MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 14TH OCTOBER 2024 - DAY 114

114

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

GWEN MALONE STENOGRAPHY SERVICES

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY KC MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MS. AMY KINNEY BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	MR. TOM ANDERSON O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MS. CLAIRE DEMELAS MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

WITNESS	PAGE
MS. BRENDA CREANEY	
EXAMINED BY MR. DORAN	10
RESTRICTED SESSION	88
OPEN SESSION	88
MS. BRENDA CREANEY	
EXAMINED BY MR. DORAN	88
EXAMINED BY THE PANEL	111
MR. GORDON SMYTH	
EXAMINED BY MS. TANG	113

THE INQUIRY RESUMED ON MONDAY, 14TH OCTOBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you.

MR. DORAN: Good morning, Chair and Panel members. This morning's witness is Brenda Creaney, if Ms. Creaney could be called, please. 10:33

CHAIRPERSON: I should just say we are all obviously aware of why we're starting slightly late, and we want to send best wishes to the counsel involved. 10:33

BRENDA CREANEY SWORN:

CHAIRPERSON: Ms. Creaney, welcome back to the Inquiry, thank you very much for your attendance. 10:34

MR. DORAN: Chair, I understand Mr. Aiken wants to address the Panel briefly before the evidence starts this morning.

CHAIRPERSON: Yes, of course. Okay, Mr. Aiken.

MR. AIKEN: I am grateful to Mr. Doran. I echo the sentiments that you have made about our colleague, it was a rather difficult few minutes this morning. 10:34

Chairman, on the 27th of June, having lodged the various statements sought of the Module 9 witnesses, the Belfast Trust raised with the Inquiry that, and I'm quoting for brevity a short passage: 10:34

"If it's the intention to question the witnesses beyond

the questions actually posed to them to be addressed in their witness statements, then the Belfast Trust asks as a matter of basic fairness for the MAH Inquiry to set out the additional matters that each witness is to be asked about. This is so that each witness can have a proper opportunity to consider the issues and prepare to respond to the questions to be asked of them."

In the 11th of July response, and obviously all of the correspondence should be read in full, but it was said: 10:35

"By way of reassurance, however, if it occurs to the Panel that there is some particular issue or matter of evidence that it would wish to be raised with a witness and that could not, in fairness, be addressed properly by a witness without further detail being provided to the witness in advance of their evidence, you and the witness will be notified a reasonable period of time in advance of the witness' evidence accordingly." 10:35 10:36

Now the Belfast Trust and its counsel recognise how difficult it is to operate a public Inquiry, but Ms. Creaney by way of example, but is not confined to Ms. Creaney, was written to on the 9th of October, last week, identifying four different areas of documentation that Ms. Creaney was asked to consider alongside the three broad topics that she was asked to address in her witness statement that was provided in June. That material was provided to Ms. Creaney. 10:36

On the 11th October, so on Friday past, a further letter was received asking for further material about a different topic to be provided to Ms. Creaney and that was undertaken and at 7.22 this morning, a further letter was received from the Inquiry directing Ms. Creaney to a series of witness statements on the Inquiry website, not providing a PDF of the actual documents that Ms. Creaney was being asked to consider on the morning of her evidence session. 10:37

CHAIRPERSON: Sorry, and this came from previous evidence to the Inquiry?

MR. AIKEN: The letter of 7.22 this morning directs her to witness statements from departmental officials that are published on the Inquiry website. 10:37

CHAIRPERSON: Yes.

MR. AIKEN: That material had to be amassed by my team and provided to Ms. Creaney this morning at about 9.30.

CHAIRPERSON: Right.

MR. AIKEN: Now, respectfully, Sir, giving witnesses material at that level of short notice is unfair to them, not just because they have to try then and deal with that material, but they won't have any opportunity to go back and try and understand the context that that material might emanate from, check minutes of other meetings, internal communications. 10:38

CHAIRPERSON: Well, can I just ask what your application is because, is it that the witness shouldn't be asked and given the opportunity to deal

with matters?
MR. AIKEN: No, I'm putting on the record that this is what is occurring.
CHAIRPERSON: Oh, I understand, okay.
MR. AIKEN: It is not confined to Ms. Creaney and you will have other correspondence you can look at in respect of Dr. Jack. It is the concern that it might continue with other witnesses giving evidence this week. And I repeat again, the Belfast Trust and its legal representatives recognise how difficult it is to operate a public inquiry, but we raised this issue in June because we were concerned that the nature of the questions asked to be addressed in the witness statement were unlikely to be all of the matters that the Panel would ask the witnesses about and it is unfair to give them material at the last minute about other topics that they then don't have a proper opportunity to consider so that their evidence can be the best possible evidence to you. 10:38 10:39 10:39
CHAIRPERSON: All right. 10:39
MR. AIKEN: I don't know how Mr. Doran will deal with it. It may be Ms. Creaney will be able to deal with it. But I'm drawing to the Panel's attention that this ought not to be occurring and a letter at 7.22 this morning is not the proper way to allow Ms. Creaney to give her best evidence to this Inquiry. 10:39
CHAIRPERSON: Thank you, Mr. Aiken. The position is that, where possible, the Inquiry does assist witnesses by giving advanced notice. Sometimes in public

inquiries witnesses are given no advance notice of the questions they are going to be asked, for instance very often there are core participant questions that come in. But I have noted and the Panel have noted what you've said. If at any stage Ms. Creaney feels that she cannot answer a question then obviously the opportunity will be given to the Trust and Ms. Creaney to respond in due course in writing. So I hope that assists, Mr. Doran, I should have asked you first if you wanted to say anything. 10:40

MR. DORAN: I was going to say that I am very grateful to you, Chair, for those remarks because they reflect almost precisely what I was going to say myself. There will be occasions when matters arise at a late hour and, in fairness, we may feel that it's appropriate to bring those to the attention of the witness prior to their evidence. If, of course, there are any issues that arise that need to be followed up at a later juncture, then that course can be adopted. 10:40

CHAIRPERSON: Yes, well the witness is present, you've heard all of that. If there is at any stage anything you feel you really can't answer without more information then you will tell us. 10:41

A. I will do.

CHAIRPERSON: Mr. Aiken, thank you for your submissions. 10:41

MR. DORAN: I should say, Chair, I did have a brief word with the witness this morning about the delivery of that material at a relatively late hour. For the

most part it is material with which the witness will have previously been familiar.

CHAIRPERSON: Well, I would expect that is right, we will see. Let's crack on.

10:41

MS. BRENDA CREANEY EXAMINED BY MR. DORAN:

1 Q. MR. DORAN: Ms. Creaney, thank you for returning to give evidence, you first gave evidence on the 11th June this year. It doesn't seem as though four months have passed since then, if I may say. Now, that day we focused on issues relating to the Ennis safeguarding process and today we're going to look at your role as a member of the Trust Board primarily. Can I just make sure that you talk into the microphone please each time you answer? 10:41 10:42

A. Yes, absolutely.

2 Q. Thank you very much, Ms. Creaney. Now you made a statement for this module dated the 19th June; isn't that correct? 10:42

A. Yes, that's correct.

3 Q. And for the reference the statement is MAHI STM-291. And I think it's right to say that you prepared that statement in response to specific questions that were raised with you by the Inquiry? 10:42

A. Yes, that's correct.

4 Q. And have you had an opportunity to read through it again?

A. Yes, I have and I have it with me today.

5 Q. That's excellent and are you content to adopt the statement then as your evidence to the Inquiry?

A. Yes, I am.

6 Q. I do want to refer back briefly to your other statements for Ennis, because we might touch upon those as we go along today. The Ennis statement was dated the 22nd of February and the reference is MAHI STM-206. And then you'll remember that a short time before your evidence in June, DLS provided the Inquiry with two bundles of material that might assist with your evidence? 10:42 10:43

A. Yes, I remember.

7 Q. And you were invited then to exhibit those documents to a further short statement; isn't that right?

A. Yes, that's correct. 10:43

8 Q. And you helpfully did so in a statement dated the 30th August 2024?

A. Yes, that's correct.

9 Q. And the reference to that statement is MAHI STM-319. So you've made three statements for Inquiry purposes? 10:43

A. Yes.

10 Q. Thank you for that. I'm going to be going back now to your statement for Organisational Module 9. As with all statements in this part of the Inquiry, it is published on the website. I'm not going to go through it paragraph by paragraph, but I want to focus on questions that hopefully you might be able to assist the Panel with in addressing the Terms of Reference. And the Panel also will probably have questions as we 10:44

go along.

Now, at paragraph 5 of the statement you give a brief description of your own role and that is as Director of Nursing and User Experience? 10:44

A. Yes, that's correct, although can I just let people know I am now retired from that role.

11 Q. Indeed, I was going to ask you about that because I think you say at paragraph 85 that you plan to retire on the 30th June. Did that plan materialise? 10:44

A. Not quite, I retired on the 12th of July.

12 Q. Indeed so slightly later than expected?

A. Slightly later.

13 Q. And you had responsibility I think for two extensive portfolios, you had the Nursing, Midwifery and Allied 10:44 Health Professionals on the one hand and then Patient and Client Support Services on the other?

A. Yes, that's correct.

14 Q. And as Executive Director you would have been a member of the Executive Team and the Trust Board, isn't that 10:45 right?

A. Yes, that's correct.

15 Q. And you were in that role actually since 2010, I believe?

A. Yes, January 2010. 10:45

16 Q. So you would have been on the Board from January 2010 onwards?

A. Yes, I was actually on the Board slightly before that because I covered a colleague who was unexpectedly ill

in the children's division prior to my appointment as Director of Nursing.

17 Q. So essentially your period of time on the Board covers the second half of the Inquiry's Terms of Reference?

A. Yes. 10:45

18 Q. Now, when you attended in June you gave the Panel an account of what those roles involved and I'm not going to go into that in detail again, but one thing I don't think I asked you about was your working background before coming into those roles. Did you have any 10:46 experience of Mental Health and Learning Disability Services when you became Director of Nursing?

A. No, I hadn't. My professional background is adult nursing, children's nursing and neonatal intensive care nursing. I had, when I was covering the Children's 10:46 Services Portfolio for a short period of time I had some experience in child and adolescent mental health supporting colleagues, but I have no professional qualifications in either area.

19 Q. Yes, I just wonder generally, you've dealt quite 10:46 closely with issues arising from Muckamore over the years. Have you ever felt at any stage that your lack of specific experience or expertise in those areas has been a hindrance in any way to dealing effectively with the issues you have had to address? 10:46

A. No, I haven't because I have had the support of expert colleagues, both within the Trust regionally and in the Universities. The role is an extensive role as Director of Nursing and User Experience so it's very

important that I have people with the required expertise, not only in my team, but who support the clinical work in all of the service directorates, which I have had over the course of my career.

20 Q. So a combination of your own experience plus the specialist experience of those around you has seen you through, if I can put it like that? 10:47

A. Yes, it has, because nursing, Midwifery and Allied Health Professionals are so diverse and cover many, many different specialties and organisations and, as you know, the Belfast Trust is a very large organisation so it's important we have the correct expertise to support the work we do. 10:47

21 Q. Yes. Just looking at your role, the last day I suggested that it could be described as working at a fairly high level within an upward reporting structure, and I think you accepted that as a fair, broad description? 10:48

A. Yes.

22 Q. Having said that, it is clear from your statement that you did have occasion to visit the hospital on multiple occasions through the years? 10:48

A. Yes, I did.

23 Q. And you give details later in your statement at paragraphs 26 to 31, I am just not going to turn to those at the moment but there is an interesting statistic in one of the sets of minutes that you exhibit to your statement. I wonder if that page could be brought up, it's page 75, please. One can see 10:48

that's the minutes of a Trust Board meeting on the 3rd December 2020. But can we scroll down to page 77 please. And yes, if we just have that table please on screen and we scroll down to the bottom of the table. Now this is a document I think that sets out statistics on the frequency with which non-executive and executive team members have visited the hospital since being appointed to their current positions, isn't that right?

A. Yes, that's correct.

24 Q. And I think you say actually in your statement that the document was prepared to answer questions from a member of the public who was attending the meeting? 10:49

A. Yes, that's correct.

25 Q. If we look at your entry then at the bottom, Director of Nursing. The figure in the middle is 17 plus, and then the entry says: 10:49

"Visits, meetings, Trust Board workshop, executive team meeting, celebration event, carol services, et cetera. In addition since 2017 the Director of Nursing located herself and regularly worked from Muckamore Abbey Hospital." 10:49

Does that mean that the 17 plus figure relates to visits prior to 2017? 10:50

A. Well it includes that period as well. How I have always done my job is that I like to be visible across all of the areas. So prior to 2017 I would have been in Muckamore at least once, if not twice a year. But I

was also regularly invited to different events, as I've stated here and I would do that, would I have done that rather across the entire Trust to get to know the teams who were working in the various hospitals.

26 Q. Yes? 10:50

A. And community.

27 Q. Yes, now, it also says that you located yourself there since 2017 so you were actually working on site?

A. Yes, well I located myself there as a base very regularly after the events of 2017. You will be aware 10:50 from my colleague, Moira Mannion, I had asked Moira to spent sometime to provide support into Muckamore on a number of occasions. And it was also to support the team because it was a very challenging time. And I also gave staff the opportunity to come and meet with 10:51 me as well so I would have located myself in the headquarters, usually on a Tuesday.

28 Q. Just to be clear, that was specifically in response to what had occurred in 2017?

A. Yes. 10:51

29 Q. The Leadership and Governance Review, of which I'm sure you are aware, raised this issue about the visibility of senior management at the hospital. I needn't bring the extract on screen but they said at paragraph 10.1: 10:51

"There was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walk abouts scheduled for all Trust facilities in 2012 did not result in a site visit to

MAH until 2016."

Now you mention that I think those walk abouts at paragraph 28 of your statement?

A. Yes. 10:52

30 Q. Do you recall why it took so long for Muckamore to feature?

A. I don't recall why it took so long, although leadership walk arounds were organised on a rotational basis through the Medical Director's office and all directors 10:52 and non-executive directors were provided with a schedule to attend. But I can't recall why it took so long, although certainly I would have been in Muckamore prior to that.

31 Q. Yes, although I assume those meetings were preplanned, 10:52 not unannounced?

A. No, usually preplanned and obviously, given the patient profile, it was important that the staff knew you were coming and to gain access to the wards you needed to be accompanied by a member of staff. 10:52

32 Q. And you refer to meeting staff at those events?

A. Yes.

33 Q. And were families and patients ever invited to those events?

A. Not prior to 2017, but post 2017 I met with families at 10:53 a number of different events, but not prior to that unless I had met them on the wards.

34 Q. Yes, but as a general proposition would you accept that the visits of senior management would have been

relatively limited to Muckamore?

A. I think they were commensurate with the number of times I would have visited other areas. Certainly my focus would have been on nursing and the Associate Director of Nursing would have met with me monthly at my team meeting and they would have updated me on issues. But I know before the events of 2017, for example, I was in Muckamore three times over that summer because we had an Executive Team meeting there. 10:53

35 Q. Yes? 10:54

A. And we also had a number of other scheduled meetings as well.

36 Q. But of all the Board members, you probably had the most direct experience of the hospital itself I suppose?

A. I think it's also important to note I was and remained until my retirement one of the longest serving directors as well. It's unusual a director stays in a job 14 years. 10:54

37 Q. Yes, but I suppose then if one were to look at the Board members in the round, you probably had the closest understanding of how the facility was operated? 10:54

A. Yes, well I had understanding and I also had the expertise of the Associate Director of Nursing and the clinical team who would have updated me regularly. I also coached an AHP, for example, who was based in Muckamore. So I was there for a number of reasons. 10:54

38 Q. Just tell us a little bit more about that initiative, you coached an AHP you say?

A. Yes, I trained as a coach some years ago now and as

part of my experience I coached an AHP. The Trust had a coaching strategy and if people wished to engage with coaching, they applied through our human resources department. So I would have met with, it was a speech and language therapist, I would have met with her regularly and we used a particular methodology called "growth methodology" to coach her around a particular piece of work she was doing. 10:55

39 Q. Was that pre-2017?

A. Yes, it was. 10:55

40 Q. And you say in your statement at paragraph 28 that you visited the wards as well?

A. Yes.

41 Q. But, you say that you didn't at any time see behaviour that caused you concern or indeed concerns were not raised with you on the wards, is that correct? 10:55

A. Yeah, well now, concerns would have been raised about staffing levels, for example, and we had an ongoing issue. But specific concerns about care were not raised with me and I didn't see anything that caused me concern. 10:56

42 Q. Yes, but as you say, you would have been informed on an ongoing basis about issues such as staffing?

A. Yes, staffing or incidents particularly.

43 Q. On the last occasion I think we discussed the number of adult safeguarding referrals, for example, that were taking place and presumably you would have received ongoing information about those? 10:56

A. No, not necessarily. If it involved a nurse I would

have a report from the Associate Director of Nursing, but the adult safeguarding referrals were managed within the Directorate.

44 Q. But you would have had an awareness?

A. Yes. 10:56

45 Q. Of the issues so to speak, and certainly Ennis, for example, would you have been informed of Ennis?

A. Oh, no, absolutely, where there were particular nursing issues or issues which required regulatory referral or disciplinary action, I would have been informed. 10:56

46 Q. Yes, I think the last time when we discussed the safeguarding statistics, you referred to a change in policy that had occurred around 2012 to 2013 and I suppose you suggested there was perhaps a heightened awareness of the need to speak up after that? 10:57

A. Yes, there certainly was and there was a lot of training for not only staff in Muckamore, but across the Trust around adult safeguarding.

47 Q. I'm just reflecting now, do you have any thoughts as to how it seems that many healthcare staff, including 10:57 registered nurses, appear not to have spoken up about incidents of abuse or neglect, which presumably they must have witnessed?

A. Sorry, can you rephrase the question?

48 Q. Yes, looking back, I mean it seems, given the breadth 10:57 and scale of the issues that have emerged from the hospital since 2017, one might suppose that there must have been nursing and healthcare staff who witnessed issues or incidents of neglect or abuse but actually

never spoke about them. Can you understand how that situation could have come about?

A. I don't understand how it came about, but I know, I know it happened because subsequently when we had access to the CCTV, we could see that other people were in the surroundings and hadn't, hadn't reported any concerns. I don't know why that was the case because certainly that was a huge concern to us and where people didn't appear to be aware of their responsibilities to report, we provided them with supervision and training around that. 10:58 10:58

49 Q. Does it surprise you now looking back. Apologies, Dr. Maxwell.

DR. MAXWELL: Can I just ask you about that because in other areas of healthcare a common complaint of staff is that they report concerns, particularly if they report them through Datix and they never hear anything back and so they stop reporting. Do you know the way in which staff got feedback when they did raise things and is it possible that they had raised things but nothing had happened so they stopped raising them? 10:58 10:59

A. I'm afraid I don't know the answer to that question, but certainly if staff had raised issues then I would have expected they would get feedback, either from the Ward Sister or one of the lead nurses. But I do understand that Datix has been criticised where people will put in reports and they don't get feedback, which is a concern. But certainly, I would expect staff to raise concerns, given the seriousness of what actually 10:59

occurred in Muckamore, and unfortunately they didn't.
DR. MAXWELL: And do you recognise the term "to Datix somebody", it is commonly described on social media that staff will be aggressive to each other by "Datixing" them. 11:00
A. Yes, I do recognise that I actually had occasion, more than one occasion to ask a nurse what that meant. Because Datix is a process to escalate a concern, as you know? It shouldn't be used as a threat it should be used to record an incident, learn or improve care, 11:00 that's obviously the rationale. So I think that's a very unfortunate term and I have heard it.
DR. MAXWELL: So recognising, as we both do, that incident reporting doesn't always get feedback and is seen as negative by some staff, if somebody had seen 11:00 something serious that they thought constitutes abuse of a patient, what would you expect them to do if they didn't have confidence in the Datix system?
A. I would expect them to report it to their next line of management, and if something hadn't occurred, I would 11:01 expect them to escalate it further. That's what our regulatory guidance tells us do. I do believe, though, that in a culture sometimes people feel very uncomfortable about doing that, but it is a professional duty. 11:01
DR. MAXWELL: So if I had been a newly qualified Staff Nurse and I was concerned about the behaviour of some of my colleagues, I Datixed it and had no response, I'd reported it to the ward manager and had no response,

how far up can I escalate it and how would I do it?
A. Well, our guidance is very clear. You can escalate to a senior person in the Trust as you chose. I know that's difficult when you are a junior nurse, but certainly that is part of our induction for all nurses and midwives. And, you know, I would speak at induction and I always remind people of our decision tree around raising and escalating concerns up to and including myself and if you don't feel I have responded, then this is where you go after me. I think its very important that we encourage that confidence in the nursing and midwifery family. 11:02 11:02
DR. MAXWELL: So would you explicitly have said to nurses they can contact you directly?
A. Yes, yes, I would have. 11:02
DR. MAXWELL: Would they know how to do that?
A. Either pick up the phone, e-mail. And I have been contacted by nurses and midwives over the course of my career, sometimes with great justification. And certainly as an organisation we do encourage openness and transparency and to try to demystify raising a concern. And certainly a lot of the work we've done previously with places like Salford, you know their great work they've done around safety and the standard you walk past is the standard you accept, and certainly that was very much the way we encouraged staff to raise and escalate concerns. But also being, recognising the size and scale of the organisation as well. There are lots of different places you can go to raise your 11:02 11:03

concerns and if you don't feel, even at my level, then you can go to your trade union colleagues or, you know, other colleagues as well. I've always encouraged, and we as a team would encourage our staff do that.

DR. MAXWELL: Can I just ask one further question on that note, presumably you had regular meetings with the Royal College of Nursing? 11:03

A. Yes.

DR. MAXWELL: Did they ever raise any concerns that their members had brought to them about Muckamore Abbey? 11:03

A. Yes, they did raise concerns, largely around staffing. They also raised concerns about how we managed the investigation at the start of the process particularly. I do believe I provided some of those letters to the Inquiry. But certainly we would work very closely, not just with the Royal College of Nursing, but all of our trade unions around the management of this issue. 11:04

MR. DORAN: Thank you, I think you've answered the questions that I was going to ask as well in that sequence, helpfully. 11:04

DR. MAXWELL: Oh sorry.

50 Q. MR. DORAN: I'm going to move on and deal with some issues now relating to the Board and it's relationship with the Executive Team. I think can we go back to page 3, you talk about this at paragraph 12 of your statement, and at paragraph 12 you say: 11:04

"The Executive Team comprises the executive members of

the Trust Board. Its remit is concerned with ensuring that governance and service improvement is applied throughout the Trust. The Executive Team meets weekly. Its functions include ensuring that the Trust Board is appraised of progress or other issues affecting performance within the Trust."

Can I just ask you to expand on that. I mean let's say if you were asked to provide a brief layperson's guide as to how those two entities relate to each other within the Trust's governance structures, how would you explain that? 11:05

A. Well the Executive Team is the operational team of the entire Trust and is comprised of directors, both executive directors and service directors who are responsible for their particular specialty area or patch, which we call a Directorate and then a division. Sorry, can you restate the question, the two entities? 11:05

51 Q. It was just to explain in general terms how the Executive Team and the Board work alongside each other? 11:05

A. Okay, so the Board is comprised of the executive directors and the non-executive directors and service directors attend the Board as well. And we would, we met -- well we met quite regularly, monthly as a Board. One month as a public Board, the second month as a confidential Board or workshop. We also would have met as part of the Assurance Committee. I think I said further on in my statement I sat on a number of different committees with members of the Trust Board, 11:06

non-executive members, either as Chair or contributors to a number of the committees I sat on. We would also have had a standard of reporting from the executives to the Board around our key priorities for work and that covered everything from quality and safety, experience of our service users, complaints, finance, performance and so on, so it was quite a hefty agenda. And the Trust Board non-executive directors would have held us to account. So, for example, I would have taken particular reports on a yearly basis as part of my executive function around regulation, supervision, revalidation and so on. I also would have reported on infection prevention and control which was one of my safety responsibilities. And I took on AHPs, probably about, I think about 2015, 2016, so then I would have provided a yearly update on AHPs as well to the Trust Board. 11:07 11:07 11:07

52 Q. So it is the Trust Board's function to call the executive to account?

A. Yes. 11:08

53 Q. I have a very technical question for you about directors. It's probably best to look at the minutes of a Board meeting to assist with this. Can we go to page 75, please. Now that's the minutes of a meeting, just scroll down, please, the meeting was held on 3rd December 2020. Just looking at the membership of the Trust Board there is an obvious distinction between the executive directors on the one hand and the non-executive directors, but are there operational 11:08

directors who don't actually have an executive role?

A. Yes, if you go down a little bit to the "in attendance", they are all of the operational directors but they are noted as in attendance because they are not full members of the Trust Board, as such, unless they have an executive function. So, the legislation requires each Trust to have a Medical Director, a Finance Director, a Chief Executive, a Director of Social Work and a Director of Nursing. So that is why they are listed separately. And actually when I was, I told you earlier about covering for a colleague who was ill and the Trust Board has changed its format over the tenure of mine, it used to be that only the executives sat around the table, but that changed when I became Director of Nursing and all the directors sat around the table. 11:08 11:09 11:09

54 Q. So in a way is it fair to say there are three categories of director, you have your non-executive directors, directors with an executive role and then other directors who have an operational role but they don't form part of the Executive Team? 11:09

A. No, in attendance people there are part of the Executive Team but they are not, for want of a better expression, full members the Trust Board because they are there in attendance, they don't perform an executive role. And since this time we have an executive directors group who are the directors I listed and we would meet, we would have met with the Chief Executive on a regular basis as well as attending 11:10

Executive Team and that was about our executive function as opposed to our operational portfolio, if that makes sense.

DR. MAXWELL: Would it be fair to say the executive members of the Board are full voting members of the Board, I think that's what the legislation says? 11:10

A. It is what the legislation says but, in practice, it was more equal than that, although that is what the legislation says.

DR. MAXWELL: Technically if there was a dispute there are voting members of the Board and the people from the directorates didn't have a vote? 11:10

A. That's correct.

55 Q. MR. DORAN: Now I want to look at the arrangements in place for oversight of the hospital and you describe those at paragraphs 14 to 17 of the statement, that's back to page 4, please. Is it a fair summary that essentially escalation of an issue to Board level is a matter for the relevant director? 11:11

A. That's correct, yes. 11:11

56 Q. And the CCTV revelations in 2017 was an example of that happening?

A. Yes, although it came to the Executive Team before it came to Trust Board.

57 Q. And as we discussed in June, that didn't happen specifically as regards Ennis? 11:11

A. It did but it was noted, I think I reported the note in the Executive Team and then the Trust Board but it was just one line in the minute.

58 Q. Yes and I think we looked at that before and indeed we might have a look at it again later. But, given these arrangements, is it fair to say that really they place a very high level of dependency on individual directors to escalate issues to the Board? 11:12

A. Yes, to individual directors and to their teams as well.

59 Q. You can correct me if I'm wrong, but let me suggest how it appears reading your statement. The approach of the Board seems to have been to proceed on the assumption 11:12 that individual facilities are working effectively, you don't need to go out and seek positive assurances that individual services are functioning well, the Board really only needs to become involved if something is reported to it that a director thinks requires the 11:12 Board's attention. So essentially the picture presented by the relevant director is taken at face value by the Board without challenge?

A. Not necessarily. Non-executive members would also go out to services or on occasions may be approached by 11:13 either members of the public or members of staff as well. So, it's not my place to speak for non-executive directors, but they also would have had a series of engagements and visits with services, including learning disability. 11:13

60 Q. But is there any direct or was there any direct downward monitoring of decisions by directors as to whether particular issues should be escalated within the governance framework?

A. I would say the expectation was that issues would be escalated, but also if the board had issues they would raise them with the specific director and that happened on a number of occasions, both within learning disability, or indeed within other areas of concern. 11:14

61 Q. But not in relation to Muckamore prior to 2017?

A. The people responsible for Muckamore, one of them, for example, prior to Marie Heaney's appointment was also the Executive Director of Social Work, a gentleman called Cecil Worthington. So he would have 11:14 responsibility for both the executive role and indeed the operational role. And certainly from my recollection the Board took place at Muckamore. The non-executive directors would have gone to do a number of visits, but obviously I shouldn't really speak for 11:14 them. So they would seek information as well as look at the overall performance or concerns where they were raised.

62 Q. We can certainly ask Mr. Worthington about that as he is coming to give evidence tomorrow afternoon actually. 11:15

A. Oh, right.

63 Q. But just a governance query, if I can put it like that; could or should that role have been played by the Assurance Group?

A. Sorry, which role? 11:15

64 Q. The role of calling directors to account or challenging decisions by directors as to what goes forward to Trust Board?

A. That is the role of the Assurance Group and there are

certain parameters, whether it's patient client experience, safety metrics, financial performance, as I've said. The Assurance Committee and indeed the Audit Committee would hold directors to account.

65 Q. You have mentioned the Assurance Committee and the Assurance Group, there is a distinction between those two; isn't that correct? 11:15

A. Yes, the Assurance Group is the Executive Team's preparedness for Assurance Committee, but Assurance Committee is Trust Board performing that assurance function. 11:15

66 Q. But the Assurance Group would have advised the Assurance Committee?

A. Well, they would have provided reports in line with all of the parameters considered by the Assurance Committee which, as I've said, went from patient client experience, complaints, all the other parameters around safety would have been reported to the Assurance Committee, but the Assurance Committee is effectively Trust Board. 11:16 11:16

DR. MAXWELL: Can I just clarify that?

A. Yes.

DR. MAXWELL: Because I think it's actually non-executives, isn't it, with execs in attendance?

A. Yes but they still report, they will report on their service. 11:16

DR. MAXWELL: Yes, but the people who are hearing it and deciding whether they are assured are the non-execs?

A. Yes, the non-execs, yes.

67 Q. MR. DORAN: And, just to be clear, did the Assurance Group receive reports from directors then?

A. They would have done, yes.

68 Q. And in your experience would the Assurance Group have actively challenged the directors about the contents of those reports? 11:17

A. Yes, we would have.

69 Q. So I suppose what I'm getting at, that is a possible route through which Ennis or other staffing matters might have made their way to the Board? 11:17

A. Yes, it is, it is a route available to people.

70 Q. But it didn't occur prior to 2017?

A. No. Sorry, may I just restate, it did occur in relation to Ennis but not through Assurance Committee, it was the Board in its entirety. 11:17

DR. MAXWELL: That does sort of beg the question why didn't the Assurance Group challenge the Trust on Ennis when you knew about it because you reported it to the Board? 11:18

A. Yes.

DR. MAXWELL: But the Directorate wasn't putting forward a paper through the Assurance Group to go to the Assurance Committee on Ennis, why didn't you challenge them on that? 11:18

A. I can't say why I didn't challenge because we had a piece of work we were doing around Ennis. So when Ennis came to my attention and that of my team, we put a number of pieces of work in place which appeared to

work for Ennis.

DR. MAXWELL: But why did you not think that the assurance -- so the non-executive directors of the Board are the people who are supposed to hold the execs to account? 11:18

A. Yes.

DR. MAXWELL: You were taking action appropriately, why did you not think at the Assurance Group, this is a significant issue, the police have been involved, this is something that needs to be reported to the 11:18 non-executive Assurance Committee because you were well aware of it and yet what we hear is it didn't go through to the Board and the non-execs didn't know about it?

A. It did go through from the director, I recall it went 11:19 to Executive Team and it did go to the Board.

DR. MAXWELL: But as you said earlier it was one line.

A. Yes.

DR. MAXWELL: Why did you not ask the Directorate why they hadn't included Ennis in their reports to the 11:19 Assurance Group to go to the Assurance Committee?

A. I can't say why I didn't do that, but I was satisfied we had a plan in place around Ennis.

DR. MAXWELL: That wasn't quite the question. The question is why the non-execs didn't know? 11:19

A. Well I believe they did know through the Board but it was reported by the Service Director.

71 Q. MR. DORAN: Now, at paragraph 16, if we can scroll down, you refer to a change in structure that had

implications for learning disability where you say "over time the structure has changed." Sorry:

"Muckamore Abbey Hospital initially resided within the Directorate of Mental Health and Learning Disability at the time of my initial appointment in 2010. This service had a director who was a member of the Trust Board. Over time this structure has changed. Subsequently Mental Health and Learning Disability Services formed part of the Directorate of Adult Social and Primary Care. The primary responsibility for MAH therefore, resided with the director of that directorate who is a member of the Trust Board." 11:20 11:20

Do you recall when that change occurred? 11:20

A. I am afraid I can't give you the exact date. I would have to go back and look at my notes in relation to that.

72 Q. Let's not worry about that because that's something we can find out as a matter of fact. But I wanted to ask you this: Is it possible that that change in structure diluted the oversight of Mental Health and Learning Disability Services in that they were now being subsumed within a larger structure than one confined to mental health and learning disability? 11:20 11:21

A. Although they still had a very clear collective structure with a co-director, a chair of division and a senior nurse. So, yes, it was a much bigger Directorate but certainly, it's difficult to say, as I

wasn't the director, if it diluted it or they felt the portfolio was too large. However, certainly it was a very large Directorate but the infrastructure to support it was also significant with a number of senior colleagues. 11:21

73 Q. Let's step back and take broader overview, not just of that particular Directorate, but I'm just interested in your own professional view on this matter with the long experience you have. Is an area such as Learning Disability optimally served within such a huge 11:22 organisation as the Trust? Is there not almost an inevitability that it will be somewhat overshadowed by acute services?

A. I don't believe that would have been the case in this structure because we had Adult Social and Primary Care 11:22 which was Mental Health, Learning Disability and Community Services, so none of those were acute services so they had that focus. The other acute services were managed in a similar fashion but as separate entities or divisions. 11:22

74 Q. But you can see the point I'm making, can't you?

A. Yes.

75 Q. There is a risk that an area such as Learning Disability could become lost in the context of such a large governance structure? 11:23

A. I know from my own perspective, and there were challenges which you're aware of in relation to staffing and issues around the adult safeguarding arrangements in Learning Disability, not only in

Muckamore but in Community as well. And certainly when I spoke to the director responsible for this service, I suggested and she agreed that we put in particular collective arrangements for Learning Disability, because I felt Mental Health and Learning Disability, mental health actually, tended to have more of a focus than learning disability, that was Catherine McNicholl, she agreed with that so we put in place mirrored arrangements for Learning Disability which gave it a focus. 11:23

76 Q. When was that development?

A. That would have been around 2015.

77 Q. So prior to the issues at Muckamore coming to light?

A. Yes, yes.

78 Q. When you're asked in your statement to consider how effective the structures were in providing adequate oversight, you say at paragraph 18: 11:24

"The structures had the capability to provide adequate oversight at Trust Board level." 11:24

But I suppose the question is given the nature and the scale of the issues that came to light in 2017, and that this Inquiry is now examining, can it confidently be said that the Trust or the structures the Trust had in place were actually working effectively? 11:24

A. In hindsight, given what we know now, obviously very regrettable instances occurred. Our expectation was that the investment in that collective team should have

provided that oversight and that's why I said it had the capability. Certainly there was a great deal of expertise in Learning Disability and it should have had the capability, would be my view.

79 Q. Would you accept that essentially the structures failed in this instance? 11:25

A. Do I accept that the structures failed? I think the structures should have worked better to have a better oversight of what was happening in Muckamore. And, do you know, certainly I firmly believe had we not had CCTV it would have been very difficult to uncover this because I know when I went to Muckamore, people were welcoming and I didn't see anything that caused me concern. RQIA did a series of inspections, sometimes they raised concerns, largely around staffing. The divisional nurse regularly raised concerns with me about staffing and we put in a place a number of different mechanisms to address staffing. But I'm also very mindful I was invited to Muckamore, you know, I didn't go unannounced and I didn't have the ability to do that because the wards were closed environments. So certainly I would have expected that infrastructure to have a greater level of understanding. And certainly one of the things I did after 2017, I insisted that the lead nurses were based within their patches and not within the admin building because I wanted them to have that senior oversight in a uniform on the ground and we put that change in place, albeit after the events of 2017. 11:25 11:25 11:26 11:26

CHAIRPERSON: Could you just help me with something you said a little bit earlier, I think we are going to come on to the RQIA material, but you said there were mirrored arrangements that were put in place between Learning Disability and Mental Health. Can you just explain a bit more what those mirrored arrangements were? 11:27

A. Originally Learning Disability and Mental Health had one Associate Director of Nursing, one Associate Medical Director, Governance Manager and so on. 11:27

CHAIRPERSON: Between the two.

A. Across the two but those arrangements then were put in place solely for Learning Disability by Catherine McNicholl.

CHAIRPERSON: And that was in 2015? 11:27

A. Around 2015, 2016.

CHAIRPERSON: Yes, thank you.

80 Q. MR. DORAN: I suppose back to the big question about the Board, should the Board have been more vigilant about the possible risks to patient safety at Muckamore prior to 2017? 11:27

A. Should the Board have been more vigilant? I do think as a Board we dealt with the information brought to us. The Board was visible, although I appreciate the Leadership and Governance Review said it wasn't visible enough. I do think we were vigilant to adult safeguarding issues, but in retrospect could we have done more? Undoubtedly. 11:28

81 Q. Yes, that maybe brings us back to Ennis. You've

mentioned the way in which it was brought to the attention of the Board, we looked at this briefly the last day. Let's just have a look at the relevant Board minute on screen please, it's at MAHI 319-101. And I think, Ms. Creaney, this was exhibited to your bundle of documents related to Ennis? 11:28

A. Unfortunately I don't have the Ennis information with me.

82 Q. Yes, we are just going to have a brief look, if you don't mind, at the actual report or the minute of the report to Board. We looked at it briefly the last day. So it should be, 319-101. That was from the 11th April 2013. MAHI STM-319-101. 11:28

AV TEAM: I'm sorry there is only 93 pages?

83 Q. MR. DORAN: We can come back to that later if need be, but I think the point is Ennis was formally brought to the attention of the Board in April 2013. The reference was to the PPS bringing forward Prosecutions in relation to two individuals? 11:29

A. Yes. 11:30

84 Q. Ought that in itself not to have prompted a higher level of curiosity on the part of the Board as to the functioning of the hospital?

A. I do believe it was reported in the context of this was a court case and advising the Board. Yes, it should have. 11:30

85 Q. Yes, thank you. Now just staying on Ennis very briefly, and I know we're not dealing with that in a major way today but I just wanted to ask you briefly

about one matter that you raised in your supplementary statement with the bundle of materials for the assistance of the Inquiry, and that is at STM-319 page 3, please. Now if we can just scroll into paragraph 8. Now you say: 11:31

"On the 28th May the Inquiry notified Core Participants that it had uploaded a supplementary bundle of documents on to box. This supplementary bundle which can be found at tab 2 in the exhibit bundle was 11:31 intended by the Inquiry to be the documents referred to in my first witness statement but which were not exhibited and which were otherwise not contained within the first bundle. The same paragraph of the note to Core Participants also said that the documents to which 11:31 I had referred but not exhibited to my first witness statement would in any event not assist the MAH Inquiry Panel in addressing what were said to be the key issues arising from the Ennis report. I do not know what the key issues arising from the Ennis report are said to 11:31 be, but the documents I either exhibited or referred to in my first statement were the documents I considered necessary to answer the questions posed to the Belfast Trust by the Inquiry and through which I was trying to assist the Inquiry." 11:32

And then you go on to refer to the name of the supplementary bundle. Now I just very briefly wanted to ask you about this because I appreciate fully that

you were providing documents that you regarded as necessary?

A. Yes.

86 Q. To assist the Inquiry and that's the context in which this was written. But I just wanted to ask you about that phrase: "I do not know what the key issues arising from the Ennis report are said to be". Now in fairness to you, I wanted to give you an opportunity to comment on that because all of these statements of course appear on the Inquiry's website, but obviously the Inquiry looked in a very focused way in June on Ennis and the aftermath of Ennis? 11:32 11:32

A. Yes.

87 Q. And you contributed to that exercise through your written and oral evidence to the Inquiry. And you will recall we looked at how the response to the issue was managed. We looked at why a serious adverse incident was not submitted at the time. We looked at whether this was a missed opportunity to detect wider problems within the hospital. And we also looked at the issue of whether this ought to have prompted an intervention at a higher level within the Trust. So given that, I suppose, someone looking on might be surprised at your saying that you do not know what the key issues arising from Ennis are said to be and I just wanted to, in fairness to you, I wanted to give you the opportunity to comment on that? 11:33 11:33

A. I mean it's a little while since I've written this but I believe I thought there were additional key issues

other than what we had discussed. I believe that's what I meant.

88 Q. But is it fair to say that you're not in any doubt as to what the key issues arising from the Ennis episode are? 11:34

A. Yes, I believe we discussed those in June.

89 Q. But you wanted, are you saying you wanted to provide the documents to raise other issues that you felt were important?

A. No, I felt they supported my evidence in June. 11:34

CHAIRPERSON: Could I just ask, did you write this statement on your own or with the assistance of others?

A. I wrote it with the assistance of counsel, but it's my statement, in fact I added considerably to this statement so it's my statement. 11:34

CHAIRPERSON: Yes, I understand.

90 Q. MR. DORAN: But I hope you understand why I'm raising that, because obviously you're a very senior person within the Trust and you've said that you don't know what the key issues arising from the Ennis report are 11:34 said to be?

A. I don't think that's what I meant.

CHAIRPERSON: Mr. Aiken is on his feet again. Mr. Aiken, I really don't encourage objections in a Public Inquiry to questioning which seems to me to be 11:35 appropriate but what do you want to say?

MR. AIKEN: Well its unfortunate that you've decided in respect of my objection before I've made it.

CHAIRPERSON: I haven't decided. I am saying I don't

encourage it.
MR. AIKEN: Well, it is not about whether you encourage it, Sir, it is about whether it is fair to the witness and what is occurring, Ms. Creaney provided her witness statement, it exhibited to or referred to documents that she considered answered the questions that the Inquiry asked. That prompted a response from the Inquiry which is italicized in the statement that is now on the screen indicating that those documents, or some of them, wouldn't assist the Inquiry with the key issues. And the context of the paragraph that's being read is Ms. Creaney is explaining that she provided the documents and answered the questions trying to assist the Panel and isn't in a position to know what the Inquiry was saying the key issues were, which her effort to disclose documents relating to the questions she asked she was told wouldn't assist the Inquiry. So, this is not about, respectfully, whether Ms. Creaney knows what the issues do with Ennis are, she clearly does and gave evidence about it. This is about her being told by the Inquiry that the documents she disclosed or referred to in the statement wouldn't assist the Inquiry with the key issues and she is explaining in the latest statement well, she doesn't know what it was the Inquiry was referring to but the material she provided was her attempt to assist the Inquiry with the questions that it had asked.
CHAIRPERSON: Yes, I see.
MR. AIKEN: So this line of questioning is unfair.

11:35
11:35
11:36
11:36
11:36

MR. DORAN: Chair, very regrettably I think the witness was on the verge of explaining her position when my learned friend intervened. I have to say that when a senior member of the Trust makes a comment such as:

11:37

"I do not know what the key issues arising from the Ennis report are said to be but the documents I either exhibited or referred to in my first statement were the documents I considered necessary to answer the question posed to the Belfast Trust by the Inquiry and through which I was trying to assist the MAH Inquiry."

11:37

I am entitled as counsel to the Inquiry, in fairness to the witness, to give them an opportunity to explain exactly what they meant when they said that they did not know what the key issues arising from Ennis are said to be. It's an episode that we explored at length in oral evidence in June, this statement was made on the 30th August so I'm simply giving the witness the opportunity to comment.

11:37

11:38

CHAIRPERSON: Well let's give the witness that opportunity, she can choose whether she comments or not and whether she can give the explanation that Mr. Aiken has just given on her behalf, and we can move on. Thank you, Mr. Aiken. You heard what Mr. Aiken said, I don't know if you agree with him or not but can you give your own answer please to counsel's question?

11:38

A. Yes, I can.

MR. DORAN: Thank you.

A. I perhaps misread the letter. I was concerned there were additional issues that had not been covered in my evidence which is why I made the comment I did. I'm fully aware what the key issues were that we discussed in Ennis on the 11th June.

MR. DORAN: Thank you very much, Ms. Creaney.

A. I hope you didn't think I was being impertinent but I just felt I needed to clarify if there was something which had been missed.

91 Q. MR. DORAN: And I felt it was important to give you the opportunity to comment on that sentence. 11:39

Now, you were asked about whether the Trust Board received reports on a number of specific issues relating to the hospital, safeguarding seclusion rates, complaints, resettlement and staffing, and you deal with these matters at paragraphs 32 to 44 of the statement. We'll look at staffing in a little bit more detail later, but generally is it fair to say that prior to 2017 there would have been no specific reporting on such matters to Trust Board? 11:39 11:39

A. Yes, that's correct, except through the reporting of accidents, incidents, complaints and so on from the Assurance Committee which I've discussed before but not in this level of detail. 11:39

92 Q. But then after 2017, given the revelations and the investigation, systems were put in place to ensure that regular reports would be provided to the Board on these matters, is that right?

A. Yes, that's right.

93 Q. Now, I just want --

A. Sorry, might I just say as well there was also a request from the Department of Health that we reported to them regularly as well. So the information we provided to the Trust Board then formed the basis of the report to the Department of Health. 11:40

94 Q. Yes, so it wasn't just the case of the Trust developing those systems on its own initiative, it was encouraged to do so by the Department of Health? 11:40

A. Yes.

95 Q. I just wanted to ask you a number of specific questions about the pre-2017 arrangements. The first one, and I think you have been referred to this material, the first one is a reference in one of the earlier evidence 11:40 module statements to the Inquiry of Chris Hagan and that's STM-101 at page 33, please. And if we can just focus on paragraph 63, please. If you just scroll up he says:

11:41

"By way of illustration and to assist the Inquiry the Risk and Governance Team has collated the relevant data concerning violence and aggression incidents at MAH, specifically for the periods since the Belfast Trust's Datix records commenced. The overview charts provided 11:41 behind tab 5 in the exhibit bundle reflect the incident figures in the following key areas in the period from January 2009 to December 2022."

And then you've four categories of information:

"Inappropriate/aggressive behaviour towards a patient by staff.
Inappropriate/aggressive behaviour towards a patient by another patient.
Inappropriate/aggressive behaviour towards staff by a patient.
Inappropriate/aggressive behaviour towards staff by staff." 11:41 11:42

And then if we can go then to the exhibit itself at page 5490 of that statement. It is perhaps not the most easily navigable of documents, but if one has a look at the green line on the chart to the left, that refers to inappropriate aggressive behaviour towards staff by a patient, yes, that is the one I'm looking for, inappropriate aggressive behaviour towards staff by a patient. Now, you can see there at 2014 and thereafter there is a fairly steep rise in incidents of that kind. Now, my question is would information of that kind ever have been produced for the Board prior to 2017? 11:42 11:43

A. No, and I have to say I hadn't seen this graph until it was provided to me by the Inquiry last week. Normally whenever incidents are reported they go through the operational line. Now, if there was a concern, such as an Ennis as we have discussed, or a particular issue it may come through the Assurance Committee but I have not 11:43

seen, I have not seen this information prior to it being provided last week.

96 Q. And that goes back to pre-2017?

A. Yeah.

97 Q. But is that the kind of information the Board would now receive through the live governance reports? 11:43

A. Yes, we actually receive it not only to the Board but our arrangements now are a daily safety huddle, the Executive Team weekly and then the Trust Board monthly. Although don't receive it in this format, we receive it in a numerical format. 11:44

98 Q. I think there are some examples of those reports exhibited to other statements within the Inquiry --

DR. MAXWELL: Can I ask, would you have expected the Directorate to have this level of data and to have known that there was a very steep rise in the reported aggressive behaviour towards staff? 11:44

A. Yes, I would have.

DR. MAXWELL: It sort of goes back to our question about reporting by exception rather than seeking assurance, if the Directorate had this information you're saying they weren't sharing it with the Assurance Group? 11:44

A. Well, some of the information they would have shared in relation to accidents, incidents, but not this level of detail. 11:44

DR. MAXWELL: And so the Assurance Group only knows what the Directorate chooses to share with them?

A. The Assurance Committee?

DR. MAXWELL: The Assurance Group.

A. The Assurance Group is Executive Team.

DR. MAXWELL: I know.

A. So yes, but we have a standard reporting format and this is not the standard reporting format. 11:45

DR. MAXWELL: I understand that. So my question still stands, this clearly was known because this is taken from Datix and we discussed previously about, you know, whether anybody does anything with Datix data and that's a common fear or common frustration of staff 11:45 that they report things and nothing happens. So this was contemporaneous data, even though it is the first time you've seen it, so it would have been available to the Directorate but as the Assurance Group, the Executive Team you weren't supplied with this? 11:45

A. That's correct.

DR. MAXWELL: And so that does go to the comment Mr. Doran made to you, is the assurance process in the Belfast Trust actually reassurance because nothing is being reported to you or is it positive assurance 11:46 because you're looking at data?

A. I do believe now we are, we use data much more effectively in the Trust and certainly there's been a lot of learning. I don't know, this is a very long period of time, 2009 to 2022, so I wouldn't be aware 11:46 what format the Directorate would have had this in, for example, in 2017. But certainly, the green line which you've referred to, behaviour towards staff by a patient, there was obviously a significant spike.

DR. MAXWELL: And that might go to the staff feeling what's the point of reporting things because we've been reporting all this and nothing has happened?

A. Yes, that could be a factor and, as you have referred to, people talk about Datix and I certainly think there is, we have a much more robust mechanism now for reporting incidents from a live governance point of view. 11:47

DR. MAXWELL: Thank you.

CHAIRPERSON: I'm just looking at the time, should we finish this topic and then -- 11:47

99 Q. MR. DORAN: Yes, Chair, I have three very short questions relating to pre-2017 arrangements. So my second question then about pre-2017 is can you explain what the precise governance arrangements were for adult safeguarding reports? 11:47

A. The adult safeguarding reports would have come in through all divisions or directorates and they would have reviewed those and the issues around adult safeguarding would be -- sorry, would be reported through the Directorate governance arrangements and then escalated through the Adult Safeguarding Committee, which is the subcommittee of the Assurance Committee. 11:47

100 Q. So the Adult Safeguarding Committee was a subgroup of the Assurance Committee? 11:48

A. Yes, yes.

DR. MAXWELL: Still? Because I think I've seen organisational charts where it reports directly to the

Board?

A. Yeah, that changed, but originally it would have reported into the Assurance Committee. But the statutory functions report which it oversees goes directly to the Board.

DR. MAXWELL: Do you know when it changed and went directly to the Board?

A. I would have to check.

DR. MAXWELL: Don't worry.

101 Q. MR. DORAN: The third question then, later in your statement you deal specifically with SAIs and you say before 2018 those weren't routinely reported to the Trust Board, they were managed within the Directorate? 11:48

A. Yes.

102 Q. What about Level 3 SAIs, would they not have come to the attention the Board routinely prior to 2017? 11:49

A. On occasion, but not all of the time.

103 Q. Was there no sort of specific reporting mechanism whereby the Board would have received at least a summary of Level 3s? 11:49

A. The Assurance Committee would have received a summary of the SAIs. The Assurance Committee met quarterly so that would have been part of the overarching report to the Assurance Committee.

104 Q. And again presumably that information would now be contained within the live governance reports? 11:49

A. Yes, it is. We actually would report on events on a daily basis and certainly over our learning from this and also over Covid, we actually reported seven days a

week, we now report five days a week.
CHAIRPERSON: You said they wouldn't routinely be brought to the Board, but they would on occasion so what's the test?
A. Usually if there is something of reputational significance it would have come to the Board whereas now they all come. 11:50
CHAIRPERSON: But doesn't any SAI Level 3 have reputational significance?
A. Well yes, now, knowing what we know, but the reporting arrangements were different at that time. But certainly they would have always gone to the Assurance Committee to the quarterly meeting. 11:50
CHAIRPERSON: Sorry, Mr. Doran.
105 Q. MR. DORAN: My final question in this section just is as regards reports on resettlement. I'm wondering, even allowing for the size and scale of the Trust, does it not seem unusual in retrospect that such a large scale resettlement programme wasn't the subject of direct reporting to the Board prior to 2017? 11:50
A. Well it was part of the statutory function report which would have been produced by the Executive Director of Social Work. But the day-to-day management of resettlement would have been managed within the Directorate. 11:51
106 Q. I'll maybe ask you a little bit more about those reports later, but I think, Chair, that might be a suitable moment to have break?
CHAIRPERSON: Okay, we will take a break now until

about 12.05 and then we will probably sit through to about 1.15, so we'll take a slightly later and shorter lunch.

MR. DORAN: Yes, Chair, I have had a discussion with the witness about the possibility of spilling over into the afternoon and she is of the understanding that that might be required. 11:51

CHAIRPERSON: That looks likely I'm afraid. All right, thank you very much.

11:51

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you.

MR. DORAN: I want to ask you about staffing and workforce monitoring and I have a number of issues to raise. The first point is a very specific one. In paragraph 52 of your statement, that is at page 14 STM-291-14. You say: 12:07

"In 2011 due to the resettlement plan, there was no permanent recruitment of nurses to MAH. I raised this as a concern and the staffing levels were reassessed. This led to permanent recruitment recommencing on my recommendation in 2012/2013." 12:07

12:07

When you said you raised as a concern who did you raise it with?

A. I raised it as a concern with the Associate Director of Nursing, then Divisional Nurse and the director and the

co-director responsible.

107 Q. And that then led to permanent recruitment recommencing on your recommendation in 2012?

A. Yes, it did.

108 Q. The Inquiry has been provided with a report that I think has been provided to you also, it's the DeLoitte Workforce Planning Report which dates back to 2009 which was prior to your period in your post? 12:08

A. Yes.

109 Q. Were you familiar with that report at the time? 12:08

A. I refreshed my memory with it when I received it last week. I can't say I absolutely remember seeing it, but on reading the recommendations and the way forward, certainly I would have been familiar with those recommendations about, you know, resettlement, closing of institutions and a different model of care for nurses. 12:08

110 Q. Yes, and do you know was the ceasing of permanent recruitment as a result of that report?

A. I don't believe it was as a result of that report, but it was due to the retraction of the hospital over that period of time. 12:09

111 Q. I see, I suppose it was the outworkings of Bamford and the report?

A. Yes. 12:09

112 Q. And do you recall who or what body made the decision to cease permanent staffing at the time?

A. I don't know who made the decision, but certainly when I raised it with the director, the co-director and the

Divisional Nurse, you know, they took my concerns on board. Also, Esther Rafferty, who was the Divisional Nurse would have attended my workforce meeting and raised her concerns with me through that forum as well. But, certainly, I had a concern that due to the retraction, I understood the rationale but the staffing was too tenuous and nurses do not apply for temporary posts, they just don't when there are permanent posts elsewhere. And certainly, learning disability nurses were much sought after in other areas such as emergency departments, the brain injury unit, for example, which actually I reminded myself when I read that report, that was actually noted in the 2009 report. 12:09 12:10

113 Q. Yes, well, you've mentioned Ms. Rafferty actually who gave evidence at the time of Ennis and will give evidence again tomorrow, but you will recall in June that we discussed the report that she presented -- 12:10

DR. MAXWELL: Just before that, can I just ask one more question about the DeLoitte review, the original Equal Lives report was very clear that there would need to be new roles in the community and new support teams to support people in resettlement? 12:10

A. Yes.

DR. MAXWELL: And the DeLoitte report sort of countered that and said they will just recycle the Muckamore staff into the community and this seems to be what was happening, that the assumption was that as the wards contracted the staff would go and work in the community but that didn't really work out. When you were raising 12:11

your concerns about the lack of permanent recruitment, did you also revisit the original Equal Lives report that talked about having new roles to support people in the community to enable resettlement?

A. I do recall reading it and it reminded me when I read the report the other day and it referenced the Equal Lives report. I do believe, and actually one of the important recommendations in that report, it talks about the impact on staff from hospitals and how that should be managed. I think that was assumed it would happen and that's the big assumption, given the location of Muckamore and it's a very different type of working. 12:11 12:11

DR. MAXWELL: But given Equal Lives talked about a new type of worker, was any investment put into defining what this new type of worker would be, how you would prepare people for it, how you would prepare somebody who was no longer required at Muckamore Abbey to work with patients in the community; was any work done on that around this time? 12:12 12:12

A. I believe the Directorate did work on it. I'm not -- I don't recall there being additional investment, I don't recall that.

DR. MAXWELL: Thank you.

A. There was investment in infrastructure such as suitable accommodation, but I don't recall investment in staffing. 12:12

DR. MAXWELL: Thank you.

114 Q. MR. DORAN: I was just going to remind you of the

report that we looked at in June that Esther Rafferty had presented. It was in September 2012 and it was actually titled "Patient Safety Situation." It referred to staffing in the hospital being dangerously low and also referred to there being a crisis. And when I asked you about this in June, I asked whether the existence of a staffing crisis at a facility such as Muckamore, was that not a matter that ought to have been escalated to Board level, and I think you said then, well it would not have been at the time but it would be now? 12:13 12:13

A. Yes.

115 Q. So, that kind of issue simply wouldn't have been brought to Board attention back in the day?

A. It may have been brought if there was a requirement for additional investment, but the management would have been with my workforce team and with the service team at the time. 12:13

116 Q. The mechanism for bringing it to the Board now, would that be again through the live governance report? 12:14

A. It would be through the live governance report but it would go to the Board with an action plan and a strategy around it and that's something I would have led.

117 Q. Now, I think in your evidence in June you also then, during this exchange, referred to a very recent recruitment plan that had the specific approval of the Board? 12:14

A. Yes.

118 Q. I wonder is that the initiative that you refer to at paragraphs 56 and 57 of your statement, if you can just go down to page 15 please. So at paragraph 56 you say:

"In 2021 with the ongoing impact of suspensions resulting in learning disability nurse staffing availability being compromised, the Chief Executive arranged a risk summit to discuss the vulnerability of the service and to seek further regional support from fellow Trusts and other key stakeholders in the planning of any contingency requirements. The Belfast Trust team, of which I was part, emphasised the precarious nature of the services at the hospital and resultant concerns on the part of patients, families and staff. 12:14 12:14 12:15

With the increasing vacancies at the MAH site, by 2020 the workforce was composed largely of agency staff. The DoH agreed to a 15% recruitment and retention premium for all staff. Other Trusts were also approached to provide additional learning disability staff for MAH, however this approach did not realise many new staff and other Trust's staff could not commit to working at MAH on a full-time basis. The work to more fully integrate agency staff into the workforce was more successful and provided more consistent stability of the nursing workforce, albeit as an agency staff." 12:15 12:15

So was that the recent development that you were referring to?

A. No, the recent development commenced in 2018, 2019. We had a nursing workforce strategy which was chaired by the Director of Finance and a non-executive. We put in a place a number of plans to stabilise nurse recruitment across the entire Trust, which was largely very successful in adult acute areas by bringing in more international nurses, but unfortunately there wasn't an available source of learning disability nurses so we looked at other options. So it was still my team doing it, but it was separate to that workforce strategy. 12:16 12:16

119 Q. Yes. Does it remain the case that the majority of staff are agency staff? 12:16

A. Yes, it does.

120 Q. And presumably the difficulty has been that those staff are often not specifically learning disability trained?

A. The majority of the staff have a mental health training background. We weren't able to source learning disability staff. We have had some success in our recruitment in recent years, but the numbers are small and certainly anyone we recruit now, we have a plan that they know it will be a hospital and community post. However, we do have particular training and support for those agency staff. Quite frankly I don't know how we would manage Muckamore without those staff. A lot of those staff now have been with us five, six years and whilst they remain agency staff, we have a 12:16 12:17

contract with the agency and we work very closely with them. And off contract agency for nurses in Northern Ireland has been stopped for almost a year and the only exception to that is Muckamore Abbey Hospital because we need those staff to stay with us for the remaining 22 patients who are on site in Muckamore today.

121 Q. I was going to ask you about training, is that mandatory then for those staff?

A. It is a requirement, yeah, it is a requirement and it's positive behaviour, I've forgotten the new name for MAPA. MAPA is our managing potential aggression but there is a new name for it which I cannot recall, but it's that management of aggression in the workplace. They also have particular training around being in charge and leadership as well. And actually some of the agency staff have been appointed to substantive posts but for the staff nurses it's more financially advantageous that they remain an agency member of staff. 12:17 12:18 12:18

122 Q. Yes. Going back again to your evidence in June, and I'm sorry for jumping back to that, I was asking you about whether the situation, the staffing situation, had ever been properly resolved between 2012 and 2017. I can tell you now your answer then was: 12:18

"It was resolved somewhat but we had a real issue with recruiting to Muckamore Abbey. We also had nearby facilities who were recruiting learning disability staff so it was a balance and we did look at bringing

in non-learning disability staff which again was a balance because we needed to have the correct level of skill mix and speciality mix of the nurses."

And I asked: 12:19

"yes, so the crisis may not have entirely abated but improvements were made?"

And you said: 12:19

"No no, it didn't. There were improvements at a point in time but certainly it was a very fragile environment I would describe it as and remains so to this day." 12:19

A. Yes, because agency staff by their very nature, now we're very lucky with our agency staff, they have provided us a very effective service but contractually they could leave with no notice. Now obviously we do a lot of work with those staff. We've done a lot of 12:19 integration work with those staff, but the fact remains, they could leave.

123 Q. I just, with that background, wanted to refer you to another document that has been provided to the Inquiry recently and I think you were provided with a copy last 12:20 week it's a duty roster document. The reference is MAHI Mitchell M Bundle - 74. If one can go to page 74, please. Yes, now, that's a document called MAH Roster Analysis. It was undated but it was with papers that

was presented to the Task and Finish Group in July 2017. I don't think you are a member of the Task and Finish Group?

A. No.

124 Q. The witness who referred to the material, Mairead Mitchell, thinks the reference to November and December in the document must be 2016. Now I think in fairness to you, this document was a document that you hadn't actually seen before it was presented to you by the Inquiry? 12:21

A. Yes, that's right.

125 Q. And in most of the wards the skill mix shows as being under 50% registered staff. Now, I just wanted to look at a sentence in the third paragraph relating to Cranfield 1 where it says, yes, "it has been identified that the funded establishment is set at 26. 25 WTE". WTE if you can just --

A. It's whole time equivalent.

126 Q. "When they actually need 41.78 WTE as per a Telford exercise. This highlights a deficit of 15.28 WTEs before considering the reasons or increasing statistics for the unavailability of staff, sickness, maternity, annual leave, et cetera."

And then it goes on to refer to the skill mix as being 45% registered to 55% unregistered. Now that seems to suggest that the wrong establishment figure had been fixed, was that something that you were ever aware of?

A. I hadn't seen this paper before it was provided to me

last week. If this paper had been provided to me, I would have had a lot of questions about the exercise that made this assessment. I can only assume, but I don't know because I'm not -- I imagine this was developed by our roster manager but I don't know that, 12:23
but I saw that they were at the meeting. I'd like to know how they reached these figures. It appears to me that it's based on the number of one-to-one staff they were using and they talk about specials. I asked the team to do another piece of work around patient need 12:23
because what we actually found was, as the number of patients reduced in Muckamore, their complexity increased and we needed to look not only at behaviour management, but also physical health, mental health and so on. But I don't know if that was considered within 12:23
this, but it seems a huge increase to me.

DR. MAXWELL: Can I just ask you, you have regular meetings with the Assistant Director of Nursing for the directorates.

A. The Associate Director of Nursing. 12:23

DR. MAXWELL: The Associate Director of Nursing. This is, as you say, quite exceptional. I don't think I have ever come across a skill mix review that showed quite a big deficit between the funded establishments and the identified need. Would you not have expected 12:24
that person to bring this to your attention?

A. Yes, I would. But the one thing I would say is I don't know if this information was validated and discussed. At the minutes, the minutes of the meeting you provided

for me, I mean my deputy was at that who was in charge of workforce and the roster manager. But I would need to understand the analysis of this and what the need was because, because of the number of patients who were in Cranfield 1 at that time, it seemed significant and I would have expected this to be brought to me, yes, and I don't recall seeing this.

DR. MAXWELL: I understand that you would want to see more detail for the verification, but do you not find it very astonishing that such a significant finding was not raised with you by one of your deputies or the Associate Director of Nursing. 12:24 12:25

A. I find it very surprising because both Esther Rafferty and Moira Mannion would have raised with issues with me on very regular basis. As I said earlier I supported them in bringing additional bands of staff and a different skill mix. I'm not certain this is actually correct but I don't have the background really to say that. It just seems hugely significant to go from 26.25 to 41.78, that's significant. 12:25 12:25

DR. MAXWELL: It's even more significant for Cranfield 2.

A. Cranfield 1?

DR. MAXWELL: When you scroll down to Cranfield 2, it's an even bigger gap? 12:25

A. But, there were issues with roster compliance in Muckamore. There was, we had brought in an electronic roster system and the team in Muckamore were not keen to use the system.

DR. MAXWELL: But this is about establishments, not roster.

A. I actually am not certain it is correct but I would need to, I would need to have more information. As I say, I didn't see it until last week. It just seems so significant, had this been presented to me I would have asked for considerable information as to how these figures were arrived at. 12:26

CHAIRPERSON: But setting this document aside, you would certainly have expected there to have been a discussion at your level? 12:26

A. Yes.

CHAIRPERSON: If somebody thought these were the correct figures?

A. Absolutely I would have expected this to come to my workforce meeting which happened alternate months, or to my monthly meeting where the Associate Director of Nursing was present. I do know we put in a number of strategies to improve the staffing so that's why I am not clear how these figures were arrived at, given the number of patients who were in these wards at that time. 12:26 12:27

CHAIRPERSON: Thank you. Mr. Doran.

127 Q. MR. DORAN: Now staying with staffing, later in your statement you deal in some detail with your role as Director of Nursing and user experience in paragraphs 99 to 115 and you refer there to a monthly meeting of the Senior Nursing Management Team, were you the Chair of that meeting? 12:27

A. Yes, I chaired that or my deputy. Sorry, what paragraph?

128 Q. Yeah, it was at paragraphs 99 to 115 and that's down to pages 29 to 32 of the statement. We're back now with the witness' statement please? 12:27

A. Yes, no, I chaired that meeting monthly and all of the then Associate Directors of Nursing, latterly Divisional Nurses and my senior team attended that. One month, we had an entire Friday morning once a month. We did workforce then for the second part of 12:28 the meeting one month and then we did regulatory matters the second.

129 Q. I wanted to look briefly actually at the minutes of a meeting that you have exhibited at page 43, please, because it's interesting, it's from Friday the 21st 12:28 July 2017, so it's not too long before the CCTV revelations at the hospital. So the minutes begin at page 43 and then if we move down, please, to page 45. At page 45 one sees the adult and social primary care reports to the meeting, you see beginning at 5.2 and 12:29 then can we move down to page 48 please. So these are the adult social and primary care reports to the meeting in July 2017. At page 48 there is a reference, towards the bottom of the page, to Esther Rafferty updating the team on patient quality and safety. 12:29 Presumably that was specific then to Muckamore?

A. Yes, it was, yeah.

130 Q. And can we just go down, sorry, if we stay on patient quality and safety.

"Ongoing issues with staffing deficits on all wards. HSCW Band 3 posts have been processed to address the shortfall in staffing alongside further recruitment for Band 5 staff. This remains on the Service Risk Register. Issues also arising due to a number of staff taking up the health visiting course as learning disability nurses have been very successful again and community infrastructure investment which has led to staff seeking promotional opportunities. A number of Datix reports have been completed re: Staffing levels. Pressures arising from number of patients on one-to-one or two-to-one care and outreach to facilitate discharge to community placements. Band 5 staff in the community are leaving to go to other senior posts in other Trusts and this will need reviewed in the context of staff retention. Only two posts are Band 5 with rest all at Band 6. 12:29 12:30 12:30

Staff sickness in some wards is 2% however overall sickness was at 10 but this is now down to 2% over the last three months and this downward trend is continuing. 12:30

Staff incident whereby Band 5 staff nurse sustained injured to hip, ongoing support given and work is ongoing to review staff supports available to staff following incidents. Additionally four wards have received quality network accreditation status. Iveagh 12:30

won the national patient safety awards in July 2017. SQB project in PICU was around daily safety briefings and this is being rolled out to all wards including the communications Champion."

12:31

Then scrolling down please:

"Patient experience - the number of patients delayed in their discharge has shown a very small decrease in the last two to three months." 12:31

And then there is a fairly detailed reference to issues pertaining to resettlement and a couple of paragraph down it says:

12:31

"The patient experience is directly impacted upon as they can't leave hospital when medically fit increasing the number of safeguarding incidents between patients who no longer require in-patient care."

12:31

So that was a snapshot really of the state of play in July 2017?

A. Yes.

131 Q. And there is a reference there to ongoing issues with staff deficits on all wards, perhaps some echo there of 12:32 2012, those problems existed in 2012 around the time of Ennis as they did in 2017?

A. Yes, although this refers to all of the hospital, not just Ennis.

132 Q. Yes, so these are hospital-wide staffing issues essentially. So, I mean, we've referred to materials dating from 2012, 2016 and 2017 and indeed I think going, now that you mention it, going back to the document from 2012 that was presented by Esther Rafferty. That related more broadly to the hospital also, but it's really a recurring theme, isn't it, that there have been staffing problems at the hospital? 12:32

A. No, certainly it is and there have been, we were having nurse recruitment difficulties across all specialities but particularly learning disability because of the provision of learning disability staff and the numbers were much smaller than other categories of nurse and there were other opportunities for these staff to apply, as Esther has referred. We did a lot of bespoke recruitment for Muckamore, particularly because of its location in the Antrim area, but our success was limited. 12:33 12:33

133 Q. And obviously --

DR. MAXWELL: Can I just ask, that was about registered nurses, but you also had significant vacancies for unregistered staff? 12:33

A. Yes.

DR. MAXWELL: And that isn't a supply problem from the supply from Universities, that's making a job attractive to local people and supporting them? 12:33

A. Yes and to support that we did recruitment again in the local area because people for that level at a Band 3 level were not going to travel out of Belfast when

there were opportunities closer to home. So we, we have had an issue with recruiting healthcare support workers into Muckamore and in spite of the efforts we made to do that.

DR. MAXWELL: Did you ever give any consideration to creating Band 4 assistant practitioners? 12:34

A. Not at that stage, no.

DR. MAXWELL: Because that's something that has been used very successfully in the rest of the UK?

A. Yeah, no, we didn't. We focused on Band 3s largely for Muckamore, not Band 2s and we also encouraged our healthcare support workers to consider applying for nursing posts as well or nurse training through the Open University, which has been latterly very successful. But it was a very challenging place to recruit to. 12:34 12:34

DR. MAXWELL: Can I ask why you didn't consider assistant practitioners, because that's really what they are designed for, scenarios like this.

A. There wouldn't have been roles that we would have used at that time. 12:35

DR. MAXWELL: So you didn't give any consideration to that?

A. No, it wouldn't have been within our way of working at that time. 12:35

DR. MAXWELL: Have you ever, have you subsequently looked at assistant practitioner roles?

A. No.

CHAIRPERSON: When you say we do you mean across

Northern Ireland?

A. I mean across Northern Ireland yes.

DR. MAXWELL: But agenda for change would allow you to do it, you wouldn't need any specific permissions?

A. No, I am aware of that, it wasn't part of our workforce strategy, I have to be honest about that. The only place where we use Band 4s are s maternity support workers. 12:35

DR. MAXWELL: So you have used them, you have set the precedent of using them? 12:35

A. Yes.

134 Q. MR. DORAN: Following on from those questions, it's fair to say that within the Trust as Executive Director of Nursing, you would be the professional lead on issues of this kind? 12:36

A. Yes.

135 Q. And looking back now, and I'm sure you have reflected on this, are there other steps you think you could have taken to resolve the staffing crisis that was consistently being raised in relation to the hospital? 12:36

A. I do think we took a lot of steps in relation to recruitment, encouraging students to apply, encouraging people within the local community to apply to Muckamore. I take your point about associate practitioners but that was not part of our framework at that time. You know, we did put in place considerable educational support for the staff who remained in Muckamore and we worked closely, I would have brought issues to the Chief Nursing Officer, spoken to my 12:36

colleagues, looking at different ways of working, but the supply unfortunately was not there.

136 Q. Just for the record, that was Dr. Maxwell's point, not mine for transcript purposes, I don't want to take credit for it? 12:37

A. I beg your pardon.

137 Q. We've touched on this before but I think I should ask you again, should the issue of staffing difficulties at a facility like Muckamore for persons with severe learning disability not have been formally escalated to 12:37 the Board before 2017?

A. In retrospect, yes.

138 Q. At paragraph 71 then you say that you spoke to the Charlotte McArdle, the Chief Nursing Officer about staffing on one occasion, I'm sure you spoke to her on 12:37 a number of occasions through the years. Would that have been a consistent practice over the years?

A. Yes.

139 Q. Contact between you and the Chief Nursing Officer?

A. Yes, I also would have met with the Chief Nursing 12:37 Officer and with the other Directors of Nursing on a monthly basis.

140 Q. What was the forum for that?

A. The forum?

141 Q. The forum, was there a specific group? 12:38

A. The Chief Nursing Officer's business meeting it was called.

142 Q. Thank you. Now you talk about Francis Rice then being offered to assist and I think that was in or around

September 2019?

A. Yes, I had very regular contact with the Chief Nurse over the period at this time both formally and informally and she had written to me in the spring of 2019. Unfortunately my father was dying in the Cancer Centre over that period of time so I was a little bit delayed in my response. But I did respond to her with all of the actions we had taken, I think around, towards the end of June and you shared some papers with me today which support that. 12:38

143 Q. Yes.

A. But certainly bringing in Francis was very helpful because we needed actually, rather than just looking at rosters and numbers, we needed to, we needed to have support for the agency staff but we also needed to be clear what the patients needed with their specific needs at that time. So Francis supported the management team and indeed me. Francis' background is actually in mental health but he has huge experience and worked with the team in Muckamore and the specialist groups to look at what each ward needed and we still use that methodology to this day and he produced a report. 12:39

144 Q. I just wanted to ask you about the build up to that appointment, actually, as I say which you touch on in your statement and you refer to the materials that you were given today, I apologise for the late delivery of those? 12:39

A. No, it's okay.

145 Q. It is something that I want to ask you about and if you feel, on reflection, that you're not in a position to comment now please do let us know?

A. The letter, obviously because I am now retired, I don't have access to my emails and my work diary, but I've read those documents briefly this morning. I did a very comprehensive report to the Chief Nursing Officer at the time. 12:40

146 Q. Yes?

A. I would have to give more information by reviewing other documents if you don't mind. 12:40

147 Q. In fairness to you I am going to refer to that detailed response that you made?

A. Okay.

148 Q. I just wanted to, I am not going to labour this material, I'll ask you a few questions about it and if you don't feel in a position now to give an answer you can let us know. But the material arises from the statements of the Chief Nursing Officer, who we've mentioned, and the Permanent Secretary at the time, Richard Pengelly and we'll hear from both of them as witnesses next week. But the first document I wanted you to look at briefly was a briefing paper from Sean Holland to Richard Pengelly. Of course Sean Holland was the Chief Social Work Officer, isn't that correct, he too will be giving evidence next week? 12:40 12:41

A. He was at that time.

149 Q. It's a briefing paper that is exhibited to the statement of Richard Pengelly and it's at MAHI

STM-299-196. At page 196 please.

CHAIRPERSON: I think we're trying to scroll through to the right thing.

150 Q. MR. DORAN: There we are. So it's a paper from Sean Holland to Richard Pengelly and, as you can see from the title, the background is the second RQIA unannounced inspection, that's the context, the follow up to an unannounced RQIA inspection. Can we just scroll down to have a look at paragraph 5, please. Now it says: 12:42

"Separately the Department has sought assurances from Trust colleagues, in particular on the staffing point. Although they acknowledge that issues remain at MAH, they do not share RQIA's assessment as to the position on staffing numbers. They have advised that staff levels are safe and are regularly reviewed. This suggests some discontinuity between RQIA and the Trust." 12:42 12:43

Can we move down then to paragraph 12, please, it's on page 199.

"The Chief Nursing Officer in light of the RQIA concerns about nurse staffing levels has sought and has been given verbal assurances by BHSCT Director of Nursing that staffing is currently safe. This is being followed up in writing. The Trust is being asked to detail patient nurse staff ratio on each shift, how 12:43

these have improved and will include details of senior nurse governance assurance arrangements to ensure staffing levels are safe. The Trust are also being asked to clarify the comments made by RQIA about the structural disconnect between staff and senior managers."

Now, we'll come on to that follow up in writing in a moment.

A. Okay. 12:43

151 Q. But I just wanted to ask you about the description of the staffing situation as "safe". Can you recall is that how you described it and, if so, was it appropriate to use that word?

A. I don't recall having this conversation, but at this time I've said "currently safe". But back to my earlier point, it was we were doing a lot of work in this area but it was tenuous, but it was safe, I'm assuming what I meant, but I would have to go back to my notes, is safe on a given day, but it's something we kept a very close eye on. 12:44 12:44

152 Q. Yes, I'm going to come on to look at the information that you put in writing in a moment. As we've seen from the note there was a follow up in writing and those letters are exhibited to the statement of the Chief Nursing Officer. I wonder can we just go to MAHI STM-294-512. So this is the statement of the Chief Nursing Officer to the Inquiry. That is directed to yourself as Executive Director of Nursing and User 12:44

Experience in the Trust and it's dated 31st May 2019. Can we just scroll down a little bit, please.

So:

"Dear Brenda, further to the concerns raised in relation to nurse staffing levels by the RQIA at our meeting on 14th May 2019, I would be grateful if you could provide confirmation of the actions that the BHSCT has taken to ensure that each ward in Muckamore Abbey Hospital is staffed to deliver safe and effective care, and that staffing levels are commensurate with all individual patient needs, including those requiring enhanced levels of observation." 12:45 12:46

And then the letter goes on to say: 12:46

"I would appreciate if you could provide detail on" a wide number of issues."

And I am not going to read those in. But then you responded on the 19th June 2019 and that's at page 512, just down a little bit, please. My apologies, it is page 514. This is your letter dated 20th June 2019. It's from you to the Chief Nursing Officer? 12:46

A. Yes. 12:46

153 Q. And if we could scroll down the letter briefly, and I'm not going to revisit the detail if you don't mind, unless there is anything that you want to highlight, but it's fair to say that in fairness to you it is a

very detailed letter?

A. Yes.

154 Q. It is seven page letter that covers a wide range of issues. It's there, it's on the record, everyone can read the detail. But what I did want to ask you about was what the Chief Nursing Officer says about the exchange in her statement, and that's at STM-294 page 54. I just want to read in, you were invited to consider these paragraphs, I am going to read in paragraphs 175 and 176. What the Chief Nursing Officer says is: 12:47 12:47

"Further to two unannounced inspections at Muckamore by the RQIA in February 2019 and April 2019, the RQIA raised a number of issues including staffing levels at Muckamore with the department in an Article 4 letter sent to the department on 6th March 2019. Following correspondence with the department and a follow up unannounced inspection at Muckamore, they subsequently wrote to the department again on 30th April 2019. In response to the issues raised around staffing levels, the Department wrote to the Belfast Trust through the Chief Nursing Officer, on 31st May 2019 to seek further information on the current nurse staffing ratio and skill mix at Muckamore. The Belfast Trust response from Ms. Creaney dated 20th June 2019 is appended as Exhibit 20." 12:48 12:48 12:48

That's the correspondence we've just looked at briefly.

"My team and I remained concerned. Our concerns were that the staffing profile in the letter were almost a month out of date and therefore, required further assessment of actual staff and skill mix required and the details of access to senior decision makers was not specified." 12:48

I am going down then to paragraph 176, please.

"Further to the assurance gaps identified by the Department in the response received from the Belfast Trust on 20 June 2019, a professional nursing advisor, Francis Rice, was appointed on 18th September 2019 to work alongside the clinicians and management in the Belfast Trust. This was to provide professional assistance with the stabilisation of the nursing workforce amongst other items. As a result of the work undertaken in conjunction with Francis Rice, the RQIA lifted the Improvement Notices around staffing at Muckamore in full following a further inspection in December 2019." 12:49 12:49

Now I don't need to go any further than that, but can we just go back to paragraph 175, please. I just wanted to ask you if you will, to comment on what might be described as the critique of your letter of the 20th June 2019 that appears in the final sentence at paragraph 175? 12:49

A. I'm not aware of these concerns, although I would need to check my correspondence. I don't recall receiving a reply to my letter. But I don't believe the staffing profile I described was out of date. Obviously it moved with absence or what you have you, but the overarching plan was accurate. I would need, however, to check my correspondence to see if the Chief Nursing Officer raised those concerns because I don't, I don't have a recollection that she did. Whenever she called me to ask me how I felt about Francis coming to assist, I was very happy with that additional level of support because we were working very hard, as I've outlined in the letter. 12:50 12:50

The other comment I would like to make is that I do believe the role of the senior decision makers was clear because they were on each ward so they were there as much as we could, preferably 24 hours a day when available. And we also had revised how the more senior nursing staff worked as well so I believe that is quite clear in my letter. But as I said to you earlier, I only had the opportunity to read the letter this morning and I would need to check any other correspondence I had. 12:51 12:51

155 Q. Absolutely and if there is other material obviously that is of assistance to the Inquiry's consideration of this issue, you can present that to the Inquiry in an appropriate way? 12:51

A. Yes, but certainly the work expertise and input of

Francis was invaluable.

156 Q. Do you accept the description in paragraph 176 of the circumstances in which Francis Rice was appointed?

A. That's not my recollection, however I am not party to what conversations were being had between RQIA and Department of Health colleagues. We did have the Improvement Notice, absolutely, and I do believe it was lifted, not only on the basis of the work Francis did, but on the huge efforts the team and my team made in Muckamore. When Charlotte called me, and it was a telephone call in an evening, but I can't remember the precise detail, I was very happy to accept the assistance and help because we needed it. 12:52 12:52

157 Q. Yes and these are of course matters we can raise with the Chief Nursing Officer as well at the appropriate time? 12:52

A. But certainly at the end of 175, I'm not aware of the concern of it being out of date that I can recall, but I will need to check.

158 Q. Just in relation to the RQIA Improvement Notices to which reference has been made, one of those related to staffing obviously? 12:53

A. Yes.

159 Q. Again we're dealing with the benefit of hindsight, but given the persistent nature of this problem over the years, do you think the matter ought to have been more effectively grappled with prior to 2019? 12:53

A. As I said earlier, I think this was a really thorny issue for us that we worked very hard to address. I

accept there were perhaps other initiatives nationally that we didn't consider at that time. But certainly huge efforts were made to stabilise, albeit with the temporary workforce. Should it have been -- well it was actually escalated at this stage to Trust Board but prior to 2017 it wasn't. 12:53

CHAIRPERSON: Could I just ask this, the overarching question over all of this is could you give reassurance that staffing was safe and you did give that reassurance as we heard a bit earlier? 12:54

A. I said currently safe but it was fragile.

CHAIRPERSON: Yes.

A. You know, and that was because of the large number of the temporary workforce that we had.

CHAIRPERSON: Sure. And you must have been asked that question previously, not just in relation to this particular instance, but in acute services and in other areas over which you had responsibility. Have you ever given the answer no, it is unsafe? 12:54

A. Yes, I have. 12:54

CHAIRPERSON: And can you remember the circumstances?

A. I can remember precisely because I don't think I will ever forget it. It was in 2014. It was with regard to the Emergency Department at the Royal Victoria hospital. 12:55

CHAIRPERSON: An acute service obviously?

A. Yes.

CHAIRPERSON: Thank you. Sorry, Mr. Doran.

160 Q. MR. DORAN: I want to move on and ask you some brief

questions about the Corporate Risk Register and Delegated Statutory Functions Reports. These are matters that we can raise with other witnesses, I am not going to deal with them at length. At paragraph 65, if we can go back to the witness' statement please, that is STM-291-65, sorry, it is paragraph 65 which is page 18. You say there in relation to the Corporate Risk Register: 12:55

"I believe that issues relating to staffing, choking and resettlement may have been escalated although I cannot be precise about when that escalation occurred. The Corporate Risk Register contains risks that apply across the Belfast Trust and there may be certain risks, for example in relation to Learning Disability that are relevant to MAH but which do not specifically mention MAH. For example, I believe that choking risks were considered to fall within the Learning Disability Service generally, although those risks would have been relevant to the operation of MAH." 12:55 12:56 12:56

Now the Inquiry is currently researching the entries on risk registers at various levels. But I take it from paragraph 65 that you don't recall any of those topics being escalated to the Corporate Risk Register with specific reference to Muckamore, as such? 12:56

A. No, I don't have a recollection.

161 Q. And just in relation to the other mechanism for reporting, if I can put it like that, the delegated

statutory functions reports, you say at paragraph 64 that they are presented to the Executive Team and the Board and then to SPPG annually. And you say:

"Learning disability has been included in the Delegated Statutory Functions Report since 2010. It has evolved over time and the section was much expanded in 2020 to 2021." 12:57

Again we can pursue this perhaps in more detail with other witnesses but do you recall the extent of discussion at Board level of the content of DSF reports, was it a matter of noting or considering briefly or analysing in depth, if I can put it like that? 12:57

A. It was a very large report which covered all of the statutory functions which the Executive Director of Social Work would have presented. I recall some questions being raised by particular non-executive directors but I would need to look at the minute to see the detail of that but it was a very significant report. 12:58

162 Q. But you can't recall consideration of a DSF report leading directly to consideration of Muckamore related issues through the years? 12:58

A. No, I have no recollection of that.

MR. DORAN: Chair, I should say that for the assistance of all the Inquiry team has extracted the Learning Disability sections of those reports to distribution to

Core Participants and witnesses where appropriate.
CHAIRPERSON: I think it was distributed over the weekend which has caused some anxiety in some quarters but in fact the review of them has been very limited so far as this witness is concerned. 12:58
MR. DORAN: Yes indeed and I trust the compilation will be of assistance to all in due course. I've got one brief issue perhaps that I can deal with prior to the break.
CHAIRPERSON: Yes, please do. 12:59
163 Q. MR. DORAN: I just wanted you to clarify what you say at paragraph 71, we are moving on to deal with resettlement briefly. And at paragraph 71 which starts on page 19, you say:

12:59

"As Director of Nursing and User Experience I corresponded with the Chief Nursing Officer in relation to MAH as the circumstances required and in line with the professional requirement as a Registrant on me to do so." 12:59

Then you say:

"Resettlement was core operational business and did not fall within the ambit of the Directorate of Nursing and 12:59 User Experience, although I would advise the director in question if there were any areas on which I could assist. I did speak to the CNO, Charlotte McArdle, about staffing on occasion which resulted in the CNO

offering a former Executive Director of Nursing and Chief Executive in the Southern Health and Social Care Trust as well as being a former CNO, Francis Rice, to assist on the issue of staffing."

And that's the appointment we have discussed. I want you to clarify the reference to resettlement was core operational business, does that mean that fell outside your portfolio?

A. Yes, it did. It fell within the division of Learning Disability. 13:00

164 Q. What about your patient and client support services portfolio, would it not fall within that brief?

A. Yes, it would. Obviously PCSS as I call them, Patient Client Support Services were affected by the resettlement and redesignation. So I had operational staff who supported those staff in Muckamore. So the issues which we're dealing with currently around the impact, trade union engagement absolutely fell within my portfolio. And perhaps I misunderstood that, but for me I was, I was considering that in terms of the resettlement of the patients in Muckamore. 13:00 13:00

165 Q. Yes?

A. I didn't consider it in terms of staff for this response. 13:01

166 Q. Yes, so from the patient angle, yes, it did form part of your portfolio?

A. Well, from advising what the staffing should look like going forward but the actual management of resettlement

was within the division of learning disability, the sourcing of appropriate accommodation, staffing, liaison with the families, liaison with the patient and so on was managed within the division of learning disability. 13:01

167 Q. You speak broadly there about advising the director. Can you be more specific about occasions on which you might have given advice and what the advice was?

A. If there was a particular patient who had requirements, I used the choking example earlier, myself and my team would have supported staff in the management of the particular needs of certain patients, appropriate nutrition, management of infection, management of physical healthcare. They would have been the matters I would have worked closely with, not only the director, but the Associate Director of Nursing on. 13:01 13:02

MR. DORAN: Thank you for that. Chair, that might be a suitable moment to take a lunch break?

CHAIRPERSON: Would it be sensible to take a slightly shorter lunch break today? 13:02

MR. DORAN: Probably yes to facilitate the witness evidence this afternoon. Chair, I would anticipate perhaps needing a further 45 minutes with the witness.

CHAIRPERSON: Okay, with apologies to everybody we will take a 45 minute break and we'll sit again at a quarter to. 13:02

MR. DORAN: Thank you, Chair.

LUNCHEON ADJOURNMENT.

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

THE HEARING RESUMED IN RESTRICTED SESSION 13:43

THE INQUIRY RESUMED IN OPEN SESSION

CHAIRPERSON: Thank you, Ms. Creaney. Welcome back, Mr. Doran. 13:58

MS. CREANEY EXAMINED BY MR. DORAN:

168 Q. MR. DORAN: I want to turn back briefly to committees and governance. At paragraph 82 on page 22 to 23 of your statement, you refer to a couple of groups of relevance to the hospital. If we can scroll down, please, to the end of paragraph 82, you say: 13:58

"I'm also a director of the oversight group for MAH and Chair meetings of the MAH Nursing Assurance Group. These roles all feed into the assurance and governance structures that relate to MAH which are not directly linked to the Belfast Trust's Trust Board." 13:59

13:59

Now I take it that both of those groups were formed after 2017?

A. Yes. The Director Oversight Group was formed probably around end of October 2017, early November, and then

the Muckamore Nursing Assurance Group, that was how we managed the regulatory and disciplinary issues because the standard regulatory meeting I had with all of the divisional nurses wouldn't have had the time or wouldn't have been appropriate to discuss the complexity of Muckamore. So we set up originally it was three weekly, then it went to monthly and that happens to this day. 14:00

169 Q. Just briefly going back to the Oversight Group, we have heard some evidence about this, but could you give just a broad description of its remit and your role in the group? 14:00

A. My role was to support the director. It was set up initially by Marie Heaney and then it was chaired latterly by Dr. Cathy Jack. Originally it was an informal meeting which happened every week at Muckamore, but it became a much more formal meeting and it reported, we took report from the Operational Group. I would have brought reports from my Assurance Group and we looked at human resource issues, staffing issues, not just nursing, staffing issues across the site, safety issues, information on the CCTV and we also invited staff on occasion to come and speak to us as well. 14:00 14:01

170 Q. Would patient families have any role in that particular group? 14:01

A. No, on occasion the carer consultant came, but not very often.

171 Q. I need to digress slightly, Chair, in relation to the

other group the Nursing Assurance Group, that was set up in August 2020; isn't that correct?

A. No, that's not correct.

172 Q. Oh, I'm sorry, I must have got that wrong. When was that established, that's the Nursing Assurance Group? 14:01

A. It was set up around 2018. It changed in its format. Originally I would have met with the team at Muckamore to discuss particular issues. In 2019 we appointed nurse advisors who then became part of that group so it changed in its focus as the Muckamore situation 14:02 developed, but it was set up quite early on in the process.

173 Q. Yes. Just Chair, Panel, for note the Directorate of Legal Services notified the Inquiry on Friday that the minutes of the MAH Nursing Group, also referred to as 14:02 the Update Group; is that right?

A. No.

CHAIRPERSON: Is that DLS getting it wrong or us getting it wrong?

174 Q. MR. DORAN: I need to get to the bottom of it Chair, 14:02 but basically the indication was that the minutes of the MAH Nursing Group also referred to as the Update Group had not yet been provided to the Inquiry and the Trust had identified that the minutes, it is the MAH Nursing Assurance Group minutes had not been disclosed 14:02 to the Inquiry to date and the witness considers that the Inquiry should see the minutes of the Nursing Assurance Group?

A. And I would agree with that suggestion. I understood

they had been provided.

175 Q. Yes. What I can say is that I'm not going to be going into any degree of detail about the group today but if something arises from the minutes we can of course follow that up with you? 14:03

A. Absolutely.

176 Q. In due course?

A. And on occasion I should have said occasionally DLS would have come to that meeting as well, which is probably why they have suggested if we needed 14:03 particular advice.

177 Q. And this is the MAH Nursing Assurance Group, just so that I've got that right?

A. That's right.

178 Q. I wanted to ask you about this, you say that those 14:03 governance structures are not directly linked to the Trust Board. Can I ask you about that. Could issues raised at those meetings never be escalated to the Trust Board?

A. No, they could be escalated but it is not part of our 14:03 assurance structure because it just concerns Muckamore. But very much so, I would have brought regular updates in the report around management of staff issues, protection plans, those sorts of things up to Trust Board, so they would have formed part of the regular 14:04 report which Marie Heaney wrote.

179 Q. So if a serious issue were to emerge in the course of those meetings, it could ultimately find its way to the Trust Board?

A. Absolutely, yes.

DR. MAXWELL: So just to clarify, you're saying that that would be reported up through the director of ASPC as the Directorate's report?

A. Well the Director of Adult Social and Primary Care did a regular update. 14:04

DR. MAXWELL: Yes.

A. Around Muckamore but I would have contributed to that.

DR. MAXWELL: You would have contributed on an exceptional basis. 14:04

A. No, I would have contributed to that regularly.

DR. MAXWELL: I suppose what I mean by that is was there a standing item to receive information or was information provided as and when you felt it was necessary? 14:05

A. No, there was a standard format.

DR. MAXWELL: A standing item?

A. On the agenda, yes.

DR. MAXWELL: Of which committee?

A. Of Trust Board and Executive Team. 14:05

DR. MAXWELL: So there was a standing item for --

A. For Muckamore.

DR. MAXWELL: Muckamore on the Trust Board agenda and both yourself and the director of the Directorate.

A. Yes and the Director of Human Resources, all of us who contributed to the report would have contributed at Trust Board and it always happened in the confidential section. 14:05

DR. MAXWELL: So there was one report?

A. Yes.

DR. MAXWELL: So the lead author would have been the director of the Directorate with contributions from yourself and any other Executive Director?

A. Yes. 14:05

CHAIRPERSON: And from when would that have been a standing item?

A. That started, and it changed, it became a very detailed report from the November 2017.

CHAIRPERSON: Right. Thank you. 14:05

180 Q. MR. DORAN: Thank you. I want to ask you about a couple of matters that arose after the CCTV revelations. You say at paragraph 45 on page 13 that you became aware of the concerns in September 2017 on return from leave following an update from the then 14:06 Service Director, Marie Heaney?

A. Yes.

181 Q. You say you updated the Chief Nursing Officer and/or her team as the situation evolved?

A. Yes. 14:06

182 Q. And then you also say that in late 2017 you engaged an external team comprising Ms. McKnight, Professor Barr and, Ms. Frances Cannon?

A. Yes.

183 Q. And the Inquiry heard from Professor Barr in June about 14:06 that exercise. I just wanted to ask you about events between you becoming aware of what had occurred and commissioning that particular exercise later in 2017. What was your immediate reaction on hearing of the

revelations?

A. Shock, I have to say, very shocked and surprised. I was also concerned that a complaint had arisen in August and it hadn't been brought to my attention because there were serious allegations about nursing staff. As I said, I had been on two weeks leave so I only returned towards the end of September but Marie updated me right away and I updated, as I would normally, I updated the Chief Nursing Officer about the situation. At that time it involved PICU, the Psychiatric Intensive Care, and then there was a second concern raised about Six Mile Ward which was the forensic ward. 14:07 14:07

184 Q. And were you contacted about it when you were on leave in fact? 14:07

A. No, I wasn't.

185 Q. So you just found out when you came back?

A. Marie was waiting for me on the Monday morning when I returned.

186 Q. That was the first news you received presumably? 14:08

A. Yes.

187 Q. You have talked about updating the Chief Nursing Officer as the situation evolved. How soon after hearing the concerns did you speak to the Chief Nursing Officer? 14:08

A. It was, I couldn't tell you the exact time frame but it was very soon. I would have had a very good relationship with the Chief Nurse and I would have updated her or her deputy if she wasn't available about

issues as they arose. That's how we have always worked.

188 Q. How would those exchanges have occurred?

A. Usually by telephone.

189 Q. I just wonder what other immediate steps did you take at the time to address the concerns that had arisen? 14:08

A. Well, we discussed it at the Executive Team and we also, I also went to Muckamore to speak with the team and continued to do that, as we've already said, very regularly. 14:08

190 Q. Had you any hands on responsibility for dealing with the subsequent viewing of CCTV?

A. No, I did see some CCTV but the viewing was done by people, some people external and other people who were employed by the Trust, but not within Muckamore. 14:09

191 Q. Yes. Now, Chair, I need to just digress slightly again for good reason. Mr. Dillon, the Panel will be aware, gave evidence last Wednesday, you may have seen his evidence?

A. I unfortunately didn't. 14:09

192 Q. Well in summary he said at the time that as far as he could recall he was first made aware of a specific safeguarding concern relating to the hospital on 20th October 2017 when he received correspondence from the Chief Social Work Officer and Chief Nursing Officer in 14:09 the Department of Health about a safeguarding incident at Muckamore Abbey Hospital.

Now, since then, Chair, DLS has informed the Inquiry on

behalf of the Trust that after his evidence Mr. Dillon had the opportunity to see the minutes of an Executive Team meeting that occurred on 27th of September 2017. Mr. Dillon was the Chair of that meeting. The minutes confirm that, and these are the precise words: 14:10

"Marie Heaney advised Executive Team in relation to a serious incident in the PICU ward in Muckamore."

So the Inquiry has asked for a supplementary statement from Mr. Dillon to explain that situation. Now, the reason I have given that explanation today is that after Mr Dillon's evidence perhaps one might have thought an obvious question for this witness was -- 14:10

CHAIRPERSON: Yes, quite. 14:10

MR. DORAN: Why did you not inform the Chief Executive long before the 20th October but I am not now going to pose that question.

DR. MAXWELL: Can I ask an alternative question, you said you returned from leave and Marie Heaney was waiting for you. Would you have expected her to have as much enthusiasm for sharing with the chief Exec as well. 14:10

A. Yes, I would.

DR. MAXWELL: And not wait until the next Executive Team meeting? 14:11

A. I would have expected Marie to speak to the Chief Executive like she spoke to me.

193 Q. MR. DORAN: Would you have expected her do that before

you?

A. Yes, because she was there when the information came into the Trust, I wasn't. And she was the director responsible.

194 Q. Now finally in this period of time, and we've touched upon it slightly already, I just wanted to ask about the reactions of the Department of Health after it received the information from the Trust about what had occurred at the hospital and this issue was also raised in the course of Mr. Dillon's evidence last Wednesday. Now I think you've had an opportunity to look at the correspondence around this issue? 14:11 14:11

A. Yes, I have.

195 Q. Presumably that correspondence was familiar to you before? 14:11

A. It was familiar, yes, both the correspondence from the department and the replies from Mr. Dillon, yes.

196 Q. Yes, I want to look very briefly at that, Chair, just by way of preface to my questions. This correspondence appears exhibited to Martin Dillon's organisational module statement and that is at MAHI STM-272, page 335. Now, if I can scroll down, please, we are familiar with this correspondence, it's dated 20th October and that is a letter from the Chief Social Worker and the Chief Nursing Officer specifically and the Inquiry will be hearing from both of them in due course. It's a letter to the Chief Executive of the Trust. Now I don't want to go into the detail but basically it sets out a number of concerns, you will recall that. Just in 14:12 14:12

brief there was concerns about a delay in the Department being made aware through an early alert; isn't that right?

A. That's right.

197 Q. Also there were concerns about the delays you have mentioned of the reporting of the matter within the Trust? 14:13

A. Yes.

198 Q. There was also a concern that significant developments in the emerging story weren't being relayed quickly enough to the department and also about whether the safety policies had been properly implemented. There was then a request for comprehensive information from the Trust? 14:13

A. Yes. 14:13

199 Q. So that was, I suppose, the first item of correspondence in the chain. Now then there was a letter from the Trust on the 3rd November 2017, that's at page 338. If we can just scroll down briefly to that, I am not going to spend too much time on it. So that's the letter on behalf the Trust to the Chief Social Work Officer and the Chief Nursing Officer who would have been, I suppose, the two major players in this whole turn of events. And the letter, as I say, I won't go through it in detail, it provides a timeline of events in 2017 and then it goes on to set out a series of assurances as to what the Trust was doing to address the situation. Now the letter that I do want to look at in a bit more detail is the reply. It's a 14:13 14:14

further letter then from the department. Again it is the Chief Social Work Officer and the Chief Nursing Officer. It's dated 30th November 2017 and appears at STM-272 page 335. If we just scroll down actually to the next item of correspondence. I think I may have got my page reference wrong. Scroll down please. Sorry, can we go back to page 335 again please. My apologies. If we go down again to the letter that we've just looked at, actually, if we keep scrolling down, that's the original letter from the department? 14:14 14:15

CHAIRPERSON: So that's 20th October. We are now on 3rd November.

MR. DORAN: And we then have the 3rd November and I think it's the next one I'm looking for, if you scroll down please, that's the lengthy letter from the Trust. Yes, that's the one. It is the letter dated the 30th November 2017 and the page reference is 342, my apologies, Chair. 14:15

So that's the further letter from the department. If we can just have a look at the first, the opening paragraph please. 14:15

"We are writing following the meeting with Marie Heaney and Brenda Creaney on 17th November. As you will know, this meeting was to discuss the detail of your letter of 2nd November and the subsequent briefing report which was prepared for the Trust's Quality Assurance Committee. This letter now seeks further written 14:16

assurances on the range of issues which were raised during the 17th November meeting and on related matters which have emerged in parallel."

So essentially the Trust was still seeking assurances notwithstanding -- sorry, the Department were still seeking assurances notwithstanding what the Trust has said, isn't that right? 14:16

A. Yes, that's right.

200 Q. I think ultimately then, and we don't need to go to this, but the Chief Executive then issued further update and assurances on 22nd December 2017? 14:16

A. Yes.

201 Q. Just for the reference, that's at page 345 within this statement. But just dwelling on the opening paragraphs of the letter of the 30th November 2017, first there's a reference to a meeting that you and Marie Heaney had with the department on 17th November and a briefing paper. I am not going to go into the detail of the briefing paper, all Core Participants have been issued with a copy. Just to ask you did you write the briefing paper? 14:17

A. No I didn't but I contributed to it.

202 Q. You contributed to it. I believe through correspondence from DLS that you have retrieved your notebook entries around the meeting? 14:17

A. Yes.

203 Q. I don't think we need to drill into that level of detail about what exactly occurred at the meeting, but

I do have a couple of questions about these exchanges with the Department. The correspondence came from the Chief Executive of the Trust but what role did you have specifically in liaising with the department at that time? 14:18

A. Well I liaised with the Chief Nursing Officer or her team predominantly. From my recollection the Chief Nursing Officer wasn't at the meeting, I think it was her deputy but I'll have to go back and check my notes on that. That tends to be the way. You liaise with 14:18 your professional opposite number effectively in the department. But I also would have been supporting Marie, Marie Heaney in the management of the situation which was evolving at that time.

204 Q. Yes. I was going to ask you in what precise capacity 14:18 you attended the meeting?

A. I attended in my role as Executive Director of Nursing.

205 Q. Presumably you were a senior member the Trust oversight Group that handled the communications with the department? 14:18

A. Yes, yes that's right.

206 Q. And I suppose the main question I wanted to ask you was, looking back now at these exchanges, do you accept that the early concerns expressed by the Department about the Trust's early handling of the matter were 14:19 entirely justified?

A. They were justified, yes.

207 Q. Thank you. Now, in the final section of your statement at paragraphs 116 to 121, you give a resume of your

commitment to your colleagues in Learning Disability and you reiterate the roles that you played in respect of the hospital and beyond. I am going to read them in actually:

14:19

"Within the delegated authority of the Belfast Health and Social Care Trust I have always supported my colleagues in Learning Disability and indeed Trust-wide in an open, supportive and constructive manner. I strive to develop and support the Nursing and Midwifery 14:20
workforce across all specialities within the Belfast Trust and have worked consistently in developing the capacity of nurses and midwives at all levels. I have led the development of advanced nursing roles for Northern Ireland, writing the regional guidance. I 14:20
have played a major role in assurance for MAH working within the joint protocol to support the safety of patients and ensuring consistent approaches to fitness to practise and regulation.

14:20

whilst I could not have foreseen the extent of issues within MAH from September 2017, I took immediate, consistent and fair action to try to address what has been uncovered in respect of some nurses and nursing assistants who were working at MAH. I remain committed 14:20
to safe and effective care of all patients."

Now, you say that you couldn't have foreseen the extent of the issues within the hospital but since September

'17 you have taken immediate action to address the issues. Can I ask you, maybe depersonalising the matter if you like, could and indeed should the Trust have foreseen the extent of the issues within the hospital? 14:21

A. As I said earlier, I do think that the availability of CCTV really supported us to get to the bottom of what was happening. Certainly, initially in 2017 we believed this to be an issue in PICU, but the provision of test CCTV told us it was a wider issue which we now know. Could we have foreseen it? It's very difficult to answer that question knowing what I know now. But certainly, we felt we had appropriate safeguards in place at the time and clearly they weren't, they weren't satisfactory. So, it is difficult for me to say I could have foreseen it because as a nurse I expect nurses to work appropriately and put the safety and care of their patients first and that did not happen. 14:21 14:21

CHAIRPERSON: Could I just ask this, you know we looked earlier at that graph? 14:22

A. Yes.

CHAIRPERSON: Which showed a dramatic increase of, that was I think patient on staff assaults effectively, and that didn't get to your attention as it were? 14:22

A. No.

CHAIRPERSON: But since then has there been any review of Datix reports to see what was being put into the Datix that wasn't actually getting through to

escalation; you understand what I'm asking?

A. Yeah, no I understand. I wouldn't be aware of any review of Datix. However, our entire way of dealing with incidents has changed, it's virtually unrecognisable today compared to what it would have been in 2017. So issues of concern are raised, we don't even wait for an Executive Team now, they are raised daily now at our safety huddles. Certainly there has been a large focus on the effectiveness of incident reporting. I still think we have more do, but certainly it's a much more open, transparent culture in incident reporting, I believe, since this time. 14:23 14:23

CHAIRPERSON: But do you accept, I'm sorry Dr. Maxwell, do you accept that with Ennis and then post Ennis if you had had rather more data, such as the material we were looking at earlier, there might have been red flags that things were going wrong at Muckamore? 14:23

A. As I said to you earlier, the first time I saw that graph was during the week, that would have been a red flag. There were other red flags as well, such as complaints, patient feedback, safety metrics which all tell us what is happening in an area, but there was nothing at that time. The other point I should make, over the course of that August there were awards made to wards in Muckamore from the Royal College of Psychiatrists about the care and treatment patients were receiving. So that does not sit with what we then learned had occurred in August 2017. 14:24 14:24

DR. MAXWELL: Can I ask you about something a bit

further upstream. So, yes, learning early on that things that shouldn't have happened did happen would be important, but in an ideal world and if you know the term safety one and safety two, we'd want a safety two approach which is to anticipate things before they happen?

A. Yes.

DR. MAXWELL: This client group is extremely vulnerable, they lack, often lack mental capacity to express themselves. They don't understand and read what is going on particularly well, but there were other things. It is well established there were problems with staffing. It has been well established that there were problems with the estate, people with autism for example, were struggling in what was a poor estate, very noisy. The contraction of the hospital and closing wards meant that some patients were changing wards very frequently, which was going to be challenging for patients. Was any thought ever given to what are the risks factors for abuse and are we tracking whether those are going up or down as part of our overall approach to managing Muckamore?

A. I don't know if I can answer that question fully because I am not aware of any risk assessment. However, there were indicators such as behavioural changes. We were aware of the impact on the changing wards. Muckamore was also going through a large redevelopment and there were old wards closing which were the Nightingale style wards and new wards opening

and with that it brought challenges because, as you rightly say, the patients were very accustomed to their environment. I mean I remember one day going up to Muckamore when I was just into this job and a patient came over to ask me if I was there to close the hospital because he didn't know who I was. You know, so certainly I can't say whether or not there was a risk assessment done. There have been subsequent risk assessments done but at that time, I'm sorry, I don't know the answer to that. 14:26 14:27

DR. MAXWELL: And that's fair enough. On reflection with all you have learned do you think there is an opportunity to identify risk factors that health services could use in the future?

A. Yes, I do. I think if we put the entire picture in front of us, yes, there is an absolute, and it's not just the barn door safeguarding issues, it is the other parameters, absolutely. 14:27

DR. MAXWELL: Beforehand and that actually we are going to need that for people in placements in the community. Closing Muckamore doesn't necessarily mean this problem won't happen somewhere else. 14:27

A. No, it doesn't and we have had those conversations, we also -- excuse me, I am terribly sorry. We also regularly review the contemporaneous CCTV. I know families have raised concerns, what happens to my relative when they go to their new accommodation, will they have CCTV there. 14:27

DR. MAXWELL: But going further upstream, it's one

thing closing the door after the horse has bolted and saying we've caught it. In an ideal world you wouldn't have to catch it on CCTV because it wouldn't happen.

A. No, absolutely and I believe that there has been a lot of learning and opportunity to reflect on how we, how we pick up on those cues and all those metrics together which we hadn't, which we hadn't done prior to this. 14:28

DR. MAXWELL: So are you saying that now for people who have been placed in the community there is enough data to show that risks are increasing and action can be taken before abuse happens? 14:28

A. I think there is more to do. But certainly, I think our approach to safeguarding, our knowledge of the needs of particular patients is much greater. I think we still need to ensure that our staff and all of us, no matter what our role is, that we are fully sighted on the potential risks as well as actual risks. And certainly there has been a lot of learning as a result and there is an opportunity to learn more, absolutely. 14:28

208 Q. MR. DORAN: You've talked about the Trust there and you have used the word we? 14:29

A. I am only retired a couple of months, apologies.

209 Q. You are fine but what I am going to do is actually to ask you about yourself again and your own role and I'm sure you have reflected on this a lot. Is there anything looking back that you feel you could or should have done that might have resulted in early awareness, earlier awareness of the issues that came to light in 2017? 14:29

A. Certainly it's something which we are all very salient of, safeguarding is everybody's business and I think no matter what my role is, or anyone else's role, we need to ensure we are fully up-to-date with safeguarding protocols, procedures and ways of managing. Certainly one point actually I wanted to make, whenever the Chair asked me about safety and had I raised concerns, I was thinking there when I was having lunch, I have raised safety concerns on many occasions over many years in this role and indeed before this role, but I omitted to say that I actually closed PICU in Muckamore at Christmas 2018 because of issues where we couldn't safely staff the ward. That was very difficult because you can close a ward in an acute hospital and just not admit patients, but it's the placement of the patients in Muckamore was the real challenge but we couldn't safely staff the ward over that Christmas period so we had to engage with families, engage with the patients, explain what was happening, anticipate that there would be potentially some disruption by doing this, but we could not keep the ward safely open. I worked, obviously I advised the Chief Nursing Officer, advised the Department of Health, advised the PHA about our plans, but I felt we had nowhere to go, we could not safely staff that ward. 14:30 14:30 14:30 14:31 14:31

CHAIRPERSON: That deals with things after 2017 but what Mr. Doran was asking you was whether you, individually, feel that there could or should have been more that you could have done in terms of early

awareness of the issues pre 2017, I think is that he is asking.

MR. DORAN: Yes indeed.

A. Sorry, I do believe the infrastructure I had in place should have supported the assurance. Could I have been more inquiring? Potentially. But, you know, our process around assurance is looking at metrics which indicate safety. We could have done it better, absolutely, you know, and I could have, with the knowledge I have now I could have asked more inquiring questions. 14:31 14:32

210 Q. MR. DORAN: More curiosity, more inquisitiveness I suppose?

A. Well I would actually view myself as quite curious and having a high profile. But I also was in a scenario which was alien to me and I took assurances from people I viewed as experts. 14:32

211 Q. Now, we've had two fairly full evidence sessions. My questions are complete but the Panel may have more questions to ask. But just before I hand over, is there anything further that you wish to say now that would assist the Panel in its work or indeed anything else you wish to say to the Inquiry more generally? 14:32

A. Okay, there are just a couple of things. I was scribbling notes. The first is in relation to, I read Moira Mannion's transcript which was very full and Moira was, as I've said before, hugely helpful in supporting me and providing assurance in relation to Muckamore. But she talks about, in her statement, not 14:33

being clear about her role and certainly it would be my view that I was very clear about what her role should be. And I was not only clear with Moira, but I was also clear with the team in Muckamore. It was a stressful, it was a stressful time and the Divisional Nurse had stepped away but certainly I felt I was very clear. Moira did meet with me with the Chief Executive and I know she had said the Chief Executive didn't provide her with direction, but that was my role to provide that direction and the Chief Executive was there to support me, support Moira and out of a courtesy it would have been my role to provide her with that direction. I was a bit concerned that --

DR. MAXWELL: Can I just ask you about that, I think what she was saying was she knew in general terms what she was there to do but she didn't know what level of authority she had and she certainly had some interesting interactions with other people.

A. And I appreciate that, I appreciate that.

DR. MAXWELL: Was that clearly explained to all members of the team, what her responsibility, authority and accountability was?

A. Yes, it was. And secondly, there was a comment, I'm not certain who made it, "were you there to knock heads together?" That was not her role. Her role was to provide senior nursing support and guidance and to provide assurance to me and to the team, so I feel I need to be very clear about that.

And finally in relation to Moira's evidence, she had a very busy job, she was my deputy and I was very grateful for all she did. But I also brought in additional support for Moira. I brought in two senior nurses to support her in the workforce portfolio because I needed Moira to concentrate on Muckamore and she had a very busy portfolio.

The final thing I just want to say that it is with profound regret and shame that this has occurred, I said that in my Ennis evidence as well. And certainly, on reflection, I do think we could have done things better. I certainly think we could have relooked at the adult safeguarding approach. However, I believe we would have been, we would have still had the additional level of scrutiny because of what has occurred. But, you know, I am certainly committed and have had the opportunity to develop excellent relationships with patients and their families in Muckamore and I hugely regret what has occurred.

14:35

14:35

14:35

MR. DORAN: Well thank you, Ms. Creaney, those are my questions. There may be some more from the Panel.

14:36

MS. CREANEY EXAMINED BY THE PANEL:

212 Q. CHAIRPERSON: If her role was, going back to Moira Mannion, if her role was clear and the hierarchy was clear, the authority was clear, why do you think she had such trouble?

14:36

A. I think Muckamore is and remains an interesting place.

I said it earlier, I always felt welcome there, however, there was suspicion when people came in and one of the reasons I asked Moira to go in is she had been there twice before, had developed a good relationship. However, the management team particularly felt under huge scrutiny, which they were, and it was a very difficult situation.

213 Q. CHAIRPERSON: But then lines of responsibility and the hierarchy is even more important, isn't it?

A. Absolutely, which is why we met with the staff and explained Moira's role going forward. There were other issues within the team as well which were very challenging to manage. I certainly, I was very grateful for Moira being there because of her background and expertise. But certainly I was very clear, not only with Moira but with the team, what her role was and that she was there as Deputy Director of Nursing and my person in Muckamore, I was very clear with them about that.

CHAIRPERSON: Okay. Ms. Creaney, can I thank you very much for coming to assist the Panel. I think I can assure you that is the last time that you are going to appear here. So thank you very much for all your evidence.

14:37 14:37 14:37 14:38

We'll take a short break before the next witness. Mr. Smyth. We will take 10 minutes now and then we'll carry on.

MR. DORAN: Thank you Chair.

CHAIRPERSON: Thank you very much.

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you. 14:54

MS. TANG: Good afternoon Chair, Panel. This afternoon the Inquiry will be hearing the evidence of Mr. Gordon Smyth and that's as part of Module 9, the evidence which focuses on the Trust Board. If there are no issues the witness can be called. 14:54

CHAIRPERSON: Yes.

MR. GORDON SMYTH, HAVING BEEN SWORN WAS EXAMINED BY MS. TANG AS FOLLOWS:

14:55

CHAIRPERSON: Mr. Smyth, thank you very much for coming along and for your statement and for giving your time this afternoon. Sorry we are starting a little bit late but we should be able to finish you at a reasonable time and I'll now hand over to Ms. Tang. 14:55

214 Q. MS. TANG: Hello again, Mr. Smyth. You and I met a short time ago. Just remind you my name is Shirley Tang and I am one of the counsel to the Inquiry and I am going to taking you through your evidence. Can I check first of all am I speaking loud enough? 14:56

A. Yes.

215 Q. Because I am told sometimes I speak too quietly.

A. No, that is fine, thank you.

216 Q. Don't be afraid to shout if you need me for any reason

to repeat anything. Thank you for your statement you have provided that, it's dated 7th June 2024. I should say the page number for that is STM-280. Your statement comprises nine pages and you exhibit a number of documents with your statement in tabs 1 to 7. You should have a hard copy of your statement in front of you, I understand you have your own with you, but also any relevant section I refer to you will come up on the screen as well? 14:56

A. Okay. 14:56

217 Q. You are welcome to use whichever you find most convenient. Can I check with you, you indicated when we spoke that there were a couple of corrections you might wish to make to your statement?

A. Yes, with the organisational Module 9, table 5, the Audit Committee's annual report for 2021, should actually have been 21/22 and that was the one I got in my pack. 14:57

218 Q. Yes, thank you. So tab 5 relates to report for the year '21 to '22 as opposed to a slight typo on that index page? 14:57

A. Mhm-mhm.

219 Q. Yes, thank you. With that in mind can I confirm that you're content to adopt the contents of your statement as your evidence to the Inquiry? 14:57

A. Yes.

220 Q. So turning to your statement, Mr. Smyth, you tell us that you were a non-executive director in the Belfast Trust Board between April 2016 and the date of your

statement which was June 2024, although I understand you have since resigned from that role?

A. I did, I resigned at the end of July. Just to be clear, it was on health grounds on opposed to anything else that was going on within the organisation, so that was all do with it. 14:58

221 Q. Thank you. That's noted. You tell us in your statement that you were Chair of the Trust's Audit Committee throughout your time as a non-executive director and you chaired the Assurance Committee from July 2023. You tell us in paragraphs 10 and 11 of your statement that the Audit Committee would have met quarterly and that typically you would have reported, it would have reported to the Trust Board after each of those quarterly meetings. And there was also an annual report prepared and submitted to the Trust Board? 14:58 14:58

A. Each June, yes.

222 Q. Each June, yes. You yourself come from banking background you tell us in your statement and you had previously been a non-executive director in another organisation, the Northern Ireland Fire and Rescue Service? 14:58

A. That's right. My banking career started in May of 1977 when I was 17 and I left in August of 2012 when we were given the opportunity to leave, all managers were given the chance to leave at that stage and I was very lucky to get into the position within the Fire Service because my audit background and the financial background that I had was useful for what was going on 14:59

within the Fire Service. There were a lot of issues there and it taught me an awful lot. Then when I moved into the department in the Belfast Health and Social Care Trust, a lot of that experience came with me to the Trust.

223 Q. So, that role, your second time as a non-executive director in a public body, effectively?

A. That's right.

224 Q. When you think about your role as a non-executive director, what kind of attributes do you think non-executive directors bring to public organisations?

A. It's clearly the skill set that comes with it because you're coming from, in my background, for example, I came purely from banking. I had a lot of different experiences through the banking side of things. But what I learnt from coming through the public service (A) it was a very different service to what I was used to in the private sector but what I found was there was an awful lot to learn very quickly and, using the Belfast Trust as an example, I came in with no medical background whatsoever but I had a role to play because I had a niche within that particular Board and we worked very well during that period. So I can say more if you want me to.

225 Q. I think the thing I suppose I am curious about is what you feel a non-executive director will bring to, what you would bring in terms of your approach. I am not thinking so much of your technical knowledge from banking but more the way a non-executive director would

approach things as opposed to being a Trust employee as such?

A. Well, yeah, we are there to make sure that the governance issues are addressed, that we have a strong structure to enable people going forward that they have got the skill set necessary to bring forward the sort of issues that sometimes cause concern. In my case, because of my background again in audit and then I was involved in the Assurance Committee before that, you learn so much, it is just an ongoing learning process. 15:01

226 Q. Would it be fair to say that a non-executive director is expected to bring a degree of independence to their role?

A. Well my experience has been, going back to the Fire Service, we were basically dealing with an awful lot of issues and that made us very much a very solid team. Likewise within the Belfast Trust, when I came into it I was a wee bit concerned about some of the audit things that were coming through and what I mean by what was going through was, we were seeing a number of limited assurances coming through on an annual basis and there seemed to be a downward trend which I was concerned by. We had approached this in the Fire Service and we had made an awful lot of progress. In 18 year, 18/19, I believe it was the year we got a limited assurance from the Belfast Trust, which I had never heard of before. We had to look very closely at what we were doing as an organisation. I spoke very quickly and closely with the Chair of the Belfast Trust

and then we had to meet with the Chief Executive and the Finance Director and it was a very, very difficult meeting, it lasted for quite some time. We had to get them to understand that from where we were coming from, looking at this from outside there is an lot of issues in here that they didn't see and we were able to put in place a programme which was based very much on what we learned from the Fire Service, but we brought it into the Belfast Trust and it worked very well. What happened was that Maureen Edwards, who was the director, her co-director, Fiona Cotter, and I forget the other girl's name, but immediately they started to bring in the things that we were doing within the Fire Service and immediately people who within the Belfast Trust weren't necessarily taking audit as an important thing, we brought it forward that every Directorate had to take ownership of it and they had objectives at local level and we had to go round and go round every single Directorate, thankfully I only had to go round two of them but it gave me the confidence that it was being done right. That took us around within one year we had turned everything round to satisfactory.

CHAIRPERSON: Can I just ask you in what aspect was there limited assurance, what was the specific area?

A. That particular, there is a range of products that they look at, a range of issues that they look at. There would be some that would have come from the finance side of things. There would be some coming from internal audit and external audit and those were the

things we would have been looking at, does that give you the information that you're looking for?

DR. MAXWELL: What was the limited assurance on. You have financial audit by external auditors?

A. Yes.

DR. MAXWELL: I think that's probably more familiar to most people. Then you have internal audit on things that are not financial, necessarily, but it's looking at the controls of the risks. When you say you turned things round in a year, what was it that you had limited assurance on that you managed to turn round in a year?

A. Okay, in that particular year's report you can see the breakdown of the things that caused limited assurance and there is a range of things that were doing that. What we found was, as a consequence of the shock that we had by getting limited assurance overall then we had to take a step back and very quickly change things.

DR. MAXWELL: So can I just clarify, did you have limited assurance on both finance and non-finance issues.

A. Yes, you could do.

CHAIRPERSON: I am looking at paragraph 17 when you are talking about limited assurance for complaints, was that just one of the aspects. Sorry, Ms. Tang.

227 Q. MS. TANG: I was going to suggest that we perhaps pull up page 32 of the witness' statement because that may be what you refer to and you'll see it on the screen if that helps us?

A. Yes, that gives you a better handling in terms of the type of things that were being looked at that year.

DR. MAXWELL: This is internal audit, so you are not talking about external audit having limited assurance as well? 15:06

A. External auditors come in at the year end to look at the financial side of things. Internal audit comes from BSO and they are independent. So the head of the BSO would come in to us, we were given a year's plan in advance and we know what's going to come through. 15:06 During the course of those audits that have taken place, at the end the Committee are given the report and at that stage if it's limited then we need to bring in the directors to see what's going to be done to change things round. If it's anything other than that, 15:06 and it's assurance, then we can move away from that, if it's a satisfactory situation.

DR. MAXWELL: So you're referring at this moment to the internal audit programme, are you?

A. Yes. 15:07

CHAIRPERSON: Right. Ms. Tang.

228 Q. MS. TANG: We will come back and we will drill into a wee bit more of the internal programmes specific to Muckamore further down through your statement.

Can I ask you, before you came into your role as a 15:07 non-executive director in Belfast Trust, had you had any experience of Learning Disability Services?

A. Sorry.

229 Q. Had you any experience or exposure to Learning

Disability Services before that?

A. No, no.

230 Q. Had you ever visited Muckamore before that?

A. Not before it, no.

231 Q. Did you visit Muckamore during your time as a non-executive director? 15:07

A. I did, yes. I think it was 2022 and the Board collectively we went down to see round the place and to meet the staff and to meet some of the patients as well. It was a -- it was a very, it was a really strong -- like I don't know how to put it in words for you. It was a meeting I'll not forget. The staff that were there were doing an excellent job. They had alarm bells going off at different times but they kept -- they were doing an excellent job. Then as you got round to see all the different patients and all the different things they were doing, some of it was challenging to see the way that they have to be looked and helped. I suppose it wasn't something that I had been exposed to up until that point. I'm not, as I said earlier on, of a medical background but I bring other skills and that's the same with all the non-executive members. We all come from different areas and we can bring things that help the organisation go forward. 15:07 15:08 15:08 15:08

CHAIRPERSON: But 2022 was the first time you went there?

A. Yes, for me to go there in '22.

CHAIRPERSON: Having been in the Trust since 2016?

A. That's right, yes.

CHAIRPERSON: Thank you.

232 Q. MS. TANG: I want to focus in a little on the Audit Committee that you chaired and I want to find out a wee bit more from you in terms of the structure and the way that committee worked. You tell us in paragraph 8 of your statement that there would have been four non-executive directors, including yourself, a Director of Finance would have been an attendee at those committee meetings if I understand correctly and some others may have done as well. Can I clarify would other people who attended have included, for instance if a director's area of responsibility had been subject to internal audit, might that director have attended the Audit Committee meeting? 15:09

A. Yes, that was one of the things we introduced after the limited assurance that we got in 18, 19. We brought in at that stage, where we had limited assurance, the director had to come in, they had to explain what had gone wrong. They had to explain what they were going do to correct things and we needed a timeline in terms of things were going to be brought forward. Then we did each quarterly audit after that. We would want to see an update in terms of what was happening so that we could see that progress was actually happening as opposed to just saying yes, we'll tick the box. There was a lot of proactive stuff at that time. 15:10

233 Q. So, for instance, for learning disability where there had been an audit, we will go to the details of these

in a wee minute, but where there had been an audit and a timescale suggested such as an action had to be implemented by June 2018, did the Audit Committee build in an action plan or a regular review?

A. No, the director had to come in with their action plan in terms of what they were going do to correct things. We were making sure at the next quarterly meeting that this progress was taking place. They had promised they were going to do all these different things within a certain timeline and we wanted to see that was being done and it was being done effectively. 15:11 15:11

DR. MAXWELL: Did you ask to see outcome measures as well as process, because a lot of these action plans are we are going to set up a committee, we are going to have a new process that doesn't necessarily guarantee an improved outcome. So did you ask for outcome data as well as confirmation that actions had been implemented? 15:11

A. No, what we got was the report from the internal audit, then the director in that particular case had come in and said we have got limited assurance, this is what we are going to do. 15:11

DR. MAXWELL: Yes.

A. We said what was going to happen and they agreed with that, we had to make sure that was being implemented but there was no one from outside coming in. 15:12

DR. MAXWELL: No, no, I am asking whether you asked for outcome data about whether things had improved because a lot of the action plans that we have seen are about

set up a committee, write a policy, but that doesn't necessarily guarantee that things improve in practice.

A. No, we saw it from the next quarter to the next quarter. It was down to the Directorate to make sure what they were saying they were going to do, they were going to make the improvements that were needed. 15:12

PROFESSOR MURPHY: So do you re-audit?

A. Sorry?

PROFESSOR MURPHY: Do you re-audit if something has come out as limited? 15:12

A. The way it works is on an annual basis the Head of Internal Audit from BSO would meet and Maureen Edwards, who was the Head of the Financial Department at that stage, they would put together a programme for that, the next year and that's what was going to happen. 15:13 Some of the things that were brought in were particular issues that some of the directors knew were going to end up with limited assurance but they have identified something and they wanted to take it forward. So this was bringing it into the system. If it came out as 15:13 limited, that's just it was just confirming what they said was going to happen. But we wanted then to see the next stage and see what corrective action was going to be taken and that is what we saw as a benefit going forward. 15:13

234 Q. MS. TANG: Just building on Professor Murphy's question about re-auditing, did the Audit Committee have any role in deciding what was audited generally, did the Committee recommend to internal audit areas which they

wanted to focus on?

A. No, at the start of the year whenever the plan was set for the next year, that is what was done. The Directorates had put their input into it in terms of areas of concern that they had and that was the example I was giving you there where one of them had real concern about his particular area of what was going on so he made sure that the audit was completed and was done. We then saw how bad that was when it came to Committee and then we saw how it was going to be improved going forward. 15:14 15:14

PROFESSOR MURPHY: Did you ever check that it was improved, I think that is what we are trying to get at.

A. Yes, sorry, on a quarterly basis after that, whenever that had come to us and we had listened to the director then quarterly after that we had to see what progress was being made and we had to see evidence that progress was being made. That's where we got our comfort from in terms we could see it the next year. I will give you an example of if I might the Fire Service that there was in Grenfell. I was still in the Fire Service at that stage, I had got an awful lot of information of what was going on and was horrified at what had happened over there. 15:14 15:14

CHAIRPERSON: I think it is more useful if you give us an example from the Trust. 15:15

A. Sorry?

CHAIRPERSON: It might be more useful if you give us an example the Trust, Professor Murphy is asking you about

re-auditing.

A. No no, what happened, audit had come in and looked at Fire Service within the Belfast Trust and we discovered a number of areas of concern right across the building and then we got -- I had a report the following year and it was still limited and what was frightening to us was the fact that we had examples of people who were using the same fire escape as had been blocked from one year to the next. That's what the concern was. What we were also doing then was bringing in maps all over the place that people could do, simple things, fire escape stuff that you would expect to see everywhere, that wasn't happening there. We had some senior people within the organisation who thought it wasn't anything to worry about. But what had happened across the water showed that it could happen over here and we needed to make sure that the systems were in place that if something did go wrong that we could evacuate people. Up until that point we couldn't guarantee it.

15:15

15:15

15:16

DR. MAXWELL: Can I go back to the question about deciding what the internal audit programme is. Because the BSO don't decide what the internal programme for each client is. They are contracted to undertake the work but the Board directs what the internal audit programme should be; is that correct?

15:16

15:16

A. The way it works in Belfast Trust, I don't know what happened in other Trusts but basically, as I said before, the head of the Audit Committee -- sorry, the head of BSO, she would meet and between them and

Maureen Edwards and her team they would pull together a programme and that programme would include areas of concern that some of the other directors had brought up and that's what will be the plan for that next year.

DR. MAXWELL: So what happens in most organisations is that the Board assurance framework forms the basis because the internal programme, the internal audit programme is there to look at the controls that have been put in place with the major risks for the Trust which would be the same in a commercial organisation or a bank. And given that the internal audit programme was largely around the non-financial risks, it must have been more than just the Director of Finance who was identifying what the areas you needed assurance on were? 15:17

A. Yeah, when I came in, it seemed very focused on just finance but what then expanded year by year were other things were being brought in. And I'm thinking in terms of some of the Directorate who had got an issue within their area. They wanted to see this going through an audit because they knew that there was something there and it had to be flagged up and addressed and that's why it was changed.

DR. MAXWELL: But the responsibility for the governance and the running of the organisation is the responsibility of the Trust Board. The way you describe it, the Trust board had nothing do with this, BSO were doing things that individual directors wanted to be assured, whereas my understanding has always been

that the Audit Committee and the Internal Audit Programme is to assure the Board that sufficient controls are in place. I am not quite sure where the Board fits into deciding.

A. The Board came in on a monthly basis in terms of what actions were being taken to improve things within the Trust. 15:18

DR. MAXWELL: I am just asking about setting the agenda. Did the internal audit programme have to be signed off by the Trust Board? 15:19

A. Yeah, well it was signed off by the Directorate.

DR. MAXWELL: But not by the Trust Board?

A. I can't honestly remember whether that was done or not. In my world the two were working together. So if it was brought to the Trust Board then we would have already approved it at that stage but they would have been told what was happening. So they were never kept in the dark. 15:19

235 Q. MS. TANG: Just to probe that a little bit, was there a weakness that if then a Director of a service area didn't see something as a problem, it might never be audited? 15:19

A. That's right, yes. And we have got examples coming in this evening where you can see one of the Directorate was very concerned with what was going on in his Directorate and he made sure an internal audit did the programme. It came to us then as a limited assurance that limited assurance then we took forward on a regular basis. So whereas before you just had, you 15:19

didn't know what was going on in a particular Directorate, this was the thing actually fixed on an ongoing basis.

236 Q. MS. TANG: So as long as a director knew there was an issue and wanted to attract the audit gaze on to it, it could get onto the internal audit resource list at some point? 15:20

A. Yes.

237 Q. But if a director decided they didn't want something to be audited, is it quite possible that it might never be audited then unless it was picked up some other way? 15:20

A. Yeah, this is where the meeting between the Directorate, I'm talking about Maureen Edwards and the rest of the Executive Team, and the Head of Internal Audit, they would make the plan and that was what was done, that is really now it worked. 15:20

DR. MAXWELL: So it had no relationship to the Board assurance framework?

A. I know what you're trying to say to me and I'm not sure how to answer to it. Because what my understanding was, we had a good system in place, it was working well, that's -- 15:21

DR. MAXWELL: Well my understanding is that non-executive directors are in post to assure the service and not to leave it to executive directors alone to provide the assurance. So if you are saying the Board did not oversee the internal audit programme and that it wasn't checked against the Board assurance framework, I can't see how non-executive directors were 15:21

involved in setting the internal audit programme which is their primary function?

A. Covid changed some of the programmes that we were using. Up until that point I would have met after the Directorate and the head of the service, BSO, had agreed the plan and then they would go through it with myself in terms of what was going happen. So we did know but once Covid came in that process dropped by the wayside. But we were still getting a plan each year and there was a clear -- 15:21 15:22

DR. MAXWELL: It is certainly not the way the Good Governance Institute that guides English Trusts would recommend doing it, that's all I can say.

CHAIRPERSON: Could I just ask, I wonder if it's helpful to actually use a specific example which you deal with in your statement at paragraph 16, just so I can really understand how this works. Can we have 16 up. Ms. Tang, is this something you were going to explore. 15:22

MS. TANG: I can pick up on it certainly if you wish. 15:22

CHAIRPERSON: Let me just ask and then you can pick up anything I have missed.

"The internal audit department sent me out to take reviews of individual service areas as part of its role." 15:23

It is part of BSO, as you have told us, and is independent of the Trust you. You say:

"It is my understanding that following discussion with the director and co-director for Adult Social and primary Care it was agreed that the focus of the audit would be on MAH specifically in relation to complaints."

Do you remember this first of all?

A. Yes.

CHAIRPERSON: Who would have agreed that that would be the focus of the audit? 15:23

A. In this particular case it was Adult Social and Primary Care Directorate who then put that forward as something that needed to be looked at as part of the information that was coming through from Muckamore Abbey at that stage. 15:23

PROFESSOR MURPHY: It is a very social process, isn't it, and I suppose I am worried and I think the rest of the Panel is worrying, that if you're worried about being shamed by the result of an audit, you might not say I think this needs auditing? 15:24

A. Well my experience within this, and I'm trying to be as honest as I possibly can, was that all the sought that we saw had been put forward and in many cases where any of the Directorate had come across something that was causing concern, they put it forward to the Board and there would have been an audit carried through at that stage. In this particular example that you talked about, we had management of complaints and incidents 15:24

and the patient supervision and part of that came out as limited assurance and the other part came through as satisfactory.

PROFESSOR MURPHY: And as I recall the bit that came out as satisfactory, there were actually something like 11 recommendations. 15:24

A. Mhm-mhm.

PROFESSOR MURPHY: So it seemed to me very surprising it was called satisfactory if there were 11 recommendations? 15:25

A. Well that was the assessment given to us by BSO. They went through the process and at the end of it all they deemed that in that particular case they wanted limited assurance on half of it, and this is going back, so that I am being clear, normally you would have limited assurance if something was wrong. You had satisfactory if most things were right and you had unacceptable where the three basic areas. But what you have got, the breakdown then of that is you can get some where there is a limited bit in part of it and the other bit is satisfactory. So it is a split outcome if you like. That's why the number of items that were there caused some concern, but not enough for the whole thing to be turned down, they could see there was progress there and they had to agree what was going to have to be done so next time round, those things would have been addressed. 15:25 15:25 15:26

PROFESSOR MURPHY: Was there an objective criterion for when something was coded as limited and when something

was coded as satisfactory in terms of audit?

A. If it was a split one and came to us, yes, we would have to see the Directorate, see their action plan in terms of what they were going to do in terms of the timeline that I mentioned earlier on as well and then we would see on a quarterly benefit after that, on a quarterly basis, we would see that progress was being made and progress was being made and that was the way it worked. 15:26

CHAIRPERSON: Just to finish this, this paragraph finishes: 15:26

"The audit committee would not have had a role to play in deciding what services should be audited or what the subject of the audit should be." 15:26

Yeah?

A. Yeah, that's right.

CHAIRPERSON: So effectively your committee is working, whether this is good or bad I don't know, you are effectively working as an audit tool for the Directorate? 15:27

A. That wouldn't have been my interpretation of it and I can understand where you're coming from, but we were working on the basis OF the whole time I was there, we had an audit plan that was agreed the year before, that was pulled together by the directors. 15:27

CHAIRPERSON: By the directors of each service?

A. Each service, yes, they would be involved in it. And

where there was a concern which, say, a new director had come in and found something was really wrong within his Directorate, he would have put that forward and said look, we need to get audit to come and look at this, that was what was being done. That's what we did. We made sure then going through that process that things did correct. And we went through, in each of these situations where the management comments were made at the end, we wouldn't have let it go through unless they had agreed that things were going to change and they would have said on the documents in terms of what we have to do to turn this round. 15:27 15:28

CHAIRPERSON: Thank you.

238 Q. MS. TANG: I want to look with you more closely now at one of the particular audits that was discussed in your statement. If I can pick up at paragraph 17 of the statement and we will look a wee bit further on to one of the later pages where the detail of the audit finding was published. The audit relates to incidents and complaints and we are told in the audit findings that the number of incidences was 2,705 over nine months which would be about 10 per day and in that same period of time there were four formal complaints. I want to ask you did the Audit Committee find those figures surprising in any way? 15:28 15:28 15:29

A. Yes, startling and the reason being the fact that there was only four complaints came through the system. We had one of my colleagues, a non-executive colleague who was also looking at this whole area and was trying to

improve the work that there was from Muckamore Abbey into what was going on within the Belfast Trust. Because effectively the complaints section in Belfast, in Belfast Trust, Muckamore Abbey didn't seem to connect with that. It was doing slightly different things in terms of what way things were being put forward and he was working very hard to try and make sure that the same process that we were using within the Belfast Trust was being used within Muckamore Abbey but it wasn't moving forward at a great speed, it was happening but it was -- progress was being made. 15:29 15:29

239 Q. So can I clarify with you, when the report says there were four formal complaints, is that that there were four complaints within the central system?

A. No, that was just out of Muckamore Abbey. 15:30

240 Q. Sorry, that the central system knew about?

A. Yes.

241 Q. Of Muckamore, there may have been more, in fact we saw evidence that there was more. Was there any concern that the overall number of complaints looked quite low? 15:30

A. Well the formal bit of it was very concerning, that only four had come through. I think was it 1,762 over and above that, there was a figure, I can't remember what it was, but it was shocking at the same time. But to see four as coming through as formal and the rest coming through as just whatever way they were being forwarded, it did make us worry a wee bit in terms of how they were being captured locally and how that was being fed up to the Trust. 15:30

242 Q. Yes, there was the incidents number of 2,705 was cited, a large number of incidents, but then conversely I suppose a different things would be the complaints. Was there, to your recollection, anything done by the Audit Committee or any scrutiny which looked at were complaints actually being made or was there any issue with people's understanding of how they could make a complaint? 15:31

A. It would appear, again using my colleague, he was frustrated that there didn't seem to be joined up thinking down there, down there being Muckamore Abbey. They were all using their own system in different places and what he was trying to do was collate the information within the right time frame that we could take it forward within the Belfast Trust. 15:31

243 Q. So when you talk about different systems, is what you're saying that it appeared that there wasn't an overall complaints system within Muckamore, that it was left up to individual clinical areas to deal with them?

A. That seemed to be our concern initially, that there was an awful lot of work needed to be done. 15:32

244 Q. Did you raise that concern with the Trust Board as an Audit Committee?

A. It would have been brought up. With all these inspections or audit, outcome, we would have orally briefed the Trust Board each month in terms of what was being done. 15:32

245 Q. So these are at your quarterly briefings, when you say each month was there some separate section?

A. In the case of Muckamore Abbey everything we saw was, and leaving aside the Audit Committee, the Board members and non-executive Board members, we got stats every month in terms of what was going on in terms of everything that was happening within Muckamore Abbey and what had been done to improve it. We had sent down senior staff from the top to bring down stability at the very start when this thing came to light and that work was ongoing. You could see the progress that was being made, but at the same time then we also saw the down sides in terms of what was coming forward from HR, in terms of the number of staff that had to be suspended and all that went on with that, so there was a lot of stuff happening down there. 15:32 15:33

246 Q. You made reference to stats and data that you were getting on a regular basis. Can you remember what time frame you started to get, you got that data over? 15:33

A. I remember seeing it in and around towards 2017 but we certainly got them every month once it had come to our light. 15:33

247 Q. Can you remember what kind of data you would have been sent?

A. It changed from one which went right the way the whole way through, where there were numbers of patients. I think there was a hope that patient numbers would change to different places because they were trying to put better places for them to live. But that never really got down to where we hoped it would go because there always seemed to be new people coming in. 15:33

248 Q. Are you thinking about the resettlement targets?
A. Yes.
249 Q. Is that what you mean?
A. Yeah, then we got an awful lot of stats about the staff that had been suspended, what was happening to them, where they were in the process, how the police had been involved and all those sort of things were involved at the same time. 15:34
250 Q. That was approximately 2017 onwards?
A. Mhm-mhm. 15:34
251 Q. Would you have seen incident data and things like that coming through on those monthly stats?
A. We got very detailed reports from each of the senior people that were down there would send accurate information through to ourselves. We, as non-executives, learnt an awful lot from what was going on and we felt that the organisation was going in the right direction but at the same time our Chair at that stage was very concerned that we needed to help the patients and deal with their concerns. Whereas before maybe that hadn't been looked after as properly as it should have been and that's why so many staff members got into difficulties. But he was very keen early on that we, as an organisation, made sure we made progress within Muckamore Abbey. 15:34 15:35 15:35
252 Q. Would the data that you received, do you recall seeing any figures on staff shortages or levels of vacancies?
A. There were quite a lot of staff vacancies. They tried to bring in people from other areas but there were

concerns. I think at a time they had to bring in people at a higher level of salary to try and get people to come in and move things forward. But I know Brenda Creaney, that was here today, she was heavily involved in trying to bring in the nursing side of things. So, it's hard to get across the amount of work that was happening at that time and it was happening everywhere and we were being kept up as a Board in terms of what should have been happening.

253 Q. I think in view of the amount of work that you describe and the level of interest that it sounds that the Trust Board were having in all things Muckamore at this time, there is a relatively modest amount of audit focus on Muckamore related issues such as the staffing shortages, the pressures on recruitment. Is that a fair comment? 15:36

A. That would have been picked up through the Assurance Committee and that was always, the information was always there in terms of what was happening. Everything to do with that particular area at that stage was under assurance. I was part of the Assurance Committee at that stage and there was an awful lot of effort being put in to trying to improve things and address the concerns that were there. 15:36

254 Q. So this is the Assurance Committee that you became Chair of in July '23, but you say you were a member of it before that, do I understand you correctly? 15:37

A. At that stage all the non-executives were part of the Assurance Committee.

255 Q. I suppose the thing I'm trying to clarify with you is the audit projects that were undertaken, the internal audit things that were done in relation to the Trust, given the amount of problems that you describe that you were being made aware of in terms of the data that was being sent in, about whether it be staff shortages or resettlement targets, difficulty meeting those, I just wonder why there wasn't more audit focus, internal audit energy directed into looking into those things and trying to understand why they were problems? 15:37

A. Because it was coming through the Assurance Committee and they were dealing with all of that.

256 Q. What does that mean, how is that different?

A. The Assurance Committee basically looked at all things that were relevant to anything to do with the medical side of things. The audit side of things was going back to this plan that came in on an annual basis which had been agreed the year before and that was what was going forward. The Insurance Committee and Chair at that stage was Mr. McNanny, our chairman, he took ownership and he made sure we were taking things in the right direction. He was very close to the people within -- the patients in particular and their families and we were all very conscious of what they were going through. I understand some of the frustration that members have. 15:38

257 Q. So do I understand correctly that the role of the Assurance Committee was following up on these issues that we've discussed. So, for instance, if there were

significant staff shortages would you have expected the Assurance Committee to have a workstream focusing on that?

A. I can't remember what the stream would have been. I've got a copy that I've used which I would have used previously in terms of how the assurance framework worked and what was done, but that is maybe not something you want to see at this stage. It is all there and you can see the structure that was there. But there wasn't the same situation with audit as there would have been with the Assurance Committee. So the audit stuff that we dealt with was different from what was an assurance. That was down to the Executive Team to actually make sure that things were being done to improve things and we got the assurance from that, from seeing the monthly reports that came through. So we weren't left in isolation, we were told exactly what was going on. 15:39 15:39 15:39

258 Q. Okay. I want to move on to some of the issues around the governance systems that the Trust had. The Inquiry has heard evidence in relation to the Leadership and Governance Report, are you familiar with that report or do you have recollection of it? It was into Muckamore Abbey particularly. 15:40

A. Yes, it would have been through the Assurance Committee that I would have picked it up. 15:40

259 Q. I don't plan to put that report to you?

A. No.

260 Q. But I just wanted to ask you, in terms of the Trust's

governance structures, one of the things that the Inquiry heard that the Review of Leadership and Governance highlighted was that the Trust had adequate governance structures, but that they weren't necessarily implemented adequately throughout the Trust and I wanted to ask you for any comment on that?

A. Yes, that was one of the issues that caused us an awful lot of concern when we got the limited assurance from internal audit. And it was -- the last sentence you gave me there, sorry. 15:40 15:41

261 Q. About the Trust had adequate structures but they weren't necessarily implemented at all levels?

A. When we brought in the changes after the limited assurance we made sure that people at all levels of the organisation understood what their role was. So if you were a committee, for example, and there were issues within that committee that needed to be upscaled to the next level, then that had to be done going forward. Up until that point there didn't seem to be any sort of correction method. So what happened was it was moved up and up and up. And using the example of the audit one that was given in terms of the -- oh, I can't find it, apologies for that. Basically where we had asked for -- I'm sorry, I can't remember the name of it. It was where the decision was made to send out audit down to Muckamore Abbey and that decision was made through the system that we have decided already. Going forward those sort of things were taken, local people were taking ownership of their management, which was 15:41 15:41 15:42

required, and up until that point that hadn't been happening. It was gradually moving up and moving up and we could see when the Medical Director could see the improvements that were coming through, his corporate side of things, that was all coming from the benefits that was done after they introduced, after the limited assurance.

262 Q. Would you say it would be fair comment that the structures around governance were relatively complex?

A. It would be an incredibly easy comment to make because the organisation is such a complex organisation with 22,000 staff or thereabouts, spread all over Belfast, the greater Belfast area, and it's only within the last number of years that you're starting to see the continuity that you would need to see in the organisation. And for a long time we hadn't got to that stage, our Chair, Peter McNanny was brilliant in making sure that things were done right and done correctly, but there was an awful lot of change that needed to be made to get the organisation to where it needed to be.

263 Q. Do you feel that it could have been a challenging system for team leaders, for managers, senior managers even within the Trust to navigate and to know how to escalate issues?

A. Yes a lot of it was down to training and where people didn't take the training opportunities that were given to them. For whatever reason, a number of people felt that the centralised process that had been put in for

training and all that side of things, it just wasn't working and it caused HR an awful lot of concerns where people who weren't getting the credit for the work that they had done. In this particular case, it showed the weaknesses that there were at the time.

264 Q. So for staff, for instance, who were perhaps struggling to navigate a system, obviously if an area might be pressured in terms of staff shortages, would it be fair to say that could make it more difficult for people to then go and access training because they couldn't leave their post? 15:44

A. Yes, the central training bit just didn't work and a lot of people it failed. Whenever Covid came in, a lot of the training levels dropped substantially and that didn't improve things as a consequence. But it was unfortunate that we didn't have the same training people locally that we would have had elsewhere. Because what was happening as a consequence of this was that some managers, some local managers at local level really weren't doing what they should have been doing. 15:45

265 Q. And was there any way of assessing what the risk in that was? 15:45

A. That's when the information got to the medical director because he was then picking up what was coming through the system and he could see where committees were starting to work through and get the benefit of what was happening. What was happening up until that point was some people basically at local level didn't do what they should have been doing.

266 Q. Can you give me an example of that?
A. I can't. I can give you umpteen examples that came through to the Board because we were seeing, for example, the training, the mandatory training figures were going backwards because people weren't doing the training they should have been doing. 15:46
267 Q. Mandatory training, basic life support or --
A. Local managers were not doing their job sometimes to make sure that things were actually going to improve. What was happening in some cases was that, well, some people, just no matter what you said to them it didn't change and that was a weakness. That was where you had -- I've often said so many times within the Trust, you know, we are only as good as our weakest link and unfortunately at times we had a lot of weakest links. 15:46
268 Q. So to try and pull that all together then in terms of the governance process, I think what we've discussed is complicated system, training seems to have been a problem, people couldn't necessarily fully engage with that system perhaps if they didn't have the training and this was an ongoing pressure, if I understand you correctly, within the Trust? 15:47
A. There was an ongoing pressure and, as I say, Covid had a big impact during that period of time because so many people, so many staff were ill and that increased the number of people and it really has, it is still impacting on things because some people just, the number of people that are currently off are very high compared to where they should be and a lot of that is 15:47

down to the issues that are around Covid.

269 Q. Okay. I want to move down, if I can, to paragraph 26, please, and that deals with an internal audit which happened in 2020 of patient finances. It refers to a previous RQIA inspection, it had highlighted some issues around patient finances and that resulted in an Improvement Notice being given by RQIA to the Trust in August 2019. Can I ask, did the Audit Committee to your knowledge have any previous engagement with areas of the Trust over patient finances, had there been any audits previous to that that you're aware of? 15:48 15:48

A. We would have had regular financial audits around an awful lot of our care homes and that type of thing. And again, very often you would see a split decision where in a particular home I can think of where eight were approved and two were not. So that two bit was taken as limited, the rest were taken as satisfactory. 15:48

270 Q. Anything in terms of Muckamore that you're aware of in terms of patients' finances before this particular one that you mentioned? 15:49

A. The particular one in the example that you are giving or you have given, RQIA had gone in in August 2019, and at that stage they had felt that there was an issue around the way that finances were being looked after. There was a lot of work being done locally to improve things and when internal audit came down in 2020, at that stage they could see enough improvement to see that they could give a satisfactory rating. But they also had to make sure that all the issues that RQIA had 15:49

raised were still being addressed at local level.

271 Q. And can I just check with you, was that internal audit commissioned directly because of the RQIA findings and Improvement Notice?

A. No, that came as a consequence of the plan that had been set out the year before. 15:49

272 Q. So do I take from that that that audit would have happened even if RQIA hadn't found as they did?

A. Yes.

273 Q. I see. Looking at paragraph 27, there was an audit of patient property and that came to a "satisfactory" finding and I acknowledge we've discussed satisfactory and you've given us the definition of that. So I hear from what you're saying that it doesn't mean that everything was perfect but that in terms of findings they were relatively modest. 15:50 15:50

The findings in that situation, though, that the audit team found, they made 11 recommendations and I want to ask you if a rating of "limited" might not have been more appropriate, given all of those recommendations? 15:50

A. Well, we came back, they came back with the satisfactory assessment on the basis of the progress that had been made and when we looked at it as an Audit Committee we saw that there had been significant improvement from the previous year and that's how it ended up being satisfactory. I would have to say that Catherine McKeown, the Head of Internal Audit, is very strict in terms of what goes through and doesn't go 15:51

through and her team had felt that we had done enough as an organisation to say at this point it is satisfactory but it would need to be very carefully monitored to make sure it stayed at the level it needed to be. 15:51

274 Q. Can you recall from your time whether there was a review period following that, whenever that satisfactory finding was made, but there was still some recommendations outstanding?

A. Yes, the RQIA stuff, as part of what they'd said was wrong -- or not wrong, what they had said was concerning for them in 2019, they had given a list of issues that we needed to address, and we had gone through those to the point that internal audit felt it was satisfactory. But the rest of those issues had to be completed and work was ongoing to make sure that was satisfactory going forward. 15:51 15:52

275 Q. So would the Audit Committee have set any kind of deadlines for work to be completed?

A. In that particular one where it was satisfactory, we didn't really need to do that because it was deemed at that stage to be satisfactory. It was really where there was a limited issue that we had to then make sure we brought things back to being satisfactory. 15:52

276 Q. So in the RQIA report, if I understand correctly, there were a total of 15 actions that were required and at the point in time when the internal audit happened, nine had been completed, so six outstanding. Who made them do the six, who made sure those got done? 15:52

A. That was the Directorate that were there making sure that the progress they had already made was continued through to the end and the records would be there to show that.

277 Q. So the Audit Committee, if I hear you correctly, at that point when they saw satisfactory they didn't necessarily progress any further follow up? 15:52

A. No, it wouldn't come to us. If there was a slippage at some stage then it certainly would come back to us but we would need to see evidence from the Directorate that we were still making progress with the issues that were there. 15:53

278 Q. I want to go to the page 35 of the exhibits, to your statement. At the very bottom of that page you will see a little (c)? 15:53

A. Sorry?

279 Q. There is a (c) in brackets, that's it on screen now. I just wanted you to help me understand that particular paragraph, I'll read it out, it says: 15:53

"32 significant findings (weaknesses that could have a significant impact on the system under review) were identified during 2017/18. Internal audit reported 57 priority one findings in 2016/17 and 59 priority one findings in 2015/16." 15:54

Is there a difference between a significant findings and a priority one find?

A. Priority one finding is where you have to make, you

should be focussing to make sure that's the most important one. Priority two, again, is seen to be significant but not as big an impact. And priority three tends to be something that's left to be sorted locally. 15:54

280 Q. Okay. So whenever it talks about 32 significant findings, what are they?

A. Weaknesses that could have had a significant impact on the system under review. This must be coming from, would that be coming from the head of internal audit's reports by any chance? 15:54

281 Q. It could well be.

CHAIRPERSON: If you go back to the beginning of 7.3 I think it gives the context of this.

A. Internal audit report, I see that. 15:55

282 Q. MS. TANG: Top of the page.

A. So you've got a list there of all the satisfactory and all the limited ones. There still would have been, that would have been the time when I was getting concerned about the number of limited things that were coming through and that was when, at the end of that year, we got the limited assurance and that's when we corrected things after that and it was a substantial change that needed to be made amongst the managers and directors that there were at that stage. 15:55

283 Q. And you refer to the list of limited things, that was on, I think if I'm right that is page 32 of your statement, you may well have that in front of you, I recognise that grid and that was a long list, well a

list of things, a number of which were rated as limited in terms of assurance rather than satisfactory?

A. And that's the ones, for example, that there were splits, you can see on that table the whole way through the different stuff that was there. 15:56

284 Q. Can I go down to page 45 of your statement, please?

A. Okay.

285 Q. And that refers to an annual Audit Committee report of 2021 and notes that: 15:56

"Internal audit found some limited assurance in relation to the management of whistle-blowing."

And there was a note that: 15:56

"Audit opinion carried forward from 2020 to 2021, audit given deferral of planned 2021/22 audit due to limited progress in addressing the recommendations from the 2020/21 report." 15:56

Was that issue escalated to the Trust Board to your recollection?

A. Sorry, say again?

286 Q. Was that issue escalated to the Trust Board that there was limited assurance in relation to the management of whistle-blowing? 15:56

A. Which one was that, if you don't mind?

287 Q. If you look on the screen at the moment you will see "Management of whistle-blowing" at the bottom of that

page?

A. Management of whistle blowing?

288 Q. Yes.

A. Right, okay.

CHAIRPERSON: This is part of the 21/22 annual report. 15:57

MS. TANG: Yes, that's correct.

A. Okay.

289 Q. MS. TANG: Do you recall discussing that or making the Trust Board aware of that issue?

A. There was a lot of issues in the Trust Board at that 15:57 stage because we had found that whistle-blowing, the level of service that was expected wasn't happening and we brought in, I think it was a new manager was brought in to address things. We had, I think last year we were told that we were going to, I think it was limited 15:57 last year, but since then whistle-blowing in particular has got a completely different structure to it.

290 Q. Can I clarify with you, when you say the level of service wasn't what was expected, do you mean the service as in the people dealing with whistle-blowing? 15:58

A. The whistle-blowing things were being allowed to stay there for an awful length of time.

291 Q. To stay there?

A. Effectively what was happening, instead of something coming in and being addressed within a certain period 15:58 of time, which is what you would normally expect, in this case there were a number of issues that just seemed to go week after week after week and nothing, nobody was taking ownership of it. There was people

within the organisation that were trying to look after it but they just weren't getting where we needed to be and, as I understand it now, they brought in a new management leader for whistle-blowing and I believe that's working much more satisfactorily now. 15:58

292 Q. So if I understand you correctly, it was taking too long?

A. Yes, yes.

293 Q. And was the Trust Board concerned about issues that effectively if things were taking too long to be dealt with as whistle-blowing reports, was there a concern there might be risks in that that were unmanaged? 15:58

A. Of course there was, yeah, there was risks in that but we didn't seem as an organisation to be able to deal with that. It was a weakness we had at that time. 15:59 We've since addressed it and the last information I had from the head of internal audit was that things had improved substantially.

294 Q. Was this particular issue re-audited to your knowledge?

A. My understanding is it has been done at this stage but I can't, I wouldn't just say 100%. I can say that my understanding is that it has been improved because I did hear there was a dramatic improvement with the people that are in now. But again, it was one of those situations where it just seemed to be lost and no-one was taking ownership of it. 15:59 15:59

CHAIRPERSON: And could I just understand, this is an audit opinion carried forward from the previous audit and the level of assurance was limited in respect of,

is it, governance and reporting?

A. Mhm-mhm.

CHAIRPERSON: When it refers to governance does it mean the system of governance was lacking or the operation?

A. Both to be honest, it was both. We hadn't got the right people in place to deal with it and no-one seemed to be taking ownership of it at that time. And again, that's something that as an organisation we did, we did work to progress it. I unfortunately don't have the report with me today to say where we are with it but as I understand it, whistle-blowing has been corrected. 16:00 16:00

CHAIRPERSON: And this is referring across the Trust?

A. Yes. No, sorry, not across the Trust, through this Belfast Trust just I am talking about here, yes.

DR. MAXWELL: As I understand it, there is an annual staff survey and one of the questions is whether staff feel safe in raising concerns? 16:00

A. Yes.

DR. MAXWELL: Did you triangulate internal audit programmes with that sort of data that you were getting on a regular basis? 16:01

A. Audit wouldn't have been looking at that.

DR. MAXWELL: Because of course one of the challenges of the whistleblowers, is you can have the system but if the staff don't think it's psychologically safe they won't use it? 16:01

A. HR would have been giving that information to the Board.

DR. MAXWELL: So you're measuring it in two separate

places, you've got internal audit over here looking at something and you've got HR over there looking at the staff survey, and you don't think it's the role of the Audit Committee to bring all that data together?

A. No, it would be -- the triangulation of data is there but somebody has to understand how to use it and we now have someone in place who is able to get the best information from those things that we can get. We didn't have it up until now. 16:01

DR. MAXWELL: Who would that person be? 16:01

A. It's Alistair Campbell I think ---

DR. MAXWELL: What's his role?

A. I can't remember what his role ---

DR. MAXWELL: Roughly?

A. He is one of the directors anyway. 16:02

DR. MAXWELL: Of?

A. The director of, I can't remember his name, he's involved with collating all sorts of data and taking it round, not only round the Trust but also going, he was doing something recently with Lisburn Council and sharing information with them. 16:02

CHAIRPERSON: And again coming back, I'm sorry, I really want to understand it. This is your, the annual report of the Audit Committee and we see this table. Your decision, is that right, is that the level of assurance around the management of whistle-blowing was still limited and it had been limited the year before? 16:02

A. Mhm-mhm.

CHAIRPERSON: Just so I understand what you actually --

what's your process for coming to that decision?

A. Well it wouldn't have been my decision, that's the main thing. That would have come through from internal audit and the head of internal audit, that's where that would have come from. I could give you another example of, we touched on earlier on fire safety, for three years in a row we were finding the same problems with fire escapes, the same fire escapes where people were there. And it was only when we eventually got through the message that people then took it seriously. And it must have been the same situation with whistle-blowing, because now we are in a situation where we do have someone looking after the whole whistle-blowing exercise. 16:03 16:03

CHAIRPERSON: Thank you. 16:03

295 Q. MS. TANG: I want to pick up on the interaction, if there was one, with the Audit Committee and the Trust's Corporate Risk Register. Have you any recollection of issues that the Audit Committee picked up on or were concerned about or that escalated to the Trust Board then becoming part of the Trust's Corporate Risk Register? 16:04

A. It would have gone through the Assurance Committee. The Medical Director would have taken the stuff through to the Board and also to the Assurance Committee. If there was an improvement that was required then he would make sure that it was being taken forward. If it had been sufficiently dealt with then it could be taken down a notch to a lower level. But it was the Medical 16:04

Director that looked after that.

296 Q. So if there was an internal audit report, for instance the one we discussed on complaints where there was limited assurance, would you have expected the Directorate in question to have that on their risk register, the Directorate's risk register? 16:04

A. It should be, yeah.

297 Q. Would the Audit Committee have directed that?

A. On that particular one, yes, they came to us. And that was going back to the same system whereby they had to come in, explain why they got limited assurance, what they were going do to improve it, what sort of time scale they were working to and then we could see on a quarterly basis that the thing was improving and was working. 16:05 16:05

298 Q. I want to move to paragraph 29, please, this is my last question for you. That should come up on screen shortly, paragraph 29 please. Thank you. The very last sentence of that paragraph you remark that:

16:05

"The Audit Committee, therefore, had not had cause to raise any concerns in relation to MAH to the Trust Board within the context of the Audit Committee's work."

16:05

And prior to that you had set out how the Audit Committee had dealt with some issues that came before it.

On reflection, do you feel that you and your non-executive director colleagues were getting enough information about what was happening in the Trust in order to let you bring your judgment that all was as it should be? 16:06

A. Well, in that particular case one was satisfactory and the other was a split one between satisfactory and limited and we dealt with that at the time. With the benefit of hindsight, it would have been much happier if more audit time had been given to Muckamore Abbey to 16:06 see the standards. But from what I can gather, when the issue became known there were an awful lot of senior executives sent down from the Belfast Trust to try and put some order in place and that was effectively what was done. 16:06

In terms of the example that you have given, we have still been working on the basis of this previous year's plan, if you like. The plan for next year is agreed around this time and then that's carried on the next 16:07 year and see what happens. But there will also be the examples again where a director, and it's important to put this in, a director who has concerns who has gone into a new directorate and sees something wrong, they make sure it is taken to internal audit straight away 16:07 and that can be addressed.

299 Q. Do you feel that the Trust Board, when you look back on it, were you as a Board sufficiently curious about what was happening in Muckamore? Should the Board have been

more curious? Should they have been alerted?
A. When we became aware of it in 2017 it couldn't have been higher in our dealing with it. Up until that point it wasn't something that we really heard very much about, and I'm coming from my personal sort of experience, coming from a financial background, not knowing really what the medical side of things were, we just thought this was something that was okay and then all of a sudden it just exploded. And I remember the day we were told there was a real issue down there and we know that we sent people down to help and try and address a lot of the stuff. And since that time, I know our Chairman could not have worked harder to make sure that things were going in the right direction. But the non-executives, we all felt exactly the same way in terms of what he was saying and we were getting the right information to enable us to know where we were. We didn't have the experience to go down and do audits, that wasn't our role. As non-executives it wasn't for us to go down and see what was happening at the coal face. We were relying on our directors coming back to us and saying this is A, B, C and what we were seeing from the reports we were getting back was that we were making progress.
16:08
16:08
16:08
16:08
CHAIRPERSON: And what you seem to be saying is that there are no circumstances in which your Committee could have picked up any red flags or signals because they weren't being brought to you by the Directorates?
16:09
A. If there was an issue there it would have been brought

to us, but we, it would have happened before the event. So in other words, if going back to using the same director again, new director, insight, seems horrendous, that is put on the Audit Committee flag for that year, so that's the sort of thing that was being done but we didn't see that happening on a regular basis.

CHAIRPERSON: But even if that had happened that would have formed part of your work for the following year?

A. If it was something that was particularly urgent they would have made time for it because, again, if you check with Katherine McKeown. The head of internal audit, there were occasions where she needed to step in and provide the Trust with the report that they would need. So if it was something that a director had said there's an issue here we need to address it, then we would have addressed it. We wouldn't have left it to next year and we would have said, no, this needs to be dealt with now. And whatever the outcome was, in most cases where that happened the Directorate had done the right thing by putting this through the internal audit. Internal audit came back with a horrendous report and then we had to change it, not change the audit, we had to change the situation to make sure it was right going forward.

CHAIRPERSON: But in relation to Muckamore that didn't happen until 2017 when ---

A. That would be our understanding of it, yes. I mean I started in 2016 and I really hadn't heard anything of

Muckamore Abbey until that point and then this all came out after that.

MS. TANG: Mr. Smyth, we've covered all of my questions, I am going to hand over to the Panel now in case they have any additional ones that they want to ask you.

CHAIRPERSON: No, we've asked our questions as we've gone along so, Mr. Smyth, can I thank you very much for giving up your time this afternoon. Okay. We are sitting at 10 o'clock, I think, tomorrow. Yes, we have two witnesses.

The next couple of days might be quite long ones so we all better be prepared, and indeed the same for Monday and Tuesday of next week when I think we are going to sit at 9.30 or try to. So can you just all be warned that Monday and Tuesday of next week are going to be longer sitting days. Okay. Thank you very much.

THE INQUIRY ADJOURNED UNTIL TUESDAY, 15TH OCTOBER AT 10.00.