expressed some reservations around resettlement particularly in relation to ensuring they were involved in the process; the other patient they met was in the process of being resettled and was very positive about the experience, although they highlighted some areas that could have been managed better. He added that the patients involved were keen to have their views heard on the future of the hospital, and after the meeting TILII had reiterated the request for direct patient involvement with MDAG and the Regional Resettlement Oversight Board.

7. Mark advised members that given the sensitivities around some of the issues discussed at MDAG, he had advised TILII that the PCC was represented on MDAG to present the patient voice. The potential for TILII to join the Regional Resettlement Oversight Board had been raised with the Chair of the Oversight Board and again, given the Oversight Board's role in overseeing the resettlement arrangements for individual patients, there were issues around protecting the confidentiality of those discussions. As an alternative, Mark proposed that he and David Petticrew would instead act as a conduit to continue to engage with TILII's to discuss MDAG and the Oversight Board, and sought members views on this proposal.

8. Meadhbha Monaghan highlighted that the PCC do not currently have a direct connection to patients at Muckamore and agreed that it was important to find a mechanism for the patients' voice to be heard at MDAG. Meadhbha, considered that the views of the family representatives and the other advocacy services represented on MDAG should help inform this. Grainne Close confirmed that Mencap were happy to be involved in consideration of this.

9. Sister of P90 agreed the importance of patient views being heard, and asked for clarity on the appropriateness of the discussion of individual patients' circumstances at MDAG meetings. Peter Toogood advised that MDAG was not an appropriate forum for discussions on issues relating to individual patients, as these should be raised with the responsible Trust. If however these issues pointed to broader systematic issues, then these would likely fall within MDAG's remit. Mark McGuicken agreed it was important that any discussions at MDAG should protect the confidentiality of individual patients' circumstances.

10. Following discussion, Peter requested that representatives from the Department, PCC, Mencap and Cedar consider this action further, and bring a proposed way forward to the next MDAG meeting.

11. In relation to the remaining open actions from the December meeting, Peter advised that progress on 13/12/AP2 and 13/12/AP3 was dependent on the work underway to develop the Learning Disability Strategic Plan. He noted this was not yet at a stage that would allow these actions to be addressed. Peter confirmed that these actions should remain open, pending further work on the Strategic Plan.

12. Finally, in relation to 13/12/AP4, Peter noted that initial work had been taken forward to remove some areas of duplication although more work was needed to streamline reporting mechanisms. He advised that work to support the Department's response to the Muckamore Abbey Hospital Inquiry had taken priority since the last meeting, so this action will remain open and be revisited at the next meeting.

Agenda Item 4 – RQIA Inspection Update

13. Lynn Long provided an update on the recent unannounced inspection on Muckamore in March 2023 advising that it had been an intelligence led inspection, informed by Early Alert activity and other information provided to the RQIA. The inspection had been carried out by a multi-disciplinary team over a three-week period and had been conducted over a range of time periods covering day, night and weekends.

14. In general terms, the findings of the inspection had indicated that patients were receiving a good level of care which was reassuring given the current pressures on staffing at the hospital. However, some issues in relation to staffing remained, and the RQIA were engaging with the Trust on work to address these.

15. A number of areas for improvement were identified including staffing, safeguarding and the general environment, and Lynn advised that commitments had been provided by the Trust that work would be progressed to address these areas.

16. Lynn confirmed that the RQIA had provided feedback on the inspection to the Trust on 6 April and that a draft report has been prepared, pending feedback from the Trust which was due to be received in the first week of May. Once this had been received and the report finalised, it would then be published on the RQIA website and shared with carers.

17. Members were also advised that the RQIA would continue to monitor the situation at Muckamore and that, following the inspection outcomes, an updated action plan would be submitted by the Belfast Trust.

18. Peter thanked Lynn for the update and members were reminded of the confidentiality of discussions at MDAG.

Agenda Item 5 – Update on Staffing Position

19. Peter Toogood drew attendees attention to the staffing updates contained in the Highlight Report that had been circulated with the meeting papers, and invited the Belfast Trust representatives to provide an update. Peter Sloan outlined that the nurse staffing position remained a challenge, however the Trust had maintained safe staffing levels since January. Brenda Creaney advised that the staffing position was stable at present with around 90% achievement of the staffing requirement, although 80% of these staff were agency staff. Brenda further advised that she appreciated the concern raised in the RQIA unannounced inspection report around agency staff, but highlighted that the agency staff had been working in Muckamore for some time and had developed relationships during that period. However, she acknowledged that they were temporary staff, and the situation remains fragile. Attendees were also advised that the Belfast Trust were planning to end off-contract agency staffing, although it had been agreed with the Department that this would not apply at Muckamore in the current circumstances.

20. Brenda also highlighted that a new Divisional Nurse had been appointed and had taken up post at the start of April. The postholder is an experienced nurse who has worked in learning disability services previously, and has also worked with Muckamore on staffing and rostering. Brenda also confirmed that the other senior nurses recently appointed by the Trust were now well embedded in the team.

21. In relation to the wider workforce, Peter Sloan advised that the medical staffing position remained challenging as the Trust had not yet been able to replace the two consultants who left recently. Currently there is one consultant on site and arrangements to maintain cover are also in place.

22. Peter Toogood thanked Peter and Brenda for the update and noted that whilst the staffing situation remains challenging, it was reassuring to hear mitigations were being put in place.

Agenda Item 6 – Safeguarding Audit Update

23. Darren Strawbridge updated members on progress, advising that as a result of continued engagement with the Belfast Trust the action pertaining to the Departmental ASG audit report action plan was now in a position to be closed with the ASG action plan remaining a live document for implementation by the BHSCT.

24. In response to a query from Peter Toogood on how the action plan would be monitored, Tracy Reid confirmed that the Trust had been providing updates to Aine Morrison and Darren Strawbridge throughout the action plan process and that the RQIA will include an assessment of Trust performance against the actions in their inspection arrangements.

Agenda Item 7 – Update on the MAH Public Consultation

25. Sean Scullion provided an update on the MAH public consultation confirming that six requests were received for short response extensions, in advance of the consultation closing on 24 January, as outlined earlier in the meeting. A total of 117 responses were received on the consultation by the Department.

26. Sean confirmed that the PCC had also facilitated 19 responses from their engagement activity and had provided the Department with a report summarising the key messages from their engagement.

27. Members were advised that responses had been received from a range of individuals and organisations including relatives and carers of current and past patients, former patients, patient representative groups, Trust staff, Trade Union Side, political parties, independent sector organisations, professional bodies and academics.

28. A summary of the key findings and themes from the analysis of the responses was also outlined for attendees, and these will be reflected in the consultation summary report.

29. Sean highlighted that advice on the way forward was now being prepared for the Permanent Secretary, in the continuing absence of a Health Minister. Once the Permanent Secretary had considered the advice and agreed a way forward the report would be published on the Departmental website and circulated to MDAG members.

30. Mother of P77 queried the likely timeframe for a decision to be made on the outcome of the consultation. Mark McGuicken advised that the expectation was that it would be within a matter of weeks.

31. Gavin Davidson queried the need for ongoing specialist responses, and whether some of these should be designated as hospital services. Mark McGuicken referred to the ongoing work in relation to the Learning Disability Strategic Plan, which was considering future service provision, including the level and location of assessment and treatment services. Mark confirmed that should a decision be taken to close Muckamore, it will be critical to ensure that an adequate alternative level of provision is developed to replace the assessment and treatment services currently being provided at the hospital. Sean Scullion noted that this was a clear message coming through responses to the consultation.

32. Peter Toogood advised members that, subject to consideration by the Permanent Secretary, they will be updated on progress.

Agenda Item 8 – Thematic Report Update (MDAG/04/23)

33. Peter Toogood advised that the Thematic Report Update (MDAG/04/23) had been circulated with the papers for the meeting, and noted that work on the actions on the development of the report and removal of any areas of duplication with the Highlight Report continued.

34. Darren McCaw provided a summary of the paper, including detail from the initial meetings of the Learning Disability Strategic Action Plan Task and Finish Group, with the third meeting of the Group due to take place at the end of June. Members were also advised that the number of patients that had been resettled since the Regional Resettlement Oversight Board began meeting in August 2022 remained at seven, and an outline was provided on the recent work of the Regional Workforce Review across Adult Learning Disability Services in relation to the draft analysis reports on the different elements of the workforce.

Agenda Item 9 – Highlight Report (MDAG/05/23)

35. Sean Scullion summarised the detail of the circulated Highlight Report (MDAG/0523), drawing the attention of members to the updates provided on Adult Safeguarding Referrals, which included detail on CCTV viewing and the associated processes for this, and family liaison activity. Sean also highlighted the additional information provided on Adult Safeguarding trend data at Section 2.1 of the report. Attendees were advised that a summary of the current inpatient population and progress on the individual resettlement schemes was also included the report at Section 1.1.

36. Sean also flagged the update on patient safety metrics in Section 2 of the report which set out trends from the safety dashboard and the current staffing position at Muckamore in Section 3, drawing attention in particular to the graph included on page 14 that provided a breakdown of the workforce at Muckamore by profession.

37. In relation to the workforce graph included on page 14, Mother of P77 queried why the data included did not include any information for March. Billie Hughes confirmed that, due to the way the information is gathered, there was a four-week data delay on staffing reporting.

Agenda Item 10 – AOB

38. No other business was raised.

Agenda Item 11 – Date of Next Meeting

39. Attendees were advised that the next MDAG meeting was scheduled for Wednesday 28 June 2023 at 2pm via videoconference.

Summary of Action Points – MDAG 26 April 2023

Ref.	Action	Responsible	Update	Open/ closed
No new actions were raised at this meeting.				

Adult Safeguarding Transformation Board Meeting

Monday 26 July 2021, 3:00pm

Minutes and Action Log

Members in attendance:			
Sean Holland	*DoH (Chair)*	Amanda Logan	*DoJ*
Kerry Loveland-Morrison	*DoH*	Aine Morrison	*DoH*
Mark Lee	*DoH*	Debbie Murray	*DoH*
Jillian Martin	*DoH*		
Brendan Whittle	*HSCB*		
Apologies:			
Anthony McNally - PSNI		Martin Quinn – HSCB	
Rosaline Kelly – DoH		Yvonne McKnight – BHSCT	
Anthony Harbinson – DoJ		Tom Cassidy – WHSCT	
Others in attendance:			
Philip Totten	*DoH*		
Kevin Myles	*DoH*		

1. Welcome and Apologies

Sean Holland welcomed everyone to the meeting and noted apologies from Anthony McNally (AMcN), Rosaline Kelly (RK), Anthony Harbinson (AH), Martin Quinn (MQ), Yvonne McKnight (YMcK) and Tom Cassidy (TC).

2. Minutes of previous meeting (28 June 2021)

SH accepted minutes of the previous meeting. All attendees agreed.

3. Adult Protection Bill Consultation – updates

Submission to Minister and letter to Justice Minister

Kerry Loveland-Morrison (KLM) outlined the focus of the Bill Team throughout July was seeking the DoH Minister approval of the draft Policy Proposals paper and, as raised at the previous board meeting, seeking the DoJ Minister's views on the aspects of the Proposals Paper that related specifically to Justice. The Justice Minister responded to propose an amendment on behalf of the PSNI, who noted that there was a duty on a number of bodies to cooperate with the Trusts but felt there should also be a duty to cooperate with them.

KLM asked the board members if they had any additional thoughts on the duty to cooperate, specifically, if any additional bodies should be included.

Aine Morrision (AM) suggested also including the Regulation and Quality Improvement Authority (RQIA), given their responsibilities under the joint protocol.

SH felt that the statutory duty was greater than having a role within the process and that the joint protocol did not meet this criteria.

KLM highlighted that the RQIA did not raise this issue during the engagement session with them. AM noted that in the past, Trusts have wanted RQIA to use their investigatory powers more regularly than they do currently.

Jillian Martin (JM) raised the possibility of also including the Office of Care and Protection (OCP) in the duty to cooperate.

SH suggested that the inclusion of RQIA and OCP under the duty to cooperate could be revisited at a later date and that the Bill Team should liaise with the sponsor branches of both bodies to ascertain whether this is something that could and should happen. KLM confirmed that further amendments would be possible and the Bill Team would approach the sponsor branches for RQIA and OCP.

Amanda Logan (AL) highlighted the PSNI's request for clarity around what their role will be in the process going forward. Kevin Myles (KM) noted that this would be included in the ongoing work of the Bill Team.

SH advised that current procedures in relation to HSC and PSNI joint working on child protection works well and would be a good model to follow for adult protection.

AM suggested the following amendments to the Policy Proposals:

- 'Prevention' Principle – consider adding wording to "always as safe as possible" to allow for risks that adults want to navigate themselves
- 'Empowerment' Principle – consider adding wording "led by the wishes of the adult"
- Remove reference to "Approved" in approved social workers

AM also suggested revisiting the lack of appeal within the Removal Order, and proposed that one should be included. KLM highlighted that this power is based on the Scottish powers and they only allow for appeals against Banning Orders JM was in agreement with AM. AM made the comparison to the Mental Health Order's admission for assessment and right to appeal. SH asked the Bill Team to look into Review Tribunal procedures and timings to see if appeals for Removal Orders would be feasible.

AM suggested that RQIA could provide input on where adults removed under a Removal Order could go.

AM raised the issue of whether volunteers should be included under the offences of ill treatment and wilful neglect. SH suggested that this could not be included as it had not been consulted on. ML highlighted that it could be raised during the Assembly Stages if necessary.

JM raised the point of unpaid family carers and benefit appointees as areas where financial abuse can take place due to the significant control they have over an individual's finances and could be considered under the offences for ill-treatment and wilful neglect.

SH confirmed that the actions for the Bill Team should not hold up progressing the draft Bill to the next stage (Executive approval to engage the Office of the Legislative Counsel). SH confirmed that members were content that the Policy Proposals could be signed off

subject to the inclusion of PSNI in the duty to cooperate and removal of reference to “approved” social workers.

Action 1 – Adult Safeguarding Unit to make final amendments to Policy Proposals (inclusion of PSNI in duty to cooperate and removal of references to “approved” social workers) and issue to Minister for final approval.

Action 2 – Adult Safeguarding Unit to carry out review of Review Tribunal procedures and timings to consider whether appeals for Removal Orders are feasible.

Action 3 – Adult Safeguarding Unit to engage with RQIA sponsor branch in DoH on (i) whether RQIA would want to / should be included in the duty to cooperate and (ii) RQIA input on potential locations to which adults could be removed under a Removal Order.

Action 4 – Adult Safeguarding Unit to engage with the Office of Care and Protection sponsor branch in DoH on whether OCP would want to / should be included in the duty to cooperate.

Action 5 – Adult Safeguarding Unit to retain list of potential issues for further consideration on the Bill. These are:

- **Duty to cooperate – add RQIA and Office of Care and Protection**
- **Liaise with Aine Morrison for clarification in wording of Principles –**
  - **Prevention – consider adding wording to “always as safe as possible” to allow for risks that adults want to navigate themselves**
  - **Empowerment – consider adding wording “led by the wishes of the adult”**
- **Appeal for Removal Order – consider whether appealing a Removal Order is merited and how realistic the timescales might be**
- **Offence of ill-treatment and wilful neglect –**
  - **Formal volunteers – consider applying the offence to formal volunteers**
  - **Informal non-paid roles – consider applying the offence to people in informal non-paid roles but with significant influence over the adult at risk (e.g. unpaid family carers, benefits appointees)**

4. Discussion: Initial Costings Estimate for Adult Protection Bill

KLM noted that submission to Minister included initial costings estimate which has been circulated to board members.

KLM highlighted that as the content of the bill becomes clearer the estimates will be clarified and a business case will be developed down the line.

AM highlighted her discussion with KM previously and noted the current figure for use of the powers is currently very high, although she appreciates this is an estimated figure at this point.

5. Discussion: Adult Safeguarding Policy 2015 – review document

KLM provided a recap of the paper brought to the board in the June meeting and noted the next step will be to look at the CPEA and OSS papers and engage with adult protection practitioners to discuss the current policy.

Anything that has not worked well will not be carried over to the new guidance.

KLM confirmed that another consultation would likely be required for this as well as engagement sessions.

6. Discussion: HSCB Interim Adult Protection Board (IAPB)

Brendan Whittle (BW) provided a recap of the most recent IAPB meeting, where he updated them on Adult Safeguarding Transformation Boards work and Deborah Hanlon presented (24 June).

BW confirmed that all IAPB sub-groups are now populated and that funding for the board secretariat has now come through.

The next step will be to recruit for the secretariat and have a meeting with all sub-groups in early autumn.

7. AOB

ML asked AM if there may be a potential read out from the Muckamore report at the next board meeting. SH suggested AM feeding in to the policy team with feedback from the report as well as the Interim Adult Protection Board.

AL highlighted a question from BBC relating to adult protection where an individual was held in custody due to a lack of available space. ML said he is aware of this and will discuss with AL after the meeting.

JM highlighted an ongoing issue of families and others using covert CCTV as evidence when bringing forward adult safeguarding queries and a lack of consistency with how Trusts are approaching it. SH suggested this may be a regional policy issue going forward.

ML highlighted a COPNI recommendation relating to CCTV and that any reference to CCTV within the Adult Protection Bill and relating guidance will need to be consistent with this.

Action 6 – Adult Safeguarding Unit to engage with DoH Muckamore Review Team (Maire Redmond) and Learning Disability Unit (Jerome Dawson) on actions being taken forward in relation to COPNI Report recommendation on CCTV.

8. Date of next meeting

SH thanked members for their participation and closed the meeting.

The next Adult Safeguarding Transformation Board meeting is on Friday 27 August 2021. Zoom details to follow.

Action Log from Board meetings

Action	Board date	Owner	Update
1. HSCB to update the Interim Adult Protection Board ToR and have further discussions with DoH re resource requirements prior to convening the Board's first meeting.	26 October 2020	Marie Roulston, HSCB	Updated ToR signed off. Discussions ongoing – 26 November 2020.
2. DoH to undertake pre-consultation engagement with COPNI and HSCT Directors (Adult and MHLD).	26 October 2020	Mark Lee & Lisa Trueman, DoH	Complete. LT reported to board at 26 November meeting.
3. DoJ to consider the draft consultation internally and feedback any comments to DoH.	26 October 2020	Anthony Harbinson, DoJ	No comments received from DoJ.
4. HSCB to develop Business Plan for Interim Adult Protection Board	26 November 2020	Marie Roulston, HSCB	Draft paper discussed at Board on 25 January 2021
5. HSCB to have discussions with Yvonne M and other relevant Board members to identify areas that could be progressed in the absence of an IAP Board meeting.	26 November 2020	Marie Roulston, HSCB	Complete
6. DoH to review definition of 'adult at risk and in need of protection' post consultation and seek OSS views.	26 November 2020	Mark Lee and Kerry Loveland-Morrison, DoH	Ongoing
7. DoH to draft business plan for Adult Safeguarding Transformation Board.	26 November 2020	Mark Lee and Kerry Loveland-Morrison, DoH	Draft paper discussed at Board on 25 January 2021.
8. Gauge stakeholder interest and organise stakeholder events.	25 January 2021	Mark Lee and Kerry Loveland-Morrison, DoH	Complete

9. Circulate to Board members a list of stakeholders contacted so far to gauge interest in online events.	25 January 2021	Mark Lee and Kerry Loveland-Morrison, DoH	Complete
10. Board members to consider list of stakeholders and suggest additional names/organisation by close of play 28 January 2021.	25 January 2021	Board Members	Complete
11. Ensure Adult Safeguarding and Adult Protection Board forward work plans align.	25 January 2021	Marie Roulston and Brendan Whittle, HSCB. Mark Lee and Kerry Loveland-Morrison, DoH	Complete
12. Board members to provide any additional comments before next Board meeting.	25 January 2021	Board Members	Complete
13. KLM to seek Ministerial approval to extend the consultation period by one month.	25 February 2021	Mark Lee and Kerry Loveland-Morrison, DoH	Complete
14. Approach relevant Unions, BASW and NI Social Care Council again asking whether they are interested in attending stakeholder events.	25 February 2021	Mark Lee and Kerry Loveland-Morrison, DoH	Complete
15. Report to Board on independent workforce engagement and provide the Board with a list of who will be represented on the sub groups.	25 February 2021	Brendan Whittle HSCB	Complete
16. Amend FWP to reflect consultation extension if approved by Minister Swann.	25 February 2021	Mark Lee and Kerry Loveland-Morrison, DoH	Complete

17. Adjust FWP timeframe for deliverables to stretch into next year.	25 February 2021	Kerry Loveland-Morrison, DoH and Brendan Whittle	Complete
18. Interim Adult Protection Board to rework wording to capture impact of changes and if there have been adult safeguarding improvements.	25 February 2021	Brendan Whittle HSCB	Complete
19. Scope/benchmark against existing legislation and highlight what is currently in place that could be underpinned or amended to relate to training	29 March 2021	Kerry Loveland-Morrison DoH	In progress
20. review existing powers in relation to access/visitation rights and ensure they are being used appropriately before reviewing further	29 March 2021	Brendan Whittle HSCB	
21. bring forward the issue relating to health care assistants delivering social care and propose to close the job description loophole that currently exists	29 March 2021	Kerry Loveland-Morrison and Rosaline Kelly DoH	In progress
22. Scoping exercise to be carried regarding independence of investigations. BW to raise joint protocols issue at his board and report back	29 March 2021	Brendan Whittle	In progress
23. Issue of pressure sores to be raised with PHA group	29 March 2021	Rosaline Kelly	Complete
24. Finalised Adult Protection Bill analysis paper to be brought to May board meeting	26 April 2021	Kerry Loveland-Morrison, DoH	Complete
25. Finalised GAANT Chart to be brought to May board meeting	26 April 2021	Kerry Loveland-Morrison, DoH	Complete

26. Policy papers on Power of Entry, power to access Financial Records, and Principles to be brought to the Transformation Board	26 April 2021	Kerry Loveland-Morrison, DoH	Papers on PoE and Access to Financial Records brought to May meeting. Paper on Principles brought to June meeting.
26. Engagement with SCIE in relation to Human Rights Framework aspect of the bill	26 April 2021	Kerry Loveland-Morrison, DoH Jackie McIlroy, DoH	In progress – issue being explored with Jillian Martin.
27. Consider appeals process for powers when bringing updated policy paper to next Board Meeting	28 May 2021	Kerry Loveland-Morrison, DoH	Complete
28. Consider any enhanced safeguards that could be applied to power to access financial records	28 May 2021	Kerry Loveland-Morrison, DoH	Complete
29. Get back in touch with Scottish Officials and ask for any further materials e.g. case studies or statistics they can provide to help with decision making process. AM to provide papers from previous discussions with Scottish Counterparts	28 May 2021	Kerry Loveland-Morrison and Aine Morrison, DoH	Complete
31. Issue consultation response from BASW to all Board Members for information	28 May 2021	Kerry Loveland-Morrison, DoH	Complete

32. Adult Safeguarding Unit to include in the next submission to Health Minster a letter to the Justice Minister asking for her consideration of the policy proposals for the Adult Protection Bill	28 June 2021	Kerry Loveland-Morrison, DoH	Complete
33. Adult Safeguarding Unit to make final amendments to Policy Proposals (inclusion of PSNI in duty to cooperate and removal of references to “approved” social workers) and issue to Minister for final approval.	26 July 2021	Kerry Loveland-Morrison, DoH	
34. Adult Safeguarding Unit to carry out review of Review Tribunal procedures and timings to consider whether appeals for Removal Orders are feasible.	26 July 2021	Kerry Loveland-Morrison, DoH	
35. Adult Safeguarding Unit to engage with RQIA sponsor branch in DoH on (i) whether RQIA would want to / should be included in the duty to cooperate and (ii) RQIA input on potential locations to which adults could be removed under a Removal Order	26 July 2021	Kerry Loveland-Morrison, DoH	
36. Adult Safeguarding Unit to engage with the Office of Care and Protection sponsor branch in DoH on whether OCP would want to / should be included in the duty to cooperate.	26 July 2021	Kerry Loveland-Morrison, DoH	
37. Adult Safeguarding Unit to retain list of potential issues for further consideration on the Bill. These are:	26 July 2021	Kerry Loveland-Morrison, DoH	

○ Duty to cooperate – add RQIA and Office of Care and Protection ○ Liaise with Aine Morrison for clarification in wording of Principles – ▪ Prevention – consider adding wording to “always as safe as possible” to allow for risks that adults want to navigate themselves ▪ Empowerment – consider adding wording “led by the wishes of the adult” ○ Appeal for Removal Order – consider whether appealing a Removal Order is merited and how realistic the timescales might be ○ Offence of ill-treatment and wilful neglect – ▪ Formal volunteers – consider applying the offence to formal volunteers ▪ Informal non-paid roles – consider applying the offence to people in informal non-paid roles but with significant influence over the adult at risk (e.g. unpaid family carers, benefits appointees)			

Exhibit 14

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Chief Executives of HSC Trusts

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH345

Date: 24 January 2020

Dear Colleagues

It has become increasingly clear to me through my engagements with family representatives of patients in Muckamore Abbey Hospital that mixed messages around the future of the Hospital are being shared with them causing a great deal of distress and uncertainty around their family members future. I feel that a number of issues in relation to the resettlement process now need to be clarified.

Firstly, it is important to stress that no policy decision has been taken to close Muckamore Abbey Hospital and messages to the contrary must not be communicated to either family representatives of patients or staff at the hospital.

Secondly, there is a policy, brought forward following the Bamford Review, that no-one should call a hospital their home. This is why we are progressing with the programme of resettlement by supporting people to live safely and sustainably in local communities. However, any planning for resettlement needs to clearly respect and take account of the views of patients, family members and carers whose knowledge and lived experience cannot be under estimated.

Finally, I have to emphasise that resettlement should not, and must not be pursued with disregard to the possibility of success. The decision to proceed with resettling a patient must be on a sound basis of expectation that a placement will succeed, the simple possibility that it might is not strong enough grounds to proceed with it. Placement breakdowns are very costly and very traumatic for both patients and their families and must be avoided if at all possible. I acknowledge that even the most well planned resettlement placement can break down but I would not expect this to be the norm.

I am asking you now to ensure that your staff in the Trusts are very clear about this communication to ensure that an accurate, consistent message is shared with patients, families and carers.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

cc: Charlotte McArdle

Circular Reference: HSC (F) 67/2012

Revised HSC Delegated Limits and requirements for Departmental / DFP approval

Date of Issue: 21st December 2012

For Action by:

Chief Executives, Directors of Finance, Litigation Managers of all HSC Bodies

Summary of Contents:

This circular sets revised delegated limits for HSC bodies

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Paula Shearer
Financial Policy, Accountability and Counter Fraud Unit
DHSSPS
Room D3, Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 9076 5689
paula.shearer@dhsspsni.gov.uk

Related documents:

DAO(DFP) 06/2012

Superseded Documents:

HSS(F) 31/2009

Status of Contents:
For information and action

DHSSPS website:

www.dhsspsni.gov.uk

Revised of HSC Delegated Limits and requirements for Departmental / DFP approval

1. DFP has issued guidance (DAO (DFP) 06/12) on the revised arrangements for Departmental delegations and the associated requirements for DFP approval. The guidance reminds organisations of the principles contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money and the requirement to ensure that the principles of appraisals are applied when expending resources. This is attached at Annex A and contains a full list of delegations.

2. This circular sets out the delegations between DHSSPS and Health and Social Care bodies. The table below summarises the main financial delegated limits for HSC bodies but must be read in conjunction with annex 2 of attached DAO for a full list of all delegated limits. This letter conveys delegated authority to commit and incur expenditure subject to the restrictions shown below and per annex 2 of attached letter. All proposed expenditure which is set to exceed the HSC delegated limit must receive the appropriate prior approval before commitment to spend.

Area of Delegation	HSC Delegated Limit	DHSSPS Delegated Limit
Use of External Consultants	£10,000	£75,000
Capital Expenditure (excluding hospital schemes)	HSC Board &Trusts - £500,000 BSO £250,000	£1,000,000
	PHA - £50,000	
	NIBTS - £200,000	
	Other HSC Bodies - £10,000	
Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure	HSC Board &Trusts - £500,000 BSO - £250,000 PHA - £50,000 NIBTS - £200,000 Other HSC Bodies - £10,000	£5,000,000
IT Projects	HSC Board; Trusts; BSO; PHA; £250,000	£1,000,000
	NIBTS - £200,000	
	NIMDTA - £20,000	

Area of Delegation	HSC Delegated Limit	DHSSPS Delegated Limit
	Other HSC Bodies - £10,000	
Gifts	£100	£100
Losses – write off of cash losses and cash equivalents, bookkeeping losses, exchange rate fluctuations, fruitless payments and constructive losses, property in stores or in use due to any deliberate act	£10,000	n/a*
Losses - Waived or Abandoned claims	£10,000	£100,000
Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances	£1,000 (pay) £500 (pensions)	£20,000
Overpayments - Foregoing the recoupment of overpayments of grants	Nil**	Nil**
Losses arising from failure to make adequate charges for the use of public property or services	Nil**	Nil**
Special severance payments	Nil**	Nil**
Compensation payments for Clinical Negligence (to include interim payments if overall settlement is expected to exceed delegated limits)	£500,000	£2,000,000
Compensation payments following legal advice (This would include all personal injury and public liability claims)	£25,000	£100,000
Compensation payments without legal advice	Nil	£10,000
Ex-Gratia Payments to be made as a result of a recommendation from the NI Assembly Ombudsman & NI Commission for Complaints	£10,000	£50,000
Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes)	£250	£500
Extra-Statutory and Extra-Regulatory payments	Nil	£100,000
Extra-Contractual and other Ex-Gratia Payments not covered above	£10,000	£100,000

* DHSSPS has full delegated authority

** Prior DHSSPS and DFP approval required in all cases

3. It is mandatory for HSC bodies to obtain prior Departmental approval for expenditure above those limits outlined above and per annex 2 of attached letter. Failure to obtain the required DFP approvals will result in regularity and

propriety issues. Any expenditure which falls outside a Department's delegated authority and which has not been approved by DFP is deemed irregular and could result in qualified accounts and investigation by PAC.

4. Where expenditure proposals exceed the Department's delegated limits, DFP Supply will act as the approving authority.

5. All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation **must** have Departmental and DFP approval before expenditure is committed.

Further Guidance

6. For further details on these categories of expenditure, including approvals procedures, HSC Bodies should refer to Managing Public Money Northern Ireland[1] and NIGEAE[2], as well as current Departmental finance guidance on:

- The use of professional services (including consultants)
- Losses and special payments
- Claims handling (including clinical negligence and personal injury litigation)
- Fraud
- Capital

Process for approval of expenditure

7. Any payments / expenditure that require Departmental approval must be submitted through Financial Policy and Accountability Unit, who will act as a single point of contact through whom all liaison with DFP on significant financial matters, including approvals, should be conducted. This is to ensure that appropriate Departmental approvals have been obtained and that regularity, propriety and VFM have been adhered to.

[1] http://www.dfpni.gov.uk/index/finance/afmd/afmd-key-guidance/afmd-mpmni.htm
[2] http://www.dfpni.gov.uk/eag

It has been agreed that the Director of HEIG will be the contact point for all such submissions concerning capital.

Should you have any queries please contact the following

Paula Shearer 02890 765689
Lorraine Clegg (Capital) 02890 522173

Action Required

8. HSC Bodies to note the requirements to obtain prior Departmental approval before committing expenditure outside the delegations conveyed by this letter. This circular should therefore be circulated as appropriate throughout your organisation, and schemes of delegation revised and updated accordingly.

Yours sincerely

PAULA SHEARER
Financial Policy, Accountability and Counter Fraud Unit

Exhibit 15

ANNEX A

Richard Pengelly
Public Spending Director

Central Finance Group
Room P6
Rathgael House
Balloo Road
BANGOR BT19 7NA
Tel No: 028 91858240 (x 68240)
Fax No: 028 91277078
email: richard.pengelly@dfpni.gov.uk
and jill.downie@dfpni.gov.uk

DAO(DFP)06/12

7 JUNE 2012

Dear Accounting Officer

DEPARTMENTAL DELEGATIONS/REQUIREMENTS FOR DFP APPROVAL

Purpose of this letter:

- **to replace DAO(DFP) 06/05 in the light of Managing Public Money NI (MPMNI) and other developments. DAO(DFP) 06/05 is hereby cancelled; and**

- **to set out the requirements that apply from the date of this letter for departments to obtain prior DFP approval before making commitments or incurring expenditure.**

Action:

Accounting Officers to note the requirements to obtain prior DFP approval and the delegations conveyed by this letter, some of which may differ from practice to date – and to take whatever action may be necessary to secure compliance. If departments consider that their particular circumstances warrant a change to the delegated arrangements under this DAO, they should raise the issue with their relevant DFP Supply Officer.

Scope of this letter

1. This letter relates to the delegated arrangements between DFP and departments, including their agencies. The principles contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money apply to all public expenditure, whether incurred by departments or other public bodies. The principles for approval and control described below also extend to NDPBs, North - South Bodies and or other public bodies, however it is for sponsor departments to agree specific individual arrangements for such bodies, subject to overall delegations to departments set out in Annex 2, and any specific DFP approval required.

Background

2. DAO(DFP) 06/05 set out the requirements in relation to departmental delegations and the associated requirements for DFP approval. This new DAO updates references and provides clarification on those areas requiring DFP approval for all Departments which are set out in Annex 2 of this letter. There are also specific delegations which DFP has agreed with individual departments and while these do not form an integral part of this letter, they will be sent directly to departments by their Supply Officer, and can be accessed on DFP’s AFMD website. The overriding guidance of financial management remains MPMNI which can also be accessed on the AFMD website.

Delegations

3. In practice, DFP has delegated to departments authority to enter into commitments and to spend within defined limits, subject to certain restrictions. Delegation arrangements are established with departments on the basis of criteria set out in MPMNI A.2.3.8 (reproduced as Annex 1).

4. This letter conveys delegated authority to commit and incur expenditure subject to the restrictions shown in Annex 2 i.e. departments have full delegated authority to commit and incur expenditure, except in relation to the areas listed in Annex 2, or as otherwise agreed with individual departments. The

delegations are also subject to the general requirement that DFP approval is always required for any proposal in any of the categories in MPMNI Box A.2.3.B (laid out in Annex 2).

5. From time to time, certain types of expenditure, other than those listed above, will require DFP approval. Departments will be informed of the conditions attached to such expenditure by DFP as appropriate.

6. The delegated limits identified in this letter and its annexes generally refer to central government expenditure i.e. any expenditure by a department or its Agencies, NDPBs or other sponsored bodies. Expenditure funded from other sources such as, for example, spending by District Councils and the private or voluntary sectors does not generally count when calculating whether a proposal is above or below delegated limits. For instance, if a capital project is to be funded partly by central government and partly by a private firm, it is only the central government expenditure that counts towards the delegated limit.

7. Delegation levels should be reviewed by both departments and DFP as to how they are operating. They can be changed, in the light of circumstances, with DFP approval.

Expenditure Appraisal and Evaluation

8. FD(DFP) 20/09 draws departments' attention to the Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), which contains DFP's core guidance on the appraisal, evaluation, approval and management of policies, programmes and projects. The principles of appraisal should be applied, with <u>proportionate</u> effort, to every proposal for spending or saving public money, or proportionate changes in the use of public sector resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

- involve capital or current spending, or both;
- are large or small;

- are above or below delegated limits.

9. Appraisal is a systematic process for examining alternative uses of resources. It is designed to assist in defining problems and finding the solutions which offer the best value for money. It is a way of thinking expenditure proposals through, right from the emergence of the need for a project through its implementation, to post-project evaluation. It is the established vehicle for planning and approving projects and other expenditures. Good appraisal leads to better decisions and use of resources. It facilitates good project management and project evaluation. Appraisal is not optional; it is an essential part of good financial management, which is vital to decision-making and crucial to accountability. But it must also be proportionate.

10. It is important to begin applying appraisal early in the gestation of any proposal which has expenditure or resource implications. The justification for incurring any expenditure at all should be considered. Appraisal should be applied from the emergence of a need right through to the recommendation of the most cost-effective course of action. It should not be regarded merely as the means to refine the details of a predetermined option.

11. It should be noted that delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

Implementation of delegated authority

12. This DAO restates a number of working arrangements which are intended to facilitate the efficient implementation of delegated authority and the achievement of accountability and value for money. They are part of the internal controls of a department and should facilitate an Accounting Officer in signing the Statement of Internal Control.

Management Arrangements

i. Departments should nominate a senior official, preferably the Departmental Finance Director, to assist in the discharge of all aspects of the delegation arrangements within the department. This official should act as a single point of contact through whom all liaison with DFP on significant financial matters, including approvals, should be conducted, unless alternative arrangements are agreed with DFP. Departments should inform DFP of the name and job title of this point of contact and notify DFP of any subsequent change.

ii. Expenditure above delegated limits generally requires specific DFP approval. The normal procedure for seeking DFP approval is to submit a suitable business case to the appropriate DFP Supply Division in accordance with the guidance in NIGEAE.

iii. All cases presented to DFP for approval must confirm that the department is content with the regularity, propriety and value for money of the project and the project has the necessary approvals within the departmental Accounting Officer's delegated arrangements. Where it is clear to DFP that a case has been submitted without proper departmental approval procedures being followed, the case will be returned without consideration.

iv. It should be noted that where DFP approval is required, expenditure should not be committed until DFP approval has been granted. Where DFP's approval has not been sought, DFP will not generally grant retrospective approval where the relevant expenditure has already been committed or the works have commenced.

v. The practice of consulting DFP informally during the course of development of a project is strongly encouraged, particularly where the project is deemed to be complicated, novel or contentious. However, such informed consultation does not remove the need for a department to formally submit the project for DFP approval if that is required. DFP

will not confirm its formal view of any proposal unless the department has provided confirmation of its Accounting Officer's view (under the responsibility of the Accounting Officer) on the regularity, propriety and value for money of the relevant proposed expenditure.

Appraisals and Post Project Evaluations

vi. All departments should ensure that their operating procedures and guidance on conducting economic appraisals comply with NIGEAE, are recorded in a Finance Manual, that this Manual is kept updated regularly, and that those who are involved in the economic appraisal process have access to it.

vii. The Departmental Finance Director should ensure that commensurate Post Project Evaluations (PPEs) are completed in accordance with the principles set out in NIGEAE that lessons learnt are shared within the department (and, where appropriate, with other departments). A copy of the PPE should be forwarded to DFP Supply if it formed a condition of the approval. Departmental Finance Manuals should ensure that appropriate procedures are established for PPEs.

Review of Processes

viii. Each department should carry out an annual review (independent of the spending areas) of the processes in relation to the appraisal of cases and PPEs that fall within its delegated limits, to ensure that the proper processes are being followed and the delegation limits set out in this DAO adhered to. If a department has evidence-based confidence in its internal controls, it may decide to implement a cycle of reviews, taking a different part of the department each year.

Review of Economic Appraisals/PPEs

ix. In addition to the annual review of processes described at (viii) above, departments should conduct ad hoc 'test drilling' of economic appraisals

and PPEs that fall (a) within their delegated limits and (b) within the delegated limits given to their sponsored bodies, to ensure that the appropriate appraisal standards have been applied in accordance with NIGEAE guidance and that decisions have been taken on a proper basis. The review should be undertaken independent of the spending area. A department may undertake a cycle of reviews concentrating on the higher risk areas. A report of the findings of the examination of individual cases should be provided by departments to the Departmental Accounting Officer and to DFP Supply on an annual basis, by 30 June each year. This should provide further assurance to the Departmental Accounting Officer in signing off the Annual Statement of Internal Control.

x. Departments should submit to DFP Supply a list of all appraisals above the level agreed with their Supply Officer. Supply may request a sample of those cases for review, to confirm the effectiveness of departments' control systems (in line with the criteria in MPMNI A.2.3.8). Any necessary corrective action identified should be implemented within an agreed timescale.

Conclusion

13. The delegated limits attached to this letter will be applicable with immediate effect. The content of this letter should be drawn to the attention of relevant staff in your department, agencies and other relevant sponsored bodies. Any queries should be addressed to John McGinnity on 028 91277687 (ext 69087) or your departmental Supply Officer.

RICHARD PENGELLY

ANNEX 1

Extract from Managing Public Money Northern Ireland (MPMNI) – A.2.3.8

Criteria for setting authorities

A.2.3.8 In establishing delegated authorities, DFP will:

agree with the department how it will take spending decisions (e.g. criteria and/or techniques for investment appraisal, project management and later evaluation);

establish a mechanism for checking the quality of the department's decision-taking (e.g. by reviewing cases above a specified limit, or giving full delegation but requiring a schedule of completed cases of which a sample may be examined subsequently); and

encourage delegation of authority within the department to promote effective financial management. In general, authority should be delegated to the point where decisions can be taken most efficiently. It is for the Accounting Officer to determine how authority should be delegated to individual managers.

ANNEX 2

AREAS REQUIRING DFP APPROVAL FOR ALL DEPARTMENTS

	Details	Reference
Where DFP approval (in writing) is required:		
Use of Resources		
1	Public statements which might imply a willingness on the part of the Executive to commit resources or incur expenditure beyond agreed levels	MPMNI Box A.2.3.A
2	Guarantees, indemnities or general statements of comfort which could create a contingent liability	MPMNI Box A.2.3.A
3	All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation	MPMNI Box A.2.3.A
4	Expenditure that could create pressures which could lead to a breach of: 1. Departmental Expenditure Limits (DELs); 2. resource limits or capital limits; or 3. Estimates provision.	MPMNI Box A.2.3.B
5	Expenditure that would entail contractual commitments to significant levels of spending in future years for which plans have not been set	MPMNI Box A.2.3.B
6	Legislation with financial implications as per guidance in MPMNI	MPMNI A.2.2.1
7	New services under the sole authority of the Budget Act	MPMNI A.2.5.15
8	Loans – on borrowing from the Northern Ireland Consolidated Fund for Contingencies	MPMNI A.2.5.9
Accounting Officers		
9	Appointment of the permanent head of each central government department to be its Accounting Officer	MPMNI 3.2.1
10	Appointment of an Accounting Officer for a Trading Fund (TF)	Financial Provisions NI Order 1993 and MPMNI 3.2.2
Internal Management		
11	Gifts – Giving any individual gift in excess of £100	MPMNI A.4.12.3
12	Insurance – Decision to purchase commercial insurance.	MPMNI 4.4.1 – 4.4.2
13	Losses – The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of	MPMNI Annex A.4

	Details	Reference
	public property or services - as per guidance in MPMNI	
14	Losses - Waived or Abandoned claims above £100,000	MPMNI A.4.10.2 & Box A.4.10.A
15	Losses - Special payments e.g. ex gratia over £100,000	MPMNI A.4.10.2 & Box A.4.10.A
16	Payments – Advance payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.5
17	Payments – Deferred payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.9
18	Payments - Special severance payments	MPMNI A.4.13.9
19	Payments – Financial Remedy Payments over £500 (ie payments made to complainants through an organisations internal complaints procedures/processes)	MPMNI A.4.14.8
20	Payments – Payments over £50,000 to be made as a result of a recommendation from the NI Assembly Ombudsman & NI Commission for Complaints	
21	Foregoing the recoupment of overpayments of pay, pensions and allowances over £20,000	MPMNI A.4.11
22	Foregoing the recoupment of overpayments of grants.	MPMNI A.4.11
Funding		
23	Banking – Proposals to open an account outside the pool or any proposed changes to Banking Pool arrangements	MPMNI 5.8.2 MPMNI A.5.7.3 MPMNI Box A.5.7.B
24	Banking – Requests for indemnities that commercial banks may seek to replace their normal arrangements	MPMNI Box A.5.7B
25	Borrowing from the Private Sector for all Arms Length Bodies (ALBs)	MPMNI 5.7.1
26	Borrowing on terms more costly than those usually available to government	MPMNI A.5.6.11
27	Borrowing – foreign borrowing	MPMNI A.5.6.12
28	Foreign Currency - Any proposals to negotiate contracts in foreign currencies other than the euro, yen or US dollar	MPMNI A.5.7.13
29	Income - Use of income and cash by departments to meet expenditure needs if there is no specific legislation	MPMNI A.5.3.1 MPMNI A.5.3.5
30	Income & Receipts - Increases to the amount that can be treated as an accruing resource during a financial year in order to finance a comparable increase in expenditure as per in-year monitoring/budgeting guidance	MPMNI A.5.3.8 MPMNI A.5.3.9
31	Letters of comfort	MPMNI A.5.5.18

	Details	Reference
32	Liabilities – Departments seeking statutory authority to accept liabilities	MPMNI A.5.5.5
33	Liabilities – Assuming statutory liabilities including the liabilities of any sponsored bodies in excess of £1 million for any single transaction	MPMNI A.5.5.14
34	Liabilities – Non-statutory guarantees and liabilities in excess of £100k	MPMNI A.5.5.11
35	Liabilities – Reporting a contingent liability in confidence by writing to the Chair of the PAC	MPMNI A.5.5.28
36	Liabilities – Departments should consult DFP about reporting a liability outside Assembly sessions during a dissolution	MPMNI A.5.5.34
37	Loans – proposals to make voted loans	MPMNI 5.6.1 MPMNI A.5.6.2
38	Loans – premature repayment	MPMNI 5.6.3 & MPMNI A.5.6.4
39	Loans – write offs	MPMNI 5.6.6 & MPMNI A.5.6.5
Fees, Charges and Levies		
40	Charges - Primary legislation to empower charging	MPMNI 6.2.1
41	Charges - Restructuring charges using the Fees and Charges (NI) Order 1988 No. 929 (N.I.8) in line with guidance in MPMNI	MPMNI Box 6.2
42	Charges - Public sector supplier moving away from full cost charging	MPMNI A.6.4.8
43	Interdepartmental Transactions – where the transaction may require legislative procedures or where DFP agreement is required under statute	MPMNI A.6.6.3
Working with Others		
44	Agency framework documents and the methods of financing an agency	MPMNI 7.4.2 & Box 7.2
45	All Management Statements and Financial Memorandums (MSFM) or other relationship documents	MPMNI 7.7.6
46	The establishment or termination of an NDPB	Public Bodies: A Guide for NI Departments
47	The establishment and operation of a Trading Fund including sources of capital	Financial Provisions NI Order 1993 and MPMNI A.6.6.3, MPMNI 7.5.4 & Box 7.3
48	Grants to Councils under the Local Government (Finance) Act (NI) 2011	Local Government (Finance) Act (NI) 2011
Other Delegations		
49	Wider market projects where the full annual cost	MPMNI A.7.6.6

	Details	Reference
	or aggregated annual income from such services exceeds, or is expected to exceed thresholds agreed by DFP	
50	Assets - Transfer or disposal of assets at less than best consideration reasonably obtainable	
51	Assets – to appropriate any sums realised as a result of selling an asset above the deminimis level in the DFP Budget/In-year Monitoring Guidance	
52	Assets – to allow an organisation to retain receipts arising from the sale of assets funded by grant or grant-in-aid above the deminimis level in the DFP Budget/In-year Monitoring Guidance	
53	Compensation payments without legal advice - Individual compensation claims settled out of court over £10,000.	
54	Compensation payments following legal advice - Individual compensation claims settled out of court over £100,000 where the legal advice is that the department will not win the case if contested in court	
55	Consultants – Expenditure on external consultancy projects over £75,000	FD(DFP)04/09
56	Consultants – Expenditure on external consultancy assignments co-funded by the Strategic Investment Board over £150k	Minute to Principal Finance Officers dated 19 April 2004
57	Estimates – form and content of Main and Supplementary Estimates.	Supply Estimates in Northern Ireland – A Guidance Manual
58	Virement	Supply Estimates in Northern Ireland – A Guidance Manual
59	Fraud – any departure from immediate reporting (not including National Fraud Initiative (NFI) for which separate arrangements have been agreed	FD(DFP) 04/11
60	IT projects over £1 million	
61	Land - Disposal of land at less than LPS valuation or Purchase of land at more than LPS valuation	
62	Capital Projects - All other expenditure on Capital Projects involving over £1million of Central Government expenditure unless other delegations specifically allow	
63	Projects - All PFI projects at key stages as stipulated in NIGEAE	NI Guide to Expenditure Appraisal and Evaluation MPMNI A.7.5.4

	Details	Reference
		FD(DFP) 20/09 FD(DFP) 17/11
64	Receipts – repayment of CFERs from the Northern Ireland Consolidated Fund	
65	Redundancy – All staff redundancy schemes not covered by existing regulations or which are more generous than existing NICS scheme.	
66	EU - All expenditure over £2 million under the EU Programmes for which the Special EU Programmes Body is responsible	Letter to Finance Directors & EUSG Members 2 March 2011
67	Pay Remits	FD Letter - Pay Remit Approval Process and Guidance

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Ref number	Details	Reference
Where DFP approval (in writing) is required:		
1	Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure over £5m.	
2	Third Party Development schemes for health and social care/ service provision.	
3	All grants/awards to the Voluntary and Community Sector: - Revenue Grants £100,000 per annum - Capital Grants £200,000	
4	Medical/Clinical Negligence settlements over £2m.	
5	Staff redundancy schemes.	
6	Provisions concerning appointment of officers.	Fire Services (NI) Order 1984
7	Doctors Qualifications.	HPSS Order 1972 Article 107(6)
8	Doctors Rights/Working Conditions.	HPSS Order 1972 Article 107(6)
9	Requirement to maintain list of Doctors/Dentists by Boards/Departments.	HPSS Order 1972 Article 107(6)
10	Terms of Service for Medical Professionals.	HPSS Order 1972 Article 107(6)
11	Prescription Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
12	Optical Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
13	Dental Charges.	HPSS Order 1972 Article 98 (2) Schedule 15

From: Hanna, Arlene
To: Crawford, Graeme; ONeill, Josephine
Cc: Morrison, Anna; McRobbie, Muriel
Subject: (COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)
Date: 07 January 2016 12:24:45
Attachments: image007.png
image018.png

Graeme

I refer to Mr Lyons' (MLA) correspondence to the Minister of 17th December 2015.

All allegations of this nature are fully investigated in accordance with Adult Safeguarding Policy and Procedures. This therefore applied to the allegations highlighted by Mr Lyons and these investigations were led by the Northern Health & Social Care Trust in partnership with the PSNI and Belfast Trust in accordance with the above requirements. None of the allegations were substantiated.

Unrelated to this correspondence the Belfast Trust is currently exploring the possible piloting of CCTV technology within a small number of wards at Muckamore Abbey Hospital commencing later this year. At present key stakeholders, including patients and their carers, are being consulted and detailed consideration is being given to the ethical and human rights issues associated with such an initiative including those relating to patient dignity, privacy and respect.

Let me know if you need any further information.

Regards

Arlene Hanna
Public Liaison Officer

Corporate Communication | Nore Villa | Knockbracken Healthcare Park | Saintfield Road | Belfast | BT8 8BH |
Tel: (028) 9504 **6802** | Email: arlene.hanna@belfasttrust.hscni.net

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From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 30 December 2015 11:12
To: ONeill, Josephine
Cc: Morrison, Anna; McRobbie, Muriel
Subject: RE: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Josephine
That's ok, grateful if you can forward by then.

Happy New Year.

Graeme

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

From: ONeill, Josephine [mailto:Josephine.O'Neill@belfasttrust.hscni.net]
Sent: 30 December 2015 11:06
To: Crawford, Graeme
Subject: RE: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Graeme
Unfortunately, due to staff leave, we are unable to respond to this COR until next week. I have been asked to seek an extension until 7 January.

Josephine

Mrs Josephine O'Neill
Public Liaison Service
Belfast Health & Social Care Trust
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9504 6871

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From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 30 December 2015 09:20
To: ONeill, Josephine
Subject: FW: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Josephine

Hope you had a good Christmas. Do you think the Trust response will be available later today?

Thanks
Graeme

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

From: ONeill, Josephine [mailto:Josephine.O'Neill@belfasttrust.hscni.net]
Sent: 22 December 2015 11:46
To: Crawford, Graeme
Cc: McRobbie, Muriel; Morrison, Anna
Subject: FW: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Graeme
I will get back to you.
Kind regards.

Mrs Josephine O'Neill
Public Liaison Service
Belfast Health & Social Care Trust
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9504 6871

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From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 22 December 2015 10:39
To: PublicLiaison-SM
Cc: McRobbie, Muriel; Morrison, Anna
Subject: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY
Reference: COR-1890-2015
Raised By: Gordon Lyons MLA
Subject: P27 – Muckamore Abbey Hospital

Dear colleague

The attached correspondence has been received in the Department for a reply and I would be grateful if you could provide a response.

Can you please provide this by noon on **Wednesday 30th December 2015**.

Many thanks

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

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EA 98/17 (Trust update) **RECEIVED 26/09/2017**

Initial call made to: Sean Scullion **(DHSSPS) on** 07/09/2017 **ATE)**

Follow-up Proforma for Early Alert Communication: UPDATE 22/09/2017

Details of Person making Notification:

Name: Mairead Mitchell

Organisation: BHSCT – EA/17/32

Position: Head of Service

Telephone: 028 95 047394

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation x***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

On 21st August 2017 adult safeguarding concern raised regarding alleged assault of patient in PICU ward Muckamore Abbey hospital on 12th August 2017. Named staff member was not on duty but was placed on precautionary suspension on 22nd August 2017 pending outcome of investigation. Patient examined 21st August no noted injuries. Delay in reporting noted and staff training records checked and up to date. Staff reminded of their responsibilities regarding timely notification of any adult safeguarding concerns. Referred to Designated Adult Safeguarding Officer and PSNI, single agency PSNI agency agreed. Interviews scheduled for week commencing 11th September 2017 due to officers leave.

Update (22 September 2017)

CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of CCTV footage.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Esther Rafferty

Contact details: Telephone (work or home) 02895047225

Mobile (work or home) RO1

Email address (work or home) esther.rafferty@belfasttrust.hscni.net

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the **'EarlyAlertNotificationMedDir'** mailbox.

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: .... Office: ....

Forwarded for consideration and appropriate action to: .... Date: ....

Detail of follow-up action (if applicable) ....

- RESTRICTED -

HIAI(76)C - TAB 6.

From the Permanent Secretary
Dr Andrew McCormick

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

To: Chief Executives Trusts (North & West Belfast, Down Lisburn, South & East Belfast, Homefirst, Armagh & Dungannon, Sperrin Lakeland, Foyle)

c.c. Board Chief Executives

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 9052 0559
Fax: 028 9052 0573
Email:
andrew.mccormick@dhsspsni.gov.uk

22 September 2006

Dear Chief Executive

SAFEGUARDING CHILDREN AND VULNERABLE ADULTS IN LEARNING DISABILITY HOSPITALS AND MENTAL HEALTH HOSPITALS

Information has emerged recently suggesting the possibility of sexual abuse of children and vulnerable adults, while inpatients in Muckamore Abbey Hospital. While this relates to incidents dating back some years, it remains essential that we have in place appropriate and proportionate procedures to prevent such abuse and to ensure that any incidents that may arise are dealt with properly and effectively. Hence I am writing to you as Chief Executive of your Trust to seek your formal assurance that:

- comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff;

- appropriate child and vulnerable adult protection procedures are in place with regard to the recruitment, supervision and management of staff;

- recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place, understood by staff and being adhered to; and

- all appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied.

Given the need to maintain the confidence of patients, their carers and families and the wider public, the Department needs to be assured that services are safe and where instances may have occurred in the past, patients and their carers have been appropriately supported. It is also vital that any risk of abuse that may have been perpetrated either by patients or staff has been appropriately identified and dealt with so as to minimise any further risk.

I would advise you that the Department has asked the Regulation and Quality Improvement Authority (RQIA) to provide independent assurance in this matter for inpatients of Learning Disability hospitals and Mental Health hospitals on a regional basis. RQIA is expected to complete this work programme by May 2007.

Due to the extended time period over which the initial allegations of abuse were made i.e. from the late 1950s, I would ask you to consider the need for a retrospective review of notes of inpatients.

Given that criminal offences may have occurred it would be necessary that any such review would be carried out according to a strict methodology agreed centrally with PSNI. Such a review has already been carried out by the EHSSB and the N&W Belfast Trust, and they would be willing to provide a process template for such a review should you consider it necessary.

I should also advise that the EHSSB and the N&W Belfast Trust will shortly be writing to you in relation to this matter, where the information collected to date has potentially identified the involvement of patients now resident within your Trust/Board area.

I would welcome your formal response by 31 October 2006 and I would thank you in advance for your co-operation in this sensitive matter.

Yours sincerely

DR ANDREW McCORMICK
Permanent Secretary

c.c. Other Trust Chief Executives
CE MHC
CE RQIA
David Sissling
Andrew Hamilton
Michael McBride
Paul Martin
Martin Bradley
Leslie Frew
Ian McMaster
Pat Newe

FROM: **Andrew Hamilton**

HIA1(76)C-TAB 5

DATE: **14 September 2006**

1. **Andrew McCormick** ***approved. I am writing to HPSS Chief Executives as indicated at paragraph 26 below. AGMcC 21/9***

2. **Paul Goggins**

ABUSE OF PATIENTS (BY OTHER PATIENTS) AT MUCKAMORE ABBEY HOSPITAL IN THE PERIOD 1960-1986

Issue:	**Allegations of sexual abuse of patients at Muckamore Abbey (Learning Disability) Hospital.**
Timing:	**Urgent.**
Presentational Issues:	**None at present, but there is a risk that imminent police enquiries could lead to negative publicity.**
Freedom of Information:	**Non-disclosable.**
Recommendation:	**You are asked to note the background to this case and the action currently being taken.**

Main issue

1. In December 2005 the Eastern Health and Social Services Board (EHSSB) settled a legal claim from a former inpatient (initials "P325") of Muckamore Abbey Hospital (Muckamore) who alleged that he suffered "personal injury loss and damage due to negligence, assault, battery and trespass of him". Correspondence on this legal claim began in November 2002 and normal legal processes were put in place by EHSSB and its solicitors. The potential wider implications only became apparent to the EHSSB in the autumn of 2005.

Background

2. Muckamore is the largest of the 3 hospitals for people with learning disability in Northern Ireland. It provides general learning disability services for both the Eastern and Northern Board populations as well as specialist regional services for forensic and challenging behaviours and for children and young people. It currently has some 280 inpatients but had considerably more over the extended period covered by the Reviews described below.

3. The patient (P325) was admitted to Muckamore in 1971 at just under 13 years of age by a Welfare Officer following a series of incidents in the community, school and family. He had been a victim of sexual assault prior to his admission to Muckamore. He alleged he was sexually assaulted, while in Muckamore, by two other patients and by two nurses and that these assaults were reported to medical and nursing staff on a number of occasions. However, he alleges the assaults continued.

4. The legal claim was withdrawn and the respective Senior Counsels negotiated terms of settlement which were agreed on 19 December 2005. These terms included a payment of damages, a payment for therapy provided to the Plaintiff, EHSSB using its best endeavours to assist the Plaintiff in respect of where he should live, and an agreement that these terms would remain confidential between the parties and their legal advisers.

Preliminary Fact Gathering Review

5. P325s medical and nursing notes were reviewed on a strictly confidential basis by nominated senior EHSSB and North and West Belfast HSS Trust (N&WB Trust) officers. They confirmed that the notes indicated that there were incidents reported and recorded of a sexual/homosexual type in respect of P325 In following up contacts identified in P325's notes, it was confirmed that similar incidents were reported/recorded in the notes of some other patients (both adults and children). Consequently the EHSSB and N&WB Trust Chief Executives commissioned a Fact Finding Review to determine if there was

any other relevant information relating to activity of a similar nature involving other patients in the care of the hospital in the 1970s and 1980s.

6. This initial Review was limited to an examination of the files of inpatients identified in P325s file and related contacts and was completed in December 2005. In total the Review encompassed an examination of 64 separate files. It found evidence of sexualised behaviour of a homosexual nature involving both young people and adults in which some patients were both victims and perpetrators. The earliest recorded incident dated back to 1960 and the latest record related to an incident in 1982. Fourteen individuals were identified and the matter was referred to the PSNI. Although P325 had originally alleged staff involvement in these events no evidence of any such involvement was found by the Review Team as part of this exercise.

Review of current practice and care within Muckamore Abbey Hospital

7. The EHSSB and N&WB Trust Chief Executives also commissioned a Review of current practice and care within Muckamore. The Review Report (completed in December 2005) has confirmed that relevant policies and procedures in relation to safeguarding children and the protection of vulnerable adults are in place. EHSSB and N&WBT have also welcomed the recommendations of the Review which are now being actively pursued and, when implemented, should offer further assurance to both the Trust and Board.

PSNI investigation

8. The results of the preliminary fact gathering review (Phase 1) were presented to PSNI in December 2005. PSNI analysed the information and classified it in the following way:

(a) Homosexual behaviour between adult and minor

(b) Homosexual behaviour between adult and adult (non-consenting)

(c) Homosexual behaviour between adult and adult (consenting/non-consenting)

(d) Homosexual activity – general – unknown parties

(e) Physical abuse allegations involving actual bodily harm.

9. In total 18 incidents of homosexual activity between adults and minors were identified and a further 6 incidents were deemed to represent non-consenting homosexual activity between adults. These incidents could be potentially pursued as offences.

10. A further 31 incidents across the remaining categories were identified but these do not constitute sex-offending offences under existing law.

11. Assistant Chief Constable, Sam Kincaid subsequently wrote to Andrew McCormick on 13 and 20 February 2006 with a number of issues he wished to be considered in relation to the clinical notes at Muckamore. Senior officials from DHSSPS, EHSSB, N&WB Trust and PSNI met on 23 February 2006 to discuss next steps. At that meeting the following action was agreed as Phase 2 of this Review:

(i) To undertake a fact gathering exercise of patient files for the period 2004/05 to 2005/06

This review would note any references to incidents of a sexual nature and note any actions taken in relation to these. The review would be directed at those wards deemed to be high risk in terms of sexually offending behaviours.

(ii) To undertake a further exercise, on a sample basis, of patient files for the period 1986/1987 to 2003/2004

This review would focus on patients deemed to be high risk and would take into consideration any organised movements of the patient population over the period. The review would also note any references to adverse incidents of a sexual nature and note any actions taken.

(iii) N&WB Trust investigation

Phase 1 of the Review identified that allegations were reported by the patient to N&WB Trust staff in 2002. This further investigation would look at whether those allegations were properly addressed.

(iv) DHSSPS action

The Department at an appropriate time would seek assurances from the wider HPSS regarding compliance with accepted procedures governing the care of vulnerable adults and children.

12. PSNI asked that there would be no press or public comments on the issues being examined and consequently it was agreed that this work should be taken forward by a small team of selected personnel in as discreet a way as possible.

Progress and results to date – Phase 2

13. Following the meeting on 23 February 2006 a Review Team of Senior Board and Trust Officers was established and included in its core membership – a lawyer, a Senior Social Work Professional with experience in Child Care and an experienced Nurse with specialist experiences in Child Protection.

14. Terms of reference were agreed and the Review Team redefined the focus of the fact gathering exercise into the following broad action points/groups of patients. This ensured that both the most vulnerable i.e. children/minors and those in high risk wards i.e. Forensic and Admission Wards were covered by this exercise.

    1. To review all files of "minors" presently classified as inpatients in Conicar (Children's Ward) for the period 1 April 2004-23 March 2006.

    2. To review all files of "minors" admitted to adult wards (Movilla A and Movilla B) for the period 1 April 2004-23 March 2006.

    3. To review all remaining files of "minors" admitted to Muckamore between February 1980-December 1986.

    4. To review all files of patients aged over 18 years of age who were inpatients in wards Mallow and Movilla (i.e. High risk wards) respectively on 1 April 2004.

    5. To review all files of new admissions to wards Mallow and Movilla respectively from 1 April 2004-23 March 2006.

    6. To review all files of patients named in records where instances of potential inappropriate behaviour(s) were noted in any of the case files reviewed as part of this exercise.

15. The Review Team, on conclusion of the fieldwork, and based on the PSNI risk framework developed a categorisation of the incidents which were found in the case files.

16. The categories are as follows and are denoted in order of seriousness and potential risk:

Category 1: Sexualised behaviour between Adult/Minor
Category 1(A): Sexualised behaviour between Minor/Minor
Category 2: Sexualised behaviour between Adult/Adult (Non-consenting)
Category 3: Sexualised behaviour between Adult/Adult (Consent unclear)
Category 4: Sexualised behaviour (Consenting)
Category 5: Suspected sexualised activity (General details unknown)
Category 6: Physical abuse involving actual bodily harm and above
Category 7: Sexualised behaviour – low significance
Category 8: Issues noted – dealt with thoroughly using recognised procedures.

Note: where more than 1 issue was identified in respect of an individual patient, the patient was placed in the most serious Category available to prevent double counting. However, this means that incidents of a lesser risk could also have occurred to that patient.

Summary of Findings of Phase 2 of the Review

17. The Review Team found that in all cases of sexualised activity which occurred in the 2004-2006 period all the appropriate procedures were deployed including Vulnerable Adult Procedures, communication with parents, next of kin etc, communication with PSNI, multi-professional involvement and the deployment of appropriate risk mitigation measures.

18. However, the Review Team also identified a number of incidents involving non-consensual sexual activity impacting on 41 patients. These included 8 Category 1 cases (6 new and 2 previously identified in Phase 1 of the Review involving sexual activity between adults and minors. Of these 8, 5 are still inpatients at Muckamore, 2 are deceased and 1 has been discharged. All of these incidents occurred between 30-46 years ago. A further 33 adult inpatients were identified as being involved in non-consenting sexual activity (i.e. Category 2 cases). A number of these incidents related back to the 1950s and 1960s. Given the nature of the patients served by Muckamore

such incidents present an ongoing risk. However, the Review Team are satisfied that from the late 1980s to the present such incidents, when identified, have been responded to appropriately.

19. The Review Team also found that there were a significant number of patients referred for admission to the hospital because of previously recorded sexually offending behaviours. On some occasions the request for admission was at the request of the Courts as an alternative to a custodial sentence in HM Prisons.

20. The Review Team are currently finalising their report and it is planned that the findings will be forwarded to the PSNI week beginning 18 September 2006. In all 277 records were examined by the Review Team and issues affecting some 118 people identified and categorised in the Table below:

Category	Description	Persons
1	Sexualised activity between adult/minor	8
1A	Sexualised behaviour between minors	3
2	Sexualised activity between adult/adult – non-consenting (most recent cohort of patients)	33
3	Sexualised activity between adult/adult – consent unclear	13
4	Sexualised activity - consenting	7
5	Suspected sexual activity – general details unknown	18
6	Physical abuse allegations involving actually bodily form and above	0
7	Sexualised behaviour – query significance	25
8	Issues noted, dealt with thoroughly using recognised procedures (Board/Trust category).	11
	Total	118

Further details are provided at Appendix 1. It should be noted however that the most serious Categories 1, 1A and 2 involved a total of 44 patients.

N&WB Trust investigation of 2002 Allegations

21. This element of Phase 2 of the Review has been initiated and is ongoing.

DHSSPS Action

22. Departmental officers have quality assured the processes adopted by the Review Team in their review of files at Muckamore. They found that the exercise was managed in the strictest confidence and appeared robust and thorough.

23. The nature of the exercise was that of a detailed fact gathering exercise and the Review Team were not asked to provide evaluative comment on how well the issues identified were addressed at the time.

24. We understand that the Review Team were of a mind to recommend that the case files should now be the subject of further independent quality assurance and professional comment sought on the adequacy or otherwise of the care regime provided and responses made, taking account of professional practice and the role of the hospital at the time. This issue was discussed at a recent meeting between the Board, Trust and Department and it was agreed that this would not be pursued at the present time, as the priority must be for the police to determine their approach once the full details of the latest file reviews have been made available to them.

25. In the interim, the Department has asked RQIA to provide independent assurance, as a priority, on the care afforded to vulnerable adults and children at Learning Disability Hospitals and Mental Health Hospitals and this will be scheduled into its forward work programme to be completed by end May 2007.

26. Given the nature of the detailed findings at Muckamore, the Department is also seeking formal assurances from Chief Executives regarding the current application of policies and procedures to safeguard Children and Vulnerable Adults in Learning Disability and Mental Health Services. Chief Executives will also be asked to consider the need for completion of a retrospective review of records, adopting the Muckamore methodology, for patients in the other Learning Disability and Mental Health hospitals in Northern Ireland.

Such a retrospective review would cover the period of the Muckamore Review.

Issues for the PSNI

27. We should highlight that the issues for PSNI will not be restricted to patient activity. Whilst this no doubt will be a significant focus for their interest, they will also be interested in whether there was any involvement of staff. Although the file review has not demonstrated any evidence of abuse perpetrated by staff, it is unlikely that patient records would have highlighted this. It cannot, however, be ruled out that testimony from victims may, as the police investigation ensues, lead to disclosures of this nature. PSNI have already indicated that because of the nature of the cases identified, staff who were thought to have played a role in this are to be treated as suspects rather than witnesses. They have also drawn attention to the obligation to report potential criminal activity to the PSNI under section 5 of the Criminal Law Act 1967.

28. PSNI have also emphasised that the case is unusual in that they have not been approached by the potential victims or their families and the 'complaint' as such has emanated from a third party. It is likely that as a result they will need to conduct 'clarification' interviews with the individuals and families concerned subject to the outcome of these there would follow a process of formal interviews leading to the production or otherwise of formal complaints and statements. It is our understanding that these 'clarification' interviews are scheduled to begin this month (relating to the incidents identified in the initial review of files in the P325 case). Prior to these interviews the EHSSB Chief Executive will alert the relevant Trust Chief Executives in the respective Trusts where those patients that it has been possible to trace are currently resident.

Recommendation

29. You are asked to note:

- the background to this issue;

- that the review of files/case notes at Muckamore has identified potential criminal sex-offending activity between adults and minors, and non-consenting adults in the 1960s to early 1980s, and that this information has been/is being brought to the attention of the PSNI;

- that a review of current policy and procedures at Muckamore has confirmed that relevant policies and procedures in relation to safeguarding children and the protection of vulnerable adults are in place and are operating satisfactorily;

- that the Department has commissioned an independent review of current practice from RQIA to be completed by end May 2007; and

- that the Department is seeking personal assurances from Chief Executives regarding the current application of their policies and practices regarding safeguarding children and the protection of vulnerable adults and asked them to consider the need for completion of a retrospective review of records for patients in the other Learning Disability and Mental Health hospitals over the same period as the Muckamore review.

30. A draft line to take should the matter emerge in the public domain is at Appendix 2 (we are currently clearing this with the PSNI, the EHSSB Board and the N&WB Trust.) Further information on planned PSNI action, together with the outcome of the personal and independent assurance sought will be provided when this becomes available.

ANDREW HAMILTON

cc Nigel Hamilton
Michael McBride
Paul Martin
Martin Bradley
Leslie Frew
Ian McMaster
Pat Newe
Phil Taylor

Appendix 1

Results of Review Group's File Review

Category	Description	Persons
1	Sexualised activity between adult/minor	8
1A	Sexualised behaviour between minors	3
2	Sexualised activity between adult/adult – non-consenting (most recent cohort of patients)	33
3	Sexualised activity between adult/adult – consent unclear	13
4	Sexualised activity – consenting	7
5	Suspected sexual activity – general details unknown	18
6	Physical abuse allegations involving actually bodily form and above	0
7	Sexualised behaviour – query significance	25
8	Issues noted, dealt with thoroughly using recognised procedures (Board/Trust category).	11
	Total	118

Category 1

In all cases these referred to incidents in the late 1960s-mid 1970s. Some of these patients would be classified as perpetrator, victim or both. There have been no other recorded incidents of this type, in all the case files examined. Of those patients to whom a Category 1 has been attributed, 5 are still inpatients in Muckamore, 2 are deceased and 1 has been discharged.

Category 1A

The Review Team found two incidents of sexualised activities involving 3 patients who were classified as "minors". These incidents occurred in 1978 and in 1980. All three of these patients have been discharged from the hospital some considerable time ago.

Category 2

The Review Team found a number of patients (33 in total) involved in incidents that were categorised as sexualised activity of a non-consensual nature. These incidents date back to the late 1950s and early 1960s. However, it is likely, given the nature of the patients served and the environment that there remains a risk. The Review Team are satisfied that from the late 1980s onwards such incidents have been responded to appropriately.

Category 3

13 adult patients were identified by the Review Team to be involved in sexualised behaviour, it was unclear from the records whether this behaviour was consensual.

Category 4

The Review Team identified 7 patients involved in sexualised activity where it was clear from the records that both parties had consented.

Category 5

18 patients were suspected to be involved in sexualised activity, the details were unknown or not recorded in the files.

Category 6

There were no recorded incidents of physical abuse involving bodily harm and sexualised behaviour.

Category 7

The Review Team identified 25 patients who displayed some form of sexualised behaviour e.g. inappropriate touching. In these cases the Review Team have queried the significance of that behaviour.

Category 8

In a further 11 cases the Review Team identified issues which were followed up with clearly documented evidence of investigation, involvement of appropriate parties and complying with recognised procedures.

ANALYSIS BY THE SPECIFIC GROUPS OF PATIENTS IDENTIFIED AT HIGHER RISK FOR PHASE 2 OF THE REVIEW

Group 1: To review all files of "minors" presently classified as Inpatients in Conicar Ward (Children's Ward) for the period 1 April 2004-23 March 2006.

Findings: 22 files examined; no issues were found in 21 case files: 1 file denoted sexualised behaviour between minors that was not significant in nature but well managed. This behaviour was instigated by one disturbed child and included attempting to kiss other patients and inappropriately touching staff. This behaviour was closely monitored by staff.

Group 2: To review all files of "minors" admitted to adult wards (Movilla A and Movilla B) to the period 1 April 2004-23 March 2006.

Findings: 5 files examined; no issues were found in 4 case files; 1 case file denoted sexualised behaviour which was well managed. An adult patient on the ward attempted to grab at the 'minors' groin area. All

minors in adult wards were on constant supervision, this involved having a designated nurse with them at all times.

Conclusions: Groups 1 and 2

In relation to patients classified as "minor" who were/are inpatients in the 2004-2006 period, the Review Team found very little of concern. Indeed, consistent with our interim findings in May 2006, there was substantial evidence of very good practice of robust supervision, multi-professional reviews, communication with parents and community based social work teams, regular LAC reviews and the application of behaviour management programmes. This was evidenced in case files from Conicar (children's Ward) and also in wards Movilla A and B.

Group 3: To review all remaining files of "minors" admitted to Muckamore between February 1970-December 1986.

Findings: 66 files examined; no issues were found in 57 case files; 9 case files denoted sexualised behaviour and have been categorised.

Category 2 – 2
Category 3 – 1
Category 5 – 5
Category 7 – 1

Conclusions: Group 3

These case files referred to "minors" who were inpatients during the period 1970-1986 with the majority of case files presenting no concerns. However, in 2 case files sexualised behaviour of a non-consensual nature was denoted, although both patients were classified as adults at the time of the stated incidents (Category 2). In 1 other file the issue of consent was unclear and similarly this patient had been classified as an adult at the time of the stated incident (Category 3). The remainder contained insufficient detail or were of low significance. (Category 5 and 7).

Group 4: To review all files of patients since admission who were aged over 18 years of age and who were inpatients in wards Mallow and Movilla respectively on 1 April 2004.

The files in this area were the most demanding as many of these patients have been in these wards for many years. These are the highest risk wards and patients are often placed here because of offending behaviour as Mallow is the Forensic Ward. Some patients may have been discharged (to hostels) and readmitted over the years. Some files dated back to the 1950s.

Findings: 52 files examined; no issues were found in 22 case files. The remainder have been categorised as follows.

Category 1 – 4

Category 2 – 12
Category 3 – 4
Category 5 – 3
Category 7 – 2
Category 8 – 5

Conclusions: Group 4

These case files referred to patients aged 18 years of age who are/were inpatients in wards Mallow and Movilla in April 2004. Of these case files 23 presented with no areas of concern. However, 16 case files were classified as either Category 1 or Category 2 findings. All 4 Category 1 findings relate to patients who have been inpatients for a considerable period some dating back to the late 1950s and the incidents noted are recorded as occurring in the 1960s and 1970s (1 of these patients had previously been identified in Phase 1). In the remaining 12 of these case files the Review Team are of the opinion that the sexualised activity was non-consensual in nature.

Group 5: To review all files of new admissions to wards Mallow and Movilla respectively from 1 April 2004-23 March 2006.

Findings: 64 files examined; no issues were found in 46 case files; 18 case files have been categorised below. 15 of these denote incident(s) of low significance; 2 include little or no detail of the incident(s).

Category 3 – 1
Category 5 – 2
Category 7 – 10
Category 8 – 5

Conclusions: Group 5

The case files examined related to new admissions to wards Mallow and Movilla respectively in the period 1 April 2004-23 March 2006. Of these records 46 case files presented no concerns, 2 files contained references to sexualised activity but lacked sufficient detail on which to base a firm opinion and 1 remained unclear in terms of consent.

Group 6: To review all files of patients named in records where instances of potential inappropriate behaviour(s) were noted in any of the case files reviewed as part of this exercise.

This was the process by which the Review Team ensured that any patient names identified in any of the Groups examined which referred to sexualised activity were logged and the files for those patients were scrutinised using the framework developed.

Findings: 68 files examined; no issues were found in 9 case files; the remaining 59 have been categorised as follows:

Category 1 – 4
Category 1(a) – 2
Category 2 – 19
Category 3 – 7
Category 4 – 7
Category 5 – 7
Category 7 – 12
Category 8 – 1

Conclusions: Group 6

68 case files were examined in detail and 4 cases were classified as Category 1 (1 of these patients had previously been identified in Phase 1) with a further 2 case files classified as Category 1(A). A further 19 case files denoted sexualised activity which the Review Team considered was non-consensual.

Appendix 2

DRAFT LINE TO TAKE – IF ISSUES IDENTIFIED COME INTO THE PUBLIC DOMAIN

A recent review of aspects of care provided to patients at Muckamore Abbey Hospital reaching back to the 1950s and 1960s has identified a number of cases of suspected abuse of patients by other patients. The PSNI have been informed of the review.

These cases relate to matters many years ago. A review of current practice and procedures at the hospital has confirmed that relevant policies and procedures in relation to safeguarding children and the protection of vulnerable adults, reflecting current best practice, are in place and are operating satisfactorily.

The Department has sought assurances from Chief Executives of other Trusts that best practice policies and procedures are in place at their institutions and are being adhered to, and has asked the RQIA to provide independent assurance in this regard.

Exhibit 18

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Appendix 1

Results of Review Group's File Review

Category 1

Through Phase 2 work the review group have classified the activities of 8 patients as Category 1 ie Sexualised activity between adult/minor which by virtue of this classification is deemed to be non-consensual (2 of these patients had already been identified in phase 1). In all cases these referred to incidents in the late 1960's-mid 1970's. Some of these patients would be classified as perpetrator, victim or both. There have been no other recorded incidents of this type, in all the case files examined.

Any Category 1 sexualised behaviour recorded occurred between 30 and 46 years ago.

Of those patients to whom a Category 1 has been attributed, 5 are still inpatients in MAH, 2 are deceased and 1 has been discharged.

Category 1a

The review group found two incidents of sexualised activities involving 3 patients who were classified as "minors". These incidents occurred in 1978 and in 1980. All three of these patients have been discharged from the hospital some considerable time ago.

Category 2

The review group found a number of patients (33 in total) involved in incidents that were categorised as sexualised activity of a non-consensual nature. Again, some of these incidents dated back to the late 1950's and early 1960's.

Category 3

A further 13 adult patients were identified by the review group to be involved in sexualised behaviour, it was unclear from the records whether this behaviour was consensual.

Category 4

The review group identified 7 patients involved in sexualised activity where it was clear from the records that both parties had consented.

Category 5

18 further patients were suspected to be involved in sexualised activity, the details were unknown or not recorded in the files.

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Category 6

There were no recorded incidents of Physical abuse involving bodily harm and sexualised behaviour.

Category 7

The group identified 25 further patients who displayed some form of sexualised behaviour eg touching. In these cases the group have queried the significance of that behaviour.

Category 8

In a further 11 records the group identified issues which were followed up with clearly documented evidence of investigation, involvement of appropriate parties and complying with recognised procedures.

More detailed analysis by the groups of patients identified for the Phase 2 review

This section analyses the full categorisation of the review group's findings in each of the patient groups which were actioned in this review.

Action Point 1

"To review all files of "minors" presently classified as Inpatients in Conicar Ward (Children's Ward) for the period 1 April 2004-23 March 2006 – 22 files".

Findings: No issues were found in 21 case files: 1 file denoted sexualised behaviour between minors that was not significant in nature but well managed. This behaviour was instigated by one disturbed child and included attempting to kiss other patients and inappropriately touching staff. This behaviour was closely monitored by staff.

Action Point 2

"To review all files of "minors" admitted to adult wards (Movilla A and Movilla B) to the period 1 April 2004-23 March 2006 – 5 files".

Findings: No issues were found in 4 case files; 1 case file denoted sexualised behaviour which was well managed. An adult patient on the ward attempted to grab at the 'minors' groin area. All minors in adult wards were on constant supervision, this involved having a designated nurse with them at all times.

Conclusions: Action Points 1 and 2

In relation to patients classified as "minor" who were/are inpatients in the 2004-2006 period, the review group found very little of concern. Indeed, consistent with our interim findings in May 2006, there was substantial evidence of very good practice of robust supervision, multi-professional reviews, communication with parents and community based social work teams, regular LAC reviews and the application of behaviour management programmes. This was evidenced in case files from Conicar (children's Ward) and also in wards Movilla A and B.

Action Point 3

"To review all remaining files of "minors" admitted to MAH between February 1970-December 1986 – 66 files."

Findings: No issues were found in 57 case files; 9 case files denoted sexualised behaviour and have been categorised.

Category 2 – 2
Category 3 – 1
Category 5 – 5
Category 7 – 1

Conclusions: Action Point 3

In relation to action point 3, these case files referred to "minors" who were inpatients during the period 1970-1986, the majority of case files presented no concerns. However, in 2 case files sexualised behaviour of a non-consensual nature was denoted although both patients were classified as adults at the time of the stated incidents (Category 2). In 1 other file the issue of consent was unclear and similarly this patient had been classified as an adult at the time of the stated incident (Category 3). The remainder contained insufficient detail or were of low significance. (Category 5 and 7).

Action Point 4

"To review all files of patients since admission who were aged over 18 years of age and who were inpatients in wards Mallow and Movilla respectively on 1 April 2004 – 52 files".

The files in this area were the most demanding as many of these patients have been in these wards for many years. These are the highest risk wards and patients are often placed here because of offending behaviour as Mallow is the Forensic Ward. Some patients may have been discharged (to hostels) and readmitted over the years. Some files dated back to the 1950's.

Findings: No issues were found in 22 case files. The remainder have been categorised as follows.

Category 1 -4

Category 2 – 12
Category 3 – 4
Category 5 – 3
Category 7 – 2
Category 8 – 5

Conclusions: Action Point 4

These case files referred to patients aged 18 years of age who are/were inpatients in wards Mallow and Movilla in April 2004. Of these case files 23 presented with no areas of concern. However, 16 case files were classified as either Category 1 or Category 2 findings. All 4 category 1 findings relate to patients who have been inpatients for a considerable period some dating back to the late 1950's and the incidents noted are recorded as occurring in the 1960's and 1970's (1 of these patients had previously been identified in phase 1). In the remaining 12 of these case files the review group are of the opinion that the sexualised activity was non-consensual in nature.

Action Point 5

"To review all files of new admissions to wards Mallow and Movilla respectively from 1 April 2004-23 March 2006 – 64 files".

Findings: No issues were found in 46 case files; 18 case files have been categorised. 15 of these denote incident(s) of low significance; 2 include little or no detail of the incident(s).

Category 3 – 1
Category 5 – 2
Category 7 – 10
Category 8 – 5

Conclusions: Action point 5

This action point centred on new admissions to wards Mallow and Movilla respectively in the period 1 April 2004-23 March 2006. Of these records 46 case files were of no concern, 2 files contained references to sexualised activity but lacked sufficient detail on which to base a firm opinion and 1 remained unclear in terms of consent.

Action Point 6

"To review all files of patients named in records where instances of potential inappropriate behaviour(s) were noted in any of the case files reviewed as part of this exercise – 68 files".

This was the process by which the review group ensured that any patient names in any of the other action areas which referred to sexualised activity were logged and the files for those patients were scrutinised using the framework developed.

Exhibit 18

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Findings: No issues were found in 9 case files; the remaining 57 have been categorised.

Category 1 -4
Category 1(a) – 2
Category 2 – 19
Category 3 – 7
Category 4 – 7
Category 5 – 7
Category 7 – 12
Category 8 – 1

Conclusions: Action point 6

A further 68 case files were examined in detail and 4 case files were classified as Category 1 (1 of these patients had previously been identified in phase 1) with a further 2 case files classified as Category 1(A). A further 19 case files denoted activity which the review group were of the opinion that the sexualised activity was non-consensual.

Recommendations from Phase 2 work

In summary therefore as a priority:

8 case files have been classified as Category 1 (6 new and 2 visited from Phase 1 work)

2 case files have been classified Category 1(A) (2 separate incidents involving 3 patients)

33 case files are deemed Category 2.

Exhibit 18

we, Pat

From: Newe, Pat
Sent: 15 August 2006 10:49
To: Hamilton, Andrew
Cc: Norris, Hilary; Harrison, Hilary; McMaster, Ian; Martin, Paul (dhssps)
Subject: Notes re Muckamore Abbey

Importance: High
Sensitivity: Confidential

Attachments: mtg ehssb 2 - 10 08 06.doc

Andrew

Further to our recent conversation, please find attached our notes of the meeting with Board/Trust officers re Muckamore Abbey. These notes have been cleared by N&W for factual accuracy but **we have not shared our written initial conclusion** with Board/Trust at this stage.

I am aware that you are to meet with Board/Trust officers on 17th 10:00 - 12:00. I will be on leave but Hilary will be available and Ian (tentatively) if you wish either or both to attend.

I hope you find this useful

Pat

ntg ehssb 2 - 10 08 06.doc (96...

Tracking:

Recipient	Delivery
Hamilton, Andrew	Delivered: 15/08/2006 10:49
Norris, Hilary	Delivered: 15/08/2006 10:49
Harrison, Hilary	Delivered: 15/08/2006 10:49
McMaster, Ian	Delivered: 15/08/2006 10:49
Martin, Paul (dhssps)	Delivered: 15/08/2006 10:49
Newe, Pat	Delivered: 15/08/2006 10:49

CONFIDENTIAL

10 AUGUST 2006 - MEETING AT EHSSB HEADQUARTERS WITH REGARD TO MUCKAMORE ABBEY HOSPITAL

Present:

Mr S Adams, EHSSB
Mrs B Connelly, N & W Belfast Trust
Dr H Harrison, DHSSPS
Dr I McMaster, DHSSPS
Mr P Newe, DHSSPS

Purpose of meeting - to receive an update in relation to the exercise undertaken at Muckamore Abbey Hospital by the Board and Trust and, as far as possible, to quality assure the process used.

Stephen provided a brief background to the origins of the case.

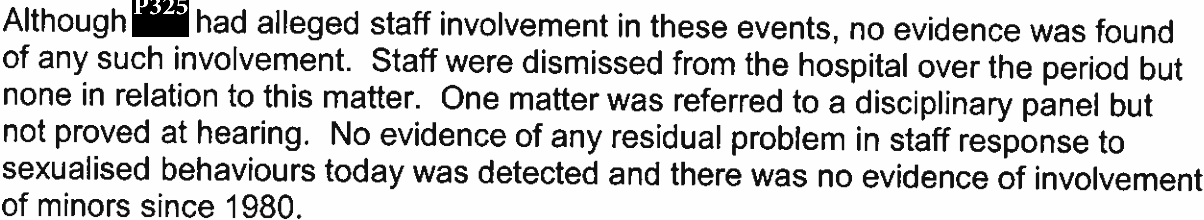
P325 alleged homosexual behaviour at the hospital dating back to the 1960s and 1970s. The Board made an out-of-court settlement, which includes a "no publicity" clause, with P325 and the Trust continues to provide support to him. Alert to the possibility that this was more than a "routine" legal case, the Board and Trust agreed to undertake an immediate investigation.

Phase 1 of the investigation

Donna Scott, Assistant Director of Legal Services, Carol Beattie, Public Health Consultant and Brenda Connolly carried out an initial examination of the files of inpatients identified through examination of P325's file and related contacts. They found evidence of sexualised behaviour of a homosexual nature involving young people as well as adults in which some patients were both victims and perpetrators. Fourteen individuals were identified and referred to PSNI who were already acquainted with 13 of these.

It was felt that the behaviour and apparent tolerance of the same by staff needed to be set in the context of the times in that people admitted to hospital were not necessarily admitted for treatment; the need for "training" featured frequently as a reason for many admissions, some individuals had been admitted because of homosexual activity in the community and a control element to admission appears not to have been unusual.

Many victims of these events under examination may have been victims elsewhere e.g. a number originated from children's homes. All relevant material detected was processed to PSNI, whose initial line appeared to be one of no complaint, no prosecution. The current train of events was set in motion following contact between Secretary and PSNI and a subsequent meeting with Departmental officials and PSNI. The police are now on the verge of doing some "cold calling" on those identified victims. This is scheduled to commence in September to ascertain whether there is evidence of criminal activity and, if so, whether any of these persons wish to initiate a complaint. The Board/Trust are putting in place systems to support any persons called upon, if so required.



Although P325 had alleged staff involvement in these events, no evidence was found of any such involvement. Staff were dismissed from the hospital over the period but none in relation to this matter. One matter was referred to a disciplinary panel but not proved at hearing. No evidence of any residual problem in staff response to sexualised behaviours today was detected and there was no evidence of involvement of minors since 1980.

Phase 2 of the investigation

A Board/Trust Team, which included individuals from management, human resources, legal, nursing and social work backgrounds was established to examine records of patients in a number of identified high risk wards, as follows:

- 2 male admission wards (Movilla A and Movilla B);
- Forensic ward (Mallow);
- Children on site; and
- Adolescents admitted to adult wards.

Records of patients in other wards were only examined where those patients were identified during this process. A Pro-forma (attached as Tab 1) was devised to record issues identified in files by the Team, a group exercise at all times. The aim was to record all incidents where there was any indication of sexualised behaviour and incidents involving significant violence.

The focus was medical and nursing records and other records e.g. social work files were examined where referenced. Significant events were cross-referenced, where possible, between medical and nursing records. Community records were not accessed. Many of the patients whose files were examined continue to be inpatients in Muckamore Abbey. Where the name of another patient was mentioned in a file, that patient's records were also examined. In some cases this "tracking" went back to 1966. The files of some female patients were also examined in cases where their names appeared in the record of a relevant incident. Only 1 recorded name was unable to be linked to any patient who had been an inpatient in Muckamore Abbey Hospital.

In all, some 277 records were examined by the team. In addition, 6 records of minors were examined by a multi-disciplinary team as part of a separate exercise to test the robustness of current child protection procedures (report to be provided). The number of pages of issues identified in each case ranged from 1 to 35 reflecting that there were few issues in some records and multiple issues of varying degrees of severity in others). The Team can therefore maintain an audit trail to every record examined.

As agreed with PSNI, all relevant incidents were categorised in accordance with a slightly revised version of a 7 tier police categorisation of offences, with category 1 being the most serious. A further classification, category 8, was added by the Board and Trust – see explanatory Table below.

An outline summary of findings is set below.

1. **Children in Conicar from 1:4:2004 - 23:3:2006**

   28 files were examined (22 by the Team; 6 by a multi-disciplinary team as a separate exercise). Care was taken to cross-refer to LAC Reviews in particular, where appropriate.

   The multi-disciplinary team exercise was a parallel one in the context of testing current child protection procedures on site. The files of 6 children (randomly chosen) were examined. Whilst this exercise did not use the template devised, no issues were identified. A report was completed and is reported to have been positive in its findings (will be provided).

2. **Minors (up to age 18) admitted to the Hospital Feb 1970 - Dec 1986**

   66 patient records examined; **9 records with issues** identified categorised as follows:

   - Category 2: 2
   - Category 3: 1
   - Category 5: 5
   - Category 7: 1

3. **Minors admitted to Movilla A and Movilla B 1:4:2004 - 23:3:2006**

   5 records examined, **no issues** were identified.

4. **Mallow (Forensic) & Movilla A and B admission wards (over 18 years) on 1 April 2004**

   52 patient records examined; **30 records with issues** identified, as follows:

   - Category 1: 4 (1 previously identified in Phase 1 work but records re-examined)
   - Category 2: 12
   - Category 3: 4
   - Category 5: 3
   - Category 7: 2
   - Category 8: 5

5. **Mallow (Forensic) & Movilla A and B admissions (over 18 years) 1:4:2004 – 27:3:2006**

   65 patient records examined; **18 records with issues** identified, as follows:

   - Category 3: 1
   - Category 5: 2
   - Category 7: 10
   - Category 8: 5

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6. Other records examined as individuals were identified in files

62 patient records examined; **54 records with issues** identified, as follows:

- Category 1: 4 (1 previously identified in Phase 1 work but records re-examined)
- Category 1a: 2
- Category 2: 17
- Category 3: 7
- Category 4: 6
- Category 5: 5
- Category 7: 12
- Category 8: 1

7. Other records examined

6 patient records examined; **5 records with issues** identified as follows:

- Category 2: 2
- Category 4: 1
- Category 5: 2

Category Table

Category	Description	No of persons involved
1	Sexualised activity between adult/minor	8
1a	Sexualised behaviour between minors	2
2	Sexualised activity between adult/adult – non-consenting (most recent cohort of patients)	33
3	Sexualised activity between adult/adult - consent unclear	13
4	Sexualised activity - consenting	7
5	Suspected sexual activity - general details unknown	17
6	Physical abuse allegations involving actually bodily form and above	0
7	Sexualised behaviour – query significance	25
8	Issues noted, dealt with thoroughly using recognised procedures (Board/Trust category).	11
	Total	116

If "multiple issues" were identified in respect of 1 person, the person was placed in the more serious category so there is no double counting. Consequently, 116 out of 277 cases, some 42%, generated issues of concern related to sexualised activity or severe violence. It should be noted that the incidents were graded according to situation, e.g. between adult and minor (Category 1) rather than the severity of the activity itself.

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Confidentiality

The exercise has been managed in the strictest confidence with only the Chief Executives of Board and Trust and relevant senior officers, PSNI and certain Departmental officials aware of the substance of the exercise. Chief Executive of other Boards using Muckamore Abbey have a general awareness of an exercise being undertaken at the hospital. This level of confidentiality and the hospital-focus are the reasons why the Team did not go out to Trusts to check community records of the patients files examined. In addition, many of the patients remain in Muckamore Abbey

Next steps

A draft report is to be made available for the meeting with the Department and Chief Executive, EHSSB on 17 August to include recommendations for further action.

It was stressed that the exercise to date has been factual both in terms of recording any event of a sexualised nature and how it was handled. The Team did not append evaluative comment of its own as to how well the issues were responded to.

We were assured, however, that had anything untoward been identified in the process it would have been immediately acted upon. Nothing presented in this exercise to necessitate such action. One individual P326 (currently a patient) presented concern, the Team checked on the level of awareness of the risk presented by this individual. Staff were aware of the risk presented and appropriate processes were in place.

Having collated the factual evidence from a large number of files, the Team is likely to recommend that the next stage in the process should entail engagement of an independent clinician, supported by appropriate legal and POCVA expertise, to:

(a) quality assures the process undertaken by the Team; and

(b) assess appropriateness of action or lack of action taken against accepted practice, policy and guidance for the time and context.

116 individuals appear to have been affected by events. In 11 cases it was noted by the team that recognised procedures were brought to bear (Category 8). However, no further financial provision has been set aside by the Board and it was pointed out that this cannot realistically be done until a closer assessment of victims and the likelihood of action ensuing is undertaken. There are no outstanding claims with Board or PSNI.

Initial Conclusion:

The exercise in fact finding focused as it was on specific wards within Muckamore Abbey Hospital and conducted within severe strictures of confidentiality appears robust and thorough. Close contact has been maintained with PSNI throughout. Commissioning an independent review of process and assessment of actions taken/not taken against the standards of the time does seem appropriate.

For the Department, a wider concern must be that the response or lack of response to such behaviour by staff at the time is not confined to Muckamore Abbey Hospital or indeed to the particular wards examined. In which case there are implications for the need for a much wider exercise, including the remaining wards at Muckamore Abbey Hospital, the remaining 2 learning disability hospitals, the 6 psychiatric hospitals with long-stay mental health provision and other community residential facilities where appropriate. Similarly, patients resettled from institutional settings having experienced a heightened sexualised environment may have carried these behaviours into community settings.

Finally, while there does not appear to be any evidence that staff actively engaged in the behaviours described, it is unlikely that the patient records would have yielded any evidence of this; it cannot be ruled out that testimony from victims may, as police investigation ensues, lead to disclosures of this nature.

DHSSPS – 11 August 2006

Tab 1

Record sheet for patient information from Medical Records

Patients name

D.O.B.

1st Admission to M.AH.

Date of last entry in record

Relevant extracts from Medical Records

Date of entry	Extract from record	Name of Doctor

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Record sheet for patient information from Nursing Records

Patients name

D.O.B.

1st Admission to M.AH.

Date of last entry in record

Relevant extracts from Nursing Records

Date of entry	Extract from record	Name of nurse

Newe, Pat

From: Newe, Pat
Sent: 11 August 2006 19:19
To: Harrison, Hilary; McMaster, Ian
Subject: FW: Notes of Meeting

Importance: High
Sensitivity: Confidential

Attachments: mtg ehssb - 10 08 06.doc

Hilary/Ian

Please find attached note of EHSSB meeting re Muckamore Abbey. The version sent to Brenda **did not** include the section **"Initial Conclusion"**. Happy to receive your comments/suggestions/amendments on Monday.

pat

From: Newe, Pat
Sent: 11 August 2006 19:15
To: 'Brenda Connolly'
Subject: Notes of Meeting
Importance: High
Sensitivity: Confidential

Brenda

I should be grateful if you could look over the attached to ensure that it is factually accurate. And that it accurately reflects our discussion on Thursday last. A response by close of play on Monday would be appreciated.

Regards

Pat

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HIA1(76)C- TAB 3.

10 AUGUST 2006 - MEETING AT EHSSB HEADQUARTERS WITH REGARD TO MUCKAMORE ABBEY HOSPITAL

Present:

Mr S Adams, EHSSB
Mrs B Connelly, N & W Belfast Trust

Dr H Harrison, DHSSPS
Dr I McMaster, DHSSPS
Mr P Newe, DHSSPS

Purpose of meeting - to receive an update in relation to the exercise undertaken at Muckamore Abbey Hospital by the Board and Trust and, as far as possible, to quality assure the process used.

Stephen provided a brief background to the origins of the case.

P325 alleged homosexual behaviour at the hospital dating back to the 1960s and 1970s. Alert to this being more than a "routine" legal case, the Board and Trust agreed to undertake an immediate investigation. Donna Scott, Harold Beattie and Brenda Connolly carried out an initial examination; evidence of sexualised behaviour of a homosexual nature involving young people as well as adults was identified. P325 had also been a victim, matter settled out-of-court. Continuing support provided to P325

It was felt that the behaviour and apparent tolerance of the same by staff needed to be set in the context of the times in that people admitted to hospital were not necessarily in need of treatment; the need for "training" featured frequently as a reason for many admissions and some individuals had been admitted because of homosexual activity in the community, a control element to admission appears not to have been unusual.

Many victims of these events under examination may have been victims elsewhere e.g. a number originated from children's homes. All relevant material detected was processed to PSNI; whose initial line appeared to be no complaint/no prosecution. The current train of events was set in motion following contact between Secretary and PSNI. The police are now on the verge of doing some "cold calling" on victims. This is scheduled to commence in September to secure a complainant. The Board/Trust are putting in place systems to support any persons called upon, if so required.

A number of individuals identified from the current exercise are perpetrators, others victims or both.

While P325 had alleged staff involvement in these events, no evidence was found of any such involvement. Staff were dismissed from the hospital over the period but none in relation to this matter. One matter was referred to a disciplinary panel but not proved at hearing. No evidence of any residual problem in staff response to sexualised behaviours today was detected and there was no evidence of involvement of minors from the 1970s.

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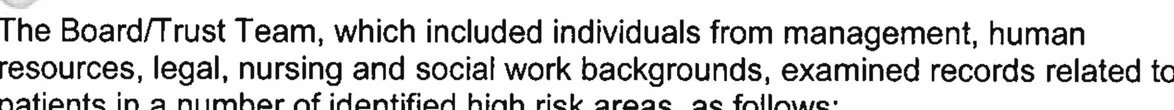

The Board/Trust Team, which included individuals from management, human resources, legal, nursing and social work backgrounds, examined records related to patients in a number of identified high risk areas, as follows:

- 2 male admission ward (Movilla A and Movilla B);
- Forensic ward (Mallow);
- Children; and
- Adolescents admitted to adult wards.

No other wards were examined unless named during this process. A Pro-forma (attached as Tab 1) was devised to record issues identified in files by the Team, a group exercise at all times. Issued to be recorded were any evidence of sexualised behaviour or of significant violence.

The focus was medical and nursing records and other records e.g. Social Work were examined where referenced. Significant events were cross-referenced, where possible, between medical and nursing records. Community records were not accessed. Many of the patients remain at Muckamore Abbey. Records of every name mentioned in a file were also examined and in some cases this "tracking" went back to 1966. Some female records were also examined where a name was mentioned. Only 1 name that was mentioned was unable to be linked to a patient.

In all, some 279 records were examined by the team. In addition 6 records of minors were examined by a multi-disciplinary team as part of a separate exercise to test the robustness of current child protection procedures (report to be provided). The number of pages of issues identified ranged from 1 to 35, so the Team can maintain an audit trial to every record examined.

An outline summary of findings is set below.

1. **Children in Conicar currently or from 1:4:2004 - 25:3:2006**

   28 files were examined (22 by the Team; 6 by a multi-disciplinary team as a separate exercise). Care was taken to cross-refer to LAC Reviews in particular, where appropriate.

   The multi-disciplinary team exercise was a parallel one in the context of testing current child protection procedures on site. The files of 6 children (randomly chosen) were examined. While this exercise did not use the template devised, no issues were identified. A report was completed and is reported to have been positive in its findings (will be provided).

2. **Minors (up to age 18) MA Hospital Feb 1970 - Dec 1986**

   66 patient records examined; **9 issues** identified categorised as follows:

   - Category 7: 1
   - Category 5: 5
   - Category 3: 1
   - Category 2: 2

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3. **Records Minors admitted to Movilla A and Movilla B 1:4:2004 - 23:3:2006**

   5 records examined, **no issues** were identified.

4. **Records Mallow (Forensic) Movilla A and B admission wards Over 18 years on 1 April 2004**

   52 patient records examined; **28 issues** identified, as follows:

   - Category 8: 4;
   - Category 7: 2;
   - Category 5: 3;
   - Category 3: 4;
   - Category 2: 11; and
   - Category 1: 4.

5. **Mallow Movilla admissions 1 4 2004 – 27 3 2006**

   65 patient records examined; **18 issues** identified, as follows:

   - Category 8: 5;
   - Category 7: 10;
   - Category 5: 2; and
   - Category 3: 1.

6. **Other records examined as individuals were identified in files**

   62 patient records examined; **52 issues** identified, as follows:

   - Category 8: 1;
   - Category 7: 11;
   - Category 5: 5;
   - Category 4: 6;
   - Category 3: 6;
   - Category 2: 15;
   - Category 1a: 2; and
   - Category 1: 6.

7. **Other records examined**

   6 patient records examined; **5 issues** identified as follows:

   - Category 5: 2;
   - Category 4: 1; and
   - Category 2: 2.

The Categories identified above in relation to issues reflects a slight revision of Police categories related to offences, as agreed with PSNI (Category 8 added by the Board/Trust. The categories and numbers in each category are set out below. Category 1 is the most serious and so on.

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Category	Description	Persons
1	Sexualised activity between adult/minor	9
1a	Sexualised behaviour between minors	2
2	Sexualised activity between adult/adult – non-consenting (most recent cohort of patients)	33
3	Sexualised activity between adult/adult - consent unclear	13
4	Sexualised activity - consenting	7
5	Suspected sexual activity - general details unknown	18
6	Physical abuse allegations involving actually bodily form and above	0
7	Sexualised behaviour – query significance	25
8	Issues noted, dealt with thoroughly using recognised procedures (Board/Trust category).	11
	Total	118

Patients
8
3

If "multiple issues" were identified in respect of 1 person, the person was placed in the more serious category so there is no double counting

The exercise has been managed in the strictest confidence with only the Chief Executives of Board and Trust and relevant senior officers, PSNI and certain Departmental officials aware of the substance of the exercise. Chief Executive of other Boards using Muckamore Abbey have a general awareness of an exercise being undertaken at the hospital. This level of confidentiality and the hospital-focus are the reasons why the Team did not go out to Trusts to check community records of the patients files examined. In addition, many of the patients remain in Muckamore Abbey

Next steps

- Draft report to be made available for the meeting on 17 September to include recommendation for further action.

It was stressed that the exercise to date has been factual both in terms of recording any event of a sexualised nature and how it was handled. The Team did not append evaluative comment of its own as to how well the issues were responded to.

We were assured, however, that had anything untoward been identified in the process it would have been immediately acted upon. Nothing presented in this exercise to necessitate such action. One individual P326 currently a patient) presented concern, the Team checked on the level of awareness of the risk presented by this individual. Staff were aware of the risk presented and appropriate processes were in place.

Having collated the factual evidence from a large number of files, the Team is likely to recommend that the next stage in the process should entail engagement of an independent clinician, supported by appropriate legal and POCVA expertise, to:

(a) quality assures the process undertaken by the Team; and
(b) assess appropriateness of action or lack of action taken against accepted practice, policy and guidance for the time and context.

Over 100 persons appear to have been affected by events. However, no further financial provision has been set aside. It was pointed out that this cannot realistically be done until a closer assessment of victims and the likelihood of action ensuing is undertaken. There are no outstanding claims with Board or PSNI.

DHSSPS - 11 August 2006

Initial Conclusion:

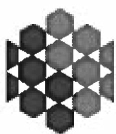
The exercise in fact finding focused as it was on Muckamore Abbey Hospital and conducted within severe strictures of confidentiality appears robust and thorough. Close contact has been maintained with PSNI throughout. Commissioning an independent review of process and assessment of actions taken/not taken against the standards of the time does seem appropriate.

However, a wider concern must be that the response or lack of response to such behaviour by staff at the time is not confined to Muckamore Abbey Hospital. In which case there are implications for a much wider exercise focused on the remaining 2 learning disability hospitals and potentially the 6 psychiatric hospitals with long-stay provision. Similarly, patients resettled from these settings having experienced a heightened sexualised environment may have carried these behaviours into community settings.

Finally, while there does not appear to be any evidence that staff actively engaged in the behaviours described, it is unlikely that the patient records would have yielded any evidence of this; it cannot be ruled out that testimony from victims may, as police investigation ensues, lead to disclosures of this nature.

Exhibit 18

Andrew Hamilton
Deputy Secretary
Primary, Secondary & Community Care Group



Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Room A3.3
Castle Buildings
Stormont BELFAST BT4 3SQ
Tel: 028 90523263
Fax: 028 90 523425
Email:
Andrew.Hamilton@dhsspsni.gov.uk

Dr P Kilbane
Chief Executive
Eastern Health and Social Services Trust
12-22 Linenhall Street
BELFAST
BT2 8BD

Your Ref:
Our Ref:
Date: 9 August 2006

Dear Dr Kilbane

MUCKAMORE ABBEY MATTERS

Further to our previous discussion I am writing to confirm that I have asked Pat Newe to engage with Stephen Adams and Eamonn Molloy with a view to undertaking a short exercise to provide further assurances regarding the robustness of the process adopted on renewing the relevant files.

Pat will complete a short report on this which hopefully will be available for our progress meeting later this month.

Yours sincerely

ANDREW HAMILTON

cc Pat Newe
Stephen Adams
Eamonn Molloy

Exhibit 18

Newe, Pat HIA1(76)C - TAB 2.

From: Hamilton, Andrew
Sent: 08 August 2006 15:23
To: Newe, Pat
Cc: Harrison, Hilary; McMaster, Ian; Martin, Paul (dhssps)
Subject: RE: Muckamore Abbey QA Exercise

Pat, this is exactly what we need. The purpose is to give additional assurance about the rigour of the process.
Andrew

-----Original Message-----
From: Newe, Pat
Sent: 08 August 2006 14:05
To: Hamilton, Andrew
Cc: Harrison, Hilary; McMaster, Ian; Martin, Paul (dhssps)
Subject: Muckamore Abbey QA Exercise

Andrew

Just to confirm my understanding of the exercise you wish undertaken in relation to Muckamore Abbey and your agreement to the approach we plan to adopt. I understand that you wish us to quality assure the robustness of process undertaken by the Trust/Board in relation to the screening of case records at the hospital in light of past events and complete and report on the exercise by 17 August.

Given the short time-frame, we would intend meeting with Stephen Adams and Eamonn Molloy who led the process so as to review actions taken, including in relation to those suggestions previously made by SSI. We would then sample 6 files "screened in" and 6 "screened out" by the process, interviewing members of the team as to decision-making where this appears necessary.

Is this OK for your purposes? Is there anything else that you think we need to be aware of before we embark on the exercise, e.g. Board concerns or messages from the screening to date?

We may be hampered with regard to timing as a number of key personnel in N & W are on leave and will not return until after 17 August but will seek to do our best in the time available.

Pat

Miskelly, Gwyneth

From: Newe, Pat
Sent: 08 August 2006 14:05
To: Hamilton, Andrew
Cc: Harrison, Hilary; McMaster, Ian; Martin, Paul (dhssps)
Subject: Muckamore Abbey QA Exercise

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We may be hampered with regard to timing as a number of key personnel in N & W are on leave and will not return until after 17 August but will seek to do our best in the time available.

Pat

Mis[illegible]lly, Gwyneth

From: Newe, Pat
Sent: 04 August 2006 09:36
To: Hamilton, Andrew
Cc: McMaster, Ian
Subject: FW: STRICTLY PRIVATE & CONFIDENTIAL

Andrew

Copy of the Muckamore Abbey "initial report".

pat

From: Newe, Pat
Sent: 19 June 2006 19:43
To: 'Eamonn Molloy'; Newe, Pat
Cc: Stephen Adams (E-mail)
Subject: RE: STRICTLY PRIVATE & CONFIDENTIAL

Eamonn

Just to advise that I have submitted the report of our meeting to Paul (copy attached).

In particular, I have drawn his attention to:

(a) the need to follow-up on the report has been made available to the Department at the end of November 2005;

(b) the need to explore the possibility of taking forward any regional learning from your exercise through the "Care at its Best" Implementation group;

(c) shared concerns about the absence of an adolescent treatment unit for young people with learning disability.

Thank you for your help in this matter. I would, of course, be interested in the outcome of your exercise.

Regards

Pat

From: Eamonn Molloy [mailto:molloye@nwb.n-i.nhs.uk]
Sent: 25 May 2006 11:45
To: Pat Newe (E-mail)
Cc: Stephen Adams (E-mail)
Subject: FW: STRICTLY PRIVATE & CONFIDENTIAL

Hi Pat,
Please see attached........the final version of the notes of our discussion..........hopefully!!
I've received a response from Stephen and he is happy with their contents
Happy to speak and sorry it took so long to turn these around
Eamonn

MAHI - STM - 297 - 230

Exhibit 18

-----Original Message-----
From: [illegible]ela O'Mahoney
Sent: [illegible] May 2006 11:23
To: Eamonn Molloy
Subject: FW: STRICTLY PRIVATE & CONFIDENTIAL

Eamonn

As requested

Angela

-----Original Message-----
From: Angela O'Mahoney **On Behalf Of** Eamonn Molloy
Sent: 23 May 2006 15:56
To: 'sadams@ehssb.n-i.nhs.uk'
Subject: STRICTLY PRIVATE & CONFIDENTIAL

Stephen

Please find attached draft notes of a meeting held on 3 April 2006. Please see my amendments highlighted in red.

I would be very grateful if you could forward your comments to myself as a matter of urgency prior to the dispatch of these notes to Pat Newe.

If you have any queries, please do not hesitate to contact me.

Kind regards

Eamonn Molloy

<<Meeting with P Newe, H Harrison, E Molloy 03-04-06.doc>>

C FIDENTIAL H1A1(76)C-TAB 1

3 April 2006 – Meeting with E Molloy, Muckamore Abbey Hospital

Present: P Newe & H Harrison

Eamonn provided a background to events and process to date. In relation to the original case, a settlement between the individual and the Board has been reached. PSNI are following up on an estimated 14 individuals (13 of whom are known) who were involved in inappropriate behaviour, and those who may have suffered some form of abuse as a consequence of their actions. The Board/Trust have initiated further actions flowing from original case discussions in relation to evaluation of responses made to disclosures made at a meeting with the plaintiff in 2002.

Deriving from the above, current procedures have been reviewed, updated where necessary and re-issued to staff to ensure fitness for purpose. A report has been made available to the Department at the end of November 2005 which was undertaken by a multi-professional team of Board and Trust officers, who were requested to review current practice on the Muckamore Abbey Hospital site. The Department will consider the best way to disseminate learning regionally arising from this report and the further actions which are now underway. It was noted that the process of implementing the Action Plan arising from the Disabled Children's Inspection may prove a useful vehicle for dissemination of the learning.

File Review

The Board/Trust have assembled a Team comprising E Molloy (N&W), S Adams (EHSSB), Donna Scott (Legal, CSA), B Connolly, (Nursing), F Donnelly, (Social Work – Child Care) and will draft in further professional assistance as required to screen remaining files. This exercise has three phases.

Phase 1 – screening of all files of all minors which is virtually complete.

Phase 2 – screening of all files from identified "high risk" wards for the period 2004-2006. This is now underway.

Phase 3 – screening of all files prior to 2004 not covered in Phase 2 on a sample basis.

Screening covers **all** files and records relating to the individual and the Team will identify any complaint or episode that may be suggestive of abuse using the PSNI risk definitions given at the last meeting with the PSNI/DHSSPS/Board/Trust and to record the source of the record and note actions subsequently taken. Any file so identified as "Red Risk" will be made available for independent review as to whether or not all reasonable actions were taken at the time in relation to concerns raised. An independent clinician from outside Northern Ireland is to be identified to undertake this exercise. All other files will similarly be available for independent inspection within a controlled environment. SSI suggested that this individual should be joined by an expert in child protection or adult protection issues as determined by the nature of the case, assisted by a person from a legal background. The Board and Trust are anxious that any learning from the scrutiny of practice which has regional implications should

b[illegible]ared. SSI suggested that the "Care at its Best" implementation group which is to be set up may provide a useful vehicle for this.

PSNI have "signed off" on the approach being followed by the Board/Trust and will base any further action on the information gleaned from the exercise currently underway. The approach was agreed at last meeting of Department officials, Board and Trust officers and PSNI.

The approach undertaken by the Board/Trust appears to be comprehensive, is multi-disciplinary in nature, structured with use of agreed pro-forma and files secured to the degree that they can be in what remains a live hospital environment.

Concern was expressed by members of the Screening Team that in the absence of an adolescent treatment unit for young people with learning disability a risk remained from the need to care for these young people in adult wards. On average 6-8 such young people are estimated to be in Muckamore Abbey at any given time. Concerns were also expressed about the fact that the planned new provision of Muckamore Abbey's services does not include a dedicated treatment service for adolescents. As there are no plans to admit young people to the new provision this will mean that there is no regional inpatient treatment provision for young people with a learning disability in Northern Ireland. This issue has already been raised in the SSI "Care at its Best" report.

Action Points

1. Review process to disseminate learning on a regional basis.

2. Consider range of expertise needed if Independent Review of cases becomes necessary i.e. add expertise in relation to protection issues and possibly legal expertise.

3. Raise issues of treatment needs of adolescents with learning disability.

4. Take forward any regional learning, perhaps through the "Care at its Best" Implementation group

PATRICK NEWE
3 April 2006

Newe, Pat

From: Martin, Paul (dhssps)

Sent: 30 March 2006 08:49

To: Newe, Pat

Subject: FW: Legal Case - Muckamore

-----Original Message-----
From: Eamonn Molloy [mailto:molloye@nwb.n-i.nhs.uk]
Sent: 29 March 2006 14:27
To: Martin, Paul (dhssps)
Subject: RE: Legal Case - Muckamore

Thanks Paul,
thats fine...i'm in the office for most of the day on Thurs...you can contact me on mob RO1 or at the office 90821251
Cheers
Eamonn

-----Original Message-----
From: Martin, Paul (dhssps) [mailto:Paul.Martin@DHSSPSNI.GOV.UK]
Sent: 28 March 2006 18:30
To: Eamonn Molloy
Subject: RE: Legal Case - Muckamore

Many thanks for the update Eamonn.I am interviewing all day tomorrow but hope to have a word with Hilary and Pat Newe at some stage.I will give you a ring on Thursday if it suits?

-----Original Message-----
From: Eamonn Molloy [mailto:molloye@nwb.n-i.nhs.uk]
Sent: 28 March 2006 18:00
To: Paul Martin (E-mail)
Cc: Brenda Connolly; Richard Black; Hugh Connor (E-mail); Stephen Adams (E-mail)
Subject: Legal Case - Muckamore

Hello Paul,
We have had several meetings over recent weeks regarding the next phases of fact gathering work at the Abbey, and quite a bit of work has been concluded, in the period since we last met, on the remainder of the files of "minors" who were patients in the Abbey over the timeframe of RM's inpatient episode. No red flags to post, I'm happy to report. Some residual examination to do but few in number.

All files associated with the 2004-2006 high risk ward areas have now been isolated and are hopefully going to be ready for inspection very soon.

I know that you have made mention of Hilary becoming involved in either a QA or in a direct role in this activity, although we haven't spoken about this directly.

We met this morning and have set aside Monday 3rd April - Wednesday 5th April to begin the detailed examination of the files concerned. Hilary is most welcome to join us and I can give her additional details of venue etc, if it is suitable, or if this is in keeping with your idea of her likely involvement. The group will comprise Brenda Connolly and myself from the Trust, Donna Scott, Asst Chief Legal Advisor CSA and Stephen Adams EHSSB. You may remember Brenda and Donna were key members of the initial fact gathering work, and have worked tirelessly on the "minor" work mentioned above.

I'd be grateful if you could give me a ring to discuss, and of course I'm happy to supply any

further information if that's helpful.

Regards Eamonn

Newe, Pat

From: Martin, Paul (dhssps)

Sent: 28 March 2006 18:28

To: Newe, Pat

Subject: FW: Legal Case - Muckamore

Can we discuss asap?

-----Original Message-----
From: Eamonn Molloy [mailto:molloye@nwb.n-i.nhs.uk]
Sent: 28 March 2006 18:00
To: Paul Martin (E-mail)
Cc: Brenda Connolly; Richard Black; Hugh Connor (E-mail); Stephen Adams (E-mail)
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Regards Eamonn