MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 15TH OCTOBER 2024 - DAY 115

115

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

GWEN MALONE STENOGRAPHY SERVICES

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THE INQUIRY RESUMED ON TUESDAY, 15TH OCTOBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you.

MR. DORAN: Good morning, Chair, Panel. This morning's witness is Esther Rafferty and her evidence is for the purpose of organisational Module 7. She is in fact the final witness to give evidence within that module. So if Esther Rafferty could be called please. 10:03

ESTHER RAFFERTY HAVING BEEN SWORN WAS EXAMINED BY MR. DORAN AS FOLLOWS:

CHAIRPERSON: Thank you Ms. Rafferty, welcome back. You know the form having been here before I think on 17th June when you were giving evidence about Ennis, but thank you for coming back and I am going to hand you over to Mr. Doran. As I said before, normally we take a break normally after about one hour and a quarter but if you need a break earlier than that just let me know, all right. 10:04 10:04

A. Okay, thank you.

1 Q. MR. DORAN: Ms. Rafferty, thank you again for coming back to give evidence. As the Chair said, you were last here on 17th June of this year. Whilst we talked primarily about the Ennis process that day, today we're going to look more generally at your role in management within the hospital? 10:04

A. Mhm-mhm.

2 Q. And can I just ask when you answer me that you speak clearly into the microphone because obviously the stenographer has to take a full record of what's being said. Now, you made a statement on 27th of June of this year, isn't that correct?

A. Yes.

3 Q. And for the record the reference is MAHI STM-295. And have you got a copy of your statement with you?

A. Yes, there's one in front of me.

4 Q. That's great. I think it's fair to say you prepared that statement in response to specific questions that had been put to you by the Inquiry; isn't that right?

A. That's right.

5 Q. And did you prepare the statement yourself?

A. Yes.

6 Q. And have you had the opportunity to have another look through it before today's evidence session?

A. I prepared it just from my recall.

7 Q. Yes?

A. I don't have access to other information other than my memory.

8 Q. Yes, so you did the best you could?

A. Yes, I could.

9 Q. Relying on your memory to answer the questions put to you by the Inquiry?

A. Yes, yes.

10 Q. Have you had the chance to have another read through it?

A. Yes, I have.

11 Q. And are you happy to adopt the statement as your evidence for this part of the Inquiry?
A. Yes, I am.
12 Q. I am going to make brief reference as we go along to your earlier statement for Ennis also and, just for the record, that's MAHI STM-229. I'm not going to be going through every paragraph in the statement. As you know, all of the statements for these kind of organisational modules are in fact published on the Inquiry's website? 10:06
A. Yes. 10:06
13 Q. Now, if we can just go to paragraph 5 first of all. You explain that you took up the post of Service Manager in 2012, isn't that right?
A. That's right.
14 Q. And on the last day you gave the Inquiry some details of these dual roles that you had, Service Manager, and Associate Director of Nursing? 10:06
A. Yes, I held both roles. The process within the Trust at the time was that you could be appointed to Service Manager, but 30% of your role was to do the Associate Director of Nursing role and the Directorates within the Trust had, there was about 11 Associate Directors of Nursing that were linked to a Service Manager role. 10:07
15 Q. That's interesting, so those two posts always went hand in hand with each other then? 10:07
A. There hadn't been one in Learning Disability before, this was the first time that they had done one in Learning Disability.
16 Q. When you say this was the first time they had done one,

what do you mean by that?

A. I had recruited to a dual post for Learning Disability. The previous Service Manager in Muckamore was not an associate manager of nursing, the post was held jointly with the mental health post under that, his Service Manager role.

17 Q. So before you took up your post in 2012 the role of Service Manager in the hospital and Associate Director of Nursing in the Trust were two separate things?

A. Yes -- they weren't two separate things within the Trust, a different Associate Director of Nursing for Mental Health also held the remit for Learning Disability. 10:07 10:08

18 Q. But you were the first dedicated --

A. Why he. 10:08

19 Q. To Learning Disability so to speak?

A. Yes.

DR. MAXWELL: Can I just clarify, are you saying there was one post of Service Manager and Associate Director of Nursing across LD and Mental Health prior to your appointment? 10:08

A. There was two Service Manager roles.

DR. MAXWELL: But one --

A. But one, the Mental Health Service Manager held the remit for Learning Disability as well. 10:08

DR. MAXWELL: So there were two posts, one person was Service Manager for MAH only.

A. Yes.

DR. MAXWELL: The other was Service Manager for Mental

Health and Associate Director of Nursing for both Mental Health and LD.

A. Yes.

DR. MAXWELL: Okay, thank you.

20 Q. MR. DORAN: Thanks for that clarification. Now, as I say, you described, you described the role, the two roles in some detail the last day and I'm not going to go over all of the ground. I think you've just referred to one of them being a 30% role, is that correct? 10:09

A. Em, it was a nominal 30% because we got a 30% up lift in our salary because we took on that additional role.

21 Q. So it wasn't the case that you were expected to spend 30% of your time on one of the roles?

A. No, it was a recognition of the role that they paid a percentage in our salary, but some weeks you spent a lot of time on the nursing roles because you had a lot of meetings to attend within central nursing and issues within the hospital and outside in relation to developmental areas. 10:09 10:10

22 Q. Yes?

A. With NIPAC and other organisations and, you know, but it's with any job you juggle the remit of the role.

23 Q. I was going to ask you about that, because looking on from the outside one might say that the role of Service Manager within the hospital is a fairly significant role in itself and fairly time demanding and, likewise, the role of Associate Director of Nursing for Learning Disability across the Trust. Were those two roles 10:10

possibly too much for one person?

A. Certainly there was a review of the roles within the organisation and I think that was around 2014-15 and the Beeches Management Centre was involved in the review of the roles and then collective leadership came on board and they split off the roles, it became a Divisional Nurse role, which was full-time, and Service Manager's role was full-time. 10:10

24 Q. Right, when did that occur?

A. Well the collective leadership came in late 2016 I think it was, or, no it came in in 2016. I was appointed to Divisional Nurse in September 2016 but I didn't take up the role until April 2017 because the Acting Head of Service had said, you know I couldn't be released until the post was backfilled. 10:11 10:11

25 Q. Yes. But does that mean there was a period of four to five years when essentially you were performing the two roles?

A. Yes.

26 Q. In tandem? 10:11

A. Yes and I also, when our co-director retired and that post was given up under efficiency savings, I was allocated also Community Resources. I took on 13 residential and supported living schemes to manage as well on top of my current remit. 10:12

27 Q. Let me just ask about the two roles first, did you ever find that responsibilities on one side were keeping you away from work that needed to be done on the other?

A. As with any job, you prioritise your workload on a

daily basis but certainly you had responsibilities in both areas. I did certainly have an experienced team of assistant service managers within Muckamore who I found very supportive.

28 Q. But if you were looking back now and asked to make a judgment? 10:12

A. Huge remit.

29 Q. On whether it was an ideal arrangement, what would you say?

A. Certainly, I don't think having both jobs was an ideal arrangement and certainly that was the feedback from all of us within the Associate Director of Nursing roles and we fed that through in relation to the review. I think it was fortunate that the review indicated that both of them were stand alone roles, but it was a very demanding period. 10:12 10:13

30 Q. Yes. Now, in paragraph 6 you explain that in your service management role you were responsible for nursing and social work and social care staff on the hospital site, isn't that right? 10:13

A. Yes, that's right.

31 Q. And one specific aspect of your role that you refer to in paragraph 7, is that you were to lead on the resettlement agenda, working closely with John Veitch's team. Was that right from the start of your time in the hospital? 10:13

A. Yes, from the very beginning I was tasked in relation to resettlement.

32 Q. Do you remember, did you replace someone else in that

resettlement role or was it a completely new role with you being the first person to take it on?

A. There was different professionals from the Trusts, from all the Trust who were involved in resettlement. On the site it tended to be the Community Service Manager in the other Trusts who led on it. The Community Service Manager who retired was a key person in the Belfast Trust who was leading on it before I took up post, but he left shortly afterwards. But we worked as a team but I certainly had to take much of a lead on it from that point. 10:14 10:14

33 Q. But there was a resettlement lead before you came along?

A. Yes.

DR. MAXWELL: Sorry, can I just clarify that, you said that the community Service Manager was leading on resettlement, so it wasn't -- was there a separate resettlement lead or was it part of the job as a Community Service Manager? 10:14

A. I suppose I believed it was part of the job of the Community Service Manager because in all the other Trusts it was the Community Service Manager as well who attended the meetings. 10:15

DR. MAXWELL: So when the Belfast Trust Community Service Manager left, is that why you took responsibility, because that person had left? 10:15

A. I'm not sure, but I came from a background of where I had completed a lot of resettlements in Mental Health and I had a lot of experience in resettlement because

that was a core function of the post I was in before.

DR. MAXWELL: So did you always understand when you applied for the job that you would have a big focus on resettlement?

A. Yes, even from a hospital perspective to support it, but certainly it was something that I had been heavily engaged with in the past. 10:15

DR. MAXWELL: Yes.

A. And I think maybe they were using that knowledge base.

DR. MAXWELL: Yeah, so they were taking the experience from Mental Health. 10:16

A. Yes.

DR. MAXWELL: Where resettlement appeared to have been more successful.

A. Yes. 10:16

DR. MAXWELL: And applying that in Learning Disability?

A. Yes.

DR. MAXWELL: Thank you.

34 Q. MR. DORAN: We will go on to deal with resettlement and discharge in some more detail later, but can you tell the Panel just something more at this stage about how that aspect of your role worked, were you set performance targets, for example? 10:16

A. Now, I suppose I need to be clear, I don't remember exactly what the target was, you know, specific, but there was through, it was priorities for action. There was a target set each year in relation to the number of priority targeted list patients that had to be resettled. There was a number set. And then there was 10:16

also a number of delayed discharges each year. And year by year there was sometimes more of one than the other that was achieved. But we worked towards that target but it was --

35 Q. Can I just interrupt very briefly, were the targets set on an annual basis? 10:17

A. They were set on an annual basis but there was also like a year end. So they were saying like by 2015 they wanted it all to be completed, but they set an annual target to say can you achieve this number this year, you know, and there would be so many next year. But it was -- you had to work with each of the Trusts, each Trust was set a target as well as an overall one for the hospital. 10:17

36 Q. Yes? 10:17

CHAIRPERSON: So I'm sorry, Mr. Doran, but is that set by the Department of Health?

A. I think it was the Board.

CHAIRPERSON: The Board or the Trust?

A. As in the Health Board. 10:18

CHAIRPERSON: Right.

DR. MAXWELL: And did you have personal targets? So in your personal development plan did you have a personal target to contribute to this overall ambition?

A. No, my personal plan would have stated that as to work proactively with the resettlement teams to achieve their targets. 10:18

DR. MAXWELL: And were there any metrics in that, was there any quantitative measure that would be looked at

at your end of year appraisal?

A. Well, we were, I would have attended the performance management meeting with Mr. Veitch, with I think it was Mr. Devlin who was the director at the time and they would have asked how many were achieved, but the performance department would have done monthly returns both to the Board and to the Performance Director. 10:18

DR. MAXWELL: But in terms of your personal annual appraisal every year, which I presume Mr. Veitch was doing at that time. 10:19

A. Mr. Veitch, yes.

DR. MAXWELL: Would they have looked at it and said this was your plan for the year and your plan was to ensure that five patients were successfully resettled, you have or haven't achieved this? 10:19

A. It wasn't as specific as that. It would have been that we would have met so much throughout the year to discuss those achievements that at the end of the year it was well, you know, X number was resettled, well that was the maximum we could have achieved this year given our constraints, whether it be money or placements or engagement. 10:19

DR. MAXWELL: But was resettlement one of those points in your --

A. We would have discussed it every year, yes. 10:19

37 Q. MR. DORAN: And what if the target wasn't met, what was the consequence, if I can put it like that?

A. We had a discussion around what other actions do we need to do this year to improve the outcome, you know

to achieve more resettlements. However, both myself and Mr. Veitch would have, you know, said we have to bring the patients and the families along in relation to the placement itself. Any placement that was brought forward, the lead psychiatrist and ourselves would have sat down and said well, you know, is the family happy with this placement. You know, there would always have been discussions at ward level but it was individual families, and I know some of the resettlements took a very long time to agree because some families felt that a particular placement they weren't happy with so others were looked at and discussions happened on, you know, on an ongoing basis to ensure that, you know, people were prepared to explore is this one going to work. And sometimes it was that staff member on the ward who was very familiar with the family and things would have actually went out to the placement themselves and come back and they would have said whether or not it would have worked for that particular patient and sometimes that was the reassurance that the family needed. 10:20 10:21 10:21 10:21

38 Q. I am going to come back to that a little bit later. What I want do now is just to clarify your various roles throughout your years at the hospital. You refer in paragraph 8 to the reduction from three service managers to two in 2016. I think we've touched on this briefly already? 10:22

A. Yes.

39 Q. Can you explain exactly how that impacted on your role

at the hospital?

A. I suppose that was a bit of a surprise at the time because the director and the co-director were both retiring and both posts were given up. Adult Social and Primary Care had been a bigger entity before under a previous director and, when she left, it had been split because of its size. 10:22

40 Q. Yes?

A. So it was a surprise then that it was going back into a big Directorate again. 10:22

DR. MAXWELL: Can we just go back to the Service Manager posts rather than --

A. It was a community one.

DR. MAXWELL: The director posts. You said that there was a reduction from three to two, so that was for the Directorate? 10:22

A. No that was for Learning Disability.

DR. MAXWELL: That was for the division. So what were the three Service Manager posts, there was you for the hospital? 10:23

A. Me for the hospital, one for community teams.

DR. MAXWELL: Yep.

A. And one for day care and supported living.

DR. MAXWELL: So there were three. Which one was given up? 10:23

A. The day care and supported living.

DR. MAXWELL: So you took on some responsibility for day care?

A. No, the Teams Service Manager took on the one for day

care.

DR. MAXWELL: The Community?

A. Yes.

DR. MAXWELL: Service Manager took on responsibility for day care. 10:23

A. Mhm-mhm and I took on supported living and residential care and the community support team.

DR. MAXWELL: So the Community Service Manager gave up responsibility for the community teams?

A. No, it was just another small resource that was linked to residential and supported living. 10:23

DR. MAXWELL: Oh, I see, a team to support supported living.

A. That supported people living, yeah, it was like floating support into housing. 10:24

DR. MAXWELL: So at this point you had been responsible just for the hospital?

A. Yes.

DR. MAXWELL: And you are now responsible for supported living facilities. 10:24

A. And residential.

DR. MAXWELL: And residential care.

A. I think there were 13 more stand-alone facilities.

DR. MAXWELL: And these were largely patients who had previously been in Muckamore? 10:24

A. No, an awful lot of them were community patients who, you know, had moved into supported living just as part of their --

DR. MAXWELL: Okay.

A. Ongoing life development and maybe moving out of home and things like that. Yes, there were certainly people who were in those homes who had been resettled and there was a mixture of both and there was also respite facilities in I think three of them as well.

41 Q. MR. DORAN: Yes, but I think you actually make the point at paragraph 9 you say:

"I then held managerial responsibility for this on top of my existing responsibilities for Trust Supported Housing, Residential Care and Community Support Services until July 2017."

Does that mean that in 2016 you suddenly were presented with these three extra areas of responsibility?

A. Yeah and certainly both myself and the other Service Manager indicated that we felt that the workload was a lot, that, you know, the additional workload was exceptional.

42 Q. Did that lead then to the further change of role that you mention in paragraph 11 in September 2017 where there was a new post of Divisional Nurse for Learning Disability?

A. When the Acting Head of Service took up post she, we discussed with finance and the Service Manager post was advertised again because both of us were saying it was too much.

43 Q. Right?

A. But I held the workload for I think ten or eleven

months, I think it was ten or eleven months.

44 Q. When exactly was that ten or eleven month period?

A. From I think it was around August, September '16 to July '17. And certainly during that time the workload, because I was spending probably two days a week in the community supporting those facilities. 10:26

45 Q. So this new post then caused you to move away from the Service Manager post; is that right?

A. Yes. It was where the Associate Director of Nursing role and the Service Manager role was separated out. It was part of establishing the Collective Leadership Team For Learning Disability and the Clinical Director had been appointed at that stage and the Acting Head of Service was in place and the two posts that had to be filled were Divisional Nursing and Divisional Social Worker. 10:26 10:27

46 Q. But I think you say you kept on the two -- in your statement you say kept on the two posts to March 2018 and then in April 2018 you worked full-time in the Divisional Nurse role; is that right? 10:27

A. Yes and that certainly was to facilitate the backfill. The posts had went out to recruitment, I think twice from what I recall, and I think too there was a couple of applicants and in the end an internal applicant was appointed who was able to take up the post in April '18 and at that point I was released. 10:27

47 Q. Yes. So how long did you stay in the hospital after April 18?

A. Until August.

48 Q. Until August. And was that your last post with responsibility for the hospital?

A. Yes.

49 Q. So you left, essentially you left the hospital in August 2018? 10:28

A. Yes.

50 Q. Now, just before we move on from your role or roles at the hospital, I just wanted to ask you about your working background prior to Muckamore. And, again, we've touched on this, you have explained to the 10:28 Inquiry that your experience was primarily in the mental health field?

A. Yes.

51 Q. In fact I just very briefly want to look at something that you said in your previous statement, it's at 10:28 paragraph 52 of your Ennis statement, if we can bring that on screen, it is MAHI STM-229-18. And what you said then was:

"One of the biggest hurdles that I faced when I joined 10:28 MAH in 2012, which continued during the Ennis Investigation, was that some staff questioned my ability to work in Learning Disability when I came from a mental health nursing background. I did, however, have extensive experience to undertake the role of 10:29 Service Manager due to my previous roles working in hospital and community teams management, leadership roles, lead nurse experience, care management experience and project management. I also recognised

that I had an excellent team of senior learning disability nurses who could fill in the gaps in my knowledge base of learning disability."

And then you refer also to the fact that someone had applied internally and failed to get the post and you refer to issues arising from that. 10:29

But, your experience then was in mental health as distinct from learning disability but you point to your previous management experience and also the experience of those around you? 10:29

A. Mhm-mhm.

52 Q. When you say that staff questioned your ability to work in the role, do you mean that they directly challenged you or was it more of an impression that you got from them? 10:30

A. I suppose a bit of both. There was some disquiet that the first time that an Associate Director of Learning Disability nursing post was appointed, that it had went to a mental health nurse and that they felt that, they felt that why were they not considered -- why was it not solely advertised as a learning disability role given that it was the first time this posted ever been advertised. So, but certainly -- 10:30 10:30

53 Q. So are you saying people took the view that that ought to have been part of the essential job description, if you like?

A. Yes, and I certainly would have had that raised with

me. What I certainly would have discussed with my colleagues at the Assistant Service Manager role, and I would have had meetings with those at that level in the community as well and I would have said well, this is the first time that this role has been recognised and achieved within the Trust so what do we need do in relation to yourselves, as learning disability nurses, to build up your experience so that, you know, in future you can apply for this type of role so that there is more opportunity for learning disability nurses to actually achieve that position. So we discussed, you know what sort of training opportunities those leaders within their areas could have that would build on their capacity to apply for that type of role in the future. 10:31 10:31 10:32

54 Q. Let's forget for the moment about what other people were saying, I'd just like you to reflect on this yourself, do you think that your previous lack of experience in learning disability may have made it more difficult for you to discharge your role effectively? 10:32

A. There's pros and cons to both aspects of it. Certainly I think the breadth of experience that I came with assisted me in the management of the hospital and assisted me with resettlement. But certainly, I did a lot of reading and I did a lot of self learning in relation to learning disability so that I, you know, I didn't go in and think I don't have anything to learn here. I certainly went in with the thing that I need to learn from other people but also, you know, read and 10:32

obtain further knowledge in respect of learning disability.

55 Q. Aside from --

A. I also would have done visits to learning disability hospitals as well to expose myself to see was I doing things in line with maybe other people. 10:33

56 Q. And aside from --

DR. MAXWELL: Can I ask which hospitals you visited? Were they all in Northern Ireland?

A. No, well part of the review of Iveagh we went to see a couple in England. Part of our work in relation to the modernisation of the hospital, we went to see hospitals in Scotland. We did have, I think it was six or eight clients still in accommodation and hospital care in southern Ireland. So I actually undertook to do their care reviews because of my previous experience in care management so that I could go down and see those that were resettled and how it had fared. But also one of the hospitals down there had a patient council a bit like the one in Muckamore so I went down to meet them and that was to inform myself around sort of how those places functioned and see if I could tap into some of their learning. 10:33 10:33 10:34

DR. MAXWELL: So would it be fair to say that you were exposed to a wider range of management of learning disability hospitals than some of the staff in Muckamore? 10:34

A. Well I certainly tried to expand my knowledge in those areas.

57 Q. MR. DORAN: You've mentioned trying to expand your knowledge. Was that all on your own initiative or was that offered to you?

A. No, it was certainly offered in relation to the review of Iveagh and the modernisation because the directors, I think Catherine McNicholl accompanied us on the Scottish trip as well as two of the consultants and the co-director. I'm trying to think who actually was there. 10:34

DR. MAXWELL: So if this was about the review of Iveagh, were you doing some of this whilst you were in still in your mental health role? 10:35

A. No, this was after I took up post in Muckamore. Certainly with the Iveagh one we went with the Community Service Manager, Service Manager, co-director and consultant. And the modernisation of Muckamore, we went with I think Catherine McNicholl and two of the consultants Mr. Veitch, myself and then -- it's terrible, I can't remember the name of that hospital down south. 10:35

58 Q. MR. DORAN: Let's not worry too much about that now. I was going to ask you a more general question, again reflecting on your experience, and I know this may be difficult for you to answer, but obviously you're someone with considerable management experience within the hospital. You've performed that role within the learning disability field. We've talked about job specifications, let's say you were putting a job specification for the role now, would you include 10:36

experience in learning disability as part of the essential criteria for the role?

A. I'm not sure. I think what I found beneficial was that I also was a set of fresh eyes coming into that area. Learning disability is such a small field but I do think maybe one of the criteria should be that there is a robust induction in relation to exposure to other sites and environments that would support learning in relation to the management of it.

59 Q. So even if the individual appointed doesn't have a learning disability background, they ought to be exposed to experience in that field at an early stage? 10:37

A. Yes, yes, I believe that would have been helpful to me earlier in the post.

60 Q. Now I am going to go on and look at admission and discharge and services available to patients and you provide quite detailed information about that in paragraphs 14 to 42 of your statement. We're going back to statement No. 295, please. You took about the admission process in paragraphs 14 to 15. In paragraph 14 when speaking about -- sorry, paragraph 15 you say: 10:37 10:37

"Alternatively if patients were assessed under the Mental Health Order an approved social worker would phone requesting an admission bed. If the patient was detained a bed had to be allocated as soon as possible. If the patient required admission but was agreeable to admission and had capacity to consent, they would be admitted voluntarily, however, a bed usually was 10:38

difficult to allocate as there was only usually pass beds available due to the ongoing requests for admission until a planned discharge took place. The acute admission wards were aware and could keep the nursing informed of planned discharge dates of the patients in their care. I think we averaged about 1.5 admissions per week."

Now you refer there and later indeed at paragraph 18 to a pass bed in the admission ward. Can you just explain what exactly a pass bed was and tell the Panel a little bit more about how that worked? 10:38

A. If a patient was at home, on leave, or on trial resettlement or on in another hospital, that bed was considered a pass bed. It would have been reported as a vacant bed to the Health Board which were reported on every month, as in how many beds are occupied and how many patients were not in the hospital, so you had to report on how many were actually in the hospital each month. So if a pass bed was used it could have been someone who could have been in Musgrave Park Hospital having a hip operation, and we know that they are going to be there for a month, or it could have been someone who was out on weekend pass to their parents. 10:39

61 Q. But how long typically would a patient have to be accommodated in this kind of temporary arrangement? 10:40

A. When you use a pass bed you have to look at, well, what's the viability of that pass bed in relation to when is the next planned discharge likely to happen, so

you would have been discussing with the ward. Dr. Hughes would have been the consultant for the admissions wards so he would have had a plan as in was there any patient likely to be discharged over the incoming week or fortnight. So you would have, there would have been a number of patients who came and went with very short spells in hospital which would have been sort of a week, 10 days, sometimes even less. So Dr. Hughes would have known if a bed was coming up for a planned discharge but there was an empty bed over the weekend and possibly a discharge planned for Tuesday. So sometimes if you were thinking, well, the person is due back on a Monday, you may have contacted the parents and said can you bring them back on Tuesday as opposed to Sunday and had an extended leave period and that would have freed up that bed right through to Tuesday when the discharge was going to happen so you could have brought an admission in. 10:40 10:40 10:41 10:41

62 Q. Is it fair to say that that is a slightly ad hoc arrangement that you're describing?

A. It might be ad hoc but it was common in both mental health and learning disability. It was an expectation from the Board that we used pass beds to manage our patient flow. And whilst I think, I mean good practice would have indicated that acute admissions wards should have operated at around 85% occupancy, that is never the case, most of them are over 100% in relation to admissions and discharges. 10:41

63 Q. But presumably, particularly for patients with a

learning disability, that wasn't entirely satisfactory?
A. It's not satisfactory for any patient. It wouldn't matter whether you have a mental health -- you will be equally distressed if your care is being disrupted. But you have to, I suppose, try to minimise the impact by moving the least number of people or impacting the least number of people and it really depended on how acutely unwell the person at home was. And it may well have been on occasion we said to the person at home, look, we're going to have a discharge on Tuesday, is there any way we can support you to Tuesday until we get the person out so that person could come in. 10:42 10:42
DR. MAXWELL: I think it's fair to say it isn't unique to LD or mental health, it happens in acute services as well, it affects all health services. 10:42
A. It's not ideal in any circumstance for this, but you try to minimise the impact. And if -- and I did indicate I think in my statement as well that, on occasions, a patient may have been moved to a resettlement bed. That patient would have been someone who was on the delayed discharge or resettlement list who would have been moved, it wouldn't have been one who was on active treatment. 10:43
PROFESSOR MURPHY: Can I just ask, sorry, you mentioned that some admissions were very short, like for 10 days and I'm just wondering to myself what could you achieve in 10 days. Were they basically coming in to give families a short amount of respite? 10:43
A. I think sometimes a situational crisis would have

happened. And because learning disability community resources were not enhanced or developed enough to manage some of those situational crises, that an admission could have occurred. Now, I think when we reviewed a lot of the admissions that we recognised that should, and that's where I think where I've read other people's feedback has been that, you know, 70% of admissions could have been avoided. They could have been avoided if the community resources had been sufficiently developed to even possibly the level of Mental Health. And even, I mean Mental Health isn't where it should be, but, a home treatment or crisis response service in the community that operated out-of-hours could have possibly picked up on some of those cases and supported them for a couple of days, that would have avoided an admission. But because those services were not available or commissioned, that, you know there was limited alternatives and some of those limited alternatives were Muckamore.

10:44

10:44

10:44

PROFESSOR MURPHY: And even, it sounds like there weren't enough respite care beds because, although you mentioned that there were three respite facilities, it sounded like you needed more?

10:45

A. Respite facilities, certainly that I was aware of in Belfast, were very limited. We're talking about I think six beds in total for the Trust and those were pre-booked really throughout the year and very few of them were for situational crisis because they were linked to existing supported housing and the existing

10:45

supported housing staffing model would not have supported some people in situational crisis.

PROFESSOR MURPHY: Yes.

A. And it may not have been an appropriate use of that respite bed. If it was someone who had used the respite service on a regular basis and it could have been freed up for them to come there as opposed to going to hospital, the community team would have almost certainly attempted to do that. But -- 10:45

PROFESSOR MURPHY: But the respite services were for regular users, preplanned -- 10:46

A. On the majority of cases, yes.

PROFESSOR MURPHY: There weren't respite beds really for people with challenging behaviour for example.

A. They certainly weren't a crisis house or a crisis bed and certainly that type of provision hadn't been developed in Learning Disability Services. 10:46

PROFESSOR MURPHY: Thank you.

64 Q. MR. DORAN: Now, at paragraph 18 you say that even though roughly equal numbers of male and female admissions occurred there were disproportionately more male beds than female beds when you started working in the hospital, do you know how that came about? 10:46

A. I think when the hospital was, the new hospital wings were built, there was more male beds than female beds. But when, so when admissions happened it tended to be females who were displaced because the same similar numbers were coming in. 10:46

65 Q. Yes?

A. So, it tended to be an admission to Ennis or -- Ennis or Greenan that they were transferred to sleep out and then transferred back.

66 Q. Did that remain the case throughout your time at the hospital? 10:47

A. As part of our modernisation paper we discussed evening up the beds and that was to transfer the acute admission from Cranfield 2 over to Killead and that would have balanced the numbers out to exactly the same, male and female. We did that in 2016 and the 10:47 staff, the patients and, you know, all transferred over and we swapped over the two wards and that led to less sleeping out.

DR. MAXWELL: Can I ask, does Northern Ireland have a policy, like the rest of the UK, that there shouldn't 10:48 be mixed sex wards?

A. We do have, we do have it that it should be minimised as much as possible but that, I'm trying to remember how the policy is worded. I think it is worded the preference is single sex but where they are mixed it 10:48 should be individual rooms.

DR. MAXWELL: That's different from the rest of the UK then?

A. Yeah, but when I first went to Muckamore, Cranfield 1 and 2 was an open ward, one side was male, one side was 10:48 female, they could walk between the two, it was like open plan. I think within the first few months I was there Mr. Ingram had done a business case through the Trust to actually separate them because of the number

of safeguarding incidents between the two patient groups and that's where the corridor was put in, in Cranfield, so that you could walk between the two wards and they were separated into a male and female provision.

DR. MAXWELL: So before that did you have males and females sleeping in a common area at times?

A. No. Well in Iveagh, yes, we did, in the children's ward is the one mixed area. The other areas we didn't have any mixed. So Erne and Ennis was like one big building but female one side, male the other. When Rathmullan was closed they all moved to Greenan but we done a full wing of males and females in the other half but they weren't a mixed group.

67 Q. MR. DORAN: Now you move on in paragraph 20 to deal with community resources and you make the point that community resources for persons with learning disability were limited?

A. Mhm-mhm.

68 Q. I'm not going to read the full paragraph 21 but you list nine shortcomings, I think in -- you refer to:

"1. Lack of resources in the community generally.
2. No specific self-harm services.
3. No home treatment team options.
4. Limited behaviour management services.
5. Large case loads held by community professionals.
6. Very limited number of community LD nurses.
7. Limited number of vacancies in staffed supported

housing options.

8. Limited number of respite beds or services to support carers or reduce carer fatigue.

9. An under pressure approved social worker rota."

10:51

I wanted to ask you this: From your perspective working primarily within the hospital, how much knowledge and awareness did you have of the community resources that were available, was it part of your other role to go out and check them out so to speak? 10:51

A. As Associate Director of Nursing I also had responsibility for community learning disability nurses. So I would have met with the community nurses and certainly their case loads were high. They also -- there wasn't that many of them. I think you could have 10:51 counted them on both hands for the Trust from what I recall. Because there was three service managers, we met every month, so we had an understanding of each other's area. And, I mean, I would have met with team members in, you know, with the other Service Manager, I 10:52 would have visited some of the facilities with the community Service Manager in the supported housing, so I was aware of what we had. And certainly the amounts of money that the Board gave us, to the Trust on a yearly basis was to build that infrastructure but it 10:52 was small gains each other as in you were building it up as opposed to --

69 Q. Yes, you've mentioned the Board, you mean the Health and Social Care Board?

A. Health and Social Care Board.

70 Q. Can you recall this issue of limited resources being raised with the Board?

A. I certainly was at meetings where the resources were discussed. Myself and our directorate accountant and Mr. Veitch would have went to the Board on a regular basis and indicated that we needed additional resources. Every year when the -- I forget what you call, it but there was an investment plan on a yearly basis for your service improvements or new services and it would come in, you know, it might have been, you know 250,000 or around that amount. So if you're missing one team, 250,000 won't even build one team, but if you're missing five or six core services it takes a long time to develop those. I remember in mental health it took us 10 to 12 years to build up those types of services, they are not done overnight and you incrementally build on them. 10:53 10:53 10:53

71 Q. Was it part of your role to make those kinds of representations to the Board? 10:54

A. Certainly Mr. Veitch and ourselves would have raised them with the Board as did -- I mean we had the monthly resettlement meeting where the service managers from the other Trusts were there as well and everyone was saying the same thing to the Board; yes, we're thankful for that investment but we need more because the more people coming out of hospital, but also the prevalence of learning disability in the community and more patients being identified meant that services were 10:54

continually being stretched, even with this investment.

72 Q. But you do refer in paragraph 21 to services continuing to improve. From your perspective working in the hospital itself, what were the key improvements and how were those improvements achieved? 10:55

A. Certainly there was a service developed, I'm talking about in Belfast, outside of the core learning disability community team, around response to people who maybe placement was failing or becoming unwell, that they would put in additional resources to support 10:55 the staff team, supporting them or support the family. But, from my recall that very much was at the start a Monday to Friday service. It went then to a seven day service but it was still nine to five so those were improvements. There was also I think, I'm trying to 10:55 remember, there was additional behavioural nurses within the community and psychology input in the community was strengthened. So there was certain aspects that were being developed.

73 Q. Yes. Well you refer to those and some other 10:56 initiatives in paragraphs 22 to 26. You also mention there the Iveagh approach and consideration being given as to how that approach could be adopted at the hospital. Can you just tell the Panel briefly more about what the Iveagh approach was and how it differed 10:56 from the MAH approach at the time?

A. When Iveagh was reviewed in I think it was '13 I think it was, it was recognised that there was high levels of physical intervention and high levels of seclusion with

the children and it tended to be the older children within the setting. We went to other hospitals in England and we listened to some of the approaches they were using and we felt that some of those could be adopted back into Iveagh. That included positive behavioural support, increased psychology input, using more of a proactive engagement with the patients so that a lot of the trigger points, there was like weekly discussion around the trigger points as to why someone becomes more distressed and some of that was around transitions and moving from school to hospital and back to school again. So there was recommendations made within the paper around implementing. 10:57 10:58

74 Q. Which paper is that, that is the Iveagh specific paper?

A. Iveagh, there was a paper specifically for Iveagh. The Board, somebody Stevens at the Board and the Trust jointly commissioned the work and then they worked -- we brought back the paper and there was discussion around how it could be implemented. We shared, I think Mr. Veitch also shared the paper with RQIA and certainly, as I think indicated in my statement, RQIA using that intelligence inspected us against a lot of those areas that we felt were lacking. 10:58 10:58

75 Q. But essentially was the initiative about reducing --

A. Restraint. 10:59

76 Q. Seclusion and restraint?

A. Restraint, yes.

77 Q. And you were suggesting perhaps that a similar initiative then could be applied to Muckamore?

A. Well certainly we hadn't implemented any of our learning at that point. We did that over the incoming into 18 months in relation to training of staff, recruiting of professionals required to implement the positive behavioural support. And then it was systematic training and we had and Assistant Service Manager who took up post who held a behavioural qualification. We also had a behavioural nurse appointed to the unit. They both trained staff on the ground and walked alongside them to learn the methodology. 10:59 11:00

78 Q. Yes but does that mean that essentially that it was recognised as a problem at the hospital?

A. We recognised certainly that Iveagh was -- it was very restrictive input for the kids and it wasn't a good experience and we wanted to have a more positive experience whilst in hospital and that the treatment was more therapeutic. To achieve that we had to manage the presenting behaviours in a different way. 11:00

79 Q. But I'm talking about Muckamore? 11:00

A. When we seen the outcomes of Iveagh, which was a period of time after we implemented it and we had feedback on the reduction in restraint and the reduction in seclusion, certainly Dr. Milliken and myself would have said, you know, this could be a model we could use here in Muckamore to see could things be improved. 11:01

80 Q. But what I'm asking you is, does that mean that the issues of seclusion and restraint were recognised then as problems within Muckamore?

A. We recognised that there was too much.

81 Q. Yes?

A. We recognised that, you know, it was how things were being managed and that seclusion was only happening in one ward, but it was high incidence in that one ward because there is only two seclusion rooms and that was in Iveagh and in PICU, seclusion wasn't in any other ward. So, the high incidence of physical intervention tended to happen in the acute admission wards, in PICU I think. But actually in the resettlement wards there was lower levels, it didn't happen as often. 11:01 11:02

DR. MAXWELL: Can I ask you, so there was a review in Iveagh ward in 2013 after which there was a plan and there was a reduction in --

A. Reduction about '14, '15 I think we note. 11:02

DR. MAXWELL: So the point at which you realised there was another way was '15, '16?

A. Yes and certainly that's when we commissioned our specialist practice for learning disability nurses to train up staff. We were identifying that we needed more behavioural nurses and psychology because those were the core components that made the input in Iveagh work. 11:02

DR. MAXWELL: So would it be fair to say, before that, people recognised seclusion and physical intervention was not a good experience and was not therapeutic, but didn't know what else they could do, and then after the pilot on Iveagh ward there was a recognition that there were alternatives and then you set about training the 11:03

Muckamore nurses in these alternative approaches?
A. I think the staff would have advocated de-escalation and I would have had lots of discussions with the MAPA coordinators who talked about restraint reduction, talked about de-escalation, talked about how they trained the staff in that and that was also a core component and they talked about positive behavioural support within that training. But it didn't seem to translate to more of an outcome because when we talked about Positive Behaviour Support the staff would have said to me 'but we're doing that', you know. 11:03 11:04
DR. MAXWELL: So what was it that was done at Iveagh that actually led to the reduction? If people were being trained in the principles of de-escalation and Positive Behaviour Support but were still using seclusion and physical intervention -- - 11:04
A. I mean Iveagh still used MAPA, Iveagh still used seclusion.
DR. MAXWELL: I understand but you're saying that you did this project and it reduced, so it might never be completely eliminated, but it reduced. What was it that happened on Iveagh, given that there was this understanding that it was not therapeutic, it was not good practice, that you should only use it last resort when you had done other things, what was it that actually, despite all that, made the difference? 11:04 11:05
A. I think, looking at it I think it was the ward leadership and the co-working, there was co-working between the psychologist, the behavioural nurse and the

ward leadership together. They demonstrated to all the staff that every, I think every time the incidents occurred in Iveagh there was a discussion about what could have happened differently and there was a lot of ownership of the incident where staff sat down and discussed what went well and what didn't. And I also think the psychologist was very good at offering reflective practice to the staff in Iveagh and it was a dedicated resource to that team and we had very little of that in Muckamore. 11:05 11:06

DR. MAXWELL: And that was the point I was going to make because we've heard a lot about how little psychologists --

A. Yes.

DR. MAXWELL: They were doing assessments but they weren't there working there alongside patients and stuff. 11:06

A. In Iveagh they were integrated into the team.

DR. MAXWELL: Would you say having a dedicated psychologist working on this was a key to reducing -- 11:06

A. A key thing, yes, alongside the behavioural staff and the team and the psychiatrist because the psychiatrist, you know, they worked. And I think it was because the ward itself had these dedicated resources that were ring fenced for that service and it made, it definitely made a difference to the quality of life for those patients. 11:06

DR. MAXWELL: So, having learnt that, and knowing that you didn't have those dedicated resources for PICU at

Muckamore, was that learning ever shared up with the Board to say if we just invest what is actually relatively small amounts of money we could make this transformation at Muckamore as well?

A. We did get investment in psychology into Muckamore around 2015, '16.

DR. MAXWELL: But I don't think it was ever dedicated ward based, was it?

A. I think it was, my understanding was that a proportion of that was dedicated solely to PICU. 11:07

DR. MAXWELL: Okay.

CHAIRPERSON: You also mention, though, that it was ward leadership?

A. Yes.

CHAIRPERSON: So does that mean that on Iveagh the ward managers were embracing a new way which wasn't embraced when you tried to transfer it to Muckamore? 11:07

A. Iveagh also had its own Assistant Service Manager as well as a Ward Sister. So we had a dedicated resource both at senior level and Ward Sister to Iveagh. So, the Ward Sister was very well supported through senior management and the senior manager then could also challenge, you know, constructively discuss those issues that where the Ward Sister was having issues with both the psychologist and the psychiatrist and all to keep the team gelled. Because there was times when they were under pressure, whether it was to do with staffing or other resources, that that person was also there to unlock that. 11:08 11:08

PROFESSOR MURPHY: Was it also to do partly with numbers? So how many children were in Iveagh and how many at the time were in MAH?

A. In Iveagh there was eight kids.

PROFESSOR MURPHY: Eight? 11:09

A. Yes and --

PROFESSOR MURPHY: So they had a whole psychologist for example?

A. And can I say in Iveagh you had the same challenges in relation to resettlement and delayed discharges because 11:09 on average I would say four of those kids were delayed discharges and on occasion we would have had to put a ninth bed up in Iveagh.

PROFESSOR MURPHY: In 2015, '16 how many were still in Muckamore? 11:09

A. Probably over, about 150 maybe.

PROFESSOR MURPHY: Exactly, thank you.

DR. MAXWELL: So there was quite a lot more resource per patient going in in Iveagh than in Muckamore.

A. That was one of the things that we noted when we 11:09 visited the hospitals in England was that they were stand alone units but they had the appropriate resources to support the children and they did have the dedicated behavioural staff psychology. And we also had an OT and speech and language input into Iveagh as 11:10 well as half of a social worker which compared to Muckamore, you know, I think it was two and a half social workers for the whole of the site in Muckamore, whereas there was half a social worker just for the

eight kids.

DR. MAXWELL: And do you think the Trust, the Board, by which I mean Belfast Trust Board, understood the stark difference?

A. I do think our Director did because she was heavily involved in the review of Iveagh. She was heavily involved in the improvement plan. 11:10

DR. MAXWELL: Who was that at that time?

A. That would have been Catherine.

82 Q. MR. DORAN: Catherine McNicholl is that? 11:11

A. Yes but Catherine had weekly meetings with us in relation to the Improvement Notices that we got in relation to Iveagh and would have -- certainly we would have held to account to make sure those Improvement Notices were met. 11:11

DR. MAXWELL: And Catherine visited other countries with you?

A. Catherine certainly, I mean I remember Catherine in Scotland with us. I don't think she was on the Iveagh one. It would have been Mr. McNaney and Mr. Veitch. I'm trying to think, I'm trying to think who else was there but -- 11:11

DR. MAXWELL: No, that's fine.

83 Q. MR. DORAN: And so I take it those issues were the subject of the work that you did then with Dr. Milliken and later Dr. O'Kane, is that right? 11:11

A. We certainly would have started to develop a paper around the modernisation of Muckamore. There was a Modernisation Group that was joint, I think it was

joint with Mental Health at the time. There was a paper, Maurice O'Kane was our Business Partner who helped develop business cases and --

84 Q. I'm sorry, I think I referred to Dr. O'Kane. It was Maurice O'Kane I was thinking of. 11:12

A. No it was Maurice O'Kane, he would have helped us develop a paper but the paper was very much about the background to Muckamore and the philosophy of going forward as an assessment and treatment unit and around the configuration of the core wards in the future. 11:12 That paper was later refined by Fiona Davidson who would have been like a project manager within the Trust. She certainly looked at benchmarking against other hospitals in England and that's around the time we also got involved with the Quality Network. 11:13

DR. MAXWELL: This is the Royal College of Psychiatrist Quality Network?

A. Quality Network For Learning Disability and Quality Network For in-Patient CAMHS, Iveagh. We went through their assessment processes and we got accredited on 11:13 five out of the six wards within Muckamore. Iveagh being the first one and then Cranfield 1, Cranfield 2, Killead and Donegore and I think Six Mile. PICU was not because they didn't complete their process.

85 Q. MR. DORAN: But was one of the objectives of the 11:14 exercise then to secure greater AHP resources?

A. AHPs were, I suppose, not very visible in Muckamore. When I first started there there was I think one and a half speech and language therapists and one and a half

physios. There was no OTs. And through representation to the Board, we were given two full-time temporary Band 7 OTs, one for postural management and the other one for something else which I can't remember.

86 Q. And when was that? 11:14

A. That would have been end of 2012, I think, even mid 2012 they came on board and they helped greatly with resettlement in relation to looking at some of the physical health needs and functionality of some of the patients that were being resettled, around appropriate 11:15 seating, around, you know, wheelchairs and other mobility aids. But also they did some assessments in relation to some individuals going into a supported house around safety in the kitchen and road safety and use of equipment. 11:15

87 Q. But would it be fair to say that at that time as regards AHP resources generally?

A. It was very, very limited.

88 Q. It was limited?

A. Very limited. 11:15

89 Q. And particularly in the context of a facility such as Muckamore?

A. Yes, and dietetics, we had 0.4 whole time equivalent for the whole site and I think that was still the same when I left. 11:15

PROFESSOR MURPHY: How many psychologists when you went there?

A. One and that was a person was based in Six Mile for the Forensic Unit and she was a forensic psychologist.

DR. MAXWELL: So did you not have psychology input into the other wards?

A. There was some students and people working with the psychologists there and I don't think we got our psychologist until 2015. I don't remember another psychologist there before then. 11:16

DR. MAXWELL: You didn't have a dedicated fully qualified clinical psychologist until 2015 except for the forensic psychologist in Six Mile?

A. I don't recall another one. 11:16

90 Q. MR. DORAN: But is it fair to say the position improved somewhat from 2015/2016 onwards as a result of the initiatives you have described in your statement?

A. Certainly input from psychology helped us further develop care plans and with some of our more challenging behaviours that were presented with some individuals, it was a better understanding that could, you know, was developed of that. And the behavioural nurses then were then managed under psychology which I suppose provided a lot more reflective practice for them as practitioners. Before that they also had limited support. There was only three, I think, on the site that we had of behavioural nurses. So, all of the resources in Muckamore were limited -- there was -- and that included psychiatrists. All of them had workloads that were beyond what would have been expected in other settings. 11:16 11:17 11:17

91 Q. Yes.

A. You know.

92 Q. I want to ask you about a very specific point that you make at paragraph 27. You say:

"There were challenges between Trusts when discharging patients from hospital to a service in another Trust location which could meet the patient's assessed need." 11:18

And then you give an example of:

"The director of SHSCT would decline to allow the patient not originally from the SHSCT locality to avail of primary care services such as speech and language therapy. Some patients were disadvantaged by this approach and it would be raised at meetings and with the Trusts." 11:18

Does that mean that if a patient from one Trust area was resettled to an area within the responsibility of another Trust, there would be an argument over who should fund the patient's services? 11:18

A. Because the resources were very limited going to Trusts and new monies were limited, we had private providers and the voluntary providers who would develop services, sometimes at risk in localities that we later used. So an example would have been -- are you allowed to mention a particular organisation? 11:19

93 Q. Yes, indeed?

A. But the Priory Group developed very small nursing homes that were individual bungalows that would cater for

only six patients that were, you know, en suite bedrooms, spacious and they would have recruited learning disability nurses to staff those. They were nice environments and in small units that looked more homely. But they, on a couple of occasions, built those facilities at risk knowing that there was a resettlement programme within Northern Ireland and they developed those schemes and then approached the Trust and said we've registered for learning disability, you know, is there any patients that would be suitable for this type of environment. We did have some individuals, patients within the hospital, who had long-term nursing care needs who required ongoing input from nursing staff as opposed to it being supported housing. So certainly, the ward staff would have went to visit those areas and said, you know, I think this would meet such and such's needs and would have raised that at a resettlement meeting. When we would have identified that at maybe our monthly resettlement meeting, if a manager from, or director from another Trust said if they are coming down here you will have to pay for some of our core services because you are using, that patient is using our services. 11:19 11:20 11:20 11:20

94 Q. Yes, you say some patients were actually disadvantaged by that? 11:21

A. We did have some patients move into the Southern Trust area who, the consultant who was covering them had to do a number of communications both with the GP and with the Trust and with Mr. Veitch and our director and

Clinical Director to highlight the fact that they were being refused access to speech and language at that time and that had to be addressed.

95 Q. How often did that occur?

A. I think that was the most memorable one, but there was discussions at meetings where providers were discouraged from building schemes or developing schemes because it would have meant an influx of patients into that area. But sometimes the Trust would have said well, we don't want any of your patients using this, we are going to reserve all these beds for ourselves, even if it had have been maybe an appropriate placement. 11:21 11:22

DR. MAXWELL: So are you saying that somebody's resettlement to an entirely suitable environment, such as the one you described that Priory built, was compromised by the fact that it was geographically not within the area of the Trust that was responsible for funding the care? 11:22

A. It was verging on compromise, as in we were pushing for it to be resolved as quickly as possible because these things would have got flagged to us in the hospital really quickly because it would have come back to the nursing home and because we were following up on the patients after discharge for a period of time, the consultant and ourselves would have flagged that really quickly. 11:22 11:22

DR. MAXWELL: But I'm struggling with this, because if I live in one county here and I am registered with a GP and I move to another county, I am not denied access

because at one point in my life I lived in a different county.

A. That was the argument we used back.

DR. MAXWELL: So are you saying that if a patient was admitted to Muckamore from one county in Northern Ireland, for the rest of their life... 11:23

CHAIRPERSON: Or Trust.

DR. MAXWELL: For the rest of their life they would be considered from that county?

A. Yes, that's how the PTL list was -- 11:23

CHAIRPERSON: Sorry, is it the county you're talking about or the Trust?

A. If a patient originally was from Belfast and moved into Muckamore, they were always a Belfast patient. So if we moved them to Armagh we continued to pay for them from Belfast. 11:23

DR. MAXWELL: Even though you don't do that for any other class of citizen?

A. We do that, we do that in Older People's Services and all, if somebody moves to another area, that is into a funded placement, they remain the responsibility of the Trust. If they moved to an address which is not a funded but a personal home, residence, they move Trusts. 11:24

CHAIRPERSON: Right. 11:24

96 Q. MR. DORAN: And when this issue arose in respect of an individual patient was it always resolved and, if so, how it was it resolved?

A. I know it went to, went up to the co-director and the

co-director raised it with the director and the directors spoke to each other. And certainly I know that my understanding is it was resolved. But it was resolved through, you know, intense discussion because the other Trust really wanted some additional investment in relation to more people requiring the service.

CHAIRPERSON: And do you mean resolved on a case by case basis or resolved universally?

A. I don't know. 11:25

CHAIRPERSON: Let's move on.

A. Certainly that was the type of thing that would have come back from a placement that we had. Now, I'm not saying it happened all the time but there was issues in relation to input, you know, the care manager still had to follow up from your home Trust. If there was a break down in placement your own service had to go out to them. 11:25

CHAIRPERSON: Right.

A. But those were because they were funded placements in other areas. 11:25

DR. MAXWELL: But this extended to primary care as well, because normally you fund the provider providing the care. The primary care service should have been separate? 11:26

A. Mhm-mhm but I suppose that's why certainly the consultant who was involved in this case ensured that there was follow up in relation to this particular issue because it was a primary care service.

MR. DORAN: Chair, we have been going for some considerable time. It might be a good time for a break.

CHAIRPERSON: And we're on page 7, I am aware of it. But this is important evidence and we mustn't rush it so we'll take a break now. I suspect we are going to need this witness certainly this afternoon. 11:26

MR. DORAN: Yes, and I have explained that to the witness, Chair.

CHAIRPERSON: That is fine, thank you. We will take our usual 15 minute break, thank you. 11:26

MR. DORAN: Thank you Chair.

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS: 11:48

CHAIRPERSON: Thank you.

97 Q. MR. DORAN: Now I am going to speak about delayed discharge and you talk about the process of discharge at paragraphs 31 to 41 of your statement. One thing you say at paragraph 32 was that discharge could occur quickly for some patients if an existing package was already in place. So in other words in some cases it could be relatively seamless? 11:48

A. Yes.

98 Q. But then you go on to say in paragraph 37 the opposite could often be the case and you say: 11:49

"Some of those awaiting discharge could be waiting 10 years or more and included children who had been

delayed in their discharge in Iveagh ward, transferred to MAH to await finding a service in the community."

Now presumably you will agree that such a state of affairs is highly unsatisfactory from all perspectives? 11:49

A. It was very unsatisfactory in that we would have had distressed parents in Iveagh who did not want their child to transfer to Muckamore and would have resisted that. However, some of those children, there was no immediate package that was forthcoming and current 11:49 community services could not have managed their care. So there was quite a number of young, predominantly males, who were transferred from Iveagh to Muckamore and then continued to be delayed discharges within that setting. 11:50

99 Q. But stepping back from that specific transition from Iveagh to Muckamore, the general proposition that one could have waits of 10 years to be discharged is quite startling, isn't it?

A. It's very startling. There was patients who were 11:50 awaiting discharge and because more people came forward as delayed discharges, some of those were easier to resettle and sometimes they went out quicker than the one who was waiting the longest.

100 Q. So for the patients affected and their families, this 11:50 must have been highly unsettling?

A. It was highly and I think at one point there was a judicial review on a particular patient who was a delayed discharge and he took a judicial review around

the delay that he was being subjected to.

101 Q. Yes, I think the Inquiry is aware of that case. But I just wanted to ask from your perspective, what were the primary reasons for this situation developing?

A. Lack of community placements and lack of support services for that individual once they were placed. A number of the individuals required a robust staff team that would have been numerous. So it had to be part of an overall service for that placement to have worked, simply because you couldn't recruit possibly 15 staff for just one person to manage them if they were on a two or a three to one. So it had to be, the team to support the individual needed to be part of a bigger service or placement so that the staff could rotate and as that individual would have had complex needs and sometimes other behavioural issues that, you know, could have been aggressive or impulsive behaviours, that you needed to be able to rotate the staff to keep them safe. 11:51 11:51 11:52

102 Q. But was the key issue then one of resourcing? 11:52

A. It was resources, but it was finding a suitable placement because -- and some of those individuals found it difficult to live with others and what we found is that some of those individuals who lived with others within a ward setting, the incidents of adult safeguarding would have increased because of their assaults or attacks on other patients. And when we would have taken steps in relation to their adult safeguarding to reduce those attacks on another 11:53

patient, the attacks on staff would have increased. Because if that person hit another patient and we said look, we are going to put a support in alongside you so we can redirect you to another activity to avoid the incident, sometimes that staff member got hit as opposed to the patient.

103 Q. But that's all about the constraints within the hospital?

A. It was constraints but then if that person found it difficult to live with others, to move them out into a community placement, they had to be somewhere that was their environment and not sharing with others which meant it had to be possibly a flat alongside a service or a stand alone. 11:53

104 Q. Which of course itself would require -- 11:54

A. Additionals.

105 Q. Significant resources potentially?

A. Yes.

106 Q. Now in your previous statement you touched on something that I want to go back to, it's at paragraph 57 of the earlier statement, that's MAH STM-229-20. And if we scroll down to paragraph 57, please, you say: 11:54

"There were patients in MAH who were ready for resettlement but a decision was taken, long before I started in MAH, that resettlement would be done on a ward by ward basis. Therefore, patients who were ready for resettlement remained as patients, delayed in their discharge simply because they were not on a ward which 11:54

was designated next for resettlement. This made no sense to me. Surely it would have been better to resettle patients on their ability to be resettled, not on what ward they were on. This was changed so that resettlement became a requirement and process on all wards."

Can you remember at what point during your period was this changed?

A. That was back in 2012. 11:55

107 Q. 2012.

A. That was the PTL patients, as in the priority list. The delayed discharges, there was always movement on them regardless of what ward they were on if they could find a suitable placement and package for them. But on PTL patients, they were doing it ward by ward. So when I got there in Muckamore in 2012 the ward that was identified for closure and resettlement was Finglass but we moved, we were concentrating on Finglass and it was like when Finglass closed, we'll move on to another ward. 11:55

108 Q. Are you saying there were patients elsewhere who would have been ready for discharge but because they weren't residing in a particular ward they wouldn't be discharged? 11:56

A. That was my understanding because there was patients in other wards such as Greenan or Rathmullan or Erne that could have went out to a placement, but because they weren't on that designated work that they were doing at

that point, they waited until Finglass was finished and then the team would move into another ward and start working with those patients.

109 Q. But that approach was changed fairly early in your period of time in Muckamore? 11:56

A. It was.

110 Q. Did you bring about the change or did you raise the issue?

A. I think, I mean I know I raised the issue and certainly the discussion was well, who else could be moved and we 11:56 were saying well, you know, these other patients, there is placements out there so let's look at what placements can be achieved to move the patients who are ready for going. So it might have meant that three patients out of Greenan went and, you know, one out of 11:57 Erne and one out of Ennis, so they could leave. But that just decreased the numbers on those wards a little.

111 Q. Yes. Can we come back to your more recent statement, that's STM-295 and it's page 9. STM-295, page 9. If 11:57 we scroll to the bottom of the page I just wanted to highlight paragraph 39. You say:

"Some detained patients during assessment processes were deemed not to fall within LD criteria for 11:57 detention to in-patient LD services and subsequently discharged from detention to their community team for follow up and if a further admission was required they accessed a Mental Health in-patient bed. Some patients

transferred to mental health in-patient community services or brain injury services."

Does this relate to the earlier point you made in your statement about some patients not actually being suitable for the Muckamore environment? Or, sorry, the Muckamore environment not being suitable for them? 11:58

A. Some people actually didn't have a learning disability who were detained in Muckamore and with the assessments that were undertaken in Muckamore that was -- I mean I know of a couple in Six Mile who, the assessments were undertaken by the psychologist there, who determined they didn't have a learning disability. They might have had a learning difficulty or a lower IQ but not into the realms of meeting the criteria to be detained under learning disability under the order. 11:58

112 Q. Should they not have been in the hospital?

A. They shouldn't have been in the hospital because of that. So in some instances the Order would have been lapsed and the person would have agreed to remain on the ward and leave at a time that was suitable to make sure their placement was sorted. Some people who were, their status was changed to voluntary, they left and the community teams were notified of that. Because they were detained they had to go through the Mental Health Review Tribunal on a regular basis. So if an assessment indicated they were no longer detained, they couldn't be held within the hospital. And we had some who were transferred to a ward in Knockbracken. There 11:58 11:59

was a couple transferred to Knockbracken under Mental Health Services.

113 Q. And in what way did that impact on the work of the hospital?

A. I think it was - well those were always ongoing assessments but some patients came, well equally some patients went into Mental Health who they assessed were learning disability patients and would have transferred them to us. But we had some patients who transferred to Mental Health and if the person had ongoing needs and was supported by Learning Disability for a long time and they were discharged from hospital, the Community Learning Disability Team Usually followed them up until they were settled and were able to transfer them appropriately to another service because they still had ongoing needs. If they had been in hospital they would have needed ongoing supports once they left. 11:59 12:00 12:00

114 Q. Yes?

A. So within Trust there can be transfers between those service groups and that would have been facilitated. But we would have had a number of patients each year, I would say, who were admitted who didn't have a learning disability. 12:00

DR. MAXWELL: Can I just ask you about that, some of those were admitted under the Mental Health Order as detained patients? 12:00

A. Yes.

DR. MAXWELL: Surely when making a detention order

under the Mental Health Order there needs to be clarity about what their needs are?

A. If that person has been known to Learning Disability Community Services and hasn't had a review assessment once they became an adult --

DR. MAXWELL: But I'm just a bit perplexed about how somebody without a learning disability or intellectual disability gets admitted under, gets detained under the Mental Health Order to a learning disability hospital. That sounds like misuse of the Mental Health Order? 12:01

A. Well, there was an assumption they had a learning disability because they were known to Learning Disability Services and they, whether they were admitted because of a situational crisis or a significant event in their life, they became detained, possibly by an assessment by an approved social worker who would have looked at their history of being known to Learning Disability Services and if they met the criteria at that assessment point they would have been admitted. Some were reviewed after admission and were determined not to have a learning disability. 12:01 12:02

115 Q. MR. DORAN: So the initial assessment caused them to be detained at Muckamore but on review that was not the right decision?

DR. MAXWELL: So the decision maker for the admission, the approved social worker and the doctor, whether it's GP or psychiatrist, didn't have to make their own assessment about the patient's needs, they just said oh, they saw a learning disability service once? 12:02

A. I'm not sure on that, other than I know the people that we're talking about had been known to services prior to admission, as in Learning Disability Services, but on reassessment some of them were determined not to have a learning disability.

CHAIRPERSON: Right.

A. There would have been a couple each year.

116 Q. MR. DORAN: I am going to move on to look at paragraph 40. You say there:

"All patients who were deemed not in active treatment, options were actively being explored during my time as Service Manager with the exception if they were assessed at end of life care. A number of patients passed away in the hospital each year due to frailty and/or old age."

Now I know it's perhaps a troubling thought, but can you recall were there patients who actually passed away whilst awaiting discharge?

A. There was quite a number of patients died in Muckamore awaiting discharge and there was a section on the returns that highlighted, you know, deaths within the hospital and certainly they were for frailty, but it also could have been someone who was being treated for a cancer or other illness. But there was certainly a number who died within the hospital.

117 Q. Whilst awaiting?

A. Whilst awaiting discharge.

118 Q. Now in paragraphs 41 and 42 you describe the restructuring that was going on within the hospital as the resettlement programme progressed and I want to ask you a few things about that. As the wards were being restructured, presumably this was potentially very disruptive for the patients remaining in the hospital?

A. Yes, it was. The wards were closed usually when they got down to single figures of patients and usually around five or six, or eight, around that number, the ward was considered for closure. A number of other wards were closed for different reasons. Finglass ward was highlighted due to, was due for closure but highlighted due to staff shortages and it was brought forward following discussion within the Trust at senior level with the Deputy Medical, Chief Medical Officer and Clinical Director and director, you know, so Finglass was brought forward.

Other wards were closed for other reasons. Rathmullan ward was closed as we had a maintenance issues where the pipes for the heating burst in the summer time and maintenance had informed us all that the heating system could not be guaranteed over the winter and we brought that to the Core Management Group and the Core Management Group I think raised, I know Mr. Veitch raised that with the Board that we needed additional funds to do some work in Greenan to make sure that ward was capable of managing those patients.

119 Q. We looked in your statement at the individual wards and

the closures in the wards, but I want to ask you a more general question, that is how did you make sure that the new arrangements were suitable for the individual patient who was being moved?

A. Any time a ward was deemed for closure the Ward Sister would sit down with the consultant for the ward and they would talk through the needs of the patient and which other ward was the most suitable for the patient on-site. And they would discuss that with the receiving ward and the receiving ward, Ward Sister or charge nurse, would meet with them and discuss how they would support the patient on moving, which member of staff was the key worker for the patient and which staff from the team was going with the patient to the ward. 12:06 12:06 12:07

120 Q. Well I was going to ask about that, did that require then fresh staff training, because presumably staff were going to be allocated to patients with whom they had never worked before?

A. Staff moved over to the ward with the patient but staff on Muckamore really worked across the whole site. Lots of them moved about on a regular basis and would have been out on relief to other wards on a regular basis. And staff even in the admission wards were used to new people presenting every week in relation to assessing their needs. The sharing of information from one ward to another was around sharing the care plan, sharing what worked for that patient, talking about what activity they had in day care and the other staff who 12:07 12:07

would have went with them as well would have been talking to the staff on the wards, saying this is how this patient is managed. Equally the staff on that ward would have been inducting and integrating that staff member into the ward.

DR. MAXWELL: We have heard from some staff witnesses who moved from resettlement wards as they closed that they found it very difficult to move to the assessment wards because the patient's needs were very different, they were much more unsettled and much more distressed. And so they may well have known the patient that they were the key worker for, but they didn't know the patients on these assessment wards who had very different needs from the case mix they had looked after. What training was given to those staff who are now going to deal with a completely different set of patient needs? 12:08

A. No, I don't think was adequately addressed.

DR. MAXWELL: Okay, thank you.

CHAIRPERSON: And since we've paused for a moment, could I just ask what level was the ward closure decided at? Who would have decided which ward was going to close once you got down to single figures? 12:09

A. We would have had that discussion at the Core Management Group. It also would have been discussed at the resettlement monthly meeting. 12:09

CHAIRPERSON: Right.

A. Because the Board representative and their finance and all were there and they would have been how many

patients have you now left on this ward, what's the timeline for the closure. We would have said well, we anticipate patients leaving by November and this is now August, the patients will be left by November, we would anticipate then that if we're down to four or five we will be discussing with the Ward Sister where those patients will go to and with the other wards then they'll decide who is taking them in, excepting the ones that were closed quickly. But there would have been a lot of discussion with -- the consultant who was over that ward was also the consultant for all of the resettlement wards, bar Rathmullan, so she would have been saying to the other ward I think such and such should come over here because he's best suited. So, there would have been discussions at those levels and then that would have been communicated every three months to the staff on the site. And there was meetings with all the staff on-site that the staff side and trade unions attended and there would have been 500 and 600 staff come out to those meetings. 12:10 12:10 12:10 12:11

CHAIRPERSON: Well could I just ask about that, because we've heard some evidence that wards were sometimes closed with almost no notice to staff and you just said in your evidence sometimes this happened suddenly or quickly. Did it happen occasionally that a ward would be closed? 12:11

A. Suddenly?

CHAIRPERSON: Suddenly.

A. Moylena was closed very suddenly. We had a fire and

the unit itself went on fire.

CHAIRPERSON: Yes, not for that reason I don't think. We were just hearing that staff were getting very, very little notice and therefore patients, it was very difficult to prepare patients for the move. Can you comment on that? 12:11

A. The ward itself knew when it was closing and the staff knew and for the weeks and all before that the community integration officer who was leading on the ward closure with the Ward Sister would have been talking to the staff about which ward they were going to, did they want to be redeployed to the community setting with some of the patients. Some of the staff opted to do that and that was even though -- we had our own Staff Nurses but some of our staff opted to possibly go to a community placement with patients and move that post there. So they were also told which wards they were being considered for and those meetings would have been held with that Community Integration Officer coming up to the ward closure. 12:12 12:12

CHAIRPERSON: And whose responsibility would it have been to make sure that happened?

A. Well, the Community Integration Officer was tasked with meeting those staff and they met them with their staff side. 12:12

CHAIRPERSON: I'm talking about, the Community Integration Officer would presumably be focused more on resettlement, I am talking about a move from ward to ward.

A. They were doing some of those meetings with the staff.

CHAIRPERSON: They were?

A. They were doing some of those meetings with the staff. But also their line manager, as in the operations managers, would have actually sat down together and said I need X number of Staff Nurses for this ward and they would have agreed between them which staff were going to what wards. 12:13

DR. MAXWELL: Can you tell us what the Community Integration Officer post was, I don't think we've heard about it before, is this an HR person? 12:13

A. No. It's like a resettlement officer. Maybe it's been called that here. But we -- when I took up post in Muckamore the Board had a Community Integration Officer that was funded by the Board who inreached into Muckamore. 12:13

DR. MAXWELL: The Health and Social Care Board?

A. Yes. At some point in 2012, I think it was around March or so, they withdrew that post and gave the money to Muckamore to have one of our senior nurses take up that role and I think there was three of them at different who took, you know, who held the post at different times. 12:14

DR. MAXWELL: The decision to close a ward, either because it was planned or because there had been a fire or shortage of staff or whatever, has to be an operational decision, despite the fact it might have been discussed with lots of people. Who made that operational decision; was it you, was it the director? 12:14

A. I would have recommended it to the co-director and the director and they would have agreed or disagreed.

DR. MAXWELL: So which one of them had the authority to close a ward?

A. If I was recommending it they would have said to me -- 12:14

DR. MAXWELL: Which one of them had the ultimate responsibility? Because you're presumably saying you didn't have the authority to close a ward, you had to recommend it and somebody authorised it?

A. Because even, I'm even thinking back to when we had the 12:15 fire which was an urgent situation. Myself and Dr. Humphries went to see Mr. McNaney who was the co-director at that time and Mr. McNaney discussed it with Mr. Worthington and they agreed it should close.

MR. MAXWELL: It sounds like the director ultimately 12:15 had to approve it?

A. On that occasion I know Mr. McNaney spoke to Mr. Worthington. I know we always discussed what was happening next. I think it was just more streamlined in the other ones that were part of the community 12:15 integration where it was -- there is an expectation it was closing once it got down to certain numbers so it would have been me notifying them that we are ready to do this one now which is slightly different.

DR. MAXWELL: If I put it another way, there wouldn't 12:16 have been an occasion when a ward closed that the director wasn't aware of the date it was closing?

A. Well they should have been aware, yes, I think they would have been aware.

PROFESSOR MURPHY: Can you tell us at what stage in all of this families and patients themselves were consulted about moving wards?

A. As part of the resettlement meetings that were held on the wards, families were engaging with us in relation to the placement and some of them would have said to us what happens if my relative has not left by that stage and we would have been saying well, once the ward gets down to a certain number we will be moving them to another ward. I know one family did say to us, well, if I object to moving, what happens and we were saying we have to move the patients where it is going to be safe and we won't be able to keep staff, a ward with just one patient in it so we will, you know, unfortunately it will be a decision taken within the hospital to move your relative but we will make them, place them in the most suitable place we have on-site whilst we continue to work for their resettlement. 12:16 12:16 12:17

PROFESSOR MURPHY: So we've heard lots of the patients had autism and challenging behaviour and for them it might have been very disturbing to move to a different ward, but nevertheless you wouldn't have allowed them to stay on a ward with fewer patients? 12:17

A. It wouldn't have been feasible.

PROFESSOR MURPHY: Three or four, five numbers. 12:17

A. It wouldn't have been feasible to do.

PROFESSOR MURPHY: Financially or --

A. Managing a staff rota, managing the unit itself. It wasn't feasible to manage a very small group of

patients because, in a way, it would have diluted the staff across the site even more.

DR. MAXWELL: So when you got down to eight or less patients on a ward did the funding that you were receiving go down? 12:18

A. I'm not sure. I know finance would have -- finance, we always sent cost pressures to the Board. As opposed to saying our money went down, we were always asking for more as opposed to saying we had given up and having less because our specialing, we had to submit those 12:18 hours every week to have that funded.

DR. MAXWELL: To pick up Professor Murphy's point, did specialing go up because you'd moved them and they were distressed?

A. A lot of the specialing was to do with those on-site 12:19 that were young females transfer -- or young males transferred from Iveagh, the majority of the specialing was down to those individuals on-site.

DR. MAXWELL: Rather than people moving from resettlement wards to assessment wards? 12:19

A. Yes, yes.

121 Q. MR. DORAN: Just again following from on Professor Murphy's question about communication with families pending ward closure, certainly some of the evidence that the Inquiry has heard suggests that that kind of 12:19 communication was not always effective. Were you personally responsible for communicating such developments to individual families?

A. I know in relation to Rathmullan ward, it was me that

sent the letter out on behalf of the Core Management Group that we were closing it due to the issues. In relation to the other wards, the communication very much came from the ward itself as in the Ward Sister and the consultant directly to the families around the closure.

122 Q. And would that have been done by way of meeting or correspondence?

A. I would say it was direct contact with the families was my understanding was people were contacted and informed by phone when a ward closure was coming round, but the families would have been at meetings where we were, they were, the resettlement was being discussed and family were told if it had to happen the relative would have been moved. But the contact with families very much was more telephone calls and that type of thing. 12:20 12:20 12:21

123 Q. And just looking back now, do you think perhaps that those sorts of communications could have been handled more effectively?

A. Of course these things could have been improved upon and maybe there should have been more standard letters coming up to any closure that may be set out and say this closure is coming forward, you have been, this has been discussed at resettlement meetings but it is now time, it's happening and it could have been probably more formal communication. 12:21 12:21

124 Q. Because obviously due notice really is needed in situations like that, isn't it? Families need to be fully aware of what's going to occur as regards a

patient being moved from one ward to another. It's very important that families be informed at the earliest opportunity at what's happening and what the new environment is going to be like?

A. Mhm-mhm, yes, that would be right. 12:22

125 Q. You would accept that perhaps that could have been handled more effectively?

A. Yes.

126 Q. I am not going to go through all the individual closures that you mention, but I do want to ask you 12:22 briefly about Oldstone because one of the Inquiry witnesses, Dr. Hughes, described it as a very successful initiative. He said it was a kind of helpful bridge between the hospital and the community. He was asked by the Panel if it was so successful why 12:22 did it close and he recalled that at the time he was told it was down to resources. Can you recall the precise circumstances in which Oldstone closed?

A. Oldstone was on the list as a resettlement ward for closure and was always on the list for closure. The 12:22 ward itself was a group of houses that had been adapted. When I first went there, there was a number of patients in it who very much lived there longer term and all of them were delayed discharges and had been there for quite a number of years. So it was more like 12:23 a supported living environment. I had some concerns from a governance point of view in relation to the staffing of Oldstone as well, in that as a ward it was separate houses and that you had to go between those

houses in the middle of the night to monitor the patients and to -- because we had also a very ill patient who was there who was end of life care. So, I had some concerns about the building being used as more supported housing as opposed to designated as a ward because RQIA were assessing us against ward standards but it was very much being operationalised as a supportive housing type environment.

PROFESSOR MURPHY: One of the things that is very difficult for people with learning disabilities when they are leaving hospital is to suddenly have to do all the kinds of things that you would do in the community like shopping, cooking, making your own bed, cleaning, blah, blah, blah. Our understanding was that that's what Oldstone taught people before they left and surely if you're resettling a lot of patients you need it more, not less?

A. The unit itself, yes. A lot of -- there was individuals who made breakfast and things like that but the main meals themselves were actually delivered to Oldstone as well. So whilst they did cooking experiences and things like that in Oldstone, they equally did those on the wards. Killead had its own kitchen and were teaching social skills as did the day care within the hospital. They weren't doing all of those activities in Oldstone all of the time like you would do in a supportive housing scheme because the meals were actually brought over from the canteen. So it was a bit of a --

PROFESSOR MURPHY: Missed opportunity.

A. Hybrid type setting. But those sort of activities were also operational in that there was areas of wards where you could do cooking, so the site itself did have some other facilities. Don't get me wrong, Oldstone, yes, was a step down to some people. But equally it was part of the retraction of the hospital as well and that some of the services that needed to be developed in the community were possibly more of those type of services of step down where they went into a tenancy and learned those activities because housing support do those short-term facilities as well. 12:25 12:26

127 Q. MR. DORAN: Just from the tenor of what you're saying, does that mean you were actually in favour of Oldstone closing at the time? 12:26

A. It met certain people's needs for a while, but certainly we had some operational difficulties near the end of its life in that there was individuals who had been placed in Oldstone for whom meeting their care needs were difficult. You know, we're talking about a bungalow bathroom where someone needed assistance with showering and personal care that you couldn't actually put two staff into. So there was operational difficulties in relation to the layout of it. It was suitable for those who were physically able but there was people being placed in it who required additional support for their personal care needs and it didn't lend itself as well to that. 12:26 12:27

128 Q. But back to my question, were you in favour of it

closing then?

A. It had got down to a small number of patients and it was -- operationally I would have recommended its closure because we, I suppose it was the next step in -- 12:27

129 Q. When you say would you have recommended its closure, did you --

A. I did, I did.

DR. MAXWELL: Can I just ask you, you said it was on the list to close when you arrived. So that sounds as though there was a list of wards to close prior to your -- 12:27

A. Yes, all the wards except the core hospital.

DR. MAXWELL: And do you know who made that decision and when? 12:28

A. There was a project document, project initiation document or PID or whatever it is, for community integration, and all the wards were in it.

DR. MAXWELL: So the decision that Oldstone would close had already been made before you arrived? 12:28

A. Yes my understanding was it was a resettlement ward as well.

DR. MAXWELL: And did this document, the PID, say the order in which wards would close?

A. Originally, yes, but then because we moved to taking patients out of all the wards who were fit for discharge, the sequence changed. 12:28

DR. MAXWELL: And can you recall whether --

A. Oldstone probably was near the end.

DR. MAXWELL: Near the end?

A. Yes, but it was also closed near the end.

DR. MAXWELL: Yes.

CHAIRPERSON: And just before we go back to Mr. Doran, how many patients did it hold? 12:29

A. Originally?

CHAIRPERSON: Originally and at the end.

A. 24.

CHAIRPERSON: 24 and it was down to what when it closed? 12:29

A. Probably six or eight.

CHAIRPERSON: And those six or eight obviously had to be rehoused in the main hospital?

A. Back, yes.

CHAIRPERSON: Mr. Doran. 12:29

130 Q. MR. DORAN: Thank you, Chair. Now before we leave the topic of delayed discharge, I want to ask you about a meeting that was discussed in the evidence of Mr. Veitch a couple of weeks ago and he exhibited a set of Core Group minutes from the 13th October 2015. The 12:29 page reference is MAHI STM-275. And 38 is the page number please. If you can scroll down there is a paragraph beginning:

"Dr. Milliken raised concerns about delayed discharge 12:30 numbers increasing, he feels it is patient safety issue for the Trust. Mr. Veitch advised that this should be raised at the next modernisation meeting and also with Mr. O'Kane and Dr. Jack. Mrs Rafferty informed the

group that she raised the issue of delayed discharges at a recent Senior Midwifery Team and how there is no consistency in the Trust on how we deal with the delayed discharges."

12:30

I just wanted to ask you about that. I mean, I take it you were talking about the Senior Nursing and Midwifery Group meeting?

A. Yes, it was a monthly meeting Brenda Creaney held with all the Associate Directors of Nursing. I believe two 12:30
of the Associate Directors of Nursing raised that they had delayed discharges within their areas which were exceeding three months, three and six months, something of that nature, and that they were requesting support to have increased focus on them and bringing in 12:31
community resources to get them resettled as soon as possible. And there was a lot of talk around doing the placements at risk without identified funding and this is what I recall from it. It was around that they were prepared to place it, you know, a financial risk and go 12:31
ahead with them. Whereas, within Learning Disability we identified our monies and then placed against our funds and then people had to wait for the next round of funding. So I felt that was an inconsistency within the Trust in that other people without a learning 12:32
disability were being prioritised and placed, but that people with a learning disability had to wait. And there was, I have to say this, I actually told them that day that there was somebody waiting for 12 years

and there was a round of shock at the table at our own meeting.

131 Q. I think you've answered my next question, but just for clarification, you were talking about inconsistencies within different disciplines across the Trust, not inconsistencies within Muckamore itself? 12:32

A. No, not within, no.

DR. MAXWELL: What was Brenda Creaney's response to that?

A. I think, and I don't want to misquote her, but I think she was supportive that people with learning disabilities should have the same access to services and that she recognised the complexity of some of the individuals we were trying to manage. 12:32

DR. MAXWELL: And did she ever come back to you after that saying that she had raised it with the Board and they were going to see how they could have more equity between patient groups? 12:33

A. No, I don't recall that.

132 Q. MR. DORAN: You've mentioned Ms. Creaney and I want to ask about another of those particular meetings that took place on the 21st of July 2017, so it was very close to the date on which the CCTV revelations began to emerge and in fact it is exhibited to Brenda Creaney's statement. That's at MAHI STM-291-43. So that's a Senior Nursing and Midwifery Team meeting on Friday the 21st July 2017. Can we just scroll down to page 49, please. You were at this meeting and reported to it obviously. And if we scroll down a little bit 12:33 12:33

more, please. Yes, this is the text of your report to the meeting and I just wanted to ask you about this patient experience section. You say:

"The number of patients delayed in their discharge has shown a very small decrease in the last two to three months. Outreach to new providers to build up their resilience and confidence is essential to success. However, this also put additional pressures on an already stretched workforce and staffing on the wards. I hope that continued support to the new schemes opening in the next three to six months will positively impact on the number of patients on the wards. Hospital plan is to further reduce the number of beds and have less patients per ward but higher staffing ratios and skill mix to meet the acuity of the patients' needs. The lack of strategic planning now that the Bamford phase is completed between the Department of Communities and Department of Health in respect of further new schemes to meet year on year demand is impacting on our ability to provide suitable community placements for individuals to be discharged with complex needs. The patient experience is directly impacted upon as they can't leave hospital when medically fit, increasing number of safeguarding incidents between patients who no longer require in-patient care." 12:34 12:34 12:34 12:35 12:35

That was the position in July 2017. Do you want to

expand on any of those points for the Panel?

A. Supporting people project with the community integration project was time limited in relation to its funding base. There was a number of schemes that had been delivered upon but there was a number still outstanding. There wasn't loads of new schemes coming on board and you need new services coming on board year on year to increase your capacity in relation to managing complex individuals. I know one of the things that we did at Muckamore was we worked, the OTs who were recruited in 2012 actually worked with one of the providers, developed plans for a development across the road from the Muckamore site for very complex individuals who couldn't live with other people but as part of a bigger scheme, very similar to the concept of Oldstone but as stand alone bungalows. That scheme did get planning approval but was objected to by a number of key players within Learning Disability because they felt that being so close to Muckamore meant it was still likely to be an institution. 12:35 12:36 12:36 12:36

DR. MAXWELL: When you say key players in Learning Disability, who are you referring to?

A. Well one of -- there was lecturers at the University of Ulster objected to it and some other people felt that the scheme itself, because it was so close to Muckamore, would just be an extension of Muckamore. The OTs themselves had designed it for key individuals who were, key patients who required substantive staffing but in a bungalow, in a way that Oldstone was 12:37

designed but there were individual houses so that people could be supported even though they had complex needs.

DR. MAXWELL: Designed by OTs so it was better designed than Oldstone? 12:37

A. Yeah.

DR. MAXWELL: It sounds from what you were saying earlier that Oldstone wasn't designed to meet complex needs?

A. The OTs themselves actually designed it that it had walkways that were round the external of the scheme and internally to the scheme so that, even if you were out with staff supporting people to walk, that you could, there was ways you could walk to avoid meeting other people so to minimise incidents, but actually give the patients themselves opportunity to live in their own space and home. But unfortunately that scheme didn't come off. Other schemes of a similar nature did progress and I know the OTs supported one in West Belfast around some of the adaptations they could do to make it more appropriate and adapt it for the clients, for the patients. 12:37 12:38 12:38

133 Q. MR. DORAN: But the particular scheme close to Muckamore didn't progress?

A. It didn't progress and there was full planning permission for it. 12:38

134 Q. I am looking at the picture you were painting in July 2017, did that position improve throughout the remainder of your time at the hospital?

A. There was still private providers coming forward for more residential care options as opposed to supported housing and residential care options meet the needs of some people but not all. It also impacts on the financial circumstances of the patient, because when they go into it they are assessed under People First and they are left with pocket money as opposed to their income. So, their quality of life can be, I suppose, more impacted upon by moving into residential care as opposed to going into a supported housing scheme because in supported housing you have access to all of your resources and monies so that you can go out and do things. There is differences. But I think there was concern on my part at that point that there seemed to be a downturn in the number of new schemes coming forward. 12:39 12:39 12:39

135 Q. I'm going to move on slightly and back to the original statement please, that's at STM-295, and you were asked about co-production and MDT working with patients at the hospital. And obviously we have touched on this already to some extent, but you deal with the subject in some detail from paragraphs 65 to 78. You describe various initiatives in those paragraphs and I am not going to drill into all of the detail but I want to focus in on some specific points. At paragraph 81 you say: 12:40 12:40

"A social worker was aligned to all core wards but resettlement wards were assigned social worker input

upon request due to capacity issues."

What do you mean by due to capacity issues?

A. Well there was only two and a half social workers so it was a limited resource and our senior social worker at the time, who I would have directly supervised on a monthly basis, would have indicated to me that the workload coming from the core hospital wards was substantial and that he would respond to individual requests for social work input into the resettlement wards as required. 12:40 12:41

136 Q. Now to someone working from outside the system that might come as something of a surprise because one would perhaps expect that every resettlement ward would have a dedicated social worker? 12:41

A. All of the wards didn't have a dedicated social worker.

137 Q. Didn't have?

A. Most of them, most of the core wards had the equivalent of a day, you know, or day and a half, that would have been it. 12:41

138 Q. But presumably the social worker would have taken the lead on finding suitable placements for patients who were fit for discharge?

A. It was the care manager who was responsible for finding the suitable placement, not the social worker in the hospital. The care manager, there was care managers from each Trust employed within resettlement teams who would come into the hospital, they would get the commissioned assessments from the ward, whether it be 12:41

from social work or nursing or OTs or the day care, and they would fill in those forms and from that information develop a community care plan that would identify the service the client was most suited to and the care manager would have talked to the families. The consultant would have invited the families to the resettlement meetings. The care manager would have attended those meetings. The social worker wasn't the lead person who led on the discharge, it would have been the care manager. 12:42

139 Q. But is the point you're making at paragraph 81 that the availability of social worker input was limited?

A. It was very limited in the hospital.

140 Q. Presumably you'd agree that was unsatisfactory?

A. Unsatisfactory to have limited resources of all of the additional professionals. 12:43

141 Q. Again I want to hone in on a few specific points that the Panel might be interested in. You make a very specific point at paragraph 83 about dental services. Who provided the dental services? 12:43

A. There was a dentist out of the Belfast Trust came up and there was a dental technician came up as well.

142 Q. Did they only attend on request?

A. The dental technician was there a lot more often and would have done a lot more dental hygiene as I recall. But there was a dental suite within Muckamore as I recall. The dentist did come up on planned sessions. But if there was specific and I suppose invasive treatment that was required, a lot of our patients went 12:43

to The Royal.

DR. MAXWELL: Did the patients get a regular check up twice a year like you might, any other person might?

A. It was more the dental hygienist I think done that and I'm unsure. But I know the patients did attend the dentist on-site who would have referred them down to a service in Belfast should they need one. 12:44

DR. MAXWELL: Was that on demand or was everybody given a check up, weather they needed it or not?

A. I know a lot of our admissions got a check up. 12:44

DR. MAXWELL: You're not sure.

A. I'm not sure about people who resided there.

143 Q. MR. DORAN: What about GP services, how did that work?

A. If a patient is admitted to hospital the GP is no longer responsible for them so they didn't have access to GP services when you are an in-patient. We did have a GP who provided emergency cover out-of-hours and that was reviewed in 2013 or '14. And then we had an agreement with Beldoc and Dr. Coen where we had a rota for a GP from it to be there every evening for a couple of hours. 12:44 12:45

144 Q. Every evening?

A. Every evening for a couple of hours. But that wasn't core GP services, we didn't have that. That was for more a deteriorating patient. So we did do a paper, myself and Dr. Humphries, to the PHA in relation to core GP services for the hospital because I know Dr. Milliken would have raised this frequently at the Core Group and I do believe that he wrote to the Board, the 12:45

Health Board on occasion around this. We did the paper and we submitted it to PHA but that was after -- I was part of a group in relation to the annual medicals for people with learning disability from a community perspective and myself and Dr. Maginnis from the Southern Trust raised that people in hospital were disadvantaged because they had no access to a GP and we were encouraged to submit a paper.

145 Q. When was that, approximately?

A. About '15, '16, around that time. 12:46

146 Q. Did that result in change?

A. No. The paper went in. It resulted in a change after the abuse was uncovered in 2017, that they looked at GP services following that and I think -- but I wasn't there when it was introduced. 12:46

DR. MAXWELL: So does that mean until 2017 nobody was getting routine screening?

A. The consultants had some system were they could refer for cervical screening and breast screening, but it wasn't through -- it was like a dummy system on the thing but it was psychiatrists referring for it. 12:46

DR. MAXWELL: And were people getting their blood pressure checked regularly?

A. On wards people routinely got checked. We commissioned a nurse prescriber around 2015 and he, as part of one of his initiatives on-site, was doing health checks on patients and going in around annual checks and checking. 12:47

DR. MAXWELL: So they were getting annual health checks

from an advanced nurse practitioner?

A. Yes, but that was at a later point and it was being developed because we were using his skill set and he -- one of the things, as part of his training we had given him work experience within mental health, around mini mental health assessments and he had done a placement with them and was coming back and using those skills on-site and we wanted to utilise him within his knowledge base and training. So we were creating projects to develop that further on-site whilst awaiting funding for, I think we'd asked for one GP session per week in relation to the hospital, but we were trying to equate it across to what Mental Health had requested in relation to their resettlement wards. 12:47 12:48

CHAIRPERSON: And that was from 2015 onwards? 12:48

A. Onwards.

CHAIRPERSON: But not before?

A. Not before it, no.

147 Q. MR. DORAN: I wanted to ask you a question about the MDT arrangements in the round because you describe a lot of them in our statement. Let me just summarise briefly. You talk about the, and this is from paragraph 75 to 78, you talk about the input of community professionals after admission. You talk about the development of patient advocacy services. You talk about social work input, the allocation of a primary nurse, arrangements for the involvement of family, dedicated psychiatrists and the ongoing work of MDT. Now, stepping back from that, there were a 12:48 12:48

significant number of professionals involved in the process of assessing a patient's readiness for discharge. Can you recall any red flags being raised in those processes about the possibility that a patient or patients had been treated inappropriately by hospital staff?

A. As in where alleged abuse occurred?

148 Q. Yes. You see obviously the Inquiry is looking at the issue of abuse and the revelations emerged strikingly in 2017. But during all of these processes can you remember any red flags being raised about potential possible abuse of patients? 12:49

A. I was aware of a number of instances of abuse being, occurred within Muckamore during my time there.

149 Q. We'll come on to that later. 12:50

A. But certainly, it wasn't, it normally wasn't reported by a professional within a setting as in a social worker visiting or a doctor visiting or whatever. The reports tended to come from another staff member on the ward, a nurse on the ward, a domestic on the ward, a healthcare assistant or the Ward Sister. Those were the incidents where they came from or in the case of Ennis, the visiting healthcare worker. 12:50

150 Q. Yes and we discussed that in detail the last day?

A. We did also have one visiting support worker from a scheme within Antrim reported an incident of verbal abuse in, I'm trying to remember which ward it was. 12:50

151 Q. When was that, approximately? Well I needn't -- it's obviously difficult for you to remember the exact time

at this remove, but just, you can't recall any issues being raised by any of the many professionals involved in the process of discharge?

A. No.

152 Q. Now, we've spoken a bit about the mechanics of discharge and the recurring problem of delayed discharge. I just want to step back for a moment and look at the bigger picture of the transition within the hospital that you were presiding over. So fundamentally, the hospital was moving from a home model to a hospital model for many patients. Did you see it as part of your role to drive that forward? 12:51 12:51

A. There was certainly, when I first arrived in Muckamore there was two distinct areas within Muckamore, very much the core hospital and then the resettlement wards. The resettlement wards were very cluttered. Staff didn't wear uniforms in lots of areas. The approach was, it was just, it was around people living there and socialising on the site and off the site and they weren't, they weren't even as advanced as some resettlement wards that I would have witnessed in Mental Health. I think they were very antiquated. The buildings themselves weren't very conducive and they were all overcrowded. 12:52 12:52

153 Q. This is when you arrived in 2012? 12:53

A. Yes. You know, they were all overcrowded environments. So a lot of my first year in Muckamore was around decluttering the wards, changing some of the processes around hygiene and those sorts of standards. And

whilst some wards superficially would have been clean but other, you know, the building itself didn't lend itself. There was shared products, you know, communal use of shampoos and deodorants and things like that. You would have went into the bathroom and there just would have been a shelf full of stuff. Clothes and things would have been just stored in -- there wasn't a lot of personal space for individual patients and a lot of it was just big dorms. 12:53

154 Q. Some witnesses made the point that the hospital perhaps became somewhat more sterile and lacking in warmth when it moved towards the new arrangements. Can you understand how some people would feel that way? 12:54

A. I can understand it because we actually had to take an awful lot of clutter out of the wards. 12:54

CHAIRPERSON: What do you mean by clutter?

A. Well, you could have went into an area that was a store and there would have been commodes and bowls and belongings to people who were deceased. There was patient files that were, you know. 12:54

CHAIRPERSON: I understand that, what about patients' possessions, patients who were living there in the hospital?

A. They would have had them in their own personal rooms and a lot of that stuff remained. But one of the things that we did say was that if patient wanted a new bed that the hospital provided it and that the family didn't because we had to meet certain standards under fire and health and safety that they had to meet 12:55

certain levels for the equipment we used. If they needed new chairs under postural management, that we provided them. Before that some families had to fund those. But patients did have lots of their own personal items in their own space. The problem in relation to some of that was that it was some patients had a lot of belongings in their own space and other patients had none. So in Ennis there would have been four patients up the front who had their own bedrooms who were very personalised and had a lot of their own stuff. But equally there would have been patients down the back who were four to a bedroom and they had, they didn't have curtains in the room, you know, as in between beds. 12:55 12:56

PROFESSOR MURPHY: But was your action then to take it down to the lowest common denominator? 12:56

A. It was to take it up because a lot of the rooms, I mean in the dorms we put in curtains, we put in new furnishings. A lot of it was pulled down immediately and had to be re-erected every week. In Moylena ward we worked with RQIA in relation to having individual spaces created within the dorms. Now they were like more wall height, cubicles, I'm trying to think of the wards. 12:56

CHAIRPERSON: Pods? 12:57

A. Well, no, the pods were different. The pods were actually a designated space to a person. The cubicles were more like --

DR. MAXWELL: A divider?

A. Dividers. And we met with a lot of opposition and resistance to that. But, I mean, staff would have said like 'I can't see down the dorm to see who is up' whereas actually they had to walk up. There was things that we had to bring a lot of staff along with us on. And one of the things after we did it was that some staff came up to us and said such and such is sleeping so much better now that he's in his wee cubicle. You know, because he has his own wee space. Then it was about putting their pictures up in that cubicle and putting things on the wall that they liked and incrementally we raised it up for that. 12:57 12:57

PROFESSOR MURPHY: So you weren't depersonalising it, because that's how it's been described to us by some witnesses? 12:58

A. I think there was a lot of opposition to things like infection control where we said don't be hanging things over the mantelpieces and those areas have to be cleaned. And here would have been personal objects put in day rooms that were difficult for the cleaners to work round and stuff. We always encouraged patients' personal space to be more personal, but certainly our day rooms we tried to create more of a place where they could clean and keep clean and serve the purpose of the ward. 12:58 12:58

PROFESSOR MURPHY: So the day rooms were more hospital-like but their bedrooms were more personalised?

A. Yes, and even in the core wards that was adopted but they would have had, some patients brought in more than

others. But, you had to strike a balance between the room being cluttered and not being able to go into it as opposed to it being totally clinical.

PROFESSOR MURPHY: The trouble was some people were living there for 10 years? 12:59

A. Mhm-mhm.

PROFESSOR MURPHY: So you wouldn't want it to look like a hospital for 10 years, would you?

A. You wouldn't want it to look like a hospital but what you want is the chairs and the furnishings to be 12:59 homely, but it also has to be clean and because you have to maintain the hygiene standards and you have other responsibilities alongside giving the people and the patients a lot of their own items that they need. I know, you know, some families would have brought up 12:59 things for the patient and we created space for that, but there is limitations to what you can bring into a hospital.

DR. MAXWELL: Some people have said there was a difference between the old and the new hospital and 13:00 that actually the core hospital was very clinical and felt like a hospital and actually it is designed as a hospital ward. Did you think there were different challenges to the core hospital from the resettlement?

A. The core hospital had its own challenges in that, yes, 13:00 it was very clinical, it was very white, it was nice if there was a splash of colour in places that actually broke that up. But, you were balancing that against maintenance would have always said look, try to keep to

two or three colours because it's really difficult to keep on top of this because there is so much damage to the walls and to the equipment and stuff like that. But the core hospital was designed as every bedroom was identical and a lot of the furnishings that were bought originally were identical in every room. And certainly we had to do a lot of replacements of furniture after we got there, simply because it was stuff that was done because it was already, you know, you have to buy new stuff every year. But a lot of the difficulty in the older wards was keeping the stuff up because patients would pull it down and, you know, you could put it up and the next day it was down and you were hanging it again and it was down again. 13:00 13:01

155 Q. MR. DORAN: Yes, I just want to come back briefly before lunch, Ms. Rafferty, to the needs of individual patients. Do you think, looking back now, that sufficient thought was given to how difficult the transition was going to be for some patients, particularly those with high levels of autism? 13:01 13:01

A. I think where we encountered most difficulty with those, with autism, certainly was when the numbers decreased and a lot of the patients with autism had a lot more space and got used to that space and then other patients come into the area again, they felt overwhelmed I think. And it was, when the numbers were high it was almost like they had a smaller span of personal space and as that grew they like, it was hard for them to give that up again in relation to more 13:02

people moving back into their area.

156 Q. If you were managing the transition again would you go about it differently?

A. I think that certainly there is other strategies that could be used now and certainly that having more psychology input and behavioural input and allowing them to take the lead on some of those transitions would certainly have helped. But we certainly didn't have enough of that resource there at the time that would have helped us and maybe we prioritised some of the wrong disciplines early on in the resettlement process over others. 13:02 13:03

157 Q. Such as?

A. Well, from my perspective, I know I brought in additional nursing roles into the mix and brought in additional deputy Ward Sisters and that type of role into those resettlement wards that hadn't been there before. But, maybe I should have prioritised more the psychology input and more OTs and other staff who could have assisted those nurses in doing things in a different way. 13:03 13:03

MR. DORAN: Chair, that might be a suitable moment for a break?

CHAIRPERSON: I'm just thinking about the progress. It looks to me as if you could be the rest of the afternoon with this witness. 13:03

MR. DORAN: Yes indeed Chair, I think we are going to have do a little bit of rescheduling. Perhaps I will report back on that after lunch.

CHAIRPERSON: All right, thank you very much. 2 o'clock please. Thank you very much.

LUNCHEON ADJOURNMENT.

13:04

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

MR. DORAN: Before the lunch break, I mentioned we may have to make a slight change in the schedule. I can 14:06
indicate that Mr. Worthington, who was due to give evidence this afternoon, will now be attending tomorrow morning at 9.30 to give his evidence. The Inquiry is obviously very grateful to him for changing his time slot. Now, Ms. Jack, Cathy Jack is due to give 14:06
evidence, she was scheduled to give evidence tomorrow at 10 but her evidence is now likely to start in or around 11 o'clock.

CHAIRPERSON: That's fine. And we'll see how we do, but hopefully we could finish her tomorrow. 14:07

MR. DORAN: Yes, indeed.

CHAIRPERSON: We'll see how that works. Okay so we will be sitting at 9.30 tomorrow morning, thank you very much.

158 Q. MR. DORAN: Ms. Rafferty, you were asked when making 14:07
your statement to answer a range of questions about induction, training and professional development of staff?

A. Yes.

159 Q. And you deal with those issues at paragraphs 89 to 116. I've got a number of specific questions arising from the answers that you have given. You talk about the induction process at paragraph 89 and you say:

14:07

"Induction processes for new staff were developed and led by the nurse development lead once appointment."

Now the Inquiry has heard from some witnesses that the induction process was very short, perhaps just a few 14:08 days, was that the norm?

A. The induction at Muckamore was part of an overall Trust induction so there was some induction days that were led by the Trust and they were in overall processes around HR, payroll, health and safety, so generic 14:08 issues for all staff. Then there was a localised induction on the site and around, for the learning disability aspects on-site and then there was the MAPA training and fire safety on-site and things like that and basic life support. So there was like three 14:08 aspects to it.

160 Q. Yes and how long would a typical induction process last?

A. Well the Trust one I think is, from recall, I think four days and then a couple of days at Muckamore and 14:09 then the MAPA and basic life support and fire safety would have been a further five days.

161 Q. And in your view was it adequate, given the challenges that staff would face working in the hospital?

A. Well feedback from the management team that I had felt that we were covering what needed to be covered and then when the person started on the ward they would have had a local induction into the ward and its layout and individually feedback with the patients, you know, introducing the new member of staff to patients and things like that, so there was different stages to it.

162 Q. Had you any direct input into that process?

A. Well certainly they would have showed me the schedule and there was a number of occasions that staff would have been allocated to take some sessions at the induction process on Muckamore and some of those occasions I was there as well for new staff starting. I wouldn't have been at all of them but I would have been at some of them. 14:09 14:10

163 Q. Did you play a role at all in the process?

A. More around signing off that that they had the induction performing and they would have showed me and discussed with me what they were planning to do and I would have agreed and said yes, go ahead with that. 14:10

CHAIRPERSON: Quite apart from induction, would a new member of staff have somebody to look after them, sometimes they are called sponsor or sister or an aunt or an uncle.

A. On the ward they would have a buddy usually or someone, all new Staff Nurses would have been under preceptorship so their first six months to a year would have been part of their preceptorship and they would have been supported. 14:10

CHAIRPERSON: But that's for a new nurse?
A. That's for a new nurse. For healthcare assistants, the Ward Sister would have aligned them to someone on the ward to support them. And we also had the nurse development lead on-site who was a resource for the whole site in relation to issues with wards and they would have supported the Ward Sister in relation to some of the supervision sessions for the Band 5 nurses and done group supervisions on occasion. 14:11
DR. MAXWELL: Clinical supervision, the requirement for clinical supervision? 14:11
A. Yes.
DR. MAXWELL: You said preceptorship but that's for newly qualified nurses isn't it?
A. Yes. 14:11
DR. MAXWELL: What would happen if you took somebody who worked as a learning disability nurse, registered learning disability nurse who wasn't newly qualified, what sort of package would they get?
A. They would have done the induction into the hospital and the Trust induction especially, usually when you took up a new job within the Trust you had to do the Trust induction again. But they would have been under the supervision of their Ward Sister and they would have linked in with them to see what additional supports they needed. 14:11 14:12
DR. MAXWELL: It would have been a personal plan?
A. Yeah but the majority of staff who came to the hospital were mainly newly qualified staff.

164 Q. MR. DORAN: You say in paragraphs 91 to 92 that the staff were made aware of policies through the Intranet. How were agency staff apprised of the relevant policies?

A. Agency staff only started in the hospital in 2017 onward. We didn't have any agency staff in the hospital before then. 14:12

DR. MAXWELL: I think the point is agency staff don't have access to the Intranet, I think you call it the hub or The Loop, I can't remember what it's called. 14:12

MR. DORAN: Intranet I think is the term.

A. Intranet.

DR. MAXWELL: Intranet, yeah, but it has got a different name hasn't it? Anyhow.

A. So well, we would have -- any staff starting in the hospital was given a log in. 14:13

DR. MAXWELL: We have heard from other witnesses that agency nurses didn't get a log in because they are not employees.

A. I'm surprised at that. 14:13

165 Q. MR. DORAN: In your recollection were they permitted access to the internal communications system?

A. Well my understanding was that they would have had a log in.

DR. MAXWELL: Well we can check that out with the Trust. 14:13

MR. DORAN: That's something we can check.

A. Because how else would they have been able to do their notes?

CHAIRPERSON: I don't think we can answer your questions.

166 Q. MR. DORAN: Indeed. But I want just to ask you another question about policies being communicated to staff and the operation of policies, had you any role in auditing policies? 14:13

A. We had a resource nurse on-site who would have indicated to us when a policy was due for renewal. She would have taken the lead on a lot of policy renewal and met with -- we would have identified key people who would work with her in relation to policy renewal. 14:14

167 Q. But I'm not just thinking of renewal, what if someone in your position, for example, thought that a particular policy wasn't working. Was there a mechanism for you to feedback your views about the operation of the policy? 14:14

A. I think, well most of the policies at the time I think came under scrutiny when they were up for renewal as opposed to we then would have said well, we think that's not working as well as it should. There was some policies would have had addendums to them which we would have taken to the governance team and said -- I'm thinking of when we did the review of Iveagh there was the MAPA policy and there was the Positive Behaviour Support. But like there was an overarching addendum to that to say this was the new philosophy we were working to. But it would have been in discussion where we felt something wasn't working, we would have taken that probably to the Core Management Team. I'm thinking, 14:14 14:15

one that springs to mind is when we reviewed the patient transport on-site.

168 Q. Tell us a little bit more about that, what did that policy relate to?

A. It related to the use of hire, lease cars and hire cars for patient use alongside a mini-bus that the Trust provided and we had a policy on it so I knew it was reviewed mid, I think because we -- because wards were closing some of those vehicles were coming up for lease renewals so the use and policy was reviewed to identify was there things that we needed to change and if other vehicles were needed to be purchased and the ones that needed to be let go. And so at the time I know we reviewed the usage and how patients were charged, because we felt that some of the charges were very high and that some of the journeys were therapeutic journeys and part of their treatment within the hospital and they shouldn't be charged for them. So we made the distinction in that policy around a use of, you know, outings and social outings that were part of treatment as opposed to patients having social outings that were purely, you know, like to go to a concert somewhere or that they wanted transport for. 14:15 14:16 14:16 14:17

169 Q. So you've given that as an example of a policy being reviewed? 14:17

A. As an example.

170 Q. I am trying to think of some of the more significant policies such as on the use of restraint and seclusion, would they have been subject to ongoing review at your

level within the hospital?

A. I think they weren't reviewed as often as they should have been, given that we had concerns about the level of restraint. We were aware that there was high levels of restraint in the hospital but we continued to use the current policy and that was that we commissioned MAPA and training for staff to support de-escalation and support for staff to manage patients safely. 14:18

171 Q. But do you think perhaps looking back there should have been more vigorous oversight of that policy? 14:18

A. Certainly I think both it and seclusion, I learnt more around some of the things that we were doing that weren't right when we got a new divisional social worker. Because one of the things in the old policy was that a supervising person on seclusion could be any member of staff, but when the new Divisional Social Worker started she highlighted to us that the supervising person should be a Registrant. 14:18

DR. MAXWELL: I think there is two questions. One is was the policy evidence based and updated. But there is a second question, whatever your policy was, how did you audit compliance with it? So even if your policy wasn't the best policy it could be -- 14:19

A. Yes.

DR. MAXWELL: Did you audit that staff were complying with it? 14:19

A. Some policies were looked at in that fashion, as in we had an accountability framework within nursing in relation to infection control, you know, uniforms,

environments, things like that. It wasn't as structured with other policies.

DR. MAXWELL: So one of the things that's become apparent later on is that it appears as though record keeping around the use of physical restraints was not adhering to the policy. Did anybody ever audit that? 14:19

A. The MAPA coordinator would have coordinated all the MAPA forms that would have come in, so any incidents of use of restraint, a form was completed. That was reviewed I think around '13, '14, to include it on the Datix system so that it was easier for staff to complete when they were completing the incident so that -- and I know our MAPA coordinators worked with the MAPA coordinators in Mental Health and the Trust ones to look at that. 14:20

DR. MAXWELL: If I can take you back a step, it appears that sometimes in the nursing progress records on PARIS they talk about using a clinical hold with a patient.

A. Right.

DR. MAXWELL: And they haven't filled in an incident form? 14:20

A. Okay and that should have been done because any restraint or movement of patient where they actually held the patient and moved them somewhere else should have been actually completed because the MAPA coordinator would then to look to make sure they were using them appropriately. 14:21

DR. MAXWELL: If the MAPA trainer hadn't highlighted to that, I realise it is very easy to look in hindsight

but with hindsight would it have been useful to audit the notes to make sure the policy was being properly adhered to?

A. Yes, it would have been.

172 Q. MR. DORAN: I think you used the expression "some of the things we weren't doing right." Can you give us some other examples of that? 14:21

A. I think I need to come back to that because I'm a wee bit --

173 Q. We will come back to that, there is no difficulty. I'll ask you some other questions in the general area of staffing? 14:21

A. That's okay.

174 Q. One point that the Inquiry has heard is that there was a lack of protected time for staff to take training. Often training had to be cancelled because staff were needed on the wards. I think Mr. Veitch said "there were occasions when Esther explained it proved difficult to release staff for training courses." Is that right? 14:22 14:22

A. It was right and certainly we did try to facilitate staff to attend but I would have had some contact from the Assistant Service Managers and said to me look, we are very short today, we need to pull five out of training today and there may have been 20 released to train, but we would have had to pull five out to make sure that the wards were safe. That did on occasion. We would have asked some staff if they were willing to do some of their training on bank shifts as opposed to 14:22

identifying it within their core working week because we knew then that they were off site doing that training and it had less impact on the shift. So it was a balancing act in relation to some training, but we did --

175 Q. When you say it was a balancing act, looking back was the safety of patients ever compromised?

A. I think not having staff trained up in some of the mandatory training will always be a risk and I think you're trying to mitigate your risks by saying well, which is the greater risk today, do we actually need some people on the ground here to be there directly for the patients. Occasionally, there is peak times of work within Muckamore, as in very early in the morning, lunchtime and things because a lot of our patients would go out to day care during the day, so there was lulls. So we would have said even when we were organising some training could we organise it between 10 and 12 and 2 and 4 in the afternoon to try and maximise when it was less disruptive.

176 Q. Did those management issues become more difficult after the revelations in 2017?

A. There was additional staffing concerns after that period and we had brought in agency staff at that point, but we also had to release the agency staff for training. So, we did have to prioritise some of them to get training and then when we brought in the next batch I actually organised a lot of the training to happen as they arrived and not to be released

afterwards. So we pre-booked training on the knowledge that they were arriving on a certain date. So some of that was organised in that way to take account of some of the challenges we faced when we brought in the first ones. But, given that staff were suspended following the allegations and more staff were suspended over that incoming period that I was there up until August '18, staffing was extremely difficult at that point.

177 Q. So were those pressures on training more acute after 2017 in your recollection? 14:25

A. I would say, yes, they were.

178 Q. And how did that effect the running of the hospital?

A. As part -- the Service Manager, I wasn't in the post of Service Manager after March of that year so for that last six months Barry Mills would have been the Service Manager and he would have been highlighting those probably to Mairead and myself. But we certainly had, we still would have been looking at what we needed for the service and very much that we were pushing positive behavioural support and promoting that and how we were going to implement that within the site, with the support of psychology. 14:26

179 Q. I have a very specific question for you now. You refer at paragraph 113 to nurse prescribing courses and obtaining approval for Muckamore nurses to attend. Were there any nurse prescribers at Muckamore? 14:26

A. We had one. It's actually quite an intensive course, I think it's 18 months and you have to have a supervising doctor that supports the nurse through the course. But

we did have a nurse who completed it. We had, we commissioned I think --

180 Q. But was the nurse, can I just ask, was the nurse an independent prescriber or supplementary?

A. An independent prescriber. And to support him in rolling that out even after qualifying, he did a six month placement in mental health because he felt that he needed to understand not only the physical or the prescriptions for physical health but also those for mental health. So he did that in addition to the training post. 14:27 14:27

DR. MAXWELL: This is the person you referred to earlier?

A. Yes.

DR. MAXWELL: Who also did the checks? 14:27

A. Yes, mhm-mhm.

DR. MAXWELL: The routine screening checks.

A. Yes. Part of starting to commission those roles, we commissioned those roles because nurse prescribing is one of the core training for nurses who later want to become nurse consultants. So it was about starting to create pathways for nurses within learning disability because that was always an issue that was brought up around that there was limited pathways working in the hospital or working in a community setting as a Community Learning Disability Nurse. 14:28 14:28

181 Q. MR. DORAN: And, again, when did that particular nurse undergo the training then, what year was that, in or around?

A. That would have been '15. And then we had other courses commissioned as well in '15 and '16 which would have been specialist practice. But part of that, I had to negotiate directly with the other Trusts because the university will only commission a course if it's a minimum of 12. So to actually achieve some of those specialist courses for learning disability nurses, I had to make a commitment that six would come from Muckamore and Belfast and then the other Trusts, because of their smaller cohorts of learning disability nurses, they agreed to put forward two each and that was how we finally got the course commissioned and that was with making that commitment. Even though that was a challenge to us because the course itself, yes, gives you backfill, but backfill money is not really useful if you can't actually get the staff. But to actually move the service forward you still have to train the staff and it's challenging. 14:28 14:29 14:29

182 Q. I'm going to move on to more general staffing issues, because obviously you were involved in reporting those at various points in time. But I want to ask a specific question about the review of staffing levels using the Telford formula to which you refer at paragraph 122 of your statement, that's on page 23. So you refer to: 14:29 14:30

"I am the senior nurse manager who is working with Margaret Devlin in Corporate Nursing to review staffing levels for nursing using the Telford model for the

wards."

The Telford Model obviously uses professional judgment about need, isn't that correct?

A. Mhm-mhm. 14:30

183 Q. As we discussed earlier you weren't specifically trained in learning disability so when the Telford Model was being applied was there professional learning disability input into that decision making?

A. Every time. 14:30

184 Q. And from whom?

A. From the senior nursing team and in their discussion directly with the Ward Sister. The senior nurses would talk about the staff they needed on the ward, the minimum number of registrants and the minimum number of 14:31 nursing assistants. I mean, all of those staff were always involved in those decisions and that was in 2013 with Margaret and later with Aisling Phelan who was more senior in the workforce team. She did it with her team with Muckamore Ward Sisters as well. And when the 14:31 rostering team came on board they did it with the Ward Sisters as well. Then when we talked about delivering care and working to getting learning disability assessed against those standards, Moira Mannion came in and done presentations to the Ward Sisters and Deputy 14:31 Ward Sisters and charge nurses. There was work done specifically on each ward and they were doing what their current staffing was and what their projected staffing should be, given the acuity levels that were

starting to present, and should the service -- being discharged, the delayed discharges and being left and we were noting that the Ward Sisters were recommending acuity, you know, balances of 70/30 compared to what they currently had.

185 Q. Can you explain that that a bit more, a balance of 70/30 in respect specifically to what?

A. As in 70% registrants, 30% unqualified. I think when I started in Muckamore most of the wards were sitting at 50/50 in the acute admissions and in Six Mile. The resettlement wards were 40% qualified 60% unqualified.

DR. MAXWELL: Can I ask, you talk there about acuity, did you have a specific acuity model to make sure the Ward Sisters were using the same criteria?

A. The rostering team set an acuity level in discussion with the Ward Sisters and ourselves in that those that needed constant supervision, those that needed intermediate supervision, those that needed oversight and those that needed low level care. So there was different levels and they had to apportion different patients to each group.

DR. MAXWELL: There were clear criteria so the Ward Sisters were using the same criteria?

A. Yes.

DR. MAXWELL: So this change in the requirement, the registered nurses, did that reflect a change in the acuity of patients from when you started to this later date?

A. You have to understand an awful lot of the patients

that were resettled were less complex. So we would have had two full wards who had a lot of physical health needs as opposed to challenging behaviours. So their acuity levels in relation to challenging behaviours would have been low but their acuity levels in relation to co-morbidity of conditions was quite high, so they had different challenges. You had to put in some additional supports for people who had a lot of physical health needs. Some of the intensity came from the more behaviours that challenged, I don't know if I am explaining that right. 14:34 14:34

186 Q. MR. DORAN: We are going to go onto the bigger picture as regards staffing, you will remember the last day when you gave evidence in June you referred to preparing the report for the RQIA in 2012, you may recall that, it was the report that referred to patient safety and staffing levels being dangerously low. 14:34

A. Yes, and certainly when we got to the end of that summer, every year in Muckamore, because the profile of the staff was leaning towards older population of staff, the staff in Muckamore had an option to retire at 55 because of the Mental Health Officer status and special classes. So in a way lots of staff left earlier than would naturally be the case in other settings. And the staff who worked on, we had a number of Ward Sisters who worked into their 70s and older, but that was more do with because they had taken time out away from the workplace for a while and they hadn't their contributions fully paid. So you would have had 14:35 14:35

a high number who could leave the service and we would have had quite a number leave each year based on that, both from a nursing assistant and nursing thing, so we had a turnover. But I think, I mean that would have been the case in other Directorates as well, Mental Health and all. So we did have in Muckamore and the staffing at that point was critical which is why we brought forward Finglass because that would have released that team into the hospital to support the other wards. 14:36

187 Q. But, the issue of staffing, I think you indicated on the last day, was on the service area Risk Register, isn't that right?

A. It was. I mean, I put it on the Risk Register when I first got there noting that there was a high use of bank, there was a high use of internal processes, you know, as in using our own staff a lot and not external people coming in so it was about also engaging with the nurse bank to make sure they released other people to us as well. 14:36

188 Q. When you say you put it on the Risk Register then presumably that was exclusively a decision for you to make as Service Manager?

A. Yes because all service managers tried to indicate their risks as they arose. And I'm not saying, I don't think every risk we come across went on the Risk Register. There was ones that -- we reviewed our Risk Register usually every two to three months to see is it still relevant, is there other ones that should go on 14:37

here and I think sometimes there is probably ones we missed as well that should go on.

189 Q. But how long did the staffing issue remain on the Risk Register?

A. I think it remained on it and it went up and down, as in at times throughout my Service Manager role there. 14:37

190 Q. So it was there, it was on the Risk Register throughout your period in the hospital?

A. Yes, as was overworking of some staff as well I think was on it. 14:37

191 Q. Well I wanted to ask you about that because you refer in paragraph 126 to adding to the Risk Register concerns about some staff working excessive hours which required monitoring by the Senior Nurse Managers. Can you tell us how this works, was that a separate item on 14:38 the Risk Register or was that added --

A. I think that was, no I think it was on as an item on the Risk Register or a subsection of the staffing one, I'm not sure. But I do remember it being on because the Ward Sisters and the Nurse Managers had to monitor 14:38 the additional hours that staff were working. Occasionally it was difficult because they would -- some staff would work across a range of wards and that could be difficult, but the nursing office, because they had an oversight of all the wards, who was in the 14:38 nursing office, they could see if the same name was cropping up. So one of the areas that we tried to address that, we did have a member of staff, I know the year I got there, there was a member of staff who

worked six nights a week for a year.

192 Q. Did that or was that issue resolved during your period of time at the hospital?

A. What we did was we built in rest periods for that person and talking to them about ensuring they took their holidays, you know, and things like that, their annual leave was protected. So we had individuals who the Assistant Service Managers would speak to to highlight those concerns with the person and to make sure that, you know, they were keeping themselves safe as well. 14:39 14:39

193 Q. And was it your job to take action to deal with that kind of situation?

A. Well, if it was flagged, I would have directed someone to go speak to that person individually. Occasionally an assistant Service Manager would have taken the step to cancel a shift to make that person and say to them, no, this is excessive, you need to... 14:40

194 Q. But presumably --

A. It was monitored. 14:40

195 Q. Yes but placing of that issue on the Risk Register suggests that more than one individual was presenting with issues of that kind?

A. There was -- I think lots of people worked extra shifts, it wasn't one or two. It seemed to be more common practice in other areas that I have worked you would you have found a small proportion of the team would do bank shifts and agency work. It just seemed to be more of the culture within the hospital that 14:40

everybody did extra shifts.

196 Q. What specific concerns did you have about that?

A. Well, around patient safety as well as staff safety.

197 Q. That's what I was going to ask, it's surely not only a matter that might have implications for the individual themselves? 14:41

A. It is about patient safety, and staff safety, about people being overtired. About, you know, being able to deescalate properly as opposed to, you know -- people who are tired can also be a bit short or, you know, there's behaviours that maybe are more uncomfortable that you are saying to someone no, you actually need to rest, this is too much. 14:41

198 Q. That can have implications potentially for patient safety? 14:41

A. Yes, yes.

199 Q. I just want to refer to another document that was brought to the attention of the Inquiry recently in materials provided to Mairead Mitchell for the purpose of her evidence. And I think you've had the opportunity to look at this document, it is a duty roster analysis document. I don't want you to say anything about it for the moment, I am going to bring it on screen. It's in Mitchell M bundle at page 74. Now, the document is titled as you can see, "MAH Roster Analysis". It's not dated but it was with papers that were presented to the Task and Finish Group in July 2017 and Mairead Mitchell in her evidence said she thought the reference to November and December in the 14:42 14:42

document must have been to 2016, so this appears to relate to winter 2016 which is obviously a time at which you were in the hospital?

A. I'm not sure which year it relates to.

200 Q. It is just we touched on this earlier but in most of the wards the skill mix shows as under 50% registered staff? 14:43

A. The hospital did, staffing was reviewed, I think, when the new hospitals were built and it was determined but I think there was a scoping exercise done around 2010, 2011 which removed a number of posts from all of the wards and reset their staffing and I think at that point it was, their staffing levels were set around 50/50 for the core wards and 40/60 for the resettlement wards. 14:43

201 Q. But this was late 2016 we think. First of all can I ask did you recognise the document?

A. I'm trying to remember it. I think I have had sight of it and it would have been around the time we were bringing -- it was around the time we were training staff up around delivering care. 14:44

DR. MAXWELL: I think it might have been 2015 actually.

A. No it wasn't, that's too far back. I think it's probably late '16/'17.

DR. MAXWELL: Okay. 14:44

202 Q. MR. DORAN: I think certainly Mairead Mitchell suggested it was probably late 2016.

A. I would have thought it more '17, simply because, I think Mairead took up post around, October, November.

DR. MAXWELL: I think this was presented at the meeting for data collected the previous November.

203 Q. MR. DORAN: Yes so it was presented to a meeting in July 2017 but the document refers to November and December? 14:44

A. Right.

204 Q. I suppose Mairead was suggesting that the reference to November and December must have been to the previous November and December which would have been 2016. But in any case -- 14:45

A. No because I was not actually at work for a period in December '16 I think it was, no, December '17 it was.

205 Q. You say you may have seen the document, do you recall having any input into its preparation?

A. When the roster analysis was performed it would have been a team coming up from Central Nursing who would have worked directly with the Ward Sisters and then this information would have been presented to myself and Mairead and the operational managers. 14:45

206 Q. Just looking at the third paragraph, it says: 14:45

"It has been identified that the funded establishment is set at 26.25 whole time equivalent when they actually need 41.78 WTE as per a Telford exercise. This highlights a deficit of 15.28 WTEs before considering the reasons or increasing statistics for the unavailability of staff such as sickness, maternity leave, annual leave et cetera." 14:46

Now I should flag up that the witness, Ms. Creaney, had some reservations about the accuracy of some of the figures in this document. But do you recall that statistic being presented, that is the funded establishment being set at 26.25 when there was actually a need for 41.78? 14:46

A. When we did any of the Telfords the core staffing on the ward was your whole time equivalents but all of the wards would have used an additional probably 10 whole time equivalents in relation to specialing. 14:46

DR. MAXWELL: But that's not what that this says. This is talking about funded establishment being significantly less than required for fundamental establishment. This is the amount of budget.

A. I know. 14:47

DR. MAXWELL: Set aside by the Board.

A. When we were doing it all of our wards were working to what was required as opposed to what we were funded to because if we needed 10 staff --

DR. MAXWELL: I understand you brought in extra staff, we understand that, we know that. 14:47

A. Yes.

DR. MAXWELL: The question is whether the ward staffing budget was set at the right point in the first place and this seems to suggest that it wasn't. 14:47

A. It probably met the acuity levels and staffing requirements of the original ward that was set when the ward opened, not at that point in time.

DR. MAXWELL: I accept that but I think the question is

do you accept, were you aware that some people from Central Nursing had come in and found a big difference between the funded establishment and what the starting establishments for the ward should be? Set aside the fact that you needed extra for specialing and you were using it anyhow, because that's quite a big finding? 14:48

A. Well when we did our initial paper to Brenda, Aisling Phelan and myself and with Moira Mannion and we highlighted the shortfall in what was required and it was a large shortfall in that there was too few Learning Disability Nurses, too few qualified staff on-site and the skill mix was not the right balance, and that was highlighting that we needed more staff per ward. 14:48

DR. MAXWELL: But it seems from this that even though you had identified that and written a paper, that hadn't been addressed because when the Corporate Nursing team came in to do the roster analysis, they were finding the same thing, that there weren't enough funded nursing posts? 14:49

A. Yes and we would have highlighted to the Board that we felt that the team or the staffing structure in Muckamore wasn't right and wasn't meeting the acuity levels and that was why they asked us to do the paper about modernisation. They then gave us additional funding, but it was all temporary, in relation to the additional staff we required to run the wards but none of it was baselined. 14:49

DR. MAXWELL: No I understand what you are saying, it

was non-recurrent funding. So this seems to you quite a reasonable finding, does it, even though you were not present in December 2016?

A. I would agree that the wards were not funded to how they should be and I would agree that the skill mix wasn't what it should be either. I would also agree that as the patients were discharged the acuity level was going up and we needed more registrants. 14:50

DR. MAXWELL: Can I ask what you think, the Corporate Nursing team who were doing the rostering review, what would you have expected them to have done if they found such a big difference between funded establishments and required establishments? Would you expect them to have brought that to the attention of anybody in particular? 14:50

A. Well myself and the workforce lead and Brenda, as in through us. 14:50

DR. MAXWELL: Yeah. Do you recall them bringing that to your attention?

A. They would have shared their findings with me and in reading that I would have been looking at, well, how are we going to, how am I going to work with my co-director to get additional funding for the service. 14:51

DR. MAXWELL: And if you had looked at this and thought, no, I think they've got something wrong here, this doesn't feel right, if you had wanted to challenge what they had said -- I'm not saying you did want to challenge it, hypothetically if you thought this just doesn't look right, what would you have done? 14:51

A. We would have drilled down through some of it and like,

some of the sickness rates look extremely high there because even when we print out our sickness rates on our own finance sheets they would have been sitting, our worst ward was probably 15%.

DR. MAXWELL: I am asking you hypothetically what you would do, not was it correct, because Brenda Creaney said she didn't feel the figures were correct so I am wondering what would happen if the Corporate Nursing team did a roster analysis and it came back to people who run the service who didn't feel it was correct, what would be the process for challenging this? 14:52 14:52

A. I think you would get another analysis run to correlate it and see if it's coming out the same with a different team to come in and do it, to double check those figures. 14:52

DR. MAXWELL: And do you recall that happening?

A. I think that they did come back but it was more to re-engage and to continue doing the analysis to make sure that the staff understood how to use the roster properly, to make sure that they were eradicating some of the -- 14:52

DR. MAXWELL: I understand, but given the question is about the funded establishment which isn't how people use the roster, it's the budget, you don't recall anybody challenging this and re-calculating this at that time? 14:53

A. Ehm --

DR. MAXWELL: If you can't remember, say so.

A. No I'm actually just thinking even when I met with the

finance, our financial accountant it was more a case of a lot of our overspend was going into one central point in relation to even how we managed the hospital. There was, I suppose, a discussion about well how do we raise this with the Board to say, you know, our budget isn't right. But equally the Board come back to us and said make a paper and tell us exactly what the new funding is going to be. So at times you felt you would have gone round in circles a little bit in relation to well, the problem is there, to get the money to get it you have to produce the paper, to get the paper to justify the expenditure. 14:53 14:54

207 Q. MR. DORAN: You will be glad I am going to move on from the fine details --

CHAIRPERSON: Before you do could I just ask, this doesn't have an MAHI number on it at the moment, does it? 14:54

MR. DORAN: Yes, because, it's reference is Mitchell M bundle, 74, there was a specific bundle of materials prepared. 14:54

CHAIRPERSON: I don't think that's on the website yet is it? I have just had a look.

MR. DORAN: If not it ought to be and it will be.

CHAIRPERSON: We'll get that sorted, okay.

208 Q. MR. DORAN: So, getting away from the specifics of that document, you were obviously raising staffing issues in 2012? 14:54

A. Yes.

209 Q. And presumably you were doing so throughout the period

of your time at the hospital?

A. At different times, different reasons, but there was some initiatives that would happen within Northern Ireland like recruiting the health visitors.

210 Q. Yes? 14:55

A. That would be a regional approach that all Trusts had to support recruitment. We had a high proportion of nurses within the hospital over the four years of health visiting recruitment that left. That was mainly around career progression that a lot of them did that 14:55 because, because the hospital was downsizing there was limited opportunities for promotional opportunities on-site and to get from a 5 to a 6 in your banding would you have had to take a community post or whatever. So that would have meant staffing leaving, a 14:55 reduction in nurses. So those sorts of things were flagged to both Mr. Veitch and through the central nursing forums. And I know myself and another Associate Director of Nursing actually got agreement not to support the health visiting cohort one year so 14:56 that we could have I suppose an easement from that process to safeguard our own staffing. However our staff went ahead and applied, and were succesful and took up the posts without even secondment so --

211 Q. You are quite rightly referring to individual 14:56 developments at certain points in time but is it fair to say that throughout your period at the hospital staffing issues presented constant difficulties?

A. Yes, but that was because there is not enough learning

disability nurses trained in Northern Ireland. There is only a set number each year. And, in fact, I think it was Mr. Devine who was at the department at the time, there was discussion with us as lead nurses across the region around cutting back on the numbers that were being trained, even in 2013, '14. All of us as lead nurses challenged that and asked for the nurses to at least be maintained, not to have it reduced. But the majority of nurses who come out every year came to Muckamore or the Learning Disability Unit in the western Trust. So on average we would have taken in 30 to 35 nurses, new nurses each year. 14:57 14:57

212 Q. But you highlighted these issues, you are raising them and I think you mentioned various meetings that you attended at paragraphs 120 and 121 of your statement. So you're raising issues like this in various forums. You're working as Service Manager within the hospital, within a hierarchical structure if you like. Do you think that the issues that arose as regards staffing within the hospital were properly and adequately tackled by those in higher positions of responsibility? 14:57 14:58

A. I think there was some strides to improve because I know Brenda would have taken that to the directors meeting with Charlotte McArdle in relation to the reviewing of the numbers being trained. This was not an issue that was contained within Learning Disability. We're short of all grades of nursing in Northern Ireland whether it be adult, mental health or learning disability so. 14:58

213 Q. Let's focus on learning disability specifically, what could have been done and what should have been done to address the issues?

A. I know there was discussions around raising the numbers of Learning Disability Nurses being trained. There was the development of the Open University learning disability course. So up until, you know, there was ongoing discussions over I think a two or three year period with the Open University around having an employment based route for Learning Disability Nursing and it finally did happen later on. 14:58 14:59

214 Q. When exactly was that?

A. I know discussions would have been happening. I know I would have spoken to Donna Gallagher in OU around is there an opportunity for Learning Disability Nursing simply because I was involved in the OU Mental Health Nursing Programme when it was established. So my previous knowledge of that would have been having discussions with Donna in OU and saying well look, what's the chance of setting up a learning disability one. That certainly translated as I would have had that discussion with Moira Mannion and I know Moira took it to her commissioning things, but these things are all medium to long-term strategies. 14:59 14:59

215 Q. Yes. 15:00

A. Short-term strategies are around using bank and agency and other staff grades to support you whilst those other initiatives build. And resettlement, longer term, was also one that would help free up staff

because it would release staff to come to core services, whether they be hospital or community.

216 Q. That was the theory?

A. That's the theory, but in practice a lot of people also, instead of deciding they want community or things, they decided to choose retirement and it's -- an employment based route is actually a very practical way of encouraging people because we found that happened in mental health. When we wanted to develop more Mental Health Nurses we developed a clear pathway. People have already agreed to work for that Trust and in that locality so supporting them to become professionally trained, they tend to remain with their host Trust and carry on in a professional capacity, so the Open University programme and employment based training is a really good way to retain staff but give them a pathway into a profession. So, those options, and I know central nursing explored and continued to develop those and I think they were successful in getting that set up. 15:00 15:01 15:01 15:01

217 Q. Albeit that it took some time?

A. Albeit it took time and after I left.

218 Q. Now I just want to ask you about after 2017, you refer in paragraph 127 on page 24 to the efforts made to recruit staff to fill the gap that was left by suspensions. You mention that the staff brought in had a background in mental health rather than learning disability specifically. Presumably it was recognised that that was far from an ideal situation? 15:01

A. These were very experienced staff that we recruited and we asked for Margaret and Colm who were the two in the central nursing who I had worked with at the time. They had asked for things like as to what type of experience, so we were asking that they had understood in-patient care. That they, you know, had an understanding of the needs of someone with a learning disability. They didn't necessarily have to -- but they understood their needs and that they, in some of the units that we also had seen in England that a lot of learning disability patients went to mental health units in England for their care and treatment. So when we got, we got people with 20 and 30 years experience who were coming on these agency block bookings. 15:02 15:02

219 Q. Were you satisfied that they were properly prepared for the specific kinds of work they would be doing in Muckamore? 15:03

A. I think they had transferable skills that could support them into the placement and with induction on-site and they weren't expected to take charge of the ward but to be a support to the learning disability nurse who was on the ward. So later on I'm aware that because they were there for sustained periods of time that they take charge, but that was I think after a minimum period of a couple of years within the setting. But certainly when they first arrived there wasn't an expectation that they would be taking charge but they would be a registrant supporting the Ward Sisters, supporting the other registrants on the ward. I think that was a 15:03 15:03

reasonable --

PROFESSOR MURPHY: Sorry, we have heard from other witnesses that agency staff were disproportionately involved in alleged abuse. Was that your impression as well? 15:04

A. Well that would have been after I left because I had no allegations against agency staff during the period up until I left and they would have been there for close on a year and I can't remember one being involved in that when I was there. 15:04

DR. MAXWELL: We've also heard that they were predominantly trained outside the UK.

A. They were?

DR. MAXWELL: Predominantly trained outside the UK for their first registration, was that the case when you were there? 15:04

A. That does not ring a bell with me. I felt there were people who came from England -- I thought they were English nationals.

DR. MAXWELL: Maybe it was later that they had more overseas trained nurses. 15:04

A. I did not perceive any that I spoke to to be foreign.

DR. MAXWELL: We have heard some witnesses say there were some cultural problems?

A. There was cultural difficulties when they first arrived because a lot of the nurses who came were black nurses and I don't recall having nurses within Muckamore before who were black. 15:05

DR. MAXWELL: The patients weren't used to being cared

for by people from different ethnic groups?

A. Yes and they weren't used to that. And I do think that some of the things that I encountered in the first couple of months that they started was complaints from patients that they didn't want that person caring for them and some of that work had to be done with the patients and the Ward Sisters and Nursing Development Lead going in and talking to the nurses about how to support the patients to recognise that they were a person as part of the whole team. And there was also instances of where we had to support some of our own registrants to recognise that these staff were qualified registrants and that they weren't limited to just doing patient supervision, but that they could support them with other registrant tasks such as medication rounds and things like that, because they said oh, but they are not learning disability trained. But we were saying they are a registrant on the NMC, they have the capabilities and practicalities to do these other tasks. So some of that had to be prompted as well. 15:05 15:06 15:06 15:06

220 Q. MR. DORAN: I'm going to move on from staffing to the specific issue of seclusion. At paragraphs 150 to 157 you deal with the monitoring of seclusion at hospital level. Did you, as Service Manager, have any direct role in decisions around seclusion? 15:07

A. Seclusion was usually requested by a Registrant on the ward in relation to a distressed state of a patient who was being overtly violent or aggressive or distressed.

The seclusion had to be authorised by a doctor. The decision never sat with me as to the use of seclusion.

221 Q. But when it was authorised would you have found out about that decision?

A. Not on all occasions because I would have reviewed a number of reports each week in relation to incidents, accidents and situations on the wards so I would have been aware at a number of points during the week of when seclusion or additional instances had occurred. But I was also aware when we reviewed them at the core management group because Mr. Mills would have come in and discussed what led up to the seclusion because he was responsible for the wards on which the seclusion room was based, or Iveagh manager would have come up, but those were the two areas where seclusion was. So they would have talked about what incidence was, how many patients were involved and if there was any significant duration. So the majority of seclusion would have been under 20 minutes and on most occasions it would have ended at that. Occasionally you would you have got on the report a seclusion lasting over an hour or over two hours and when those happened there was a formal review by, I think it was the Nurse Manager or the nursing office had to go in and review the patient with the nurse in charge after an hour and then there was a point where the doctor had to be called and review the patient with the doctor at a set point as well. 15:07 15:08 15:08 15:08 15:09

222 Q. Now some families have suggested that the communication

with them about the use of seclusion was inadequate, would it have been part of your role to ensure that families were receiving full and proper information about the use of seclusion?

A. Certainly that would have been the role of the Ward Sister in relation to feedback, and the consultant, in relation to feedback at the MDT meeting and around any incidents of seclusion that had occurred. 15:09

223 Q. Were you ever aware of issues around communication and dissatisfaction with information that was being communicated to families? 15:10

A. No family was happy that seclusion was used in relation to their relative, but usually we, the Ward Sister would have sat down and explained the circumstances that led up to it. It tended to be very small number of patients for whom seclusion was used for or managed. Even in PICU where you had six patients, there may only have been two or three patients out of that six who used it. Some patients didn't use it. 15:10

224 Q. Looking back I know you're suggesting perhaps it wasn't your direct responsibility but could more have been, do you think, to improve communication with families about the use of seclusion? 15:10

A. I think, as with the wards having their information booklets in relation to what happens when someone comes into hospital, I think any person who was transferred to PICU for whom the option of seclusion was then, I suppose, an imminent possibility because it's contained within that environment, maybe we should have had more 15:11

information that we shared with families around, well PICU is -- where your relative is transferred to PICU, that is because they can't be managed in the acute admission ward or another ward therefore they need to go to a more secure environment, there is an area in this ward that we will use if we need to to keep your family member further safe.

225 Q. So you would accept that perhaps more could have been done around that?

A. I think that sort of thing would have been helpful, yes. 15:11

226 Q. Now, I wanted to ask you about paragraph 157, that's at page 30. You say:

"In supervision and meetings with the other senior nurses we discussed increasing the registrant nurse to bed ratio in ICU to see if this reduced incidences. The bed to patient ratio was increased in PICU and a Service Improvement Project undertaken in this ward in 2016, to 2017." 15:12

Can you say more about that, what was the Service Improvement Project?

A. I'm trying to remember now. We did increase the registrants in it so that there was a higher balance of registrants on during the day. 15:12

DR. MAXWELL: Should this Sentence read "the registrant to patient ratio was increased"?

A. Registrant to patient -- -

DR. MAXWELL: It said the bed to patient ratio was increased, should it say the registrant to patient ratio was increased?

A. Yes, but I don't think it makes any difference because there was six beds and we catered to the six beds being full all the time. 15:13

CHAIRPERSON: So six beds equal six patients?

A. There usually was six or seven staff on for the six patients from what I recall and I think normally we increased it to four or five registrants, there was four registrants on. 15:13

DR. MAXWELL: You didn't at any point get a one-to-one registered nurse to patient.

A. No, that never got to that point. But the Service Improvement Project was one of those PDSA models of where, plan, do. 15:13

227 Q. MR. DORAN: What does PDSA stand for?

A. Plan, Do, Study and Act. And Dr Humphries, the charge nurse and a couple of Staff Nurses actually were leading on that and done training on PDSA and it was a communication model that they were rolling out around daily, like a daily update on patients, it was like a quick --- 15:13

DR. MAXWELL: Safety huddle.

A. That's it. So they got there and they were doing this and they were promoting it and what they were hoping for was they would alert things around the environment, around the staffing, around the patients, every day at the same time so that they would see whether or not 15:14

this was improving the communication and getting things fixed faster and alerting the right people to the problem. That was attended I think fairly robustly by, there was a junior doctor who attended alongside the consultant and there was a Staff Nurse who was very engaged with it and they were promoting that and I know they did, or were improving the number of incidences within the ward.

CHAIRPERSON: Do you remember when the safety huddles started? 15:14 15:15

A. It was in 2016 I think it started and it ran into 2017.

228 Q. MR. DORAN: So this was just before the CCTV revelation emerged?

A. Yes, I think they were due to present their findings around that time when all the abuse come to light. 15:15

229 Q. So the project was under way at the time when the revelations emerged?

A. Yes.

MR. DORAN: Chair, I am going to move on to a different topic. Shall we take a short break. 15:15

CHAIRPERSON: Are you going to finish this afternoon?

MR. DORAN: Yes, indeed, definitely.

CHAIRPERSON: Okay, we'll take a 10 minute break, thank you very much indeed. 15:15

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you.

230 Q. MR. DORAN: Now, I'm going to ask you about management

and management meetings. You set out a range of the meetings that you attended at paragraphs 43 to 56 of your statement, that's STM-295 page 12. I am not going to delve into each of those but I do want to ask you about the Core Management Group of which you were obviously a part. I think you say at paragraph 43 that meetings were held fortnightly, is that right?

A. Yes. I think there's times when they were more frequent maybe because things were happening but there was always usually one at least a fortnight. 15:30 15:31

231 Q. And one word that the Inquiry has heard on a number of occasions to describe the management of the hospital is dysfunctional. Now I know, if you give me a moment I'm going to refer you to one example of the use of that word from Leadership and Governance Review Report, and I think in fairness this was brought to your attention prior to today's, is that right? 15:31

A. Yes.

232 Q. For the record this appears to MAHI Ennis 1 587 at pages 672-3 but I don't need it to be brought up on screen. This was at paragraphs 7.21 and 7.22 of the report. 7.21 reads: 15:31

"The Review Team found a culture clash at MAH (see para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This 15:32

led to a period of supervised practice with support provided by the co-director of nursing for workforce and education and the leadership centre."

Then paragraph 7.22: 15:32

"Documentary evidence confirmed that the efforts by the Service Manager to highlight the staffing difficulties through the hospital's Risk Register created tension between her and the Service Improvement Governance 15:32
Manager who asked her to downgrade it from a serious to a moderate risk. The Service Manager also provided an SAI to the governance department on the 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to 15:33
meet the criteria (see 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was in the view of the Review Team failure of the Service Improvement 15:33
and Governance Manager to escalate it appropriately."

I want ask, would you accept that working relationships among the Core Management Team were dysfunctional, as the review described them, or I should say as the 15:33
review reported what -- reported that it had been informed of dysfunctional working relationships. So would you accept that description of dysfunctional?

A. I would accept it for a period of the time that I was

there.

233 Q. What period?

A. Certainly between 2012 and 2016 the working relationships within the Core Management Group I felt were productive. We worked quite well together as a team. We all would have brought things to the table and whilst there would have been some disagreements, that those were managed and supported through the discussions. So, working with Mairead Mitchell, John Veitch, myself, the senior social worker and Dr. Milliken, within that group it was a fairly cohesive team. 15:34 15:34

234 Q. How did the change come about then?

A. In 2016 Mr. Veitch retired. Mental Health took over the co-director for both Learning Disability and Mental Health and an Acting Head of Service was appointed who was Mairead Mitchell. That was late that year. In, I think, late December or early January that year she requested a meeting with Brenda Creaney to which Brenda actually invited me to and phoned me and I attended with Brenda and Mairead attended and Mairead was clear with Brenda that she felt as she was a nurse that she didn't need a lead nurse within Learning Disability Service and that she felt that her role was sufficient to take the service forward. 15:34 15:35 15:35

235 Q. Was this just a change of personality on the team leading to a change in the relations between the team members?

A. So at that point Brenda was very clear with her that

these, that the Head of Service or co-director role and Associate Director of Nursing part of the role were two distinct roles and was clear with Mairead that I had her full support. Shortly after the complaint did come in at which I responded to with both Mairead and Moira Mannion. They supported me with that investigation into those concerns. This was also at a time when I had taken on the additional responsibility for the community resources when Mr. Veitch retired, so when the Service Manager role in the community was given up so I had taken on additional responsibilities. So, during that period up to, I handed it over to the other Community Service Manager who took up post in May, she took over the day services and I finally gave her my additional remit in July. And then in July I met with Mr. Worthington and Mairead Mitchell and they suggested that I look at informal capability in relation to some of my approaches with staff and attitude. I agreed that I would go into coaching with the leadership centre and support both through an action plan with Mairead Mitchell and I worked through that. However, during that period I continued to receive probably a lot of negative feedback from Mairead in that, things like, you know, I got an e-mail from her asking me to leave the site and go and base myself somewhere else in the Trust in North Belfast and saying that I would be more part of the collective leadership team down there and I didn't need an office in Muckamore. So there was things that I suppose I felt I was being alienated a

15:36 15:36 15:37 15:37 15:38

little bit within my role.

236 Q. Ms. Rafferty, I am not going to explore in detail intra-personal relationships within the workshop, I am not going do that for the purpose of the Inquiry, but I want to come back to this word dysfunctional. You have accepted that that was an appropriate word to use in the context of management. How did that effect the management of the hospital? 15:38

A. Certainly it was more difficult from a communication point of view because sometimes Mairead would liaise directly with Barry and bypass me so that I would hear about things afterwards and would pick up on certain things that were happening in the hospital but that I hadn't been informed about. So I had to remind her to keep me in the loop in relation to certain things that she wanted achieved within the hospital. 15:38 15:39

237 Q. But trying to move away from whether what one individual was doing was right or wrong, how did this impact on the running of the hospital?

A. Well because we weren't communicating as effectively as we should have been, it made running the hospital difficult. I think our interpersonal skills in relation to both I suppose, I could have become more defensive because I was watching to see well, what have I missed. So I think both my practice I think changed during that time and I think as a team we weren't meeting as often as we should have. We didn't meet, the Core Management Team didn't meet as often as we did before. It went to sort of monthly. So, operationally 15:39 15:39

it felt a bit more disjointed.

238 Q. But of course Muckamore is more than just a hospital, it is a facility for individuals with learning disabilities and presumably you'd accept that those kind of dysfunctional relationships at management level could ultimately be to the detriment of those who are living in the hospital or residing in the hospital? 15:40

A. Yes, and certainly, I mean both, we both recognised that our relationship wasn't as good as it should be and I know Brenda and Marie raised it with us and said look, you two need to communicate better. I certainly accepted that but I think we both found it challenging. 15:40

239 Q. Yes and looking back now, do you think there is more you could have done to improve the situation?

A. I think if we had both maintained some of those core processes that were already in Muckamore, it might have helped because we were meeting more frequently. I think because we didn't meet as often it didn't help the process. Plus we were a new team because we also had other people joining our team who were new to the group and we didn't have, our team hadn't gelled and as a new team coming together, I think it would have been helpful to do team building and a bit of time away just to rebuild those relationships again. 15:41 15:41

240 Q. Critically do you think it did impact on the experience of those within the hospital? 15:42

A. It probably did because I think ultimately staff would have witnessed some of that disjointed thinking and, you know, the lack of communication and someone saying

well I don't know anything about that and I need to go and check it out. So it probably wasn't as cohesive as it had been before. And maybe that is with any new team forming, but certainly it wouldn't have helped. But I'm sure relatives as well as staff on the ground noticed it.

241 Q. I want to talk about concerns about the abuse of patients at the hospital. Obviously that's right at the heart of this Inquiry. You were in a management position essentially, but how often would you have been on the wards? 15:42 15:43

A. You would have been out on the wards every couple of weeks and it would have been a particular ward and would you have been somewhere different the following week. You could have been in day care or visiting over at the swimming pool. Even I was in the maintenance departments talking about, well, what's the delays on things being fixed. 15:43

242 Q. I am thinking of the wards themselves, did you regard it as an important part of your role to be present on the wards? 15:43

A. I felt it important to visit the wards but I wasn't in the wards on what I would say was regularly be in that ward every month because that was the role of the Assistant Service Managers to have an active presence in each of their wards. I certainly did visit them but I would say in my last year that I was there I wasn't on the wards as much as I would have been before that and that very much was down to my added 15:43

responsibilities that I held.

243 Q. When you did visit the wards did you ever pick up on any conduct that caused you concern?

A. I didn't see personally staff being abusive to a patient. That is not something that I personally witnessed. But however, I was aware of incidences that required investigation during my time there. 15:44

244 Q. Now I'll come on to those in a moment but you're saying you didn't witness anything yourself but you became aware of incidents or alleged incidents? 15:44

A. Yes, both through being reported to me and later on viewing the CCTV.

245 Q. We will come on to that in a moment. I am asking again about your visits to the wards, did you ever pick up on any differences in culture or attitude throughout different wards? Were there some of them that you might have regarded as more welcoming environments than others, if I can put it like that? 15:45

A. Well some wards you needed keys to get into because they were locked environments. Some wards you knew the code for the door and you could punch it in and just go on in. You know, any time you walked into the ward, staff would have come over 'well, how are you', when you were talking to people. I would have spent time on the wards on occasion as well as if I was called in and covering shifts, I could have spent a whole night on a ward on a shift. 15:45 15:45

246 Q. But did you pick up on any differences between wards as such?

A. No, staff -- I mean there is a lot of good staff in Muckamore and there is a lot of people who care passionately about the patients. You would have went in and staff would have talked to you about such and such is here today, we are getting on well, this is an issue we have. There was a lot of people who were good practitioners but I didn't come across people who were dismissive of patients or being derogatory or commenting in a way that I felt uncomfortable with.

247 Q. Or behaving in a physically inappropriate way? 15:46

A. I didn't see people physically hurting a patient.

248 Q. The last day we obviously spoke at some length about the Ennis episode and you were then asked to provide details of other occasions on which you became aware of concerns and how management reacted. In paragraphs 158 15:46 to 172 of your statement, you go through a whole series of incidents that you recall occurring at the hospital and presumably that were reported to you over the years?

A. Yes. 15:47

249 Q. I'm not going to take you through those in detail. You then refer at paragraph 171 to the 2017 CCTV revelations, but presumably all of those incidents that you mention prior to para 171 predated 2017, is that right? 15:47

A. Yes.

250 Q. And presumably they are only examples of incidents that you became aware of?

A. I think the reason I recall them is because they ended

up in disciplinary hearings.

251 Q. Yes?

A. And I would have been the one to organise a disciplinary Panel, so you would have received the report and you would have liaised with HR to say right, we need a Panel on this and I would have worked closely with HR in relation to establishing that and the Terms of Reference for that or Terms of Reference for any of these investigations. 15:48

252 Q. So in your statement you are specifically referencing those incidents or allegations that led to a further disciplinary process, is that right? 15:48

A. Yes, we would have had others.

253 Q. Yes?

A. That investigations would have come back and said there is no evidence to support this allegation. 15:48

254 Q. Yes?

A. So there was, you know, there wasn't action that we could take at that point.

255 Q. Obviously we've focused on Ennis, you have recorded a number of other occasions on which you were aware of allegations against staff resulting in disciplinary proceedings and then as you've just mentioned there were other occasions on which the allegations didn't come to anything ultimately or weren't investigated further for one reason or another? 15:49 15:49

A. Yes.

256 Q. Now, that's a fairly significant body of information about inappropriate behaviour, alleged inappropriate

behaviour of staff towards patients within the hospital. I am wondering, given those incidents, do you ever have concerns that they weren't simply isolated incidents but actually evidence of a wider culture within the hospital? 15:49

A. I discussed, when we had these incidents they would have been discussed at various levels both within our own team at the hospital but with my co-director, but also at nurses in difficulty and with the senior nursing team. Certainly in those, you know, I would 15:50 have said look, what else should I be doing and I felt the actions I was taking were appropriate at the time and I wasn't given further advice as in, well, do I need to do something else at this point.

257 Q. You weren't giving or you weren't given? 15:50

A. Well I wasn't given but I also felt we were addressing the issues that were brought up that feedback from families would have been that the care that the relative received in Muckamore was overwhelmingly positive. Yes, we would have had some complaints from 15:50 relatives and certainly those were explored and where they were upheld, you know, we would have looked at how we would have improved things in those circumstances. And I think the other thing that, I suppose, different from Ennis, was that these were staff themselves coming 15:51 forward and saying I have witnessed another colleague here who is mistreating a patient, and that in itself gives you some reassurance that people are aware, No.1 of safeguarding and No.2, that they are not overlooking

it and ignoring it and failure to report.

258 Q. But did the Core Management Group never think of suggesting some wider review of practice within the hospital, given the number of incidents that were being reported and of which the Core Management Group became aware? 15:51

A. No, I don't think we discussed a broader review of culture or, I don't recall that being discussed.

259 Q. Do you think that might have been a missed opportunity looking back? 15:52

A. I think part of our reasoning around implementation of CCTV was very much around safeguarding because the feedback that we had got from staff very much was lots of people are making accusations, but actually we are delivering good care here and we would like a tool that would support us and exonerate us from harm or from having done harm. So staff very much, I think, viewed the CCTV in the initial discussion as in this would be useful for us. So it was almost like we want to prove to you that we're treating patients well. 15:52 15:53

260 Q. Were you in favour then of the installation of CCTV?

A. Yes.

261 Q. What role did you play in the implementation plans?

A. When it was discussed I think it was the senior social worker who initially raised it and I know Mr. Mills discussed it on occasion and then a business plan was developed with Mr. Ingram. I was supportive of it because I felt this would, you know, provide an assurance to relatives that their family member was 15:53

treated well, but it would also give us a quick and easy way to rule stuff in and rule stuff out because when someone, there is an accusation of abuse against a patient, in a lot of those instances that staff member is placed on precautionary suspension until it's fully investigated and that can take either a few days but it can equally take a couple of months. So some of those processes I felt could be expedited by the use of CCTV and that that would actually help us in relation to some of our staffing concerns about having to remove someone on a precautionary basis from the site. So, there was pluses to helping it manage some of our staffing concerns, but also protect patients and alleviate some staff concerns in relation to accusations. 15:54

262 Q. Let's move on to what actually happened then in 2017 when the CCTV revelations came to light, and you gave a brief description of how you became aware at paragraph 171 to 173 of the statement. I wonder do you want to just tell the Panel in your own words how the information came to you and what the response was? 15:55

A. The charge nurse of PICU came over, we were in the middle of a Monday briefing with the Assistant Service Managers, I would have met with them for an hour on a Monday afternoon. He was coming on a late shift, he came over and told us that an incident had occurred, I think it was nine or 10 days previously and he was back off leave that day. He had just been informed about it, he came straight over to tell us and at that point 15:55

we instigated the adult safeguarding procedures, completed the forms. The member of staff was invited to a meeting with his staff side rep and was placed on precautionary suspension. The police were notified through the Senior Social Worker For Safeguarding who 15:56
was there, and it isn't the one that the cipher is for, it was the newly appointed one. So the police were notified. They advised not to interview people at this point, that they would conduct the interviews. The senior went back and said to them about contacting one 15:56
of the staff who was on annual leave and could we get some clarity from him when he returned and we did that. Basically he said he witnessed an incident on the day, he reported it to the nurse in charge. The nurse in charge did not complete the normal processes on that 15:56
event and sent an e-mail to the Deputy Ward Manager who picked it up the following Wednesday and he waited until the Ward Manager returned on the Monday. It all was processed once the Ward Manager informed us about it. 15:57

CCTV I think was the following day, Mr. Mills and Mr. Ingram came into my office and said 'we think we might have this on CCTV' and I asked 'well how can that be because it's not running?' And he says 'we run it a 15:57
day a month to check the maintenance contract'. And I said 'well when did that start?' And he says 'well I think it's on that date that we run it'. And he says 'but can you check with legal services are we allowed

to access it because the system isn't up and operational yet'. So I contacted DLS. DLS I think came back a week later and told us that because it's communal areas and areas that are covered by CCTV, that there is an expectation that people can be viewed in that area so go ahead and access it. So Brendan Ingram got training on how to do that. He came back on 20th September. I was driving home and he phoned me and he said 'you need to see this' I said 'right, what's up?'. He says 'I viewed the CCTV'. I said 'I am in the office first thing in the morning, are you there?' And he said yes. So me and him went and viewed it on 21st in the morning. 15:58 15:58

263 Q. So you would have been one of the first to view the early CCTV footage as it emerged? 15:58

A. Yes.

264 Q. But is it fair to say that you were really only involved in the very early viewing and not in the subsequent focused viewing by the Trust?

A. I viewed it for probably four or five months. 15:58

265 Q. So you were involved for quite a while?

A. I was involved for viewing. They asked us to look initially at 25% of what we thought was six weeks of CCTV footage because that's what we thought we had and that was when Brendan told us that it was available from the 12th August up until we were having this discussion at the mid of October because there was meetings around what we had viewed on CCTV so we thought we had about six weeks of footage. So I was 15:59

asked, with the divisional social worker, to agree a schedule of viewing of that. And because there was only a number of people identified in the policy to view it, so what we did was one of us who was designated viewed it with another person who was to assist us, so there was a named person from the policy on that initial viewing. I viewed a number of days and you had to fill in a report and come out and if there was anything you seen on that, you had to action it. 15:59

266 Q. Now the Inquiry has heard quite a lot of evidence about the viewing of CCTV and the process involved, I am not going to go into further detail on that with you. I just want to ask you this: What was your reaction when you first saw the footage? 16:00

A. I think very much a gut reaction of disbelief and just shaking my head going 'oh, my God'. I'm so sorry. 16:00

267 Q. Take a moment. I watched it and I just literally came out and went to Brendan 'I am away to tell everybody'. And that's what I did. I think to tell you the truth every time I watched it I just got more distressed and having to go in and do it on a regular basis, it actually just messed with my head. 16:01

CHAIRPERSON: Okay, stop there. Have a drink of water. You probably don't need to go any further, Mr. Doran, or do you? 16:01

MR. DORAN: Another couple of questions I'd like to ask.

CHAIRPERSON: Okay. Just give the witness a moment. Would you like a break or do you want to carry on?

A. If you don't mind.

CHAIRPERSON: No, certainly, we'll just take five minutes, okay.

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS: 16:02

CHAIRPERSON: Thank you.

268 Q. MR. DORAN: It's been a very long evidence session, Ms. Rafferty, I can assure you I am not going to be too much longer. A couple of questions actually you might 16:09 be able to assist with. You referred to the seeking of legal advice?

A. Mhm-mhm.

269 Q. In advance of the footage being viewed, can you answer why was legal advice needed at that point, was it not 16:09 permitted to view the footage within the policy?

A. It wasn't operational and we had an operational date of the 11th September because we had to do, as we had agreed with the staff side organisations once the policy was signed off that we would go out and inform 16:10 all the staff of what was being viewed, when it was going live, the build up to it, any further questions they had, just that everybody was fully aware.

270 Q. So it was the fact that the footage wasn't operational that caused the need to go and seek legal advice as to 16:10 whether it could be viewed?

A. Yes, that was advice from Brendan Ingram to myself.

DR. MAXWELL: Can I clarify, you just said it was because you had an agreement with staff side

representing the staff?

A. Yes, that we would do like a briefing with staff before we had an operational date once the policy was signed off.

DR. MAXWELL: So you felt that because you had an agreement with staff side you wanted to check it was still permissible do this? 16:10

A. Yes.

CHAIRPERSON: Also I think we heard the unions were involved in the -- 16:11

A. In the development of the policy, they were involved in it. They also wanted to attend the staff briefings with us to say we are on board with this.

CHAIRPERSON: Yes, quite.

A. So that staff were not saying when did this happen, we know nothing about it. 16:11

DR. MAXWELL: And staff side is the unions isn't.

A. Yes and we had four different unions that worked with us on it.

271 Q. MR. DORAN: I have another question about the Way to Go Report, the exercise undertaken by Margaret Flynn? 16:11

A. Oh, yes.

272 Q. It is a question about the preparation for that exercise because we know that certain materials were provided to Margaret Flynn for the purpose of carrying out her review and producing her report, were you involved in any way in the selection of materials to be provided to her? 16:11

A. No we got a request for materials and we produced them,

but I did have an interview with Margaret alongside my Senior Nurse Managers and Assistant Service Managers, we were all in the room together talking to Margaret for about an hour. Early on in the discussion, I think it was not with Margaret but with the whole team, and I know I requested further input with Margaret. But in liaising with the secretary and Brendan who were organising it, Margaret came over once a month and all of the sessions was booked up very quickly with the people Margaret and the team wanted to talk to. I had a session with her I think early July because I wanted to talk to her about my experiences in Muckamore, what I found when I arrived and sort of the processes we went through around some of the improvements we have done on-site. That opportunity was cancelled and I requested another, but Margaret's draft report came out about two weeks later, so it was a missed opportunity on my behalf. 16:12 16:12 16:12

273 Q. It was just the Inquiry has heard that there were 69 patients safeguarding files provided to Margaret Flynn, the question is on what basis they were selected. Had you any involvement in that exercise? 16:13

A. No, we had, we introduced a stand alone Safeguarding Officer after the Ennis Investigation, there were two and then it went down to one. He had lots of files that were there from that period. He also done a lot of work around training staff on how to safeguard and process so I know a lot of those files were done as well as some of the Senior Social Worker's safeguarding 16:13

files and the new senior. So I assume they just randomly selected a number of those.

274 Q. But you didn't...

A. No.

275 Q. ...select them, you weren't involved in that exercise yourself? 16:14

A. No.

276 Q. Just coming towards the end of your evidence and we've talked about the CCTV footage emerging. I'm sure you have reflected on this, but do you have any thoughts on how inappropriate treatment of patients could seemingly have been happening in the hospital without being detected? 16:14

A. If some of the incidences that I viewed had been in areas that were isolated you could understand how some of that was hidden. Unfortunately what I was viewing on CCTV was instances of people abusing or staff abusing patients in full view of registrants and non-registrants and the disregard that I witnessed was unbelievable because it seemed to be in the open. But yet when people walked through the ward, including myself, there was no obvious actions that were taken in front of us that would lead you to believe that someone was being hurt. And I think that's what shocked me more was how open it was and that some of the behaviours, even of staff going into a patient's room of just kicking the door open or something was just -- 16:14 16:15 16:15

277 Q. I should say, Ms. Rafferty, I am not asking you to describe what you saw, what I'm asking you to do is to

reflect on how this kind of thing could have been happening without being detected within the hospital. Do you think, looking back, were there any warning signs that the Core Management Group missed?

A. I think, I mean, I have questioned myself about this on a number of occasions just saying well, how did we all miss it. But equally I thought to myself, is there something about well this is a major training hospital and people are coming here to be trained and are they witnessing stuff that they think is acceptable and then they think it's acceptable. I mean all of those thoughts have went through my head. And equally I have thought, well, how do you get to a point where you walk past that. Is it that some people have more power than others? And is there a level of power in the hospital that sits with a small amount of people who can bully others? You know, all of those thoughts have went through my head in relation to this and I really haven't come up with a definitive answer. I think very much Muckamore was a very closed environment. I do think a lot of the people, and this is with hindsight looking back at some of the incidents that were reported over the years, were done by either bank or a lot of new staff and maybe the open recruitment and bringing those new people in allowed for some of that to come to the fore. And as you said earlier, maybe we should have explored the culture more at an earlier stage. But there was no obvious signs, walking into a ward, that patients were being mistreated there and

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

then. But it was really odd when you looked at it, how open it was.

278 Q. Now, Ms. Rafferty, you've been through two lengthy evidence sessions. You gave evidence in June of course and you've been giving evidence all day today, I have completed my questions. The Panel may have a few more things to ask you, but before I hand over to them I just wanted to give you the opportunity of adding any further observations that you would like to add at the end of your evidence. 16:18

A. I stood aside from my role in Muckamore in August 2018 and I felt at that time that it was the right thing to do, but I was asked to do so but I did think it was the right thing do. But I did highlight to the directors at that time that I felt that some of our team were not being as open and transparent with the level of abuse that was being uncovered. And to that end I did produce some evidence to the Trust and I asked them to explore that further. And certainly I am aware, because of my representation to the Trust, that the Trust had to go back on a number of occasions to continue to ask for it to be viewed because they were misinformed that it was complete. But, very much so that when I felt I was telling the directors, especially late or mid-2018, that there was a lot more going on and coming forward, it was not being shared as well as it could have been. 16:18 16:19 16:19 16:20

CHAIRPERSON: Sorry, how do you mean it wasn't being shared among who?

A. A lot of viewing was going on and safeguarding was not being done in a timely manner as in some of the viewing was taking place and it was months before it was shared with the team and with the directors so that action plan --

CHAIRPERSON: Even though it revealed incidences that should have been reported?

A. Yes.

CHAIRPERSON: Do you know why that was?

A. They were in a process of trying to collate it into bundles and a bundle would come forward but it could have been from a few months of viewing. But equally my concern was that those people were continuing to work in that environment with the patients, that some people were aware of that information. And I continued to share that after I stood down. And that was to ensure that -- because in my role in the collective leadership team I felt that the director should be notified of the information in a very timely manner. My own team was holding me to account and telling me that I was oversharing and that I shouldn't tell the directors as much and that their view was that I should be escorted to all my meetings.

CHAIRPERSON: Escorted, what?

A. By one of the collective leadership team because I was oversharing and telling them what the CCTV was viewing in a more timely manner. And when I shared directly one of the reports, that was when the two directors actually called HR and all in to that huge meeting of

where we planned what we were doing with X, Y and Z because I felt that they were being briefed but they weren't getting the detail and I made a point of making that happen.

CHAIRPERSON: You also said that directors were being told that the viewing was complete when it wasn't? Can you just expand on that? 16:22

A. The Acting Head of Service had confirmed to the directors that the viewing was complete at 100% and it wasn't. There was, I mean I am sure it's still being viewed, there is that many thousands of hours. But we were going to the director oversight meetings, you know, and they said at the meeting, 'well I'm aware' and giving an example of Six Mile is complete, it's all done, all of its viewed. I had seen some views of that where a section been viewed and I did go back and check out with the viewing team coordinator, who was Mr. Ingram at the time, and said 'is this not all viewed?' And he said 'oh, we're getting round to it' so I knew it hadn't been done. I escalated that to the directors and told them that I believed that they were misinformed. 16:23 16:23 16:24

CHAIRPERSON: And which directors are you talking about?

A. I spoke directly to Marie Heaney and informed them that they had been misinformed and that things -- I stood down from my post. I later met both Brenda Creaney and Marie Heaney a couple of months later and I told them it still hadn't been completed yet they were still 16:24

being told it was 100% completed on those wards.

CHAIRPERSON: So in your view they were being misled?

A. That was my perception, yes.

CHAIRPERSON: Anything else.

279 Q. MR. DORAN: Aside from those matters, have you any more general comments that you want to make to the Inquiry before your evidence completes? 16:24

A. No.

CHAIRPERSON: Right, okay.

MR. DORAN: Thank you, Ms. Rafferty. 16:25

CHAIRPERSON: Ms. Rafferty, we've asked quite a lot of questions as we've gone along. This is the second time you've come here. I can tell you it is the last time you will have to come here. So can I thank you very much indeed for your evidence this afternoon and you can go with Jaclyn, thank you. 9.30 please tomorrow morning. 16:25

MR. DORAN: Yes Chair, Mr. Worthington.

CHAIRPERSON: Okay, thank you very much.

16:25

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 15 OCTOBER 2024 AT 9.30 AM.