MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY 17TH OCTOBER 2024 - DAY 117

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THE INQUIRY RESUMED ON THURSDAY, 17 OCTOBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you. Mr. McEvoy.

MR. McEVOY: Good morning, Panel. This morning's witness is Mr. Peter McNaney, if he could be brought in whenever it's convenient. 10:03

CHAIRPERSON: Do we pronounce him McNaney or McNanny?

MR. McEVOY: I believe it's McNaney.

CHAIRPERSON: Shall we ask. 10:04

MR. PETER MCNANEY HAVING BEEN SWORN WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

CHAIRPERSON: Good morning Mr. McNaney. 10:04

A. McNaney is correct, unless you're my old headmaster, who used to call me McNaney just to annoy me.

CHAIRPERSON: We won't do that. Thank you for giving us your statement and thank you for giving us your time this morning. I don't know if you have watched any of 10:04 the proceedings.

A. I've watched a bit.

CHAIRPERSON: So you know how it works. I'll hand you over to Mr. McEvoy. If you need a break, we normally break after about an hour and a quarter, but if you 10:05 need a break before then just let me know.

A. Thank you, Mr. Chairman.

1 Q. MR. McEVOY: Good morning Mr. McNaney. We met a few moments ago. My name is Mark McEvoy. I am one of the

Inquiry counsel team and I am taking you through your evidence this morning. First of all before you in the two blue folders, hopefully, is your statement to the Inquiry dated the 3rd July this year?

A. That's correct.

2 Q. The statement is 40 pages in length and including exhibits it runs to 1,257 in total. Would that be right?

A. I can't tell you how many pages there are, but I accept.

3 Q. All right and are you content then to accept that, to adopt that statement as your evidence to the Inquiry?

A. Yes.

4 Q. All right. Well, look, you have followed the format which was requested of you in providing your statement to the Inquiry in that the Inquiry asked you a series of questions or asked you to address a series of questions and you have very helpfully done that in formatting your statement to us. The statement is indeed on line and therefore available to the public. It also then means we don't have to regurgitate it unnecessarily, but it means --and it also means I can focus in on particular areas of interest to the Inquiry.

So, bearing that in mind, in the section under your qualifications, experience and position, which is at the very outset, you tell us that you are by profession a solicitor. You were Chief Executive of the Belfast

City Council and retired in September '14. You describe then what your responsibilities where as Chief Executive of the Council. Then at paragraph 9 you tell us about how you came to apply for and obtain the role of Chair of the Belfast Trust in 2014.

Prior to taking up that role as Chair of the Trust had you any prior experience of either mental health or learning disability issues?

A. No, I didn't have any specific experience, personal experience maybe of mental health.

Q. Yes?

A. From family circumstances. But I had no experience. In fact, I mean if I could just add, I say in paragraph 8 that whilst I was Chief Exec of Belfast City Council I chaired the Health Inequalities Working Group for the city. I remember meeting Michael Marmont in 2010 who had written a seminal report on health inequities which I found really quite shocking, the impact that poor housing or poor education or living in deprived areas could have on your health. I mean I always remember the chart for Belfast that showed, depending on were you lived, if you lived on the Malone Road which is a rich, well-off area, the average age you would live to would be 80. Whereas if you lived on the Shankill or Lower Falls you would live until you were 71. I always found that really shocking. So I decided that we should have a Health and Equity Group for the city and I sat with the Chief Execs, there was a number of

health Trusts at the time and the Public Health Agency. And we did a lot of work in setting up a health welfare unit and the health and wellbeing centres were being built. And we integrated public services and we put four or five centres across the city, Grove in North Belfast, East Belfast, and they had integrated services and were a real boost to deprived areas. I then became interested in health.

6 Q. Yes.

A. It wasn't until I started in the Belfast Trust that I realised that being the Chair of a health trust, even though you had a duty to promote health inequities, was really just about service delivery. There was extreme pressure in the health service, well known to many of the Panel members I'm sure, but I was shocked and I'm a pretty seasoned manager, I was shocked at the -- you know, you didn't get your budget until October even though you plan year for year. Every time you got a budget there wasn't enough money. Two out of the first three years I was Chair we had to make large savings. So it was, it was a considerable shock. So, I didn't have any experience in learning disability and later on in my statement I refer to some work that we did, and we had an extraordinary Trust Board meeting in Knockbracken Health Park when there was a proposal to make the cuts to day centres for the learning disabled and I would like the opportunity later on to refer to the minutes for that because I was really struck by -- I mean there was about 200 people at this meeting. I

10:08 10:09 10:09 10:09 10:10

was struck by the powerfulness and the compelling stories told by the parents and the carers. Certainly one of the most challenging metres I have ever chaired. We eventually withdrew the proposal to close the day centres.

7 Q. So that related to Knockbracken?

A. No, the day centres were the learning disability day centres which are around the city.

8 Q. Okay?

A. That people with a learning disability who live at home -- 10:10

9 Q. Yes?

A. Would go to some four or five times a week, some two or three times a week.

10 Q. Might some of those service users have been patients, former patients of Muckamore? 10:11

A. Well some of them might have been, but I mean I'd like to go to the minute of it.

11 Q. We'll locate it at the appropriate juncture?

A. One of the -- I can remember very, very clearly how compelling the relatives and the loved ones of learning disability people were and they explained their lives and I found it, I found it very affecting. 10:11

12 Q. Okay, well indeed, and you foreshadowed it but you tell us in your statement about some of the challenges that faced you when you took up the role. At paragraph 9, for example, you detail a couple or you certainly mention a couple of crises between 2012 and '14. The serious data protection breach, serious overcrowding in 10:11

emergency departments with the death of two patients on trolleys, the dental inquiry call back, pseudomonas review into the neonatal unit investigating the deaths of a number of babies and being placed on special measures by the Minister. You then go on at paragraph 10 to make the point that the Trust is a massive organisation: 10:12

"I've always thought its sized and complexity makes its governance very difficult." 10:12

The same theme at 12 on page 5:

"It is perhaps difficult to convey but given the level of risk carried and the extent of services provided by the Belfast Trust, what can be brought to the Board of an organisation of the size and nature of the Belfast Trust may be considerably different to what could come to the Board of a much smaller organisation carrying much less risk." 10:12 10:13

The sense that you're giving us is very clear, that this is a massive organisation facing massive pressures. Is the Trust, in your experience, simply too big? 10:13

A. I think there is a legitimate debate about that. I think different people would look at it from different perspectives. I was and had been used to dealing with smaller trusts and I do think the removal of social

care community trusts, and there used to be two in Belfast, South and East Belfast and North and West Belfast, I think their amalgamation into a monstrous monolith that is the Belfast Trust didn't allow the focus that those two Trusts had with their communities. The argument is that it helps the integration of social care and I think in theory that's right. In practice --

13 Q. Yes?

A. I am not convinced that there is as much integration as perhaps there might be. But, I remember, and I have had this conversation with numerous people over the years about the scale and the size of Belfast Trust, and I remember having a conversation with the Deputy Chair of the Trust who had been the Chief Nursing Officer who had been there in the department at the time the reorganisation took place in 2007/2008. His recommendation at the time was that on a Northern Ireland wide basis there should be a learning disability and mental health trust, discrete. And I, having had the experience that I've had over the last nine years, have no doubt that such an organisation would have the detailed focus and expertise, because we always struggled to get people with learning disability knowledge, experience, either doctor level or nurse level. When you deal with some of the specialist trusts in England and Wales I think that focus is necessary. I don't think it will happen now but I do think that it's a loss not to have those community

health and social care, that's my personal opinion, I'm sure there is more learned people than. I but I firmly believe we need more community and social care focus.

14 Q. We touched on, I mentioned to you some of the examples that you had cited in terms of the Pseudomonas Review, the Dental Inquiry Call Back, special measures, the difficulties in emergency departments and so on, on taking up the post, had you any sense of lessons having been learned from those episodes? 10:16

A. I sort of knew it would be choppy, but I didn't know it would be as much of a culture shock as it actually was. I, on my first week in the Belfast Trust the Chief Exec got a job for a health trust in England. The Deputy Chief Exec retired and in my second week the Medical Director retired. That is a massive loss of knowledge and capacity from an organisation at one time. The organisation had just come out of special measures, had a very fraught relationship with the Department of Health. There were big issues around trust because the original special measures were introduced, around the Department not being satisfied that they had been advised of early alerts and significant issues, which was completely right I have to say. 10:16 10:17 10:17

The second thing I then experienced in the first month was an RQIA report on our Emergency Department which the RQIA visit had arisen because the doctors in the Acute Medical Unit had written to the regulator directly to say that care was unsafe. That meant there 10:17

was a massive report from RQIA on safety in ED and there was an enormous amount of work, particularly in the absence of seriously qualified staff who had left.

What became apparent to me very early on was we need to stabilise this organisation, we need to rebuild its capacity to be truthful and honest and open and we need to work really hard on our relationship with the department, which led to, we then went out to try and recruit a chief exec, of course we couldn't get one. Two times we went out to recruit. Eventually I spoke to the Minister, I spoke to the Permanent Secretary and I spoke to the Chief Medical Officer, Michael McBride or as he is now Professor Sir Michael McBride, who was the CMO, had originally been the director of, the Medical Director in the Royal Group of hospitals and an enormously capable individual, displaced a lot of weight, water in the health field. I knew Michael. I spoke to him. He suggested he might be prepared to come and work in the Trust as an Interim Chief Exec to stabilise things four days a week. I bit his hand off. We got in discussions with the Permanent Secretary and we agreed that he would come into the Trust and he came into the Trust in December of 2014 retaining one day a week of his Chief Medical Officer job. I have to say I have constantly been astonished by the capacity for hard work by senior medical and other health professionals, nurses and allied health professionals and everyone. Over the next two and a half years when

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he was Chief Exec he certainly brought an authority to the role and he worked really hard.

DR. MAXWELL: Can I just ask you about that, because when Mr. Dillon came to give evidence he said that when Professor McBride came the Department issued two responsible officer letters, so that the responsibility of the Chief Executive was split? 10:20

A. Well that's not how it felt on the ground, on the ground it felt --

DR. MAXWELL: But were you aware of the letters because the authority comes from the letters for responsible officers issued? 10:20

A. Well I take it responsible officers account, being the accounting officer.

DR. MAXWELL: Yes. 10:20

A. Well, I think --

DR. MAXWELL: Well firstly were you aware there were two letters.

A. Yes, I was aware.

DR. MAXWELL: What was the split of responsibilities in those letters? 10:21

A. Well I can't recall the letters now specifically, but I can recall that in practice Martin Dillon was an accountant, came from a financial background. Clearly the budget of the Trust I think then was about 1.3, 1.4 billion, which is about a tenth of the total DEL, department limit for the whole of Northern Ireland. So Martin kept the financial accountability role and he was accountable through the finance. And also Michael, 10:21

because of his role of Chief Medical Officer, wanted to be careful in case there was anything that conflicted with it. But I'm sure we can get you the letters.

DR. MAXWELL: I think that would be helpful because Mr. Dillon seemed to infer that he was responsible for the operational running of the Trust and Professor McBride was responsible for the strategic development? 10:21

A. Well in the time he was there I think Martin Dillon acted as Deputy Chief Exec and was of great assistance to Michael and they worked closely together. But I had my one-to-ones as Chair and Chief Exec mostly with Michael, except if Michael wasn't there then I would meet Martin. But I was in no doubt and I think the organisation was in no doubt that the Chief Exec was Michael McBride. 10:22

DR. MAXWELL: It would be interesting to see the letters. 10:22

A. Absolutely, I will get the letters.

DR. MAXWELL: Can I just ask one other thing, Mr. McEvoy asked you at the beginning about what had happened as a result of the various concerns prior to your appointment, so if I can reframe that, what changes had the Trust made to their governance prior to your appointment as a result of these investigations? 10:22

A. Well, again, that's difficult for me to recall 10 years away. 10:23

DR. MAXWELL: Okay.

A. But also, I think there was, there was very skilled people. I mean June Champion was the head of office,

Tony Stevens was Medical Director, they were both recognised in the health service of Northern Ireland as being very learned in issues of governance. I mean I never in my whole time in the Trust, I never came across the Trust trying to hide something.

DR. MAXWELL: But you did say in your response to Mr. McEvoy that the Department was concerned that they weren't getting information?

A. No --

DR. MAXWELL: Do you agree with that? 10:23

A. I absolutely did say that. Well there is many reasons why people don't tell people things. One is, you know, that they are trying to conceal it, and the other is that the systems and processes are not sufficient.

DR. MAXWELL: And that's -- 10:24

A. To ensure or assure the Department within the time scales. The time scales for early alerts are really, I think it was 72 hours. I always thought in an organisation scale of the Trust, depending on where the problem manifested itself, that 72 hours was going to be a bit of a sprint. So I think at the time the issue was not concealment, but that there was media -- my experience of the Belfast Trust is that it lived in a complete media headlight. You know, as I always used to say everything comes from somewhere and all the people who work in the Trust are deeply dedicated to the services they provide to the public. If they don't think those services are being provided properly they have friends and relatives who are journalists and

there was constant stories about the Belfast Trust and it's in Belfast and it's close to the papers and it's close to the BBC and it's close to everywhere else. The other thing, if I may say to the Panel, Northern Ireland is a really small place and it's got a very crowded field in health. You know, if people were going to complain about the health Trust they would occasionally come to the Chair but the vast majority of times they would go to the Minister and the Minister was four miles up the road. And, you know, people told me that the Belfast Health and Social Care Trust was an autonomous body. I was used to coming from a counsel who set its own rate in terms of resources and had no restriction on what it decided about staffing. Everything that the Trust did in terms of improvement of services, by and large and if it had involved resources needed the consent of the Health and Social Care Board.

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When there was the change of Permanent Secretary we then had to seek permission from the department to fill senior posts. We then had members of the Department, civil servants sitting on our interview Panels. I mean, it really felt stranger, much stranger than -- now over time we worked really hard to build trust, rebuild relationships and, you know, by the time I left we had certainly more autonomy in relation to staffing. But, it is --

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DR. MAXWELL: The question I asked was about

governance, not about autonomy.

A. Well forgive me.

DR. MAXWELL: Actually the fact that people get to the Minister and the media suggests that you, but not to the Board, suggests that the governance systems weren't working that well. 10:26

A. Well I'm disappointed that you think that. I would, my answer would be that people go to where they think the power is and if you had a choice of speaking to the Chair of the Trust or to the Minister For Health who makes determinations about the budget and who can direct the Department to direct the Health and Social Care Board, then --of course I was approached during my time in the Trust as Chair, but people in Northern Ireland like to talk to the big chiefs. 10:27 10:27

CHAIRPERSON: But do you agree that the correct route would have been through the Board, for that sort of conversation?

A. Well, yes, but you can't dictate to people who want, who have concerns about their services or how their treatment, I can't dictate to them, you know, you can't go to the Minister, you have to go to the Chair. Down through the years on many occasions I had conversations with senior health officials to say look, it would be far better if they came through the Trust and then we could report to you. But, people will go to whoever they think in government will resolve their issue the quickest. Now, of course we had loads of people within the governance system of the Trust, but I just wanted 10:27 10:27

to make the point, Northern Ireland is a small place. The assembly is four miles up the road and people will go where people will go.

CHAIRPERSON: Mr. McEvoy.

15 Q. MR. McEVOY: Mr. McNaney, once you had got your feet under the table so to speak within the Trust and had appreciated the size, its size and the challenges facing it, as Chairman how did you ensure that the most significant risks, rather than the most obvious challenges, were considered by the Board, notwithstanding what you've told the Inquiry about where people might have gone with issues? 10:28 10:28

A. Well I was trying to make the point about the parochiality of Northern Ireland but in terms of governance there was a well established governance system which I have exhibited through the Assurance Framework. The Assurance Framework is essentially based on a template that had been produced by the Department when the trusts were set up in 2008. We had a governance framework, an assurance framework with a whole set of committees, with a whole set of roles. It had a Board which consisted of non-execs and execs, which meant it was an integrated Board. By legislation you had to have a Medical Director, a Director of Nursing, a Chief Financial Officer, a Chief Social Worker and the Chief Exec. So it was an integrated Board which, I had sat on boards before, I hadn't really come across integrated boards, and one of the things I tried do over the first couple of years was to 10:29 10:29 10:29

work hard to try and ensure that the integrated Board started to function as effectively as it could and that non-execs would play a role and contribute to the overall good governance of the organisation, would listen to the voices, would bring their expertise and would add to the skill set of -- I mean the worry in an organisation of the scale and size of the Trust is the degree to which it becomes institutionalised and that people have their own truth within an organisation of that scale and size. 10:30

I came from a background of a council that does it's work through committees which are open to the public and all its reports are on-line. It is not like the Civil Service, everything is open and transparent and I wanted to bring my experience of open and transparency to the Trust. Now, that was aided by the IHRD report, Mr. Justice O'Hara report which I will refer to later. So yes, I hope I've answered your question, apologies if I have rambled on there. 10:31

16 Q. That's helpful. In paragraph 13 you detail the history of how the issues, the allegations and revelations at Muckamore came to light and how the Board handled them. The history is familiar to us but you say: 10:31

"Staff had been suspended because of abuse. Police investigation was under way. The father of one of the affected patients had also made a complaint to the Department of Health and the Department of Health had

then written to the Trust to express various concerns including that an SAI had not been reported to the HSCB within 72 hours."

One view on reading that fairly plainly is that the escalation to the Board was because of the involvement of the Department, is that correct? 10:32

A. Well what I can say is that there was a letter from the Department that came to Martin Dillon. I think the letter is dated 17th October 2017. He says it was sent by e-mail on 20th October. But when we interrogated this at the time it was clear that action had already been taken in the interim period. Now there is no question that we did not comply with the Early Alert processes and that's not good enough. But, action had been taken to suspend staff, to invoke the Joint Protocol with the police, to involve the RQIA. I did listen to the evidence of Mr. Dillon and I know it's a long time ago and he had lost his diaries but I specifically went back to my diaries and I checked. In terms of when I was told, the letter was dated 20th October. Mr. Dillon was away from the 16th to 30th October. I met him on Monday the 30th October, I met him on a standard one-to-one. I met him in his office and he showed me the letter at that meeting. 10:32 10:33 10:33 10:33

DR. MAXWELL: Had you not been told about this before, the letter from Charlotte McArdle and Sean --

A. My recollection, I have no recollection of being told.

DR. MAXWELL: As Chair would you not have expected, we

know that Mr. Dillon has sent us a follow up that he did know in the September, we know that Cathy Jack knew. We know that Cecil Worthington knew, we know that Brenda Creaney, most of the executive knew. Would you not have expected them to have told you verbally? 10:34

A. I was advised about the receipt of the letter and obviously on the back of that then I was advised about the other issues that had come to light.

DR. MAXWELL: Prior to the letter of the 20th October, nobody had alerted and you wouldn't have expected them to? 10:34

A. I have no recollection of being advised. Now I instantly said we need to take this to the --

DR. MAXWELL: If I can just stick on the notification, would you have expected the Executive Directors to tell you something of this significance prior to a letter from the Department of Health? 10:34

A. I would have hoped that I would have been told and later on in my Chairmanship with different people in different circumstances, I almost certainly would have been told and I had a very good relationship with Cathy Jack when she was the Chief Exec and Cathy Jack would have phoned me often and regularly. So, I would have wanted to be told. But my recollection, firm recollection is I found out on 30th October and we went to the Trust Board on 2nd November. Now, if I may be permitted because I think this is illustrative of the action that was taken at the Board level. An oral report then came to the Trust Board on 2nd November 10:35 10:35

from Marie Heaney and we asked for full report. But I had on my Board, and I have spoken to this individual who is happy that I tell the Inquiry, she has a learning disabled child and has a great knowledge of learning disability issues. The day after the Board. Miriam Carp rang me at home to tell me and express her real concern that there was more to this issue than met the eye and that we needed to unpack it and unpack it --

10:36

DR. MAXWELL: Does that mean she was concerned that the briefing to the Board on 2nd November hadn't been as complete as it should have been?

10:36

A. No, I took from it that the briefing had ignited in her a real concern for the safety of patients at Muckamore and she rang me, she said look, I'm really worried about this, Peter, you know, we really need to get underneath this. I then said look, Miriam, happy do that. I told her I'm happy to go and speak to Marie Heaney and Brenda Creaney with you and she said no, I want to do that myself. She did that, she came back to me and we then, I then involved -- I can't remember his name. Forgive me for my senior -- Martin Bradley, sorry, senior moment. Martin Bradley was on the Board. Martin Bradley had been a previous Chief Nursing Officer for Northern Ireland, an enormously capable individual, very wise. We involved Martin, we had a meeting with Marie Heaney, we then had a meeting with the Chief Exec, with the three of us and with Brenda and Marie Heaney and we got into a real level of

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10:37

detail. It became clear that these were significant issues and there was a significant management response which, at that time, appeared appropriate.

Now, what I do want to share with the Inquiry is Muckamore evolved over time. My experience of it is it's like things, when you look back on it you go, 'goodness'. But what you know at the time is what we knew. We knew that there was, I think there were three staff suspended. I mean as it evolved, and it probably was the September of the following year, that's when it became clear after an amount of CCTV had then been viewed, that this was a very significant issue and many more people were involved than one would have wished. And thereafter then a whole host of things happened. But I just wanted to be clear about when I was told. I also have to say that in, you know, from Cathy became Chief Exec in 2020, she has always been very open and very clear. You know, it's been a journey in terms of ensuring that the organisation organises itself to be as transparent as it can. 10:38 10:38 10:38 10:39

17 Q. MR. McEVOY: At paragraph 15 and again at 17 on pages six and seven, I can put the point in a fairly general way, you again refer to the pressures and challenges that the Trust and therefore the Board were facing. But you specifically mention then at 15 the reporting from public inquiries in relation to Hyponatraemia which you touched on a few moments ago, also Neurology, each of which required a number of significant 10:39

governance changes, of course you make the point that this Inquiry is ongoing, and Infected Blood which has just recently reported --

A. If I may just say, sorry to interrupt you, Hyponatraemia was a massively significant issue in terms of governance because essentially it had gone on for a number of years. And I have exhibited, I don't know whether the Inquiry know the background to Hyponatraemia, a number of children had died from hyponatraemia who had not -- and there was also allegations of cover up by the doctors and other people concerned. It led to a public Inquiry that went on for a long time and when it reported it made 98 recommendations. 10:40 10:40

18 Q. Yes? 10:40

A. Many of which related to boards, about the training and the qualifications of people who are on boards. Specifically Mr. Justice O'Hara said, you know, the health service exists to serve the patients, it doesn't exist to serve its own interests. He recommended that there should be a duty of candor, not just on organisations but on individuals. Obviously Mid Staffs had recommended that as well. There was a big debate then in Northern Ireland over the individual duty of candor. 10:41 10:41

19 Q. Yeah?

A. I think later on in the statement I say that the Health Department --

20 Q. Sorry, I'll give you an opportunity to tell us about it

actually.

A. My apologies.

21 Q. We are coming to it. But the point just in mentioning Hyponatraemia, Neurology and others, also then what you say in paragraph 17 when you refer to the Hyponatraemia report again in January '18, you make the point that the Trust, and I think this is what you were about to tell us or were telling us in general terms, needed to learn from its experience of failures of care. You are referring then to the recommendations. Some of those, many of those indeed involved changes around governance and assurance? 10:41 10:42

A. Yes.

22 Q. And you mention at paragraph 16, just if you can help us understand this sort of possible or potential governance issue. At 16 you say: "The Chair of the Trust Board also serves as Chairman of the Assurance Committee"? 10:42

A. Yes.

23 Q. And you have exhibited the Board Assurance Framework but helpfully you have actually quoted from it. 10:42

"The Assurance Committee is a standing committee of the Board of Directors comprised of non-executive directors only. The role is to assist the Board of Directors in ensuring an effectively assurance framework is in operation for all aspects of the Trust's undertakings other than finance." 10:42

But if you read your first sentence there at first blush?

A. What paragraph are we referring --

24 Q. 16, sorry, bottom of page 6. The Chair of the Trust Board serving as Chair of the Assurance Committee might to the interested bystander or lay person raise a question of conflict? 10:43

A. Well, I mean, in many ways when I joined the Trust I inherited that as a situation. The former Chair had, since the inception of the Trust in 2008, had chaired the Assurance Committee. I also joined, the former Chair, before I joined there was an interim Chair for one year, but before that the Chair was Pat McCartan but he had resigned in 2012 and that meant that when I came onto the Board there was a whole host of Board members whose term of office was shortly going to expire within the next year or 18 months and I took on the Chair of the Assurance Committee as Pat McCartan had done because really I couldn't impose it on somebody else because they had all been Board members of long standing, probably from the successor Trusts and then from the new Trust. So I took it on and I learnt, or I hope I learnt, that there was a massive amount of stuff going on in the Trust and I just would have felt very vulnerable not knowing about it. Now in terms of the conflict, the whole Trust Board were, all of the Neds were on the Assurance Committee and the Assurance Committee obviously had to assure the Board. I, in the time that I was there, never experienced a 10:43 10:44 10:44 10:44

real conflict about that.

DR. MAXWELL: Can I just ask, does your Board have, did it have a senior independent director as some boards do?

A. No.

DR. MAXWELL: Non-executive director?

A. No and it didn't and I was on the Board of Northern Ireland Water, the utility regulator for water in Northern Ireland and I was the senior independent director. I think what I should try to explain is that the Trust is an arm's length body of the Department of Health and its accountability and governance arrangements flow from the accountability and governance arrangements prescribed by the Department of Health. It's accounts are led before and assurance statements are led before Parliament. It also prescribes the role of internal audit. We have -- I mean clearly the vital role, we have an independent internal auditor, again it's in the accountability framework.

DR. MAXWELL: I think we are going to come on to that.

A. Sorry, my apologies.

DR. MAXWELL: I take your point, that it's not the same as a private company or a fully independent organisation, but there are NHS Trusts outside Northern Ireland, including those that are not foundation trusts, that have chosen to appoint a senior independent non-exec precisely because the Chair might be perceived as needing that extra independent

assurance, that wasn't something that you had?

A. No, it wasn't. And I worked very hard to have a good relationship with my non-execs. I got a new squad, that's the wrong word, a new team of non-execs in 2015 and '16. I sat on the interview panels myself. I mean 10:47
I want to take the opportunity if I'm allowed later on in the statement to refer to who was on the Board from that period, 2015, 2016 onwards. We had very capable people. Because the Trust is such a scale you could only manage it by delegation. You have to delegate 10:47
and, you know, I was putting Martin Bradley to lead up on complaints. We had Ann O'Reilly who was a social worker and the ex Chief Exec of Age Concern who was leading on the Social Care Committee and later became the Learning Disability Champion. I was working with 10:47
Miriam Karp in terms of her membership of the Social Care Community. We brought Nuala McKeagney who was a management consultant and we brought her expertise in. We worked, I think, well as a Board. There was challenge, and hopefully you will be able to see from 10:48
the minutes of the Board meetings that from '15, '16 onwards, I mean we were not a Board that just agreed with everything that came to us. There was challenge.

CHAIRPERSON: But could I just ask, maybe conflict was the wrong word to use, but if the same Chair and Neds 10:48
are on the Assurance Committee as are on the Board that the Assurance Committee is meant to be assuring, is there not a lack, an immediate lack of governance there in terms of challenge?

A. That's what the accountability framework provides for. The accountability framework says this is the Assurance Committee and it made up of the Neds. We were following guidance. I think of course there is a theoretical risk there, but I didn't come across it to be absolutely honest.

CHAIRPERSON: So in your view it is a theoretical issue --

A. Forgive my iconoclasm but sometimes when you read some of these governance and accountability documents, they are not really related to the real life of work and how things get done and how things are known and how, you know, everything has to be done through people. Forgive me, I am not -- we absolutely need to have our Assurance Framework. In my view it did not adversely affect our independence or our scrutiny or our constructive challenge, I think it informed it. And we had a commonality of much of the membership of the Assurance Committee and [inaudible] shared committee.

25 Q. MR. McEVOY: Nonetheless, Mr. McNaney, with the reports that you have just mentioned, principally the Hyponatraemia report and its recommendations, was your belief in the systems of governance within the Trust shaken at all?

A. By Hyponatraemia.

26 Q. Yes?

A. I think Hyponatraemia is a very powerful report. Essentially what Hyponatraemia is about and what it came down to in terms of the recommendation is candour.

And, you know, I absolutely vehemently believe that public service serves the public and it's job is to inform them in a transparent and open way and concealment of information for our own interests is unacceptable, I have never accepted it, I never will accept it. So a very powerful comment by Mr O'Hara to say, you know, that the health service must not look after its own interests. And I mean, I think I do exhibit the executive summary of the report and there was -- what then happened actually was, and I applaud this from the Department, the Department then set up a process of about six sub groups which would then work on the main elements of what had come out of the O'Hara report. So there was a sub group on clinical governance. There was a sub group, which I was on, on how non-executives could be trained and developed and it subsequently led to this document here, Board Member Handbook which isn't probably the greatest document that's ever existed but is substantially more than was there before. It also dealt very -- one of the big things it dealt with was SAIs and essentially there was a recommendation that any SAI that had a death or serious injury must be reported to the Board. You will see later on that we tried to implement that on our Board and we then became, we were then, as we moved to weekly, we had weekly governance meetings and we, it was shared with the Neds, the early alerts. Now it always used to be frightening when you read that every week. You know, serious things go on in big, big

10:50 10:51 10:51 10:51 10:52

hospitals. They are not, you know, they are full of people and, you know, serious things happen in hospitals. I mean, you know, and this isn't through negligence but 170 people die in the Belfast Trust every month, just through natural causes and the 10:52
natural end of their lives. But you have to be extremely vigilant, and I'm talking mainly about the clinical side of things. As we went on it became clear to me that the social care governance side, and hopefully we will get an opportunity to talk about 10:53
that, also needed to be upgraded. But O'Hara raised the bar for boards in terms of openness and transparency, in terms of training and development, in terms of their responsibility to oversee their organisation in a way that was candid and open. 10:53

CHAIRPERSON: In relation to that report, can I just ask, I think that was published in January '18?

A. '18.

CHAIRPERSON: Did you have early access to it at the Trust since it concerned the Trust? 10:53

A. No, the report was launched and there was a formal launch, Mr. Chairman, and we were at the formal launch and we got the report at that stage.

DR. MAXWELL: Presumably you had seen a draft beforehand? 10:53

A. No, we didn't see a draft.

DR. MAXWELL: Not even to check for accuracy?

27 Q. MR. McEVOY: When you say "we" do you mean you as the Board or the Trust corporately?

A. My recollection now, which is pretty firm, is we didn't see it in advance. There were accuracy failures in it because one of the recommendations in the report was that you shouldn't have student doctors in paediatrics which we soon pointed out --

DR. MAXWELL: F1s I think. They are not students, they are qualified.

A. My apologies, shouldn't be in paediatrics which of course meant that you would never be able to train anyone in paediatrics. But my understanding is we didn't see it in advance. There might have been, there may have been, what do you call it, Maxwellisation process.

CHAIRPERSON: Maxwellisation so you would have been warned about criticism.

A. There may have been, I wasn't involved in it. But I mean IHRD then became a big issue because, quite understandably, the families of the people who had, of the children who had died wanted action taken against the doctors who were involved and that became a big process within the organisation.

DR. MAXWELL: Can I just pick up on that because one of the recommendations, as you've said, was that non-executives and the whole Board would see SAIs?

A. Yes.

DR. MAXWELL: Cathy Jack mentioned this yesterday and she said that started in 2018 but last year that stopped and she wasn't clear why the Board stopped receiving notification of all SAIs.

A. I am no longer the Chair, I am not able to help you with that.

DR. MAXWELL: When did you --

A. I stood down in April '23.

DR. MAXWELL: So this happened after you stood down? 10:56

A. Happened after I left. I am offering no view but I don't understand it.

DR. MAXWELL: Okay, we will have to ask the current Chair.

28 Q. MR. McEVOY: Perhaps just one further point before a break Chair? 10:56

CHAIRPERSON: I would go on a bit longer if you can.

A. I am happy to go on.

CHAIRPERSON: Are you okay?

A. Yes, I'm happy to go on. 10:56

29 Q. MR. McEVOY: You touched on the Board Assurance Framework, Mr. McNaney, and I want to ask you about that. If we could open, it should hopefully be page 128 in your exhibits, it will come up on the screen hopefully for you. 10:56

A. Sorry I am a sad --

30 Q. It's quite hard to tell because the page numbering disappears into the navy heading?

A. Yep, thank you.

31 Q. Can we bring that down just a little bit, thank you. 10:56 You tell us at paragraph 19 about three lines of assurance within the Board Assurance Framework?

A. Yes. This is the 22/23 Board Assurance Framework.

32 Q. Yes, this is the one that is referred to in your

statement?

A. I refer to two assurance frameworks in my statement.

33 Q. Okay?

A. I apologise, just to explain because I think this is important. There is no question that the Trust and I as an individual went on a journey in terms of assurance and understanding how the Assurance Framework would evolve and the 22/23 Assurance Framework is the byproduct of our experiences. I also exhibit the 15/16 Assurance Framework and I draw out in the document, we went through a process, an internal process within the Trust to review the Assurance Framework and when the drafts came to me, and I think Chris Hagan was leading on it, my question was how would this new Assurance Framework help to prevent or alleviate or stop the Muckamore or IHRD or other things we were involved in. We did a number of things to the Assurance Framework. Now, I'm not saying that adding in to the Assurance Framework, you know, the bits and pieces that we added into it would stop poor practice. What I'm saying is, as a statement of what we stood for, as a statement of what we expected of a statement of what we had learnt, I think it captures that. 10:57 10:57 10:57 10:58

34 Q. Yes?

A. We went through a whole range of iterations and we had workshops and other things but a document is a document. A document only works when it is embedded in the organisation and people are trained and developed and held to account for complying with it. 10:58

35 Q. But, be that as it may, and this is potentially in ease of what you told the Inquiry a few moments ago, Mr. McNaney, we discussed the role and the standing of the Assurance Committee and any perception of a lack of challenge or independence. We can see within the lines of assurance, and this relates to what you tell us in paragraph 20, that the Assurance Committee provides a second line of assurance within the integrated governance and Assurance Framework? 10:59

A. Yes. 10:59

36 Q. But we can then see in this 2022/2023 document that over and above you, and you are wearing your Assurance Committee hat as it were, there is a third line of assurance which is described under the arrow there as independent and more objective assurance. It 10:59

"Focuses on the role of internal audit but can include other sources including external audit and independent inspections, for example the RQIA." 11:00

A. Yes.

37 Q. "Placing reliance on the first and second lines of assurance mechanisms and tests and controls."

So is there anything you would wish to tell us about the operation and inter-relationship between the second line of assurance, in terms of the Assurance Committee, and then this third line of assurance, in other words potentially external sources of examination and audit? 11:00

A. Well I think we would have always looked for and paid considerable attention to the independence of internal audit reports. The valued advice of the RQIA, particularly in a hospital like Muckamore, which is a regulated designated hospital and I cite in my statement the role the new Assurance Framework, adult safeguarding framework came out in 2015 and contains within it the critical role of the RQIA in terms of every incident has to be reported to them and their role in inspections and assuring safety. And of course, we would take their, I mean as this process evolved and we went into, you know '18, '19, '20, '21, the RQIA issued notices, I mean my view was, as Chair of the Board, that that was extremely valuable information for me. I read or I've tried to read all the minutes, Mr. Chair, and I've come across examples where, I mean obviously things became, on occasion, strained between people trying do a really hard job to make things better in Muckamore and the inspections. There were, the bottom line is the RQIA are the RQIA and we need do what they tell us to do and we need to develop a better relationship with them to get those things done.

DR. MAXWELL: Can I ask you a little bit about the third paragraph there, so it is saying that the independent and objective assurance is actually testing the controls that have been put in place in the first and second lines of assurance. So they are not just randomly appearing, they should be used to check

against the first two lines of assurance. And the result of your second line assurance is your Board Assurance Framework.

A. Yes.

DR. MAXWELL: Now, when Mr Smythe came to tell us about the audit committee -- 11:02

A. Apologies, I didn't pick that up.

DR. MAXWELL: When Mr Smythe --

A. Mr. Smyth?

DR. MAXWELL: You pronounce it Smyth, sorry. When he came to tell us about his experience as Chair of the Audit Committee, he said that the internal audit programme was not based on the Board Assurance Framework? 11:02

A. Well, that's not right. 11:03

DR. MAXWELL: Well I was a bit surprised.

A. That's not right. I think and maybe we can advise the Inquiry in correspondence [REDACTED] No, that's not how it works. That's not how the process works. The prescribed accountability framework then prescribes that health Trusts need to use the services of BSO, who are the Business Services Organisation that serves all Trusts and they have an internal audit unit and the head of internal audit reviews, on a three year basis, and then updates on an annual basis, reviews the Assurance Framework, the corporate plan, the risk registers and the vital thing about internal audit is their independence. They independently then come up with a list of what they say internal audit plan should 11:03 11:04

have for the following three years, dependent on the risks and what we are trying to achieve. They then, consult is the wrong word, they then circulate that list to the organisation and gives an opportunity for the organisation to make representations.

DR. MAXWELL: So where --

A. But the internal audit determines what the plan is. The plan then goes, there's minutes which we can show you, which we should write to you about with, it used to go to the Assurance Committee.

DR. MAXWELL: Not the Audit Committee?

A. Up to I think about 2016 it went to the Assurance Committee and I read minutes, because when I heard that I said look that's not right so I went in and picked the minutes and said we should write to the Inquiry and correct that. They went to the Assurance Committee, Catherine McKeown then came to the Assurance Committee, she is the internal auditor, and then its approved and that then changed in 2016 and it went to the Audit Committee.

DR. MAXWELL: The internal audit report goes to and is considered by the Audit Committee and in fact we've seen that that is included in the Audit Committee report to the Board. So I'm slightly confused why part of internal audit is being discussed in the Assurance Committee and part in the Audit Committee?

A. No, I think it was the practice up to 2000, I am just reflecting to you, up to 2016 it came to the Assurance Committee, post 2016 it came to the Audit Committee.

DR. MAXWELL: Because potentially you can fall between two stools.

A. Absolutely, absolutely.

DR. MAXWELL: The second part of my question then is if you are losing these three lines of assurance, any external assurance such as an RQIA report should be cross-referenced back to the Board Assurance Framework and I am wondering where that happened? 11:06

A. In terms of the process carried out by the internal auditor, I can't -- 11:06

DR. MAXWELL: I am not talking about the internal auditor, I am saying when the Trust receives the RQIA report how does it cross-reference that to the BAF?

A. I think the Trust has a well developed governance office. The governance office has the reports from the various sources and, you know, if you're asking me is there a formal -- 11:06

DR. MAXWELL: I am asking how non-executive directors independently scrutinise the governance process?

A. Well I think that any -- certainly in relation to Muckamore the RQIA findings and reports were reported to the Board, were reported to the Assurance Committee and, you know, that then, that becomes part of the sum of your knowledge. In terms of how that is systemised, I am not able to answer that, I can go away and ask the question but I am afraid I am unable to answer you. 11:07 11:07

CHAIRPERSON: Can I just ask in relation to the third line of assurance, it mentions other sources including external audit and the RQIA, apart from the RQIA,

during the time that you were Chairman what other external audit did you have?

A. Okay. Well what I had to become used to in the Trust is, there is a pile of regulators, depending on the function and the service. For instance we use a lot of radiography in the treatment of cancer and there is a whole pile of regulatory requirements. 11:08

CHAIRPERSON: In relation to individual services?

A. In relation to individual services. There is umpteen, Mr. Chairman, now again we can bring those to the attention of the Panel, but I was astonished. I mean there is all sorts of -- also in social care there is obviously a whole range of, and then you come to the DSF reports which are a different form of explanation about social care and the delegated statutory functions, but there is piles and piles and piles. 11:08

CHAIRPERSON: And in relation specifically to Muckamore and Learning Disability Services, can you name any external audit, apart from the RQIA inspections, that was taking place? 11:09

A. Not to my knowledge but that's qualified to not to my knowledge.

CHAIRPERSON: You can come back to us.

A. I'm happy to come back to you but not that would instantly come to mind. 11:09

CHAIRPERSON: No.

38 Q. MR. McEVOY: You touched on, a few moments ago, the introduction of a new adult safeguarding policy in 2015. You joined the Trust in 2014?

A. Yes.

39 Q. But, were you cited on or had you been given an idea of or indeed formed your own impression of what the shortcomings were of the previous adult safeguarding procedures? 11:09

A. Well I mean I do want to make this point, not specific to me, but for good governance going forward, when I joined the Trust in 2014 the training which was provided to me by the Department of Health was a SIPFA course on managing public money, that was my training. 11:10 Now, when I was in the Trust I obviously then arranged for briefings by all the directors of all the services. I mean, I tried to come to terms with these directors were managing portfolios of 300, 400 million which were massive portfolios. I met all of them. I asked them 11:10 the question that I always ask is 'let me know what keeps you awake at night. What are the things that you are most worried about?' I specifically remember talking to Catherine McNicholl. I have her slides which she then produced to the new intake of directors 11:10 for induction in 2016. There was no mention of Muckamore as one of the things that kept her awake at night. There was no mention of Learning Disability. My awareness of Learning Disability, as I've indicated previously, really started to get greater when we had 11:11 to go through the extraordinary Trust Board meeting when we started to deal with Learning Disability and perhaps we can touch on that -- but I've lost my thread now, I apologise.

40 Q. You are okay. For example, had you been made aware of the issues that arose from what went on in the Ennis Ward and the related investigation?

A. Ennis, when I've checked the minutes, was reported to the Board I think some time in 2013, so obviously I didn't pick that up. It certainly wasn't drawn to my attention. I never heard of Ennis until 2017 when the initial report came to Trust Board on 2nd November. 11:11

41 Q. Okay?

A. There was mention there, it wasn't named as Ennis, but there was a mention of previous safeguarding reports. Subsequently when Ennis became an issue for the Leadership and Governance Review, I got the Ennis Report. I read the Ennis Report and I became aware of it then, but I had no direct -- now, I need to reflect, having read the Ennis Report, and forgive me, Mr. Chairman, I know that you've dealt with Ennis in some detail and you have a far greater understanding than I did. But I mean obviously Ennis, there was a shocking incident with two people were subsequently prosecuted. But, having read the report, from the information I have read, it appeared that it was contained to that ward. I mean I think Aine Morrison says there was no suggestion that there was, from the Bohill staff on other wards, there was no suggestion that there was inappropriate activity. The RQIA were also involved heavily and the PSNI and there was no broader investigation at the time, and I know monitoring went on. So, you know, one always asks 11:12 11:12 11:12 11:13

oneself what one would have done if you would have had -- I don't know what I would have done if I had received the Ennis report. I definitely think the Ennis Report should have come to the Board. I definitely think it should have been an SAI. But is it evidence of broader institutional abuse? I'm not equipped, from the information that I have read, and that's a proper matter for determination by the Inquiry. 11:13

42 Q. I suppose on one view if it had come to the Board, those sorts of investigations and inquiries could have been conducted? 11:14

A. Well I think there were investigations happened at the time that it happened, you know, it predated it. The only thing it made me think, I mean one of the questions you ask is about Winterbourne which was I think in 2010/2011. So this was, it was close to Winterbourne. So I'm not, I wasn't in the Trust during Winterbourne. I would have to say in all frankness not everything that happens in England and Wales and Scotland is translated into activity here, albeit we have tried, when I have been Chair of the Trust Board, to learn from things like the Augharan report, to learn, like we had all sorts of issues Embrace about our stillbirth figures and things, so we would have tried to learn from the Patterson reports and other reports. But I don't remember talking about, ever talking about Winterbourne or Ennis before 2017/2018. 11:14 11:14 11:15

CHAIRPERSON: Would that be a convenient moment? All

right, we'll take a break there. Thank you, we will have 10 to 15 minutes.

A. Thank you, Mr. Chair.

CHAIRPERSON: Then we'll carry on.

A. And I won't talk to anybody. 11:15

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you. We'll try and keep going to lunch but, again, if you want a break at any stage, 11:31 just let me know.

A. Thank you Mr. Chairman.

43 Q. MR. McEVOY: All right, Mr. McNaney, before the break we had just been touching on the Adult Safeguarding Policy introduced in July '15. I am at paragraph 23 11:31 now on page 9?

A. Yes.

44 Q. And we see that under this, it set up a Northern Ireland Adult Safeguarding Partnership. Each Trust was to establish a Local Adult Safeguarding Partnership, 11:31 LASP or "Lasp", I'm not sure whether either of those are used.

"Chaired by its Executive Director of Social Work. The LASP was responsible for ensuring that an effective 11:32 adult safeguarding policy was in place with robust governance arrangements and the commitment to zero harm and ensuring compliance with the agreed delegated statutory functions."

Can you recall from this policy, or perhaps more accurately from its workings, how the LASP related to the Trust's risk and quality governance systems?

A. Yes, well the Executive Director of Social Work was the Chair of the Belfast LASP, which was a Panel which included people from outside the organisation. It included community sector, independent, criminal justice, local commissioning groups, faith community and it did an annual report on adult safeguarding which I have exhibited at page 1,027. 11:32 11:33

45 Q. Yes?

A. Which I think is very useful actually to have a look at.

46 Q. 1027?

A. Yes. Of course I need to find it now. 11:33

CHAIRPERSON: We'll bring it up.

MR. McEVOY: It will come up on screen now.

A. Sorry, Mr. Chairman, I have written on my copy. Yes, 1027. So it did an annual report and that annual report was always presented at the same time as the Delegated Statutory Functions Report was being produced. And, you know, I mean I've read this last night or the night before and I think it's, there's good stuff in it, particularly in relation to Muckamore. If you look at page 1057 to 1060, there is specific discussion of Learning Disability. 11:33 11:34

47 Q. Yep?

A. There is discussion about the Muckamore investigation. You know, there is discussion about the number of

referrals. There's discussion that CCTV is now running across all the wards at Muckamore. There is good discussion then about the themes from the Flynn Report on 1059 and 1060. There is detail about how they are actually being addressed. When I was reading it last night I remembered, you know, that this, the annual Safeguarding Report was a very useful document. 11:34

48 Q. Yes.

A. And we incorporated that into -- we dealt with it at the same time as we dealt with our Delegated Statutory Functions. It would have come through the social care, not the Committee, the Social Care Working Group or whatever, the steering group, the Social Care Steering Group. 11:35

49 Q. Was the steering group then the mechanism by which the LASP would have reported or effectively advised the Trust of what it was doing? 11:35

A. Yes.

50 Q. And what information it had to hand?

A. Yes and then it would also come to the Board. 11:35

51 Q. Right, okay. Who would be the person then who would have been the liaison then to the Board?

A. The lead on the ASG report is the Executive Director of Social Work.

52 Q. Executive Director of Social Work, right, okay? 11:35

A. A lot of his written work and support would have come from John Growcott.

53 Q. Yes?

A. Who was the deputy lead and the lead on things. When

you go through it, it is a very comprehensive document and it sets out really a lot of the themes from the Flynn Report and the actions.

54 Q. Yes?

A. And the learning. 11:36

55 Q. All right, well that's helpful and obviously we have it and its exhibited and it's been made available on the Inquiry website, so thank you for that. Picking up then on the Executive Director of Social Work, something that you have quoted for him, or from him on 11:36 paragraph 25 then which relates to his discussion of the report but also, in particular, we can see in the quote in italics mention of a Trust Adult Safeguarding Committee. Can you help us understand what that is and how that relates to the Local Adult Safeguarding 11:36 Partnership? You can see the last line there in paragraph 25?

A. Would you mind if I just read it?

56 Q. Yes, of course, of course.

A. Well I think what he's saying there, and actually it 11:37 reminds of one of the points that comes from the report later on, the problem about adult safeguarding in the Trust was that it was done, even though the Executive Director of Social Work was the lead and was the advisor and had people to advise services, adult 11:37 safeguarding was the responsibility of the individual service and there was no central coordinating committee, and I think that's what the Trust's Adult Safeguarding Committee was established to give that

corporate focus. Now, later on, as things progressed, I mean the worry that I or Ned colleagues, I mean clearly what was happening in Muckamore was deeply distressing. But it put into sharp focus that we have vulnerable people across the organisation, we have 11:38
dementia wards, we have older peoples' wards, we have, you know, young children, we have children with learning disabilities in Iveagh. We have -- across the Trust there is a significant number of vulnerable people in vulnerable areas and we had to make sure that 11:38
we were conscious of that and that there was a proper governance system to assure safety in those areas. And we supported, as a Board, the Adult Safeguarding Committee and we later supported, further down the line, Mr. Chairman, in I think 2020, I asked for a 11:39
specific review of social care governance and it's in the minutes that Carol Diffin, the then social care, or the then Executive Director of Social Work, she then undertook that with the assistance of a few people we brought in to help her. That eventually led to the 11:39
separation of roles from -- well the Executive Director of Social Work was also responsible for childrens' so at that stage working with Cathy Jack we made a submission to the Department to increase our number of directors and we then, the Executive Director of Social 11:39
Work role was split into two and childrens' and Community Social Work had its own director and that came from the director of thing. But we were very conscious of the number of vulnerable people that we

cared for and that we had to assure ourselves that work was being taken on Valentia ward, Meadowlands, these were all the wards and particularly the children's homes which we, as non-execs tried to visit, we tried to visit these wards. Sorry, the whole point was the services were responsible but we had to assure ourselves there was coordinated action -- and later on, just to complete the story, there was, after the Neurology Inquiry, which involved a big call back of 3,000 patients to determine whether they had got the right treatment from a neurologist, Neurology being principally an out-patient activity, there was a thematic review by the RQIA into the operation of out-patients across the organisation. One of the issues that they raised was there needed to be a greater awareness of adult safeguarding issues across the services. And we then tried do work to ensure that training and that awareness was given, particularly with, you know, ward sister, charge nurse level.

11:40 11:41 11:41

57 Q. Okay. Paragraph 26 then:

11:41

"In the period from 2015 through to late 2017 the Board did not receive any warnings of a major safeguarding issue at Muckamore Abbey, whether from the LASP or from any inspection by the RQIA in relation to Muckamore Abbey. I do not mean there would not have been information in the system as to issues at Muckamore, as there obviously will have been, as there will be for every service operated by the Belfast Trust, but there

11:42

was no information coming to the Board including through the likes of the Social Care Committee or the presentation of the Delegated Statutory Functions Report, that there was something out of the ordinary or the type of problem that came to the Board in 2017." 11:42

Now the Inquiry has heard evidence, including from among others, John Veitch, that conversations were taking place between the Chief Executive and the Health and Social Care Board about issues with, for example, 11:42 staff shortages, increases in violent and aggressive behaviours and changing of the mix of patients on wards.

A. What Chief Executive would this have been, if you don't mind me asking. 11:43

58 Q. This is 2015?

DR. MAXWELL: Martin Dillon.

A. Or Michael McBride. Michael McBride would have been there as well, wouldn't he, he was there from end of 2014. 11:43

DR. MAXWELL: Well we can check, it's in John Veitch's statement and he talked about it when he gave evidence.

A. That wasn't visible to me.

59 Q. MR. McEVOY: The identity of the specific CEO is possibly secondary, but I suppose the point is then, 11:43 there is that degree of soft intelligence in the possession of directors about those sorts of issues. How would you have expected that to have been communicated to you and to your fellow non-executive

directors?

A. Well, again, I have to talk about the wider picture before I focus down. Staffing, particularly nursing, across the organisation, across the organisation was always a matter of deep concern. You know, we didn't have enough nurses. 11:44

60 Q. Yes?

A. We didn't have enough theatre nurses, which of course then led to even more delays and even longer waiting lists. We didn't have enough nurses to work in ED. We didn't have enough midwives. We didn't have -- and there was a constant debate about nursing and how we would have got more nursing, but that was across the organisation, that was the conversation of the Board. The conversation at the Board was around -- you know I remember the Board, I mean again, workforce planning and development was a departmental function. Of course we worked with them and there was a work plan strategy and I remember the Board actually brought the director of that service down to the Trust Board and we had a conversation with him and he was very helpful now to be frank. But workforce was the biggest risk that the organisation as a whole had. The action the Board took, but I never got this on a Muckamore only basis, the Board did actually intervene in the strategic workforce issue I think in 2019, 2020 when I needed more impetus given to the issue and we set up a particular unit headed by Maureen Edwards who was our Director of Finance. If you want something done get

11:44 11:44 11:45 11:45

the person who manages the money do it. We then had a task force and I think we then brought in overseas, nurses, Philippines, south India, 300 or 400 a year for about three years. Regretfully it was very hard to acquire learning disability nurses but we did, as an example, we had Board members on that working group, you know, Martin Bradley and Nuala McKeagney who added value. But the short answer to your question is I wouldn't have seen that, didn't see it.

61 Q. Paragraphs 27 through to 30 then you discuss the 2016/ 2017 Assurance Framework. You touched on it before the break. You helpfully have isolated some useful quotes which set out its objectives, risks and so on. In particular then: 11:46

"The framework should provide the Board with confidence that systems, policy and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate they have been informed about key risks affecting the organisation." 11:47

You then go on to describe the organisational methodology that the framework contains and at 30 then the risk management strategy and so on. Pausing there, can I draw your attention just to a document, I hope you had a chance to look at it before today, which is in the nature of an exhibit from a Trust witness who came to give evidence to us last year, her name was Brona Shaw? 11:47

A. Yeah, she was a nurse.

62 Q. At the time when she came to give evidence she was the Deputy Director of Nursing, Quality, Safety and User Experience within the Trust. And she produced with her statement, among other things, some documents in the form of a synopsis of exit interviews and she told us that she had asked her team to conduct exit interviews in 2018 and 2019 with staff leaving Muckamore. You will see it, it will come up on screen if I could just ask for it to be brought up at page 22, because it is a small, isolated document, but it will be familiar hopefully to Core Participants and others. This is a synopsis of quotes from the 2018 document from staff leaving Muckamore. You can see, if we can sort of scroll down through it, the first heading is "patient safety and governance". Just by way of example: 11:47 11:48 11:48

"Not enough staff for the number of patients and their needs.
Insufficient dangerous staffing levels. 11:48
staff need to be MAPA trained.
Use of agency staff not realistic as they are unfamiliar with clients, not a true replacement for staff on the ward.
Registration at risk, there are not the resources to deliver. 11:49
I submitted around 50 IR1 forms, never was there any follow up or debrief or learning yet in one of these incidents three people were injured."

Those are just some examples. Moving on down.
Wellbeing at work:

"Physical aggression, daily risk of physical harm, mental scars from violence. Incidents of completely unexpected aggression. Staff just going through the motions of their role as everyone feels compromised due to investigations." 11:49

Then moving on down please. 11:49

"Staff morale low."

I am picking examples at random. 11:49

"Poor staff morale affects mental health.
increasingly challenging more recently.
moved from pillar to post..."

11:49

A. I'm happy to -- I have read that.

63 Q. I've given you the gist of it. Did you see that report or anything like that?

A. No. But, what I would say is we had constant reports from the various Directors and Heads of Service who took forward management of Muckamore from 2017 onwards. We had reports from Marie Heaney for a time. We had reports from Bernie Owens. We had reports from Gillian Traub. We had reports from -- and there was no 11:50

question, there was no lack of candour in reporting the difficulty that staff were having in Muckamore. So I didn't see this report. I note from the report that it's 11 staff.

64 Q. Yes? 11:50

A. And four of them retired.

65 Q. Yes?

A. So essentially it's a sample of seven. Now, I am not for one moment saying that this document does not reflect the honest feelings of the Muckamore 11:51 environment, and there is no question at that time the Muckamore environment was extraordinarily difficult. We had staff working who were being told they were being investigated but weren't told what they were being investigated for. We had the IT equipment that 11:51 we used to view the historic CCTV seized by the police. We had, you know, desperate trouble in trying to staff Muckamore. We had to use lots of agency staff. So there is no question that I recognised that some of the really serious problems exhibited in this document, 11:51 which I commend, I mean of course we should be asking people what the issues were. And the Trust made enormous efforts. I mean we tried to put our best people into Muckamore at various times. I mean Gillian Traub, I know she has given evidence, Gillian Traub is 11:52 one of the best officers I have worked with. These were intractable problems that despite monumental effort we found hard to solve. Now, I have always, my management philosophy is when things are difficult then

you need to seek help and you need to share responsibility. And at Board level we specifically had conversations about using critical friend and I wrote to the Permanent Secretary, because at the time money was really tight, to get permission to avail of a critical friend. And as the tribunal, Inquiry will know used East London Foundation Trust and we insisted, we had an independent Chair of the SAI, we brought in Margaret Flynn, but we retained Margaret Flynn as an advisor and she did all sorts of work in relation to the thing. So there were numerous groups of, I remember Brenda Creaney at the start got an advisory group with Eoin, the Professor from the University of Ulster and various others. We also shared, we were absolutely open and shared all of this with the Department of Health. The Department of Health set up the MDAG committee. They very helpfully offered us Francis, sorry --

11:52 11:53 11:53

DR. MAXWELL: Rice.

A. My apologies. To come and work for us. They, through the MDAG approach with the direct involvement of the Chief Nursing Officer and the Chief Social Worker, they gave us all the help they could give us in trying to deal with the issue. You know, and I mean I was struck yesterday actually, and forgive me, Mr. Chairman, I just want to refer to this briefly, there was talk yesterday with Cathy Jack about the risk summit and that was held on 29th April 2021. That was with the Belfast Trust, the RQIA, the Department of Health, the

11:53 11:54

Public Health Agency. And again that's again another example of our approach, we needed to draw in all the expertise we could find to explain to them and share with them the great difficulties we were having. I just wanted if I would be permitted to read into the records the comments of the RQIA, which is on page 334 of 497 of Cathy Jack's statement. 11:54

"During the last couple of inspections RQIA have been impressed with the quality of care being provided despite all the risks described. There will always be a risk of poor care but we are not seeing poor care when we visit, we are seeing effective and compassionate care. There has been an increase in adult safeguarding referrals but we see this as a positive increased recognition with staff being proactive. We do not believe this represents a deteriorating position and we feel it is only fair that we congratulate the Trust on what it has achieved in the last two years." 11:54 11:55 11:55

And then Sean Holland, the Chief Social Worker says:

"Sean felt that the focus that had been given to Muckamore by the Trust should be recognised and said that the rest will be slow. It is accepted that Belfast is managing the risks on day-to-day basis. Sean said he was seeing the collective approach in use increasingly and that there are discussions happening 11:55

with a thoughtfulness between Trusts that he would not have experienced before. It is being managed as well as it can be and the risks are collectively recognised."

11:55

I have been involved in management for a long time. I am a Chair, not a manager, I can't go in and manage the staff. This was one of -- it was like a snowball rolling down a hill. It just got bigger and bigger and bigger and it had -- it also had the difficulty that 11:56
there was no established future for Muckamore until I think, what was it, 2023, or 2022, end of '22 when they did, the Department of Health did the consultation on the closure of Muckamore. And even that consultation showed that 46% of people wanted to keep it open and 11:56
54% of people wanted to keep it closed. This is like so many complex problems, you don't solve it because it's so hard. And it wasn't for want of throwing resources at it. It wasn't for want of sharing the issues with our colleagues in the Department of Health 11:56
who -- and PHA and the Board. It wasn't that we didn't put additional resources and scaffolding in. It just was enormously complex and enormously difficult. And I recognise the comments that are being made there, but I will not, I would I like to put on the record, the 11:57
Trust made enormous efforts and we had to make enormous efforts because we had to keep our clients and the people we were looking after safe. And there was nothing, there was no denial of money or resources.

And if you look at it overall, there was still incidents occurred but much fewer. There was much less use of seclusion. There was much less use of medication. There was a lot of things that happened and regretfully, I mean, if I had been a member of staff in those most difficult of circumstances, I probably would have felt some of the things that are exhibited there as well. 11:58

66 Q. All right.

CHAIRPERSON: Will you be guided by counsel to the Inquiry. I am not stopping you if there is something -- 11:58

A. Sorry, Mr. Chair.

67 Q. MR. McEVOY: That is a comprehensive answer. So if we can turn on to page 13 and to paragraph 37 please. 11:58

A. Page?

68 Q. 13?

A. And what paragraph?

69 Q. 37. It is back to this sort of theme or topic of committees and the interrelationship of various committees. We've talked about the Assurance Subcommittee as set out within appendix B, that's of the earlier framework document. You refer then to a Social Care Steering Group. After 18 months as Chair of the Trust you say you: 11:58 11:59

"...realised that many issues arising from the acute side of the Trust's services were overwhelming the space and time available on the agenda of meetings,

leaving insufficient time to interrogate social care issues which accounted for 48% of the Trust budget."

You then describe having a discussion with the Executive Director of Social Work, Mr. Worthington, and the then Chief Executive, Dr. McBride as he was then. 11:59

"After consideration by Trust Board members at a development day it was agreed that we should, from the beginning of 2016, set up a Social Care Committee chaired and populated by non-executive directors." 11:59

And you can on to describe who those people were. Can we understand first of all did that Social Care Committee report to the Assurance Committee? 11:59

A. No, it didn't. It didn't report, it reported directly to the Board.

70 Q. Right.

A. My purpose, there was still the Social Care Steering Group that reported to the Assurance Committee. 12:00

71 Q. It didn't replace the Social Care Steering --

A. No it didn't replace and my thinking around this was I needed more non-exec involvement in the interrogation of the DSF report and the annual report on children. And what I had understood from working in the Council and working through a committee system is the development of staff, it was essential to put our social care staff in an environment where there could explain their problems directly to non-execs and gain 12:00

from the experience of those non-execs like Anne O'Reilly, as I have said before, who was a social worker who was involved -- forgive me, there is a body which is responsible for social work training and development in Northern Ireland, Anne was on the Board of it. I think the Social Care Committee, having spoken to Cecil Worthington, having spoken to social work staff, they really valued that access and interrogation and explanation.

72 Q. Okay? 12:01

A. Now, that was to get that access to the non-execs. The non-execs could then bring that additionality of information back to the Board, because the DSF Report would go to the Board. The DSF Report was informed through the Social Work Steering Group and the Social Work Steering Group went through the Assurance Committee. But my purpose at that time was visibility of social care. 12:01

73 Q. Okay?

A. And the issues surrounding social care. 12:01

74 Q. That's quite clear.

A. My final sentence, forgive me. My final sentence is, the issue about acute is that it's so immediate, you know, and you have to deal with it. And my issue about the scale and size of the Trust is not in any way to not accept our responsibility for safe care at Muckamore, which I do absolutely. It's just to say it's about room and space. 12:02

75 Q. Yes.

A. You know, you cannot deal with everything. And, you know, I do exhibit at paragraph 12, at tab 2, I exhibit copies of confidential Trust Board meetings to try and illustrate that. On the 5th July '18 and 3rd December '20.

12:02

76 Q. We will come on to look at some of those Board minutes in due course, I can assure you of that. Can we just understand, in terms of, you have very clearly explained what your concern was in terms of giving the space and time necessary to social care?

12:02

A. Yes.

77 Q. Were there any particular events that percolated it, if you like, to the top of your mind or was it just a lurking concern that you had given --

A. It wasn't a lurking concern, it was an obvious concern that we were spending, our agendas and time were being dominated by acute care.

12:03

78 Q. All right?

A. I'm sure --

79 Q. No particular events, no catalyst as such?

12:03

A. Well even when you looked at the budget breakdown, we spent 48% of our budget on social care and domiciliary care, so we needed more balance in terms of the time that we spent looking at it.

80 Q. What was the effect then of having set up the Social Care Committee, did it have the intended effect of ensuring that social care issues got their place on the agenda?

12:03

A. I think it did.

81 Q. And acute matters didn't dominate to the same extent?
A. I think obviously it is for the Inquiry, but the Inquiry will be greatly informed by Anne O'Reilly who chaired it, who is very knowledge able about social work at a regional level, very influential in terms of moving the social care agenda. I mean one of the big problems in social care is people at domiciliary level are paid so poorly. So I think the Social Care Committee, I can say first of all anecdotally I had loads of chats with social workers who appeared before the Committee that really went out of their way to say how much they appreciated the time and the access that the Committee provided. I think it informed the overall discussions in the organisation about balance. 12:04 12:04
82 Q. Now, at 38 and following then you say you indicate on the basis of what you knew at the time: 12:04

"in '14 through to late '17 the Assurance Framework processes did appear appropriate and did appear to be functioning effectively in the context of the many serious events and matters that were escalated to and did receive the attention of the Trust Board." 12:05

I am asking you to comment, I suppose, from a position of hindsight, but looking back, do you still hold that view? 12:05
A. Well things happened at Muckamore, appalling things happened at Muckamore. So clearly the governance system didn't pick them up.

83 Q. Yes.

A. What I would say is, and I've heard questions being asked about red flags, you know, I genuinely can say that I am an inquisitive person, that I try to be as analytical as I can be and I did not pick up red flags. 12:05
Now, maybe there wasn't reports to us or whatever, but I did not pick them up. I didn't pick up -- and there were issues, I referred to the risks, I've referred to, you know, other things in the DSF Report and Kathy said this yesterday, refers to the March '17 report that 12:06
talks about the NHS benchmarking service which were favourable figures in relation to Learning Disability, except it is Learning Disability, it's not Muckamore. I tried, I mean, I always tried to interrogate things myself by looking offline at reports and 12:06
correspondence. I mean again, I mean there is an RQIA report dated March 2015 entitled "safeguarding of vulnerable adults in learning disability hospitals" which examined the six wards in Muckamore and reported:
12:06

"It was recognised that the ongoing development of the DAPO role is invaluable in invaluable and establishing more effective safeguarding arrangements."

Then says: 12:07

"Overall governance arrangements in place to support effective safeguarding is considered to be appropriate with clear management accountability and structures."

There was evidence there that I remember, I mean I remember reading at the time, I can't remember how I picked it up, but there were things there which did, which didn't give me cause for concern. We introduced safety walkabouts in 2016 by the Exec Team. There were three safety walkabouts in Muckamore in 2016 by Michael McBride, by Jennifer Welsh, by Shane Devlin and none of them reported back any adverse comment. The Board meeting was there in 2015. I went there.

12:07

84 Q. Do you know whether those walkabouts were announced or unannounced, would they have been advised to the management?

12:07

A. No, I think leadership and safety walkabouts, they were announced. We also had, according to Margaret Flynn, 51 RQIA reports in that period.

12:08

85 Q. I was just coming to that. If you look at paragraph 40 --

A. Sorry.

86 Q. No, I welcome your view on it. At paragraph 40 you talk about how the evidence of the CCTV showed what it showed in essence, I am paraphrasing. You say then:

12:08

"It demonstrated that the processes in place in the Trust were not preventing abuse or neglect and nor were the ASG arrangements in place at the time sufficient to stop it."

12:08

Then you make the point you were coming to similarly:

"61 inspections carried out by RQIA at Muckamore Abbey in the period 2010 to 2017 did not result in the suggestion that there was major issue of staff abusing patients. It was only the game-changing impact of CCTV that allowed the true picture of abuse on at least some wards at least in 2017 to be revealed."

The RQIA inspections, I suppose, say what they say but, from your perspective, they didn't uncover any concerns of staff on patient abuse, but from your perspective, sitting where you did at the time, what did that tell you? 12:08 12:09

A. I mean I genuinely thought we had a decent governance system. There needed perhaps to be, as we tried to do now, have more focus on the most vulnerable and have more checks in the process in terms of -- but they didn't reveal, they didn't reveal the abuse. Now eventually a staff member did report another staff member in 2017 and it was escalated. But, you know, the bottom line is unacceptable abuse was happening, we didn't pick it up, the system that was there to prevent it didn't prevent it. 12:09 12:10

87 Q. Yes?

A. I regret that deeply.

88 Q. At 42 then you move on to talk about the '22, '23 Governance and Assurance Framework again and at the very bottom of the page you begin to tell us: 12:10

"Reflected the move by the organisation to a collective

leadership structure with divisions being established across the organisation."

You helpfully exhibited the structure in your exhibits. But can you give us a very brief summary of what your understanding of what a collective leadership structure is or was and how, just in your own words if you like, how it differentiated from what had been there previously? 12:10

A. Okay, well again I need to start slightly before that. When I joined the Trust in 2014 and observed things for about a year, I kept on asking myself the question, where are the doctors involved in management leadership? I read up about it. I read up on the back of learned reports about quality improvement that the absence of engagement of staff, both clinical staff, was one of the predominant risk factors and, you know, a Board needed to be focused on quality improvement. I determined that we would try and do that. I arranged quality improvement training for the Board. I spoke to executives at the time and said we needed to do a staff survey. And we had Professor Michael west over at the Trust leadership conference and Professor Michael West at that time was one of the predominant promoters of collective leadership. And collective leadership is where you bring a big doctor or big nurse and big manager together into a division and that then manages the service collectively. It is always a problem if everyone is responsible, no one is responsible, but 12:11 12:11 12:11 12:12

collectively managed the service. So we split the organisation up into divisions and with the collective leadership teams in all the divisions and it increased the number of engaged medical and nursing staff in the management of the organisation, in my view beneficially, and then became the foundation on which we built the QMS system.

89 Q. All right, thank you. Moving on down then to paragraph 45, and still dealing with the 22/23 framework then. You discuss accountability for Trust boards having an overarching, this is the quote: 12:12 12:13

"An overarching responsibility to provide strong leadership, robust oversight to ensure and be assured that the organisation operates with openness, transparency and candour, particularly in relation to its dealings with service users and the public." 12:13

You have been emphatic in your evidence today about that. On down then in the paragraph you mention that the Assurance Committee, this is just about six or seven lines up from the bottom of that paragraph on page 17: 12:13

"The Assurance Committee received an annual report and a quarterly update on complaints and learning from experience." 12:13

A. Yes.

90 Q. You go on to say:

"The Complaints Review Group evolved into the Service User Experience Group to undertake a broader remit across the Trust to inform learning and support the progression of corrective improvement actions arising from analysis of patient, client and carer feedback."

When you left or when you stood down as Chair, retired as Chair, were you satisfied that the method and the means by which complaints or service user experiences were being brought forward was happening quickly enough? 12:14

A. I don't think you can ever do enough in complaints, I just don't think you can ever do enough on complaints. I think you can learn a lot from complaints. I think I exhibit minutes where I said that we introduced service user stories. 12:14

91 Q. Yes?

A. We introduced at my instigation more complaints. I remember speaking to various Chief Execs -- when I was in the Council one of the things I did as a Chief Exec was I sampled complaints every month. I remember having that conversations with Chief Execs because a Chief Exec needs to be doing it as well as the team. Complaints were very difficult. We evolved our complaints process, particularly in relation to professional staff like doctors because in the Neurology Inquiry what was revealed to us was that we 12:14 12:15

weren't triangulating enough information from the various sources. And secondly that the complaint, when it came in, was normally referred to the doctor who had provided the care.

92 Q. Yes? 12:15

A. So we said no, you can't do that, it has to go to a different doctor.

CHAIRPERSON: When did you introduce service user stories?

A. Back in 2015. 12:15

CHAIRPERSON: Was that service user coming to the Board?

A. Service users came to the Board. There is examples in the minutes, Mr. Chair, and I can send you a note if you want. 12:15

CHAIRPERSON: We have got the minutes.

A. We were trying, and you know, you learnt a lot from them and we heard some really -- I mean we had to balance it at the end because we heard some really sad stories, they were very, very difficult but we then 12:16 balanced it that we also had, you know, positive experiences.

93 Q. MR. McEVOY: Yes.

A. Of, you know, for instance one of the things that we did was at one stage we had lots of Syrian young people 12:16 coming to Northern Ireland, finding them in the docks, and we put in place a whole big process to house them and educate them and it was led by the Health Service, that was a positive story. And staff, you know, it

echoed with their values and it was a positive thing to do. But we tried our best. Are we doing enough on complaints? We are doing more. I mean my whole evidence is I think I left the Trust governance-wise in a better place than it was when I joined it. I learnt a lot along the way. I know much more about health services than I did in 2014. You know, I've met some desperately committed staff and I've been involved in some incidents of care which is unacceptable, so it's a journey. 12:17

94 Q. Okay. Desperately committed staff, certainly, but just looking down at page 47, where you discuss --

CHAIRPERSON: Paragraph 47.

95 Q. MR. McEVOY: I beg your pardon, paragraph 47, thank you Chair, where you discuss the informing of the Board of failings and issues which result in harm to patients and clients. You make the point and about four or five lines down: 12:17

"The Board is also dependent on issues of poor care being reported by staff who witness such care. This is the first line of defence. I must admit that I have been dismayed that so many instances of poor care by staff at Muckamore Abbey were not reported to management by other staff who witnessed such abuse or by making an anonymous whistle-blowing complaint. I am aware that such reporting is often viewed as a high risk, low benefit action. The Trust has tried over the years to promote a culture of openness which in turn 12:17 12:18

promotes quality and learning."

We'll come to the duty of candour in a moment but setting that just to one side for a moment, you described dismay which I suppose is a strong word. What do you attribute that apparent cultural failing to?

A. Well, ex-lawyer that I am, I really want to analyse the evidence. I really want to see --

96 Q. But you were in the role from 2014? 12:19

A. No, I mean I will offer a view.

97 Q. Yeah?

A. But, I mean, I do think an analysis of who was charged, where they were charged, what they were charged for, when the events took place, you know. I have heard a whole range of views that some of these events took place at night, that they took place when there were staff around. But it is obvious from my viewing of the CCTV that I have seen that they happened at all times. My sense is, and I mean I did visit the PICU ward, in fact I visited three days before the complaint that led to the investigation in 2017. My impression was of a well staffed ward. The staff were enthusiastic about their patients, this is how it appeared to me. They were enthusiastic about their patients. I remember sitting in the office with the Charge Nurse and Deputy Charge Nurse, and they went through the files, they didn't give away confidential information, they went through how they assessed the patients, how they worked

with them, how they involved them, how they tried -- I mean it appeared to me that these were staff, they were very familiar with their patients. The ward was clean, there was no evidence of things. I mean we went through the ward. I mean clearly there is some severely autistic people there, you know, and they were managed very -- appeared to me, goodness gracious, it looked to me that they were managed compassionately by the staff. So my understanding of the level of abuse would suggest to me that -- I mean as a leader you have to model behaviour and you cannot walk past what is unacceptable, you just can't do it.

CHAIRPERSON: Could I just ask this, which is perhaps the question underlying Mr. McEvoy's question, you say essentially the Board is dependent on issues of poor care being reported by staff who witnessed such care, this is the first line of defence, we understand that. What would you say was the second line?

A. Well I think unquestionably with learning disability, CCTV or some type of secondary method of capturing real-time activity and what happens is, with everyone I have spoken to, with everything that I've read, CCTV was the game changer in Muckamore. Now, it was being put into Muckamore. Very few inquiries will have to look at six months of CCTV that people didn't know was on. It's captured an enormous volume of activity. But for learning disabled people who have, who don't have speech, you have to have secondary methods and we were putting CCTV in.

CHAIRPERSON: Yeah, okay.

A. Clearly, I mean for what it's worth, and you have heard a lot more than I, Chair, I think CCTV is essential.

98 Q. MR. McEVOY: Okay, I am coming then to the question of the duty of candour, it's not yet a statutory duty here in Northern Ireland? 12:22

A. Not even for organisations.

99 Q. Yes. And it's destination is still to be determined, I suppose. But, do you think, and maybe I am asking you to put your ex-lawyer's hat on here, but do you think there's a basis on which it could be made part of the contract with each member of staff rather than relying on it being, sitting as part of a sort of a lofty governance Assurance Framework? 12:23

A. Well lots of professional staff have professional obligations within their contracts already in terms of disclosure. I think, I don't believe in a criminal sanction at an individual level. If we are going to do that we should do it for all the public service. Why should we just do it for medical staff? You know, all the public service should be required to be candid and open and transparent. I think you have to work, as our organisation has tried to work, on having a just and fair organisation. People need to report things. Unless they report things, you know, we are unable to deal with it. It is partly the same issue in Neurology, a neurologist was working with lots of other people but, you know, it came to our attention when a GP wrote to us. I have to say, it's a cultural thing. 12:23 12:23 12:24

100 Q. Yes?

A. The Belfast Trust, we did a big report on culture. We have 300 cultures. So we have to work harder in modelling the behaviour that we expect, which is honesty and transparency and candour and I earnestly tried do that.

12:24

101 Q. Moving through to page 22, this is in relation to your response to question 3 which was asking you about your recollection of how often Muckamore Abbey was included on the agenda of meetings of the Trust Board and Executive Team. Overleaf then at page 23 you deal with the first point first in relation to the meetings of the Trust Board. You say in paragraph 62 that following a conversation in 2015 between yourself and then Dr. McBride, who was the Acting Chief Executive at the time:

12:25

12:25

"We should take meetings of the Trust Board out and about, as in hold meetings in other Trust buildings to be more visible to staff."

12:25

To that end a meeting of the Trust Board Workshop was held at Muckamore Abbey on 2nd July 2015. And you recollect that:

12:25

"After the meeting we had lunch with senior members of staff at Muckamore and walked around the wards."

A. That's my recollection, it's 10 years ago.

102 Q. It's a long, long time ago.

A. I'm pretty certain we did.

103 Q. You don't, it is a long, long time ago, but you don't recollect, do you, whether staff mentioned any concerns around staff shortages or lack of resources? 12:26

A. I think I went to Moyola, which was the activity area and, you know, talked to staff, you know, heard a bit about patient stories. I might have gone into Six Mile which is the forensic unit which is always a bit, you know, locked doors, it all feels constricting. No, I didn't pick up anything. And as I mentioned earlier, you know, these safety walk arounds that they started in 2016, I mean the first year they had three walk arounds. Now they weren't, they were preannounced, but I mean staff weren't behind the door, I have found in the Belfast Trust. 12:26 12:26

104 Q. Yeah?

A. In expressing their concerns.

105 Q. Yep? 12:27

A. There is no way that, with the Trust values, which are what they are supposed to be, there shouldn't have been any doubt about the behaviour that was acceptable and the Charge Nurses should have led by example.

106 Q. Okay. 12:27

A. All of us should have led.

107 Q. Well look I think you analyse then the questioning about meetings of the Trust Board and frequency with which the hospital was mentioned. At 63 you say:

"It was only infrequently mentioned on an individual basis. It is important to appreciate it was treated in a similar way to all other Trust services and facilities in this regard." 12:27

You looked through the minutes.

"There is mainly only mention of individual services if there was an issue with quality of care or a 12:27
particularly noteworthy service improvement alongside regular reports on finance, feedback and so on."

Again perhaps I am asking you to observe from hindsight or a position of hindsight, but by its nature Muckamore 12:28
was a hospital populated by people who had, very many of whom had difficulties with communication and that might not have been the case just as obviously perhaps around the delivery of acute services. Do you think there was any appreciation that those communication 12:28
impediments might have led to an under reporting of issues or problems to managers and thus to you?

A. Well, I was aware that they had advocacy services within the Trust, within Muckamore and, depending on where the patient was from, different advocacy, you 12:28
know Bryson House did the Belfast Trust. I think there was other charities did the other Trusts. So there was an awareness that you needed some sort of advocacy service, not just for the patients but also for the

patients' relatives, families and friends. Now it transpires that the advocacy service was not, according to Margaret Flynn and others, as effective as it might have been but I was aware that there was advocacy services.

108 Q. In fairness to you, you got the material from Margaret Flynn that told you that I suppose?

A. We did, we reviewed our advocacy services. I'm not sure they are as effective, even now, as we would want them to be across the organisation. But there was, there was no suggestion that we shouldn't invest in them and we shouldn't try and learn from them. 12:29

109 Q. Yes, okay. Next question is just a possible correction to what is said at paragraph 65 there. You have very helpfully set out a table in relation to where abuse was reported to the Board, sorry: 12:30

"After the reporting of abuse on 2nd November the hospital was regularly on the Board agenda as a specific item and you have given the dates." 12:30

Would the first date there sixth of the 12th?

A. That's wrong.

110 Q. That would be 17TH, would that be right?

A. Yes. 12:30

111 Q. Just to correct that?

A. My apologies. It does mention the Extraordinary Public Trust Board. I am trying to make the point, I mean when I was going through these minutes and I was

reflecting on them, I didn't see mention, I mean if the Leadership and Governance Review said you haven't mentioned it in the minutes therefore it's out of your sight and out of your mind, that genuinely was not my impression. We don't mention the Cancer Centre in the 12:30
minutes. We don't mention Musgrave Hospital. We don't mention Somerton Children's Home. Because something isn't mentioned doesn't mean to say you don't have processes. You know, there was plenty of management presence. I know some, there were -- when you look at 12:31
all the managers from the different times, because the managers change in the Trust and the Directors, there was plenty of directorial visits. You know, maybe not as many as one would like but relatively.

112 Q. Yes. 12:31

A. There were visits.

113 Q. And just on that, just on that --

A. Sorry.

114 Q. I can help you, question 4, which is the next topic you are asked about on page 25, had you occasion to visit 12:31
the site during your time on the Board and if so please indicate how often and outline the objectives. You are able to tell us at paragraph 67 you had approximately seven?

A. It might have been seven or eight and virtual visits. 12:32

115 Q. No, in perfect fairness to you, you are able to set out your account of what happened on each occasion. Focusing in, if I could, on paragraph E which relates to a visit on 19th July 2019?

A. Yes.

116 Q. You had, let it come up on screen. Thank you.

"We had a leadership walk around with Dr. Jack who was the Medical Director at the time, visited Cranfield, and spoke to patients, management, ward managers, doctors and nurses and observed the work on the wards." 12:32

Then you tell us:

"I recall talking to a medical consultant from England who advised people with severe autism, some of whom were housed in Muckamore Abbey, would never be housed in such an institution in England and we had a discussion on the need for more community provision in Northern Ireland." 12:32

A little bit further on in your statement, just for cross-referencing purposes, something maybe you mentioned a bit earlier in the oral evidence, is that the critical friend, is that the consultant -- 12:33

A. No, that consultant was, he in fact was an agency doctor and he was from England and he was very compelling --

117 Q. Yes. 12:33

A. -- in his view that far too many autistic people in Muckamore would not have been in Muckamore in an English situation.

118 Q. It's something that stuck with you?

A. Well, of course. You learn as you go along, you have to try and learn. I mean I remember taking that back and it informed our discussions. I remember having discussions with Marie Heaney. I remember -- or maybe it might have been Marie's successor. There were conversations ongoing at system level, you know, through MDAG in relation to -- but you have to remember we didn't even have an overall policy for Northern Ireland for learning disability, still don't have one my understanding is. So I think we were anxious to have these conversations and try to inform them but I am just trying to be honest. That's what I remember. Now that tried to inform my conversation as we went forward. 12:33 12:34

119 Q. Yes, that's exactly where I was going. Did it inform your approach to Board actions going forward in terms -- 12:34

A. You learn more about autism and you learn, you know, it's very difficult for them in an environment that's noisy, it is very difficult in an environment where there is change. It is very difficult. And you know, the system, and I include myself amongst that, we all should do more. 12:34

120 Q. Yes. Okay. Question 7 on page 30 asked you to provide details of occasions on which you became aware of concerns, effectively concerns relating to safeguarding, seclusion rates, complaints, resettlement, staffing? 12:35

A. Forgive me, could you --

121 Q. I am cross-referencing to question 5 on page 28.
A. Is it paragraph 72, is it?
122 Q. Moving forward to paragraph 72. You have me?
A. Yes, thank you.
123 Q. All right.

"During my tenure as Chair the first time the Trust Board became aware of serious concerns about safeguarding was on the 2nd November 2017..."

12:35

And you mentioned this earlier in your evidence. And you set out the circumstances and the Trust Board was advised of two members of Staff, Nursing staff Muckamore Abbey being suspended and a PSNI investigation being under way. 12:35

"The Trust Board was informed the director-led oversight group had been established to review progress on action plans for the site on a weekly basis and received regular updates." 12:36

And then you go on about the actions, you go on to tell us about the actions taken in relation to the items set out in the minutes. Looking back, do you feel that you, as Chair of the Board, did all you could have done 12:36 or was there something else that maybe you think you might have done differently?
A. I tried to explain earlier on, we did lots of things, some of them didn't work.

124 Q. Yes.
A. We tried to socialise the problem, because that's what you have do in Northern Ireland to get things done. We worked hard to try and move the issue forward. I mean I understand that we still have clients, patients in Muckamore so there is still work to be done. But, I and the Board earnestly engaged and tried both to learn from it. I mean what's that quote "to err is human, to fail to learn is unforgivable and to ignore something is..." I'm sure people know the quote. When it came to the Board's attention we engaged with it fully. We put whatever resources were required of us into it. We tried to socialise the issue with the broader system. We enabled and put our best Senior Managers I remember intervening a couple of times. We put Cathy Jack in charge of assurance for a while. We put Gillian Traub. We did what we could do. Now, was that as successful as I would have liked? Well no because the RQIA served two notices, but of course we tried what we could to do. 12:36 12:37 12:37 12:38
125 Q. Question 8 then at the bottom of page 31 asks you about:

"Arrangements in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix and thereby to ensure safe care. Describe your recollection of any actions taken by the board to ensure that Muckamore staff skills matched patient 12:38

needs."

You say,

"Staffing issues in the hospital were operationally managed by the Service Manager, Co-Director, Director in Charge of the Hospital and with the assistance of the Directors of HR, Nursing and Social Work. Issues were escalated to the Trust Board in relation to difficulties in obtaining appropriate staff who were trained in learning disability and other relevant disciplines." 12:38 12:38

So you were familiar with those issues?

A. They were constantly on Trust Board, I mean staffing was, apart from the abuse itself, was the principle issue. 12:38

126 Q. And you say:

"The Trust Board sought assurances that staffing was safe, supported arrangements being made to recruit staff and the approach to the Department for a premium for staff prepared to work in the hospital." 12:39

A. That was withdrawn then of course, the premium. 12:39

127 Q. But in terms of the assurances, if you had been told, I appreciate it's a bit of a counterfactual, if you had been told staffing levels aren't safe, what do you think would you have done?

A. Well if staffing levels had have been unsafe then, in the same way as happened in PICU, it would have been closed. Clearly that was not the ideal solution. If there had of been an ideal solution, I mean I had numerous conversations with senior departmental officials and others over time about whether or not -- I mean Muckamore is five miles away from Antrim, Antrim Area Hospital. So look, we had numerous conversations of I think the RQIA at one stage suggested they needed to set up two task forces, never came to our Board, but had that conversation. Look, there was all sorts of conversations about how to deal with the contingency of Muckamore failing. 12:39 12:40

128 Q. Okay. I will take you forward to page 36 to paragraph 84. 12:40

A. Paragraph, sorry?

129 Q. 84?

A. 84.

130 Q. Yes. And it's in response to question 13 where you were asked: 12:40

"How did the Trust Board consider and respond to inspection reports relating to Muckamore prepared by the RQIA? How did the Trust Board assure itself that any required actions were addressed within the time frame of any Improvement Notices." 12:40

You have already mentioned, of course, that three Improvement Notices were served by the RQIA on the

hospital in August of '19 and you detail what those were. Were you surprised to get them, those Improvement Notices?

A. Well I was very disappointed to get them, you know. We had received all sorts of reports and assurances and I was very disappointed to get them. But once we got them, then we needed to do everything we could do as an organisation to have them lifted. You know, we put in different people into the organisation and they were lifted. I've quoted from the stakeholder forum from the RQIA. You know, people don't set out to fail, that's not my experience of people in the health service. But when we did fail we clearly took definite action with clear Board oversight to have them lifted. I think there is a Trust Board report on 20th September 2020 where there is a big report from Gillian Traub sets out all the action we took to have them lifted. 12:41 12:41 12:42

131 Q. We have that evidence all right. I asked you were you surprised, you said disappointed. I suppose the backdrop to the context of asking you that was there had been action plans, I think by this stage there was the departmental Assurance Group, the MDAG committee, there were SitRep reports you mentioned -- 12:42

A. I think MDAG came in as a consequence -- MDAG came in as a consequence of the notices being served. 12:42

132 Q. All right. But given the background, even though there were SitRep reports and all of those sources of information, is that why you were disappointed that you had so many plans and approaches and actions --

A. I was disappointed that we were failing our patients and that we didn't, you know, we had not effectively dealt with the issues. Again I refer you to the Gillian Traub's report that sets out in detail what the issues were -- I mean, it's not for me, because I don't have the understanding but, you know, the staffing one was lifted relatively quickly and then the finance one was awaiting an audit from internal audit and the safeguarding one, as far as I understand it, was that there wasn't sufficient awareness of safeguarding processes and procedures amongst staff. 12:43 12:43

DR. MAXWELL: Actually appended to your statement you have got the report to the confidential Board session in September 2020, it's on page 1210.

A. 1210. 12:43

DR. MAXWELL: Yeah. And what it actually says is:

"The RQIA determined to lift all elements of the Improvement Notice relating to safeguarding in MAH except for the action to implement effective mechanisms to evidence and assure compliance and good practice with respect to adult safeguarding." 12:43

Which takes us back to the whole issue of independent scrutiny of controls. So why was there still an issue in September 2020? 12:44

A. Well, I mean what I would have to say is --

DR. MAXWELL: This isn't the practise of staff, this is the governance mechanism to ensure that they have

practised effectively.

A. No, I understand, I understand your question. I mean I sat on boards and panels for many years and there is, we had safeguarding procedures. We had safeguarding systems. Clearly my understanding, and I'm happy to be corrected, was there was such a throughput of staff, we were getting so many new staff that there wasn't a sufficient awareness, which brings me back to the point that I made in a question you had asked me earlier, the hard part about management is not deciding to do something, the hard part about management is getting your staff. 12:44 12:45

DR. MAXWELL: This quote is specifically not about people, but about mechanisms.

A. Well I would have to revisit that. I would have to be further informed. I would be quite happy to give a full answer to the Inquiry. I am not in a position to give you that answer today. 12:45

CHAIRPERSON: Okay.

133 Q. MR. McEVOY: While we have the document open, and maybe your response is something similar, if we can just look forward to 1205. 12:45

A. 1205.

134 Q. Yes and it will come up on screen, don't worry. This is a summary, at the top of the page, it is a summary from the same, I should say it's from the same minute? 12:45

DR. MAXWELL: The same report provided to the confidential Board.

135 Q. MR. McEVOY: To the Trust Board of 21st September 2020.

And so what you have there are a number of points summarising the leadership and governance recommendations?

A. Okay.

136 Q. If you can scroll down to the final point which is No.6 there, you can see what's contained in the update is the observation: 12:46

"The size and scale of the Trust means that directors have a significant degree of autonomy. The Trust should hold directors to account." 12:46

What actions did the Board take to address that?

A. Well, I'm sure this is a question -- I don't know, I'm sure it was a question addressed to Cathy Jack as the Chief Exec. 12:46

DR. MAXWELL: Should it though? Isn't it the role of the Chair and the non-execs to hold the executives to account?

A. Yes, but it is also the job of the Chief Exec. 12:46

DR. MAXWELL: It might be both.

A. Well at a managerial level the Chief Exec will hold to account the officers. I mean all the, and I am going to come -- of course the Board have a role in this. The management of the organisation, it's clear from all the governance documents that I have seen in relation to the Trust is the management of the organisation and the management of senior staff is the responsibility of the Chief Exec. As Cathy evolved in the role she then 12:47

used to manage staff through a meeting of herself and the executive directors, you know. So herself and the executive directors met the directors to hold them to account using the QMS methodology. So that's how we -- the introduction of the QMS methodology was the way that we held the organisation to account. The Board were then informed by the QMS report and received individual reports by individual directors on their principle risks and issues they were dealing with. The systems and processes we had -- I mean QMS is not perfect but it is worlds better than we had before. And a lot of work, an enormous amount of work had gone into it. You know, the Chief Exec and the Board will do it through that process. 12:47 12:48

137 Q. MR. McEVOY: Just while we are down at this part of the exhibits, could we bring up 1157 please. I will just introduce this exhibit to everyone, this is the Trust Annual Incident and Serious Adverse Incident Report from the 1st April '17 to 31st March '18. There is a chart, a number of charts within it I'd like you to look at if that's okay. It's 1161. This is a breakdown of incidents within the Adult and Social Primary Care Directorate and you can see it has far and away the largest number of incidents. If we go down to the second part of the page, scroll down please, you can see that Learning Disability Services has, within that division, the largest incidence of incidents. Did non-executive directors get any further breakdown behind that, behind those figures? 12:48 12:48 12:49

A. There is always level of detail you can go into.

DR. MAXWELL: I think the question is if you look at these two charts, by far and away the most incidents were in ASPC and within that, the large number of incidents were in Learning Disability. Was that noted by the Board that you were having more incidents in Learning Disability than in any other area of the Trust. 12:50

A. I can recall and, forgive me, I can't take you directly to a minute, but I can recall conversations in Assurance Committee around incidents and where risks where and did certain services have greater, have a greater reason to have more incidents than others. We just didn't accept these figures, there was always interrogation. 12:50

Now, I have no recollection whatsoever of it ever being pointed out to the Board, despite interrogation, that, you know, one might have been told we are dealing with more complex issues, there was a more vulnerable client, there was more outlying -- but I can't remember anyone saying to us -- 12:50

DR. MAXWELL: I'm just wondering though, curious Board members seeing these two graphs, would they need to have it pointed out to them or is it not obvious from the graph? 12:51

A. Well I think with respect, I think that tells me that there is more incidents.

DR. MAXWELL: Yeah.

A. But it doesn't tell me why there is more incidents.

DR. MAXWELL: So did you ask why?

A. I have no doubt, I make the admission of being inquisitive. I have no doubt that over my time on the Trust that we would have drilled deeper into all sorts of figures for all sorts of reasons and, you know, I mean I can't -- I can't remember it ever being overt that there was a particular issue with Adult Social and Primary Care. I mean clearly there is significant difference there, I totally accept that. And I say, to give myself the benefit, I would have noticed that, other people would have noticed that, we would have asked questions. My recollection of the assurance was it was the inherent nature of the role of, you know, the things in adult, there was Older People, there was Mental Health, there was Learning Disability, that's my memory.

12:51 12:52 12:52

DR. MAXWELL: And so this was inherently a very risky area and within it Learning Disability was more risky than the other divisions?

12:52

A. There is no question that in relation to certain areas it was more risky, but other areas, depending upon their function, had their own risks, some of which were catastrophic, you know, as I'm sure you are more familiar than I. You know, the level of risk in an institution like the Belfast Trust is just crazy.

12:53

CHAIRPERSON: Do you agree that areas of greatest risk require the greatest attention?

A. I agree that, depending on the risk, the response

should be differentiated.

138 Q. MR. McEVOY: In the same vein if we can scroll down to 1162. Top of 1162. And within ASPC incidents by category then, there is a further breakdown, we can see that by far the greatest number of incidents related to 12:53
abuse of -- bearing in mind that this report relates to the period 1st April '17 to 31st March '18, so everyone knows the allegations, certainly within the Trust, what has been going on at Muckamore. We can see abusive, violent, disruptive or self-harming behaviour accounts 12:54
for, well it's quite clear by far the most number of incidents. Was there any curiosity about getting a further breakdown of that statistic, in other words --

A. I have to say honestly at this remove showing me this, I am unable to answer that. Happy to take it away. We 12:54
were getting SitRep reports. We were very aware at the number of incidents in Muckamore. We were aware from all the work we had done there was lots of patient-on-patient. I would have to interrogate that. I regret I am unable to answer that. 12:54

139 Q. All right. I don't have very many more questions Mr. McNaney, but just at 88, returning to your statement on page 39?

A. Yes.

140 Q. So you have mentioned your awareness of other reports 12:55
into other situations. There is the Winterbourne Review which occurred in 2011, before you joined the Trust in 2014. You became aware of it in late '17 when of course, as you have indicated, you appointed its

author as the independent chair of the Level 3 SAI. You read it and the recommendations coming from the Department of Health. You hadn't heard of the STOMP initiative which you understand wasn't fully promoted in England until 2016. You are also aware of further reviews of abuse in institutions in England such as Whorlton Hall in 2019. Do you think that within the Belfast there was sufficient communication of learning from other incidence of other scandals and their reports? 12:55 12:56

A. At what period of time?

141 Q. Well during your time?

A. Over nine years?

142 Q. Yes?

A. Well there was differential levels of learning dependent on where you are, at what point of time. Clearly, I mean I remember specifically looking at the Whorlton Hall report. I remember looking at Professor Murphy's piece of work in terms of the risk factors for learning disability. I remember during the Margaret Flynn report, Ashok Roy was a psychiatrist involved. I remember reading the guidance note on behaviour that challenges by Ashok Roy back in 2008. I constantly read up and tried to learn as much as I could about learning disability and the reason for abuse. I refer referring those reports to Gillian Traub when she did the What's Different At Muckamore Reports, attached to as an appendix. I mean there is no question that the Belfast Trust, when you're talking about the Belfast 12:56 12:56 12:56

Trust, it is made up of a whole range of different people. People like Cathy Jack have learned enormously about it. Certainly as a Chair I encouraged learning, I encouraged the access to expert evidence and I encouraged that we try and amend our behaviour to lessen those things. I remember, I have to say I remember the first time I ever went out to Muckamore, the thing I couldn't get over was how do people get here by public transport. You know, the answer was they had to go to the train station five miles away and get a taxi, I'm sure you have been, it's very remote. 12:57 12:57

143 Q. Well unless you have anything to add Mr. McNaney, I have nothing further?

A. Well obviously I would like to put on the record our sincerest apologies to the people who were abused at Muckamore. I want to apologise to their parents and their carers and their friends and their relatives. I can only imagine the trauma that they've had to withstand and go through and go through, through this Inquiry. You know, the Trust have earnestly tried to make things better. I just want to mention the FLO report, family liaison officers, only to say I was very struck by one of the issues, as our patients and clients move into other accommodation which suits them, we need to have a proper system to assure that. We absolutely need to have a really good system because I don't want this to reoccur on a larger scale. But, I'm sure -- I want to put that on record, it's deeply felt and I don't understand the pain and suffering that the 12:58 12:58 12:58

families have gone through, but I know it must be hard to bear. And for whatever small assurance I can give, we have really tried to learn from this and we will continue to try to learn from it. Now, I am not there anymore. 12:59

MR. McEVOY: Well look the Panel may have some questions, but that is all from me. Thank you.

CHAIRPERSON: No. Can I thank you for your attendance. On various occasions you have said you would like to consider something or come back to us. We will look at this transcript and write to you and if there is anything the Inquiry wants to follow up, and of course you are perfectly welcome if you wish to, on review, to come back to us and let us know if you want to bring anything to our attention. 12:59 13:00

A. Thank you, Mr. Chair.

CHAIRPERSON: Okay. Can I thank you very much for your attendance. We will sit at 2 o'clock.

LUNCHEON ADJOURNMENT. 13:54

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Mr. Doran. 14:08

MR DORAN: Good afternoon, Chair and Panel. This afternoon we're going to hear from the first witness in organisational Module 10, Department of Health. The witness is Andrew McCormick who is a former Permanent

Secretary. Ms. Briggs will be taking the witness' evidence and I will hand over to her in a moment.

The module is described as follows in the summary of organisational modules that is posted on the Inquiry's website: 14:08

"The evidence of persons in positions of responsibility for MAH and relevant professional standard systems and processes past and present at departmental level." 14:08

As was the case with Module 7 and 9, the module extends across the Inquiry's Terms of Reference.

In planning for this module the Inquiry sought and received statements from six individuals for the purpose of the module. Those individuals were asked to address specific questions put to them by the Inquiry. The six statement makers are as follows: 14:09

Sean Holland, Chief Social Work Officer since 2010. 14:09

Professor Charlotte McArdle, Chief Nursing Officer from 2013 to 2021.

Professor Michael McBride, Chief Medical Officer since 2006. From December 2014 until January 2017 he was also Acting Chief Executive in the Belfast Health and 14:09 Social Care Trust. Having regard to that latter acting role, he was also furnished with the organisational Module 9 questions for Trust Board members and he addresses those questions in his statement.

Brendan Whittle, director of Hospital and Community Care with the Strategic Planning and Performance Group (SPPG). The Panel will recall that Mr. Whittle also made two statements for the purpose of evidence Module 2, Healthcare Structures and Governance, and he gave evidence in that module on 17th May 2023. I would just note in passing that the original request for a statement on behalf of SPPG for the purpose of this module was made to Lisa McWilliams who is Director of Strategic Performance, Safety and Service Improvement. Ms. McWilliams subsequently nominated Mr. Whittle as being better placed to assist the Inquiry with the issues raised and he has duly made the statement requested.

14:10

14:10

14:11

Dr. Andrew McCormick, from whom the Panel will hear today, is former Permanent Secretary of the Department of Health, Social Services and Public Safety and Chief Executive of Health and Social Care Northern Ireland from 2005 to 2014.

14:11

And then finally, Richard Pengelly, former Permanent Secretary of the Department of Health from 2014 to 2022.

14:11

All of those statements are, of course, publicly available on the Inquiry's website. There is also a further statement that touches on issues falling within the remit of organisational Module 10. This is a fifth

statement by Mark McGookin who is Director of Disability and Older People within the Social Services policy group at the Department of Health. The Panel will recall that Mr McGookin gave evidence for the purpose of evidence Module 2, Healthcare Structures and Governance. His evidence was given in two sessions on the 3rd and 19th April 2023. His first statement and oral evidence were then followed by three further statements clarifying issues that had arisen in his oral evidence and providing further information and material for the assistance of the Panel. 14:12 14:12

As I've mentioned, Mr. Whittle also provided evidence on behalf of SPPG for the purpose of evidence Module 2.

In August the Inquiry received some follow up queries raised by Phoenix Law on behalf of Action for Muckamore and the Society of Parents and Friends of Muckamore in relation to this earlier evidence from the Department and the SPPG. Having considered those queries and also reflecting on the evidence that had been received on behalf of the Department and the SPPG to date, the Panel made a request to the Department and SPPG for a further statement to address a number of specific questions. Those questions are primarily concerned with recent and ongoing developments outside the time frame of the Terms of Reference, but they are of interest to the Panel as the Panel moves forward to consider its report and recommendations. 14:12 14:13

The fifth statement of Mr. McGookin covers all of the questions addressed to the Department and to SPPG. It is dated 9th October 2024. It has been processed for disclosure and disclosed today to Core Participants. It will be published on the website as soon as possible.

While the statement and exhibits will assist with some of the issues addressed in organisational Module 10, the Panel does not require Mr. McGookin to attend to give further oral evidence.

Having considered the various statements for organisational Module 10, the Panel wishes to hear oral evidence from the following five witnesses; as I have mentioned, Andrew McCormick who will give his evidence today after this introduction. Sean Holland will give evidence at 9.30 on Monday morning. Brendan Whittle will give evidence on Monday afternoon. Professor Charlotte McArdle will attend at 9.30 on Tuesday morning and the module will close with Richard Pengelly's evidence on Wednesday the 23rd of October. Looking at the schedule on the website for next week one will also see that Professor Sir Michael McBride is listed to attend at 3.00pm on Tuesday the 22nd of October. Having considered his statement and the other evidence, for the purpose of this module the Panel does not need to raise any further issues with him in oral evidence for the purpose of its consideration of the

Terms of Reference. He was not therefore, asked to attend the Inquiry. You, Chair, did however accede to a request on behalf of relatives of patients that he should attend to provide oral evidence. You also indicated that Core Participants would have to provide any questions they may have in writing by lunchtime today for consideration by the Inquiry Team in advance of the witness's attendance. The Inquiry is in receipt of one set of questions and I understand that there is a request for an extension for the other set of questions to be furnished. The questions that have been received will be considered by the Inquiry Team in consultation with the Panel to assess what matters require to be raised with the witness in oral session.

14:15

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There is one last thing to be said about the schedule next week. On Wednesday morning, prior to the evidence of the final witness, Mr Pengelly, Ms. Briggs will provide a brief roundabout of relevant statements that have not been addressed in the hearings to date. The Panel and Core Participants will recall that we had a round up of patient experience evidence in October of last year. Next week's round up will include staff statements, evidence module statements, organisational module statements and also one patient experience statement that was missed last time around, as well as some follow up statements that were received after the witness' oral evidenced been given. Core Participants will have been issued with all of the material covered

14:16

14:17

in the round up in advance of the session and we will also issue a full list of the statements to be referenced.

The purpose of the exercise is to acknowledge for the public record a range of statements that have not been referenced in the public hearings. I can indicate that it will be a fairly brief round up, Chair. 14:17

So we can now move on, hopefully, to hear the evidence of Mr. McCormick and I am going to hand over to Ms. Briggs to that purpose. 14:18

CHAIRPERSON: Can I just indicate, because Phoenix Law will be getting some correspondence around this, that the only extension that I can give for the submission of the questions is until 12 tomorrow. 12 tomorrow, but that is a hard stop. If they are not received by then, they will not be considered by counsel for the Inquiry. Okay, shall we move on. 14:18

MR DORAN: Yes, Chair. 14:18

CHAIRPERSON: Ms. Briggs.

MS. BRIGGS: Panel, the statement and Inquiry reference is 298. And unless there is anything in particular Panel, the witness can be brought in.

14:19

MR. ANDREW MCCORMICK HAVING BEEN SWORN WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: Good afternoon. Could I welcome you to

the Inquiry and thank you for your statement which obviously takes you back some little time to when you were Permanent Secretary. Normally we go for about an hour and quarter, I imagine you have watched some of these proceedings.

A. Some, yes.

CHAIRPERSON: You know how it works. If you want a break at any time, please just let me know and we'll do that, all right.

A. Thank you, Chair.

144 Q. MS. BRIGGS: Thank you, Chair. Doctor McCormick, as you know I am asking you questions this afternoon in relation to your statement to the Inquiry and that's in relation to organisational Module 10. You have a copy of your statement there in front of you, I can see, it's dated 28th June 2024 and it runs, the statement itself, to 13 pages and it's followed then by three exhibits. I understand that there's one correction that you want to make to your statement and it's at paragraph 5, page 2?

A. Yes, the fact of the matter is that I became aware of the Ennis issue in November 2012, very soon after the Early Alert. There had been a previous submission, it's actually implicit in the document that is referred to there, but just to change the date from 2013 to 2012.

145 Q. So then the second sentence then: "I was however made aware in 2013 of allegations of abuse" should be changed to: "I was however made aware in November

2012..."

A. Yes, that's correct.

146 Q. Of allegations. With that amendment in mind, Doctor McCormick, are you content to adopt the contents of your statement as your evidence to the Inquiry? 14:21

A. Yes.

147 Q. You give your statement in your role as a former Permanent Secretary of the Department of Health, Social Services and Public Safety and Chief Executive of Health and Social Care in Northern Ireland from August 2005 to June 2014, isn't that right? 14:22

A. July.

148 Q. July 2014.

A. Correct.

149 Q. And what experience and knowledge did you have of Mental Health and Learning Disability Services when you became Permanent Secretary in 2005? 14:22

A. No material experience in that domain. My main experience in relation to health issues was as a funder, because I had been the lead on budget and health issues had been the biggest issue there, but nothing specific in relation to Mental Health and Learning Disability. 14:22

150 Q. I am going to ask you about your previous role which dealt with budgets, that's something we are going to go into in a moment. Just thinking for the moment about your post from 2005 to 2014, how often did you visit Muckamore during that time would you say? 14:22

A. So I think I was there only twice. And one of those

was triggered by the issue of seclusion and controversy that arose which I deal with in the statement, when there was severe criticism in the public domain about that. I made it my business to go. In fairness I had been challenged as to whether or not I had gone by Stephen Nolan in the radio interview. 14:23

151 Q. This was 2007, isn't that right?

A. That's January 2007, if I recall correctly.

152 Q. The second time then?

A. I can't remember the second time to be honest. It was probably a more business orientated visit. It may even have been with the Minister, I'm not sure. 14:23

153 Q. What do you mean by a business orientated visit?

A. The first visit was purely to get a personal impression by appearing, you know, with knowledge of those in charge obviously before I turned up, but it was a Saturday morning so very informal, very much to just get a first impression. I had heard things described but, you know, there is no way to take that in without seeing the physical layout and interact with people there. 14:23 14:24

154 Q. That is something we will come to?

A. The second time I think it was probably a more formal visit. It's possible I accompanied Minister Goggins in the same time period, so it probably was in the same time period. 14:24

155 Q. So approximately 2007 then?

A. That's only a guess I'm afraid, I have no precise recollection nor I am not aware of any record that

would confirm that, given that our diaries tend to be in electronic form and therefore don't survive.

156 Q. Yes. On that second visit were you speaking with patients and staff on that occasion?

A. Mainly with staff, mainly with senior staff. I had more interaction with patients and clients on the first visit. 14:24

157 Q. Okay. At paragraph 7, on page 3, you set out your roles and responsibilities. If we can pull that up onto the screen now. One of your responsibilities that you set out at paragraph B, 7B is oversight of all of the health and social care service bodies and other non-departmental public bodies under the Department's remit. How was that oversight carried out in practice? 14:25

A. So the most formal cornerstone of that would be the regular accountability meetings which evolved over the period. Certainly after the merger of the Trusts, you know in '07 one reason for doing that was to reduce the number of organisations, simplify the structure and that facilitated -- to have attended twice yearly accountability meetings for nearly 30 organisations wasn't a practical thing from the point of view of a Permanent Secretary. But when the number came down to the six Trusts, Health and Social Care Board, PHA, that was the main rhythm. So that was a very formal, very structured way of holding to account and allowed the respective roles of the Department, the Health and Social Care Board, and the PHA to be deployed. Although I have informal contact with the Chief 14:25 14:26 14:26

Executives, that became part of how the job worked in practical terms. And then obviously there were occasions when accountability turned into something with the Public Accounts Committee and when, on occasion, I would have been giving evidence alongside a Chief Executive and all of that. So it was a way of life really, this was fundamental to the job because the secondary job title of Chief Executive was, you know, that implies the buck stops here and in terms of management and administration that was what that was all about. It's complicated because the different roles, certainly arising from the review of public administration, it requires each organisation to be playing its own part and fulfilling its own role and therefore I was having to then focus on what is the specific role of this organisation in relation to the issues arising. 14:26 14:27 14:27

158 Q. I want to turn now to your former role in relation to funding for the health service in Northern Ireland because you tell us in your statement that from 1998 to 2002 that you were the second Permanent Secretary in the Department of Finance and Personnel which involved, in part, advising on monitoring the budget for Health and Social Care in Northern Ireland? 14:28

A. Yes. 14:28

159 Q. In terms of the operation of funding for healthcare in Northern Ireland, is there a separate block sum for health provided by the UK government or is the entire budget for healthcare in Northern Ireland within the

block grant under the Barnett Formula?

A. It is entirely within the block grant and part of the whole point of devolution is to make the responsibility of the devolved executive to decide how much to spend on health and social care. 14:28

160 Q. And how are negotiations in relation to that block grant dealt with and at what level?

A. That goes through a whole cycle of process culminating in proposals by the Minister of Finance and Personnel to the Assembly. They have to be presented first of 14:29 all in draft form and then finalised after a consultation period. We're in that very cycle in the present day. But I was involved in the very first of those cycles starting in 1999. Devolution took effect late in the financial year 98/99 so the first budget 14:29 cycle was in 1999. The last department to settle under Minister Barbara de Bruin was health and we had to scuttle around to find a little bit extra before she would agree the budget. It was very much, these are very political decisions. We do an immense amount of 14:29 analysis and advice as to the meaning of possible different levels of provision but the judgment ultimately is political as to what is possible.

CHAIRPERSON: And this is, is it still called the Barnett Formula? 14:30

A. Yes, the Barnett Formula determines the total available, subject to the recent developments on need, a need based element of the allocation process. In my time in the Department of Finance and Personnel through

'98 to '05 it was entirely Barnett driven and one key factor of Barnett, deliberately on the Treasury's part, it progressively reduces the per capita advantage that Northern Ireland historically has had. So mathematically it's asymptotic, it tends to bring equivalence so because the additional amount is purely based on population share without any regard for the needs of the population.

CHAIRPERSON: But that's what I wanted to ask so forgive my ignorance. 14:30

A. It is a very important formula.

CHAIRPERSON: Is there room for negotiation within the Barnett Formula on a needs basis?

A. We tried that many times, occasionally succeeded and at the margins, but the more devolution settled down, the more the Treasury held to the view, keep this, there is a set of rules, there are exceptions, it is highly complex, there is other budgets that are dealt with separately. But everything affecting Health and Social Care came out of the pot determined by the Barnett Formula. Sometimes Northern Ireland asked for more, much to Treasury's dismay, they got pretty fed up with us over the years, but it happened. But it does mean there was a constraint. And again it's a matter of fact, I know from looking at recent documents that it did take Northern Ireland spending below any objective assessment of need for a short number of years recently. 14:31

CHAIRPERSON: And under the block grant, it's then for

the devolved government to decide where that money goes.

A. Exactly.

CHAIRPERSON: You have had at least two I think quite long periods of no devolved government. Does that then come down to the Permanent Secretary? 14:32

A. It was necessary for the Secretary of State for Northern Ireland to take budgets through Westminster in those periods. It would still require --

CHAIRPERSON: It went back to Westminster. 14:32

A. It still required a political intervention, political judgment as to the totals available and then on Civil Service advice, but, you know, the distribution of money is probably at the heart of what political decision making is all about, sorry, at least I carry that prejudice as a finance nerd. 14:32

CHAIRPERSON: Thank you.

161 Q. MS. BRIGGS: I want to turn now back to your statement and some of the questions you were asked to answer. If we can go to page 4, question 2 please. You are asked here by the Inquiry about your understanding of the structures and processes that were in place at departmental level for the oversight of Muckamore and you're asked about their effectiveness. You describe how, as is known to the Inquiry, and how you have referenced earlier, until 2007 Muckamore was part of the North and West Belfast Trust and once the Trusts were merged in 2007 as part of the review of public administration, that Trust became part of the new 14:33 14:33

Belfast Trust and that's Phase 1 of the RPA, the Review of Public Administration?

A. Yes.

162 Q. You describe how you led the work on the RPA, isn't that right? 14:33

A. Yes.

163 Q. When the Trusts were reconfigured do you know if consideration was given to the capacity of the Belfast Trust Board to effectively oversee Mental Health and Learning Disability, given that the Belfast Trust had 14:34 so many services, tertiary and regional, under its remit?

A. Yes, this was quite a significant topic of consideration and one thing I recall clearly is my predecessor, Clive Gowdy, at the hand over in '05 said 14:34 to me Bamford will be more important than RPA. He was very deliberately trying to focus my mind as coming into the post of the significance of Bamford. So then through the period when Sean Woodward was minister, which was '05 through into '06, there was very serious 14:34 consideration given to the possible creation of a specialist Trust. The issue that I think -- sorry, two points as to why that didn't happen; one is that the focus and driver of the whole RPA concept in health was integration. In other words we bring services 14:35 together, we try to break down the distinction between hospital services and community services. So integrated care is still a major theme of health service reform across the UK. But we were, we saw

ourselves in Northern Ireland as pioneers, as having an opportunity to do something radically better through integration. One thing that meant was not separating mental health and learning disability from other services. So it was, the second point is probably related to that and this is the argument, I asked my team why don't we do this, the answer was summed up in the word co-morbidities. They took the view strongly that you would provide a better service to patients and clients through having an opportunity to address their holistic needs. So looking at, yes, issues around their mental health and learning disability issues, but integrated with care for their main -- I'm not sure the right way to put this -- the mainstream health issues. That was thought about. I remember again vividly one person saying to me Belfast is going to be too big and should we do something about that, but there was a momentum. Before I arrived the RPA had been nearly settled under the previous minister, Angela Smyth, with the creation of what were going to be five integrated agencies covering all aspects of Health and Social Care. That was under one form of direct rule. When Peter Hain, as Secretary of State, and Sean Woodward as Health Minister came in just before I moved to Health, this was after the '05 general election, cabinet reshuffle, they adopted a totally different style and said we are going to apply essentially New Labour policies in Northern Ireland and if the local politicians don't like it, then they know what to do as

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in get back into government. That was a very different political style but that included driving through policies in Health and Social Care which were fundamentally New Labour, New Labour ideology, I don't think ideology is too strong a word. So hence commissioner-provider split as a key element of the Tony Blair concept of how to improve health and social care, the four principles, his four principles of public sector reform, including choice, which is at the heart of what commissioning is all about. That was a tricky process but it meant then we compromised by retaining the five Trusts, but as Trusts, as purely provider organisations with then we were well on the way to creating a strategic health and social services authority, including a chief executive designate, leadership team. Then in '07 with devolution Michael McGimpsey sent us back to the drawing board and we had to revise the structures then because he didn't like what the Labour ministers had done under direct rule.

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CHAIRPERSON: Earlier in your evidence you said five integrate agencies, does that mean Trusts?

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A. No, the previous model would have effectively removed the concept of trusts and removed the concept of a commissioner-provider split. These would have been integrated agencies covering all aspects, reporting directly to the Department, so no Board at all. There would still probably have been a public health organisation of some sort but Michael McGimpsey's concept involved a much more powerful Public Health

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Agency as part of the regional structures.

DR. MAXWELL: It would have been like regional health authorities in England?

A. Exactly, yes, there was a very direct read across. For one morning we were on the road to having primary care trusts, but that didn't fly. We ended up with local commissioning groups as well. 14:39

CHAIRPERSON: I don't think it lasted in England either.

A. It was a fleeting, passing moment. But I suppose the question is, how does this work and what does this mean for service delivery. It did mean consciously creating an enormous organisation, as in the Belfast Trust, but there was massive momentum to do so. And the dominant concept behind that was the value of integration, in other words bringing things together meaning that you could look at the holistic needs of individuals and communities and plan on that basis. 14:39 14:39

164 Q. MS. BRIGGS: And you said earlier that there was consideration given to a specialist Trust effectively, and by that do you mean a regional mental health and learning disability Trust? 14:40

A. Yes, exactly. That was thought about, not for very long, or I don't know there was a massive amount of analysis or consideration of it on paper. The momentum for the model as emerging was very, very strong. And of course also an impatience for change. We had done, ideas had been around for a long time, reorganisation is an incredibly disruptive thing, it distracts 14:40

leadership attention. So getting on and doing it was part of the drive. And certainly one reason I would argue against, you know, reorganisation as a solution to most things. Sometimes it is necessary but you do it very carefully and thoughtfully. 14:41

165 Q. You described earlier the Belfast Trust in your own language as an enormous organisation. You have also said that you recall someone saying to you that Belfast was too big, was and is Belfast too big?

A. It's probably, if not, it is probably in the top five 14:41 of healthcare delivery organisations in the UK. So it is very big. It had some very large and very capable leaders, not least the first Chief Executive, the late William McKee who was a real giant of a health service manager. So it did run into serious issues. I guess 14:41 part of the question we were thinking about at that time was if not this, then what? If we didn't want to retain the separation of acute and community services, that was integration was the big idea. And then within the acute sector the need to resolve some of the 14:42 tensions in terms of regional services between City Hospital and Royal Group, you know, to have them in separate organisations would have missed a major, major opportunity. Could we have given more of the Community Services to South Eastern Trust rather than to Belfast 14:42 Trust? Maybe but it would have been a pretty small step in the great scheme of things. As I say, it wasn't, we didn't spend a lot of time thinking about this because the momentum was so strong. You know, I

probably regret not taking what was said to me slightly more seriously and saying, it would have meant going to a minister and saying you see that plan we've got, we need to hit the pause button. That would not have been a welcome intervention.

PROFESSOR MURPHY: But in retrospect do you think it means that acute services have always overshadowed Mental Health and Learning Disabilities and that there might have been a better way?

A. I think that risk is there and it's inevitable that acute services get immense attention. That's especially when we have very significant issues of maintaining standards. We did try to mitigate that in various ways including, I spent time, we had a Core Group of the Chairs designate and Chief Executives designate along with some senior colleagues in the Department who worked through from the decision point, which was November '05 through to the implementation point which was April '07. We worked very hard on structures. We, for example, determined that the Executive Director of Social Services in each of the Trusts have to have child protection expertise. We were looking at what are the structural risks that we are addressing in designing these five new organisations. Belfast is large, they are all quite large. Belfast is very large, and getting a governance structure and organisational structure that was going to be effective was a challenge. But I think it's undeniable that it leaves Mental Health and Learning

Disability, you know, struggling to get attention, I think that's, you know, a simple fact.

PROFESSOR MURPHY: Are you saying you think that's inevitable?

A. Well the alternative model would have been the separate Trust. I think it would have taken something as radical as that to work against that, you know, apparent inevitability. 14:44

DR. MAXWELL: Taking it up a level to you at the Department of Health, one of the reasons acute services are the focus of attention is because they focus on mortality which is fairly easy to measure, not exactly an avoidable mortality, but alive, dead is quite binary, whereas Mental Health, Learning Disability and Social Care don't have such a definite metric. That is the reason it gets the media attention, the political attention. So regardless of the structure of Trusts, because in England they are largely not integrated with acute services but they still have problems, how was the Department looking at how you measure these services, regardless of which Trust they sit in? 14:45 14:45

A. So we were at that stage needing to focus on how Bamford would be taken forward. So the focus of attention in my first few years was both receiving and then responding to, developing the implementation plans on Bamford and I had the opportunity to make a structural change within the Department to give that greater weight when some of the issues had arisen before, even in '05 and '06, for example, the same 14:46

person was coming with me with Mental Health and Learning Disability issues as with acute issues. So that, he, you know, had too big a span of policy and operational issues to oversee. So again we had the opportunity and conscious decision on my part to create a post where Mental Health and Learning Disability would be at the core of the person's role. Now that, for reasons too complicated to explain right now, that structural change didn't work that well but it was a deliberate attempt to place emphasis on Bamford and therefore then include, you know, a trajectory towards the kind of change, the kind of radical service reform that had been recommended in the various reports, not least Equal Lives. 14:46 14:47

DR. MAXWELL: I am wondering about outcome measures because you can spend a lot of time looking at process. 14:47

A. Yes.

DR. MAXWELL: You can change your processes, but they may or may not change the outcome. As I say, we've got quite a clear metric for a lot of acute services. 14:47

A. Yes.

DR. MAXWELL: Alive/dead. Was much attention paid on the outcome measures rather than how successful we have been in changing the process measures?

A. I don't think we had very good outcome measures to work on in that period. We tended to revert to activity measures not least resettlement as a metric, but that's quite limited in its regard. The other factor underlying all of that is quality and the need, the 14:47

need to apply in the Mental Health and Learning Disability context the duty of quality and all the efforts that were made in that period to maintain and develop that. So it's not, I don't think it was satisfactory. 14:48

166 Q. MS. BRIGGS: Would it be fair to say then that the RPA Review of Public Administration, it was politically led process?

A. Mainly yes and certainly the changes that Sean Woodward insisted on in the Autumn of '05 were driven by, they were consistent with the Blair vision of how to deliver public sector reform, so quite idealogical in that sense. Again in my previous job, having worked with Ian Pearson as the Finance Minister, with a fair bit of contact with reform units in No. 10 and the Treasury. 14:48 14:49 So I came into Health in '05 quite familiar with the idealogical drumbeat as it were and then that's what Woodward and Goggins as well, when he succeeded Sean Woodward, insisted on in the structural reform.

167 Q. Was it driven in any way by financial considerations? 14:49

A. No, I don't think so. I suppose part of the concept would be that a well designed commissioning system should provide for an ideal world better use of resources and again, this is where part of the ideology that came across from rest of the UK in that period, or 14:49 I suppose from England to be more direct about it, would have been that services needed to be designed around the needs of the patient, individuals and communities, not -- so the horrible phrase, provider

capture, was one to avoid and that's part of what the ideology was driving. So services should not be designed for the convenience, to use a very pejorative word, for the convenience of the providers, the providers were the Trusts essentially. That I guess that indirectly should have been leading to better use of resources. 14:50

168 Q. Did the RPA with the mergers of Trusts and then the Board, did that lead to political push back from any quarter? 14:50

A. So not much overt reaction. I don't think there are many in the health community in Northern Ireland who like commissioning. It was not the preferred idealogical model before '05. So then, I think it's more that there were not very many who would have been very focused on making it work, maybe quite content to see it not work that well. Looking back I don't think it worked very well, partly because while a Minister can say this is what we should do, if the leadership community don't actually behave that way it doesn't happen. I remember saying in my early days in Health, I've learned that command and control doesn't work, you have to bring a group of leaders, a community of leaders along together and if they don't share a vision it's pretty hard to make things happen. 14:51 14:51

169 Q. Finally then in terms of the new Belfast Trust that was created, would you or others have personally examined it's governance framework?

A. So we were, in every accountability meeting we were

going through a range of governance considerations, both in the realm of financial governance, controls assurance standards, quality, evidence in relation to quality of services. So we were looking at report a clear and as strong and detailed as we could make it in terms of the Trust giving an account of what it was doing. I think we were, there would have been some norms as to how they were organised internally such as the fundamental structure of the Trust Board, but a lot of discretion. I don't remember being involved in influencing or second guessing decisions about internal structures or committee structures within Trust Board or whatever. You were looking for good practice and I guess part of the holding to account was to say, you know, if you're in line with good practice then, and things aren't working, would be more sympathetic than if things aren't working and there is evidence that you're ignoring or bypassing good practice. It wasn't an attempt to second guess or control.

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170 Q. All right. If we can move on to page 5, question 4, towards the middle of page 5. You were asked there about how concerns at Muckamore would trigger a notification to the Department and you were asked who decided that a notification ought to be made and what guidance was there to identify when that ought to happen. And your answer there is:

"I would simply note that the Trusts had a clear obligation to escalate any material concerns affecting

the standard of service they were providing under their statutory duty of quality, and that the Boards, later the HSCB, as commissioners and RQIA as the regulator had responsibilities to monitor and secure assurance on standards of care." 14:54

Did the Eastern Health and Social Services Board or later the HSCB ever raise concerns about Muckamore with you that you can recall?

A. Not directly, no. The Eastern Board were involved in the issues that arose in '05 which I deal with later in the statement. The Health and Social Care Board then, once we were in the cycle from, certainly from '07 onwards of including a target in relation to resettlement as part of the priorities for action. So they would have been fully involved in that but I don't recall them raising alerts or concerns in that sense. You know, until the Ennis one which came in in my time, and further things obviously subsequently. 14:54 14:55

171 Q. We will turn to Ennis in a moment. What the Trusts then, can you recall any other occasions or occasions where they raised concerns? 14:55

A. No, obviously it would have been Belfast Trust or North and West in relation to Muckamore, but I don't recall any such flags being raised in that sense, no. 14:55

172 Q. How did the Department then satisfy itself that Trusts were complying with their obligation to escalate any material concerns?

A. That's the heart of the matter question and one, as a

Permanent Secretary, I ask all the time. How do I know and how do I know if I know enough. So primarily you're relying on people fulfilling their obligations including -- so I remember saying, a presentation I used to Chief Executives towards the end of my time was I am expecting you to manage risks but you have the right and the responsibility to escalate to me and, you know, if you don't then the consequences for you are more difficult. If something should be escalated and isn't escalated that's not a good thing because it stops the system working, it stops the possibility of corrective intervention at an earlier point but I'm expecting you to manage these things. You know, the job, I used, I tried to adopt a very clear leadership message that says these are your obligations and it involved, you know, became cliched because I talked about a triangle, a triangle of managing finance, managing performance, so the full range of performance standards which included resettlement, but in fairness the emphasis was on the acute sector, and quality, so you have do all those three things, that's your job. If you have a difficulty, you can't manage it on those terms then you have to escalate. There were some occasions when it did happen. I don't recall very many where it was quite as direct as that but that's there, that's the first order of responsibility is because we were having the regular accountability meetings, the message about accountability I spoke about, you know, ad nauseam because it was clearly so important from my

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own point of view. But it has to be supplemented then by alternative sources of intelligence, including in the financial world, or the systems world, internal audits, RQIA as the regulator. Part of my sense of designing the system was to say RQIA needs to be strong, effective. I even used the word "scary" in relation to RQIA at one point. And whistle-blowing, you know constituency cases from MPs or MLAs, that range, triangulate and test and say well, where have I got something that is strong enough to say I need to ask some more questions or is that something that is routine and judging those things and judging what further questions to ask is absolutely the core of the job. 14:58 14:58

173 Q. What about RQIA then, the role that you had envisaged for them, did they fulfil that? 14:58

A. To a large extent, yes. So I arrived after the legislation had been taken through to establish RQIA but it was still in its formative stages at the time I arrived. I personally insisted, along with some supportive colleagues in the Department, that the emphasis had to be on a strong regulatory function. There was an aspiration within the organisation to put the emphasis on service improvement and service improvement, you know, promoting positive change has a very legitimate and important element to the work. But we needed -- service improvement of that nature can be done within the Trusts or through the Board or through commissioning, but the distinctive thing that we 14:59 14:59

absolutely needed and which only RQIA could produce was regulatory enforcement that says that's not good enough. So I was determined, and some of my actions in the Autumn of '05 would have been deliberately to accentuate that.

174 Q. In light then of Ennis and in light of the CCTV revelations in 2017, are you of the view that the whole system that you've described, was it able to ensure the safety of patients at Muckamore?

A. Well, the evidence is that it didn't and that's a matter of deep regret from the Department's point of view, from my point of view, these things absolutely shouldn't have happened. But, I guess the question, I would put the question as how do you judge proportionality the degree of intervention. If you second guess everything and adopt a very, very risk averse mentality, that itself creates adverse consequences because it takes resource away from delivery of services. It's clear that the balance of risk was not right otherwise the things wouldn't have happened. But I struggle to see precisely how you prevent these things in that, you know, okay, CCTV made a massive difference and that's very, very significant in this context. But, you know, you can't watch everything all the time. You have to hope and believe that the standards, the professionalism will apply, that managers will have ensured that adequate staffing is in place, that training is in place. Those are means of mitigating risk but eliminating risk. It

clearly isn't possible across -- this applies across the whole range of health services. Things will go wrong. What we need, and the airline industry is often used as the analogy where it takes ten things to go wrong before something crashes. That should have been 15:02
our mentality as well. The Swiss cheese model is one I've used in other contexts as well. It should be that the first things goes wrong but something else kicks in to prevent the consequence applying, that clearly didn't happen in this case and that shows, I find it 15:02
hard to judge now, having been out of the system for a while, what's the actual deep answer to that.

DR. MAXWELL: You've described the airline industry and the Swiss cheese model which are actually quite outdated thinking on safety now because they are all 15:03
focusing on finding something after it's gone wrong and safety thinking is about safety critical industry, so NASA, nuclear, places like that. They are focusing on having active positive assurance that things are going right and that's very different from counting when 15:03
things go wrong. We've heard a lot within Belfast Trust that there was an assumption that if there was a problem it would be reported up, but there was no actually going and exploring what's your evidence that it's going right. Was there ever any attempt in the 15:03
Department of Health to, whatever it was, to actually get positive assurance rather than negative?

A. So, some of the work that was being done around the time I was leaving the Department, this is probably,

I'm thinking especially of early '14, there was definitely work that the CMO and CNO were heavily involved with which is on that theme. I characterise it that way but I think there was a clear recognition that promoting good management, good professionalism, these were indeed the right ways to promote good practice. And there was work coming out of IHI which was very powerful. I was there in January of '14 with Michael McBride. So, you know, that kind of thinking was emerging. 15:04

DR. MAXWELL: But it wasn't built into policy any time?

A. I guess the -- I would suggest that the duty of quality implies a positive development, in other words looking at not purely the escalation of failure but the promotion of good practice, where I think maybe not as clear and conscious as you described it, but the obligation on quality implies designing services in a way that is as robust as possible and we expect commissioners to be saying are we commissioning something that is going to be sustainable, effective, you know, looking at the dimensions of what quality is, it's got a patient focus, it's got a safety element, those that require an element of positive thinking. 15:05 15:05

DR. MAXWELL: But it requires a measure of positive quality rather than a measure of harm which is, the focus has been on measuring harm rather than measuring quality. 15:06

A. Fair point, yes.

CHAIRPERSON: Again just for my elucidation I just want

to understand, you said:

"The question I would put is how do you judge proportionality, the degree of intervention, if you second guess everything and adopt a very, very risk averse mentality, that in itself creates adverse consequences.

I understand that in some industries. I can understand that in armed conflict. I don't quite understand how that works in the health service. What are the benefits in the sort of scenario that we're talking about that you're balancing against the risk? 15:06

A. So if the risk is that in a one on one situation of staff member to patient or client there is a risk of bad behaviour. 15:06

CHAIRPERSON: Oh, I see what you mean.

A. By that member of staff. You could put ten in and then, you know, you have to hope that at least one of the ten would below the whistle. 15:07

CHAIRPERSON: So it's a question of proportionality.

A. It sounds trite but if you gear towards massive efforts to prevent things going wrong, that consumes and undermines. So it comes down to the need at a certain level to have trust, but that requires then each individual supervisor to know the frame of mind of the person, of the member of staff that they are managing and be alert to saying, how are you doing today, and you know, there is very basic through to very 15:07

sophisticated ways of oversight, that finding a way to find a balance in that is an art. I am not a deeply trained health service manager, I came, as was drawn out earlier, I don't have that depth of experience. But instinctively finding a proportionate way to deal with these things that maximizes the chance of delivering positively, of people going into a job with training, expertise, motivation and motivation and behaviour are culturally as significant as anything else. To make things work well, managers at all levels need to promote that and strongly and as positively as possible. 15:08 15:08

CHAIRPERSON: Thank you.

175 Q. MS. BRIGGS: I am going to move on now to something else which is page 6, question 9. You were asked there about the arrangements in place at departmental level for workforce monitoring, planning, and implementation. And you say there that: 15:08

"These issues reflect the fundamental responsibilities of Trust HR departments to ensure appropriate staffing and skills mix and of professional registration and standards in relation to all of their facilities." 15:09

As Permanent Secretary did you not have any responsibility for the Workforce Policy Directorate at the department? 15:09

A. Yes, for the workforce policy, that's in the realm of workforce planning which has to be informed by the

needs of the service. That would be major, very strong relationship with what's being commissioned. So if the Health and Social Care Board want to say we need to either sustain or create this level of service, then that can turn into the mix of professional and other staff that are needed. But that's a high level planning exercise, it's not as the question, I took the question to be relating more to direct aspects of deployment of staff as opposed to --

DR. MAXWELL: Did they not determine the number of pre-registration training places. 15:10

A. Yes.

DR. MAXWELL: And that will affect the supply of staff that the Trust can employ so it does have a direct link to staffing. 15:10

A. Sure, but I was taking this to talk about the actual deployment within the Trust. That takes me to ask the question, if the Trust was struggling to deploy within its cadre of employees or through agency and bank to have sufficient people with the skills and experience and motivation to do the job well, then that's a, you know, an unmanaged risk and they should be putting their hand up and saying so at that point. You would expect that to feed in systematically to a planning process. So you want the Trusts and the Board and the PHA to be saying, here's what we think will be needed. I think the fact of the matter is that things did not work out well, our workforce planning was not up to scratch for quite a significant period and we probably 15:09 15:11 15:11

turned some things down at a time when it looked as though that was okay. Then circumstances changed and it isn't, you can't turn taps on and off very quickly in training and development of these professional groups. But it's a, there is a systematic element there which was my responsibility and there clearly were some weaknesses in that domain.

176 Q. MS. BRIGGS: Were you aware of the 2009 DeLoitte review of workforce to support Equal Lives?

A. No I wasn't, because -- 15:12

DR. MAXWELL: It was commissioned by the Department?

A. Yes, so I saw it just now and I was off work for four months between March of '09 and August of '09, I think it came in, in June of '09 if I recall, I was off after surgery. 15:12

DR. MAXWELL: So the report was delivered in June 2009 so presumably would have been commissioned some time before that.

A. Again I don't recall that being commissioned and nor -- I don't recall it being drawn to my attention on my return to work. 15:13

DR. MAXWELL: Because it is quite significant, because Equal Lives had been published in 2005 and said that to support the vision there would have to be new types of support worker in the community, there would have to be teams to support patients in the community. The DeLoitte review sort of rowed back on that and said they would be able to just redeploy staff from Muckamore. And that seems to -- the original Equal 15:13

Lives recommendation seemed to be lost never to surface again.

CHAIRPERSON: If you haven't read it. Have you not read it now?

A. It wasn't drawn to my attention, I wasn't aware of it. 15:13

DR. MAXWELL: It was clearly influencing the workforce planning of the Department?

A. Evidently but not with my knowledge or, I wasn't engaged in the process, personally.

DR. MAXWELL: Can I just ask one supplementary question, feel free to say you don't know. But you as Permanent Secretary didn't know about it, didn't commission it. Who do you think within your team would have been responsible for commissioning it and actioning it? 15:14

A. If it was focused on Mental Health and Learning Disability then the Deputy Secretary responsible, Linda Brown, would have been involved. I am trying to remember the structure, whether she was also over the Workforce Planning Directorate in the Department, I suspect she was, but I don't know. Those are points of fact to be checked. 15:14

CHAIRPERSON: And you had a separate Directorate for Workforce Planning?

A. When I say Director, I'm talking about grade 5 level civil servants in old money. The person responsible, Linda Brown, was a grade above that. So if like directorate would be one unit and group would be a group of directorates, Linda was over a group of 15:14

directorates which included certainly Mental Health and Learning Disability, I think also Workforce, but I'm not sure. Then you have a CMO with a group and then another policy deputy secretary with acute services and other aspects.

CHAIRPERSON: And even though there may have been a significant shift of focus, as it were, it wouldn't necessarily come to your attention?

A. That point, I don't -- I can understand if that point wasn't seen as something to be flagged to me. Whether it was flagged to Michael McBride who was Acting Permanent Secretary for the period of my absence, he might know about that.

CHAIRPERSON: Thank you.

A. But it maybe was also something that they felt had been resolved before my return. I can only speculate.

CHAIRPERSON: Okay, thank you.

177 Q. MS. BRIGGS: Staff shortages at Muckamore are an issue that the Inquiry has heard a lot about. At what point, if ever, were you made aware of real difficulties of staff shortages at Muckamore?

A. I don't recall being made aware of such difficulties. It certainly was, from the engagement, especially in '07, I was aware of the difficulty of the place and all the associated challenges. But the one thing that I was regularly involved with in relation to Muckamore from '07 onwards was just, you know, holding the Trusts to account on the path of resettlement.

178 Q. And that's something we are going to come to. I am

going to take you to an e-mail that you exhibit to your statement, it's Exhibit 1. It's at page 14. You provide it in relation to the Inquiry's questions regarding Ennis, so this is 2012/2013. This particular e-mail is dated 4th February 2013. It's sent from Moira Brisco in the Department to others at the Department, including yourself. It refers to RQIA ringing the Department with concerns about Ennis following three inspections that it had undertaken, following concerns about being raised and three staff members being suspended. But what we can see from that e-mail is that RQIA say and this e-mail reports, this is about half way down: 15:17 15:17

"The big issue relate to low staffing levels, safeguarding vulnerable adults and use of bank staff." 15:17

So this is an example, perhaps, of staffing levels being raised directly with the department through RQIA, was that a common or uncommon type of communication? 15:18

A. Uncommon. Given what I said earlier about my personal emphasis on the importance of RQIA, the question for me at that point would be, that's important, RQIA have flagged something up, the need was to ensure that the Department responded proportionately and, given the nature of what is said there, that would require significant pursuit, significant engagement and intervention. The fact that Moira Brisco, the Director responsible, was flagging this and bringing in Sean as 15:18

Chief Social Services officer, CMO -- I'm looking for nursing on the CC list, but not seeing them. Diane Taylor was the head of HR. And then, so, there had previously been a briefing to the Minister in November 2012 and when the Ennis issue first surfaced and then the next exhibit, the submission of May '13 shows that the team in the Department were working on this issue and keeping an eye on it. Whether enough was being done, it certainly could be argued that not enough was done. But this was unusual and I don't recall detailed discussion on it at the time. It is just, there may have been, it may have been discussed either at our informal management meetings, which were held most Monday mornings, or even possibly at Departmental Board but I have no recollection of that precisely. But that's saying that -- the fact that that exists shows that the team in the Department, including not only Moira and her staff as Mental Health and Learning Disability Directorate, but also we have got the Press Office, we have got several other leaders including Ian McMaster as the SMO or the medical side concerned about these things. So to flag, I would hope and expect that was acted on.

15:19 15:20 15:20 15:20

179 Q. I appreciate a significant amount of time has passed but can you recall at all what was done by the Department?

15:21

A. No I can't recall that, no.

PROFESSOR MURPHY: Can I just ask, we've had a number of people from Belfast Trust saying to us that it was

very well recognised that there were insufficient nursing staff trained in all sorts of areas, emergency medicine, and theatre nurses et cetera, and yet it sounds to me like you're saying you really weren't aware that there were too few nurses of any kind? 15:21

A. I don't recall either precise details or precise timings on those issues. Certainly there was a point, that's 2013, I left the Department in the summer of '14. So I think by that stage we had identified, yes, there was a workforce deficit and the question was how 15:22 to act to address that. And probably the only resort in the immediate term was for the Trust, in fact for the Trusts collectively to seek to recruit or draw on agency, we had quite a significant element of difficulty in that regard, there is no question about 15:22 that. I don't recall precise detail as to when that came to attention or whether we, as the Department, actually intervened to do more to effect that. But it was definitely there as a known issue.

180 Q. MS. BRIGGS: And thinking about Ennis in more detail, 15:23 you say at paragraph 5 of your statement, that's on page 2, it's the one that you corrected earlier, you said that you were made aware in November 2012 of allegations of abuse in the Ennis Ward and you say you were advised that departmental officials had sought 15:23 assurances from both the Belfast Trust and RQIA that all appropriate steps had been taken to investigate and address these?

A. Yes.

181 Q. You may not recall, but do you have any recollection of what the assurances were and were you satisfied with what you heard those assurances were?

A. I have no recollection. I can only infer from the record that I must have been satisfied that the right things were being done. But that then links into the advice in the submission from Neal McGowan that refers to continuous monitoring, the investigative processes had to take their course, but -- 15:23

182 Q. This is page 17 you're reading from? 15:24

A. That's the submission of 21st of May 2013. That required the Trust, it is a frontline responsibility of the Trust to provide additional oversight mentoring as at paragraph 7 of the submission. The fact that RQIA were aware and seeking assurances showed that the issue was being taken proportionately. 15:24

183 Q. Just looking at that submission to the Minister, page 17, it finishes with lines to take. I suppose for someone who hasn't seen this type of document before, is that effectively what the Minister is told to say about a certain issue? 15:25

A. It's advice to him, anyone who knows Minister Poots will know that he will not be constrained by what he is given by way of advice, but we do our best to help and say if you are asked about this, here are some things you can say. He was quite capable of saying things in stronger terms and saying how deeply concerned he would be and that he was taking action. So it's conventional, it is just good practice to at least 15:25

offer up by way of advice, but it's advice, it's not restrictive. You know, it's not constraining him to only say these things.

184 Q. It's a Mr Magowan there we can see has drafted that?

A. Neal McGowan. 15:26

185 Q. He what level of seniority would he have been?

A. Grade seven. In terms of tiers of management if you like, Permanent Secretary, Linda Brown was Deputy Secretary, Moira Brisco reported to her and Neal was in line to Moira, grade seven in old money. 15:26

186 Q. You say in your statement that the Ennis Report wasn't given to you before you left your post in 2014, is that right?

A. Yes.

187 Q. Were you and others within the Department chasing that report up, obviously being aware of Ennis? 15:26

A. No, I can't claim to have chased that up. I don't recall anything more about it, to be honest about it.

188 Q. Do you think it ought to have been drawn to your attention before you left post? 15:27

A. The issue, the fundamental issue had been drawn to attention. I would have expected that intervention to correct would have been, that action would have been taken and if there was any doubt in those dealing with the issue, either in the Department or in the RQIA, 15:27 that the actions being taken by the Trust in response were appropriate, proportionate and effective then that would have been a secondary cause for escalation. So primary cause is something bad has happened and we need

to know about it, secondary is if there's doubt, any material doubt about the effectiveness of the interventions to correct.

189 Q. Okay. If we can move on to resettlement and Bamford, page 7. 15:28

A. Yes.

190 Q. You're asked here about Equal Lives and Transforming Your Care, and it is said that the latter recommended the resettlement of all people with a learning disability from hospital to community living options with appropriate support by March 2015. You were asked what the Department did to promote that pledge and what the barriers were to achieving it. In your answer you refer to responding to Bamford and Equal Lives. Sorry, I beg your pardon. In Bamford, as part of the Nolan interview that you provided to the Inquiry, you described Bamford and I'm quoting you here as "an immensely challenging agenda" is that fair to say? 15:28 15:28

A. Absolutely.

191 Q. Did you ever discuss the implementation of Equal Lives with the EHSSB or the HSCB? 15:28

A. Yes, it would have been a topic of discussion. I can't think of precise times and so on but it was definitely both on my mind and on theirs and thinking about Paula Kilbane as the outgoing Chief Executive of the Eastern Board and then John Compton who was in place when I returned from sick leave in the summer of '09. From that point onwards it was there, did other things take more time? Yes, that's a fair point. But it was on 15:29

the agenda. It was in priorities for action from '07 onwards. William McKee, as Chief Executive of Belfast Trust, was very, very clear and said to me personally on a number of occasions how determined he was that resettlement should take place, that Muckamore should essentially be closed as soon as possible and he wanted that to happen on his watch, he was very motivated by it. But for the reasons set out, and I think others have said a lot more about this, it is challenging, it's a difficult thing. I can remember Belfast Trust taking me on a visit to an example of a placement of someone who had been in Muckamore and the complexity, the context of that was very demanding. It was an individual who had, you know, no concept of harm and therefore needed intense supervision. So that's the nature of the issue. It meant then if there were issues either of physical infrastructure, as in accommodation, or of staffing or of money, you know, any one of those other things could stand in the way of planning a resettlement, not to mention the incredible importance of being sensitive to the needs of the individual concerned and the views of their family.

15:30 15:30 15:30 15:31

So it was a complex process but it was in the priorities for action context. We were, in my time in the Department through the service delivery unit which I was involved in establishing, through to the performance management function within HSCB from '09 onwards, they were in their engagement with the

15:31

Directors in the Trusts, they were pursuing these and asking questions, what's going on, are you doing all that you possibly can to deliver these targets. It wasn't just a matter of ticking boxes and assessing. It was engagement as to what's the problem, what can we do about it, are there other things that can be done and should be done.

DR. MAXWELL: What about the things that weren't within their power? So we've seen a presentation of supporting peoples -- 15:32

A. Yes.

DR. MAXWELL: Funding stopped at some point in time so actually the physical estate wasn't available. We have already mentioned that Equal Lives talked about having a new type of worker in the community and support teams 15:32 and we heard from Cathy Jack that that was never funded. So there were things that were within the Trust's control but there were things that weren't. How was the Department addressing those things that the Trust just couldn't do? 15:32

A. I don't have a detailed account of that. Certainly the obligation was there to, if an issue was being escalated to say we want to do this and we can't because of this impediment, then to the extent we could engage with, as the Department did with the Department 15:33 of Communities on financial issues as I understand it, that kind of intervention would have been part of trying to solve the problem, you know. So yes, there was a responsibility for HSCB as Commissioner as well

as the Department, but yes, there is a need to take that on.

DR. MAXWELL: I suppose who was checking the Department was doing their bit?

A. That was a matter for the management team and the Department, the buck stops with me. So to be again active on that in terms of not just relying on people saying oh, we need help, but asking the question what's going on. I can't recall at the time when that happened but that's in principle how I went about the job. 15:33 15:34

CHAIRPERSON: I have found this so interesting I completely lost sight of the time, so apologies for that. We have gone much longer than we normally do. We should take a break now both for the stenographer and for you, so we'll take a 10 minute break. 15:34

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Ms. Briggs. 15:54

192 Q. MS. BRIGGS: Chair, Doctor McCormick, before the break there we were talking about the resettlement process and your answer on page 7 is in relation to what the Department did to promote the policy, really, of resettlement. The first thing you refer to in your answer there a paragraph 18 on page 7 is Minister's Woodward decision after Bamford to appoint a Northern Ireland Director For Mental Health and Learning Disability and this is prior to the creation of the 15:55

PCC. You say in your statement that you played a central role in the process in seeking to make an appointment to that position but the limited records from May 2007 show that no appointment was made and you don't recall the details as to why that was the case and that was some time ago obviously. Why was it that role was thought to be a good idea?

A. So the analogy would be the so-called SARS who were appointed into similar roles in the health service in England, so that's presumably where Sean Woodward as the Minister got the idea. The purpose would be to have a strong voice, an independent champion, someone to continue to speak up given that the actual work of the review had been completed. But, it was, that was the basis of the idea.

DR. MAXWELL: Do you recall if it was advertised but you didn't appoint or it didn't get that far?

A. I think it was advertised, I think it was advertised twice. I do recall that the first time round, there was a disagreement on the panel and the person in front of us who two of us thought was appointable, the third member of the panel didn't think was acceptable so no appointment was made. I'm pretty sure we did a second round of interviews. I thought we had identified a candidate but there must have been -- again given there is a very clear record in the assembly committee that no appointment was made, I can't remember why it didn't work out.

193 Q. And really that role was to provide a voice for

patients and families?

A. Yes. A champion within the system to --

DR. MAXWELL: Was it a voice for families because the SARS in England were largely doctors?

A. So the lead candidate who wasn't appointed was from a professional background. So yes, it's more, I wouldn't say -- I think the emphasis was not so much on voice for families but. 15:57

DR. MAXWELL: For the service?

A. A strong independent challenge function to say, to speak to Department, Board, Trusts to say, you know, are you giving enough attention, are you paying -- I as an expert have this view, are you doing the right things. So wouldn't have executive power but I think, in I suppose in a cultural sense, had the person been offering strong advice and that been ignored then the Minister would have heard tell of that and, you know, so you would expect it to be a positive loop. You know. 15:57 15:58

194 Q. MS. BRIGGS: And that lack of appointment, to what extent did that leave a gap? 15:58

A. So, I think there were alternative ways of looking at it and I think I have a vague recollection of a group of people being appointed, but I can't remember detail as to how that worked. We tried to make, we tried to fulfil the idea, even though the way of doing it based on an individual didn't work out. But, I have no more -- 15:58

CHAIRPERSON: It doesn't sound like that existed for

very long, otherwise we would have heard of it.

A. The other thing is devolution took effect at that time, this probably wasn't top of the agenda for the incoming Minister McGimpsey. I'm not saying he didn't give proportionate and good attempt to Mental Health and Learning Disability, he did, but that idea had come from the direct rule minister.

195 Q. MS. BRIGGS: You go in your answer in the next paragraph to describe how the Department set targets from 2007 onwards. You say that that was initially in the Priorities For Action document but then, after the HSCB was established in 2009, targets were set in the annual commissioning process? 15:59

A. Yes.

196 Q. You describe how those targets then became part of the process of performance management of the Trusts. How in the first few years of resettlement were those targets set and who set them? 15:59

A. So they were formally set by the Department but through a process of engagement and advice, so they would have taken account of, so the philosophy behind target setting, and this applied to the acute sector as well as this sector, was to have something which was within the realms of reality but with an element of stretch. So, the service delivery unit, which I was involved in establishing, I think that was in '06 was, that was a determined focus and effort to say we're going to really drive performance management. I talked to senior colleagues in Richmond House and the advice I 16:00 16:00

got was this was an effective way of doing things. Okay, target setting and performance management in that style is definitely out of fashion in the present day but for a while it was making progress and including in relation to resettlement, I would be clear that as the collective team in the Department discussed the nature of the targets, someone would have said we absolutely need to have a target in the realm of mental Health and Learning Disability, we can't allow the acute sector to dominate completely and we came around to this as a good way of expressing a top priority. It is by no means comprehensive and target setting can't be comprehensive, but it's an attempt to focus on something that really mattered. 16:01 16:01

197 Q. What research goes into targets and how achievable or ambitious they might be? 16:01

A. I don't have a detailed take on that. I just infer and imagine that it would have been discussion as to what had been achieved, what's actually been possible in the real world, what resource requirements the organisational effort, financial resources, staffing resources, so thought and analysis would have gone into that and probably you then say, well, let's add a stretch factor into that. And it's not that you are then condemning people for not meeting, you're hoping that will provide motivation, aspiration and progress. 16:02 16:02

CHAIRPERSON: It sounds as if it's a best guess with a bit of aspiration?

A. I don't think that's unfair.

198 Q. MS. BRIGGS: What were the consequences for Trusts failing to meet those targets?

A. So the capacity, the ability of the Department to intervene and have sanctions was tangible but, obviously you don't beat people about the head for one failure, you have to look at circumstance, context and have they done the reasonable things that are possible. If a target hasn't been met, are there good reasons and circumstance that explain it or is there evidence of lack of focus or lack of effort. So again, in relation to the Trusts on my watch there were a range of different interventions taken. So Belfast Trust was in special measures during 2012 because the Minister was very concerned about three or four different things that had gone badly wrong, he felt hadn't been escalated properly and so the intervention was made. That's one way to challenge. Had there been a grotesque failure in relation to delivery of resettlement target, that could have been added to, if you like, a charge sheet so to speak, sorry to speak in that style of language. But it would have been on the list of things that were ground for escalation. So we had to try and deploy interventions that would be proportionate and effective, special measures was one way to do that, basically saying we intensify the monitoring, we have monthly rather than twice yearly accountability meetings, we look for incremental targets, progress, evidence of progress on a much more tightly defined basis. An alternative intervention

16:03 16:03 16:03 16:04 16:04

which I used in a different context in Northern Trust was a turn around team. These are fairly familiar, if you look at the spectrum of interventions that Department of Health in England would have done in relation to Trusts and, you know, which of them work, I'm not sure how effective they are, but there's definitely scope to intervene and escalate but you don't do it without thought and good reason and consideration of the effects. This is tricky territory. 16:05

199 Q. What interventions were taken in relation to Muckamore, were there any?

A. I am not aware that -- there was difficulty in meeting the targets. The resettlement targets were not being met consistently but there was not -- it didn't get in the box of evidence of inadequate effort, inadequate focus. We weren't blaming the Trust for not having met that. So it wasn't on the list of measures in 2012, for example, that led to the special measures intervention in Belfast Trust. That was quite a severe thing do, you know. When I talked to Colm Donaghy as Chief Executive he was very displeased to be put in that situation. So, I think the degree of difficulty in that target and it wasn't, there wasn't I think clear evidence of systemic failure in the efforts to resettle, the difficulties were genuine, some of them were indeed issues that we had to deal with at departmental level as well. So it wasn't a clear cut. You couldn't say it was a management failure by no

means.

PROFESSOR MURPHY: You are making it sound as though it was relatively minor in a way, but we heard from a witness from the Mental Health Commission who gave us a figure in 2007 and 8 that there were 296 patients in Muckamore and 241 of them were delayed discharge. Now that sounds to me like a very big problem? 16:06

A. Sorry, yes, it absolutely was. But in terms of a trajectory to achieve resettlement effectively, it is not as though you could say if you don't get 200 of those people resettled in six months, that wasn't in the real world. 16:07

PROFESSOR MURPHY: It had to be realistic.

A. We had to set targets that were stretching, yes, but if they were -- if you set a target that is totally unachievable then the Trust will just shrug their shoulders say that's impossible, I'll not even try. So it's a judgment call. I wasn't the one making these judgments personally. I was approving and then putting to the Minister for approval. But based on advice and the analysis that was done by the performance managers who started off in the department, so the same people then moved into HSCB when HSCB was created. And also then policy colleagues in the department to say that's the best we can do in the real world. Difficult, I think it is finding and establishing the right environment, getting the right people in place, it's a genuinely challenging thing. 16:07 16:07 16:08

DR. MAXWELL: Is it finding or creating the right

environment? If you go and search for it and you don't find it, maybe you have to make it yourself?

A. Yes, sorry, yes, I think that is indeed what happened, that some of these things needed to be designed. But designing, that itself has a time factor in it. It means it is difficult to move very quickly. Difficult, sorry, this should have been done sooner. The policy of community care, the policy of resettlement was known and understood a long, long time ago. So there is a genuine indictment of the system on this, I can't escape that. 16:08 16:09

DR. MAXWELL: But it's nearly 20 years since Equal Lives so maybe when Equal Lives came out you can look back and say we didn't do enough sooner, but have these 20 years been spent effectively creating the right environment? 16:09

A. Well, certainly in my period we were trying very hard to make it work. I look at the -- I'm obviously not fully enlightened as to what has happened in the last 10 years but it feels and looks more difficult than on my watch, at the present time. 16:09

200 Q. MS. BRIGGS: You describe in your statement some of the challenges of resettlement and one of the challenges you describe is the financing of resettlement. Thinking about Bamford, would you say that its recommendations were fully costed and funded? 16:10

A. I'm not sure either, I'm not sure I can say a direct yes to either costed or funded. I think there was a need for, and again I don't have detailed recollection

of this, but within the financial planning of the Department there was a responsibility of the Mental Health and Learning Disability Directorate to put to the Finance Directorate estimates and bids for the resources needed to implement that. That would have been follow up to the report rather than integral to the report itself. And then the financial situation in Health in my time was seen as pretty difficult, but nothing like as difficult as today. So we were definitely not able do everything we needed and wanted to do in that time, so that's why I say I can't answer, I can't give you a yes to funded either. 16:10 16:11

201 Q. When you have a major project such as resettlement --

A. Yes.

202 Q. -- is there room for the Department to revert to Westminster to seek ringfenced funding for specific project work like Bamford? 16:11

A. No, that's not the way the system works. It could only ever be a component of a wider bid or demand from the Executive collectively to the UK government but it would get pretty short shrift from the Treasury. They would say, you know, ten things you could do to find that kind of money for yourself, that would be the message back to the First Minister, Deputy First Minister and the Finance Minister, and has been, that's happened a good number of times. 16:11 16:12

203 Q. And how did the Department share the challenges of resettlement with other departments like say the Department of Communities in relation to housing and so

on?

A. That was a key one. I don't recall deep personal involvement in that or detail of what happened, but it clearly mattered and it clearly at one stage wasn't working where there was a mismatch of financial planning between Health and Communities and that did cause a problem. Again, just from what I have read recently, it appears that a way forward was found but I think that's the sort of thing that needs to be sorted out, you know, and resolved. You know, I sometimes hear of things being, turning into a stand-off and what I try to give is a message, a leadership message, you know, don't have a standoff, if you can't resolve it then escalate it, you know. But that's maybe a bit trite. 16:12 16:12 16:13

204 Q. I am going to read out paragraph 22 of your statement, it's about the challenges of resettlement:

"It is well understood that creating and financing suitable community based settings for patients in Muckamore was and is a complex process as a result of the complex needs and, in many cases, the challenging behaviours of the individuals concerned. It was essential to secure the necessary staff and other resources to ensure that the care to be provided in the new setting would be suitable and to an acceptable standard." 16:13 16:13

Would you say that the Minister was aware of those

challenges?

A. Yes, both. He was very engaged with this kind of issue. You're thinking of Minister Poots? Yes.

205 Q. Did Minister Poots update the Assembly?

A. I don't recall. He may well have done. There clearly would have been Assembly questions, written and oral, on this topic over the period. Whether -- I don't recall a statement or debate, although there may have been a debate. Again Assembly Hansard would have that. 16:14

CHAIRPERSON: It would be in Hansard, wouldn't it? 16:14

A. It would be, yes, I don't recall. I would be surprised if it wasn't actually.

206 Q. MS. BRIGGS: Given how difficult resettlement was, did you or the Department seek advice from anywhere else that had had a major resettlement programme for closing hospitals for people with learning disability? 16:14

A. I am not personally aware of any such contact. Just knowing the way people worked, I would be quite surprised if there weren't conversations with counterparts in other parts of the UK or wherever. I think that, that's what I would normally expect. I know it happened in many contexts but I have no evidence on that point. 16:15

207 Q. I want to go on to page 10 of your statement where you bring some other matters to the Inquiry's attention relating to two specific occasions when you say you had direct involvement in issues relating to Muckamore, and this is paragraph 27 first of all. This is the first of the two occasions that you recall. You refer to 16:15

PSNI involvement in Muckamore in Autumn 2005 regarding sexual activity at Muckamore really. You set out the actions that were taken by you, including writing to Trust, Chief Executives, RQIA, PSNI, Assistant Chief Constable and those are all detailed at the lettered paragraphs?

A. Yes.

208 Q. I am summarising in part, you were effectively seeking assurances regarding the procedures in place at Muckamore to prevent the abuse of children and vulnerable adults, is that fair to say? 16:16

A. Yes, to establish the facts, yes.

209 Q. And at page 11, towards the bottom of page 11 you say:

"These records clearly show the action taken on these issues and my clear inference is that my own judgment and the collective judgment of the Department, the Trusts and RQIA was that we had responded proportionately and appropriately and that there was no prima facie evidence of abuse of patients by staff in that period that should have prompted further or deeper investigations." 16:16

A. Yes.

210 Q. Were any weaknesses in safeguarding processes revealed by your exchanges with the Trusts, RQIA or the PSNI that you can recall? 16:16

A. So, I suppose the fact that things were happening and were being recorded in a matter of fact way, show that

in a period some time ago there had been, you know, untoward activity. And I guess the harder question is what should managers and overseers have done in that context in the past, you know, was there anything that could have been done differently, because clearly some of the cases were affecting minors. So, all we could do in this process was to try and establish a body of evidence in relation to what had happened in the retrospective sampling. We chose a 10% target to see, well, clearly on the basis that had that revealed a larger scale of activity it would have been possible to have widened that. So it was trying to do something which was proportionate in itself but which could be expanded if there was further evidence or a need to explore, or a need to pull a thread more fully. But, I'm not sure I can identify, you know, additional interventions that might have made a difference.

16:17 16:18 16:18 16:18

DR. MAXWELL: I think the question is not were they appropriate historically, but you wrote in September 2006 seeking independent assurance, which presumably was about contemporaneous processes?

A. Yes, sorry, that's right, yes, indeed.

DR. MAXWELL: So when asking both the Chief Execs and the RQIA did anybody come up and say, actually we could improve our current practices?

16:19

A. Not to my knowledge, no, no. I don't recall any such escalation of an issue in that period, no.

DR. MAXWELL: So they all responded to your letter saying no, we have got perfect systems or appropriate

systems?

A. Proportionate.

211 Q. MS. BRIGGS: The second occasion then you recall is page 12, paragraph 28, and we have touched on this a little bit already. This is when you say that there was serious criticism of Muckamore in 2007 with the media, the press, you say, reporting that patients were being locked up and that's at paragraph 28 of your statement? 16:19

A. Yes. 16:19

212 Q. And you did an interview on the Nolan Show which we referenced earlier on 18th January 2007 and you provide the transcript of that interview as the third exhibit to your statement. Can you just provide a little bit more about the context of that media focus on Muckamore from your own understanding? Was the concern really over the environment that patients were living in and the use of locked wards, is that fair to say? 16:20

A. I think that's right. So Dot Kirby, the then BBC Health Correspondent had given this considerable attention. I think some of the advocacy groups had come in and talked about actions contrary to the individual's human rights. So very strong concern being expressed in the public domain. 16:20

Stephen Nolan, in his inimitable way, giving it a strong degree of coverage. Stephen treated me very fairly, he always has. I have not done his programme very often, that was only one of two occasions I was on his programme while I was in post. He asked of me fair 16:20

questions to ask and genuinely advocating on behalf of the affected individuals. But I, again not being an expert in the topic I had to, to an extent, seek to explain and put the thing in context, but then also assure that the Minister was requiring scrutiny and 16:21
investigation so that the actions being taken, the use of locking up or seclusion or whatever it might be, that was being subject to management oversight and only when essential and looking for the application of good practice. It's difficult, and again I'm not, I had 16:22
limited understanding at this stage, I hadn't been to Muckamore. I went there, you know -- so I put this quite gently in the statement but I recall vividly one conversation with an individual who was practically begging me to help her get out of Muckamore, you know, 16:22
which was, you know, not a normal experience for me but well said on her behalf. And, to me, that stands as a very vivid challenge to how we were working and the need for us to actually do better, you know.

213 Q. And in a way can that type of direct engagement with 16:23
patients and others be as effective or even more effective than formal oversight or governance structures?

A. Yes, yes. You know, there is a phrase I picked up in the 1980s in a different context which is management by 16:23
wandering about. It's probably more for line managers, Chief Executives than civil servants. But I think on occasion just to be there maybe without prior notice, just to catch the system unawares, if that's not

putting it too strongly, in order to hear unvarnished, you know, unprepared comment. You can't necessarily take everything directly out of that, you have to triangulate and put that in context with more systematic evidence, but to hear vivid first hand testimony I think is very a valuable.

CHAIRPERSON: You dealt with some of your visits to Muckamore earlier in your testimony and I remember that you went obviously in 2007, but did you go there after?

A. I don't recall going there after. I think it was twice in '07 is the best of my memory of it. 16:24

CHAIRPERSON: So despite the recognition of how valuable it is you only managed to get there on the two occasions after the Nolan Show?

A. I would just make the point that there were quite a number of other places I'd never been to. 16:24

PROFESSOR MURPHY: I mean given the issues about sexual abuse in 2005 I feel am bit surprised you didn't go there then?

A. My honest answer to that is that that didn't occur to me. It wasn't -- I was relatively new in the Department. I arrived there in August of '05 and probably was at that stage more sensitive to going when I was invited. I broke that taboo in the summer of '06 when, on advice from the leader of our Performance Management Group, I went uninvited to three emergency departments. At the time we were establishing the four hour targets for emergency departments. So, I didn't do it that often. That didn't go down well, the Trust 16:24 16:25

didn't like me turning up.

CHAIRPERSON: I suppose turning up in an A&E department can be quite disruptive, can't it?

A. It was done carefully.

CHAIRPERSON: Could I just ask this, I understand you had a lot of places to visit. Did you have a rota, two or three times a year you were going to visit? 16:25

A. No, it wasn't as systematic as that. It was more opportunistic and circumstantial.

214 Q. MS. BRIGGS: You say, Dr. McCormick, at paragraph 28 in relation to your visit to Muckamore, the first in 2007, you say that you do not recall: 16:26

"...that there was any allegation of any inappropriate behaviour by staff at that time though remember being told, by whom I do not remember, that there was a material concern that some staff had become institutionalised as a consequence of the duration of their postings and the low expectations that positive change was possible at Muckamore." 16:26

What do you mean by both of those things?

A. So "institutionalised", that's, I suppose, inferring that there was a defensiveness of the institution, a sort of sense that we're neglected, beleaguered and, therefore, we need to look after ourselves and close ranks. I'm caricaturing a bit there, I don't want to be unfair, this was a brief comment. I actually would be quite surprised, having heard that comment, I didn't 16:27

talk to senior colleagues about it and say look, I was at Muckamore, here's my impression. Just knowing the way things worked in the Department, probably the Monday morning I would have been talking to people about it. But I'm sorry, this is a long time ago and 16:27
nothing written down about it so I have no anchor for my memory on this. But I think there probably was also a sense of, you know, we know we have had a problem for many years, there's not much attention on it. The hope of change wasn't very strong but I'm -- I wouldn't put 16:28
too much weight on what I've said there because it isn't based on clear and strong memory, these are impressions formed but, you know, the phrase stayed with me quite strongly and I've done my best to almost reconstruct what my feelings were at the time. 16:28

215 Q. It's understood that this was a long time ago and you may not remember --

A. Sorry, I can't be more direct.

216 Q. -- can you recall any actions that were taken by the Department? 16:28

A. Well I don't recall but there must have been follow up to that set of allegations and the media coverage in relationship between the responsible people in the Department, when is this? This is still at the time of the Eastern Board and North and West as a Trust. You 16:29
know, they must have had discussions about the publicity and the question would have been is the conduct, is the regime, sorry, awful word to use, but is the regime appropriate, is the conduct of care being

delivered in the best possible way in the context and I would be very, very surprised if there wasn't some constructive discussion along those lines but I have no information or knowledge of that. But when something gets media attention and is seen as such a bad thing in the public domain, you know, surely Richard Black or his team in the Trust would have thought well, let's look at this. If I was going up, and I think the second visit it was either ministerial or certainly more official, I think I was talking to Miriam Summerville or others at the site who were leading and asking them what's going on, why is this the way it is. I would have heard, and maybe the Minister heard on his visit, explanation and context. It doesn't mean it was all right but I would be astonished if there wasn't follow-up of that nature. But that's more inference from first principles than tangible recollection. 16:29 16:30 16:30

217 Q. And you've referenced there that the Minister visited Muckamore?

A. I think that's true, I'm not sure. 16:30

218 Q. You say in your statement that your recollection is that Minister Paul Goggins also visited Muckamore a few days later. How often did ministers visit Muckamore?

A. Not very often and that would have been -- again it's the unfortunate thing things can be triggered by media coverage rather than by a systematic evaluation of standards of care and risk of harm, but that's, I'm afraid, the real world. 16:30

219 Q. Finally, my last question for you is, you were in post

for another seven years after 2007, how did you feel the concerns that had been raised in 2007 were being dealt with by the time you left, can you recall?

A. I have no direct recollection of that. I think we were into the rhythm soon after that of the focus on the resettlement targets and I was hearing regularly from, for example, from William McKee that the Trust was determined to resolve the Muckamore issues and, you know, resolve, as in move towards closure as quickly as possible. So that was, there was definitely conversation along those lines. I don't recall another instance that made, brought it back into top focus for me or for the Minister in the subsequent period. Certainly I would struggle to defend a claim that says well, should I not have followed up, you know, in the great scheme of things I probably should have but as a matter of fact I don't recall doing so. 16:31 16:31 16:32

PROFESSOR MURPHY: Do you remember discussions about the possibility that as resettlement proceeded the people who would be left would be likely to be the most challenging and that might create tremendous problems? Because, you know, there was a lot of experience elsewhere in deinstitutionalisation, not just England, but America, Canada, all sorts of places. Did that kind of thing come up in conversation? 16:32 16:33

A. I don't recall, I don't recall it. But undoubtedly it's an important theme. I've no memory of that being actively discussed with me.

MS. BRIGGS: That's all the questions I have for you,

Dr. McCormick. I am going to hand over to the Panel in case they have some more.

CHAIRPERSON: Mr. McCormick, can I thank you very much indeed for coming along to assist the Panel this afternoon. That is the last time we will be hearing from you I think so thank you for your attendance. And we will sit on Monday at 9.30. I just remind everybody I'm afraid Monday and Tuesday are going to be 9.30 starts. Thank you very much indeed. Thank you. 16:33

16:33

THE INQUIRY ADJOURNED UNTIL MONDAY, 21 OCTOBER 2024 AT 9.30