MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Aine Morrison
Dated this 02 day of February 2024

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

In exhibiting any documents, I will number my documents so my first document will be "Exhibit 1".

1. I have been asked to make a statement for the purpose of the Inquiry's examination of the Ennis Ward Adult Safeguarding Report and its outworkings. I have specifically been asked to address ten questions and I now set out my responses to those questions in sequence.

Q1. What was your job title and role in November 2012, the time of the allegations which gave rise to the Ennis investigation?

2. I was employed by the Belfast Health and Social Care Trust ("the Belfast Trust") as the Operations Manager for North and East Belfast community learning disability teams. These were multidisciplinary teams of nurses, social workers and care managers who worked closely with psychologists, psychiatrists and a range of Allied Health Professionals. I line managed the team leaders for the two teams and would have been directly involved in steering some complex cases, for example, by chairing risk management or adult safeguarding case conferences. I also had responsibility for some budgetary management and resource allocation. I was trained as a designated officer under the 2006 Safeguarding Vulnerable Adults Policy: Regional Adult Protection Policy and Procedural Guidance, also, the 2009 Protocol for Joint Investigation of Alleged and

Suspected Cases of Abuse and Vulnerable Adults and as an Achieving Best Evidence interviewer and would have acted in these roles on occasions.

3. I was banded at 8A of the Agenda for Change scale and held, social work professional lead and adult safeguarding lead in learning disability services at 8A level.

4. In my role as Operations Manager, I provided professional social work supervision for H92, Senior Social Worker in the MAH social work team. Professional social work supervision is generally provided in Health and Social Care Trusts in Northern Ireland when a staff member is in a designated social work post but operationally line managed by someone who is not a social worker. The purpose is to provide opportunities for professional reflection, development, guidance and support. In this case, the senior social worker in MAH was line managed by a nurse, Esther Rafferty, Service Manager. I aimed to meet with him approximately every three months formally although we would also discuss issues on an ad hoc basis. I would also have provided occasional professional case advice to other members of the MAH social work team when requested to do so by them. This tended to be about complex aspects of decision making in individual safeguarding cases or advice about the implementation of safeguarding policy.

5. Whilst I have been provided with the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses by the Inquiry, this does not encompass all of the records from the investigation. Some of my responses to the questions asked are, therefore, relying on my memory of events that took place approximately ten years ago. As this was a large scale, complex and high profile investigation and because I experienced some difficulties during the investigation, I believe I remember it reasonably well. However, I have been involved in many other safeguarding investigations, some of which were also large scale and complex. I have also had long involvement in adult safeguarding planning and development processes. I, therefore, cannot discount the possibility of conflating different experiences.

Q2. When and in what circumstances did you first become aware of the allegations?

6. I believe I was contacted by either Esther Rafferty or H92 on 08 November 2012 which was the day that the allegations were made known to MAH. I would have been contacted by the hospital as I was the adult protection lead and because there was a protocol in place whereby the investigation of allegations of patient abuse against MAH staff was led by community staff in the patient's originating Health and Social Care Trust. I was informed that staff from Bohill Care Home ("Bohill") were spending time on Ennis Ward getting to know patients who were to be resettled to Bohill and they had made allegations of abuse against ward staff. I was given the detail of the allegations. I was also told that Bohill staff had experienced some difficulty accessing a designated officer to tell them of the allegations and had then contacted RQIA who then informed MAH.

7. I believe I was also told that MAH staff had informed the families of the patients named in the allegations and that the MAH was taking action to ensure that the staff named were not on duty.

Q3. What actions did you take on first becoming aware of the allegations?

8. My actions were guided by the 2006 Department of Health Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance ("the Regional Policy") and informed by my Joint Protocol and Achieving Best Evidence interviewer training. I believe the Belfast Trust also had an operational adult safeguarding policy but I have been unable to locate a copy of this. My memory is that it largely followed the regional policy and procedural guidance.

9. The Regional Policy identified seven potential stages of an adult safeguarding investigation. These were: Alerting, Referring, Screening, Planning the investigation, Investigating, Making decisions, and Monitoring and Review.

10. The Regional Policy states that it may not be necessary to follow all the stages and that the process may not be completely linear as the different stages of the process may need to be revisited as further information emerges.

11. I was the designated officer. The Regional Policy defines a designated officer as, *"the person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedure and for coordinating any subsequent investigation which takes place".* The role includes, as a first priority, ensuring the immediate protection and safety of the vulnerable adult and then screening the referral and deciding whether further investigation is necessary. If the referral is screened in, then the next step is to convene a strategy discussion and appoint an investigating officer. The designated officer should also consult with the relevant PSNI liaison officer, as appropriate, and ensure the formulation of an agreed care and protection plan.

12. My involvement in this investigation started at the referral stage when the referral was made to me as a designated officer by MAH. My initial task was to screen the referral to determine what the appropriate next steps should be. At that point a designated officer may decide that no further action is necessary, that the issues meet a threshold for further investigation under adult protection procedures or that the provision of other services to provide for the adult's welfare is the best response.

13. The screening decision I made was very straightforward. The allegations made were clearly very serious and potentially criminal. The fact that it was alleged that the abuse had happened openly in front of external staff made me immediately concerned about potential widespread abuse on Ennis Ward. The vulnerability of the patients concerned and the ongoing nature of the risk were all factors in the decision that further investigation was required.

14. The designated officer also has a lead role in agreeing necessary protection arrangements. My memory is that when MAH made the referral to me, they had already taken steps to ensure that the staff named were not on duty at that point and they were in the process of suspending them. I think suspension was arranged that same day. I was content that this was an adequate immediate protection plan.

15. Where a designated officer receives a referral of alleged or suspected criminal abuse, they have a duty to discuss the case with the PSNI. The information I received clearly involved allegations of physical abuse and ill treatment so again it was a straightforward decision for me to contact the PSNI. I think MAH may have already contacted the PSNI but I am almost certain that I also spoke to the PSNI that same day, 08 November 2012.

At this point, as well as following the Regional Policy guidance, I was also following the steps laid out in the Joint Protocol as both the PSNI and the Belfast Trust were involved.

16. This initial contact with the PSNI by myself was what was described in the Joint Protocol as a Joint Agency Consultation. The purpose of a Joint Agency Consultation is to discuss the available information and reach a decision on the need for a joint PSNI and HSCT investigation. Again, this decision was straightforward and the need for a joint investigation was quickly agreed. I cannot remember exactly who I spoke to but presume it will have been someone in the Antrim Public Protection Unit.

Q4. What was your role in the Belfast Trust's safeguarding investigation into the allegations made about incidents on Ennis ward on 08 November 2012? It is anticipated that the answer to this question will include, but not be limited to:

- **A detailed explanation of your specific role(s) and actions taken;**
- **If you worked with others, an explanation of who they were;**
- **An explanation of who you reported to in respect of any actions.**

17. As stated above in the answer to question two, my role in the Belfast Trust's safeguarding investigation into the allegations made about incidents on Ennis Ward on 08 November 2012 was to act as the designated officer.

18. At the time of the allegations on 08 November 2012, John Veitch, Co-Director for Learning Disability Services was on annual leave. I believe my line manager, Barney McNeaney, Service Manager for Community Teams and Treatment Services, band 8B at the Belfast Trust was off on sick leave.

19. Having completed the screening in of the referral, contacted the PSNI and ensured that the alleged perpetrators were no longer working with the alleged victims as I have detailed above, the next stage of the process was for me to convene a strategy planning meeting. As John Veitch and Barney McNeaney were not available at the outset, I recall I spoke with and updated Catherine McNicholl, Director for Adult, Social and Primary Care and John Growcott, Co-Director for Social Work and Social Care Governance in the Belfast Trust as they were the next relevant senior people available to me. I spoke to Catherine McNicholl

on the telephone on 15 November 2012; the circumstances of that call are detailed in my response to question eight. However, I also had contact with them both at other points early in the investigation, although I do not remember exactly when.

20. I arranged the first strategy meeting for 09 November 2012, the day after the allegations were made. The meeting was held on MAH site. The minutes of this meeting are at pages 4 to 26 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. I chaired the meeting. A list of attendees appear in the minutes which included Sergeant Elaine McCormill and Constable Tracey Hawthorne both of PSNI; Audrey Murphy, Inspector at RQIA; Marbeth McKeown, Senior Social Work Practitioner at the Northern Health and Social Care Trust; Esther Rafferty; H92; Patrick Ling, Specialist Doctor, Barry Mills, Operation Manager at MAH and Doctor, Richard Cherry, CT3.

21. The core purpose of a strategy planning meeting is to decide on a protection plan for the vulnerable adult(s) concerned and to plan an investigation. In a joint protocol investigation, the PSNI has the investigation lead and the Belfast Trust has the protection lead, however, both agencies collaborated on the investigation. I appointed two investigating officers being Carmel Drysdale, who was a team leader for the North Belfast Community Learning Disability Team and Colette Ireland, who was team leader for the East Belfast Community Learning Disability Team. I chose these two individuals as I wanted people with seniority and experience given the complexity of the case. They were both designated officers but were working as investigating officers for this investigation. It was agreed with the PSNI that the Belfast Trust investigating officers, Carmel Drysdale and Colette Ireland should carry out interviews with some of the Bohill staff and also that the investigating officers and I would interview some of the Ennis staff. Information from these interviews was then shared with the PSNI.

22. It was at this first strategy planning meeting on 09 November 2012 that I recommended twenty four hour monitoring on Ennis Ward by staff external to the ward as a necessary protection plan. I believed this to be necessary because the allegations involved significant numbers of staff acting openly in front of visiting staff and I feared that this meant that abusive practice was widespread and accepted as normal practice.

23. The wards in MAH were quite self-contained with core staff working largely on just that one ward so it appeared to me to be very possible that a culture of abusive practice could have developed in one ward in what was a fairly closed setting. It was agreed at that meeting that twenty four hour external monitoring would be put in place.

24. There were then a number of other meetings to share further information, to review the protection planning arrangements and to plan further stages in the investigation. I chaired all meetings and led the decision making about care and protection plans. I also used the meetings to monitor and review protection plans and other agreed actions.

25. It was decided at this first meeting that the PSNI would proceed to interview the Bohill staff who had made the allegations. Sergeant Elaine McCormill and Constable Tracey Hawthorne led the investigation on behalf of the PSNI. It was decided that the PSNI should interview these particular staff as they were likely to provide the core evidence for a criminal investigation.

26. Esther Rafferty was my main point of contact on the investigation and protection planning and I believe I also liaised with Barry Mills and Clinton Stewart, both band 8A MAH managers on some of the more operational matters such as the availability of monitoring staff and staffing levels on the ward. Moira Mannion, Co-Director of Nursing at the Belfast Trust had been asked by Catherine McNicholl and Brenda Creaney to provide professional nursing input and support to Ennis Ward, the staff and to Esther Rafferty. I had limited dealings and interactions with Moira Mannion other than during meetings.

27. Throughout the investigation there were five inspectors from RQIA involved, being Margaret Cullen, Siobhan Rogan, Audrey Murphy, Rosaline Kelly and Patrick Convery. RQIA staff carried out their own inspections of Ennis Ward, attended the various meetings during which they shared their findings and perspectives and contributed to the decision making at meetings. There were also representatives from the Northern Trust involved being Marbeth McKeown, Lesley Jones and Teresita Dorman as at least one patient on Ennis Ward was a Northern Trust patient. Similarly, there was at least one patient from the South Eastern Trust on the ward and their representatives were also involved. These were Greer Wilson, Edna McConville and David Nesbitt.

28. At some point early in the investigation whilst John Veitch was on annual leave, I was contacted by the PSNI to ask for the Belfast Trust's view on installing covert CCTV on Ennis Ward. The identity of the person from PSNI is likely to be in my contact records but I do not recall who it was. I was asked to keep this call completely confidential but I explained that, as I was in a relatively junior position, I would have to consult with more senior colleagues. I believe I consulted with John Growcott about this and I also recall a meeting between Catherine McNicholl, John Growcott and me where I think it was discussed, but I do not think any final decision was made at that meeting. I do not remember any further discussion involving me about the issue. I think John Veitch returned from holiday shortly afterwards and may have dealt further with the issue. I did ask the PSNI at some stage if they had proceeded and was told that they had decided against it.

29. I recall visiting Ennis Ward on 13 November 2012. This was the first time I had been on this ward at MAH. I was shown around the ward by H491, the ward manager and H92. I came away from the visit with an uneasy feeling. I included my uneasiness in an email which I issued to Catherine McNicholl on 15 November 2012 which is referenced in the Timeline of Ennis Investigation (January 2010 to April 2016) included in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 577, which states, '*AM highlights concerns around recent visit to ward. "Also possibly significant is my own experience of visiting the ward yesterday. I came away distinctly uneasy about atmosphere and culture on the ward particularly in relation to the ward manager who was showing me around. This involved a lack of verbal interaction with patients and an incident where a client was ushered out of the way and a door locked in front of her".*'

30. I recall contacting Yvonne McKnight, Belfast Trust Adult Safeguarding Specialist for advice about a range of matters throughout the investigation. She also attended some of the meetings. She was a good sounding board for me and she supported me throughout the investigation process.

31. Once John Veitch returned from annual leave, I do not recall having any further contact with Catherine McNicholl. I think I may have had some further occasional informal supportive discussion with John Growcott and I did have a short interaction with him towards the end the investigation which I will detail in response to question ten below. I

had extensive contact and engagement with John Veitch throughout the Ennis safeguarding process. On his return from leave, he attended all Ennis investigation meetings. I recall a particularly difficult strategy meeting on 09 January 2013 where I faced considerable challenge from John Veitch and Moira Mannion. Barney McNeaney, my line manager had returned from sick leave and he was in attendance. After the meeting Barney spoke to me and said that John Veitch suggested that perhaps Barney should take over as chair of the strategy meetings. Given the extent of the opposition I was facing, I felt that I may have some difficulty carrying out my designated officer role if I was not also chairing the meeting. I told Barney that I would prefer to continue to chair and Barney accepted this.

32. I was in a difficult position from the outset, as I was the designated officer which has a degree of independence to it but is not wholly independent. My actions as the designated officer were still subject to line management scrutiny and reporting arrangements. Barney McNeaney was my line manager and in turn his line manager was John Veitch. Barney McNeaney moved jobs and in July 2013, I was promoted to the role Barney McNeaney had been performing and as a result, John Veitch was then my direct line manager.

33. Further investigation plans agreed in the meetings involved speaking to relatives. MAH had already contacted the relatives of the patients named when the allegations were first made to inform them but speaking further to relatives about any concerns they themselves had was agreed.

34. We agreed at an early stage to start the process of assessing which, if any, of the patients named in the allegations might have the capacity to engage in an interview. We also agreed to start the work of reviewing any relevant records. This included looking at staff rotas for the ward to determine who was on shift at the times that Bohill staff were there and reviewing any adverse incidents, adult safeguarding referrals and patient records for any previous concerns.

35. Important records of the adult safeguarding process are contained in the minutes of the strategy discussions and case discussions that took place during the course of the investigation. The minutes of these meetings are at pages 4 to 81 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me

by the Inquiry. These minutes record much of the detail about the protection response and the decision making during the investigation. As can be seen from the list of attendees recorded in the minutes, the meetings were multi agency. I do recall liaising with representatives from the Health and Social Care Board, being Joyce McKee and the Public Health Agency, being Molly Kane but these representatives are not recorded in the minutes that have been supplied to me although there are a number of meetings referenced which do not have associated minutes. It is possible therefore that discussions with the Health and Social Care Board and the Public Health Agency took place outside of the meetings.

36. All Bohill staff who had worked on Ennis Ward were interviewed by either the PSNI or the Belfast Trust Investigating Officers, Carmel Drysdale and Colette Ireland. The PSNI interviewed those Bohill staff who had originally come forward with allegations and it was agreed that Carmel Drysdale and Colette Ireland would carry out an initial interview with all other Bohill staff who had spent time on Ennis Ward. Carmel and Colette interviewed nine Bohill staff members using an agreed format and set of questions. The questioning was designed to be open to allow staff to give their own account of any areas of concern but where concern did emerge, Carmel and Collette would have asked further questions. Six out of the nine staff originally interviewed were asked to attend a further interview. The aim of the second interview was to clarify issues raised in the initial interview, particularly around identification of staff. Despite encouragement from Bohill management, only three attended for a second interview. Of the remaining three, one staff member did not attend due to illness, a second had left the employment of Bohill and a third member declined.

37. The information obtained in these Bohill staff interviews was shared with the PSNI and consideration given to whether or not the PSNI needed to follow up with any of these staff as part of the criminal investigation. My memory is that the PSNI decided that they did not need to.Carmel and Colette listed every issue of concern that the Bohill staff had brought up. This list was appended to the Ennis report. The list contains not just specific allegations of abuse but allegations of poor practice as well as negative comments and impressions reported by Bohill staff. As the investigation was large scale, this exercise was undertaken to help the investigatory team keep track of all the issues that had been reported. It also helped us ensure that each issue had been addressed.

38. The concerns raised by Bohill staff were summarised into the following categories;

- Concerns raised about the physical treatment of patients.
- Concerns raised about the verbal treatment of patients.
- Concerns raised about the management of behaviour of patients.
- Concerns raised regarding the lack of supervision of patients.
- Concerns regarding the lack of induction for Bohill staff coming on to the ward.
- Any other concerns.

Not all staff had concerns and others had relatively minor concerns.

39. This stage of the investigation was hampered by the inability of some Bohill staff to either name or clearly describe the staff they alleged were behaving abusively. Some of the Bohill staff had not spent much time on the ward. The Belfast Trust investigation team, with the support of MAH senior staff, tried to identify staff from descriptions provided. I am not certain but think it may have been Barry Mills and Clinton Stewart who supported the investigation team with this work. We also tried to identify staff by matching the names on the duty rota with the shifts the Bohill staff worked. This helped identify some staff but not everyone.

40. The Bohill staff who made allegations were very clear that they had no concerns about staff conduct on other wards that they had also spent time in and indeed had observed very compassionate care on other wards. So we did not have any reason to suspect abuse elsewhere on the MAH site.

41. The investigating officers and I conducted interview with Ennis Ward patients. The interviews with Bohill staff had identified seven patients on the ward who may have suffered abuse. The next step of the investigation was to proceed to interview these patients under Joint Protocol procedures where possible.

42. The capacity of patients named in allegations to participate in interviews was discussed by the multidisciplinary team including consultant psychiatry, speech and language therapy, nursing and social work staff as well as consultation with family members. I think H514, Speech and Language Therapist and Doctor Colin Milliken, Consultant

Psychiatrist were involved in these assessments but I cannot remember who the other staff were. There may have been different staff involved for each patient depending on who knew their needs best. Assessing the capacity of patients to be interviewed and preparing for the interviews took some time because of the complex needs of the individuals concerned.

43. Of the seven patients named in allegations, it was deemed possible to interview only three of them. All of the seven patients named had quite profound learning disabilities and their ability to communicate was extremely limited.

44. My best memory is that we only proceeded to clarification discussion stage for two of these patients. Clarification discussion stage is when a PSNI officer and a social worker jointly speak to the person concerned to establish whether or not the person has a disclosure of criminal abuse to make, to assess the willingness of the person to pursue the matter to court and to inform a decision about the best format to use for a subsequent interview.

45. In the two clarification discussions, one patient raised no concerns and it was not possible to get a second patient to engage in any discussion. I do not remember if the third interview was a clarification discussion or a formal Joint Protocol interview. This patient did make a limited disclosure but did not confirm the full details of the allegation made and could not name the staff member involved.

46. At a later stage in the investigation and as agreed with the PSNI, Carmel Drysdale, Colette Ireland and I considered interviewing all other patients on the ward who had not been specifically named in the allegations. This second set of interviews was to allow other patients to tell us about their experiences on the ward. This was part of the investigation into the possibility of widespread abuse and an abusive culture on the ward. These interviews were not planned under the joint protocol procedures as they were exploratory in nature. Had disclosures of abuse been made, I would then have proceeded under the joint protocol. Again, the plans for these interviews were agreed by the PSNI and other relevant agencies. As before, we went through a multidisciplinary process of assessing the capacity of other patients to engage with the investigating team. There were three patients in this group who were identified as potentially having the capacity to participate in an exploratory discussion. However, relatives for two of

these patients objected to the plans on the basis of potential upset to their relatives. Following discussion with ward staff, it was agreed that those concerns were valid and decided that, on balance, it was best not to proceed. A discussion was held with the third patient who was extremely positive about all aspects of ward life and reported no concerns.

47. Contact was made with relatives. Information from relatives was an important strand of the investigation. Many of the relatives knew their family member well, were skilled at understanding their emotions and communication and were in regular contact with their family member. Many of the relatives were also very familiar with the staff and with normal practice on Ennis Ward. One of the patients, I believe it was P39, had very limited family contact and we arranged for an independent advocate from Bryson House Advocacy Service to become involved as her "voice" in the investigation. As far as I remember, the patient was P39.

48. A Senior Nurse Manager from MAH made initial contact with family members for the four patients who had been named when the allegations were first made. I cannot recall who the Senior Nurse Manager was. No family member raised any concerns about care on Ennis at that point.

49. At the first strategy meeting on 09 November 2012, it was agreed that family members for all patients on the ward should be informed in general terms about the allegations. A Senior Nurse Manager from MAH made these calls and again no concerns were raised. I cannot recall who the Senior Nurse Manager was. Many family members spoke very positively about the care on Ennis.

50. At a strategy meeting on 12 December 2012, it was agreed that family members should be further updated by telephone to be followed up by letter. I believe I made the telephone calls at this point. I also drafted a letter to go to family members. My draft gave quite a lot of detail about the concerns and the investigation. On review of the letter to go out, John Veitch objected to the level of detail and I was asked to redraft. I have provided further comment on this in my response to question eight.

51. On this round of telephone calls, family members were, again, largely positive about the care on Ennis. However, three family members did raise some concerns. The brother

of one patient recounted a remark his sister made to him about a possible physical assault by a staff member. This issue was followed up by an interview with the patient and by further discussion with the brother where the evidence suggested that this concern arose following a jokey comment made by the staff member.

52. The family member of another patient who had previously reported no concerns, raised a number of concerns about practice on the ward. Some of these comments were generalised about staffing levels and the supervision of patients. Others were specifically about her sister's care. It was agreed with this family member that the specific complaints would be investigated separately under the complaints procedure by a Senior Nurse Manager in MAH. I cannot recall the Senior Nurse Manager. The family member subsequently declined to meet with the Senior Nurse Manager in MAH to discuss the concerns. However, MAH decided to proceed with an investigation in any case. The more general concerns about staffing and supervision levels were investigated as part of the safeguarding process.

53. A third family member raised concern about the number of recent incidents where her daughter had been assaulted by other patients. I undertook to review the incidents to ensure that the response had been appropriate. I spoke to H92, a designated officer in the MAH social work team about this and reviewed the actions taken. It was my assessment that the protection plans put in place were appropriate.

54. Further updates to family members during the course of the investigation did not result in any new concerns.

55. Section 2D of the Ennis Ward Adult Safeguarding Investigation Report covers interviews with Ennis Ward staff who had been named in the allegations made by Bohill staff. It was agreed with the PSNI that they would interview two of the staff named in the allegations, being H159 and H197. These interviews took place in February 2013. The PSNI subsequently referred these two staff members to the Public Prosecution Service in relation to a range of offences as listed in the Ennis report.

56. Either, the investigating officers or I conducted interviews with a further four members of staff who had either been named by Bohill staff or identified by their descriptions. Two of these staff members, H203 and H205 were alleged

to have been involved in the same incident involving rough handling and overtightening of a belt on one particular patient. The investigating team's conclusion was that while we found the Bohill staff member's report convincing in its detail, we did not feel that there was enough evidence to prove that there had been abuse in this instance. A third staff member, H206 was alleged to have witnessed another staff member pushing a patient back into a chair without much care. The staff member in this alleged incident was thought by the Belfast Trust investigation team to be H197. This was based on the description provided by the Bohill staff member. H206 said she had no recollection of any such incident. The investigating team did not feel there was enough evidence to prove that she had witnessed any abusive behaviour.

57. A fourth member of staff, H198 was interviewed about the allegation made to us by P42's brother, the brother of a patient called P42. As described in the report, the investigation team's conclusion was that H198 had probably been joking with the patient concerned. H198 was also alleged to have left a Bohill staff member on her own who had been assaulted by a patient whilst alone. H198 said that she had no knowledge of a Bohill staff member being assaulted but did acknowledge that the ward had been short staffed that day. The investigating team did feel that the staffing situation on the day suggested an increased likelihood of the Bohill staff member being left alone.

58. The Bohill staff member said that she had not reported the assault during her shift. H198 was further alleged to have come out of the office in response to increased noise levels and shouted at patients in the day room. H198 denied this and while the Bohill staff member's report had convincing detail, the investigating team's conclusion was that there was not enough evidence to prove the allegation.

59. The reports of these staff interviews were shared with the PSNI who did not believe there were grounds for them to take any further action in relation to these allegations.

60. At a later point in the investigation, Carmel Drysdale and Colette Ireland undertook individual interviews with all staff who worked, in any capacity, on Ennis Ward. These interviews took place after all the interviews with Bohill staff and asked about the general themes of concern raised by them. The interviews were semi structured with a series of questions asked of each interviewee. Individual records of each interview were made

but only a summary was contained in the Ennis Report which reported on the profile of staff interviewed and on the themes raised by each group of staff. The groups of staff interviewed were registered nursing staff, band 3 nursing assistant staff, band 2 domiciliary support staff and medical staff. A total of 34 staff were interviewed.

61. Apart from one previous adult safeguarding incident, all staff denied any knowledge of or involvement in any abusive behaviour. The investigating team did note that the Ennis staff appeared to be genuinely caring about the patients in their care and spoke very warmly about them.

62. Most staff reported significant staff shortage on Ennis Ward at various points and were concerned about the impact of short staffing on patient care and on staff wellbeing. Some staff reported that they did not feel that the arrangements for Bohill staff coming on to the ward were well managed. Some staff felt unsupported in managing challenging behaviours and the investigation team noted differing views on how challenging behaviours should be responded to. Some staff felt that there were insufficient services available to ward patients.

63. Sections 2f – 2i of the Ennis Report details the review of various records which was undertaken as part of the investigation. This part of the investigation was about looking for any previous incidents of concern and any previous trends or patterns which might have indicated concern.

64. A review of a sample of adult safeguarding referrals found referrals and responses appropriate. A review of incidents and accidents for any relevance to the investigation noted two reported incidents of low staffing and there was one previous disciplinary case against a member of Ennis Ward staff accused of rough handling and threatening a patient. The incident was investigated by the PSNI who did not take any further action. The staff member resigned before disciplinary action was completed.

65. I reviewed the nursing care plans for the four patients originally named in the allegations. I thought this was a necessary part of the investigation as the Bohill staff had alleged inappropriate and sometimes abusive responses to challenging behaviours. Interviews with Ennis Ward staff had also shown a degree of inconsistency in staff response to challenging behaviour as well as some reports of staff feeling

unsupported in managing such behaviour. I found that there was very little detail in the care plans about managing the patients' behaviours. However, Moira Mannion, the Co-Director for Nursing in the Belfast Trust also reviewed these and found them satisfactory.

66. Section 2J of the Ennis Report covers the information received from the twenty four hour external monitoring that was in place on Ennis Ward. Monitors were asked to make a report of each shift they spent on the ward. This information was an important part of the investigation and protection elements of the safeguarding process. While I did not expect ward staff to behave inappropriately or abusively in front of monitoring staff, I thought it was important to know if staff had the skills and aptitude to provide good quality care. The monitoring staff reported that the staff were providing good quality care. Monitoring staff did, however, raise some concerns about staffing levels when the monitoring was first introduced. They also highlighted concerns about overcrowding and a lack of space on the ward as well as difficulties caused by the level of challenging behaviour on the ward.

67. Section 3 of the Ennis Report jointly covers conclusions and recommendations. Reaching conclusions was a difficult process as there remained issues we were uncertain about. We were also completing the report before the criminal process had ended. However, regardless of the outcome of any criminal case, we felt confident that there was enough evidence of abusive behaviour by the two members of staff who were being prosecuted to warrant disciplinary action against them. The "balance of probabilities" was the usual threshold in adult safeguarding practice in making determinations about whether or not abuse had occurred. In making the assessment for these two staff members, we gave weight to the number, credibility and consistency of reports about them engaging in serious abusive behaviour.

68. Reaching a judgement about whether or not there was enough evidence of abusive behaviour by other staff to warrant disciplinary action was a more difficult task. Allegations against other identified staff were more limited and reported by just the one Bohill staff member for each incident. The identified MAH staff completely denied the allegations and we believed that there was the possibility for varied interpretations of staff behaviour in relation to the allegations about rough handling and belt tightening.

Whilst we remained uneasy about the possibility of abusive practice by these staff, we did not believe that there was enough evidence to prove the allegations.

69. The other significant concern was that, despite our best efforts, we were unable to identify all of the staff that the Bohill team had accused of abusive behaviour.

70. It is not unusual in a safeguarding investigation to be unable to reach definitive conclusions. This is particularly so when, as was the case on Ennis Ward, alleged victims of the abuse are very limited in their communication and are largely unable to give an account of what may or may not have happened.

71. The investigation team was particularly concerned about the frequency in which one particular patient featured in the allegations and concerns raised. There was a consistency in Bohill staff reports about staff behaviour towards her that carried considerable weight. It seemed likely that this patient, in particular, experienced abusive or poor practice.

72. The investigation team also concluded that there was evidence that;

- The ward environment had been somewhat neglected.
- Induction arrangements for the Bohill staff were not robust.
- Behaviour support services on the ward were insufficient.
- Hospital policy on restrictive practice was not always being followed.
- Not all staff had received the appropriate level of safeguarding training.
- Staffing levels on the Ennis Ward were, at times, inadequate.
- Ennis Ward patients did not have full access to services that were available on other wards

73. The next stage was to make recommendations to address the conclusions of the investigation. Recommendations for improvement were made throughout the safeguarding process and by the time the report was written, many of them had been implemented or were in the process of implementation. Some recommendations were Ennis specific, others were for the whole of MAH.

74. It was relatively straightforward to make some recommendations. Recommendations about training, induction for visiting staff and environmental improvements were examples. Other recommendations were aimed at improving practice standards on the ward, particularly in relation to behaviour support.

75. The investigation team remained uneasy that we had been unable to draw definitive conclusions on many of the allegations and we therefore sought to make some recommendations that were about increasing protective factors on Ennis Ward. Again, behaviour support services for patients and support for staff who were managing challenging behaviours was one such measure.

76. We also recommended the sharing of as much information as possible about the allegations, the investigation process, the outcomes and the conclusions and recommendations with all staff on the ward, believing that the discussion of these issues would be protective.

77. The report was shared with all parties towards the end stages of the adult safeguarding process and at one of the latter meetings, Esther Rafferty assured the meeting that all recommendations had been accepted and acted upon.

78. Protection plans for the patients on the ward were kept under review throughout. The two members of staff who were prosecuted remained on suspension throughout. However a number of other staff members were suspended throughout the course of the investigation when concerns about their behaviour arose but were subsequently re-instated when further investigation did not show sufficient grounds to continue a suspension. Twenty four hour monitoring remained in place for a considerable period of time as the investigation was lengthy but was eventually stood down.

79. By the time of writing the report, the staff team in Ennis had changed substantially with approximately half of the staff being new to the ward. The investigation team believed that in the event that there had been a wider culture of abuse on the ward, this would now serve as a protective factor.

Q5. How, in your perception, was the Ennis report received by senior management and how did they respond?

80. As noted above at paragraph 76, progress in the investigation, conclusions reached and recommendations were all discussed and shared throughout the investigation. The report is simply a summary of these things, produced as part of the record and for sharing with those parties involved in the strategy meetings and case conferences. The report was not intended to be and should not be read as the full record of the investigation and actions taken. The minutes of the meetings record much of the detail about the protection response during the investigation and the decision making that took place throughout.

81. Given the investigation process and meetings held, there were no surprises in the report when it was made available to senior management. On reviewing the documents made available to me by the Inquiry, I note that a draft of the report was available for the strategy meeting on 05 July 2013. At that point, there was still one interview with a patient to be carried out. A number of clarifications were sought by various meeting participants and there was some discussion about the conclusions drawn. All participants were asked to consider the report further and revert to the investigating team with any requested amendments. The minutes of the meeting held on 28 October 2013 record that comments had been received, amendments were made and the report recirculated to meeting participants. No further feedback had been received.

82. At that meeting on 28 October 2013, John Veitch, as at earlier meetings, continued to dispute my view of what constituted evidence. Moira Mannion and John Veitch both stressed that the monitoring had shown no evidence of institutional abuse. I continued to make the point that I had made in previous meetings that whilst the monitoring had not shown evidence of institutional abuse, it had been put in place after the allegations were made and therefore could not be generalised to the period before the allegations. I pointed to the conclusions in the report as summing up the best judgement that the investigating team could form. I said that the investigation was not conclusive enough to state that there was no evidence of institutional abuse. The minutes record Rosaline Kelly from RQIA agreeing with that point of view and stating that RQIA felt that there was enough evidence to justify at least some concerns about wider practice on the ward.

83. The minutes record that John Veitch wanted to review minutes of previous meetings for any discussion on institutional abuse before the case conference would conclude on this issue.

84. The minutes note that there was to be a further meeting on 20 January 2014. I do not know if that meeting took place but there is no minute of it supplied in the bundle provided to me.

85. I do not recall if John discussed the matter any further with me. At the final meeting on 08 April 2014, there is no challenge to the report recorded and I do not recall any challenge although some concern by Siobhan Rogan, RQIA and myself is noted about Ennis Ward staff disputing the allegations in the meeting held with them to discuss the investigation. There was no challenge to the recommendations in the report by John Veitch, Moira Mannion or Esther Rafferty.

Q6. How, in your perception, was the Ennis report received by ward staff and how did they respond?

86. I do not know if the written report was ever made available to ward staff. I would not have expected it to be as it contained names of the Bohill staff, details of the allegations against named ward staff, details of staff suspensions, disciplinary recommendations and details of the PSNI investigation. I had limited contact with ward staff other than the interviews which I carried out during my investigation. I was mostly liaising with Esther Rafferty who in turn liaised with the staff on Ennis Ward. There were efforts made by Esther and her team to give as much information to the ward staff as possible throughout the investigation in recognition of the fact that not knowing was stressful for staff. This approach was discussed and agreed at a number of the meetings. However there were some limits to what could be shared.

87. I recall towards the end of the investigation and in recognition of the possibility that the abuse had been more widespread on the ward than we had been able to prove, I suggested that the investigating team would meet with the Ennis Ward staff to discuss the allegations, the outcome of the investigation including the fact that we had been unable to identify some staff against whom allegations were made and the

recommendations we had made. I felt that raising awareness of this and stating clearly what was acceptable and unacceptable would serve as a protective factor in the future. I recall that Esther Rafferty arranged the meeting and Carmel Drysdale and I attended with Esther. Staff presented as very angry during the meeting, repeatedly challenging what Bohill staff had said. During the meeting, I felt very unsupported by Esther Rafferty who largely just observed the meeting. I felt that this created an unhelpful impression that hospital management did not have the same level of concern as community staff around the allegations and the investigation.

Q7. What was your role in the implementation of the recommendations made by the Ennis Report? It is anticipated that the answer to this question will include, but not be limited to:

- **A detailed explanation of your specific role(s) and actions taken;**
- **An explanation of who you reported to in respect of any actions;**
- **If you worked with others, an explanation of who they were and the role(s) they carried out.**

88. The only recommendation in the final report that I was responsible for was to have a meeting with the Ennis Ward staff, which you will note from my answer to question six above occurred. I reported back at the next strategy meeting to let all attending know that this action point was completed. None of the other recommendations related to any areas I had operational management responsibility for. However, as the designated officer, I had a responsibility to monitor and review the implementation of recommendations. I was given assurances by Esther Rafferty at a number of the later meetings which John Veitch attended that all recommendations were accepted and implemented.

Q8. Did you encounter any challenges or difficulties in your role in the Ennis Investigation or the response to it? If so, please explain what they were?

89. I encountered many challenges and difficulties in my role in the Ennis investigation. The difficulties largely involved antagonistic and confrontational behaviour towards me and on occasion, to the investigating officers by MAH staff. I experienced these behaviours

from senior nursing staff, Esther Rafferty and Moira Mannion and John Veitch, Co-Director for Learning Disability Services. I also experienced a lack of a collaborative approach from these same senior people.

90. Particular difficulties included a dispute about the inclusion of the Consultant Psychiatrist, Doctor Colin Milliken for Ennis Ward in strategy and case discussion meetings. I was put under pressure to include him in meetings and although he ultimately did not attend meetings, the dispute was a very difficult experience. My initial recall was that this happened before the first strategy meeting but on reviewing the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, it was just before the second strategy meeting on 15 November 2012 was due to begin, when I discovered that Esther Rafferty had invited Doctor Milliken to this strategy meeting. I spoke to Esther Rafferty advising that I did not think it appropriate for Doctor Milliken or any other Ennis Ward staff to be involved in planning an investigation strategy or in agreeing a protection plan which were the two main items for consideration at the meeting. This was because I was conscious that there was a need to consider the possibility of widespread abuse of the ward.

91. Esther Rafferty disagreed vehemently with this approach and tried to overrule me, stating that she was the more senior manager. Whilst accepting this, I was insistent that as the designated officer, I had the lead responsibility for immediate protection planning and agreeing a joint investigation strategy and that I was not prepared to involve any ward staff in the meeting. We were unable to resolve this issue between us and Esther Rafferty decided to contact Catherine McNicholl. I was not involved in that telephone call but following the call, Esther Rafferty asked me to call Catherine McNicholl which I did. Catherine McNicholl told me that she had agreed with Esther Rafferty a position whereby no MAH staff would attend the strategy meeting. This resolved the issue of Doctor Milliken's attendance but meant that there was no one from MAH present to answer queries or take responsibility for any agreed actions.

92. I also experienced considerable opposition from the outset from Moira Mannion and, to a lesser extent, Esther Rafferty to the part of the protection plan that required twenty four hour monitoring and although I did not accede to requests to stand down the monitoring, I was put under considerable pressure to do so. The pressure to do so

started from the very early stages of the investigation process. I was told that the monitoring staff had not observed any signs of abuse and that, therefore, there was no need for monitoring. This was despite the fact that it was unlikely that staff would behave in an abusive fashion in front of staff and that it took some months to try to identify all staff who were accused of abusive practice. I was also repeatedly told that the presence of a monitoring member of staff was causing disruption and distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion. I believed that the presence of one unfamiliar member of staff amongst a team of familiar staff who were doing most of the hands on care was unlikely to be so significant that it outweighed the need to protect against the possibility of wider abuse on the ward.

93. At the beginning of the investigation, both RQIA and I had concerns that the agreed monitoring was not in place and I had to address this with Esther Rafferty. There were further difficulties about what monitoring was in place at night and whether or not monitors were additional to the routine ward staffing ratios.

94. In the Timeline of Ennis Investigation (January 2010 to April 2016) in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 577, it states that twenty four monitoring started on 15 November 2012 whereas it had been agreed at the first strategy meeting on 09 November 2012 that the monitoring would start immediately.

95. Moira Mannion challenged many of the aspects of the decisions and actions I was making, many of which were routine safeguarding practices. Whilst some challenge and questioning is normal and often useful, I believe this was excessive and unreasonable and delivered in a tone and manner that I found intimidating. Minutes do not convey tone and manner however the minutes of various meetings, in particular the minutes of the 20 December 2012, do, I believe, show the level of challenge and opposition I was faced with. I also recall that Moira Mannion berated me in a meeting for daring to suggest that nurses could be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own practice. The strategy meeting on 20 December 2012 was one of the most difficult meetings in the investigation and I recall I came out

of that meeting shaking. I think that it was after this meeting that either Tracey Hawthorne or Elaine McCormill from the PSNI and Margaret Cullen from RQIA contacted me to see if I was ok.

96. I should note that I believe Moira Mannion also contributed positively to aspects of the safeguarding process, in particular, in supporting improvements on Ennis Ward and providing support to ward staff. Similarly, Esther Rafferty was cooperative with some aspects of the safeguarding process, particularly in facilitating access to records and staff and in actioning recommendations.

97. I was repeatedly challenged both privately and in meetings by John Veitch about the validity of the determinations I was making about evidence of abuse. I believed that John was too keen to dismiss uncorroborated witness statements from the Bohill staff. John Veitch also put considerable pressure on me to state that I had found no evidence of institutional abuse. My position was that whilst I did not feel I could definitively say that there was institutional abuse, I had enough suspicion about wide spread abuse on the ward to make me unwilling to say that there was not. I did not give into the pressure to say that there was no evidence of institutional abuse. I was also very clear that there was considerable evidence that H159 and H197 had been abusive in their practice.

98. Carmel Drysdale and Colette Ireland, the two investigating officers also reported to me that they were experiencing antagonism during their work in MAH from staff. In one such incident, the Timeline of Ennis Investigation (January 2010 to April 2016) in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 578 records an entry on 25 January 2013 whereby a Pre – Interview Assessment being carried out jointly by Tracey Hawthorne, PSNI and Carmel Drysdale, Investigating Officer was interrupted by a staff member who whispered to Tracy that the patient being interviewed had said the night before that another patient had hit her but that patient had not been there the previous night and added that the patient makes things up. The staff member also tried to make eye contact with the patient and pulled a face at her.

99. I also found John Veitch very resistant to my wish to give comprehensive information and updates to families. There are legitimate concerns to be considered in relation to

sharing information with families, including confidentiality issues, a fear of causing undue anxiety and the need not to compromise an investigation. However I felt that John Veitch's reluctance was excessive and did not sufficiently balance those considerations against the rights and benefits of families being informed and involved, as appropriate, in safeguarding investigations. There is extensive reference to this in the Timeline of Ennis Investigation (January 2010 to April 2016 in the Module b6: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry between 2012 and 2013. John Veitch maintained that it was not routine practice to write to families during an adult safeguarding investigation but I would disagree with this, particularly with larger investigations, as in the case of the investigation into the allegations at Ennis Ward. The reasons for writing were to ensure that all families were getting the same information, that they had time to consider all the issues carefully and that they had the contact details of people they could talk to. Letters were also used when staff had been unable to make contact by telephone. The usual process was to telephone or attempt to telephone families first and then follow up by letter.

100. At the time, I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced to a range of possible factors including professional defensiveness on the part of nursing and a reflection of some community/hospital and social work/nursing tensions. Whilst some defensiveness is not unusual from services which are under investigation, this was beyond the normal. I also believed there was a reluctance, perhaps subconsciously, to accept the possibility of widespread abuse on Ennis Ward. The pressure from John Veitch was one of the most difficult parts of the investigation for me as it was repeated and coming from within my own line management hierarchy,

101. John Veitch's position as Co-Director for Learning Disability Services and subsequently as my line manager; Moira Mannion's position also as Co-Director and Esther Rafferty at Service Manager level were all more senior to me up until July 2013 when I took up a Service Manager post. This made the challenges I faced from them particularly difficult to handle. I believe that the behaviour of John Veitch, Moira Mannion and, to a lesser extent, Esther Rafferty was bullying in nature and it took a significant personal toll on

me to have to maintain my own position and not give into the pressure and to carry out my professional responsibilities in the face of such opposition.

102. I also believed that I had withstood the pressure, had been able to carry out the investigation that I wanted to carry out and that the investigation report reflected what I felt able to say. The uncertainty of some of the conclusions was reflective of a lack of concrete evidence in some cases and not as a result of any pressure. Ultimately, I was not challenged on any aspects of the report.

103. When the adult safeguarding process finally concluded, it was with the understanding that there should be an ongoing protection plan that the two staff members who were being prosecuted would not have any unsupervised access to vulnerable adults and that disciplinary action would be taken against them.

104. I had no further involvement in matters until I became aware that Esther Rafferty had requested Rhonda Scott and Geraldine Hamilton to commence an investigation into the November 2012 allegations. Having had the benefit of reviewing the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 580, I note reference to an email on 19 September 2013 whereby I was contacted by Rhonda Scott by email to advise that she and Geraldine Hamilton had been asked to carry out an investigation into the November 2012 allegations. Upon receipt of this email, I note from the timeline that I was concerned that it appeared that Esther Rafferty had asked for another investigation into matters that I considered the safeguarding investigation had already covered. I queried this by email to Esther Rafferty. Esther responded to advise "*a full internal investigation will now take place to look at what action and learning the Trust needs to undertake in relation to any staffing concerns from the original complaint on 8th November. This is normal practice*". I responded asking if this is a disciplinary investigation and Esther confirmed that it was. Having had the benefit of reviewing the documents which appear at pages 293 – 376 of the Module 6b: Ennis Ward Adult Safeguarding Reports (August 2013) Bundle for Witnesses provided to me by the Inquiry, the content of these reports would appear to me to suggest that the investigation carried out by Rhonda Scott and Geraldine Hamilton did cover matters which I believed were already dealt with. The reports note that the interviews they carried out covered induction processes, training, staffing,

supervision, the environment, resources, reporting processes as well as the adult safeguarding allegations.

105. As far as I can remember, my next involvement was when I heard informally that this disciplinary investigation was well underway. I was concerned that this was the case but that no approach had been made to me to discuss the outcomes of my investigation or the rationale for the recommendation for disciplinary action. I raised my concern about this with John Veitch, who arranged for the disciplinary team to meet with me. The timeline supplied in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry records this meeting having taken place on 01 June 2015. I was concerned during this meeting that the disciplinary investigation did not appear to me to be placing enough weight on the findings of the safeguarding investigation. I note that these Ennis Ward investigation reports say that the investigation started in September 2013 and concluded in February 2015 whereas I was not spoken to until June 2015.

106. Having now had the opportunity to read the report compiled by Rhonda Scott and Geraldine Hamilton, I note that reference to information obtained and conclusions drawn in the safeguarding investigation is limited.

107. At the time, when I learned that neither of the two staff had been dismissed as I expected, I raised my concern about this with John Veitch stating that the safeguarding investigation had very clearly found significant evidence of abuse by these two staff members and that the ongoing protection plan was that these staff members should not have any contact with vulnerable adults. John Veitch arranged a meeting with a Human Resources Senior Manager who informed me that there was no route of challenge to the disciplinary findings. This senior manager may have been Cynthia Crutchley, but I am not sure about that.

108. I believe I was told that neither of the two individuals concerned were actually working, that one had retired and one was on sick leave which assuaged my concern to some degree.

Q9. Having received and considered the bundle of documents provided by the Inquiry relating to Ennis, do you wish to provide further detail or comment on any issue(s) arising in the documents?

109. I was on secondment from the Belfast Trust to the Department of Health as a Professional Social Work Officer from 5 June 2017 to 1 July 2021. On 1 July 2021, I became Deputy Chief Social Worker at the Department of Health and Chief Social Work Officer on 1 October 2022.

110. Whilst I believe I carried out a thorough investigation, that my conclusions and recommendations were sound and that I had done everything I could, I had always retained an uneasiness about Ennis, both in relation to the difficulties I experienced and about my concern that there was insufficient evidence to prove some of the allegations. In December 2019, in consultation with my colleagues Jackie McIlroy, Deputy Chief Social Worker and Mark Lee, Director of Mental Health, Disability and Older People, who in turn consulted with Sean Holland, Chief Social Worker & Deputy Permanent Secretary of the Social Services Policy Group, it was agreed that I should make a statement to the Belfast Trust concerning the difficulty I experienced during the Ennis Investigation.

111. That decision was prompted by two factors. Firstly, I was conscious that some of my experiences were potentially relevant to the MAH Leadership and Governance Review which was due to begin, in particular, the exploration of the informal culture in MAH which was included in the terms of reference. I considered it inappropriate to discuss this experience with the review team without also informing the Belfast Trust.

112. Secondly, a leak of the Ennis Ward Adult Safeguarding Report to the Irish News on 14 October 2019 had set in train a number of actions which resulted in an agreement at the Muckamore Departmental Assurance Group that I, along with a Belfast Trust representative, whom had not been identified, would be involved in briefing the family representatives on the Muckamore Departmental Assurance Group as well as the families of the Ennis patients at the time. I did not feel I could provide an open and honest briefing about the Ennis investigation without disclosing the difficulties I experienced. When the Ennis investigation was first discussed at the Muckamore

Departmental Assurance Group on 30 October 2019, the Belfast Trust was asked to provide a synopsis of the investigation. When I read the synopsis, I was concerned that the conclusions summarised included the more positive findings but omitted the findings that were of more concern. I raised my concerns about this this at a Muckamore Departmental Assurance Group meeting on 27 November 2019. Subsequent to this, both of the family members on the Muckamore Departmental Assurance Group were offered the opportunity to meet with me to discuss the Ennis investigation. Just one family member took this up. Preparations for a wider briefing to families were interrupted by the Covid pandemic and did not occur.

113. My line manager, Jackie McIlroy and I took part in a conference call on 16 January 2020 with Marie Heaney, Carol Diffin and H425 [redacted] of the Belfast Trust to tell them of my experience and difficulties I encountered during the Ennis investigation. The Belfast Trust forwarded what appears in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at pages 582 – 586 to be a minute of the meeting. I do not agree that the minute is an accurate reflection of the meeting and I responded by email when it was sent to me to say that I would provide my own statement of my concerns. This was an option offered to me by Carol Diffin when she emailed the minute to me saying; *" following our teleconference meeting on 16th January Marie and I have put together a record of the issues you raised. Could you review this record and ensure it is accurate and return to me by Monday 3rd Feb. Alternatively you may wish to put your own record of your concerns in writing to us."* I forwarded my statement of my concerns to Carol Diffin and Marie Heaney on 06 February 2020. I attach the exchange of emails from 31 January 2020 to 04 February 2020 at Exhibit 1 to this statement. I also attach a copy of my statement issued to Carol Diffin at Exhibit 2. At the time of preparing that statement, I did not have the information which has been provided to me by the Inquiry in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses.

114. Following my statement to the Belfast Trust of my experience in acting as designated officer, I understood from a conversation I had with Sean Holland that the MAH Leadership and Governance Review would include a review of events relating to the Ennis safeguarding investigation. The Leadership and Governance Review team interviewed me on two occasions. On the first occasion, all three members of the review

team, David Bingham, Maura Devlin and Marion Reynolds met with me and I went through the written report I had provided to the Belfast Trust about my experience of the Ennis Investigation. On the second occasion, only David Bingham and Marion Reynolds spoke to me and whilst they asked me a number of questions about Ennis, the focus on Ennis was limited and much of the interview was about other issues.

115. I was not given access to any of my records about the Ennis investigation before being interviewed by the team despite being asked about some of the records. I was not given a written record of my interviews with the team, had no further opportunity to engage with them on any issues, was not offered a chance to respond to any criticism of my actions and was not given the opportunity for a factual accuracy check before the report was published. Whilst I have no dispute with much of what the Leadership and Governance Review report says, there are some areas that, in a personal capacity, I do not accept. The detail of my concerns in relation to this report are contained in an email I sent to the then Chief Social Work Officer on 15 September 2020. I attach a copy of this email at Exhibit 3 to this statement.

116. Following the publication of the Leadership and Governance Review report, Cathy Jack, Chief Executive in the Belfast Trust contacted Sean Holland to inform him of a separate process in which they had engaged David Bingham, the Chair of the Leadership and Governance Review Team and Sean Holland advised me of this. This process was to provide an adjudication on the veracity of the account I had given to the Belfast Trust about my Ennis experience. David Bingham had written to the Belfast Trust to say that he did not accept my account of events relating to Moira Mannion and Esther Rafferty and the Belfast Trust had written to Esther Rafferty and Moira Mannion to tell them of this outcome. I am not aware of David Bingham investigating my account concerning John Veitch.

117. This was the first I was aware of this separate process. I subsequently learned that the Belfast Trust had originally asked the review team to adjudicate on my account of events as part of the Leadership and Governance Review but that the review team had not agreed to this, stating that it would be outside their terms of reference.

118. However, David Bingham agreed to give a personal view to the Belfast Trust and his letters to the Belfast Trust state that his views are his personal views. He does state

though, that he is relying totally on material he had access to during the course of the Leadership and Governance Review.

119. I believe I have been treated very unfairly in this process. I was completely unaware that the process was happening, given very little opportunity to engage with David Bingham on the issue and was denied the opportunity to present any evidence, including direct witness evidence. I decided to lodge a grievance with the Belfast Trust in March 2021 about this process. The content of David Bingham's letters to the Trust and the full detail of my objections to the process and the outcome are contained in my written grievance at Exhibit 4 attached to this statement.

120. I also made complaints to the Department of Health, the Health and Social Care Board and the Public Health Agency about the fairness of some of the processes in the Leadership and Governance Review and about the separate actions of David Bingham in giving a personal view about my Ennis statement. The Department of Health, the Health and Social Care Board and the Public Health Agency have all informed me that they were unaware of the arrangement between the Belfast Trust and David Bingham. The Department of Health accepted that there should have been the opportunity for a factual accuracy check of the Leadership and Governance Review report and all three organisations accepted that there were lessons to be learned for future reviews of this nature. Correspondence relating to these complaints is contained at Exhibits 5 to 9 attached to this statement.

121. My grievance with the Belfast Trust has yet to be resolved because the Belfast Trust maintains that it has no responsibility for how David Bingham went about making his adjudication on the veracity of my statement and therefore cannot respond to the majority of the issues contained within my grievance. The Belfast Trust maintains that the responsibility for the processes of the Leadership and Governance review belonged to a combination of the Department of Health, the Health and Social Care Board and the Public Health Agency and that they therefore do not have responsibility for the process. The Department of Health, the Health and Social Care Board and the Public Health Agency all maintain that the responsibility for the process used by David Bingham to make this separate adjudication lies with the Belfast Trust.

122. There are a number of issues in the timeline and in the leadership and governance review report which I was completely unaware of at the time of the investigation. As far as I can recall, I had no awareness of or involvement in any discussions about a serious adverse incident. I also do not believe I was sighted on correspondence with or about RQIA, the Belfast Trust Human Resources Department or the Health and Social Care Board.

123. There was a meeting between the Belfast Trust and the Department of Health held on 21 January 2020. Mark Lee, Jackie McIlroy and Rodney Morton, Deputy Chief Nursing Officer and I were there from the Department of Health. Marie Heaney, Director of MAH, Jolene Welsh, Governance Lead and possibly others that I do not recall attended from the Belfast Trust. At that meeting, Jolene Welsh referenced a number of records that she had reviewed whilst compiling a timeline of events relating to the Ennis investigation. Jolene said that there was an email sent by John Veitch to the Belfast Trust Human Resources Department stating that the investigation had found no evidence of institutional abuse and indeed had found evidence of good practice. I stated that I was very shocked to hear of this email as I was completely unaware of it and believed it did not reflect the outcome of the investigation accurately. Jolene also said that I had raised my concern with John Veitch that H159 and H197 had not been dismissed. Jolene also commented in the meeting that if the minutes read as they did, she would hate to think what the actual meetings must have been like. The written timeline was not made available to the Department of Health at that meeting or subsequently.

124. Having now had access to the timeline in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, I note that there is no record of an email from John Veitch to the Belfast Trust Human Resources Department making the statement above. However, there is communication from John Veitch to RQIA on 30 May 2013 or 06 June 2013 saying, "*this investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse….. I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture.*" There is missing text which means I am not sure what are the measures being referred to. However, there is another email from

John Veitch to Esther Rafferty in the timeline dated 22 May 2013 asking her to amend a letter to RQIA where he uses similar language and asking her to emphasise that the monitoring arrangements have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture. It therefore seems likely that the measures referred to in the email from John to RQIA are the monitoring arrangements. If this is the case, I feel this email is potentially misleading as it does not reference the investigation's conclusion that the monitoring reports could not speak to practice on the ward before the allegations were made and that whilst institutional abuse could not be confirmed, it could not be ruled out either.

125. The Leadership and Governance Report contained in Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 717 states that the Belfast Trust advised the Health and Social Care Board *"repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met."* I consider this advice by the Belfast Trust inaccurate as the safeguarding investigation had concluded that there was evidence to substantiate the allegations against H159 and H197.

126. Also in the Leadership and Governance Report contained in Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry at page 698, in the footnote it states that the Belfast Trust told the Health and Social Care Board, "*If it had been reported as a SAI it would then have been deescalated due to the unfounded allegations*" and goes on further to state, "*It also said HSCB are content to close this early alert on the basis the Belfast Trust had advised the safeguarding investigation found the allegations were not substantiated.*" Again, I feel this is inaccurate. I was shocked to learn of these communications and was unaware they were happening. If I had been aware of any of the communications which I have listed in this paragraph, I would have challenged them.

127. As John Veitch attended all of the strategy meetings, he would have been fully aware of the conclusions about H159 and H197 and also the suspicion of more widespread abuse on Ennis Ward and my refusal to say that the investigation had not found any evidence of institutional abuse. The existence of these records now makes

me question whether there were other discussions and decisions about Ennis that I was not party to. It also leads me to question my belief that I had overcome opposition and that my report had been accepted in good faith and acted upon.

128. The minutes of the strategy meetings included in Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, refer to other meetings but there are no minutes of meetings on those dates. I do not know if those meetings were rescheduled or cancelled or whether the minutes have not been supplied to the Inquiry.

129. The Timeline of Ennis Investigation (January 2010 to April 2016) Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry in many instances only provides extracts of records, therefore, my comments are limited to those extracts. I also note that the timeline does not include an internal email from 24 January 2013 about concern of possible institutional abuse which the Leadership and Governance review report has referenced at page 699.

130. In considering the timeline, I note a record dated 28 July 2013 which states that a complaint from a family member does not appear to have been investigated. This is incorrect, the response to the complaint is detailed in the safeguarding investigation report.

131. I am also concerned to note that a 27 July 2015 timeline entry references letters from Esther Rafferty to H159 and H197 saying that the allegations of abuse of vulnerable adults had been fully investigated under the protection from abuse of a vulnerable adult protection process and that there was no evidence to substantiate the allegations. This is incorrect. The adult safeguarding investigation had found evidence to substantiate the allegations against H159 and H197. The letters should have referred to the disciplinary investigation, not the adult protection process.

132. I was further concerned to note a 09 October 2015 timeline entry referencing an email sent by John Veitch to Gladys McKibbin, Human Resources Co-Director that he would not have received the vulnerable adults' investigation report. This is incorrect as John Veitch did have the report.

Q10. Please provide details of any matters in respect of Ennis not covered by the above or your experience of Muckamore Abbey Hospital generally that you feel will assist the Panel in addressing the Terms of Reference.

133. Following the conclusion of the investigation, I did have an informal discussion with John Growcott and expressed my thinking that where there were future major concerns about widespread abuse in a Belfast Trust service, it would be better to appoint a designated officer who did not work in the programme of care which managed the service. My reasoning for this was that it would avoid the position I found myself in where I had to challenge my own senior managers.

134. Yvonne McKnight and I also discussed our shared concern that the disciplinary process had come to a different conclusion than the safeguarding investigation and any means of ensuring that they were more joined up in the future would be worthwhile.

135. In the Department of Health in all my roles, I have given professional advice on a wide range of MAH adult safeguarding and learning disability issues. I am also a member of the Muckamore Departmental Assurance group and on appointment to the Deputy Chief Social Worker post in July 2021, I replaced the previous post holder as the Department of Health representative on the multiagency Strategy Management Group set up to oversee the current MAH investigation. However, I have confined my responses in this statement to the Ennis investigation and its outworkings.

Giving Evidence

136. I am happy to give oral evidence to the Inquiry if that would be of assistance.

137. If I am asked to give evidence, I do not require any special arrangements.

138. I do not require a supporter to attend the Inquiry hearing with me.

139. I am happy to give my name.

Section 5: 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 relevant to the Inquiry's terms of reference.

Signed: Ane Morrison

Date: 2/2/24

List of Exhibits of Aine Morrison

Exhibit 1 - Exchange of emails between Carol Diffen and Aine Morrison from 31 January 2020 to 04 February 2020.

Exhibit 2 - Statement of Aine Morrison to Belfast Trust undated but sent to Carol Diffen on 04 February 2020 by email.

Exhibit 3 - Email dated 15 September 2020 from Aine Morrison to Sean Holland.

Exhibit 4 - Grievance statement issued by Aine Morrison in March 2021 to Belfast Trust.

Exhibit 5 - Email dated 11 December 2020 from Aine Morrison to Health and Social Care Board.

Exhibit 6 - Letter dated 02 March 2021 from Health and Social Care Board and the Public Health Agency to Aine Morrison.

Exhibit 7 - Email dated 31 March 2021 from Aine Morrison to Health and Social Care Board.

Exhibit 8 - Letter dated 30 September 2021 from Department of Health to Aine Morrison.

Exhibit 9 - Letter dated 10 December 2021 from Health and Social Care Board and Public Health Agency to Aine Morrison.

Exhibit 1

From: Morrison, Aine
Sent: Tuesday, February 4, 2020 5:33 PM
To: Diffin, Carol <Carol.Diffin@belfasttrust.hscni.net>; Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Cc: 'Alexander, Karen' <Karen.Alexander@belfasttrust.hscni.net>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>
Subject: RE: Meeting with Aine Morrison Jackie McIlroy 16 Jan 2020
Sensitivity: Confidential

Carol/Marie,

When I went to amend the record that you had provided, I was finding it a bit difficult to marry my wording and yours so in the end up, decided it would be better to write my own which I have now done.

Apologies for not getting it through to you on Monday but had already a number of things scheduled and it took time to write.

Two queries, I have referred to the email from JV to Human Resources in my write –up but don't have the exact wording of this. Could I get this please, I have left a message for Jolene but haven't heard back from her yet.

Also, if possible, could I get a sense of who will have access to this please,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

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https://www.nidirect.gov.uk/articles/honours

From: Alexander, Karen [mailto:Karen.Alexander@belfasttrust.hscni.net]
Sent: 04 February 2020 14:22
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: Diffin, Carol <Carol.Diffin@belfasttrust.hscni.net>; Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Muldoon, Angela <Angela.Muldoon@belfasttrust.hscni.net>
Subject: RE: Meeting with Aine Morrison Jackie McIlroy 16 Jan 2020
Sensitivity: Confidential

Hi Aine

Further to the email from Carol can you please confirm that you are content with the notes from the teleconference or forward any amendments you may have.

Many thanks Karen

From: Alexander, Karen
Sent: 31 January 2020 09:16
To: 'Morrison, Aine' <Aine.Morrison@health-ni.gov.uk>
Cc: Diffin, Carol <carol.diffin@belfasttrust.hscni.net>; Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Subject: Meeting with Aine Morrison Jackie McIlroy 16 Jan 2020
Importance: High
Sensitivity: Confidential

Dear Aine

Following our teleconference meeting on 16th January Marie and I have put together a record of the issues you raised. Could you review this record and ensure it is accurate and return to me by Monday 3rd Feb. Alternatively you may wish to put your own record of your concerns in writing to us. Again if this is your preference could I have this by the end of Monday. We will need one of these options in order for us to take appropriate action on the back of the concerns you raise.

Many thanks
Carol

Ms Carol Diffin
Director Children's Community Services
'A' Floor, Trust Headquarters
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB

Tel: 02895047489
Mob: RO1

Exhibit 2

This is a written account of some of my experience in acting as Designated Officer (DO) into allegations of abuse on Ennis Ward, Muckamore Abbey Hospital.

In writing this account, I have had access to the safeguarding investigation report which was completed at the end of the investigation although I am not totally sure that the version received by the Dept. of Health is the final version. The writing of the report was led by me but the contents agreed with the two Investigating Officers (IOs) who worked with me during the investigation.

However, I have not had access to any other written documentation about the investigation so much of my account is based only on my memory of what occurred at the time.

I am writing this account at the request of the BHSCT following a number of conversations with the Trust about my experience.

In December 2019, I made the Trust aware that I had experienced difficulties in my role as DO in the Ennis investigation.

My decision to do so was prompted by two factors.

Firstly, I was conscious that some of my experiences were potentially relevant to the MAH leadership and governance review which was commissioned following the disclosure of allegations of abuse at Muckamore Abbey Hospital. I thought it likely that any conversations I might have with the review team would involve my discussing these experiences and therefore wanted to make the BT aware of them also.

Secondly, the leak of the Ennis report to the Irish News had set in train a number of actions which resulted in an agreement at the MDAG that I along with a BT representative would be involved in briefing the family representatives on the MDAG as well as the families of Ennis patients. I felt that I could not give an open and honest briefing without mentioning some of the difficulties I experienced and therefore wished to share this information with the Trust in advance of briefing families.

At the time the allegations were made, 8.11.12, I was an Operations Manager in BT Learning Disability Services with responsibility for community multi-disciplinary learning disability teams.

B Mc N was my line manager although I believe he was on sick leave at the time the allegations were made. JV was the Co-Director for both hospital and community learning disability services at the time. My memory is that he was on annual leave and out of the country when the allegations were made.

I was appointed to a service manager role on 1.7.13 and continued with some aspects of the Ennis investigation then.

MAH informed me of the allegations, I don't remember who in particular informed me but I stepped in to take on the role of Designated Officer under the September 2006, Safeguarding Vulnerable Adults Policy.

The nature of the allegations and the fact that it was alleged that the abuse had happened openly in front of external staff made me immediately concerned about potentially widespread abuse on Ennis Ward rather than single, isolated incidents.

I immediately contacted the PSNI and a joint protocol investigation was agreed with a strategy meeting organised very quickly.

I experienced my first difficulty before this initial strategy meeting. ER who was Service Manager for Hospital Services had invited Dr.CM who was Clinical Director for MAH but also the Consultant Psychiatrist for the ward to the strategy meeting. When I realised this, I spoke to ER stating that I did not think it was appropriate that CM or any other staff from Ennis Ward be involved in planning an investigation strategy or in agreeing a protection plan which were the two main items for consideration at the meeting. This was because I was conscious that there was a need to consider the possibility of widespread abuse on the ward.

ER disagreed vehemently with this approach and tried to overrule me, stating that she was the more senior manager. While accepting this, I was insistent that as the DO, I had the lead responsibility for immediate protection planning and agreeing a joint investigation strategy and that I was not prepared to involve any ward staff in this meeting. We were unable to resolve the issue between us and ER decided to contact CMcN,

Director for Adult Community Services. I was not involved in that phonecall but following the phone call, ER asked me to ring CMcN. I did this and CMcN told me that she had agreed with ER a position whereby no MAH staff would attend the strategy meeting. This resolved the issue of CM's attendance but did mean that there was no one from the hospital present to answer queries or take on responsibility for any actions.

At a later point, ER did rejoin the meetings but I do not remember at what point. I do not believe that CM attended any future meetings but am not sure on that point.

A further difficulty arose when making protection plans to ensure the patients were safe while an investigation was underway. While a number of staff had been suspended, I believed that the concerns were such that 24 hr monitoring of the ward by external staff was also necessary.

The Bohill staff who had made the allegations were very clear that they had had no concerns about staff conduct on other wards that they had also spent time in and indeed had observed very compassionate care on the other wards so we had no reason to suspect at that stage practice in other wards.

It was agreed that the 24 hour monitoring would largely be provided by Band 8A senior nursing staff from MAH. I believe that MM, Co-Director for Nursing also did some monitoring herself, she also made unannounced ward visits and I think she also arranged for other staff external to MAH to participate in some of the monitoring. I think that over time, Band 7 staff from other areas both within and outside MAH also provided monitoring but I cannot remember all the details.

From the outset, I experienced significant opposition from hospital staff to the part of the protection plan that required 24 hour monitoring. There were some initial difficulties with ensuring that it was happening as stipulated. RQIA found on at least one occasion that the agreed arrangements were not in place when they visited the ward. I needed to restate the expectation of 24hr monitoring on a number of occasions. Then, there were repeated requests made to me to stand down the monitoring. These requests started at an early stage of the investigation and continued for quite some time. I was repeatedly told that the presence of a monitoring member of staff was causing disruption and

distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion. I believed that the presence of one unfamiliar member of staff amongst a team of familiar staff who were doing most of the hands on care was unlikely to be so significant that it outweighed the need to protect from the possibility of wider abuse on the ward. I did not accede to any of the requests to step down the monitoring. I do not remember who exactly voiced the opposition to the protection plan but my memory is that it came from MM, ER and other hospital management staff. The minutes of various meetings may record the details of this.

During one of the earlier meetings where MM and ER were both present. MM was extremely hostile towards me. She berated me for daring to suggest that nurses would be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own professional practice. The level of hostility and confrontation was such that a number of people external to the BT who were present at the meeting contacted me afterwards to see if I was ok. While this incident was the most direct and confrontational, I continued to feel that I was not receiving adequate support from ER and MM. During much of the investigation, I felt like an unwelcome outsider. I did not get any sense of a collaborative approach between myself and hospital management, instead feeling that I was having to regularly challenge.

While it was not unusual for a Designated Officer to experience some resistance from a service under investigation, this was beyond the norm.

There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was criticism of their level of experience, expertise, perception of events and in particular their failure to speak out at the time of witnessing the alleged abuse. This was portrayed as poor practice on their part and used as an argument to doubt their credibility. While a lot of this criticism came from ward level staff, my memory is that it was also voiced by ER and MM. There appeared to be a lack of understanding about the difficult position the Bohill staff were in, the power differentials, the lack of immediate support for them in that setting and the fact that at least two of them had reported their concerns very soon afterwards.

MM and I had very different views on the care plans for individual patients on the ward. While acknowledging that I was not familiar with nursing care plans, they appeared to me to be lacking detail, particularly in relation to managing challenging behaviours. MM's view was that the care plans were satisfactory.

I also experienced very significant pressure from JV, the Co-Director for both hospital and community learning disability services.

JV repeatedly challenged me both privately and publicly in meetings about what I had determined to be evidence of abuse. My response was that I had weighed up all the information available to me and that I gave weight to the number, credibility and consistency of reports and that where these factors were sufficiently persuasive, I counted this as evidence. JV repeatedly characterised this as one person's word against another and therefore unreliable. I responded by accepting the inherent difficulties in having conflicting accounts but stated that many issues both in criminal cases and safeguarding relied on witness evidence which was challenged by the person accused and that the safeguarding task was to make the best judgement possible on the balance of probabilities.

I was also challenged repeatedly by JV to state that I had found no evidence of institutional abuse. I had not used the term "institutional abuse" up until this point. My understanding of the term was about routines, systems, regimes which created the conditions for abuse or were in themselves abusive. I felt that what I was investigating in Ennis was allegations of physical abuse and ill-treatment which were potentially widespread and potentially happening openly. My aim was to describe what was alleged and to describe what the investigation found.

However, when JV used the term, I understood him to mean whether there was or wasn't widespread or endemic abuse.

One of the major difficulties in the investigation was in identifying individuals as described by Bohill staff.

There were also a number of individual allegations which were potentially a matter of interpretation, such as "how tight was too tight in relation to a belt?".

There were also a number of instances where all we had were two different accounts, one by the person making the allegation and one by the person accused of it.

So while,the investigating team were very clear about the weight of the evidence against two named individuals, we also believed there was an absence of concrete evidence against other individuals that would be deemed sufficient evidence for disciplinary action.

However, we did believe that there was enough evidence to warrant suspicion about wider-spread abuse and for that reason, I was not prepared to say that we had found no evidence of institutional abuse. In the debates with JV about this issue, I said that while I did not feel that I could say that there was conclusive evidence of institutional abuse, I felt that equally, I could not say that there wasn't institutional abuse.

JV disagreed with this position and while I felt pressurised by him to state that I had not found institutional abuse, I maintained my own position both in the investigation report and in meetings. I was not challenged on the final wording of my report by JV or any of the other people involved.

At one point in the investigation, when we were struggling to get identification of individual MAH staff members from Bohill staff members, I explored the possibility of showing MAH staff photos to Bohill staff. I explored the possibility of getting staff photos from their staff identity cards but was advised that this would not be technically possible. I discussed the issue with JV who was very opposed to this and not willing to consider it at all. He said that it would be most unfair to staff given the risks of misidentification and that staff could legally challenge it.

I would have welcomed a discussion on it but did have significant doubts about the appropriateness of it myself, feeling that there were risks of misidentification in it and also that such a process would more properly sit with the PSNI if they thought it was necessary. For those reasons, I accepted JV's determination on that issue and did not pursue this further.

All of the investigatory actions were planned and reviewed with the PSNI throughout the process.

JV also emphasised to me that I could not make disciplinary recommendations, that all I could do was recommend someone for disciplinary investigation. Policy at the time supported two separate processes and I was unconcerned about this advice as I believed the disciplinary process would take account of what the safeguarding investigation had found.

Towards the conclusion of the investigation and in recognition of the possibility that the abuse had been more widespread than we had been able to prove, I suggested that the investigating team would meet with the Ennis staff team to discuss the allegations, the outcome of the investigation including the fact that we had been unable to identify some staff against whom allegations were made and the recommendations we had made. I felt that raising awareness of this and stating clearly what was acceptable and unacceptable would serve as a protective factor in the future. ER set up and attended this meeting. Staff presented as very angry during the meeting, repeatedly challenging what the Bohill staff had said. During the meeting, I felt very unsupported by ER who largely just observed the meeting. I felt that this created an unhelpful impression that hospital management did not have the same level of concern as community staff.

Following the end of my investigation, at some point, I was made informally aware that a disciplinary investigation into the two people I had recommended for disciplinary action was underway. I was concerned that I had not received a request for either the investigation report or any of the other documents, including in particular the records of the interviews with Bohill staff. Nor had I been contacted in relation to my reasoning for recommending a disciplinary investigation. I raised my concern about this with JV and he arranged for the two disciplinary investigating staff to get a copy of the investigation report and asked them to meet with me. During this meeting, I became concerned that they did not wish to review all my records although they had received and read the investigation report. I felt that their focus was to re - investigate whereas I felt that the investigation had been done and that they should rely on the evidence that I had already gathered. I think it

was at that meeting that I was informed that some of the Bohill staff were unwilling to be re – interviewed by them and unwilling to give witness statements in a disciplinary investigation. I argued that these were unnecessary as I already had their statements.

At a later point, again I heard informally that neither of the two staff had been dismissed. On hearing this, I raised my concern with JV, stating that the safeguarding investigation had very clearly found significant evidence of abuse and that the ongoing protection plan was that these two staff members should not have any contact with vulnerable adults. I pointed out the difficulty of two contradictory decisions being made by two separate Trust systems. JV arranged a meeting with a HR senior manager to discuss this. He and I both attended and I raised my concern about what had occurred. While JV was not dismissive of my concern, he did not express any shared concern. The HR senior manager stated that there was nothing that could be done, that the disciplinary process had to come to its own conclusion and that there was no route of challenge to this. I was told that neither of the two individuals concerned were actually working, that one had retired and one was on sick leave which assuaged my concern to some degree.

While I did experience what I believed to be unacceptable opposition and pressure as described, I also believed that I had withstood the pressure and had been able to carry out the investigation that I wanted to carry out and that the investigation report reflected what I felt able to say. The uncertainty of some of the conclusions were reflective of a lack of concrete provable evidence in some cases and not as a result of any pressure.

My report was not challenged and I believed that my conclusions and recommendations were accepted. At one of the final meetings, I was assured that all the recommendations I had made had been acted upon.

At the time, I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced to a range of possible factors including professional defensiveness on the part of nursing and as a reflection of some community/hospital and social

work/nursing tensions. I also believed there was a reluctance, perhaps unconsciously, to accept the possibility of widespread abuse.

However, at a recent meeting with the Trust on 21.1.2020, I was made aware of an email sent by JV to Human Resources stating that the investigation had found no evidence of institutional abuse and indeed had found evidence of good practice. I have not had access to this email when writing this report so am unsure of the exact wording.

I was unaware of this email or indeed of any discussion with HR about the outcome of the safeguarding investigation. Had I been aware, I would have challenged it as I consider it to be very misleading and in no way representative of either the verbal or written conclusions that I had drawn.

The existence of this email now makes me question whether there were other discussions and decisions about Ennis that I was not party to and was unaware of. The email has also led me to question my belief that I had overcome opposition and that my report had been accepted in good faith and acted upon.

During and following the investigation, I did seek some support from the Trust's adult safeguarding specialist and from JG, Co-Director for Social Work & Social Care in relation to the difficulties I experienced. Both people were very personally supportive. It was relatively informal support but I did suggest in a conversation with JG that where there were future major concerns about wide spread abuse, that it would be better to appoint a DO who did not belong to the programme of care which managed the service. My rationale for this was to avoid the position where I had to challenge my own senior managers. I also had a conversation with the Trust's adult safeguarding specialist about ensuring that safeguarding and disciplinary processes were more joined up.

 Exhibit 3

Ogle, Tutu

From: Morrison, Aine
Sent: 12 April 2023 16:09
To: Martin, Jennifer
Subject: FW: Muckamore Leadership and Governance Review report

Aine Morrison,
Chief Social Worker,
Office of Social Services,
Department of Health,
Castle Buildings,
Stormont Estate,
Belfast.

Email Address: aine.morrison@health-ni.gov.uk
Mobile Number: [redacted] RO1

From: Morrison, Aine
Sent: 15 September 2020 15:22
To: Holland, Sean <Sean.Holland@health-ni.gov.uk>
Subject: FW: Muckamore Leadership and Governance Review report

Sean,

Apologies for the delay in getting this to you to look over. Last week was a busy week! Thank you very much for talking to me about the report. I appreciated it very much.

My response at this stage is as follows;

I am conscious about the tendency for defensiveness when someone is scrutinising your practice and am also aware of the need to accept differing interpretations of events. That said, there are quite a number of areas in the report where I feel I could have offered additional context or comment. Of these, there are a number of what I feel are some more significant concerns and clarifications which I would like to note here.

1. I was concerned not to be given an opportunity to comment on any factual accuracy issues prior to the publication of the report and I believe there to be a number of inaccuracies, some of which I will detail in later points.

2. I was not offered the opportunity to review any of the records relating to the Ennis investigation prior to questioning about them. This made it difficult for me to comment on or explain some of the issues arising from the records that I was asked about.

3. I was not asked and therefore given no opportunity to comment on or explain some issues which are the subject of criticism in the report. In particular, I was not asked for any comment on the investigation timescales or the decision making about which avenues to pursue during the investigation.

4. I do not recall being involved in any decision-making about conducting an SAI review into Ennis. However, based on the information in this review report, I believe that the reasons given by the Trust for not pursuing an SAI did not accurately reflect my conclusions in the Ennis investigation and my views which I had made clear to my co-director.

5. I do not believe that the discussion I had with the review team about my considerations in relation to institutional abuse is accurately reflected in their report. I had said to the team that, at the time, I was not keen on using the term "institutional abuse" because of the varying interpretations of the term that existed. These ranged from a straightforward description of abuse that happens in an institution to a description of patterns and norms of care that were rigid, lacked respect for individual rights and were either abusive in themselves or created the conditions for abuse. My framing of the allegations about Ennis was that of potential physical, verbal and emotional abuse that was possibly endemic on the ward and happening openly. My concerns about a widespread culture of abuse on the ward were what led to my insistence on a protection plan that involved 24 hour monitoring of practice on the ward. I did not believe that the suspension of the staff named in the allegations was sufficient. I was very concerned that the allegations made by the private provider staff detailed behaviour happening openly in front of them and this concern was a key part of the considerations at the start of and throughout the investigation. When my co-director used the term "institutional abuse", I understood him to use the term to mean widespread abuse as opposed to individual instances and my responses to him on that issue were based on that understanding. As the report states, I felt under pressure by my co-director to state that there was no institutional abuse. I was not willing to state that and did not accede to that pressure. However, I also felt that while I had considerable suspicion about endemic abuse on the ward, I did not have sufficient evidence to prove definitively that there was. I believed that I only had sufficient concrete evidence of abuse by two individual members of staff. This conclusion is reflected in some of the records quoted in Appendix 7. Lack of concrete evidence is a frequent issue in adult safeguarding investigations particularly where the alleged victims may be largely unable to provide an account of what has occurred. However, in making some of the recommendations in my investigation report , I believe I showed an awareness of the possibility of wider abuse than I had been able to prove and was seeking to put in place protective factors against that possibility.

6. I was not a member of the core group at MAH which met weekly. The review report states at 6.20 that community staff were involved in these weekly meetings and 6.21 states that a community based social worker regularly attended these meetings because she had responsibility for compiling the DSF report for the programme. I presume this is referring to me. During one of my interviews with the review team, I was informed that it was minuted that I was present at some of these meetings but I didn't get any more detail. I think I remember being invited to discuss a particular topic at one meeting which might have been a core meeting and I don't discount the fact that I may have forgotten other occasional attendances but I did not attend regularly and frequently. I was a member of the clinical governance meeting which as far as I remember met every other month. There was an overlap in membership of the two groups in that all the members of the weekly core group were also part of the clinical governance meeting but they were separate meetings. Shortly before I moved to the Department, the new Acting Head of Service who replaced the co-director on his retirement changed the governance structures for learning disability and stood down the weekly core meeting at the hospital. She formed a new group which included hospital and community staff and I was a member of that group. Without access to the records the review team were referring to, I can't explain the perception that I was a member of the core group but it seems likely to me that there has been some confusion about different groups.

7. The review report notes that hospital staff were excluded from some of the earlier strategy meetings. The information I gave to the review team about this is not included in the report. That information was that I had not wished to include the clinical director in the first strategy meeting because he was the consultant responsible for Ennis ward and I thought it inappropriate to involve him in a discussion about investigative strategy on the ward. I had wanted the service manager for the hospital to be present and involved in the discussions as there was clearly a management role in providing information, liaison and taking on operational responsibility for appropriate matters. The service manager for the hospital disagreed with my view about excluding the clinical director and she contacted the director of adult, social and primary care to raise her concern about this. The director then contacted me to inform me that she had decided that no hospital staff should attend these meetings. In my view, this was an unsatisfactory arrangement which was changed at a later stage.

8. The review is critical of my involvement in staffing issues on Ennis ward. As a 24 hour staff monitoring presence was a key part of the protection plan that it was my responsibility as DO to agree and implement, I

feel that this was clearly part of my role. The review team report does not include information which was given to them and which I believe is included in minutes about the significant opposition to this part of the protection plan that I experienced. There were also conflicting reports and a lack of clarity at that early stage about what staffing and monitoring was present on the ward and I believe that these factors also justified my involvement in these issues.

9. It was also the intention that the monitoring staff would provide information to inform the investigation's conclusions and the review team's report states that they provided useful information on practice within the ward. As the monitoring staff were there at my instigation and were providing information relevant to the investigation, it seems to me to be entirely appropriate and necessary that I would be involved in their deployment.

10. The review report states that I did not attempt to break down all the statements made by the private provider's staff into separate categories and only deal with those which were clearly safeguarding issues. This opinion does not seem to take into account the fact that I did refer a number of issues that arose to the complaints process and this is clearly documented in the Ennis investigation report. I also feel that the review team's opinion on this is somewhat at odds with their opinion that I should have considered the issue of institutional abuse at a much earlier stage. I accept that I did not use this term in any of my earlier records but I believe that my inclusion of a wider range of issues beyond criminal abuse or clear cut safeguarding concerns was evidence of my efforts to establish whether or not there were broader concerns about culture, institutional practice, atmosphere etc.

11. I feel that the review report does not recognise the reality that sometimes it is necessary to investigate further before you can determine a categorisation of a particular concern or allegation.

12. The review report also notes the significant improvements made on Ennis Ward after the allegations were made. Many of these improvements were related to issues that I had looked into and made recommendations on such as environmental improvements, care plans and wider multi-disciplinary team involvement. I believe that the inclusion of these issues in my investigation was a driving factor in recognising and responding to these concerns and that the acknowledged improvements are evidence that I was justified in including them.

13. The review report does not include the explanation I gave to them for not extending my investigation into other wards in the hospital. I had informed them that this was because the staff from the private provider had made a clear distinction between practice on Ennis and good practice on other wards where they had also spent time. So, I had no information or allegations to widen the scope of what I was investigating.

14. The review team is critical of the lack of reference to the Ennis investigation in the DSF report. The DSF report was largely drafted by me for the co-director's approval and adoption of the report for the service area. The lack of mention of the Ennis investigation was not a deliberate omission of a specific incident but a reflection of the fact that the DSF report did not normally report on specific investigations.

Thanks,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ

Email: aine.morrison@health-ni.gov.uk

Tel. No. [redacted]

Do you know a social worker who deserves an Honour? If so, please follow the link:
https://www.nidirect.gov.uk/articles/honours

 Exhibit 4

I wish to submit a grievance in relation to the Trust's handling of a statement I made in December 2019 outlining my experience of carrying out an adult safeguarding investigation into allegations of abuse on Ennis Ward in Muckamore Hospital in 2012.

I believe the Trust to have;

1. Failed to apply any transparent, properly constituted process to deal with the matter.
2. Treated me unfairly.
3. Accepted an adjudication on the veracity of my statement that is flawed.

The Trust's actions in this regard have caused me considerable distress and have damaged my professional credibility and reputation.

I also believe that it is important that the Trust properly considers any information which may aid an understanding of the hospital culture and that this has not been done on this occasion.

In relation to the lack of a proper process, the following points are relevant.

1. The statement I made to the Trust was made at the request of the Trust.
2. After making the statement to the Trust, I was not consulted about any of the actions the Trust subsequently took.
3. The Trust did not tell me that it had decided to ask the Leadership and Governance Review team to adjudicate on my account of events.
4. The Trust did not tell me that when the Leadership and Governance Review team stated that such an adjudication was outside their terms of reference, it then made an arrangement with the Chair of the Review Panel that he would provide a personal opinion on the veracity of my statement.
5. The Trust decided to rely on this personal opinion as an adjudication on the veracity of my statement. The Trust also acted on this personal opinion by sending two of the members of staff mentioned in my statement the Chair's letters and informing them that the Trust accepted this judgement.
6. The Trust did not give me access to the statements these two people made in response to my statement and therefore gave me no opportunity to comment on these.
7. The Trust did not provide me with the opportunity to provide any corroboration of my statement.
8. The Trust did not provide me with any opportunity to review or refer to relevant records.
9. The Trust did not offer me the opportunity to have any representation in its dealings with my statement.
10. The Trust gave me no opportunity to challenge its decision making or actions.
11. The Trust gave me no opportunity to appeal its decision making.

As the Trust relied on the personal opinion of the Chair of the Leadership and Governance Review Panel and as he relied on information gathered during the course of that review, the following points in relation to the process followed by the review team and its individual members are also relevant.

1. At no stage, did the Chair of the panel inform me that he had agreed to provide a personal opinion to the Trust on the veracity of my statement.
2. At no stage, did the Chair of the panel inform me of his intention to use information gathered during the review process for another purpose.
3. The review team only asked me about some of the matters, not all, in my statement.
4. The review team only told me of some of the responses made by others in relation to my statement.
5. The review team did not share with me any negative inferences or conclusions that they drew in relation to any of my own evidence or evidence from others so I had no opportunity to comment on this.
6. I was not offered access to any of the records they relied on.
7. I was not offered any opportunity to corroborate the statement I had made to the Trust.
8. The review team did not give me any record of my two interviews with them so I had no opportunity to comment on the accuracy of what they had taken from my discussions with them.
9. I was not offered the opportunity to review the review team's report for factual accuracy before it was published so I did not have the opportunity to correct some inaccuracies.

I have copied here the letters sent by the Chair of the Leadership and Governance Review to the Trust giving his personal opinion on the veracity of the statement I made.

The text of the letter is in italics. Comments by me on aspects of both of these letters are in bold and italics.

Letter 1 re ER, Service Manager for the Hospital at the time of the Ennis investigation

Introduction to Allegations made against ER and Concerns Raised by Her In late 2019 the Department of Health (DoH) asked the Health and Social Care Board (HSCB) and Public Health Agency to commission a review of Leadership and Governance at Hospital for the period 2012 to 2017.

The terms of reference of the review sought to ascertain to what degree, if any, leadership and governance arrangements in the Belfast Trust contributed to the abuse of vulnerable patients going undetected. A team was appointed in January2020 to carry out the review. The team completed its work in July 2020 and its report was published on 5 August 2020.

During the course of its work the review team became aware of allegations made by Aine Morrison (AM) in 2019 against ER and other members of staff. These allegations related to events surrounding the ward Investigation that was carried out in 2012/13. Allegations had been made in November 2012 regarding the abuse of several patients in Ennis Ward at the hospital. At that time Aine Morrison was then Operations Manager in the Trust's Learning Disability Service with responsibility for community multidisciplinary learning disability teams. On hearing of the allegations, AM stepped in to take on the role of Designated Officer (DO) and led the investigations into the allegations of abuse. The Trust asked the Review Team to comment on the

allegations made by AM in 2019 against ER and another member of staff. The review team considered that such a request was outside their terms of reference and declined to make comment. It was agreed however that I would provide a written report to the Trust setting out my personal views on these matters based on the evidence collected by the review team.

Background to Ward Allegations

ER took up post as Service Manager at the hospital in January 2012. She was also designated as Associated Director of Nursing. ER came from a background of mental health nursing rather than learning disability and she told the review team that her appointment was met with hostility from some members of hospital staff.

1. ***As I was not a member of hospital staff, this point does not appear to have any relevance to a determination of the veracity of my statement.***

One of her key objectives was to resettle where appropriate, patients into community settings. This would allow the hospital to focus on treatment and assessment for remaining and new patients.

This was in keeping with the objectives of the Bamford Review and the policy of the Department of Health and the HSCB. Not everyone was signed up to that agenda. There was resistance from some relatives as well as some members of staff. As many patients had lived in the hospital for decades concerns expressed about resettlement were understandable.

2. ***The review team did not ask me for my opinion on resettlement of hospital patients. Had I been asked, I would have stated my support for the policy. Again, this point does not appear to have any relevance to a determination of the veracity of my statement.***

On 8 November 2012, the Trust received allegations that four patients in the Ward were the subject of verbal and physical abuse. The allegations were made by a member of staff employed by a private provider. Other staff from this provider made similar allegations following initial investigations. On receipt of the allegations 3 members of hospital staff were placed on precautionary suspension.

ER was involved in the suspension process and communicated the matter to the appropriate channels. A Vulnerable Adult Safeguarding Review was established immediately to investigate the allegations. The review was led by AM.

3. ***To be accurate, I did not lead a review. I acted as the Designated Officer under the Safeguarding Vulnerable Adults Policy in place at the time. My role was to implement the Joint Protocol for Investigation, to lead and co-ordinate an investigation alongside the PSNI and to establish, monitor and review a protection plan.***

The Allegations AM provided a 9-page written account of her experiences in acting as the DO into allegations of abuse on the Ward at the hospital. This account was given to the review team in February 2020. It appears to have been written in December 2019 in anticipation of a review team being appointed.

4. ***This is not wholly accurate. My statement says clearly that I was writing the account at the request of the Trust following a telephone meeting where I had informed them of my experiences during the investigation. The wording in my statement is as follows:***

   "Firstly, I was conscious that some of my experiences were potentially relevant to the MAH leadership and governance review which was commissioned following the disclosure of allegations of abuse at Muckamore Abbey Hospital. I thought it likely that any conversations I might have with the review team would involve my discussing these experiences and therefore wanted to make the BT aware of them also.
   Secondly, the leak of the Ennis report to the Irish News had set in train a number of actions which resulted in an agreement at the MDAG that I, along with a BT representative, would be involved in briefing the family representatives on the MDAG as well as the families of Ennis patients. I felt that I could not give an open and honest briefing without mentioning some of the difficulties I experienced and therefore wished to share this information with the Trust in advance of briefing families."

   I think it is also important to state that I did not seek any action against individual members of staff and was not expecting the Trust to respond in that manner. I made the statement I did because I thought it was potentially relevant to an exploration of the hospital culture which was included in the Terms of Reference for the Leadership and Governance Review and because of the particular sequence of events around the leaking of the Ennis report.

The review team understands that it was also given to the Trust. It contained a number of allegations against several members of staff. The allegations as they relate to ER can be summarised as the follows:

- *She disagreed vehemently with AMs approach to the investigation and tried to overrule her,*
- *There was significant opposition from hospital staff including X to the part of the protection plan that required 24 hour monitoring,*
- *She did not provide adequate support to AM during the investigation*
- *She criticised the external staff who made the original allegations of abuse in the Ward,*

5. ***This summary is not wholly accurate. I think it is important that any judgement is made on the exact wording I used in my statement.***

ER provided the Belfast Trust with a response to the allegations; this was made available to the review team.

6. ***I have not seen this statement and have therefore had no opportunity to respond to it.***

She stated "at no time was I uncooperative or unprofessional and in all instances I considered the safe care of patients in all wards" ER went on to give examples in her statement where she actioned further suspensions and monitoring at AMs request. There may have been a disagreement at the outset of the investigation as to whether ER in her management role at MAH should have played some part in the strategic oversight of the investigation.

7. ***There was no disagreement on this point of ER's involvement in the strategic oversight of the investigation (see point below)***

AM thought she and other members of the hospital management team shouldn't have a role, ER thought she should. ER sought the views of her Director who ruled that no member of the MAH team should be involved at least in the initial stages of the investigation. ER accepted this ruling.

8. ***Again, this is not wholly accurate and does not reflect the statement I gave. My statement clearly says that ER disagreed vehemently with my wish to exclude the Consultant Psychiatrist for Ennis Ward from the initial strategy meeting and tried to overrule me on that issue. The Chair also says that I thought that ER and other members of the hospital management team shouldn't have a role and that ER thought she should. This is not what my statement says. I did not wish to exclude the hospital management team, just this particular consultant psychiatrist and it was this that ER vehemently objected to. The Consultant Psychiatrist in question also happened to be the Clinical Director/Lead Consultant for the whole hospital. I wished to exclude this Consultant Psychiatrist because he was the consultant for the ward in question. The initial allegations suggested that there was serious abuse happening, possibly openly on the ward and as I did not know who all might have been involved at this stage, I thought it inappropriate to involve any ward staff in the investigation planning. Investigation planning was a core part of the agenda for that first and other subsequent early meetings. As my statement describes, ER contacted the Director of Adult Social and Primary Care to object to my wish to exclude the Consultant Psychiatrist. The Director decided that no member of the hospital team, including ER, should be involved in this first meeting. This was a decision I disagreed with as I believed that hospital management needed to be involved in the response to the allegations.***

The review team in its report stated that AM in her role as the DO appeared to have an oversight function in respect of the operation of the Ward during the period of investigation It was their opinion that this was not appropriate and served to weaken the focus on completing the investigation within an acceptable timeframe and had the potential to undermine the managerial system at the hospital. It may explain why there

were tensions between AM and other managers at the hospital during the investigation.

9. ***This is one of the areas that the review team did not raise or discuss with me and I had therefore no opportunity to offer any comment on their thinking in relation to this.***

   Had I been asked, I would have explained the following.

   The involvement I had in any operational aspects of managing the ward was about staffing. As a 24 hour staff monitoring presence was a key part of the protection plan that it was my responsibility as DO to agree and implement, I feel that this was clearly part of my role. The review team report does not include information which was given to them and which I believe is included in minutes about the significant opposition to this part of the protection plan that I experienced. There were also conflicting reports between the hospital team and RQIA and a lack of clarity at that early stage about what staffing and monitoring was present on the ward and I believe that these factors also justified my involvement in these issues.

   It was also the intention that the monitoring staff would provide information to inform the investigation's conclusions and indeed the Leadership and Governance Review report states that they provided useful information on practice within the ward. As the monitoring staff were there at my instigation and were providing information relevant to the investigation, it seems to me to be entirely appropriate and necessary that I would be involved in their deployment.

   Staffing issues had also been raised by the private provider staff, by relatives and by ward staff as a difficulty on the ward and as I was concerned about the ward as a whole and possible endemic abuse on the ward, again it seems to me that staffing issues as a whole were an entirely legitimate and necessary avenue of exploration.

From the outset the written statement made by Aine Morrison raised several questions. The main question being why it was written some seven years after the events that it alleged. Aine was asked about this by the review team but failed, in their view, to give an adequate explanation.

10. ***While the review team did ask me why I had not reported the issues at the time, they did not tell me that they thought my explanation was inadequate so I did not have an opportunity to comment on this aspect of their thinking.***

    I believe my explanations to be entirely plausible and they are in fact true. The Chair does not explain why he or the review team found this explanation inadequate.

In addition, neither the Chair nor the review team seem to have given any weight to the difficult position I was in, where two of the people involved in the behaviour were senior managers and were two levels above me in the Trust's management structure. Of these two people, one was the Co-Director for my own programme of care. There seems to be no recognition of the power differentials at play in this scenario.

There also does not seem to be any weight given to the fact that it is difficult to complain about matters that are somewhat nebulous and hard to prove. Had I believed at the time that there was any cover up at play or that ultimately, I had not been able to carry out my investigation satisfactorily or been able to make the protection arrangements I believed necessary, then I would have made a complaint. However, although it was made very difficult for me to carry out my role, I was able to do so. So my complaint would have been one about attitude, perceptions and personal interactions and I was very conscious that these issues would not have been easy to evidence.

To evidence the behaviours in the meetings , I would have to ask two more junior members of staff , my Investigating Officers, to back up any complaint and I was reluctant to put them in that position. I would also have had to involve others outside my own organisation to evidence what had occurred in the meetings and the awkwardness in doing so was another factor in my reluctance to complain at the time.

The Chair appears to have concluded that a delay in reporting equates with a lack of credibility. There is no foundation for that conclusion.

It is common for people not to speak of difficult experiences at the time and often not until there is sufficient space and distance for it to feel safe to do so. This does not mean that their account is untrue. I would describe the behaviour from ER, MM and JV during the Ennis investigation as bullying in nature and it took a significant personal toll on me to have to maintain my own position, not give in to pressure and carry out my professional responsibilities in the face of such opposition.

The Chair also appears to have given no weight to the fact that I did take some action in relation to my experience when I spoke, albeit informally, to the Co-director for Social Work about the fact that I found the investigation very difficult. I recommended that where there were future allegations about a Trust service, that someone from outside that programme of care be appointed to investigate to avoid the position I found myself in of having to challenge my own senior management.

The team also found that the ward investigation, which she led, took an extensive period to complete which diluted its impact.

11. The length of time the investigation took does not appear to me to have any relevance to an adjudication on the veracity of my statement.

The report of the investigation was not brought to the attention of the Trust Executive Team or Board.

12. ***Again, I fail to see the relevance of this to the credibility of my statement. The Chair also does not acknowledge that bringing this to the attention of the Trust Executive team or the Board was not my responsibility. I was not sufficiently senior in the organisation to do that. I made my report available to the two Co-directors involved, MM and JV who were fully sighted on the entire process. It would have been their responsibility to make a decision on the necessity of informing the Trust Executive Team or Board. The three people I named in my statement about the difficulties I experienced on Ennis Ward were all more senior to me. In addition, the Director of Adult Social and Primary Care who was a member of the Trust Executive team was very aware of the allegations and the investigation into them as I had a number of discussions with her about the issue in the early period when my Co-director was on leave. On my Co-Director's return from leave, I was not in a position to liaise directly with her any further. I had no involvement in any decisions about whether or not to inform Trust Board.***

Conclusions Regarding the Ward Investigation

Although the Review Team did not comment in its report on the veracity of the claims made by Aine Morrison against ER it did gather information, which I have used in reaching my conclusions. Firstly, there is the matter of why these claims against ER were documented some seven years after the event of the ward Investigation. There is no record or hint of them being made at the time of the ward Investigation. The time gap and the apparent need of the author of the allegations to get her side of the story on record some 7 years later does not lend credibility to the allegations.

13. ***Issues re the time gap are addressed in responses above. Regarding the point "the apparent need of the author of the allegations to get her side of the story on record", I'm not sure I entirely understand the point being made but I think there is an inference that I had a need to deflect from my own actions regarding the Ennis investigation. I feel no need to deflect from my own actions. I believe that I carried out my professional responsibilities well in relation to Ennis, I stand by the report I presented, the conclusions I reached and the actions I recommended so I feel no need to deflect any criticism. Had I believed that the behaviours I experienced had caused me not to fulfil my professional responsibility, then it might indeed be motive for me to seek to explain why I had not acted in a particular way but I have always been clear that this was not the case.***

    The use of language such as "the apparent need of the author" is pejorative and indicative of a predisposition to disbelieve my account.

Secondly the Review Team found that the DO exceeded her brief in becoming operationally involved in the running of the Ward. This may have brought her into conflict with ER in her role as Service Manager at MAH. The DO should have

concentrated on completing the investigation in a timely manner rather than become involved in operational matters.

14. ***Issues regarding any operational involvement I had are noted above. In addition, the review team did not put to me their opinion that the investigation took too long nor asked me for any explanation of the timescales involved. There were a number of factors which contributed to this which I could have explained. They did say that ER had said that she was frustrated by the length of time the investigation was taking and postulated that this was a factor in tensions between us. (I do not remember exactly whether they stated that ER's frustration at timescales was her reason for overall tension between us or for her opposition to the protection plan). I stated in reply that I did not accept this because the opposition to the 24 hour monitoring part of the protection plan and the attitudinal opposition began at the very start of the investigation.***

The review team could find no evidence to collaborate AMs accusations. It did however observe that ER had from the commencement of her employment at MAH sought to carry out her duties in a professional manner. Her concerns about staffing levels being an example of this.

15. ***If this is to be given weight as a factor in determining the credibility of my statement, I would have expected the Chair to have also explored any evidence and examples about my carrying out my duties in a professional manner. I do not believe this was done.***

In summary I would conclude that there is no evidence to uphold the claims made by Aine Morrison against ER. It would be wrong to leave these allegations unchallenged. During the review team's work, a great deal of evidence was collected regarding the ward investigation and none of it would support the allegations made by AM against ER.

16. ***The Chair states that during the review team's work, a great deal of evidence was collected regarding the Ennis investigation and none of it would support the allegations made by me against ER. I was given no opportunity to review this evidence and therefore offer comment on this assertion. As stated previously, nor was I offered the opportunity to present any corroborating evidence.***

    I believe that there is considerable evidence in the written records of the Ennis investigation that would support my statement. However, despite repeated requests, the Trust has not given me access to these.

    There are also a number of other people who were involved in the Ennis investigation who could provide supporting evidence and I do not believe the review team made any enquiries of them in relation to what I had said occurred.

    I do not understand why the Chair concludes that it would "be wrong to leave these allegations unchallenged". Their veracity was not a matter

within the terms of the reference of the Review. The Chair had no locus to offer an opinion on the veracity of my statement and the Trust ought not to have asked for or relied upon his opinion on that matter.

It is my conclusion that the allegations as they relate to ER in 2012/13 are not substantiated and should not cast a cloud over her record as a manager and professional nurse during that period.

Sent by the chair of the review team September 202

Letter 2 re MM, Co-Director for Nursing

The text of the letter is in italics. My comments are in bold and italics. Where points in the letter re ER are replicated, I have simply referred to comments above.

Report into allegations made against MM.

Background

In late 2019 the Department of Health (DoH) asked the Health and Social Care Board (HSCB) and Public Health Agency to commission a review of Leadership and Governance at Hospital for the period 2012 to 2017. The terms of reference of the review sought to ascertain to what degree, if any, leadership and governance arrangements in the Trust contributed to the abuse of vulnerable patients going undetected. A team was appointed in January 2020 to carry out the review. The team completed its work in July 2020 and its report was published on 5 August 2020.

During the course of its work the review team became aware of allegations made by Aine Morrison in 2019 against MM and other members of staff. These allegations related to the events surrounding the ward Investigation" that was carried in 2012/13. Allegations had been made in November 2012 regarding the abuse of several patients in Ward at the Hospital. At that time Aine Morrison was then Operations Manager in the Belfast Trust's Learning Disability Service with responsibility for community multidisciplinary learning disability teams. On hearing of the allegations Aine stepped in to take on the role of Designated Officer (DO) and led the investigations into the allegations of abuse. MM was employed by the Trust for 12 years and retired from her substantive post in 2019 as Deputy Director of Nursing. She was subsequently brought back to the Trust as a Senior Nurse Advisor from November 2019 to support the Trust investigations into more recent allegations of abuse at the hospital. MM voluntarily stood down from this role when she became aware of the allegations made by Aine Morrison.

The Review Team

The Review team in its report gave extensive coverage to the investigation into allegations relating to Ennis Ward. The team interviewed Aine Morrison and MM several times during its review but concluded that it could not deal with the disputed claims of either party in its report as they fell outside its terms of reference. It has been

agreed with the review team and the Trust that the Chair of the Review Team would write to the Trust on this matter and provide his own views on the disputed allegations.

The Allegations

Aine Morrison provided a 9-page written account of her experiences in acting as the DO into allegations of abuse on the Ward at the hospital. This account was given to the review team in February 2020. It appears to have been written in December 2019 in anticipation of a review team being appointed.

17. As per comments above.

The review team understands that it was also given to the Trust. It contained a number of allegations against other members of staff. The allegations as they relate to MM can be summarised as the follows

- *She was hostile to the DOs investigation including the monitoring plans that Aine had made for the Ward,*
- *She opposed DOs view of the patient care plans,*
- *She opposed the Dos protection plan,*

- *She did not provide the DO with adequate support throughout the investigation,*
- *She claimed that nurses could not have been involved in abuse.*

18. I think it is important that the exact wording in my statement is referred to, not a summary by the Chair which is not wholly accurate.

In all there were 10 allegations where MM was named or it was inferred that she had a role. MM provided the Trust with a detailed response to the allegations. She also provided the statement to the Review Team.

From the outset the written statement made by Aine Morrison raised several questions. The main question being why was it written some seven years after the events that it alleged. Aine was asked about this by the review team but failed, in their view, to give an adequate explanation.

19. As per comments above.

The team also found that the ward investigation, which she led, took an extensive period of time to complete which diluted its impact.

20. As per comments above

The report of the investigation was not brought to the attention of the Trust Executive Team or Board.

21. As per comments above.

The review team in its report stated that the DO appeared to have an oversight function in respect of the operation of the Ward during the period of investigation. It was their

opinion that this was not appropriate and had the potential to undermine the managerial system at the hospital.

22. As per comments above

MM, was seconded from her role as Co-Director of Nursing (Education and Learning) to the hospital in the aftermath of the allegations with responsibility to monitor nursing practice and to analysis information and provide support to the Service Manager at the hospital.

The Review recorded in its final report that "She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provide of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of hospital leadership and provided ongoing assurances to the Trust."

23. The Chair's inclusion of these comments in his letter about MM would suggest that it is relevant to his judgement on the credibility of my statement. I do not accept that it has any relevance as I did not make any allegations about the adequacy of any of her reports. Indeed, MM's reports were used by me throughout the process to determine further actions.

My statement is specific to certain actions only.

Conclusions

Although the Review Team did not comment in its report on the veracity of the claims made by Aine Morrison against MM it did gather information, which I have used in reaching my conclusions.

Firstly, there is the matter of why these claims against MM were documented some seven years after the event of the ward Investigation. There is no record or hint of them being made at the time of the ward Investigation. The time gap and the apparent need of the author of the allegations to get her side of the story on record some 7 years later does not lend credibility to the allegations.

24. As per comments above

Secondly the Review Team found that the DO exceeded her brief in becoming operationally involved in the running of the Ward. This may have brought her into conflict with other managers including MM. The DO should have concentrated on completing the investigation in a timely manner.

25. As per comments above

Thirdly the Review Team found that MM's input to the hospital at the time of the ward Investigation was carried out in a professional and caring manner. There was no evidence that she sought to undermine the claims of abuse originally brought by the staff from an external agency. There was evidence that she made unannounced

leadership visits to the ward, that she reviewed samples of patient's notes, medical files and the drug Kardex.

A more detailed account of her actions is included in section 8 of the Review Teams report.

Following her interview with the review team, the team concluded that her evidence was credible, clear and demonstrated a high level of integrity. Exercising professional judgment, it was the view of the nurse on the review team that Y had exercised both professional leadership and professionalism throughout her role in the ward investigation.

In summary I would conclude that there is no evidence to uphold the claims made by Aine Morrison against MM. It would be wrong to leave these allegations unchallenged. I believe that given the evidence that was collected during the Review Teams work the allegations can be refuted. It would be wrong to have such allegations hanging over the long and distinguished career of MM.

26. ***The Chair refers to the long and distinguished career of MM in his concluding paragraph and I believe he does so in a manner which suggests that this career is relevant to his judgement on the credibility of my statement. If this is to be given any weight in establishing my credibility, then I believe the Chair should also have established my reputation in my career. I do not believe that this was done.***

I believe she carried out her duties at the hospital in 2012/13 (and later) in a professional manner that served the interests of patients and the Trust.

27. ***While I do not necessarily accept the review team's overall opinion that the Trust did fail in its response to the Ennis investigation, it seems contradictory for the Chair to criticise the Trust's response in the Leadership and Governance Review report but in this letter praise the response of one of the two most senior people involved in the response.***

28. ***In addition, the Leadership and Governance Review Team's report states that the hospital was a very closed place, resistant to outsiders, reluctant to open itself to external examination or criticism. Again, it seems contradictory that an example of just this sort of behaviour where I, as an outsider, faced considerable resistance is so comprehensively dismissed.***

Signed Chair August 2020

I also wish to note that as stated above, to date the Trust has not given me access to the records of the Ennis investigation despite repeated requests. This has hampered my ability to respond comprehensively to these two letters and to the Leadership and Governance Review report.

In order to settle my grievance, I am asking the Trust;

1. To accept that its handling of my statement has not been correct.
2. To withdraw the letters it has issued to ER and MM about the adjudication on the veracity of my statement.
3. To give me access to the records I have requested.
4. To establish a fair process to fully consider all of the issues raised in my statement, the details of which I would wish to discuss and agree with the Trust.

I note that the Trust's Grievance Procedure states that "in cases where the Chief Executive is the line manager, the employee may raise the grievance with the Chairperson of the Trust Board or his /her nominee. While the Chief Executive is not my line manager, my understanding is that it was the Chief Executive who asked the Chair of the Leadership and Governance Review Team to provide a personal opinion on the veracity of my statement and decided to rely on that personal opinion as an adjudication on the issues I raised. Given this situation, I would wish to discuss how my grievance could be most appropriately heard.

Aine Morrison

Exhibit 5

From: Morrison, Aine [mailto:Aine.Morrison@health-ni.gov.uk]
Sent: 11 December 2020 12:54
To: Complaints HSCB
Subject: Complaint re Muckamore Abbey Hospital Leadership and Governance Review

Dear Complaints Officer,

I wish to complain about the process and conduct of the MAH Leadership and Governance Review commissioned jointly by the HSCB and the PHA at the request of the Department of Health and subsequently published by the Department.

I was interviewed on two occasions by the review team and much of their report concerns an investigation of abuse on Ennis Ward, MAH in which I was the Designated Officer. The investigation took place in 2012/2013 and in December 2019 , I made the Belfast Trust aware that I had experienced difficulties in carrying out my role during that investigation.

My decision to do so was prompted by two factors.
Firstly, I was conscious that some of my experiences were potentially relevant to the MAH leadership and governance review which was commissioned following the disclosure of allegations of abuse at Muckamore Abbey Hospital. I thought it likely that any conversations I might have with the review team would involve my discussing these experiences and therefore wanted to make the Belfast Trust aware of them also.

Secondly, the leak of the Ennis investigation report to the Irish News had set in train a number of actions which resulted in an agreement at the MDAG that I, along with a BT representative, would be involved in briefing the family representatives on the MDAG as well as the families of Ennis patients about the investigation. I felt that I could not give an open and honest briefing without mentioning some of the difficulties I experienced and therefore wished to share this information with the Trust in advance of briefing families.

At the request of the Trust, I subsequently gave them a written account of my experience of the investigation. In that account, I named three people with whom I had had difficulties during the course of the investigation. The Trust, without any consultation with me, decided to take action against two of the people I named who were still working for the Trust. I had no further contact from the Trust about this issue until September 2020 when I was informed that the Trust had concluded the matter and had decided that the two staff had no case to answer.

The written account that I had given to the Belfast Trust was given to the leadership and governance review team at the outset of their work. I have since learned that the review team were asked by the Belfast Trust to adjudicate on the account I had given about Ennis but I was not made aware of this until the completion of the review team's work. I have learned that the review team, in response to this request, stated that such an adjudication was outside the terms of reference for the leadership and governance review but that the Chair of the review team agreed to give a personal view of my account based on the evidence gathered during the review process.

My complaint relates to;

1. The leadership and governance review process.
2. The leadership and governance review report.
3. The actions of the Chair of the review team.
4. The judgements made by the Chair of the review team in his written personal opinion to the Belfast Trust on the statement I had made about my experiences of the Ennis investigation.

The specific process issues are as follows;

The Leadership and Governance Review Process and Report

1. I was not given an opportunity to comment on any factual accuracy issues prior to the publication of the report.
2. I was not given the opportunity to review any of the relevant records but was questioned on aspects of them.
3. I was not asked for any comment during the review process on a number of the issues that are the subject of criticism in the report relating to my practice.
4. I was not given any information about comments from others relating to my practice and therefore had no chance to respond to these.
5. I was not provided with a note or minute of the two interviews I had with the review team and therefore had no chance to agree the record.
6. I was not made aware prior to the publication of the report that there would be criticism in the report of some of my actions and therefore had no opportunity to respond.
7. I was not given the opportunity to offer any evidence or supporting information about a number of statements I made.

The Chair's Response to my Statement about the Ennis Investigation

8. I was not made aware that the Chair of the Leadership and Governance Review team had agreed to give a personal view to the Belfast Trust about the veracity of my account about the Ennis investigation.
9. I was not therefore aware that the information I gave to the review team would be used for that purpose.
10. I believe that the Chair of the review team has acted outside the Terms of Reference of the review in making a private and separate statement to the Belfast Trust.
11. I believe that the Chair of the review team has acted wrongly in using information obtained for one purpose for another purpose.
12. The Chair of the review team gave me no opportunity to comment on his personal views nor did he afford me any right of reply.

There has been an absence of procedural fairness which I believe has contributed to unjustified criticism of my actions in the review report.

The unjustified criticism has subsequently been used by the Chair of the review team to form what I believe to be a flawed judgement about the veracity of the statement I made to the Belfast Trust. In addition to the use of material from the review report, he references other material that I have not seen. He also imputes my truthfulness

and suggests, without evidence, an improper motivation for making the statement about the Ennis investigation to the Belfast Trust.

I am seeking the opportunity to redress this unfairness by:

1. Presenting the information I feel I should have had the opportunity to give,
2. Having this information properly considered and
3. Having the record corrected.

I am making this complaint to the PHA and the DoH also and intend to make a separate complaint to the Belfast Trust about its actions,

Yours faithfully,

Aine Morrison
Tel. No. [redacted]RO1

Health and Social Care Board

Public Health Agency

12 – 22 Linenhall Street
BELFAST
BT2 8BS

Tel: 0300 555 0115

Date: 2 March 2021

Via Email

Ms Aine Morrison

Aine.Morrison@health-ni.gov.uk

Dear Aine

COMPLAINT REGARDING MUCKAMORE ABBEY HOSPITAL LEADERSHIP AND GOVERNANCE REVIEW

You wrote to the Health and Social Care Board (HSCB) and Public Health Agency (PHA) on 10 December 2020 with respect to the process and conduct of the Leadership and Governance Review (LGR) into Muckamore Abbey Hospital (MAH). This is a joint response on behalf of the HSCB and PHA. In terms of process of the review, following the publication of "Away to Go A review of Safeguarding at Muckamore Abbey Hospital", the Department of Health (DoH), the HSCB and the PHA concluded that leadership and governance issues within MAH and within the Belfast Trust merited further examination.

In July 2019 the DoH wrote to the HSCB and PHA requesting costed option and draft terms of reference for a leadership and governance review. Terms of reference were subsequently agreed and the HSCB and PHA established a 3 person review team with organisational, clinical and professional expertise from their previous work experience within Northern Ireland. The HSCB and PHA have an existing service level agreement with the HSC Leadership Centre and it was through this service level agreement the review team were established.

We have attached for your information the terms of reference, however in summary the team were asked to review and evaluate the clarity, purpose and robustness of the leadership and management and governance arrangements in place at Muckamore Abbey (2012 - 2017).

The terms of reference required the review team to:

1. Interview key individuals and scrutinise relevant documentation.
2. Establish lines of communication with all organisations impacted by the review.
3. Act fairly and transparently in the conduct of its work.

Having agreed the terms of reference, Briege Quinn and Marie Roulston met with the review team periodically throughout the duration of the review to discuss the methodology, timeline and to address any obstacles the team encountered during the review (for example the impact of Covid in March 2020 meant that the timeline was extended to July 2020 and no visits to best practice facilities could be undertaken).

In terms of the overall process the HSCB and PHA had no direct involvement with the review team, this was facilitated directly through the Belfast Trust to the review team. We were involved in agreeing the safe storage of all notes and records, but had no discussion with the team in respect of the minuting of interviews or the reviewing of relevant records. We can confirm that there was no opportunity for anyone to comment on the factual accuracy of the report.

Within your complaint you advise that the information you shared with the review team, as part of the review, was used for a purpose outside of the terms of reference and that the review chair made a judgement on a separate matter you had raised with the Belfast Trust with respect to an earlier investigation into Ennis.

We were not made aware that the information you shared was used for a purpose outside of the review, nor that the chair of the review had made adjudication and would agree this was outside of the terms of reference.

In terms of addressing the issue of "procedural unfairness" and "having the record corrected" it is outside the remit of the HSCB or PHA to affect this, however we can keep on record your complaint regarding this matter. Since the publication of the report we have undertaken an evaluation of our contractual agreement with the Leadership Centre, in terms of governance and accountability, which will address future commissioning of independent reviews.

We apologise for the delay in responding to your complaint, but can assure you we have given it due consideration and do appreciate this has been both personally and professionally distressing for you.

We do hope our response has addressed some of your concerns.

Yours sincerely

SHARON GALLAGHER
Chief Executive, HSCB

OLIVE MacLEOD
Interim Chief Executive, PHA

Enc

Exhibit 7

From: Morrison, Aine
Sent: 31 March 2021 13:56
To: 'Complaints HSCB' <Complaints.HSCB@hscni.net>
Subject: RE: Complaint re Muckamore Abbey Hospital Leadership and Governance Review

Dear Michele,

thank you for this and apologies for the delay in responding. I had missed the email in my inbox when it first came in.

I'm sorry to say that I'm dissatisfied with the response. A key element of my complaint was that I was not treated fairly by the review team. The complaint response recognises that the terms of reference required the review team to act fairly and transparently but the response does not then address the issue of whether or not they did act fairly and transparently. It is this issue that is my key concern.

I would be grateful for the opportunity to discuss this with the relevant people,

Thank you,

Aine Morrison

RO1

Exhibit 8

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

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

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

Our Ref: SH512

Date: 30 September 2021

Aine Morrison

Email: aine.morrison@health-ni.gov.uk

Dear Aine

I am writing in response to your complaint in respect of the Leadership and Governance Review. Please accept my apologies for not responding sooner but following our meeting to discuss your complaint, we undertook to review our records to ensure that the response was fully informed. I understand that Jackie McIlroy kept you informed whilst she was your line manager.

At our meeting, you advised that you had made a complaint to the Belfast Trust regarding the actions taken by the Trust, following the Trust receiving two letters from the Chair of the Review panel adjudicating on information that you provided in respect of two staff members. You further advised that the Belfast Trust had informed you that your complaint was a matter for the Department as it was part of the Leadership and Governance Review. Whilst it is true that the Review was to consider the Ennis Investigation as part of its deliberations, we were not aware that separate to the publishing of their report, the Chair had agreed to provide an adjudication of your statement to the Belfast Trust. The Chair did mention to department officials at a meeting that he had been commissioned to do work for the Belfast Trust but did not provide details of the nature of that work. It is therefore my view that this is a matter which the Belfast Trust will need to address as it sat outside of the Review Terms of Reference and Review process. I have written to the Belfast Trust to advise of this (this email has been copied to you).

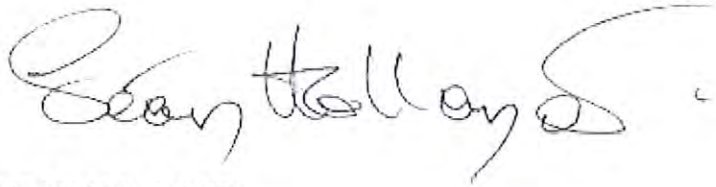
Your complaint to the Department raises a number of significant issues which the Department will wish to consider prior to commissioning further independent reviews. These include issues of accountability, use of personal information and procedural matters such as the need for factual accuracy.

The main issue that you raise was the lack of opportunity to factual check the information that you provided to the Review and their findings in respect of your role. The Department must take responsibility for that decision as we agreed with the review team that it would not be necessary. The review team were concerned that their review was already behind schedule due to the pandemic and we did not want details of the report to become public knowledge before the families of patients in Muckamore had been informed. However with hindsight we recognise that was the wrong decision and indeed there was a duty on the review team to ensure the factual accuracy of their report.

I sincerely apologise for the distress that this has caused you and in order to address this, we will accept a written record of your account which will be placed with the Leadership and Governance files.

I hope that this addresses your concerns.

Yours sincerely



SEAN HOLLAND
Chief Social Work Officer/Deputy Secretary

cc: Jackie McIlroy

Exhibit 9

Health and Social Care Board

Public Health Agency

12 – 22 Linenhall Street
BELFAST
BT2 8BS

Tel: 0300 555 0115

Date: 10 December 2021

Via Email

Ms Aine Morrison

Aine.Morrison@health-ni.gov.uk

Dear Aine

COMPLAINT REGARDING MUCKAMORE ABBEY HOSPITAL LEADERSHIP AND GOVERNANCE REVIEW

Following on from your email with us on 30 July regarding the HSCB and PHA response to your complaint dated 02 March 2021, we have now had the opportunity to consider the issues you raised.

Firstly can we apologise for the delay in getting a response to you this was due to a range competing pressures and we are sorry for that.

In the previous letter from CE of HSCB and PHA dated 2 March 2021 It had been acknowledged that information you shared was used for a purpose outside of the review. It was acknowledge that this was outside of the terms of reference. We accept that this material should not have been used without your consent in a separate investigation by the Belfast Trust.

With regard to your concern that there was a lack of fairness and transparency in the work of the leadership and governance review team we acknowledged that there was no opportunity for anyone to comment on the factual accuracy of the report prior to publication. The fairness and transparency of the report was undertaken in line with the normal arrangements that apply when this type of review is undertaken. Moving forward we will ensure that as appropriate those involved in such process are afforded the opportunity to factual check their contribution.

We do hope our response has addressed some of your concerns.

Yours sincerely

Brendan Whittle & Rodney Morton

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