MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 16TH SEPTEMBER 2024 - DAY 104

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

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THE INQUIRY RESUMED ON MONDAY, 16TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you.

MS. KILEY: Good morning, Chair and Panel. This morning we're moving on to Organisational Module 7, Muckamore Abbey Hospital Operational Management, and I just want to say something very briefly by way of introduction before the first witness is called. 10:06

10:06

INTRODUCTION OF OPERATIONAL MODULE 7 BY MS. KILEY

MS. KILEY: So, the purpose of this module, Chair and Panel, is to examine the management of Muckamore Abbey Hospital at Directorate level, and the Core Group internal management of the hospital. 10:06

The module therefore includes evidence from persons who were involved, past and present, in the management of the hospital, and the time period which will be examined spans across the time frame within the Inquiry's Terms of Reference. 10:06

The Inquiry has received some 18 statements from persons in various different organisational positions for the purpose of this module. Those who made statements were asked to address specific questions put to them by the Inquiry, and I will just list now the statement makers and say something briefly about each 10:06

of them.

The first statement maker is Bernie Owens, presently the Deputy Chief Executive of the Belfast Trust, and Ms. Owens was also responsible for the operation of Muckamore Abbey Hospital for a period in 2019/2020. 10:07

Miriam Somerville, the Former Director of Hospital Services and Community Learning Disability Services from 2002 to 2008, and a former Co-Director of Learning Disability Services from 2006 to 2011. 10:07

Mr. Oscar Donnelly, who was the former Assistant Director of Learning and Disability Services from 2001 to 2004. 10:07

Petra Corr, formally a Service Manager in Learning Disability and Community Treatment Services in the Belfast Trust from 2008 to 2012. 10:08

Catherine McNicholl, formally the Director of Adult, Social and Primary Care Services in the Belfast Trust from 2012 to 2016.

Marie Heaney, who is a former Director of Adult, Social and Primary Care in the Belfast Trust, having held that position from 2017 to 2020. 10:08

Dr. Colin Milliken, who is a former Clinical Director

for Muckamore Abbey Hospital, holding that position between 2005 and 2018.

Mairead Mitchell, former Head of Learning Disability Services in the Belfast Trust, who held that position from 2016 to 2019. 10:08

Esther Rafferty, a former Service Manager at Muckamore Abbey Hospital from 2012 to 2018.

10:09

John Veitch, former Co-Director of Hospital and community Learning Disability Services from 2011 to 2016.

H92, who was a senior social worker at Muckamore Abbey Hospital between 2009 and 2016. 10:09

Jackie Austin, a former Service Improvement and Governance Manager in Adult Social and Primary Care, Mental Health and Older People's Services within the Belfast Trust, and that was between 2016 and 2020. 10:09

Marie Mallon, who was a former Human Resources Director in the Belfast Trust between 2007 and 2014.

10:09

Damien McAllister, also a former Human Resources Director in the Belfast Trust between 2014 and 2018.

Joan Peden, a former Co-Director of Human Resources and

Organisational Development in the Belfast Trust from 2007 to 2022.

Monica Molloy, former Senior Human Resources Manager in Workforce Modernisation in the Belfast Trust from 2008 to 2020. 10:10

Neil McDaid, former Human Resources Manager in the Belfast Trust from 2009 to 2022.

And, finally, Marie Curran, former Senior HR Manager in the Belfast Trust, and Ms. Curran held the role of Interim Human Resources Service Manager for the Human Resources Investigation Team in December 2018. 10:10

So I should say, Chair, all of those statements are available on the Inquiry's website, save for two; those of Marie Heaney and Marie Curran are still being processed by the Inquiry and they will be published as soon as possible, but all the others are on the website presently. 10:10

CHAIRPERSON: Okay. Thank you.

MS. KILEY: And having considered all those statements received, the Panel wished to hear oral evidence from nine witnesses, who are as follows: First, Bernie Owens, who will be giving evidence this morning. Second, Mairead Mitchell, who we will hear from this afternoon. Third, Catherine McNicholl. Fourth, Jackie Austin. Fifth, Marie Curran. Sixth, Esther Rafferty. 10:11

Seventh, John Veitch. Eighth, Dr. Colin Milliken, and ninth, Monica Molloy.

I wish to just at this stage, Chair, say something briefly about the evidence to be given by Dr. Milliken. 10:11
As I have already said, he was the Clinical Director of the Hospital from 2005 to 2018. He was also a consultant psychiatrist at Muckamore between 2001 and 2022. So for the purpose of Module 7, he will be giving evidence about his time as a Clinical Director. 10:11
However, he has also made a further statement to the Inquiry about his time as a consultant psychiatrist, and that was for the purpose of the staff phase of the Inquiry. So whenever Dr. Milliken attends to give evidence he will be speaking to both those things. So 10:12
in effect Dr. Milliken's evidence will straddle both this organisational module and the staff phase.
CHAIRPERSON: Yeah, he crosses the divide, as it were.
MS. KILEY: Exactly. So it goes without saying that if the Panel hasn't asked a witness to attend to give oral 10:12
evidence, that does not mean that their evidence is unimportant. The Inquiry Panel has, of course, considered all the statements carefully, they have been shared with core participants, and have or will be available on the Inquiry website. 10:12

So with that brief introduction given, Chair, we can now move to hear evidence from the first witness, who, as I have said, is Bernie Owens, and Ms. Bergin is

going to take her evidence this morning. So if you're ready.

CHAIRPERSON: Yeah.

MS. KILEY: Then the witness and Ms. Bergin are ready.

CHAIRPERSON: Thank you. 10:13

MS. BERGIN: Good morning, Chair and Panel. As Ms. Kiley has indicated the first Module 7 witness is Bernie Owens. For the transcript, the internal reference is STM-279.

CHAIRPERSON: Thank you. 10:13

MS. BERNIE OWENS, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: Good morning, Ms. Owens. Can I just thank you very much for coming to assist the Inquiry. Thank you also for your statement, which we've all read. 10:13

We normally take a break after about an hour and a quarter, something like that, but if you need a break earlier than that, please just let me know and of course we can stop. All right. 10:14

A. Okay. Thank you.

CHAIRPERSON: I'll hand you over to Ms. Bergin. 10:14

MS. BERGIN: Thank you, Chair. Good morning, Ms. Owens. We met briefly this morning and I've explained to you how we'll be dealing with your evidence. You should have a copy of your statement and

exhibits in front of you, and your statement is dated 7th June 2024. Now, two points in relation to your statement. First of all, I understand that there are some notes that you've made on that statement. Have those notes been made by you? 10:14

A. Yes.

1 Q. And I understand you also have an amendment at page 5, paragraph 19 of the statement, and here you refer to Dr. Colin Milliken being the Chair of the Mental Health and Learning Disability Division, and I understand that 10:15 the clarification you'd like to make is that in fact at that time in 2019/2020, when you were in post, Dr. Milliken had in fact just stepped down from that position?

A. Yes, that's correct. 10:15

2 Q. So subject to that amendment, are you content to adopt your statement as your evidence before the Inquiry?

A. I am.

DR. MAXWELL: Could I just ask who had taken up the post if he had stepped down? 10:15

A. The post remained vacant, and the senior medical person was the Clinical Director, Dr. Joanna Dougherty, and I've said that at paragraph 20.

DR. MAXWELL: Thank you.

3 Q. MS. BERGIN: Now, as I've explained to you, and as you 10:15 may have heard this morning, your statement has now been published on the Inquiry website, so we won't be going through every paragraph of your statement, but we will be picking out some key questions. And before we

begin, if I could just remind you to, please, speak as slowly and clearly as you can in aid of the stenographer.

So, as you are aware, Ms. Owens, you've been asked to give evidence to the Inquiry in relation to Organisational Module 7, which is the Muckamore Operational Management Module, and in this module, as you're aware, the Inquiry is looking at the Belfast Trust management of Muckamore at Directorate level, and the Core Group internal management of the hospital. If you could turn to paragraph 7 - or, paragraph 5, rather, of your statement. And just while we're waiting for it to come on screen. You summarise your qualifications and experience, and you're currently the Deputy Chief Executive of the Belfast Trust and you've been in that role since January 2021. 10:16 10:16 10:16

A. Yes, that's correct.

4 Q. And your professional background is as a registered general nurse since 1983. Since 2014 you've been a Director in the Belfast Trust? 10:16

A. Yes, that's correct.

5 Q. And in 2019, you were asked by Dr. Cathy Jack to take responsibility as director for the operation of Muckamore, and you outline in your statement between paragraphs 5 and 7 that you were relieved of some of your other duties in order to take up this position, and then due to the outbreak of Covid 19 you then had to step away from Muckamore responsibilities entirely 10:17

in 2020, and we'll come to that, but this role as Director for Operation of Muckamore, is really the primary focus of our questions today, and you were in this role from October 2019 until June 2020?

A. Yes, that's correct. 10:17

6 Q. And I'd like to begin by contextualising your appointment to that role at Muckamore. And I'm jumping around somewhat, but everyone has the aid of the statement, and at paragraph 104 of your statement, you say that you first became aware of concerns over abuse 10:18 of patients in Muckamore as a member of the Executive Team on the 27th September 2017, when Marie Heaney, the then Director of Adult Social and Primary Care, advised the Executive Team, which you were a member of, of a serious incident in PICU Ward at Muckamore, and that 10:18 Ms. Heaney also raised those concerns at a confidential meeting of the Trust Board on 2nd November 2017, and at that time you weren't - you didn't have a specific role in Muckamore. Is that correct?

A. That's correct, yes. 10:18

7 Q. And you have exhibited a report to your statement, which we will come to, by Mr. Francis Rice, a nursing adviser, and his report, for ease of the transcript, is at page 38, and we'll come to that in due course. But I just want to pick up on the context again of your 10:18 appointment to Muckamore. And following on then from the 2017 allegations of abuse coming to light, Mr. Rice outlines at page 38 of his report that:

"There was a review of safeguarding at Muckamore called "A Way to Go" and that was published in November 2018."

A. Yes.

8 Q. Yes. The Chief Executive of the Belfast Trust then wrote to the Permanent Secretary indicating that it fully accepted the complexity and gravity of the situation and requested help, and the Department of Health agreed to facilitate monthly update meetings with the Trust and the HSCB to improve services at Muckamore? 10:19 10:19

A. Yes, that's correct.

9 Q. After that RQIA carried out two unannounced inspections of Muckamore in February and April 2019?

A. Yes, that's correct. 10:19

10 Q. And they highlighted serious concerns about care, treatment and services at Muckamore. The Department of Health then agreed to establish MDAG, the Muckamore Departmental Assurance Group. In June 2019, it was reported that there had been 44 staff suspensions with the potential for this to increase at Muckamore. Three RQIA Improvement Notices were then served on 16th August 2019. Mr. Rice, as I've referred to, was commissioned as a nursing adviser in September 2019, to assist in stabilising the nursing workforce, and then we come to your appointment as director in October 2019. 10:20 10:20

A. Yes.

11 Q. Is that all correct, to the best of your knowledge?

A. Yes, that's correct.

12 Q. So that's the background that you were brought in as director. You were, however, in the executive at the Trust prior to then in 2017. So as a member of the Trust Executive, you were aware of the allegations of abuse and the problems at Muckamore from as early as 2017. Is that correct? 10:20

A. Yes, I was aware.

13 Q. Given that there were concerns as early as 2017, why do you think the Belfast Trust waited until October 2019 to send in the turnaround team of yourself and other senior staff? 10:21

A. I believe that Marie Heaney, who was the director at the time, had advised as she believed where the issues were and what needed, from her perspective, to be done. So I think there was, at that time, the confidence that, you know, still within her remit as the director that, and because of her background in being, you know a senior social worker, was able to continue to have that portfolio and to take forward the necessary actions that needed to be taken and to update Executive Team and Trust Board accordingly. 10:21 10:21

14 Q. Okay. If we could then go to paragraph 9, please? And here you outline that you were asked by Dr. Jack to take on the director role at Muckamore in 2019 as part of the response to the RQIA serving the three Improvement Notices, and a key part of the brief was also to ensure the sustainable running of Muckamore. Now, again, just for context, I would like to just 10:22

refer to paragraphs 105 and 115 of your statement, where you set out the RQIA Improvement Notices. And very briefly for context, these notices, as I've indicated, were issued on 16th August 2019, in respect of failures to adhere to minimum standards in relation to three areas; staffing, financial governance and adult safeguarding. And at paragraph 107 of your statement, you outlined that RQIA carried out a three-day unannounced inspection in December 2019, and verbal and written feedback was given, and you say that RQIA lifted the staffing Improvement Notice in full and they then later lifted the other notices, but at a later stage after there were some further matters to follow up, and we'll come to that in due course. 10:22 10:23

So the RQIA notices were served in 2019, and you were brought in, in direct response to that. I've already indicated that your initial training was as a general nurse. When Dr. Jack asked you to assist, did you have any experience in relation to learning disability or dealing with patients with particularly complex needs? 10:23

A. No, I had no background in that at all.

15 Q. And did you have any experience of dealing with RQIA Improvement Notices?

A. Yes, I did. In terms of in my other portfolio of unscheduled care, where there was - the RQIA had made some improvements that needed to happen in that area. 10:24

16 Q. And when you say you had involvement, were you in at a high level in terms of overseeing improvements to

adhere to those notices?

A. I was the Director of Unscheduled Care.

17 Q. So did you feel suitably equipped then coming in to the role as director to deal with these Improvement Notices in light of the fact that it was in the Muckamore Abbey Hospital setting where there were patients with learning difficulties with particular needs? 10:24

A. I felt as somewhat anxiety going into this, not fully knowing all of the issues and the individual details of that. However, as a director, I had some years of experience, I had five years experience as a director and 10 plus years as co-director before. So I felt confident in my ability to actually engage the team and the experts that were working with me, and would be working both within Muckamore and within the Trust, or within external to the Trust, to actually engage the right people to get the knowledge and to understand what needed to happen so that we could make the necessary improvements. I wasn't going to rely solely on - because I didn't have any particular knowledge or background, but I wanted, you know, to engage and understand from those people who did and had the knowledge. 10:25 10:25 10:25

18 Q. At paragraph 12 you outline, and I appreciate we've jumped around somewhat but we will be moving mostly chronologically through your statement now. At paragraph 12 you outline that during the time that you were director at Muckamore you also had other responsibilities, including imaging and medical 10:26

physical services, among others, and you say you spent approximately one to one and a half days per week on Muckamore matters at this time, and approximately one day a week at the hospital site.

10:26

At paragraph 13 you then go on to say that from February 2020, you were asked to assist the Belfast Trust arrangements in relation to Covid 19 Pandemic, and in and fact from April 2020 you were asked to be a director lead in relation to the Nightingale ICU Pandemic Response. When you say you spent one to one and a half days a week doing Muckamore matters rather, were you referring to pre-2020, February 2020, or what was the time allocation then?

10:26

A. Yes. From October, when I took up the role, I tried to dedicate that, within my diary, that I was just at Muckamore at least one day fully, with no other responsibilities, and then at other times of the week I would be at Muckamore, depending on what the issues were, or I might even be somewhere else, but still in contact with the staff at Muckamore. So that's why I was trying to estimate what time I actually - you know some weeks it may have been more, and then others it was less, but I ruled out at least one day a week to be there in person.

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10:27

19 Q. And what about from February and then April until you left the post in June, what was your time then?

A. It was less on - once Covid hit, it was less in there in person. I don't think I was there in person. I was

in constant communication either by telephone or through Teams with the team, and I had a co-director and a Divisional Nurse and a divisional social worker who were working to me as part of the team. The co-director and the Divisional Nurse were based in Muckamore and were obviously very senior, very capable individuals, and we had regular communication as to what was going on and what we needed to do next.

20 Q. Did you feel that that was sufficient time for you to fulfil the role? 10:28

A. I did, because I had a good team of senior staff working with me, and I had every confidence in their ability, and they were very experienced individuals. So I was - obviously for myself I wanted to be on Muckamore and to walk round, to meet staff, and to understand and get a feel of the site and the issues personally. And obviously in the early part we were trying to get to grips with some early aspects that needed to happen, and I wanted to be there in person. So I probably was there more at the beginning part and then less as the time went on. 10:29 10:29

21 Q. Dealing with paragraphs 11 to 16 then of your statement. You've already referred to the co-director at Muckamore. So throughout your statement you refer to changes that were brought in around the time that you joined Muckamore, including yourself being brought in as Director for Operational Management. Also Gillian Traub as Co-Director, and then Trish McKinney, the Divisional Nurse. You've also referred to the 10:29

Director of Social Work, [redacted] being responsible for the historic CCTV investigation at that time?

A. No, sorry, can I just clarify?

22 Q. Yes. 10:30

A. It was Marie Heaney was the director, not Marie - Carol Diffin that was the Director of Social Work at the time. [redacted] was the Divisional Social Worker that was over Muckamore and the community service.

23 Q. Yes. Thank you. And then the Director of Adult Social and Primary Care was responsible for the resettlement programme? 10:30

A. And the community aspect of learning disability.

24 Q. Yes. In terms of the role of Director at Muckamore, you say that rather than one director being responsible for the whole hospital, there were different directors for different roles. So how would you describe how the director role was split up? 10:30

A. I think it became clear in August/September 2019 that the job was - and because of the various issues, the job was really undoable for one director, who was Marie Heaney, trying to manage a big portfolio. And so the Deputy Chief Executive at the time, Dr. Jack, in the absence of Martin Dillon, who was annual leave, had met with Francis Rice, who was the nurse adviser who had given her his first impressions when he had come, and knew that we needed to do something different and to give this a chance. So Dr. Jack's view was we need someone to actually stabilise Muckamore and just take 10:31 10:31

responsibility for the operational aspects of Muckamore, and deal with the Improvement Notices that needed - all the improvements that needed to be made, as outlined in the RQIA Improvement Notices.

10:32

The other aspect of it was that, you see there was the historic investigation to do with the CCTV, and it was important that any decisions that were going to be made as a result of that viewing was taken in its own right, on its own merit, as part of that, and not to be, you know, the same person to have operational responsibility for Muckamore, so that, you know, there was - because rightly at the time there was lots of, you know, mistrust and anxieties around what was happening, and the impact of maybe what was being viewed on CCTV having an impact of, you know, the staffing, and decisions may not be made for the right reasons. So it was important at that time to actually separate the two. Again, so that there wasn't the distraction from stabilising Muckamore, was around then how - because the community was still an important aspect of the service, and Marie Heaney, who was the director there, had so much knowledge and experience around that, and had already done a lot on the resettlement of the patients from Muckamore, and also had a good handle on what she believed needed to happen to - in terms of investment in the community. So that was how it was then separated out. And keeping a director of HR involved with the - whatever came out of

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10:33

the CCTV.

Another key link, obviously, was the Director of Nursing, who was, you know, I could communicate with around if there was any particular issues that I needed to discuss with her, and she also was being advised as to what was happening as an outcome of the viewing of the CCTV.

CHAIRPERSON: Sorry, when you said earlier there was a lot of - you said "rightly there was a lot of mistrust and anxiety", among who? Are you just talking about staff, or management, or right across the board? 10:34

A. Well I would say first and foremost maybe families and carers, and they had just got the news of what was actually -- 10:34

CHAIRPERSON: Hold on a second. Yeah. Sorry.

A. And obviously other organisations, RQIA, the Department of Health, would all be seeking assurances about what was actually happening and who was making decisions, and were the decisions being made for the right reasons. So I think we wanted to be, as an organisation, as open and as transparent as possible. 10:35

CHAIRPERSON: Yes. I was asking you about, you mentioned mistrust and anxiety, and I was just trying to understand who you were referring to having mistrust and anxiety? 10:35

A. Well I would say first and foremost the families and carers.

CHAIRPERSON: Right.

A. Of their loved ones in Muckamore. And then the other organisations would be seeking to get assurances from Belfast that we were doing the right things and being as open as we could. So it was important for us all that our working arrangements provided that clarity.

CHAIRPERSON: Thank you.

25 Q. MS. BERGIN: At paragraph 21 of your statement you outline that during part of the time that you were Director at Muckamore, Jan McGall was the on-site Service Improvement Manager. How did your role, which presumably was also about improving service, fit in with her role? 10:36

A. She was the Service Manager who was doing actually the day-to-day work with the Ward Sisters and teams, and she would be reporting through to the co-director and the Divisional Nurse, and any conversations about what was - what she was finding, what was the actions that needed to be taken, would be in communication. So I would either hear from Jan at times directly or as part of the conversation that I would be having with either the Divisional Nurse or the co-director. 10:36

26 Q. In terms of how that then compares, and you've already referred to a meeting with your co-director, Gillian Traub, and with the Divisional Nurse, how would your day-to-day look then in terms of what you did actually implement, the changes required to meet the Improvement Notices? 10:37

A. Initially my time was spent a good deal on trying to get our head round and understand the issue in the RQIA

Improvement Notice about a nursing model and what it was they were trying to do. The other two Improvement Notices were about safeguarding and about the finance. So I had the divisional social worker, who knew all about the, you know, the adult safeguarding and whatever, so I knew that and was able to have the conversations with her, empower her to do what was the - what we agreed needed to happen, and dealt with finance colleagues with putting in place a finance liaison officer and then working through the issues that were in the - that Improvement Notice. 10:37 10:38

However, I think the beginning was really trying to get our heads round what was this, the nursing model that the RQIA were expecting. So, again, it was trying to understand how the nursing establishment was calculated, determined at a point in time, and how could we then reflect that as best we could into something that we could interact with on a weekly basis that would be trying to anticipate what the needs were. So, again, speaking with Gillian and Patricia, and some of the Ward Sisters, just to understand that. And that took us, you know, a good, I'd say a good few weeks to try to get our heads round and try to build that up. 10:38 10:38

10:39

I had been used to, in my nursing background, about how the Telford calculation is used on wards, and for me my background was in perioperative nursing, so, again, it was around, you know, the National Association of

Theatre Nursing. So this bit for me was around, the nursing calculation was around Telford, yes, but then there was these prescribed observations and what did that look like, and how could we then try to best reflect that, that we understood then what would be required in the terms of the nursing workforce, both registered and the support staff. And given what - and keeping it person specific. So, again, the individual Ward Sisters would be, you know, what does each patient, what are their prescribed observations in relation to that? So it was building it up by patient on each ward and then reflecting that up into what was the global situation for all of the wards in Muckamore. And that did take some considerable time to try to - first of all the understanding because - and then engaging with various nursing individuals, including the Director of Nursing, and there was a member of staff who was at the Department of Health who had a learning disability background, and Francis Rice, to actually does this feel right and how do we best reflect in here what was needed? And then what we had in terms of the full-time staff that were in Muckamore, and then how the backfill occurred with the long-term agency staff that we had recruited, and then the more short-term backfill, and to make it useful for the Ward Sister that when observations, et cetera, changed, that they could just at the click of a button put in the changes in the prescription of the observations and that would reflect through on a model that was

10:39 10:40 10:40 10:41 10:41

interactive. So I'd say the first month to five weeks took us that length of time to try to get that.

DR. MAXWELL: Can I just ask you, you've mentioned the Telford model, and the Inquiry has heard a lot about, it, but the Telford model is based on a professional judgment to which you add a percentage for annual leave, sickness, training. The Telford model itself doesn't give any criteria for professional judgment, and you will know that in certain spheres of nursing, people have added that criteria for that professional judgment. So in acute hospitals, patients are often divided into four different levels of acuity and that's used to support the professional judgment. In terms of learning disability, specifically the work that was done at Muckamore, what criteria were used to justify the professional judgment? 10:42 10:42 10:42

A. I personally wasn't aware of the, you know, the individual aspects of it. It was - I had taken - we had taken the information from the Ward Sister in what they had in their professional judgment is what they needed on a ward at the various parts of the day. 10:43

DR. MAXWELL: So their professional judgment wasn't tested in any way? There's no way of checking that two Ward Sisters were applying the same evidence base?

A. No, I didn't do that, no. 10:43

DR. MAXWELL: Okay.

CHAIRPERSON: So, I just want to understand your understanding of the Telford model. First of all, do you - did you - have you yourself ever applied the

Telford model? Have you used it with your nursing background or not?

A. I was aware of it. Never actually applied it in my sphere coming up, because I was in perioperative nursing and I used another model that was used through the National Association of Theatre Nurses. 10:44

CHAIRPERSON: Right.

A. However, I was aware of it, Telford, and obviously with Brenda Creaney, the Director of Nursing, obviously tested with her the professional judgment of the Nursing Sisters at ward level, because they were the ones that had a feel for or their judgment about how many trained staff, registered staff, they needed per shift for the ward. 10:44

CHAIRPERSON: So essentially what it comes - because part of your role, as you've told us, was to try to ensure that staffing establishment was as it was needed. But does it come down to you spoke to the Ward Sisters and sought their judgment? 10:44

A. As part of the model. This was a starter for 10 for us in terms of, because there was two components of it: There was the Registrant workforce and their judgment, and then after that, which was nearly a bigger part of the workforce, which was the support staff that were needed for the observations, and that was the bit for me was totally alien to what I had understood before. So I needed to understand that in terms of the prescribed observations, and some were - so we had built into the model if an individual patient was on 10:44 10:45

one-to-one, two-to-one, three-to-one, and that changed over time. So, again, trying to understand that.

PROFESSOR MURPHY: So following this exercise, it sounds as though your calculations had led to the conclusion that there were too few staff currently, and that the calculate, previous calculations for what was needed had come to the wrong conclusion? 10:45

A. I'm not actually saying that it had all come to the wrong conclusion, because I wasn't actually - it was about how do we understand what we need? Trying to get to, as I said, a starter for 10 on what is it we need based on the - how they were operating it at the time. And it hadn't been, sort of prior to that there hadn't been that visibility of how you would get to the numbers, or closer to the numbers of the nursing staff that was needed per ward, based on the individual needs of the patient, which is what RQIA were saying, you know, we needed to get the, what were the defined needs of the patient on each ward? And that, to me, was not only the number of registrants, but the observations and how many staff were needed at various times of the day to actually meet the patient's needs. 10:46 10:46 10:47

PROFESSOR MURPHY: Yes, I understand what you were doing and why. The thing is that we've heard from lots of witnesses that they felt that their ward was understaffed and that they complained to managers that they needed more staff and they were not listened to. It sounds to me as though what you're saying is now you were listening, because you were asking the Ward 10:47

Sisters and you were making careful calculations, and it was coming out that places, that wards did need more staff. Am I understanding you right?

A. Yes, yes.

PROFESSOR MURPHY: Thank you. 10:48

DR. MAXWELL: Can I just come back to this issue of professional judgment, because this is critical to determining the numbers? As Professor Murphy has pointed out, we've heard a lot of evidence of times when Muckamore was reporting shortages of staff, it got 10:48 on to the Risk Register certainly at the Divisional and Directorate level, it's a bit unclear what happened at Trust Board level. But after you had the RQIA Improvement Notice, you're saying the work was done by Francis Rice and supported by Brenda Creaney, the 10:48 Director of Nursing, neither of whom, I believe, are learning disability nurses, but the Public Health Agency has a learning disability nurse consultant and certainly references to her being involved in staffing have come up before. Did she have any role in giving 10:49 the qualified professional advice to this staffing review after the Improvement Notice in 2019?

A. I'm not exactly sure who the LD nurse was at PHA. I had - there was a nurse, an LD nurse at the Department of Health working with Charlotte McArdle, and it was 10:49 her that I had engaged with in terms of trying to understand the nuances for LD and to talk her through the approach that we were taking here and in the nursing model. I don't think she had a role at that

time in the PHA, I think she's there now, but she was at the Department of Health, so that's who I had engaged with.

DR. MAXWELL: Thank you.

27 Q. MS. BERGIN: Yes, and we are jumping around your statement somewhat, but at paragraph 89 - and we don't need to go to it - but you say there that a nursing model that you've just referred to, to calculate safe nursing staff levels was developed and then agreed in and around November 2019, and that's what you're referring to, isn't it? 10:50 10:50

If we could go to paragraph 31 of your statement then, please? And here you refer I think to the same model, and you refer to it as a "virtually live or virtually real time dynamic nursing model", yes 10:50

A. That's what I meant. Whenever we had - and it was in essence a spreadsheet that had the various calculations behind it, so that whenever something changed at ward level, they could just put in the change and it reflected in the summary sheet as to how many nursing staff they would need, or support staff. 10:51

28 Q. And in fact you've exhibited a copy of one of the levels on page 62 of the statement in your exhibits?

A. Yes. 10:51

29 Q. Now, returning then to what I had asked you in relation to your role. So you had begun by explaining that a lot of your initial time at Muckamore in your director post was spent getting to grips with the staffing

issues, engaging with Mr. Rice and trying to develop this nursing model, which we've just heard was finalised in and around November 2019. Without perhaps going into the same level of detail, can you broadly explain to us then what the remainder of your role at Muckamore looked at in terms of meetings that you attended or the main issues you were working on? 10:51

A. Well, again, ehm, the main issues again were around, ehm, how do we - with the - the issue was around how do we get the staff who were identified that needed - ehm, I'm trying to think - the training and development plan. So it was the impact of the outcome of the decisions around the CCTV viewing. So we had, as individuals, some individuals were precautionary suspended as a result of that. Some staff were placed on, at that time, which was called the Training and Supervision Plan, so it was trying to work out, again with the Divisional Nurse, about, "Well what does that look like?" Because at the very start of this we weren't allowed to - we knew someone was being placed on this for something that was seen on CCTV, but we weren't given the detail, and so how do we, as for the nursing fraternity, what does that look like? How do we make sure that that person is supported and has the necessary training? So, again, it was working with the Divisional Nurse to work up that "Well, we have to cover off nearly all bases on the training", and making sure that the individuals then got that. I suppose the other was the communication with the Ward Sisters, so 10:52 10:52 10:53 10:53

that to try - that they understood what this meant, and I think fair to say it was frustrating for staff not knowing exactly what it was. So it was trying to get a template around that, so that we made sure that the necessary arrangements were in place for that member of staff, both for their and for the benefit of the patients that were there.

30 Q. And I'm going to ask you a bit more about that in a moment. For now, if we could go to paragraph 15, please? And you've already referred to the staffing issues in your evidence, and you say that part of your leadership role or management role was having responsibility for all of the staff who worked on-site at Muckamore, and you list the different types of staff. The Inquiry has also heard a lot of evidence about staffing issues and shortages, and issues in relation to skill mix also. Do you know what percentage of ward shifts were filled by agency staff when you began the post in October 2019?

A. I can't be absolute certain, but it was in and around 40 to 45% that were non-core Trust staff, that were - the vast majority which was block book agency staff, and then lesser, which was backfill from other staff on an ad hoc basis.

DR. MAXWELL: And how does that break down between registrants and healthcare assistants?

A. The majority of the staff that were, the block book agency were registrants. There was very few of - there was fewer number that were non-registrants.

DR. MAXWELL: So the problem was vacancies in registered nursing, not unregistered?

A. Well there were - in terms of the vacancies, there were - both were, you know, substantial in numbers. The block booked agency staff went, you know, a good deal of the way towards the registrant's side, it didn't close the gap by any stretch. And the non-registrant was more able to be filled through, you know, week to week basis, from some staff that were doing bank shifts. 10:56 10:57

DR. MAXWELL: So the unregistered staff, this was staff from the bank or staff from Muckamore doing additional hours?

A. It was a combination and some, yes, were bank, and some were from doing additional hours from Muckamore. Some of the staff were coming from other Trusts, but I think initially they were coming through registering on our nurse bank in the Trust. 10:57

DR. MAXWELL: Thank you.

31 Q. MS. BERGIN: Did the percentage of ward shifts being filled by agency staff reduce then during your time as director? 10:57

A. No. Sorry, ask the question again?

32 Q. So during your time as director, you've indicated the approximate levels of agency staff that you think were used when you began in October 2019. 10:57

A. Mhm-mhm.

33 Q. You've also given evidence to the Inquiry about engaging with Mr. Francis Rice about the dynamic

nursing model, which was agreed in November 2019. So my question is then from when you started the post in October 2019 until you left in June 2020, were the levels of agency staff decreasing as time went on?

A. No, you know the nursing model was one thing in terms of helping us understand the numbers of staff we needed and why we needed them. It was a whole different ball game trying to get the nursing staff to actually populate the numbers that we needed. 10:58

The agency workforce I would say was fairly consistent in terms of the numbers. At times we had more, but we - it was never a situation that we required less, because we still required those numbers of staff to help populate the requirements for nurses at ward level. 10:58 10:59

DR. MAXWELL: Did it go up? The use of agency go up?

A. Yes. Yes, it had gone up in terms of numbers. I think we were up at 50 people that were there on a full-time basis. I was going to say something there and it's gone out of my head. The work with Francis Rice that needed to happen was to look at how the - because these nursing staff that were there for some considerable time, and to try and do more to integrate them as part of the nursing workforce in Muckamore. They were, but it was, you know - so one of the things that was suggested which, you know, be in the same uniform as the rest of the staff that, you know, that they're all seen as part of the same team. Again, we had some very 10:59 11:00

senior staff there that, with long experience, who were doing very well, and settled well into Muckamore, and could they not be supported and developed further to be able to take charge at ward level, which lessened some of the nurse in charge issues for the Sisters? So that kind of thing was really important for us to do, rather than, you know, being seen as "Oh, this is the agency and this is the core staff." 11:00

DR. MAXWELL: So two questions in relation to that. One is, my understanding was almost all the agency nurses were mental health nurses, not learning disability nurses. So you, as a former nurse and the director of the hospital, were perfectly happy to have somebody in charge of the ward who didn't have any learning disability training? 11:01

A. Well, a case for me thought that mental health nursing - we couldn't get any more LD nurses, so it was about, you know, what could we do with what we had from LD? But for me and for others, you know Francis Rice and all, would be that the, you know, mental health nurses were a good second to that, because some of their training actually crossed over, is the advice I was getting. It wasn't all. And, again, some of the individuals who were in active treatment would have been because of mental health issues and, therefore, you know, they were a very good knowledgeable workforce to have. It wasn't that we were bringing in theatre nurses like me to, you know. 11:01 11:02

DR. MAXWELL: No, I know. I understand --

A. So it was their skill set and expertise was --
DR. MAXWELL: I understand you couldn't recruit LD nurses. So did you set a competency test for these people or, again, was it professional judgment? Was there, you know, in some areas of practice that isn't 11:02
necessarily undertaken by people who have regulated qualification, some Trusts will set a competency bar so it's applied evenly across everybody, did you do that?
A. What was done was Francis Rice had come up with a template of, yes, competencies that had to be evidenced 11:03
by the individuals, so that they attained that before being considered to apply for the, or to be - well, in Sister's roles, but obviously to be in charge. It wasn't a test, per se, you know, as in they had written exams or anything to do, but they had to - there was a 11:03
template that he had to come up with that we --
DR. MAXWELL: And was that formally assessed and kept in their records?
A. I'm not exactly sure whether it was in their records or not but - so I'd need to double-check that. 11:03
DR. MAXWELL: And my second question was, I do understand the difficulties that there weren't LD nurses to be recruited, and I understand you were doing things with the workforce you had, but did actually the demand go up? So were there more vacancies happening 11:04
over this period of time, meaning that you had to recruit more and more agency nurses, quite apart from the work you did with them to integrate them?
A. Yes, as we needed we would go back to the agency and

ask could they give us more. We were able to, at a point in time, recruit some of our own staff, some staff, and some of our - there were nursing students that were going through LD at Queen's that actually applied back. So we were getting some recruitment. Obviously there were more leavers than there were being able to recruit, so we would avail of the agency to try and supply as many as they could. 11:04

CHAIRPERSON: Could I just ask? It was put to you by Dr. Maxwell "so you were perfectly happy to have a non-LD nurse in charge of a ward?", and I just want to know how you answer that. Were you perfectly happy to have a non-LD nurse in charge of a ward? 11:05

A. I was, because of - for the reasons I've said, in terms of that I believed that they had a skill set that was akin to what LD, and I was content from the work that Francis Rice had done, in terms of their competency and what he was advising in relation to that. So I was personally content that that was the case. 11:05

CHAIRPERSON: And you said that in fact there came a point when recruitment did become a little easier. Was the - we've heard something about a 15% salary uplift, and you'd know about that. Was that a decisive point in the recruitment campaign or did that not really affect things? 11:05 11:06

A. I honestly don't think it impacted that much. It was - it was a good boost for the staff, absolutely, that were in Muckamore, but it didn't, it didn't prevent people leaving.

CHAIRPERSON: No.

A. And I don't think, you know, it had a big issue in, you know, recruiting staff either.

CHAIRPERSON: It wasn't a watershed moment, as it were?

A. No. And, again, trying to attract staff from other Trusts to come for the extra 15%, we didn't really get any benefit from that. 11:06

CHAIRPERSON: Thank you.

34 Q. MS. BERGIN: Thank you. Staying on the issue of staffing, and in relation to the work that you've referred to Mr. Rice doing in relation to agency staff, at paragraph 93, you outline career development opportunities for staff at Muckamore to ensure that they had the required specialist skills to deliver care in a learning disability setting, and you refer to various different opportunities, including training with the clinical education centre, annual nurse education development plans, adult safeguarding training, and you list some further matters there. The Inquiry has heard from other witnesses that there was very little training on, for example, positive behavioural support plans because of staffing issues, so even if there had been training organised, that because of staff pressures staff weren't able to go to those or they were often postponed? 11:06 11:07 11:07 11:07

A. Yes, on occasions that was the, was the case, but it was one of the things, particularly the Positive Behavioural Support work, that was sort of one of the things that we had seen was very important. Now we had

recruited individuals that, individual nursing staff to work with ward staff and with - but where - so it was easier when sort of training came to the bedside and to the wards, rather than trying to, you know, get nursing staff out, but there were certain things that they absolutely needed to do, and we had to find a way to get them released - to plan it ahead and get them released to do the training. I would say maybe initially Positive Behavioural Support needed a bit of time, I think, to get nursing staff really thinking about where the benefits of this might come from. So it was about getting buy-in. And I think that whenever individuals know that it's an absolute necessity, or they can see the benefits, it makes it a bit easier to get the necessary training.

11:08 11:09 11:09

35 Q. Staying with the area of training, at paragraphs 46 and 47, you deal with staff management training for line managers, and you say that:

"Someone applying for a line management role will often have experienced a colleague performing the role while they were a more junior member of staff."

11:09

And that:

11:10

"New line managers would be required to become compliant to with the core statutory and mandatory training as per Trust policy."

And you list various elements of that training. Does this mean that Ward Sisters were not giving training in managing poor practice?

A. It was -- well, we didn't have anything, you know, it was in terms of how do you manage individual performance of staff? So they would have had some experience around supervision, about - there was always a thing about appraisals, but you were not to - there was to be no surprises in appraisals, so individuals needed to be, you know, spoken to before going into an appraisal. But was there a particular course just dealing solely with that? No, there wasn't. But as part of development courses about how do you approach people and to, you know, have the conversation about performance issues. 11:10 11:11 11:11

DR. MAXWELL: But you're saying courses were available but they weren't mandatory, that largely people who went into these roles, the only experience they had was watching somebody else who might have done well or might have done it badly. And given the situation that was unfolding at Muckamore was suggesting that potentially there were members of staff who were behaving at best unprofessionally, and that ward managers didn't appear to have dealt with this, was there no consideration given to assisting these people in managing people's professional behaviours? 11:11 11:12

A. Yes, there was. So one of the things we did was align assistant service managers to embed in wards, you know at ward level, so there was one person say between two

wards that were more, you know, working with the Ward Sisters, and absolutely could have that conversation and support them in that. But what I was referring to is that we didn't have, per se, a course that just dealt with the, you know, bad behaviour, or how you address that, it was embedded as part of other work. But, again, the first thing is about the nursing staff, the sister of the ward recognising that and, yes, absolutely, having the support of someone else to help them address that with individuals. 11:12 11:13

DR. MAXWELL: What training had the assistant service managers had in managing performance before you get to a full disciplinary type process?

A. I'm not - I wouldn't be clear on that. I don't think there is any sort of formal training per se. 11:13

DR. MAXWELL: So potentially you had a Ward Sister or charge nurse and an Assistant Service Manager who weren't confident and qualified to manage staff whose behaviour was less than desirable?

A. But I think over time, you know, absolutely they were more comfortable in being able to have those conversations. It's not easy having the conversation in the first place. 11:13

DR. MAXWELL: No.

A. And - but not to shy away from it. I think we would be - had always encouraged that you bring it to the person's attention, and you bring it so that they come with staff support, you know, so that you're not having the one-to-one conversation with the individual, and 11:14

you have someone with you, and the staff member has somebody with you. But if you're asking me did we have specific courses or whatever about how to do this specifically, no, we didn't.

36 Q. MS. BERGIN: Staying on the topic of training and policies and guidance in relation to staff. At paragraph 64 you describe arrangements at directorate level to monitor staff implementation and adherence to Belfast Trust policies, and you say that: 11:14

"The Belfast Trust has approximately 750 policies on its website "The Loop"..." 11:14

- which Trust can access from any Trust electronic device. And you say that: 11:15

"When new policies are developed, they are communicated via the Divisional management to ward level."

And later at paragraph 68 you say that: 11:15

"Adherence to policies is a requirement of each member of staff."

They are personally accountable, and: 11:15

"...the ward manager also has a role to ensure all policies are adhered to within their ward."

So do Muckamore staff only have access to Muckamore specific policies and any other Belfast Trust policies that apply to them, for example, MAPA, or do they have access to all the policies on The Loop?

A. They have access to all of the policies. 11:15

37 Q. And when you say that new policies are communicated to ward level, is there any type of governance in place, or was there when you were there, to ensure that staff are actually receiving the communications at ward level and further to check that they've actually read the 11:16 policies?

A. I wouldn't have that level of detail in relation to that by individuals. I know that we had a nurse development lead, and that was one of their roles was to make sure that the new policies was understood by 11:16 the ward team or by, you know, that the Ward Sister knew. But did it go down to absolute individuals and get signed off? I'm not certain about that.

38 Q. The Inquiry has heard evidence about changes to the safeguarding process at Muckamore never formally being 11:16 approved, are you aware of that?

A. I am now, or in recent times I am, yes.

39 Q. My question around that is, does that mean that the policy on Loop that staff were looking at was essentially different to the policy that was being 11:17 applied in practice?

A. Yes. And, again, I personally wasn't aware of that at the time when I was at Muckamore. It is something that I have learned since. So in terms of the adult

safeguarding and the divisional social worker that was dealing with all of the issues, and, so, was clear, and making clear to the - and putting in place at ward level the arrangements as it applied to the wards in Muckamore, and did training according to the policy that was in place for Muckamore, and had the various aide-memoirs and working out about how individuals at Muckamore apply the policy of what steps they needed to take. So that training was based on the specific guidance that was applied to Muckamore, but it wasn't the same as what was on - there was a slight nuance on it from what was on The Loop. So, yes, it wasn't actually factually accurate. 11:17 11:18

DR. MAXWELL: Do you know who agreed the change in policy locally? 11:18

A. I have seen minutes of a meeting where there was - in August of '18 - where there was a multiagency meeting where they were discussing the safeguarding, and there's a reference in that about - now, they talked about a higher threshold within Muckamore and supporting that to be in place. We obviously had seen that as a lowering of the threshold, but I think the two mean the same. 11:19

DR. MAXWELL: Yeah. I think I know which minute you're referring to. Did that organisation have the authority to change Belfast Trust policies? 11:19

A. The - but it was done in conjunction with the Belfast Trust. So there were members of the Belfast Trust senior staff who were there that was having the

conversations and agreeing that. I think what we didn't do was reflect that and update the policy to reflect that on our system.

DR. MAXWELL: So I'm a bit confused about the governance arrangements, because governance has been a topic, it was part of the Leadership and Governance Review, although it didn't pick this up. It's very difficult for staff if the right hand is saying one thing and the left hand is saying the other, and the whole point of a governance system is to bring things together. So somebody can't make a decision over here without the people over here knowing about it. So, I'm confused that a multiagency group that doesn't report to the Trust's governance processes, but might happen to have some employees sitting on it, can change a policy without it going through any of the Trust governance process, and that you as the Director of Operations of the hospital at the time didn't even know about, how can that be in a functioning Trust governance system? 11:20 11:20 11:20 11:21

A. Yes, okay, absolutely, I agree with that. There was a process that should have happened, and it should have come through, you know, we could agree in principle, but it needed to come through our policy committee and get the - it changed and reflected the way that wanted to happen. I think, and it's my own personal view only considering, and I didn't know, as I've said, was individuals I think based on they were doing something in good faith, but we really needed to put the process 11:21

around it in the Trust, and that didn't happen.

DR. MAXWELL: So, is it fair to say then that the Belfast Trust employees who attended that multiagency meeting actually failed to discharge the governance's responsibility to bring it back to the Trust to be ratified? 11:22

A. Ehm, well to all intents and purposes it was, you know, they did - they failed to - in terms of the due process and governance, that didn't happen. Probably that was an oversight, I would think, on their part. I think they probably felt they were doing the right thing at the time, but for the reasons that they were facing at the time. But as you say, in terms of governance, we still had to close the loop, and that was, you know, in hindsight not the correct... 11:22

MS. BERGIN: Chair, I am just conscious of the time.

CHAIRPERSON: Yeah. Okay. That would be a good time for a break I think. We'll stop for about 15 minutes and you'll be looked after. Please don't speak about your evidence to anybody. All right. Thank you very much indeed. Okay, 15 minutes. 11:23

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

11:41

CHAIRPERSON: Thank you.

40 Q. MS. BERGIN: Thank you. Picking up then, Ms. Owens.

A. Do you mind if I just make a couple of points before moving on? Just I want to clear something up on what

I've said earlier.

CHAIRPERSON: Yes, of course. Yes, of course you can.

A. Because I want to make sure I'm absolutely accurate to the Panel.

CHAIRPERSON: Yes. 11:42

A. So just on reflection when I was thinking there about - and the question was asked about an Improvement Notice before, and I said about unscheduled care, and I'm not now certain that it was an Improvement Notice that was served, so I just need to double-check that. 11:42

41 Q. MS. BERGIN: Are you referring - when I asked you in your evidence if you had experience prior to Muckamore dealing with Improvement Notices, is that what you're referring to?

CHAIRPERSON: Oh, I see. 11:42

A. Yes. And I said I did.

CHAIRPERSON: Right.

A. And I did with RQIA, and we had action plans or whatever. Was it actually an Improvement Notice that was served? I am now doubting that it was, but I need 11:42 to double-check, because I don't want to mislead the Panel.

CHAIRPERSON: Okay. Well, thank you for the clarification. Okay.

A. And the other thing that I just wanted to clear up was 11:42 when I said there about seeing sight of an e-mail about where the threshold with safeguarding may have happened. It's a big assumption for me to actually then say that it was on the basis of that, that things

changed. So I just want to, in the spirit of clarification, that I want to be as accurate with my evidence as possible.

CHAIRPERSON: Okay.

42 Q. MS. BERGIN: And those are matters that can be followed up after your evidence, if necessary. Thank you. 11:43

If we could look at paragraph 67, please? And before the break we were dealing with the issues of training and Trust policies, and here you say that: 11:43

"Key Performance Indicators arise from Belfast Trust policies."

The KPIs, as I'm going to call them, are regularly monitored. 11:43

"The weekly safety report in Muckamore details the weekly performance against these and trends over time."

11:43

And just moving then to paragraph 70 to 74. At these paragraphs you outline the arrangements for monitoring staff adherence, and specifically nursing staff adherence to professional nursing standards, and you outline the various mechanisms for this, including 11:44 nurses having their own codes of conduct, professional supervision, Belfast Trust contractual obligations, and you outline that nurses have ward managers who are expected to raise any issues, which might include

referrals to Divisional Nurses, Director of Nursing, or the NMC. And you say that nurses work to a set of Key Performance Indicators. Can you tell us more about the Key Performance Indicators for nurses at Muckamore?

A. So if I go back to - I think they're set out here in paragraph 67. So this would be what the Director of Nursing has put in place for the - and it's not just specifically for Muckamore - and there is a process by which the Ward Sisters are expected to report on to observe, and that's followed up through the Divisional Nurses through to the Executive Director of Nursing. 11:44 11:45

DR. MAXWELL: These are quite generic. These are quite generic nursing indicators.

A. Yes.

DR. MAXWELL: And, actually, heavily focused towards acute hospital nursing. Were there no specific learning disability nursing performance indicators? 11:45

A. There were specific indicators for Muckamore that were, I believe, LD in general, where you call them, you know, not maybe specific nursing, but nursing has a big part in it, and that we were monitoring, you know, how to - over time how the issues around, you know, restrictive practices, the issues around the use of medication, and those were being monitored at the same time as the nursing ones were. 11:46 11:46

DR. MAXWELL: So these are negative indicators, they're harms, and I think we're going to come on to talk about later that the Belfast Trust adopted the Measuring and Monitoring of Safety Framework, which was lead authored

by Charles Vincent and published by the Health Foundation, which talks about the importance of moving beyond just measuring harms and measuring positive things. So, for example, would there have been an indicator about the number of staff trained in positive behavioural support, or the number of sessions Positive Behaviour Support? Were there positive indicators as well as negative? 11:47

A. I'm not certain on that - very definitely through the nursing hierarchy, but I didn't see any where we, you know, how many staff were trained in positive behavioural support. 11:47

DR. MAXWELL: Okay.

43 Q. MS. BERGIN: What value do you think the Belfast Trust got from reviewing the KPIs in relation to nurses? 11:47

A. Well, the value of monitoring the KPIs was obviously the experience of patients and, therefore, you know, one of the things that nurses would want to make sure that the experience of their patients was a positive one and that they would be interacting with them positively. So it was important to understand the practice that was happening at ward level and learning from incidences to improve the experience for the patients. So it was important from that point of view. And if there were issues, whether it was reducing over time or increasing, that we understood why, and I think that's important to nurses as well as the multiprofessional team. 11:48 11:48

44 Q. At paragraph 75 you say that:

"Staffing incidents and actions are monitored."

For more minor incidents:

11:49

"...a reflection of the incident is required and discussed at their next supervision session or appraisal."

And training may be required. Whereas in the event of a serious or repeated incident: 11:49

"...the matter is likely to be escalated to the Divisional Nurse for discussion, professional advice, or necessary action in line with the seriousness of the situation." 11:49

And that there can be further escalation by the Executive Director of Nursing, and you say that at Muckamore there is an additional layer of scrutiny in the form of random sample CCTV viewing, which the Inquiry has heard about. 11:49

Does the Trust distinguish between poor practice and abuse in these reviews of incidents? 11:49

A. Ehm, poor - continued poor practice, and depending on the poor practice, obviously could be, you know, at a point be abuse. So it's important for us to look at and consider any practices that were not optimum, to

give the individual member of staff the opportunity to learn and improve and, therefore, make sure it is not, you know, it doesn't proceed on to abuse. It's a bit like what was said about the Charles Vincent, anticipating, so, therefore, you know, trying to have the opportunity to learn and improve. And CCTV, whilst we looked, you know, it was - yes, you could observe whether - the extent of what had happened and the grading of the incident, but it also had the opportunity to highlight good practice, and that was fed back to the staff as well. 11:50 11:51

45 Q. You've described in your statement and also your evidence this morning that you were brought in as part of a team that implemented changes to Muckamore, and you've described the staffing changes, including you starting at Muckamore, and also changes to processes, and we've dealt with the nursing staff models. In terms of the issue of poor practice and abuse, were any of the changes that were implemented during your time at Muckamore around the specifics of staff training and procedures around distinguishing between or how to deal with bad practice or abuse? 11:51 11:51

A. I'm not clear on the question, sorry.

46 Q. So in your evidence to the Inquiry you've indicated that you were at Muckamore during a time of a lot of changes, and the backdrop to that is the RQIA Improvement Notices, and prior to that the allegations of abuse at Muckamore coming to light. 11:52

A. Mhm-mhm.

47 Q. Some of the changes that you've described during your time at Muckamore relate to staffing, including your role being created, and Ms. Traub joining, and also working with a Divisional Nurse. Other changes that you've described in your statement relate to the processes around staffing to improve staffing issues. The Inquiry is aware, as are you, of the allegations of abuse around Muckamore, and the Inquiry has also heard evidence in relation to poor practice at Muckamore. Were some of the changes that were made during your time as Director in relation to actually dealing with the issues of poor practice or abuse? 11:52 11:52

A. The incidences - if there was an incident raised, it was investigated, and CCTV was looked at to see if you could observe. So the individual incidences were followed up, and obviously there was the CCTV historic that was ongoing. 11:53

What we were trying to do was, well, how could we understand what was leading to some of the incidences occurring? And, again, through the adult safeguarding work that was - and, again, it was aligned to the RQIA Improvement Notice - was the - to try to track all of the incidences, have it on a database, where did they occur, when did they occur, what was the specific incidents, and to see if there was a trend there that we could actually anticipate and do something different to reduce the likelihood of that happening, and that was some of the, from memory, the work that was done 11:53 11:54

indicated that, you know, patients had been say for a day care during the day, they were coming back to the ward around 4:00 o'clock, and some of the - more of the incidences were happening around that time - and so it was understanding a little bit more about that, and staggering times back to the ward, staggering meal times, and noticed then that there were reductions in incidences occurring. So it was using the information that we had to try to provide us with some indication of how we could reduce. And the more that we can reduce the incidences, then there is a reduction in action having to be taken by the staff to manage the behaviour. 11:55 11:55

Again, at the time I was there they were, the staff were - they had an improvement group, and using the QI methodology, they had a team that was going through safety quality Belfast, which was a QI team. 11:55

48 Q. Sorry, could you just explain what a QI?

A. QI, sorry, it's quality improvement, and it's about how you maybe introduce small steps of change, test that change, see if you get an improved result from that. If you don't, you know, it's about failing fast and going back to the drawing board. And it was a methodology that we were, in Belfast Trust, adopting at the time. We had programmes where teams could come and learn the QI methodology, but focused on work, and I'm aware that, you know, one of the teams that were going through the safety and quality Belfast, were looking 11:56 11:56

again about how could they anticipate some of the incidences that were occurring, patient's behaviour and, again, that's where they were looking at the positive behavioural support and the plans around that. So trying to - they were testing and educating themselves and improving to try to reduce the number - the objective was to reduce the number of incidences happening in the first place. 11:57

PROFESSOR MURPHY: Given all of that work on quality improvement and trying to identify triggers, for instance, was the rate of incidents going down? 11:57

A. Ehm, yes. There are - and it didn't all happen just at once. They were tracking this as part of their quality improvement. But I'd say we've seen the benefit of it over time, where the impact of the work that they've done around the positive behavioural support over time has helped. There are other things that they've done that has also helped and, so, it did start to go down, yes. 11:58

CHAIRPERSON: And could I just ask, I'm sure we've got it, but where do we find the paper trail for the quality improvements? 11:58

A. There are - I think they're outlined in some of the minutes of the meetings to do with the improvement group that they had -- 11:58

CHAIRPERSON: The Quality Improvement Group.

A. -- in Muckamore.

DR. MAXWELL: Can I just ask, going back to this distinction between poor practice and abuse. Do you

think there was a common understanding about the tipping point when something changed from poor practice to abuse?

A. I'm not certain that I can answer that.

DR. MAXWELL: Because certainly we've heard from some witnesses that the lowering of the threshold, i.e. the taking away of the discretion of the local manager to decide how to deal with the incident, meant that some things which would previously have been described as poor practice and managed without the adult safeguarding team, were automatically being counted as abuse now. 11:59 11:59

A. I'm not certain that it was - my belief that that's - I think it was maybe a sledgehammer to crack a nut, and so that just to be certain that everything that was being reported by the nursing staff was everything, you know. So this about - it was more about the screening in and screening out. I don't know that it was about poor practice or abuse I think, because the experience of the DAPOs then was that there were things that could have been screened out by the Ward Sisters, but we probably just went the whole-hog and did - that the staff-on-patients was all referred to safeguarding. 11:59 12:00

DR. MAXWELL: And following on from that, did all the staff understand that some actions which they might have thought was rough handling or MAPA was actually abuse? 12:00

A. Again, I wouldn't have the, you know, that individual - I wouldn't have the knowledge what individual staff

actually thought about what was poor practice and what was abuse. I know that they were very concerned when I was there about their interventions and how they would, you know, with their physical interventions, and how that could be potentially misinterpreted by the CCTV and have ramifications. So there was a heightened anxiety at that time about their interventions. So I do think at that time they knew about their, you know, the potential of them not doing something correctly and what that might have for them. But previously to that, I'm not certain about what they viewed as abuse. 12:01 12:01

DR. MAXWELL: We have heard from some staff that they were very anxious because they didn't know where this tipping point was. We've heard people say that people were leaving because things that they thought were reasonable practice, they were frightened would be viewed by DAPOs who had not worked in ward environment, they're social workers but they've not worked in the ward environment, and they've often said the fact that there isn't audio made it more difficult, and that they didn't know whether practices that they presumably thought were okay, because they were doing them, would later be described as abuse. Which implies to me there was not a common understanding of what's abuse and what's perhaps old fashioned practice or poor practice? 12:02 12:02 12:02

A. Well, I absolutely, you know, accept that that's what I was getting when I was there from the staff. And, again, what we were trying to - you know, again around the training of the MAPA and the importance of that

being reiterated to the staff that, you know, anybody can have a slip trip lapse and whatever, but it doesn't account for abuse, or that it's a repetitive deliberate act for them doing the MAPA holds incorrectly all of the time. So it's about the - but, again, the anxiety for the staff was real, and I think that I suppose what didn't help was for those staff that were placed on, you know, supervision and training, and them not knowing exactly what, that added to their anxiety. So I think it was difficult to try to reassure individuals, but I felt talking to the staff at the time that they did recognise the, ehm, you know... 12:03 12:03

DR. MAXWELL: Well they recognised where they would put the boundary.

A. Yes. 12:04

DR. MAXWELL: The question is whether there was a common understanding across DAPOs, other social workers, staff on the ward, about what was abuse.

A. And I do think that viewing the CCTV helped that. Now I understand the audio not being there was an issue, but I fully accept that that still was there. But I do believe that the DAPOs - and you could see that from, you know, the CCTV contemporaneous viewing. 12:04

DR. MAXWELL: I'm not disagreeing with that, I'm just talking about understanding, because of course the staff didn't see the CCTV, did they? 12:05

A. No, but what we did was, what I was going to say was, the contemporaneous viewing was documented on the safety report, and they highlighted on that that, you

know, the good practice, and they would have highlighted maybe somewhere where the MAPA hold wasn't absolutely correct, but, you know - and maybe training opportunity. So it was available through the contemporaneous viewing that was documented on the safety report, and that was shared with the ward staff. Now did every member of staff see it? I couldn't be certain. But it was definitely available and was one of the mechanisms we were trying to share the good practice and they could see where things were seen but it wasn't seen as abuse. 12:05 12:06

DR. MAXWELL: So did you ever hold any meetings with staff to illustrate this point? So I'm thinking about Schwartz Rounds, which I'm not sure if you use in Belfast Trust, but meetings of staff to discuss an incident and for people to reflect on it and say what they think could have been done better. Did you have that sort of event with staff, as a group rather than as an individual? 12:06

A. Yeah. I'm not absolutely certain. I do believe that they did meet to look at incidences, but I can't hand on heart come up with one now. We do have and did introduce Schwartz Rounds in Belfast, but I don't believe that those were in Muckamore at the time. We started in paediatrics first of all. 12:06 12:07

CHAIRPERSON: And could I just ask about your personal responsibility for this. To what extent did you feel that you had to get a grip or an understanding of the balance between abuse and poor practice? Because it's

terribly important for the stabilisation or instability of the staff, isn't it? If they're constantly frightened that if they touch a patient they're going to be accused of abuse, or if the suspension level is so low that you're losing all your staff. Some necessary, no doubt, but perhaps some unnecessary. Wasn't that part of your function to get a grip on that balance? 12:07

A. It was my responsibility to obviously - and that's why I think when we were doing the contemporaneous viewing of the CCTV that that was communicated to the staff, that they could see that there was, by what was recorded, that the things that they were concerned about, and misholds and that, that wasn't just automatically seen as abuse. Those elements, and I think back to the threshold for safeguarding being reduced to, you know, not - the Ward Sisters not screening in and screening out of staff-on-patients, didn't mean that there was a low threshold on the ultimate sanction of precautionary suspension, because that was dealt with separately and by individuals who were looking at and judging the action taken by staff, whether that was abuse or not. 12:07 12:08 12:08

CHAIRPERSON: So who was making that decision, the actual decision on suspension? 12:09

A. That was a separate - there was a separate team that was - there were individual adult safeguarding individuals looking at the CCTV, but there was also put in place senior nurse advisers in that separate section

looking at the CCTV and the actions that were taken, and they made the decision whether - on the grading of what they were seeing - whether no action taken, or whether it was training and supervision, or whether it was precautionary suspension. So that was separate to my role.

PROFESSOR MURPHY: Can I just clarify one thing? From what you're saying it sounds as though the contemporaneous CCTV was being used to train staff, but we understood that the CCTV policy excluded its use in training. Am I misunderstanding the way that you were using the contemporaneous CCTV?

A. I think we did update the CCTV to viewing to include the contemporaneous viewing. The contemporaneous viewing, that was being undertaken by independent individuals who were recording what they were seeing and commenting on it. We were taking the opportunity where they were, you know, asking them to identify where there was good practice and where there were things that might have been seen that didn't go so well but it was a training opportunity for the staff. I think what we were, you know, hoping to move on to, and we haven't done yet, was, could we use the CCTV in some other way to actually, you know, for individual staff to actually see, you know, part of the CCTV themselves for learning, and we've never got to that point yet.

DR. MAXWELL: So you shared the written comments of the people who viewed it.

A. Comments.

DR. MAXWELL: But not the footage today.

A. Yes. Sorry, yes.

DR. MAXWELL: Can I just ask you, you've said a couple of times about grading an incident. Is there a formal set of grading criteria for viewing? 12:11

A. That's maybe just my clumsiness.

DR. MAXWELL: Okay. So there's no form that says "This is a Grade 1, a Grade 2, a Grade 3"?

A. No. No, sorry.

CHAIRPERSON: Thank you. 12:11

49 Q. MS. BERGIN: You referred to the separation between management and those dealing with the fallout of the CCTV investigation in terms of dealing with staff and assessing those incidents, and in your statement at paragraph 27 and 28, you outline this in some more 12:12 detail, and in particular you refer to it as there being "clear blue water" between management and those dealing with the ongoing CCTV viewing. One can understand from a purely safeguarding perspective how it was correct to have a complete separation between 12:12 those dealing with the safeguarding and management, but if the safeguarding bars were set too low, wouldn't the hospital have been divested of staff, and learning disability staff perhaps in particular, unnecessarily?

A. The viewing of the CCTV and the separate group were 12:12 looking specifically at the historic viewing between April and September '17. Anything that was, you know, happened on a day-to-day basis was dealt with separately, you know, through the process on the

day-to-day basis. For us it was the, the impact of the decisions that were being made by the separate group on the operational part of Muckamore, and I think we needed to get the - and particularly the viewers of the CCTV, and their judgment around what they'd seen and what sanction needed to be applied, couldn't be, and shouldn't have been taken into consideration the impact on the operation, although, you know, that was obviously being dealt with by myself and my team in relation to it. But we couldn't, you know, be seen to be accused of not taking the right sanction here because it was going to leave, you know, some staffing difficulties in Muckamore presently. 12:13 12:14

DR. MAXWELL: Is that actually correct? So the decisions they were making, based on a policy that's really designed for one victim and a small number of perpetrators, so that they were looking at that and saying "the perpetrator must be removed", they were applying that to a large scale incident, and it was having an effect on operations. 12:14 12:14

A. Yes.

DR. MAXWELL: The purpose of safeguarding is to safeguard people. If your actions, which are based on a small number, are actually having a negative impact on a large number, surely you should have been thinking about that, because the ultimate consequence was that by suspending so many staff and putting so many on supervised practice, who then chose to leave or went off sick, you were potentially making the patients more 12:15

unsafe, not more safe. So actually because this was such an extraordinary situation, surely there should have been more strategic thinking about the impact of what the safeguarding, as a result of the CCTV, was achieving? 12:15

A. Well I --

DR. MAXWELL: Well, rather than asking you to answer that, which is perhaps a bit unfair, was there ever any discussion that "Hang on a minute, the actions we are taking are making patients less safe, not more"? 12:16

A. Ehm, the - I was not having conversations with the separate CCTV viewing individuals, they were given that authority and autonomy too, because they were looking at the CCTV viewing footing and making the judgment, because this is where they were making the judgment "Is this abuse or is it poor practice?", and I believe that the poor practice ones would have been dealt with, that the individuals came back and - but those that were identified as abuse was very definitely needed to be precautionary suspended, because obviously nobody wants that individuals who - back at base that are continuing to abuse patients. So it was important that they made that distinction. Recognised that, you know, and it was difficult, where individuals were on training and supervision and at the start didn't really know why, but that was - and we were, because we were in the multiagency protocol and the PSNI did not want anything that was going to conflict with their investigations as well. 12:16 12:17 12:17

DR. MAXWELL: So there was no discussion of the fact that there were new people coming in who didn't know about learning disabilities, and we've heard from other witnesses that patients were very unsettled, we've heard from Dr. -- about this actually -- 12:18

MS. BERGIN: Apologies, if we could cut the feed, please. Apologies. Thank you. Sorry, H -- well, I'll not say, but just that's a ciphered.

DR. MAXWELL: Oh, I'm sorry.

MS. BERGIN: No. No, not at all. Thank you. 12:18

CHAIRPERSON: Okay. What was the H number we were looking for?

DR. MAXWELL: We've heard from somebody - we've heard from somebody that patients were very unsettled because staff they knew left. What I'm questioning is whether 12:18 this absolute belief that individuals absolutely had to be suspended, regardless of consequences, was ever questioned either at Muckamore or by the Trust Board?

A. I don't believe it was, not in my time, because we believed that there was - it was really important. 12:18

DR. MAXWELL: Regardless of consequences to the patients?

A. But - yes, in terms, because there could have been negative consequences as well if we had, you know, if there were individuals who might have been the 12:19 patient's favourite nurse, but was seen on CCTV, you know, with abusive behaviours, that was not in the patient's best interest in any event and --

DR. MAXWELL: So that always trumped any other

consequence?

A. Yes. And that was why then we needed to deal with it operationally. How can we - and it was difficult to provide - make sure that there was the safe staffing? But we couldn't and weren't going to influence the team that were charged with looking and assessing and judging what they seen on CCTV, just because we hadn't - because, again, it wouldn't be the right thing for patient care either if we let individuals back at ward level that were seen on CCTV doing something that they really shouldn't have been doing. 12:19 12:20

CHAIRPERSON: But it comes back to the balance, doesn't it?

A. Yes.

CHAIRPERSON: Between abuse and poor practice. Which it was crucial to identify. 12:20

A. Yeah, and I believe that's why, you know, those that were engaged in abusive, or perceived to be in abusive behaviour, were placed on precautionary suspension, and it was precautionary until that was actually investigated further in the interests of safety of the patients. Those that were seen as, you know, what they viewed was maybe poor practice, was then back to the training and supervision, and we did get that changed over time in engaging with the police to give us themes that would give the staff some idea as to what the nature of what was seen, but not the specifics. 12:20 12:21

CHAIRPERSON: Could I just ask, and it may be that Ms. Bergin was going to come on to this, but how much

more complicated was this exercise made by the fact that there was a PSNI investigation co-terminus with what you were trying do?

A. It definitely was a factor. It was a factor in not being able to give the individuals that were on the, you know, being placed on supervision and training plans, an indication of what - why they were placed on that. So, again, it was a factor, yes. 12:21

50 Q. MS. BERGIN: Thank you. If we could pick up at paragraph 29 and 30, please? And here you discuss the role of the combined collective leadership team, the CLT, that you headed, along with the Co-Director, Divisional Nurse, Divisional Social Worker and Clinical Director, and you say that the CLT: 12:22

"...was responsible for the operational management of Muckamore."

And put in place a number of structural changes and processes to try to ensure quality of care by monitoring key safety indicators, supporting staff, and making changes to address the RQIA Improvement Notices. 12:22

And elsewhere in your statement, in fact at the paragraphs above at 27 and 28, you say that following those changes in response to the Improvement Notices, the structures and processes during your time as director did provided adequate oversight of operational management at Muckamore. 12:22

In your evidence today we've discussed some of those changes in relation to the staffing models and otherwise.

Now, at paragraph 28, in relation to the work of the collective leadership team you say that you worked closely with the other directors and you felt you all worked well in providing oversight of all the aspects of service requirements, provision of safe care, professional regulation, investigation and disciplinary processes. The Inquiry has heard evidence about fractious relationships at leadership level, and in relation to poor leaderships and confusion, particularly around safeguarding. Is that something you were aware of? 12:23

A. I believe that what did not occur in the time frame that I was there, in this period, and I am aware of later in the time frame it wasn't an issue, and RQIA, in their assessment on their three days when they came in December, actually said that in terms of how much better the environment was, how the nursing staff had reported, you know, being communicated with, felt more supported, and that their issues were being listened to and addressed. So I don't believe that is in this time frame. 12:24

51 Q. And how did you feel that the staff understood the changes in terms of new director's roles at Muckamore? Do you think that was well understood and accepted by

the staff, or do you think there was confusion around the different new roles?

A. Are you talking about the time frame that I was there?

52 Q. You were there, yes?

A. Well, I, in communicating with the staff and meeting the staff, I didn't believe that there were any issues from the staff. They welcomed us as a, you know - there was myself, Gillian, and Trish McKinney, who were in at the same time, and working with them and trying to improve the communications, and listening to them, and what was it we needed to do to help support them, you know. So, again, having more on-site, easily accessible advice, management, access, et cetera, and, you know, the regular communication. So there was regular communication with the Ward Sisters on a weekly basis. But then there were the bigger opportunities for all of the staff to come and meet the team and discuss any concerns they had. So that was welcomed, and they reported that through to the RQIA on their visits at the beginning of December. 12:25 12:25 12:25 12:26

53 Q. And, again, picking up the RQIA comments in relation to management relationships. At paragraph 36 of your statement you include some quotes of comments made by RQIA, specifically relating to your time as director, and particularly in relation to the Improvement Notices, and those are improvements in relation to governance, information sharing, and quality improvement. You've referred to the fact that you didn't think there were problems at collective 12:26

leadership team level during your time at Muckamore, and given RQIA's comments in relation to improvements, was it your impression that Muckamore had been managerially neglected before your team were brought in? 12:27

A. I think what -- I wouldn't have said that they were managerially neglected. I think that the individual director and some of the staff were - the issues started to get so great for the entire Directorate that it wasn't just possible for one person or a small team 12:27 to actually manage. So it was important to try to get, you know, a grip on what was actually happening there and help support the staff, and the ultimately the patients, by getting the necessary improvements we needed. Because they were identified by RQIA, so we 12:27 needed to - and we needed to address them.

54 Q. How much comfort did you regularly take from RQIA reports? If RQIA had said that something had improved or was satisfactory, what level of comfort would the Trust have taken from that? 12:28

A. Ehm, yes, we would have - because the RQIA came in, always came in with an open mind, with a rigour, you know, that they were actually, you know, going through their assessment to standards and what was supposed to happen and whatever. So we were taking notice of 12:28 whenever they were identifying what needed to happen. So, therefore, whenever they came and said things had improved, then equally that was good affirmation in terms of - because they had tested it with rigour as to

what they found on the days that they were there.

55 Q. Previous RQIA reports that the Inquiry has heard about didn't pick up on the allegations of abuse in relation to Muckamore in 2017. Did that cause you to reflect on the assurances that perhaps the Trust had placed on RQIA reports previously, in terms of what was happening on the ground at the hospital? 12:29

A. It didn't cause me to question RQIA's assessment of what they observed. I think human behaviour is what, you know, human behaviour is. I would expect that whenever the investigators are in any of the wards doing their fieldwork and whatever, if they had seen, you know, abuse to individual patients, they certainly would have picked it up. So I don't believe that, you know, that took place whilst they were there. 12:29

56 Q. My question was around the assurance level that the Trust took from having a satisfactory report from RQIA. Did you reflect on that, in that there were obviously issues at the hospital which were not being picked up?

A. Personally I don't know how they can pick this up if they don't observe it when they're there, you know, were individuals not actually behaving in an abusive way whenever they were being watched or whatever. So I don't know how RQIA could have picked this up, unless they observed it. And I had no reason to believe - this is me personally - believe that if they had seen something or there was any hint of it being reported to them, that they wouldn't have raised it with us. 12:30

57 Q. Did that cause the Trust though, focusing less on the

role of RQIA on the day of an inspection, but the level of assurance which the Trust took when they knew that the RQIA report came in and it didn't pick up on a major issue or incident. The fact that we know that those incidents were occurring whilst there were positive RQIA reports, did that cause the Trust to, in hindsight, then reflect and think, well, in addition to RQIA we need to have stronger safeguarding and governance processes ourselves? 12:31

A. Ehm, I should say that RQIA weren't coming in with positive things all the time, going back to, you know, January, February, earlier that year, they were things that the Trust weren't meeting and needed to put our house in order in various things. So the only one that I had actually observed, which was the one in December '19 that it was more positive from RQIA. So for me that was a test what we had tried to do was actually working, but I am still of the view that RQIA were raising concerns with us, but it wasn't the areas of abuse. Obviously the Trust at some point had decided that we were going to put in CCTV, I'm not - I don't know when that was or who took that, but that was obviously something that proactively the Trust was doing anyway. So whenever RQIA raised issues/concerns it was for the Trust to take those seriously and put the necessary improvements in place. We didn't always get it in the time frame, and why there was repeated investigations that we hadn't met it fully that ended up with Improvement Notices in August '19. 12:31 12:31 12:32 12:32

PROFESSOR MURPHY: Can I ask you, I mean albeit it might be true that if RQIA comes in they won't necessarily see abuse, because people will know they're from the RQIA and will behave better, but there were DAPOs who were worrying that actually there was institutional abuse going on. Did that worry you? 12:33

A. I have to say I wasn't privy to individual DAPO's views of things, so I wasn't aware specifically of individual DAPO's concerns in my time.

PROFESSOR MURPHY: So the DAPOs didn't ever raise at meetings you were at their worries that there was institutional abuse going on? 12:33

A. By the time --

PROFESSOR MURPHY: That's a bit surprising.

A. By the time I got there we knew that there was the abuse that had happened. So I was - the time frame that I was there was to actually, you know, we knew what had taken place, and about the actions that needed to be taken to actually improve and reduce incidences of poor practice or whatever going forward. 12:34

PROFESSOR MURPHY: So your opinion is that if it had been taking place it was a thing of the past. Is that what you're saying? 12:34

A. No, I am not saying - I think you were asking me about DAPOs coming to me about individual issues of abuse. If there were incidences that they were worried about, there was the necessary communications that were made with, whether it was an SAI, an investigation, and that would have come to my attention. 12:34

PROFESSOR MURPHY: I wasn't really asking about them coming to you with individual incidents of abuse, but with their worry that there was institutional abuse going on?

A. The DAPOs coming - honestly, I wasn't aware of that DAPOs, during my time, thought that there was institutional abuse going on. 12:35

PROFESSOR MURPHY: Okay. Thank you.

MS. BERGIN: At paragraph 57 then you refer to daily multidisciplinary meetings known as PIPAs - Purposeful in-Patient Admissions, and the Inquiry has heard some evidence about this already, and you say that the purpose was to ensure that each patient received care that met their needs and was of good quality, and you explain more about this process, and in particular that any ASG issues or incidents in the previous 24 hours were raised at those daily meetings. How exactly did PIPA meetings differ from handovers? Did they replace those or were they in addition to those? 12:36 12:36

A. So my understanding of the PIPA meetings were sort of like a ward round, you know. So there might have been - the like of what I would consider the handover say at 8:00 o'clock in the morning where the team leaders and all of the wards come together and give an update in terms of what happened overnight and what are the issues of the day. So, you know, that would have been seen as a handover. But PIPA was sort of to all intents and purposes the ward round or the ward meeting with the multidisciplinary team there and, yes, it 12:36 12:37

would have involved some of the information that was given at the 8:00 o'clock handover, but the right people are in the room to discuss what happened and what needed to, from their perspective clinically, what needed to take place that day in this quality of care to the individual.

58 Q. And at paragraph 58 below you then also refer to a daily safety huddle? So can you explain where that fits in?

A. That was the 8:00 o'clock meeting I was talking about. 12:37

59 Q. Okay.

A. Where whenever there was this huddle, be it a telephone call, be it individuals at the meeting, but they were sort of, you know, what happened, what was reported to them overnight, what was their staffing situation that 12:38 morning, so and so rang in sick or whatever, where it was - and how could each other help in trying to address any staffing issues or any incidences, and agreed, you know, with the senior managers that were on the call as to what needed to happen in reaction to 12:38 whatever happened during the night or the situation they found themselves in the morning. So it was just an overview of what was happening on the site.

60 Q. At paragraph 62 you refer to a monthly MAH assurance meeting, chaired by the Executive Director of Nursing, 12:38 which included updates on the nursing workforce and:

"The core attendees were the Divisional Nurse, Co-Director and the Service Manager."

And you say that:

"The Service Director and the Directors of Social Work and HR could also have attended."

And, in particular:

"...Senior Nurse Advisors involved in the viewing of the historical CCTV provided the agenda and information for the meeting." 12:39

So what was the purpose of this meeting? What was the meeting assuring?

A. As I say, I never attended this meeting, but the Director of Nursing was viewing all of the, you know, the issues that was being raised by the - whether it was the Divisional Nurse or the Senior Nurse Advisors from a nursing perspective, what were their particular issues or areas of concern. And, number one, to bring it to her attention, but obviously to, you know, for advice and guidance and what would be reasonable to do in the circumstances that was being reported. 12:39 12:39

61 Q. At paragraph 98 --

DR. MAXWELL: Sorry, just before you go on. You didn't attend this meeting which was discussing some of the live issues, and you were the Director responsible for the operation, contemporaneous operation. 12:40

A. Yeah.

DR. MAXWELL: In terms of governance, how were you getting feedback from this meeting?

A. Through the Divisional Nurse or the Co-Director who was -- the Divisional Nurse was always in attendance, because she was doing part of the contributing to the agenda. 12:40

DR. MAXWELL: And what sort of feedback was the Divisional Nurse giving from you this meeting?

A. Well, whatever the outcome was of the discussion I would get a verbal briefing, and sometimes I got it direct from the Director herself. I can't come up with an example just off the top of my head at the moment, but if there were any decisions or any concerns that they had, they would make sure that I was briefed on it. 12:40 12:41

DR. MAXWELL: So were they - was this a decision-making group?

A. In relation to --

DR. MAXWELL: Anything.

A. Well, in relation to any nursing particular issues, yes, the Executive Director of Nursing had, you know, anything of a professional nature, could obviously make decisions based on the information she was given. 12:41

DR. MAXWELL: I'm struggling a bit with this because in matrix management usually the professional line manager has to have a discussion -- the professional manager has to have a discussion with a line manager about actions, and yet you were the Director for the hospital and you were not part of making these decisions? 12:41

A. Yeah, but the team that were working to me were there, and therefore -- you know, I couldn't be at all of the meetings, but they were aware. So we were, you know, if any one part had - if there was anything that we wanted to bring to the Director of Nursing's attention, that was the -- you could do it, you know, obviously depending on the circumstances if there was something that was on any given day you could contact her, but this was the opportunity to have a more fulsome conversation and discussion. 12:42

DR. MAXWELL: Okay.

MS. BERGIN: At paragraph 98 then you refer to patient safety reports, and if we could go to - there's a report on page 95. And at paragraph 98, as I've referred to, you explain that a patient safety report, or referred to as weekly safety report, was a weekly reporting on a range of safety metrics for the week and trends over time. It's underpinned by the use of data and was intended to demonstrate a transparent and accountable approach to care, and it includes adult safeguarding referrals, the number of incidents reported, use of restrictive practices and seclusion, and various other patient observation data. 12:43 12:43

A. Sorry, which paragraph did I say that?

62 Q. You outline the patient safety reports in paragraph 98 of your statement, and then we have on screen in front of you, at paragraph 95, an example of a weekly patient safety report. In terms of the risk factors that were included in these reports, the headings, for example 12:43

the first one at 1.1 "MAH In-Patient Numbers", did the headings remain the same in terms of key areas that were assessed in each weekly report?

A. Yes.

63 Q. Were environmental factors, for example, the condition of the wards, something that was ever considered? 12:44

A. That was -- it wasn't considered on a weekly basis, but if there were environmental factors that came up as a result of something happening or, yes, that would have been considered separately. Sometimes it would maybe be referred to in the safety report at the comments at the end. 12:44

64 Q. When you say it would be dealt with elsewhere I think in your evidence, how else would that have been? Was there a system in process for somebody to actually check? The Inquiry has heard evidence in relation to the condition of some of the wards. So was there a process for somebody to check that? 12:44

A. Ehm, I'm not certain that I totally understand the, you know, because the - some of the - the environment of some of the wards wasn't -- say, for example, Erne was an older ward, and so again what could we reasonably do to make it more conducive? There wasn't always, depending on the issue, but we took the opportunity, as the numbers of individuals in Muckamore reduced, that we would close Erne, would be one of the first ones we would close, to where into one of the more up-to-date facilities. So that was always an objective, knowing that it wasn't suitable, but we weren't reporting on it 12:45 12:45

on a weekly basis in the safety report.

65 Q. So if we talk about environmental factors as being not only the example you've given about Erne with an historic ward that's simply old and needs work done to it perhaps, but also environmental factors around the actual condition of the ward, the cleanliness, smells on the ward, the presentation of the ward generally, apart from the infrastructure of the building, was there any mechanism, if it is not in the safety report periodically, any mechanism of that being monitored by someone and tracked and actions taken in relation to that? 12:46 12:46

A. Well that would have been - I would have expected that through the assistant services managers in their, you know, observations daily, but I don't actually have sort of, you know, a paper or a plan that things were, that I can recall, documented in that way. 12:46

66 Q. I appreciate you've indicated in your evidence that if there were environmental factors that were seen as risk factors they may be included in this. 12:47

A. Yeah.

67 Q. Do you think, if I can ask you this in hindsight, that it may have been of benefit for environmental factors to also have been included as a risk factor in relation to the weekly reports? 12:47

A. Absolutely, yeah.

68 Q. In terms of challenges to safe care around the weekly reports, how would you say that was dealt with, or was it considered at all?

A. The safety reports were shared, this data was shared with the clinical teams, and that they had the opportunity to discuss that as a multidisciplinary team, and obviously that they can identify what the individual trends or what the various issues were and what they were doing about it, you know, had that opportunity with the safety. I think the importance of this was the visibility that it was - it wasn't down to individual ad hoc reporting, that there was, you know, the data based on the incidents, et cetera, that the team then could see what the impact of the work they had already done, or give them an identification of what still needed to be improved upon. 12:48 12:48

69 Q. At paragraph 99 you say that the patient safety or weekly safety report was reviewed by the senior management team in Muckamore and shared with the multidisciplinary team, as you've just referred to. You also say that it was shared with the Executive Team and the Department of Health, and monthly it was shared with the Trust Board as part of the Service Director's briefing. Would it be fair to say that at this point in time, 2019, with these processes in place, that the amount of information being received by the Trust Board was greater perhaps than at any other time beforehand in terms of the level of detail? 12:48 12:49 12:49

A. Yeah, absolutely. Once it came that there was an issue within Muckamore, then there was the requirement to actually, you know, updating with Exec team and Trust Board on the situation, and what was the key actions

that was being taken to address it.

DR. MAXWELL: Can I just pick up on that? Was it variations on this weekly safety report that were being presented to the report, was it that sort of data?

A. There would have been a report. I did sort of a summary report of the situation covering a number of things, but attached was the safety report as well. 12:49

DR. MAXWELL: Because we've heard from a number of - well, we will be hearing from a number of witnesses that the Trust Board adopted what it calls the Charles Vincent model, and one witness certainly clarifies that as the 2013 Measuring and Monitoring of Safety Framework published by the Health Foundation, of which Charles Vincent was one of the authors, and that is very clear that just measuring harms is not sufficient, there are five domains that need to be covered. Given that the Trust Board isn't operationally managing, it is supposed to be strategic, how was it hearing about the other domains? 12:50 12:50

A. Ehm, to say that the Charles Vincent model was what we put in place as an executive team, not Trust Board, Executive Team, and we first started to use it around Covid and managing the thing, Covid, and "What happened yesterday? Was there potential for, you know, that we need to be mindful of?", and to actually anticipate what we need to put in place. We have kept that up as an executive team as a safety huddle using that model. It wasn't used at Trust Board. So Trust Board I had, and still continues, that the Director provides a 12:50 12:51

report covering the various spaces about where we were with the RQIA improvements, where we were with the staffing and the suspensions. They were getting a separate report obviously from the other team about the suspensions, et cetera. So they were getting summary reports and then they were getting sort of this clinical safety report so that they could see that there were improvements over time. 12:51

DR. MAXWELL: So you weren't using the model until Covid? 12:52

A. The - yeah.

DR. MAXWELL: The measuring and monitoring of safety.

A. Yeah.

DR. MAXWELL: Because one of the dimensions in there is sensitivity to operations, and that's looking at what I would call environmental issues, not the fabric of the building, but other things that were happening. We've heard a lot about boredom of patients that might have triggered behaviours that staff responded to inappropriately. Were you or were the Board aware of any lack of day activities or lack of psychologists to therapeutic work with these patients that would all fall under that domain to sensitivities to operations, or was it just measuring the harms, which is one of the domains, but only one of the five domains? 12:52 12:52 12:52

A. Well we were -- in my time there I was aware that there were day activities. There were, you know, the day care facility. There was the day activities and excursions off site.

DR. MAXWELL: But did you know how many times those sessions were cancelled because of lack of staff?

A. No, I wouldn't have had that level of information, no.

DR. MAXWELL: And did you know about vacancies in the psychology staff or the workload of the Psychology Department? 12:53

A. Yes, I was aware. And then there - but there were psychology assistants that were, that, you know, the psychologists were, and the behavioural therapy nurses, as another way of, under the auspices of psychology, to try to improve the situation with their guidance and support. 12:53

DR. MAXWELL: I'm asking whether you collected data on these things, not how you mitigated them?

A. No, not in my time we haven't collected that data. 12:54

70 Q. MS. BERGIN: Staying on the topic of data, at paragraph 103 you say that there was no data analyst on site.

"A senior member of the Planning and Performance team provided data and trend analysis on patient safety reports." 12:54

Separately the CCTV viewers provided a summary of the CCTV viewing, and then the Divisional Nurse provided data pertaining to the nurse staff situation. Given the range of problems that we've heard about at Muckamore, do you think there would have been a benefit in there being one data analyst based on site at Muckamore? 12:54

A. And that was -- yes, absolutely. And that's why we would have been aspiring to have that, and over time we did. But in my time it was good to have the support, even though they weren't based there, so at least we got the data collected and demonstrated. So it was the next best thing that we were looking for, and I do believe there was someone, you know, shortly after I left Muckamore, that is in place now.

CHAIRPERSON: But until this point there had been no data analyst on site? 12:55

A. I think at a point in time there were some data analysts and then left, is my understanding, or moved on, and then - but we had data analyst support from the centre that was - but I don't believe that they were always situated in Muckamore in my time. 12:55

CHAIRPERSON: So I just wanted to understand how it was across the Trust, as it were, in other hospitals. In acute - in each of your acute hospitals, would you have had a data analyst?

A. Not based in every division, no. They had them centrally. It was an aspiration that each Director/Directorate would wish to have, and some did. They obviously prioritised their investment in relation to that, but we had a central, a small team centrally providing, because a lot of the data is collected centrally as well. 12:56

CHAIRPERSON: So the senior team or the director of the specific hospital could say "We are going to fund a data analyst", but otherwise the rest dealt with a sort

of central team. Is that how it works?

A. Yes, the central team - because I would even say now we don't have enough data analysts across, we could always be doing with more, and it's how can they do, you know, do the most with the few that we have. But in some areas that they chose to invest. And, again, there was - some of that was actually taken back to the centre as well to try and have the rigour around safety reports and activity reports to all areas of the Trust. 12:56

CHAIRPERSON: And after the CCTV revelations, and during your time in your role you didn't have a permanent data analyst at Muckamore, but you were using an analyst from the central team, is that right? 12:57

A. Yes, who was consistent and understood the data. You know this was, say, getting the safety report was just early in 2019 that had, you know, we had started to get to grips with all of what we should have been reporting through, and Dr. Jack, the Medical Director, would have been very instrumental in trying to get the elements that would make up this report, that we could improve over time. So it was - and then how do we get the various elements of information to populate the report to make it meaningful. So it was always meant to be an improvement over time, and so at least to have the data in this format, and that didn't have to rely on individual, say nursing staff or whatever, to collect and collate this. 12:57 12:58 12:58

CHAIRPERSON: Could I just ask this as a civilian, as it were, as a non-medical person, but is measuring

outcomes regarded as being a harder concept in a learning disability institution or hospital, than it would be in an acute hospital?

A. I think measuring outcomes is difficult regardless of... 12:59

CHAIRPERSON: Sure.

A. Of any setting. And we usually use a proxy off the measuring process leading to outcomes. There are some very specific parameters that are needed to come together to get outcomes, and my experience is that's 12:59 complicated and difficult regardless of the setting.

CHAIRPERSON: And no harder in a learning disability setting than anywhere else?

A. I don't believe so. It's about trying to understand what it is that we're doing to... 12:59

CHAIRPERSON: Yeah.

A. But I know it was an industry as well in some areas to try to come up with what's the outcomes, and needing a lot of clinical data as well. So it was no easier elsewhere. 13:00

CHAIRPERSON: Right. Okay.

PROFESSOR MURPHY: Of course, one of the ways of doing that is to measure quality of life. Was that ever attempted in Muckamore to interview patients about their quality of life? 13:00

A. I don't believe so but, you know, it's not something that I am aware of. We had, you know, as part of this what we were trying to do is patient experience, you know, to get the information from those that could give

it, and this psychology staff - well I think it was actually the speech and language therapy staff, with using talking mats to actually, you know, try to get some experience back from the individuals. And, again, we had a person who was, you know, leading for us the carer component, and trying to get feedback from carers and families to feed into that, you know, that was probably as a proxy for, you know, the experience and quality of life. 13:01

71 Q. MS. BERGIN: Yes. Just finally then, Ms. Owens, at paragraph 100 you refer to Significant Event Audit methodology, SEA, and you say that this was used following incidents where there was an opportunity for learning, and you go on then in the following paragraphs to say that the weekly Live Governance call was also an opportunity to review safety parameters, share good practice, and discuss learning from SEAs, and you then say that: 13:01

"The safety parameters demonstrated a significantly improving picture across the aspects of safety." 13:02

When you refer to "safety parameters", are you referring to those matters which are outlined in the weekly safety reports? 13:02

A. Yes, that's what I was referring to. Yes.

72 Q. And on what basis have you said in your statement that they were significantly improving? During what time period and on what basis?

A. Well, I was obviously referring to where there were, you know, the reduction in incidents occurring where there was a reduction in the seclusion, and medication incidents, and whatever. And using that information to make that statement.

MS. BERGIN: Okay. I have no further questions, but the Panel may have.

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

13:02 13:03 13:03 13:03 13:04

73 Q. DR. MAXWELL: Can I just ask on that point, Covid was obviously a big impact on health services. Do you think the reporting of incidents during Covid would have gone down because of concerns about other things, or do you think it was a genuine reduction in incidents?

A. I do believe that there were reductions in incidents, because we had seen that before Covid, because we were measuring that. Obviously Covid brought its own challenges, as you say, absolutely, and it had the potential of actually increasing because of the, you know, less opportunities for individuals to be outside but engaging in other activities or access to loved ones, et cetera, so it had the potential to, absolutely.

DR. MAXWELL: Thank you.

74 Q. CHAIRPERSON: Just could I ask this, I mean during the period of your tenure, as it were, when you had a very specific focus on MAH as opposed to your much longer

period when you were a Director of the Trust, we've heard that staff were extremely unsettled, understandably, by what had occurred, the suspensions, the introduction of agency staff, the closure of wards, et cetera, et cetera, et cetera. In your senior management role, what did you do personally to try to settle the staff down and help them in their concerns? 13:04

A. I think one of the things was obviously there was the weekly engagement with Ward Sisters in their meetings, but there were open opportunities for all staff to come and meet with the senior management team and to raise any particular concerns. 13:05

CHAIRPERSON: Where would that have happened? Where was that based?

A. It was based on Muckamore. So it was usually in - there was a room in the day centre up there that we would have used. And, you know, again other staff, it wasn't just the Director, but the Director of Nursing, Medical Director, other Social Work Director could and would be there on occasions as well to hear directly from individuals. And, again, as I said earlier, you know, trying to communicate through the CCTV viewing, the positives going back, trying to take every opportunity that we could to reassure as best we could, you know. We weren't always sure of the information that we would, or, you know, provide particular assurances to individuals about what was going to happen, we had no control over it, but tried as best as we could with the information that we had to, you know, 13:05 13:05 13:06

some of the anxieties were "Well, what's going to happen here? What's going to happen with me, you know, in terms of Muckamore going to close?", all of those things, where some was very difficult to answer, but just trying to give an honest appraisal of what we had, the information to provide them.

75 Q. CHAIRPERSON: And did you yourself walk the wards, as it were?

A. Yes.

76 Q. CHAIRPERSON: How often would that happen? 13:06

A. I -- well, I walked them, obviously, at the very start to understand the --

77 Q. CHAIRPERSON: When you say at the very start, you mean 2019?

A. Yes. 13:07

78 Q. CHAIRPERSON: Yes.

A. Well I would have been there, you know, as a Director, I had been there before actually, you know, in terms of safety quality visits that we went up to and walked round individual wards, talked to staff, talked to the Ward Sister, you know, so I had done that previously. But obviously when I was Director going to meet the staff, understand the environment that they were working in, and so then occasionally after that I would be, you know, tried to go to at least one ward a week when I was up there. 13:07 13:07

CHAIRPERSON: Okay. I think we've asked our questions as we've gone along, so can I thank you very much for coming along to assist the Inquiry. Thank you.

A. Okay. Thank you.

CHAIRPERSON: Okay. We'll sit again at 2:05.

LUNCHEON ADJOURNMENT

13:08

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. 14:06

MS. KILEY: Good afternoon, Chair and Panel. This afternoon's witness is Ms. Mairead Mitchell and she is ready whenever the Panel is.

CHAIRPERSON: Excellent. Let's get her in.

14:06

MS. MAIREAD MITCHELL, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Can I thank you for coming to assist the Inquiry, thank you for your statement, and I'll hand 14:08 you over to counsel. Ms. Kiley.

A. Thank you.

79 Q. MS. KILEY: Good afternoon, Ms. Mitchell. As you know, my name is Denise Kiley and I am one of the members of the Inquiry counsel team and I'll be taking you through 14:08 your evidence this afternoon. I think you have in front of you a copy of the statement that you made to the Inquiry, isn't that right?

A. Yes.

80 Q. That is a statement which is dated 25th April 2024, and it has the statement reference STM-240. There will be times throughout your evidence that I will refer you to particular paragraphs, and where that's the case you can follow along in your hard copy, but it will also come up on that screen just in front of you. Okay? The statement that you have in front of you has two exhibits, isn't that right? 14:08

A. It's?

81 Q. It has two exhibits? So two documents which are attached to the statement. 14:08

A. Oh, yes, yes, yes.

82 Q. Do you have a copy of those too?

A. Yes.

83 Q. Okay. And do you wish to adopt the statement as your evidence to the Inquiry today, Ms. Mitchell? 14:09

A. Yes.

84 Q. The other thing which I may also bring up on the screen in the course of your evidence is a bundle of documents? 14:09

A. Yes.

85 Q. And we recently provided you with a copy of a bundle of documents. It has been given the Inquiry reference number MAHI-Mitchell-M. You don't need to worry about that. 14:09

A. Okay.

86 Q. That's for everyone else's reference. But, again, if I am going to refer you to it, I'll bring it up on screen. Could we bring up the index, please, just so

we can all be clear what we're talking about. So it's MAHI-Mitchell-M1, please. Can you see that index, Ms. Mitchell?

A. Yes.

87 Q. And you're familiar with that? 14:09

A. Yes.

88 Q. Have you had an opportunity to consider the contents of that bundle of documents?

A. Yes.

89 Q. Okay. Well I might return to that. Just finally, you also notified me when we met briefly before that you have some notes which you have brought into the witness table with you today, isn't that right? 14:09

A. Yes.

90 Q. And they're your own notes, isn't that right? 14:10

A. Yes.

91 Q. And you have made them in preparation for coming to give your evidence today, is that right?

A. Yes. Try and remember things and jot them down.

92 Q. Okay. But they're all your own work, as it were? 14:10

A. Yes. Yes.

93 Q. Okay. Well, can we turn to your evidence then and bring up on screen the statement STM-240, please? And at paragraph 1, Ms. Mitchell, you refer to your professional background, and we can see there that you qualified first as a Registered Nurse in 1978, and then Registered Midwife in 1980, and a Health Visitor in 1983, isn't that right? 14:10

A. Yes.

94 Q. And then in terms of your employment with the Belfast Trust and the predecessor Legacy Trust, you held a number of positions which you then outline at paragraph 2 there. So if we just look at each of those. The first was Assistant Director of Quality in North and West Belfast Trust, and that was from 1997 to 2005. And then you held the post of Assistant Director of Service Improvement and Modernisation in the Learning Disability Directorate of the North and West Belfast Trust from 2005 to 2007. Then you were the Senior Manager Service Improvement and Modernisation in Adult Social and Primary Care Directorate, Belfast Trust, from 2007 to 2016. If we can just pause there. Could you explain to the Inquiry how much involvement, if any, you had with Muckamore Abbey Hospital in those roles that I've just read out? 14:11 14:11 14:11

A. So if we go back to Assistant Director of Quality in North and West Belfast Trust, I would have been involved throughout the Trust in quality improvement projects, and those projects would have scanned all different services, whether it be older people, learning disability, mental health, community mainly. And at that time we started to go forward for Charter Mark, and I helped and supported Muckamore Abbey Hospital through the Charter Mark process, and they got their first Charter Mark I think it was 1997, and they had four Charter Marks up until 2005/2006, I'm not exactly sure the exact year. So I supported and helped them through that process. Also at that time Muckamore 14:12 14:12

had a document equalled Equate, which was a quality audit tool for the wards, that had been developed by senior nurses going back I think to the 1980s, and we decided that in going forward for Charter Mark the document needed updated. So I helped the hospital in updating that document for the audits in the hospital.

95 Q. Okay.

A. And then if we go on to 2005 to 2007, I was actually based at Muckamore for those two years as an Assistant Director of Service Improvement and Modernisation, and that was to lead the new build of the hospital at Muckamore, and also the Iveagh Children's Services, which was in the community, which was both learning disability. So it was very specific in managing that new build through it's inception right through until it was handed over to the Trust. 14:13 14:13 14:13

And then also at that time I also managed some staff within Muckamore, it would really have been the admin staff and the service improvement staff, but also managed learning disability staff within the community. So it spanned not just the hospital, even though I was based in the hospital. 14:14

96 Q. Yes.

A. That's where the senior management team for learning disability would have been based up until 2007. Then in 2007, North and West Belfast Trust amalgamated with all the other Trusts and became known as the Belfast Trust, and at that stage the management team were then 14:14

moved to Belfast, and then we all had to apply for posts within the new Belfast Trust, and I got the Senior Management For Service Improvement and Modernisation, and that was across the Adult Social and Primary Care Directorate, which involved learning disability, mental health, and Older People's Services across Belfast.

97 Q. And did you have responsibilities for Muckamore as part of that role?

A. Yes. 14:15

98 Q. But you weren't at that time based at Muckamore?

A. No.

99 Q. You had moved back to Belfast. Okay. Then finally then you were Head of Learning Disability Services in the Belfast Trust from 2016 to 2019, isn't that right? 14:15

A. Until I retired.

100 Q. So that's why you left the post in 2019, is it?

A. Yes.

101 Q. And whenever you took up post in 2016, was that a role that was based at the hospital? 14:15

A. No. No.

102 Q. No. Where were you based?

A. Ehm, the role was an interim head of Learning Disability Services and that was a new post. The Co-Director for Learning Disability Services had 14:15 retired I think around the July of that year, and there had been a scoping exercise done in mental health and learning disability within the Trust in relation to the management structures, and it was decided that mental

health and learning disability would amalgamate their management structure, and so a Head of Learning Disability was put in place to bring forward that amalgamation.

103 Q. So was that a new post then? 14:16

A. Yes.

104 Q. That hadn't existed prior to 2016, is that right?

A. Yes, yes. The money for the co-director had been giving up as savings within learning disability because there was going to be this amalgamation. 14:16

105 Q. Then in terms of the role, you've talked about the amalgamation, but it wasn't then an exclusive role with just responsibility for Muckamore, isn't that right?

A. Yes.

106 Q. You had wider responsibilities? 14:16

A. It was across community services, residential, and supported living services, the community teams, Iveagh Children's Unit and Muckamore.

107 Q. And could you estimate, even roughly, how much of your time was spent dealing with Muckamore issues as 14:17 compared with other issues, part of the role?

A. Most of the issues happened to be in the community. I would have went to Muckamore once a week at the beginning, I suppose in the first six months of my role, but my role was extended because they decided 14:17 very quickly in 2017 that learning disability and mental health wouldn't amalgamate. So the Trust decided that the management structure would stay.

108 Q. And thinking then about how Muckamore sat within your

wider role, are you able to give us an impression of how big a part Muckamore played in the Trust's Learning Disability Service at that time?

A. Well the priorities at that time was about resettlement, and there was a paper drawn up between the Trusts and the Board in relation to what the new service would be, the learning disability model would be, and I think at that time it was to reduce beds down to 50, and that's only a rough estimate. 14:18

109 Q. And just to pause you there. Can you recall what number of beds there were at that time whenever you were seeking to reduce it down to 50? 14:18

A. I think there was about 100, and that's only approximate.

110 Q. Yes. 14:18

A. But resettlement process was well ongoing, and my role was to work with the other Trusts in looking at how we could expedite that process, and also work with the voluntary and charitable organisations to see what they had to offer. So I met quite regularly with the other Trusts and with voluntary and charitable organisations. 14:19

111 Q. Okay. And I'll come to that and to the topic of resettlement. If we could bring up paragraph 10? You say a little bit more here about the role itself, and you say that at your appointment: 14:19

"...the management structure in Learning Disability Services was depleted due to the funding for previous management posts not being available."

Can you explain a little bit more about what you mean by that? What posts were depleted?

A. Well, obviously the co-director's post was given up as savings. And then when I took up post there should have been three service managers, that was the level below me, and the three service managers - one managed Muckamore and Iveagh Children's Unit, another one managed residential and supported living, and then another one managed community services and day services, and at that time there was only two. So one of the other posts had been given up for savings as well, so that was depleted. 14:19 14:20

112 Q. Do you know when that happened? When the three service managers became two? 14:20

A. I think when the previous post holder had resigned or retired, and that would have been probably around maybe six months before.

113 Q. Okay.

A. I couldn't be entirely sure of that, but it was for a period of time. And the two service managers that were then there, the workload was divided between them. So when I took up post there was two service managers that had the workload divided between them. So the person that managed Service Manager for Muckamore and Iveagh, also had residential and supported living in the community across Belfast as part of their remit. 14:20 14:20

114 Q. Yes.

A. And then the person, the Service Manager for community

services also had day services and was also the lead for safeguarding.

115 Q. And when you came into post and you encountered this situation where the two service managers were dividing the role that had previously been held by three between the two of them, did you get the impression that there had been any adverse impact on the oversight of Muckamore as a result of that depletion or change in numbers? 14:21

A. Well both post holders had alerted me to it and the workload they said was unmanageable. When I had brought this forward I was told there was no money for another post because we were amalgamating with mental health services, but as time went on and a lot of talking and they decided that Muckamore and learning disabilities wouldn't amalgamate with mental health, I was able to secure the funding for another Service Manager. 14:21 14:22

116 Q. So it went back to three again?

A. Yes. 14:22

117 Q. And can you tell us at what point that happened?

A. That was probably in '17, some time in '17. I can't remember exactly the date, but it was some time in '17.

118 Q. Okay. So in terms of the structures then, the Service Managers reported to you, isn't that right? 14:22

A. Yes.

119 Q. And who were you accountable to?

A. The Director.

120 Q. Okay. And if we move on then. You were posed a series

of questions in your statement, which you have answered. If we could move to Question 2 please, just below paragraph 12. You can see there you were posed a series of questions about the admission and discharge of patients - I won't read them all out. You answer that at paragraphs 13 to 15. You haven't, in your answer, addressed those individual questions. Is there a reason for that? 14:23

A. I wouldn't have been responsible for admissions and discharges. That responsibility lay with the team at Muckamore, and that would have been the multidisciplinary team in relation to admissions and discharge, and then the Service Manager for Muckamore would have been part of that, depending on the number of beds. It only would have come to me if there was an issue in relation that there was no beds and we maybe had to speak to somebody else, another Trust or whatever, and I maybe had to step in at that stage. 14:23

121 Q. Okay. But you have told us that you had a role in the development of community services, isn't that right? 14:24

A. Yes. Yes.

122 Q. So just bearing that in mind, can I ask you to look again at Question 2(iv), and that was:

"Specifically, did a lack of resources or delay in availability of support in the community impact on whether a patient was referred to Muckamore? If so, please, explain?"

Given your role in the community and with the development of community services, are you able to answer that?

A. Many of the patients that were in Muckamore needed complex support in the community, and there wasn't always that support, and one of my roles was to work with voluntary, and community, and charitable organisations, to look at what they could offer and how they could help, and a lot of the organisations were quite supportive of helping, maybe hadn't been involved previously, but we worked through a programme in relation to patients and how many patients they could help us with. A lot of work had to be done with the Trusts as well in relation - because while the Trusts were in Belfast Trust, their owning Trust was maybe a different Trust, so South Eastern Trust, Northern Trust, Western Trust. So you had to work with those other Trusts to find out what the plan was for that patient for discharge or for admission. 14:24 14:25 14:25

123 Q. Yes. But in your experience then in working in that area and having knowledge of the patients who were admitted to Muckamore, and knowledge of the services available in community, can you say did you feel that the lack of resources or delay in accessing the resources in the community led to admissions in Muckamore? 14:25 14:26

A. Definitely. Definitely. Because the resources in the community weren't enough for the complexity of the patients that were being discharged. There was poor

support mechanisms in place, and when there was, for instance, a crisis in the community, patients were then admitted to Muckamore, and in many instances they may not have needed to be admitted to Muckamore. If there had have been more resources in the community we could have kept people in the community.

124 Q. And was it part of your function then as Head of Learning Disability to try and improve those resources in the community and keep people there whenever they don't need to be admitted to Muckamore? 14:26 14:27

A. Well, there's only a certain amount that you can do in relation to the resources that you're given, ehm, and I know - I can give you one instance where the Trust had made a decision, I think it must have been around about '15/'16, to close one of the day centres in Belfast, and families were very angry at this, and the families came forward to Trust Board and they were able to get that overturned. Now if that centre had have closed, that was break down of placements for people who needed some structure in their life. So whenever I took up post I had a lot of work do around that. Obviously to gain trust from families, because you really need the families and the carers to help, in helping to support people who are with a learning disability. Many of them are carers and they need support as well. So I did a lot of work with them in relation to that and tried to improve resources, but there was only a small amount that we got from the Board and from the Department in relation to the whole resettlement 14:27 14:27 14:28

process. So you just had to work within that budget. And in many of the people that were being resettled out of Muckamore, as I say, they were complex and they needed a lot of support. So it wasn't just finding them a home, it was finding them the support. It was finding them what they were going do with their day and how that was going to work out. So there was a lot of extra support needed, and we didn't have the funds for it. 14:28

CHAIRPERSON: And where would you go to plead for those funds? 14:28

A. Sorry?

CHAIRPERSON: Where would you go to plead for those funds? Who do you approach?

A. Well, I - where we discussed it was there was resettlement meetings, and the resettlement meetings were each of the Trusts, a representative at my level from each of the Trusts, and then there would have been somebody from the Board who would have been there and we would have highlighted the issues there. There will be minutes of those meetings, and you will see that all the Trusts were the same in relation to getting funds for the community. And when -- that was then taken forward from the Board to the Department. 14:28 14:29

DR. MAXWELL: Did you escalate it so that it was discussed at the Directorate meeting or even at Belfast Trust Board meeting? 14:29

A. I don't know if it would have been at the Board meeting, because I wouldn't have been at Board

meetings, but our own Directorate meeting, yes, it would have been discussed with the Director.

DR. MAXWELL: Okay.

125 Q. MS. KILEY: And I think you refer to those resettlement meetings at paragraph 14 of your statement, and you say there that you Chaired the meeting. There was engagement from the other Trusts and the Health and Social Care Board, and you refer there to discussing the number of patients from each Trust due for discharge and to discuss funding. 14:30

A. Yes.

126 Q. Do you specifically recall raising concerns about community funding in those meetings?

A. Yes. Yes. And there should -- we did out a large spreadsheet with the patient's names on it, what Trust they belonged to, what support they needed, you know, where their family wanted them to go. Some families maybe wanted them to go to certain areas, and what there was available. And it also would have given an approximate of what the funding would have been needed for that. So there is large spreadsheets that are updated on a regular basis. 14:30

127 Q. And I suppose that's you wearing one hat as your function of Head of Learning Disability, but the other hat is making sure that the patients who remain at Muckamore have a good quality of life? 14:31

A. Yes.

128 Q. And did you consider as part of these resettlement meetings the effect that delayed discharges were having

on the remaining population in Muckamore?

A. Delayed discharges had been happening for years. It wasn't just a new thing, it was going over a long period of time of years. But what the hospital tried to do was to have services, like day care services, for patients that would have been ready for resettlement. So you would try to do as much as possible with them. I suppose when I took up post in 2016, maybe into 2017, I was slightly shocked about how little there was for patients on site. If I go back to the two years that I was at Muckamore in 2005 to 2007, many - and there would have been a lot more patients - many patients went off site for day services, went to other organisations, so were bused off and on. Other organisations would have come in and provided some sort of service. We also had dedicated day care staff on site, and patients would have been to that, and there would have been a plan for day care and what patients wanted. We had a swimming pool and patients would have went swimming, and that was on site. 14:31 14:32 14:32 14:32

When I then had the managerial role in 2016, I was slightly shocked that there wasn't people coming in or patients going out for day care, it was very insular. Ehm, many patients didn't go off the wards for day care because staffing issues, or the day care was closed because of staffing. So when I walked the wards, you know, patients would just be sitting and very little activity. 14:33

129 Q. And you refer to issues with staffing there. So whenever you come in this post and you say that you were shocked at this situation, were you given any reasons as to why the things that you had previously experienced happening were no longer happening? 14:33

A. I was told because the hospital was decreasing in size and because, you know, we were getting ready for patients to go out into the community and that we didn't need as much day care. But the main issue for me was the staffing levels. So staff had to come out 14:34 of day care to go on to the wards to help on the wards. So there was a big issue with staffing.

130 Q. And just going back to what you said there about being told that the hospital was reducing and there wasn't as much of a need. Who told you that? 14:34

A. That would have been the Service Manager.

131 Q. Okay.

CHAIRPERSON: I'm so sorry, but of those that you mentioned, so day care was significantly reduced when you went back in. 14:34

A. Yes.

CHAIRPERSON: Swimming pool?

A. Swimming pool, ehm, there was issues with the staff in swimming pool. Because obviously they had to have lifesaver skills and all of that, I think there was 14:34 three staff in the swimming pool, and the swimming pool had to close at one stage because of suspensions.

CHAIRPERSON: And in terms of patients going off site, so not just going to the day care within MAH, but

patients going off site to do various things, was that still happening or not?

A. No. No.

CHAIRPERSON: So all of that activity --

A. All of that had stopped. I don't know how long that had stopped for, I'm not sure. But when I took up post I started to reintroduced it again and ask the Service Managers to start looking, because I felt that going on to the ward and seeing patients sitting, it's maybe one of the worst things and it causes more incidents in relation to boredom. We even got, you know, some equipment for the wards so that staff could sit with patients and do some tabletop exercises with them on the ward, if they weren't able to go out to day care. 14:35 14:35

CHAIRPERSON: But that - even that hadn't been there when you arrived, do you say? 14:35

A. No.

CHAIRPERSON: Thank you.

132 Q. MS. KILEY: And you said that you started to reintroduced those things whenever you were in post. Are you able to give us a time frame of when those things started to recommence? 14:36

A. Well I should also say that as part of my job I met with families and carers, and families were very vocal in that they had also mentioned about day services, and I do remember one particular family talking about swimming and that that was the one thing that calmed their relative down and they had missed their swimming. So we looked about recruiting extra staff for swimming 14:36

pool to get the swimming pool back and reopened. But families had mentioned about the day care. We had a choir, and there always was a choir on site of patients, and the patients loved that. We introduced very quickly music therapy, and we had a lady that came, and I can't remember the society that she was from, she came and went round the wards and did some music therapy with patients. We - I spoke to Extern and they came on site and did some day care with some of the patients that were getting ready to go out into the community, and they also took some of the patients from Six Mile to a place in Glengormley where they did different services and they got them bused there every day for their day care. 14:37 14:37

133 Q. How quickly after you took up post did that happen? 14:37

A. I would say that was probably in the first six months.

134 Q. And did it continue throughout your post until 2019?

A. Yes. Yes.

CHAIRPERSON: And - I'm sorry - and did that affect every ward? Was that right across the hospital or was that only specific wards? 14:38

A. Only five or six wards at that stage, yes.

CHAIRPERSON: But it affected each ward in the same way, did it?

A. Yes. 14:38

CHAIRPERSON: Because some of the patients obviously would have needed more assistance to get to day care or do activities than others?

A. But if day care was closed - I mean everybody had a

plan, and day care was part and parcel of that plan. Not all patients wanted to go to day care, and that was the other thing. So they may have just wanted maybe to go for a walk on the site. So that would have been facilitated as part of their plan, or then activities on wards.

CHAIRPERSON: Okay. Sorry, Ms. Kiley.

135 Q. MS. KILEY: Now you mentioned coming into post and walking round wards and seeing - being shocked, as you described it, and witnessing patient boredom. With the introduction of those measures that you have just described, did you see an improvement in that towards the latter end of your tenure?

A. I suppose if I could say my style of management is getting out and about and getting to know the services that I was involved. So obviously Muckamore being part of that, I would have, whenever I was up for meetings I would have taken the day and stayed at Muckamore and done a walk round the wards. Previously, in my previous roles, if I had have went round the wards, somebody always had to come with you, but I decided that I was going on my own because I felt that I could get a better feel on my own. So very quickly I started to notice different things, you know, ward managers would tell you things and you started to notice different things. For instance, the older wards weren't getting the best equipment, or new beds, or duvet covers, or whatever, they were having to make do. The new wards seemed to get everything and the older

wards didn't. So we tried to address that and get the ward managers to order what they needed. So hopefully we improved the living for the people there in relation to the environment. Sorry, I'm losing my train of thought now.

136 Q. I think we can go - if we can go to paragraph 38, and I'll skip ahead slightly because you refer here to the walkabouts that you undertook.

A. Okay.

137 Q. And that you've just described. And you say that they were introduced again in 2016, and included not only senior managers but senior staff from other services. Are those the walkabouts that you have just been referring to? 14:40

A. And other walkabouts. 14:41

138 Q. Okay. So you actually took part in those?

A. Yep. So you've probably heard about the Core Group?

139 Q. Yes.

A. And whenever I took up post the Core Group was very much just about Muckamore, so I decided to bring the community senior managers in as well to try and expand it, because we were looking at how people are moving out into the community and we needed - a lot of the stuff that had been discussed at core would have been about people being resettled. So those meetings also include the senior managers from the community, and at the meetings I would have said to them, you know, "Come and stay an extra hour at the hospital and do a walkabout. If there's anything you see, you know, 14:41 14:41

alert the Service Manager about it", or whatever. So that had started to happen, that other senior managers walked the wards, and that was very useful because people were able to see it with fresh eyes, and staff would have talked to people from the community rather than the staff that were on site.

140 Q. And you say there - at paragraph 38 you describe those as having been introduced again, and I just wondered in reading that, that suggests that they did take place at an earlier stage but were stopped. 14:42

A. Yes.

141 Q. Is that right?

A. Yes. Well, I don't know if they stopped, but I wasn't aware.

142 Q. Okay. 14:42

A. And staff on the wards told me that they didn't see anybody, nobody came to see them or whatever. But I do remember, you know, in 2005 and 2007 you'd have been on the wards at least weekly for myself, but the other senior managers at that time would have been on the wards, some of them maybe daily. 14:43

143 Q. And whenever you say that staff told you they never saw anyone, is that they were telling you that whenever you were taking up the post as Head of Learning Disability?

A. Yes, yes. Whenever I went out on the wards, people, you know, a lot of people would have known me because I had been in the Trust, and then some didn't, and they would just say, you know, "We never see any senior managers here. Is this something new?", or whatever, 14:43

you know.

144 Q. And going back in time then, we'll return perhaps to issues that you observed on the walkabouts, but you mentioned there the Core Group, and you've referred to that in your statement too, so I want to take you to that. If we could go to paragraph 16 first, please? And this is an answer to the question about the management meetings that took place at the hospital. You say: 14:43

"The service manager had regular meetings with the heads of departments, regular ward managers meetings and she attended the Core group meeting which was weekly." 14:43

And you describe there at paragraph 17 what you've just said about changing the format of Core Group whenever you took up post. Did those Core Group meetings then take place on site?

A. Yes. 14:44

145 Q. Always?

A. Yes. Yes. Might have changed, might have changed the name of it to Core Group Learning Disability Service, rather than just Core Group Muckamore.

146 Q. Okay. And that might have taken place whenever you were in post, is that what you're saying? 14:44

A. Yes, I changed those meetings. I Chaired them.

147 Q. Okay. And why did you feel there was a need for change at that time?

A. Because there were so few patients now left in the hospital and we were looking very much about resettlement, and I thought that we all needed to know what was going on within the hospital, because the senior managers in the community would have been the ones that were coordinating what was going on in the community, so they knew exactly what there was in the community, what housing provision there was, what day care services, what support was needed, they would have known these families, so it was very important that they were part and parcel of that from a senior level. Plus also the resources that there were. 14:44 14:45

148 Q. What do you mean by that, the resources?

A. Would there?

149 Q. What do you mean by that? You just said "also the resources"? 14:45

A. Well they would have known, you know, how many places there were in day care, what houses were available, what money there was as well, because they each had a budget, there was a resettlement budget, so they would have had the budget in relation to the patients from Belfast Trust that would have been being resettled. 14:45

150 Q. Yes, I see. So there were the Core Group meetings. Did you also attend Directorate meetings?

A. Yes. 14:45

151 Q. How often did that happen?

A. The Director had meetings I think monthly, and I was part of those, yes.

152 Q. Okay. And at Question 2 then you're asked about what

regular reports were received, and I think this might feed into the meeting so I just want to ask you about that. If we look about Question 4, you were asked:

"Did managers receive regular reports on: 14:46
The use of seclusion.
The use of PRN medication.
The use of physical intervention including MAPA.
Safeguarding.
Complaints." 14:46

And at paragraph 22 you say:

"Regular reports were received by senior managers and the ward managers which included all of the above as well as incidents/accidents and patients on special observations on a weekly basis. These were discussed at the core group meeting and latterly at the combined hospital/community management group meeting.
These reports were also sent to the consultants for learning disability."

So you refer to reports of that kind being discussed at Core Group. How often would the Core Group have received reports of that kind? 14:47

A. Every week.

153 Q. Okay. And you say at paragraph 23 that:

"These reports were collated from a data system by the

hospital resource nurse."

A. Yes.

154 Q. Can you explain to the Inquiry about that role of the hospital resource nurse? 14:47

A. The hospital resource nurse was I suppose a specialty, and her role had evolved I think over the years, and she coordinated this report. That was one of her jobs. She also coordinated the audits that were done on site, and she also coordinated the EQC, which was Equate 14:47 which then became EQC.

155 Q. So there was someone there, the hospital resource nurse --

A. Yes.

156 Q. -- with the specific role of gathering and collating 14:48 the data that was presented to Core Group?

A. Yes. Yes.

157 Q. And was that - did that exist whenever you took up post in 2016?

A. Yes. 14:48

158 Q. And do you know how long before that?

A. Yes, because I used to manage them.

159 Q. Okay. So how long?

A. So there for quite a number of years. I mean I think I can say going back to 2005 they were there. 14:48

160 Q. Okay.

A. Because we developed the report for core as part of a service improvement project. That report was developed and evolved over the years. So initially started of as

incidents and accidents, and probably if you compare the reports they don't like anything like each other from the start to what they were whenever I left.

161 Q. And can you say then when the Core Group started receiving the report? 14:48

A. Probably in - I would say it was probably around 2000 and something.

162 Q. Okay. At paragraph 23 and 24 then you explain what happened to the reports, and you say at paragraph 23 that: 14:49

"Any concerns, issues or queries were referred to the service manager for reporting back. On occasions the report was reviewed to include extra information." 14:49

Then at paragraph 24 you say:

"These reports would also have been regularly shared with the director, and information from them would have also been provided to other trusts and the Health and 14:49 Social Care Board."

So just trying to understand that. Who would have made the choice as to whether a report should be referred to the director? 14:49

A. Well the report went to the governance meetings and the governance meetings were chaired by the director.

163 Q. Okay. So as matter of course --

A. Yes, yes.

164 Q. The weekly reports that you've described --
A. Not the weekly, the quarterly reports.
165 Q. Okay.
A. So there was a weekly report to Core Group, and at Core Group you would have been able to discuss individuals. 14:50
So if there was an issue of somebody, there was a lot of incidents even in one ward and why there was so many incidents in one ward, that would have been discussed, and we would have looked to see what would happen, and there was maybe action around that. So that would all 14:50
be documented in the Core Group minutes. On a monthly basis we would have taken a collated report to the governance meeting and the director chaired the governance meeting.
166 Q. Whenever you say "we would have taken a report" -- 14:50
A. Yes, I would have taken it.
167 Q. You did that, did you?
A. Mhm-mhm.
168 Q. And so was your role presenting the report to the governance meeting? 14:50
A. Ehm, not always. It might have been that resource nurse or it might have been the Service Manager.
169 Q. And do you recall it being an interactive process? So would the governance meeting have asked you questions about -- 14:51
A. Yes. Oh, yes.
170 Q. And would they have raised concerns about anything within the reports?
A. Well, there was always issues in relation to the number

of incidents that were on site. Ehm, so that would have been highlighted and what we were doing. And I know that the governance meeting and the director meeting, you would have had all the heads of departments there, so the like of psychology, and that was one of the reasons that PBS, Positive Behaviour Support was introduced within the hospital, because of the number of instances, and to see if that could help reduce the number of incidents, and the Head of Psychology took that on board as the lead for Positive Behaviour Support in the hospital. 14:51 14:51

171 Q. Yes. I want to come to that, because you do talk about that. I think that happened in 2016, isn't that right?

A. Mhm-mhm.

172 Q. And you describe - if you bear with me I'll get you the reference so that we can look at it together. If you look at paragraph 70, please, I think this is what you're referring to. You say: 14:52

"In 2016 positive behaviour support was introduced to try and reduce seclusion and physical intervention." 14:52

So are you saying that that was an outworking of the process you've just described where the reports go to the governance meeting? 14:52

A. Yes. Yes.

173 Q. So can you tell us a little bit more about how that came about?

A. Well, at the Core Group when I had changed it for the

senior managers for community coming, I would have also invited on a regular basis the Head of Psychology, and we discussed it there first of all in relation to how we could reduce incidents, and look at the type of incidents, why they were happening, and things like the day care - that was one of the issues as well. I mean it wasn't just about putting PBS in and that would help. There was a lot of things that were discussed in relation to how we could reduce incidents, and why the incidents were happening. And obviously medical staff, psychology, nursing, all were involved, and PBS was one tool that we thought could help, because one of the things about PBS is about reducing incidents, and it's maybe working with patients in a different way. So, Psychology, as I say, said that they would take it forward, and we brought it then to the governance, and I think the directorate meeting, if I'm right, to say this was the way that we were going forward. 14:53 14:53 14:54 14:54

CHAIRPERSON: We've heard quite a lot about PBS, but are you saying that it was first introduced in 2016 to Muckamore?

A. On site. There was a pilot done on site of PBS, yes.

CHAIRPERSON: And that's the first time you're aware of PBS being used?

A. As far as I'm aware. 14:54

CHAIRPERSON: Okay.

174 Q. MS. KILEY: And it was introduced then in 2016, and you described it as a pilot. Did that service then continue whenever you were Head of Learning Disability?

A. Yes. Yes. I think the pilot was in Killead Ward, if I remember rightly, and it came back very positive. There was tweaks that needed to be done. Obviously the policy was being developed at the same time and then how we were going forward with it. So, yes, PBS was then introduced. There was -- behaviour services staff were then employed. I can't remember how many extra were employed to help with the implementation. And also - thoughts - gone blank now. Yes, staff were, extra staff were employed to help with it, and to help with the training of the ward staff in relation to the PBS and how we would introduce it. So, psychology led on that. 14:54 14:55

175 Q. And --

DR. MAXWELL: Can I just ask two questions? Firstly, if there was a pilot, was there a written review of how effective -- 14:55

A. Yes. Yes.

DR. MAXWELL: So the Inquiry could ask for a copy of it? 14:55

A. It's Killead Ward I think that the pilot was in, if I'm right? And probably Psychology would have that.

DR. MAXWELL: Okay. So Positive Behaviour Support was piloted in 2016, but there had been behaviour nurses before that, is that your recollection? 14:56

A. Resource nurse? Could you repeat that?

DR. MAXWELL: We've heard people talk about having nurses who were behaviour nurses.

A. Yes. Yes.

DR. MAXWELL: And they were in post before 2016.

A. Yes. Yes.

DR. MAXWELL: But Positive Behaviour Support, as specific initiative, was introduced in 2016.

A. Yes. A lot of their work would have been helping with resettlement. 14:56

DR. MAXWELL: Yeah.

A. And so they maybe went out into the community. When a person was being resettled they maybe had some time out in the community to help that person be resettled. So that resource was slightly taken away from the hospital. 14:56

DR. MAXWELL: Yeah. Okay. Thank you.

176 Q. MS. KILEY: And just going back a bit. You started telling us about that pilot and the introduction of PBS whenever you were telling us about the governance meetings raising issues about incidents, and you had said they were always an issue. So was the introduction of PBS effective in reducing the number of incidents. 14:56 14:57

A. Yes. In the pilot it did show that it was effective. Yes. Along with other things. I couldn't just say that it was definitely PBS. There were other things like the day care services were increased for patients as well. You know, there was a different way of working. 14:57

177 Q. You have some statistics about incidents in your exhibits and I'll come to look at those later, but if we just stick with your statement for now and return to

Question 5, please, which is at page 5. And you were asked here:

"What procedures or processes were in place to ensure co-production between MAH staff and relatives of patients at MAH?" 14:57

And at paragraph 25 you say there:

"In 2016 when I took up post, there was little evidence of co-production between staff and relatives." 14:57

Can you explain a little bit more about what you encountered of co-production whenever you took up post?

A. Well, obviously this is just relating to the hospital. 14:58

178 Q. Yeah.

A. And co-production for me is about working together in relation to whatever you're doing. And while there was lots of information given to relatives and to patients, there was very little, what I would call co-production. 14:58

I know that the Parents and Friends had been very active in the hospital in previous years and had very good relationships with management, and that seemed to have waned over time, and I know that they asked to speak to me not long after I was in post and they brought some issues to me as well. So that's where we started to look at how we could involve relatives better and do some work around co-production. 14:58

179 Q. What sort of issues were they bringing to you whenever you started post?

A. Things like I suppose the wards and not being able to visit their relative on the ward, the cleanliness of some of the wards, day care services. Those were some the issues that I remember. 14:59

180 Q. And did you thereafter have regular meetings with the society?

A. Yes. Yes.

181 Q. How regularly? 14:59

A. Or phone calls. Yes, they knew that I would have been available. We set up regular meetings, but there was also meetings in between. And then before I left I had set up like a carers forum in relation to how we could go forward with good communication between families and hospital. 15:00

182 Q. Can you tell us more about the carers forum? When did that get set up?

A. That would have been around about '18, the end of '18. I had already set up a carers forum in the community and it was co-chaired, myself and a relative joint chaired it. We held it in the community, and I invited a representative from Muckamore to come along and see what we did and to see if it was something that we could replicate or join. So we decided to try and replicate it on site for Muckamore, and invited as many relatives as we could. But obviously it's hard to get relatives. The site is quite a bit from where most people live. We didn't have big attendance. We had 15:00 15:00

already done - there was already a little group that had started as well before the carers forum, Your Voice Counts I think it was called, and that had started as well looking at some of the documents that we had and see if we could make them more readable for people, rather than the jargon that we would normally use. So that had actually good attendance, because people were seeing the fruits of that. When we started up the forum on site it really was about relatives meeting with senior people, and voicing issues, and let's see how we can do something about the issues that there were, and how can we make things better? 15:01 15:01

183 Q. Which senior people in terms of staff were on the --

A. Well, the Service Manager, myself. I invited medical staff, and I also invited community staff, community senior staff. 15:02

184 Q. If we look down to paragraph 26, which you can just see on screen there, you refer to securing funding for a user consultant. Is that something separate to the carers forum? 15:02

A. No, that's it.

185 Q. That's it. Okay. So can you explain a little bit more about that role of the user's consultant? What was the purpose of that role?

A. Well originally that was for the community, and this was something totally new, and it was really to help to bridge that gap with relatives and carers. I got the funding from the Department for that post, it was initially for a year, and it was to help - because 15:02

there had been issues within the community in relation to day services, as I said previously, we thought this - I thought that this would help in relation to gaining more trust with people, because the trust had broken down, and that they would also support me and how I was going forward in relation to whatever we were wanting to implement and work together in what there was to be implemented. But when the person took up post, we decided because things were happening at Muckamore and there were these issues with families, and families were quite concerned about what was going on, I brought the user consultant on site and in an initial period used them at Muckamore. 15:03 15:03

186 Q. So when did that commence their use at Muckamore, even roughly? 15:04

A. I think that must have been '18, maybe late '17, early '18.

187 Q. And you've described what you hoped they would do, what their purpose was. Can you tell us what they actually did on a day-to-day basis and how they actually engaged with families? 15:04

A. Well they worked with families and they met with families, they met a lot with families and relatives of people that were still in the hospital. They also worked with the advocates. There was an advocacy service provided by Mencap and by - I can't remember the other.. 15:04

188 Q. Bryson? Is it Bryson House?

A. Yes, Bryson. Thank you. And by Bryson. So they met

with them as well, and they went round each of the wards, met with staff, got staff's - what they thought should be happening and help with that. They had - they drew up a newsletter for the hospital on a monthly basis to give as much information as possible to both relatives and to staff in relation to what was happening, not just in Muckamore, but what was happening out in the community as well for people with learning disability. So a very important role. 15:05

189 Q. I'm not going to ask you to say their name yet, but can I ask you first do you recall the name of the user consultant? 15:05

A. Yes.

190 Q. And it was a single person who was in post, is that right, when you were there? 15:05

A. Would I say?

191 Q. It was one person who held that post?

A. One person.

192 Q. Can I ask you just to write down the name for the secretary and then we will see if it's a name that has a cipher or is known to us. And just while that's being checked, can you recall what that person's professional background was? 15:05

A. They hadn't a background in health and social care, I can't remember what their background was, but it didn't matter what their background was for the role. What they - one of the criteria for the post was that they had a relative with a learning disability, or they were a carer for a person with a learning disability, and 15:06

that person had a sister who was using Learning Disability Services in Belfast and had extensive knowledge of learning disability services within the Belfast area.

MS. KILEY: Chair, there is a cipher already allocated to that person. So it's H413. 15:06

CHAIRPERSON: Thank you.

193 Q. MS. KILEY: And after that person was then appointed and was doing the work that you have described, how did you, as Head of Learning Disability Services, monitor how effective that was? So whether co-production increased essentially. 15:07

A. Well, obviously I met with them on a very regular basis, and they had an office at Muckamore, so they were - we met, sometimes it might have been a few times a week. But also the feedback that I was getting from relatives and carers and from staff on the wards was all very positive. 15:07

194 Q. So in your view, as a result of that, the introduction of that measure, do you think that co-production did increase then from where it was when you started post -- 15:07

A. Yes.

195 Q. -- to where it was at the end?

A. Yes. 15:07

196 Q. And then you have also referred, you were asked at Question 6, a little bit more specifically about co-production between Muckamore staff and the community teams. You've answered that at paragraphs 27 to 29.

And at paragraph 28 there you say:

"At a management level monthly meetings were held with the voluntary and community groups and included community and hospital staff to plan the way forward for patients in the hospital who were to be discharged."

Now, is that something separate to the resettlement meeting that you have already described to us? 15:08

A. No, the resettlement meeting was with the other Trust at the same level as me.

197 Q. Yes.

A. There would have been other management meetings, the Service Manager would have met with her counterparts and would have met with hospital and community and maybe voluntary groups in relation to resettlement as well. 15:08

198 Q. So did you actually attend that meeting that you've described at paragraph 28? 15:08

A. I might have attended one or two, but I wasn't a regular attender.

199 Q. And the regular attender was the Service Manager. Is that right?

A. Yes. 15:09

200 Q. Okay. You're then asked at Question 7:

"What were the arrangements for multi-disciplinary team working with patients at Muckamore?"

You answer that at paragraph 30 and I don't have any other questions about that.

And then you're asked at Question 8: 15:09

"What arrangements were in place at hospital level to monitor the implementation of and adherence to Belfast Trust policies by staff at Muckamore?"

And you've answered that at paragraph 31 to 38. You've described a number of tools which you say were used, and I won't take you through all of them, but I want to pick up on the Evaluating Quality Care tool, EQC, and you've already referred to that this 15:09 afternoon, and you refer to that at paragraph 35, if we could bring that up, please? Now you describe that as an audit tool, but can you explain to lay people how that actually helped understand whether Trust policies were being complied with? 15:10

A. Okay. The EQC came from the Equate document. So equate was dead and gone at this stage. EQC was revised in relation to all the tools, and we used standards from AIMS, in-patient mental health accreditation standards, we used those for Muckamore in 15:10 relation to how you would audit, and the tool was developed under different headings, and so it might have been a care plan that you were auditing on a particular ward, or it might have been specific in

relation to incidents, accidents, whatever. But the report - sorry I've forgot your question now.

201 Q. I was asking how EQC essentially worked --

A. Oh, yes, helped with the policies.

202 Q. Yes. 15:11

A. So if you were looking at - if you were auditing in relation to incidents and accidents, the Trust had an overall incident accident policy and the process for reporting and whatever. So if the auditors went to the ward and they were auditing that, they would have had 15:11 the policy with them, and they would have looked at how many incidents, and if the incidents were reported properly, what the process was, and that would have been detailed on their audit reports.

203 Q. And who were the auditors? Were they internal or 15:11 external auditors?

A. So auditors were - it was multidisciplinary and they were on site. We then introduced some staff from the community as well, and two auditors went to each ward. We did an overarching audit yearly of everything, but 15:12 then during the year there would be specific audits. So we might say "For the month of March we're going to do care plans and we'll just audit care plans", we might have taken another month and done something else, or there might be something specific for one ward and 15:12 we might have just gone and done the audit there. So the resource nurse that we talked about earlier, she would have been leading that, and she did the training for the auditors, and the booklet that we had for the

auditors, that would have been through her Department. We then started to go to PDAs and were able to start using PDAs on site.

204 Q. What do you mean by PDA?

A. Like a wee handheld computer. 15:13

205 Q. Okay.

A. Rather than having to write everything down. We started to use those. So they were a multidisciplinary team. There were nurses, there was allied health professions, there was medical staff. 15:13

206 Q. So they could look at things such as whether policies had been adhered to, and care plans is another example you've given.

A. Yes.

207 Q. But is it right to say that the EQC was not a tool that helped evaluate the quality of care or quality of life for patients who were actually in the wards? 15:13

A. It wouldn't have been the quality of life, but it would have determined things like the environment, because there were specific questions about the environment. 15:13 So it would have said about the care on the ward.

208 Q. Okay. So it might have said about the care, but not about quality of life, is that right?

A. No, not about quality of life.

209 Q. And are you aware of any other tools being implemented to assess quality of life of patients on the wards? 15:14

A. There were other tools for the quality of life, but that was mainly being used for patients that were going to resettlement.

210 Q. What were the tools that you can recall?
A. Sorry?
211 Q. What were the tools that were used?
A. I can't remember the names of them. I can't.
212 Q. Were they a questionnaire? 15:14
A. Yes.
213 Q. To check quality of life?
A. Yes, yes.
214 Q. But what you're saying is that they - it wasn't something that was afforded to all patients? 15:14
A. No.
215 Q. Okay. And at paragraph 36, just before we end this section, you refer to having received a report on:

"...incidents/accidents, MAPA, etc, also was used to 15:14 determine if policies were being adhered to. If issues arose these were highlighted and one of the areas looked at was adherence to policies."

Is that the same report that you referred to earlier? 15:15
A. Yes. Yes.
216 Q. That the Core Group received.
A. Yes. So in that report - I'm not sure if you've seen it or not - but in that report it would have, you would have seen how many incidents of MAPA were being used, 15:15 what the position of the patient was in relation to the MAPA, what the hold was, you know, that would have all been documented. And so when that came to the meetings, you know, for instance if a patient was face

down, which shouldn't be face down, immediately that would have alerted you. Why was that happening? That's not adhering to the policy. So things like that would have been in that report, and that would have alerted the like of the Service Manager to see what happened in relation to that ward. So that would have been - say it was a particular ward, you would have went to see that why staff weren't adhering to the MAPA policy.

217 Q. And prior to the revelations that came out later in 2017 arising from CCTV, prior to that period, do you recall issues having been identified from those reports? 15:15 15:16

A. Yes

218 Q. About MAPA? 15:16

A. Yes. Yes.

219 Q. You do?

A. It was a very good report. It mightn't have been the best report, but it was a very good report for giving you an overall feel of what was going on on the wards in relation to some of those issues. Incidents were always the highlight in relation to the number of incidents and why there was so many incidents, and I know over the years that has always been an issue. So you would have been looking at it and looking at how can we reduce incidents? Why is there so many incidents on a particular ward? It might have been a new admission, it might have been a patient that had particular behaviour issues, but there would have been 15:16 15:16

medical staff at the Core Group meeting as well. So they would have taken that away, so that nursing and medical staff would have went away and seen what was the issue in relation to that. So over the years that report evolved. So if we were sitting at the meeting and it said something about an incident, well you would ask for more information, so that information might have been added on. We then started to ask for trends. So we were only getting them weekly. So initially you would have just had that week, the last week's information. So then we started doing them, you know, "give us the four weeks at the end of the month", and then we started to do it month by month. So when I left you were getting the whole year's on a trend sort of analysis. 15:17 15:17 15:18

220 Q. But --

PROFESSOR MURPHY: Sorry, can I ask you - sorry to interrupt - can I ask you, did the incidents across the year start to go down as you were pressing for an re-introduction of day services and so on? 15:18

A. Sorry, I didn't get that?

PROFESSOR MURPHY: You were asking for improvements in day services because they had rather dropped out since you were previously there.

A. Sorry, I can't hear that. I'm sorry. 15:18

MS. KILEY: It's perhaps the microphone. I think you were asking, and you can correct me if I get this wrong, but you were asking for and receiving data, and Dr. Murphy is asking whether the number of incidents

then decreased? I think that's the gist of it.

PROFESSOR MURPHY: Yeah, I was.

A. Yes. We started to see - I mean we started to see the number of incidents decrease when different things were implemented. So the like of PBS you could see in those reports. It also depended on the patients, and new patients coming in might have raised the incidents because they were ill, but you did start to see some changes in relation to the different things that were implemented. 15:18 15:19

PROFESSOR MURPHY: Thank you.

A. Sorry.

CHAIRPERSON: Before we break, could I just ask two things? The audits that you've been talking about, the audits of care plans, maybe we've already got them, but would they be documented? 15:19

A. Yes, yes. And they were documented and brought to the Core Group, and an action plan would also have been drawn up with the ward manager, and that was all documented. So the action plan would have come to the Core Group as well and then you would have given them maybe a month for the ward to implement that action plan, and then it would come back to say whether they had implemented everything or if there was an issue, because there might be issues maybe with the environment or with something else that was outside of the ward's control. 15:19 15:20

CHAIRPERSON: And secondly this, you came into post in 2016. You reintroduced a number of things that had

been there before. You encouraged or brought in Positive Behaviour Support plans, you encouraged more day care, more activities. So by mid 2017 would you have expected all of that to have been well embedded and started or not? 15:20

A. You could start to see more positive, more positivity on site. We also introduced a quality forum as well where staff could showcase what they were doing on the wards. So it was very ward based. And then we had monthly presentations about good things that were 15:21 happening, so you could share.

Whenever I took up post, the hospital for me was very closed. Staff were very wary and didn't appear to be sharing information. So one of the things that I 15:21 wanted to happen was that staff would start to share and learn from each other, and I suppose we started to see that. Now it might have fell away a bit at the end of '17 when things started happening on the site in relation to what the Inquiry are looking at, because 15:21 staffing levels then got really a lot worse than what they were before.

CHAIRPERSON: Well, we may press you on the timing of that in due course, but your improvements should have been taking hold by spring or mid 2017? 15:22

A. Yes. I think I've mentioned maybe in my statement about the walkabouts that I did with the director and some of the stuff that we got from ward managers, and I had done up a wee action plan. We decided - I decided

with the director that I would set up a Task and Finish Group, very specific for a few months, to work with the staff on site in how we could move forward with some of the issues that they had brought up. From that there - that was a very positive group and very positive meeting. From that there we also had listening groups for staff, and the listening groups were confidential where the staff could come along and speak to somebody off site. So, that all contributed to the Task and Finish Group, and then from that I had an action plan in relation to the transformation. 15:23 15:23

CHAIRPERSON: Can I stop you there because I imagine we're going to explore some of this after the break? But we'll take a break now for about 15 minutes.

A. Okay. Thank you. 15:23

CHAIRPERSON: You'll be looked after. Don't speak about your evidence. Okay? Thank you very much. Okay, 15 minutes.

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 15:23

CHAIRPERSON: Thank you.

221 Q. MS. KILEY: Okay, Ms. Mitchell, I want to pick up then at Question 10, please, which is at page 8 of your statement. If we could have that up on the screen. And here you're asked: 15:41

"What were the performance management arrangements for

all staff, including managers?"

And you say at paragraph 45 that:

"Personal development plans were target driven for managers." 15:41

Can you explain to the Inquiry which targets were allocated to managers?

A. Could I explain? 15:41

222 Q. Which targets were given to managers? So what were the targets that managers had to meet?

A. Well things like resettlement. There would have been a target for resettlement. The Directorate had a plan that set out the targets for the whole Directorate. So 15:41 there were things like, you know, what quality improvements, and a target around quality improvements. A target around -- the like of Muckamore would have had a resettlement. Those sort of things.

223 Q. And in fact, is it fair to say the resettlement targets 15:42 would have been significant targets in the Muckamore context?

A. Yes.

224 Q. And just to make sure that we understand it correctly, were managers then also given the target of closing 15:42 beds at Muckamore?

A. Yes.

225 Q. And thinking about the targets then, you've referred to the Directorate plan, but can you help us understand

who sets those targets, who did set them?

A. There would have been planning meetings in relation to the targets, and that would have involved some of the corporate services from the Trust, so people from performance management within the Trust, and they would have had information from the like of the Board in relation to what targets. And, for instance, the resettlement target would have been given to each Trust. So if you had patients in Muckamore, how many need to be resettled within such and such a period of time. We would have been told how many beds to close. So that would have been done at a planning meeting. 15:42 15:43

226 Q. Did you attend planning meetings?

A. I didn't attend them all, just the ones that were specific, because there would have been broader issues as well. 15:43

227 Q. Were you consulted on the targets that were being imposed, thinking particularly of resettlement, were you consulted on that and asked whether you felt that they were realistic, for example? 15:43

A. Well we would have, we would have been able to say, you know, "that's not achievable. We haven't got, you know, the resources in the community to do that", so you would have been able to - I'm not sure that the targets would have changed, but you would have been able to note that you had an objection to it. 15:43

228 Q. Do you recall objecting?

A. I don't. I don't recall that.

DR. MAXWELL: Can I ask two things? Firstly, was

anybody on performance related pay?
A. In 2016, no. That had all stopped.
DR. MAXWELL: But previously there had been performance related pay.
A. Previously there had been. 15:44
DR. MAXWELL: So somebody's pay might have been affected by achieving some of these targets?
A. Yes, yes. I mean I was on performance related pay going back a few years before that, but I can't remember when it stopped. It might have been when we 15:44
went into the Belfast Trust, but I know that whenever I was in North and West Belfast Trust we had performance related pay, and every year you had a meeting about your performance and what percentage you would be given. 15:44
DR. MAXWELL: Which related to whether you had met the targets in your --
A. Yes. Yes.
DR. MAXWELL: And, secondly, resettlement is quite complex because you're managing the service that's 15:45
providing care, but in order to resettle them in the community a completely different organisation has to provide the infrastructure. So how -- is it -- how do you get managed as a manager at Muckamore on resettlement targets if you perceive the problem is 15:45
that another Trust hasn't --
A. Well each Trust had a target. So say -- Belfast Trust had the most patients in Muckamore. So say we were asked to do, say for instance 10 patients to be

resettled in the next month, another Trust might have had two. So that would have been our target. They may have gone into some of our services within the Trust in Belfast. We had residential and supported living services, which I managed as well, in the community. So some of the patients may have gone there. But as I say, I worked very closely with the voluntary and charitable organisations, and they would have been very supportive.

DR. MAXWELL: Yeah. I'm just coming back to setting targets for managers. So the targets for resettlement at Muckamore were only about resettling Belfast Trust patients. 15:46

A. Yes. Yes.

DR. MAXWELL: So the Northern Trust patients, you wouldn't have been managed on how quickly they got resettled? 15:46

A. Well, that was part and parcel. And the meeting I had on a monthly basis with the other Trusts, I met with the other Heads of Learning Disability from the other Trusts on a monthly basis, and we would have discussed those at that meeting. 15:46

DR. MAXWELL: But I'm thinking about your PDR and the target --

A. You're thinking about? 15:46

DR. MAXWELL: Your personal development plan and the target that was set for you personally. Did that include patients from other Trusts?

A. It would have included how many beds we had to close

within the hospital.

DR. MAXWELL: So it was --

A. Yes.

DR. MAXWELL: -- meeting that target was dependant on the actions of other Trusts as well? 15:47

A. Yes. Yes. Yes.

CHAIRPERSON: Can I just understand what the targets for a manager would look like. Do you say to a manager at the beginning of the year "Right, your target is to resettle 10 patients"? How does it work? Did you hear 15:47 me or not?

A. Yes, I did hear you.

CHAIRPERSON: I beg your pardon. I'm sorry.

A. I'm just trying to think. I'm just trying to think.

CHAIRPERSON: I'm sorry. 15:47

A. Could you just say it again?

CHAIRPERSON: Yes. Well, what sort of target do you give a manager for resettlement? Do you say "You've got to resettle eight patients this year"? Is that a target? 15:47

A. Well, the plan was for reducing the number of beds within the hospital.

CHAIRPERSON: Yes.

A. And the hospital was going to become an assessment and treatment unit, rather than having delayed discharges 15:48 and people that had been there from going back maybe 30/40 years.

CHAIRPERSON: Yeah. I understand.

A. So to get down to the assessment and treatment model

that was planned, the targets were then driven in relation to getting the beds down. So we would have been told how many beds roughly to get closed within a period of time.

CHAIRPERSON: Who would have told you? 15:48

A. That would have come from the Board.

CHAIRPERSON: Right. Okay. So the Board says to you "This is your target".

A. My targets?

CHAIRPERSON: And then you say to a manager "This is your target", is that right? 15:48

A. Yep, yep. Yes. Well we had personal development plans and you would have discussed that on a regular basis. I would have discussed mine with the director, and the senior managers would have discussed theirs with me, 15:49 and those targets in that plan would have been what was going on and what was planned for the year ahead.

CHAIRPERSON: Yeah. I mean giving a target like that to a manager, do you think it helps?

A. I think they need to understand why its happening 15:49 rather than being helpful. I mean it was something that had to be done. I mean Muckamore - people shouldn't live their lives in a hospital, and we had Equal Lives, and we had a Bamford Review and, you know, people have much better lives out in the community. 15:49

CHAIRPERSON: I understand the concept of resettlement, I assure you. What I'm trying to get to the bottom of, and it's really the point I think Dr. Maxwell was also trying to see, if it's not in the manager's hands --

A. Yep, yep. But the managers, the managers were fully versed with what was happening in Muckamore. The staff on the ground may not have been, but the managers would have been versed on what was happening in relation to the whole change in Muckamore. 15:50

CHAIRPERSON: Right. Okay. Thank you.

229 Q. MS. KILEY: And in answer to one of my earlier questions, you said that you can't recall objecting to targets. Just to be clear about that, does that mean that you didn't have any concerns about the 15:50 achievability of targets that you were given?

A. We always had concerns about achievability, because it really was about the resources, and we may - and many - I mean I'm sure you will see in the documentation that many targets were not achieved, especially in relation 15:50 to resettlement, because there wasn't the resources in the community to resettle people.

230 Q. As Head of Learning Disability, whenever those targets were given to you in your role, did you not say "Hold on, this is unrealistic, and here's why"? 15:51

A. Yes, and as a group of Heads of Learning Disability from the other Trust, we made objections known to the Boards in relation to how achievable they were.

231 Q. What was your mechanism for doing that?

A. Through the meeting that I talked about earlier. 15:51

232 Q. That planning meeting?

A. No, the meeting with the other Heads of Learning Disability, and the Board attended that as well, that we had on monthly basis.

DR. MAXWELL: Do you mean the HSCB Board or do you mean Belfast Trust Board?

A. Sorry, yes, I know. The Eastern Board.

DR. MAXWELL: The HSCB.

A. Yes, yes. Yes. That's what it became known as, yes. Rather that Trust Boards. 15:51

DR. MAXWELL: Yes. So did you also inform the Belfast Trust Board that there were problems?

A. Well, that would have went up through the director.

DR. MAXWELL: But you would have assumed that the director would have been informing the Board there were problems with these targets? 15:51

A. Yes, yes.

233 Q. MS. KILEY: At paragraph 50 then you refer to Learning Disability Services being part of the NHS benchmarking network: 15:52

"...which compared services throughout the UK in relation to standards and patient outcomes."

15:52

I just want to understand a little bit more about that. Can you tell the Inquiry what the purpose of that process of benchmarking was?

A. There was a network in the UK in relation to UK benchmarking, and it had 49 Trusts as part of that benchmarking network, and we - I can't remember the year, but it was before I took up post we were already part and parcel of it, I think probably the year or two before we joined it. I think there was one other Trust 15:52

in Northern Ireland that was part of it, because it was mainly the rest of the UK rather than just Northern Ireland, and what we had thought was that we could look at areas to benchmark ourselves against in relation to the things within learning disability, and it wasn't just specific to Muckamore, it was Learning Disability Services, and I know that the Trust also did it within mental health services. 15:53

234 Q. Can you give some examples? What was being benchmarked? So what standards were you looking at? What areas in respect of Muckamore? 15:53

A. I can't remember. No, honestly, I really can't remember at the moment.

235 Q. Okay.

A. We had a person that led on that within the Trust, a service improvement manager, and she led the work on the benchmarking and did the training with staff and the collection of information. It was done on a yearly basis. I think we had two or three audits by the time I left, I think there was two or three audits in relation to that benchmarking. 15:53 15:54

DR. MAXWELL: And usually the NHS benchmarking service tells you if you are in the upper quartile, the middle quartiles, or the lower quartile. Can you remember --

A. I know we weren't in the lower quarter. 15:54

DR. MAXWELL: Do you know where you --

A. I can't remember. I can't remember.

DR. MAXWELL: Okay. But this information should be available somewhere in the Trust?

A. Oh, yes, yes. I mean there was a report in relation to it. The UK benchmarking sent you information back on where you were in relation to the other Trusts.

DR. MAXWELL: Yeah.

A. Now, I do remember that there wasn't another hospital comparable with us, but we were taking bits of it in relation to it, and bits of it from learning disability community. 15:54

236 Q. MS. KILEY: Okay. I want to move on then, Ms. Mitchell, to Question 11 at page 9, please, and you were asked: 15:54

"What opportunities were available for the professional development of staff at Muckamore?" 15:55

You answer that at paragraph 53 to 56, and you explain various training programmes which you say were available to staff. But the Inquiry has heard that from at least 2017, protected time wasn't available for training, and training ultimately had to be foregone in some circumstances because of the pressures on staffing. Were you aware of that in your time? 15:55

A. No, I wasn't aware of that, ehm, and the only thing I can think of is that because of staffing levels. But each staff member was given time for their own personal development and professional development, and there was numerous courses within the Trust for staff that they could apply to go. Now it would have been - they go through their line manager, so, you know, "I'd like to 15:55

go on this particular course and it's in a month's time", and you ask your line manager, and the line manager approves or disapproves. But in most cases, you know, it would have been approved. There were also courses outside the Trust, obviously by professional bodies like the Royal College of Nursing or wherever, and staff would have availed of those as well. We also had the Beeches Management Centre, where a number of especially management courses would have been held. So, ehm, I wasn't aware that the staff weren't getting to the courses. 15:56 15:56

237 Q. And in your experience then as Head of Learning Disability you've described the training available, but are you saying that you recall staff getting that time and being able to take up that training? 15:56

A. Yes, yes.

238 Q. Yes.

A. I mean I would have signed forms for staff as well, you know, staff that were reporting to me, numerous courses for them and signed them off. So I wouldn't have been aware of the staff in Muckamore not having. 15:57

DR. MAXWELL: And is there an electronic staff record where this would be recorded?

A. I'm not sure if its electronic. I couldn't be 100%. There was a form done and that went to Human Resources, and whether Human Resources put that on electronic, I'm not aware. 15:57

DR. MAXWELL: But it would have gone on somebody's time sheet if they were absent for the training?

A. Yes. Yes.

DR. MAXWELL: So the Trust will have records of people who were off the ward for training?

A. Yes. Yes. Yes.

239 Q. MS. KILEY: You also address staffing in answer to Question 12, and your answer there appears at paragraph 57 onwards. Yeah. So at paragraph 57 you say: 15:57

"When I took up post in 2016 there was already concerns at Trust level about staffing levels, with many staff working extra shifts and bank staff were employed to fill gaps in duty." 15:58

Do you recall that as something that was discussed at Directorate level? 15:58

A. Yes.

240 Q. Whenever you took up post?

A. Yes. And had been previously as well at Directorate meetings. I would have attended the Directorate meetings previously as well in a different role, and they would have been -- staffing levels would always have been on the agenda. 15:58

241 Q. Do you recall if they were on the Directorate Risk Register?

A. Yes. 15:58

242 Q. They were?

A. They were on the Risk Register.

243 Q. Can you recall how they were rated?

DR. MAXWELL: Whether they were red, amber, or green?

A. I would have thought it would have been red, but I mean I haven't access to them, so I don't know.

244 Q. MS. KILEY: The Inquiry has heard evidence that staffing levels were red rated at the service area since 2012. 15:59

A. Mhm-mhm.

245 Q. But what you're saying is they were on the Directorate Risk Register and you think that they were red, but you couldn't be totally sure of the rating?

A. Yes, yes. 15:59

246 Q. Okay. And returning to those discussions that you said that took place at Directorate about this, did the discussions about issues with staffing levels translate into discussions about concerns of the impact of that on patient safety? 15:59

A. Yes, it did. And I mean that was one of the reasons I think that day care at times were closed, so that there would be enough staff on the ward. I know that it was highlighted at the Divisional Nurses meeting as well with the Director of Nursing, and it was also discussed 16:00 at Directorate level.

247 Q. And as Head of Learning Disability, were you ultimately responsible for patient safety at Muckamore?

A. That would have lay with the Service Manager. The Service Manager was based on site and had overall 16:00 management on site, and then she reported to me. So what she reported to me, if it was an issue then I reported up my line.

248 Q. And did you have concerns about how staffing was

impacting on patient safety at Muckamore?

A. Well, yes, I did. I mean that was one of the reasons why we implemented some of the things that we did, the like of the day care, and brought in day care services. There were things that you were concerned about in relation to patients on the wards and being on the ward together. 16:00

249 Q. And I think in fairness you have some statistics on that in the exhibits which I will come to. But just sticking with your statement for now. At Question 14 you were asked specifically about seclusion and: 16:01

"What arrangements were in place at hospital level to monitor the use of seclusion at Muckamore?"

16:01

And you answer that at paragraph 66 onwards.
And you have described the introduction already of Positive Behaviour Support. But, in essence, you're saying there that seclusion was one of the topics?

A. Yes. 16:01

250 Q. That formed part of the report that was received by the Core Group, that's right?

A. Yes.

251 Q. The Inquiry has also heard about patients requiring low stimulus, which was sometimes in the seclusion room. 16:01
You're familiar with that term?

A. Yes.

252 Q. And are you aware whether the use of low stimulus was monitored in any way?

A. Yes, it was.

253 Q. How was that done?

A. That was on that pro forma that we received at the Core Group meetings. So that was -- all the low stimulus was highlighted there as well. 16:02

254 Q. And was that as something separate to seclusion or did that --

A. It was part of seclusion. It was seen as part of seclusion, and would have been recorded as that, but it recorded as low stimulus. 16:02

255 Q. So it was recorded as low stimulus but --

A. Part of the seclusion report.

256 Q. Okay. At Question 15 then, if we could turn to that please, page 11. You can see there in front of you, you were asked: 16:02

"Please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of the action taken at management level to address such concerns?" 16:03

And at paragraph 71 you say:

"In 2017 was notified of incident viewed on CCTV which has led to this Inquiry." 16:03

Could you elaborate please, Ms. Mitchell, on when and how you came to know about the incident viewed on CCTV?

A. Ehm, the incident that has led to this?
257 Q. Yes, and what you're referring to at paragraph 71?
A. The Service Manager informed me about it a couple of weeks - maybe three weeks after it happened.
258 Q. And you've already explained to me that you considered that the service manager was primarily responsible for patient safety, but she accounted to you, isn't that right? 16:03
A. Yes. Yes.
259 Q. And, so, having a level of responsibility of that kind then, can you tell the Inquiry how you felt whenever you were informed of that incident? Was it a shock to you? 16:03
A. Well, I heard about the incident before we knew that it was recorded on CCTV. So I was told that the person that had reported it had went off on leave and had gone off and not reported it, and then had reported it, and then it came up to the Service Manager and the Service Manager informed me. I didn't know about the CCTV for maybe another three weeks, because I went on leave, I was on holiday, and I didn't know until I came back that there had been CCTV for the incident, because at that stage we had thought that the CCTV wasn't live. We were waiting for it to go live on the 11th September, and there was work being done in relation to consultation process and policy in relation to it going live. But as far as I'm aware that the contractors who had installed the CCTV had left it running, and I didn't know that until I came back from leave. 16:04 16:04

260 Q. So when you came back from leave you discovered that there was CCTV, and presumably that was a shock because you didn't know that it had been running. But you again were Head of Learning Disability Services at the time, so can you describe a little bit more about the actions that you took?

A. Well, the actions, the actions had been -- because the CCTV had been viewed before I came back, actions had already started immediately whenever it had been viewed, as in the incident, the incident itself had been reviewed. So the actions had already started. The director had taken responsibility while I was on leave for those actions.

261 Q. Okay. So it took on a course whenever you were away?

A. Yeah. Yeah.

262 Q. But you were informed about it presumably whenever you came back?

A. Yeah. Yeah.

263 Q. And ultimately we know that it was more than just one incident, you've referred to being informed of the first incident, but ultimately we know that it was more than just one, and you continued to be Head of Learning Disability Services until 2019, and you have described various measures that you implemented to try and address issues at Muckamore. You've described increase in opportunities for day care, walkabouts, and the various measures that you've discussed this afternoon. But in becoming aware of the issues that were captured on CCTV, did you or have you since reflected on how

that could have happened in a situation where you were implementing the measures that you have described to us?

A. How the incident could have happened?

264 Q. How the number - number of incidents and the level of abuse that took place happened at Muckamore? 16:07

A. I mean all I can say is CCTV is a wonderful thing. You know, you do walkabouts and you don't see any of this, you're told things and whatever. But I, from I took up post in 2016, there were a series of things that alerted me that something wasn't right on site, and I think I have given you that information, and I never ever thought it would be what has transpired. I never would have thought that. Ehm, shocking. 16:07

265 Q. And is that a feeling that you had at the time or that you're reflecting now? 16:08

A. At the time I knew things weren't as they should have been when I took up post because of the walkabouts, and if I could refer to my bits and pieces here?

266 Q. Yeah. These are the notes that you have taken? 16:08

CHAIRPERSON: It may be paragraph 72 onwards?

A. I mean it started of in December. I took up post in November '16, and December '16 we had an RQIA visit to Erne Ward.

267 Q. MS. KILEY: I'm just going to pause you because I think you're looking at one of your exhibits I think, which we can bring up on the screen so everyone can see. 16:08

A. Yes.

268 Q. Can we bring up page 15, please? Is this the document

that you're looking at?

A. Yes.

269 Q. Is this a document that you prepared?

A. Yes.

270 Q. And when did you prepare that, can you recall? 16:09

A. I think that was July. Is that one dated? I did two. I did one in July and one in November. The second one is November.

271 Q. What was the purpose of these documents?

A. It was to give to the director after we had done 16:09 walkabouts, and really to advise how I felt about issues that had happened, and to try and set it out that it wasn't just one or two things that were happening, there was a number of things happening.

272 Q. So if this was prepared in July 2017 then, is that 16:09 because you had concerns? It's noted issues of concern.

A. Yes. Yes.

273 Q. And you wanted to document those. Is that right?

A. Yes. 16:10

274 Q. And you were referring I think to the December '16 entry?

A. '16, yes.

275 Q. And what did you want to tell us about that?

A. There was an RQIA visit to Erne Ward, and I got a phone 16:10 call from RQIA to say that they were very concerned that -- there had been a previous inspection six months before and the recommendations hadn't been implemented from that inspection, and in fact things had got worse

on Erne Ward. They felt that there was very poor management, and they were considering special measures for failure to comply, and they sort of gave me 24 hours to have an action plan or what we were going to do. So I spoke to the Director. The Service Manager was off on leave at this stage. I spoke to the Director, and at the time there was no Ward Manager, and the Ward Manager had just I think retired. So we put in a Ward Manager and we done an action plan up, and then I met with RQIA in relation to it and we got the failure to comply notice. We got a reprieve for a month to get the action plan implemented. And that really alerted me, you know, why in six months were things not done? And they were fairly simple things that could have been implemented easily. I mean they were things like the ward needed painted. It wasn't very clean. You know there were simple things that should have been done that weren't done. So we set about a plan and how we were going to fix it. 16:11 16:11 16:11

276 Q. And that was December '16, and that was in respect of Erne Ward specifically, isn't that right? 16:12

A. Mhm-mhm.

277 Q. And then there are a number of other concerns recorded in this document. At what stage did you say that you had become aware -- that you had wider concerns? So beyond Erne Ward, did you develop wider concerns and, if so, at what stage would that be at? 16:12

A. When the ward managers came to me directly to say about their concerns, and then I received a number of

anonymous letters.

278 Q. Yes. This is what you talk about at paragraph 73 onwards of your statement?

A. Mhm-mhm.

279 Q. And you refer to receiving an anonymous letter in February '17, and then you say ward managers highlighted concerns in March '17. Is that what you're referring to when ward managers came to you? 16:13

A. Yes.

280 Q. And you refer at paragraph 75 to several subsequent anonymous letters. Now, I should just pause here, Chair, to say - and Ms. Mitchell as you know, we have - the Inquiry has asked you for help in locating the letters that you have referred to at paragraphs 73, 74 and 75, and the Inquiry has also asked for Belfast Trust's assistance in locating those and related material. I should say, Chair, that is a process which is ongoing from the Inquiry, and the Inquiry will of course carefully consider any material it receives, and will consider whether any further action is necessary in respect of that material, including disclosure. But we don't have the documents today. I'm not going to ask you about the detail. But are you saying then that that anonymous letter that you received first in February '17 was the first occasion on which you became aware of wider concerns beyond Erne? 16:13 16:13 16:14

A. Yes. Yes. And there were quite a number of letters, and some were signed, and the last one that I received would have been around about August '18, which came --

it was a letter signed by all the Ward Sisters to me voicing concerns.

281 Q. And if we return then to the chronology, and if we could just zoom out on that page, please? Zoom out so we see the entirety of page 15. So you can see that you have recorded in February '17 "received anonymous letter", and then in May '17 it's said there is the first visit of Director of Adult Social and Primary Care and Head of Disability Services, and you walk around specifically to speak to staff. So if you first became aware of wider issues in February, why did the first walkabout only happen in May? 16:14 16:15

A. Well, that would have been the walkabout with the Director. What had happened was, when we received - when I received the letter - the letter was addressed to me and to the Director. It wasn't just to me. 16:15

282 Q. Yes.

A. The Director and I met about it, and then we involved the Director of HR, the Director of Nursing, and had a meeting with them to decide the way forward with anonymous letter. And a meeting was then held with the person that it was about, and a number of actions were agreed at that time. I know what you're asking me, why did it take from March to May to do a walkabout? 16:15

283 Q. Yes. Yes. So perhaps another way to put it is, what was the purpose of that walkabout in May '17? Why did you take that action at that time? 16:16

A. Well, because people, other -- other than the anonymous letter there was other issues that had come forward

from staff, plus that director at that time hadn't been long in post and didn't know Muckamore, so it was like two-fold that we would do a walkabout together on the site.

284 Q. So is it right to say then that part of the purpose of that May '17 walkabout was in response to concerns that you knew that staff had about management and leadership of the site. Is that fair? 16:16

A. Yes. Yes.

285 Q. And then if we can go on to the next page, please, page 16, we can see that there was another walkabout in July. But just - I'm not going to go through all of these entries, but underneath there is a record of MAH absence rates. If we could look at that, please, if we could zoom in on that portion? 16:17

A. Yeah.

286 Q. Now just to locate us in time, it's talking about "currently", so that's at the time of drafting, is that right, July '17? And it's recorded there:

"Currently 10%. Has ranged over the year from 9.9% to 10.30%. Target is 6.2%. Main issues: Long-term ill-health, mental health issues and stress." 16:17

Is it fair to say that one of the issues that was impacting on staff absence was level of stress and anxiety across wards, is that fair comment? 16:18

A. Yes, yes, yes.

287 Q. And is that something - when - at which point in time

would you say that you became aware that that was an issue that was impacting on staff absence?

A. Probably when I did the walkabouts with the director.

288 Q. So that earlier one in May '17?

A. Mhm-mhm. 16:18

289 Q. And what I'm trying to understand, Ms. Mitchell, is this was May '17, and as you know the later incident that we have already discussed which led to the Inquiry and later CCTV revelations came later in 2017, so what was done in order to deal with the leadership and 16:18 management issues that you were aware of from February '17?

A. We set up the Task and Finish Group in relation to a very specific piece of work, and the Task and Finish Group, part of one of the things that we set about 16:19 doing was listening groups for staff, where they could go and speak to people who were independent of the hospital and voice any concerns.

290 Q. And just to pause you, I'm going to come on to this because we have some of those documents in the bundle, 16:19 but just to be clear, what was the purpose of the Task and Finish Group, if you could summarise that?

A. I have it somewhere here because I was trying to...

291 Q. You say in fairness --

A. Yes, the priorities were the workforce, communication, 16:19 and staff engagement. That was the three main purposes.

292 Q. And I think in fairness to you, you say at paragraph 77, just to refresh your memory that:

"...the Task and Finish Group was set up chaired by myself and with representation from all wards to try and address the issues of concern."

16:20

So they are the issues of concern about staffing and absence rates, the type of issues that you've recorded on this chronology, is that right?

A. Mmm.

293 Q. And we do have some of the documents from the Task and Finish Group in the bundle of documents that you had been asked to look at before coming to the Inquiry. 16:20

A. Yes.

294 Q. So if we could bring that up, please? That's MAHI-Mitchell-M bundle. If we could go to page 68, please? If we can just zoom in there? These are the Terms of Reference for the Task and Finish Group, and if we just scroll down: 16:20

"Key objectives are workforce. To develop and implement a workforce strategy that takes cognisance of retention of staff, movement of staff on site, skill mix, opportunities for staff." 16:20

The next heading is: 16:21

"Communication:
To develop and implement a communication strategy for Muckamore site that will address how we communicate

with each other, what is communicated, and how the communication can be two-way."

3: Staff engagement:
To develop and implement tools to support and encourage staff engagement at all levels." 16:21

And then there is a list of membership.
If we could just scroll back up to the page above, please? Thank you. So does that accurately describe then -- 16:21

A. Yes.

295 Q. -- what you sought to achieve whenever you were developing the Task and Finish Group?

A. Yes. Yes. 16:21

296 Q. We do have the minutes of the group, and you saw there a list of representation. I don't intend to take you through all of those, but the representatives of the group included yourself as Chair, Service Manager. There were representatives from the nursing and clinical staff, from corporate staff and Human Resources, and governance representatives as well. Isn't that right? 16:22

A. Mhm-mhm.

297 Q. And if we could just scroll back up to the index, please, so the first page? Scroll down to the next page, please? That's it. If you just pause there. I'm not going to take you through all the minutes of these, but we can see here that it appears that the 16:22

group met between the 31st July 2017 and the 18th December 2017. Does that ring a bell?

A. Yes.

298 Q. That's around the time period?

A. Yes, yes. It was time limited. The Task and Finish Group was very time limited, and from that then we set up the Transformation Group. 16:22

299 Q. Yes. And the Transformation Group then was to look at implementing what the Task and Finish Group had --

A. Well the Task and Finish Group had implemented quite a few things, and it had done some of the work already, but the transformation -- other things came out -- from that Task and Finish Group other things that couldn't have been done within the six month period. So the Transformation Group was really to take things further. 16:23

300 Q. Well, I'll come to that, if you don't mind.

A. All right.

301 Q. But just sticking with the Task and Finish Group.

A. Okay.

302 Q. One of the things that you referred to earlier was listening groups that took place at Muckamore? 16:23

A. Yes. Yes.

303 Q. And that was part of the work of the Task and Finish Group, isn't that right?

A. Yes. 16:23

304 Q. So if we could go to page 99, please, we have here a paper entitled: "Report on listening groups - Muckamore Abbey Hospital". So is this something - this is a report that was authored as part of the work of

the Task and Finish Group?

A. Yes.

305 Q. Did you specifically write this report?

A. No. No. That would have been done by the people that were involved with the focus group. 16:24

306 Q. Okay.

A. So the three people that are named there.

307 Q. And if you can just scroll down then to "Methodology", again I won't go through it all, but in summary it's right to say that listening groups took place where 16:24 staff could come and communicate their concerns about what was happening on the wards so that you could understand those?

A. Yes. Mhm-mhm.

308 Q. And if we scroll down to page 100, please? Just pause 16:24 there. At the top there, there commences a summary:

"There is no career pathway within LD nursing. If nurses don't go into management there are limited opportunities for professional development. Staff are 16:24 having to leave Muckamore in order to develop. Many staff have left recently to undertake health visiting training and many have left to take up posts on general wards within the Ulster Hospital. Muckamore was not perceived by the staff as a place for career 16:25 progression. The training of student nurses was highlighted as an issue."

And then in the final paragraph:

"Linked in with this is the fact that some wards have poor experience mix with too many inexperienced staff starting in one area at the same time."

16:25

So scroll down then to the next heading, there's a reference to a disconnect - just back up, please? There's a disconnect between ward staff and senior management. And then scroll down again, there were issues raised about staff support. Again, I'm not going to go through all of these, but if we scroll down, please, to the next page, and the roster. And scroll down to the next heading, please?

16:25

"Issues were raised about information technology and infrastructure."

16:25

And then if we go to the conclusion, please. It's recorded that staff were welcoming and receptive of the process. There was excellent participation. And then it is said there:

16:26

"There was no engagement from senior management."

That's at the final sentence of the second paragraph. Was there a reason for that? Were senior managers asked to engage?

16:26

A. Everybody on site - it was for everybody, it didn't matter where you worked, anybody on site could go, and

it didn't matter what grade you were, it was for everybody.

309 Q. But that record really tells us that whilst it was for everybody, not everyone took it up, isn't that so?

A. They wouldn't engage. That's right. 16:26

310 Q. So senior management didn't engage in this process. And did you ever understand a reason for that?

A. No.

CHAIRPERSON: When you're talking about senior management... 16:26

A. Sorry?

CHAIRPERSON: When you're talking about senior management...

A. Yes.

CHAIRPERSON: Who are you referring to? What level? 16:27

A. The senior nurse managers, I would have thought should have attended, and they didn't.

MS. KILEY: And --

DR. MAXWELL: Can I just ask? This document isn't dated. Do you know when it was written? 16:27

A. When it was written?

DR. MAXWELL: Mmm.

A. Ehm, that would have been in '17.

DR. MAXWELL: But when in '17? I'm wondering if it was written after the revelations? 16:27

A. No. No, it was before. If I'm right, I think it was before. Is it not dated?

311 Q. MS. KILEY: Well, it's not dated, but within these documents we could see that it was considered at a

meeting of the Task and Finish Group of the 27th November 2017. So this forms part of the papers that were said to have been presented to the Task and Finish Group on 27th November 2017. So just to be clear, when do you place this report as having been authored; before or after the CCTV revelations?

A. I don't remember.

DR. MAXWELL: Because their willingness to engage may have changed after the...

A. Sorry? 16:28

DR. MAXWELL: The willingness to engage may have changed after the revelations?

A. Yes, it may have. Yes. Mhm-mhm.

312 Q. MS. KILEY: If we just look at the final paragraph on that page there in the conclusion: 16:28

"Flawed communication and engagement processes within Muckamore have resulted in staff feeling unsettled and undervalued. While there were examples of excellent nursing leadership recorded with particular reference 16:28 to two individuals, there is generally a perceived lack of nursing leadership within Muckamore Abbey Hospital."

If we just go to the next page, please? There is -- I'll come back to the next page. I think that forms 16:28 part of an action plan, isn't that right?

A. Yes.

313 Q. So just to be clear what happened with this report. It's presented to the Task and Finish Group, it seems?

A. Mhm-mhm.

314 Q. And then there was an action plan created, isn't that right?

A. Mhm-mhm.

315 Q. Who was responsible for the creation of the action plan to address those issues? 16:29

A. Me.

316 Q. Okay.

A. As Head of Learning Disability. It went then - we took it to this new group, the Transformation Group, and that's where it was presented, and then actions developed from it. It also was sent to the Director and the Director of Nursing - the Director of Adult, Social and Primary Care and the Director of Nursing. 16:29

317 Q. The listening group report was sent to that? 16:29

A. That report.

318 Q. Okay. And you refer to the Transformational Group. We do have minutes of those meetings in here. So if we look at page 142 of the bundle, please. You can see the minute of the Transformational Group dated 5th February 2018, and if we could just scroll down, please, to page 143, the Terms of Reference of this group are noted? If you can scroll up a little bit, please? That's it. Sorry, it's just there. 16:29

16:30

"Ms. Mitchell explained the background to the group and outlined the Terms of Reference: To effect change in a collaborative forum, to communicate to all staff, to ensure that patient's needs are at the centre of change

to implement the modernisation of hospital services."

And if we scroll down then to page 145, please? We see a document entitled "Task and Finish Group - Muckamore Abbey Hospital Action Plan 2018". So is this the action plan that you authored?

A. Yes.

319 Q. This is the action plan?

A. Yes.

320 Q. And it's presented to the Transformation Group, and is it fair to say then the role of the Transformation Group was essentially to take this forward? 16:31

A. Yes.

321 Q. And to try and deliver these actions?

A. Yes. Yes. And Task and Finish Group also included the unions from the hospital site as well. We included them because there was so much change happening, and so not only was it multidisciplinary, it also involved staff side and unions. 16:31

322 Q. And if we can just scroll down - I'm not going to take you through all of these, but you can see recommendations in respect of retention and recruitment, and various actions, "Workforce stabilisation". If we scroll down? "Communication", "Engagement", "Staff", "Ward Recognition". This all comes after the CCTV revelations? 16:31

A. Yes, yes, yes.

323 Q. So did it come too late?

A. Probably. Probably. Ehm, should have been done a long

time ago.

324 Q. And when you say it should have been done, reflecting back on that time, do you think that there were missed opportunities to have done this sort of work prior to the CCTV revelations? 16:32

A. I think because the hospital was changing and staff were unsure of what was happening to them. There was very poor communication on site, so I think as I've said before, staff were very much on their own wee ward based silos, and I think if more had have been done in 16:32 relation to communication with staff and bringing staff along, we may not have been in the situation.

325 Q. And ultimately how you - you responded by referring us to the Task and Finish Group and the Transformational Group, that came about because I asked you were you 16:33 shocked whenever you first heard of the incidents that you now know about. You've put that in context for us, and we can see what your knowledge was at the time. So knowing about the staffing issues that were taking place at the time, were you shocked whenever you heard 16:33 of these incidents?

A. Of course. I just thought it was incredulous. I could not believe and, you know, it kept stacking up, and I thought "how did none of us see this when we even did our walkabouts or whatever?", you know. It was 16:33 shocking and still is shocking for me.

326 Q. And, again, either then or on reflection, have you considered whether the measures that you have described, so the walkabouts and the reporting

mechanisms, were effective, bearing in mind that it did come as a shock to you?

A. I did see things starting to change with staff, especially with the staff communication, but I would have to say, and in my own reflections about all that has happened, if you go back to 2007 before we joined the Belfast Trust, North and West Belfast Trust joined the Belfast Trust, we were a Trust of 5,000 staff, everybody practically knew everybody else. Muckamore would have been the only hospital within that small Trust, and it would always have been on the Director's agenda. It would always have been on the Board agenda. We went into Belfast Trust in 2007 to a Trust that was 22,000 staff, and was primarily an acute Trust with major hospitals in Northern Ireland really at the hub. So Muckamore and Learning Disability Services, I felt, and a lot of staff felt, were at the bottom of the pile and it wouldn't have been seen as a priority. The acute services would have been the priority. 16:34 16:35 16:35

327 Q. Wouldn't have been seen by whom as a priority? 16:36

A. By the Trust and the Trust Board.

328 Q. And so do you consider that those structural changes of the Trust and the amalgamation to a bigger Trust were of detriment to Muckamore Abbey Hospital?

A. Definitely. Definitely. 16:36

CHAIRPERSON: When you say you thought the learning disability was at the bottom of the pile, what are you referring to? Do you mean the financial pile, or the focus pile, or what?

A. If you look at the Trust, the Trust is made up of acute services, and then there are community services, and then you have mental health and learning disability, and mental health would have been slightly higher than learning disability in relation to the focus of the Trust, and that in turn relates to resources.

CHAIRPERSON: So it is focus and it is resources. LD services being at the bottom of the pile?

A. Yes. Yes.

329 Q. MS. KILEY: Can I, just before we move on from the documents, clarify that the two letters or notes of concern that you have exhibited to your statement, one of them you dated July 2017. The second exhibit, can you tell us when that was prepared? 16:37

A. I think it's November. 16:37

330 Q. November. And can you just clarify who you presented those to?

A. Yes. Both sent to the Director of Adult Social and Primary Care. The second one was done in relation to, there was a new director appointed at the end of 2017, and she asked me for an update, and that was what the second one was. 16:38

331 Q. Okay. At the end of your questions about the operational management --

DR. MAXWELL: Sorry, before we go there can I just ask a question about this bundle? So on page 74 there's an MAH roster analysis that isn't dated. Can you remember when that was done? It was part of your Task and Finish Group? 16:38

MS. KILEY: If we can bring that up, please? Page 74.
DR. MAXWELL: Page 74 of the bundle, yeah.
MS. KILEY: If you just - it should be in front of you.
DR. MAXWELL: So when was that written?
A. The roster analysis? 16:38
DR. MAXWELL: Yes.
A. We had people from corporate nursing attended the Task and Finish Group, and they came along and did that whole exercise on rostering. I am not familiar with when it was introduced, so I wouldn't know the detail 16:39 of that.
DR. MAXWELL: So if I can help you? It says in the second paragraph:

"The shifts not covered in the roster commencing 13th 16:39 November to the 10th December..."

So do you think that is November to December 2017.
A. Well that must have been -- I think that must have been '16. 16:39
DR. MAXWELL: So you think it might have been '16? So if we scroll down to what they say about Cranfield 2 in paragraph 4, they look at the funded establishment, and it's half --
A. Sorry? 16:39
DR. MAXWELL: The funded establishment for Cranfield 2, on the fourth paragraph down.
A. Yes. Mhm-mhm.
DR. MAXWELL: The funded establishment is half --

A. Yes. Yes.
DR. MAXWELL: -- what was needed. And that's before you take into account vacancies and sickness.
A. Yes.
DR. MAXWELL: How was it that you and senior nurses had been working there and not noticed that they had less than half the staff they needed? 16:40
A. Well they used the Telford exercise to do this, and I'm not sure if that had been done before, but this analysis hadn't been done on the wards before, and the wards weren't using the formula that the audit was done. 16:40
DR. MAXWELL: But Telford is based on professional judgement...
A. Mhm-mhm. 16:40
DR. MAXWELL: Which is presumably what the original establishment had been based on. Telford is based on the Ward Managers telling the auditors "This is the number of staff we need" --
A. Yes, yes. 16:40
DR. MAXWELL: So how do we end up having only half of the staff we need? And was that -- well, to put it a different way, was this report a shock to you and other managers to see that you need to double the number of nurses? 16:41
A. It definitely was a shock to me. The Service Manager may have been aware before, because she did monitor the staffing levels on site, and the rostering, and she was -- and I think this is why we brought Corporate Nursing

in, because the staff on site weren't using the rostering properly.

DR. MAXWELL: So you think -- if we went back and asked Corporate Nursing, they'd be able to give us a little bit more detail about when this was done? 16:41

A. Yes, yes. Yes.

DR. MAXWELL: Okay. Thank you.

332 Q. MS. KILEY: I think we have it within the materials that were presented to the Task and Finish Group on the 31st July 2017? 16:42

A. Okay.

333 Q. So it would have been before that stage.

DR. MAXWELL: So it has to have been '16. It would have been the December of '16 then.

CHAIRPERSON: And when you say the rostering wasn't being done properly, right at the bottom of the page there's a reference to 19% of the roster has rule -- sorry, can we get to the bottom of the page? Yes. 19% of the roster has rule breakages. Is that what you're referring to? 16:42

A. So I'm lost a bit at the moment.

CHAIRPERSON: Right at the bottom.

A. Is it up now on the screen?

CHAIRPERSON: It should be.

MS. KILEY: Yes, just at the bottom. 16:42

CHAIRPERSON: You just said the rostering wasn't being done properly and then right at the bottom you see a reference to --

A. Rule breakages. Yes. Yes.

CHAIRPERSON: Is that what that's --
A. So they weren't adhering to the way the roster should have been done.
CHAIRPERSON: Whose responsibility was that?
A. The Ward Manager for each -- each ward, the Ward Manager did the rosters on a weekly basis. 16:42
CHAIRPERSON: And would that be rule breakages because simply there might be a lack of staff?
A. Well there was a procedure in relation to rostering. So, for instance, you maybe had - you could ask for two weekends off, or one weekend off. I don't know exactly what it was. But it may be that certain people got the weekends off more than somebody else, and this did -- I know in the listening groups I think it's in the report, staff said that they weren't getting what they should have got, and that other people were getting more than what they got, and that was a bone of contention for staff. Right. Okay. 16:43 16:43
MS. KILEY: I just want to move on, Ms. Mitchell, to some of the final questions that you were asked, because you were also asked some questions relating to the Ennis Investigation. So if we go back to your statement, please, STM-240. 16:43
CHAIRPERSON: Can I just ask how long do you think you've got? Ten minutes? 16:44
MS. KILEY: Five minutes.
CHAIRPERSON: Five minutes. All right. Okay.
MS. KILEY: STM-240-12. If you just scroll down to "In addition". There you go. At Question 1 you were asked

what your role was in the Belfast Trust at the time of the allegations which arose in relation to Ennis Ward, and you say there that your role wasn't specifically for Muckamore Abbey Hospital, but you did have some responsibilities in relation to Muckamore at that time, isn't that right?

A. Yes.

334 Q. Can you explain what they were?

A. In relation to my role?

335 Q. In relation to Muckamore? 16:44

A. Well it wouldn't have been Muckamore, it would have been Learning Disability Services.

336 Q. Yes, but what responsibilities did you have over Muckamore at that time?

A. I was, at that time, Senior Manager for Service Improvement and Modernisation, and that included governance. So my role would have been in relation to any service improvement project or any governance issues, and I did attend the Core Group in that role. 16:44

337 Q. And so you say later on that you had no role in the Adult Safeguarding Investigation, but were you aware of it at that time? 16:45

A. Yes.

338 Q. Do you recall having seen the report at the time?

A. Yes. 16:45

339 Q. And did you have any responsibilities in terms of the implementation of the recommendations of the report?

A. If I can remember rightly, the report came to governance and also came through as part of the

statutory functions report that would have come to governance as well, and that's the overarching Directorate Governance Group, and we were asked about -- I know there was questions asked about the implementation of the recommendations, and different lead people were taking forward those recommendations. I do remember whenever I took up post in '16 asking the Service Manager if all the recommendations had been implemented, and did that in writing, and I was told that they were all implemented. 16:46

340 Q. And at Question 4, if we could move to page 13, please? You were asked there:

"Why was a Serious Adverse Incident Report (SAI) not submitted in respect of Ennis? Please provide your recollection of the process that resulted in the decision not to submit an SAI report." 16:46

And you say:

"It would not have been my decision to submit an SAI. That was the role of the Director and the lead for the safeguarding investigation." 16:46

But could you answer the second part of the question there, about your recollection of the process that resulted in the decision not to submit an SAI? Do you have a recollection of the process that resulted in the decision to submit --

A. No, I wasn't, I wasn't involved in it. I just got a phone call to say that it was going down the vulnerable adult route, and if I remember rightly, that an Early Alert had been sent to the Department.

341 Q. But are you saying that you had no recollection of having a role in respect of the submission of an SAI? 16:47

A. No.

342 Q. The Inquiry has, as you know, heard evidence from other witnesses who were involved in the Ennis Investigation, one of whom was John Veitch. Are you familiar with Mr. Veitch? 16:47

A. Mmm.

343 Q. And at one stage Mr. Veitch told the Inquiry about conversations, he recalls conversations between, or communications between you and he about submitting an SAI report and whether that was necessary. Do you recall that? 16:47

A. I have no recollection of it, you know. I do remember getting a phone call, I think from the Director at the time, telling me about the incident, and telling me that it was going forward as a Vulnerable Adult Investigation and who the Chair would be. 16:48

344 Q. That's the extent of your recollection?

A. Yes.

MS. KILEY: Okay. I have nothing further, Chair. 16:48

CHAIRPERSON: Okay. I think Dr. Maxwell has.

MS. MITCHELL WAS THEN QUESTIONED BY THE PANEL AS

FOLLOWS:

345 Q. DR. MAXWELL: Yeah, I just want to take you to page 17 of your statement, and it's your summaries of events that you prepared for the Directors. On page 17 it talks about the number of incidents in May 2017. There were a total -- it starts slightly above, so if you could just go to the bottom of the page before? It says the number of incidents in the month was 369, of which 279 were abusive or violent behaviour, which seems a very high number. And it goes on to say that some of these had resulted in staff injuries, but also some of these were patient-on-patient behaviour. And it says that these incident are going up, up 2% on the last month and up 6.5% for the same period last year. Did you have any idea of why violent and abusive behaviour was going up? Because if there's this much violence it's not going to be a safe place for everybody? 16:48 16:49 16:49

A. No. 16:49

346 Q. DR. MAXWELL: If it's not safe for staff, it's not going to be safe for patients either?

A. And that was one of the things why I did some of the things in relation to day care, because patients were on the ward quite a lot and there were incidents because patients were in a crowded area, and there was an increased number of incidents because of that. We also were getting quite ill patients into the hospital that had a lot of behavioural problems. So I don't 16:50

remember if that explains it or not. I don't remember all the ins and outs in relation to those incidents.

347 Q. DR. MAXWELL: So you think the nature of patients being admitted was different? There was more patients being admitted with behavioural problems? 16:50

A. Yes.

348 Q. DR. MAXWELL: Would that have been significantly different from your experience --

A. Yes.

349 Q. DR. MAXWELL: -- in 2005? 16:50

A. Yes. Yes, definitely. They were more ill, you know, they were ill patients.

350 Q. DR. MAXWELL: Yeah.

A. That did need intensive care in relation to their behaviours. 16:50

351 Q. DR. MAXWELL: And yet we've seen from my last question there weren't nearly enough staff to look after them?

A. No.

352 Q. DR. MAXWELL: According to your own assessments.

A. No. And it was very difficult to attract staff to 16:51 Muckamore. Because of the proximity of where it was, it was out in the country, and I'm sure you've heard most of the staff came from areas around the hospital.

353 Q. DR. MAXWELL: But what we heard from my last question is that even if you had had people, there weren't posts 16:51 for them?

A. Yeah. Yep. Well there should have been.

354 Q. DR. MAXWELL: There was only half the number of posts that was later decided was needed. So it wasn't just

that they couldn't be recruited, there wasn't any money to pay people if they were available.

A. Mhm-mhm.

355 Q. DR. MAXWELL: I think my second point is, you've talked about the staff being unhappy. If 46 staff were injured, one as it says here with a fractured hip, were staff concerned about their own personal safety? 16:51

A. Yes. Mhm-mhm.

356 Q. DR. MAXWELL: And what was done about that?

A. Well there was a number of things done. There was a procedure in place for supporting staff when they were involved in incidents and about giving them time out. We also employed an on site counsellor for staff to go for confidential sessions with the counsellor in relation to incidents on the ward. The Senior Nurse Manager was to be on the ward when there were incidents, to support the staff. We based the Senior Nurse Manager -- the Senior Nurse Manager originally were in the admin building, so we based them out in the wards so that they would be near the staff in relation to that. PBS was one of the things that we implemented, obviously to see if we could reduce it, and then day care services. 16:52 16:52 16:52

357 Q. DR. MAXWELL: But this is May 2017. So it sounds as though PBS wasn't reducing violent behaviour? 16:53

A. Mhm-mhm. I would need to go back and look at the reports, and if you look - if you have access to those reports you'll see the trends. Some wards were better than others.

358 Q. DR. MAXWELL: So was there a particular ward where this violence, or wards where this particular violence was happening?

A. I really don't remember.

DR. MAXWELL: Okay. 16:53

A. I don't remember, sorry.

359 Q. CHAIRPERSON: Just going back to the roster analysis that we were looking at, at page 74 and 75 of the bundle. Having identified this fairly massive gap between what there was and what was needed, how quickly 16:54 did you try and do something about that?

A. There was a large recruitment exercise happening to try and improve --

360 Q. DR. MAXWELL: But what this report is saying is it wasn't about recruitment, it was about funding? 16:54

A. Yes, but we were able --

361 Q. DR. MAXWELL: So did Belfast Trust immediately fund all the additional posts?

A. Yes. We got extra funding. We did get extra funding. But there was a lot of posts that were unfilled because 16:54 we couldn't get the staffing for them. So there were a lot of vacancies already.

362 Q. DR. MAXWELL: Yeah. But you got all the funding you asked for, did you?

A. We got extra funding. We did get extra funding. Not 16:54 just only for nurses.

363 Q. DR. MAXWELL: But did you get all of the funding that this review said was required?

A. If I remember rightly, yes. Anything that I asked for

I got.

364 Q. CHAIRPERSON: But then you weren't able to fill the posts anyway?

A. Yes, exactly. And it ended up we were using agency and bank. 16:55

365 Q. CHAIRPERSON: And then that got worse and worse presumably as people were suspended.

A. Yes. Yes. And people then were leaving because of what was happening in the hospital. It was a vicious circle. 16:55

366 Q. CHAIRPERSON: Presumably as your sickness rates go up, as we've seen here...

A. Yep.

367 Q. CHAIRPERSON: Those get worse and worse because the stress on the people remaining increases and more people go off sick. Is that a fair analysis? 16:55

A. Yes, yes.

CHAIRPERSON: Yeah. Okay. I think we're all done. Can I thank you. We've had quite an extended session this afternoon, so thank you for your patience. Thank you for your evidence. Okay. We'll start again -- ah, tomorrow morning, I suppose a little reward for sitting late this evening, we're not sitting tomorrow morning, but we'll see everybody at 1:30 tomorrow. Thank you very much indeed. And thank you to our stenographer. 16:55 16:56

THE INQUIRY ADJOURNED UNTIL TUESDAY, 17TH SEPTEMBER 2024 AT 1:30 P.M.