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MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 9TH OCTOBER 2024 - DAY 113

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

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THE INQUIRY RESUMED AT 10:30 A.M. ON WEDNESDAY, 9TH OCTOBER 2024, AS FOLLOWS:

CHAIRPERSON: Morning. Thank you.

MS. BERGIN: Good morning, Chair, Panel. This morning's witness is Paul McBrearty, and he's been asked to give evidence in respect of Organisational Module 5. The purpose of this module is to examine the mechanics and effectiveness of RQIA and Mental Health Commission inspections. 10:31 10:32

Panel, you will recall that this module was first opened to the Inquiry on 19th of June. The Inquiry heard from RQIA witness Lynn Long on that date, and I indicated that the Inquiry was making efforts to trace former members of the Mental Health Commission. 10:32

The Inquiry has now received statements from two former Mental Health Commission staff; Mr. McKenna, who was chair of the Commission between 2007 and 2009, and then this morning's witness Mr. McBrearty, who was the former Interim Chief Executive of the Commission during the same time period, 2007 to 2009. 10:32

Now, Mr. McKenna has provided a statement to the Inquiry dated 23rd of September 2024, and that statement reference is STM-325. A copy of his statement has been shared with Core Participants and will be uploaded to the Inquiry's website shortly. 10:32

In summary, Mr. McKenna was a member of the Mental Health Commission from 2004 to 2007 as a commissioner, and then as Chair of the Commission from 2007 to 2009 until the Commission's functions were transferred to the RQIA. So, Mr. McKenna was the last chair of the Commission. He was in this role, as I've said, at the same time that this morning's witness was the Chief Executive. 10:33

Mr. McKenna describes in his statement visiting Muckamore on one occasion. He's unsure of the date, but he describes visiting a room of 15 young men, and he describes the atmosphere in the room as being filled with tension, and he was saddened by the experience of what he saw during this visit. He remarked that the patients didn't seem to have a lot of therapy, and were standing in the room. His observation was that there was a lot of tension and an oppressive atmosphere, with people looking angry; that there was no furniture or television in the rooms, which were big and bare; there was no talking or laughing; staff were not very talkative. He said it was the most intimidating atmosphere he had ever encountered in a hospital, and he said that he would have said this to his colleagues visiting with him, and that they didn't disagree. 10:33 10:34 10:34

Unless there is anything further, Chair, Mr. McBrearty is ready to be called.

CHAIRPERSON: No. So as is common now with these statements, it is not intended to read Mr. McKenna's statement into the record because, as you say, all the CPs have it, and it is also going to be posted on the website. 10:34

MS. BERGIN: Yes, Chair.

CHAIRPERSON: I think there was one alteration that needed to be made to it.

MS. BERGIN: That's correct.

CHAIRPERSON: All right. It's also right to say that he also gave evidence to the Committee for Health and Social Services but, of course, so did Mr. McBrearty, and we will be hearing from him about that. 10:34

MS. BERGIN: Yes.

CHAIRPERSON: All right. Thank you. 10:35

PAUL McBREARTY, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: Mr. McBrearty, thank you very much for coming along to assist the Inquiry. Thank you for your statement, which obviously goes back to events now some time ago, but you have the advantage also, I think, of having seen the transcript of the Select Committee which you appeared before? 10:35 10:36

A. Yes.

CHAIRPERSON: And you may be asked some questions about that. I don't think you will be very long as a witness but if you are going for longer than an hour, we will

probably take a break, unless you want one sooner.

A. Thank you.

CHAIRPERSON: All right. Thank you.

1 Q. MS. BERGIN: Thank you, Chair. 10:36

Good morning, Mr. McBrearty, we met earlier. As I've explained to you, my name is Rachel Bergin; I'm one of the counsel members from the Inquiry team and I'll be dealing with your evidence this morning. 10:36

You should have a copy of your statement in front of you and it's dated 12th September 2024. You have exhibited some documents to your statement. You have signed the declaration of truth at the end of your statement. So, the first question for you this morning 10:36 is are you content to adopt your statement as your evidence to the Inquiry?

A. I am.

2 Q. As we go through your statement, in addition to the hard copy in front of you, you'll also be able to 10:36 follow along on the screen.

Now, you've been asked to provide evidence to the Inquiry in your capacity as the former Interim Chief Executive of the Mental Health Commission, and you held 10:37 that role from mid September 2007 until 31st March 2009; is that correct?

A. That's correct.

3 Q. So, you were the last chief executive of the Commission

before the transfer of functions?

A. Yes.

4 Q. In terms of your professional background, you have a Masters in Business Administration?

A. I do. 10:37

5 Q. Now if we turn to your statement at paragraph 5. You were asked a number of questions by the Inquiry, and the first is to provide a synopsis of your role at the Commission and your dates of your appointment, which we've already dealt with. The functions of the 10:37 Commission, as I've just referred to, were transferred to the RQIA, and that was on 1st of April 2009?

A. That's correct.

6 Q. At paragraph 5 you say that you were seconded from the South Eastern Health Trust as the Interim Chief 10:38 Executive of the Commission, and your role was to maintain the functions of the Commission and to work closely with RQIA and DHSSPS to ensure a timely and effective transfer of statutory responsibility from the Commission to RQIA. 10:38

Can you tell us a little bit more about that role in terms of being Chief Executive as opposed to, for example, the role of Mr. McKenna, who was Chair?

A. Yes. The role was specifically to ensure that the 10:38 Mental Health Commission, which was due to transfer across, was able to continue to provide its statutory function across a wide range of areas that are in the legislation, but also to liaise specifically with RQIA

to ensure that they were able to take on the function and deal with it from 1st of April 2009.

When I went to the Commission, I was faced with a number of things that required immediate attention, the 10:39
first one being that the previous chief executive had left, other staff, experienced staff, had left the organisation. They are civil servants, they had their own particular way of gaining other posts within the Civil Service. I came from the health service which 10:39
had a slightly different culture than that of the Civil Service, and I was faced with a situation of how do I maintain the work required within the Commission with a dwindling group of staff and staff who were inexperienced. So, that was one significant part of 10:39
what I was looking at.

The second thing was how does the Commission continue to exist, because its building, the building that it was in, the lease was expiring and there had not been 10:40
any arrangement made to find somewhere else for the building. So, I had to focus in and around how we would actually get somewhere else to live basically. In conjunction with the Department of Health, we subsequently managed to move away from Elizabeth House, 10:40
which housed the Commission, to new offices at Lombard Street; Lombard House. That in itself was a challenge for the Commission, because if you think yourself of it, how do you move house, how do you move an office,

how do you continue to provide a service when you're moving all of this across? So we had to work through the processes associated with that while, at the same time, making sure that the programme of work that the Commission had was met. 10:40

The other significant thing, quite apart from visits, was the fact that you had the issue of detentions. One function - and a primary function - of the Commission was to ensure that a detention was legal. That meant 10:41 that documents would come on a daily basis to the Commission which had to be scrutinised, ensure that it met the requirements of the legislation and, if it didn't, had to be flagged up. We needed to ensure that that was carried out, otherwise people could have been 10:41 detained illegally and that would not have been a good thing to happen. So, these were the primary issues in terms of that.

Alongside that, as I say, I had to make sure that we 10:41 had good relationships with RQIA to be satisfied that they were able to take on the transfer of the functions and run with it from day one.

7 Q. In terms of you starting in that post, I've two questions around your time there. Did you have any 10:42 background in learning disability or mental health at all when you began?

A. I had a background in the sense that I spent 35 years within the health service, and during that time I

worked within, as a manager, as an administrator, not as a clinician in any shape or form, within mental health facilities as well as acute hospitals and learning disability centres.

8 Q. Did you ever, during your time with the Commission, have cause to visit Muckamore? 10:42

A. No.

9 Q. What about your previous time, your previous career?

A. Many years previous to this I worked within North and West Belfast, and I would have visited Muckamore on one or two occasions but it was literally to go to meetings rather than doing any visits. 10:42

10 Q. Apologies.

A. Okay. That's it.

11 Q. Thank you. We are going to continue to move through your statement but for now, if we could just go to page 16, that's exhibit 2. This is the Hansard report that the Chair has already referred to. 10:43

A. Okay.

12 Q. So this is from a committee for Health and Social Service and Public Safety meeting that you attended as a witness to give evidence on 3rd July 2008 -- 10:43

A. Yes.

13 Q. -- in your capacity as Chief Executive, and Mr. Noel McKenna attended in his capacity as Chair? 10:43

A. He did.

14 Q. The context for this evidence, as you've already referred to, was that on 23rd June 2008 the Minister had announced an intention to transfer the Commission's

functions to RQIA, and you were providing evidence to the committee about this. It appears -- and this document doesn't have paragraph numbers but throughout the document, if I can summarise it in this way, the Commission had concerns about this transfer and weren't in favour of the transfer. Would that be fair to say?

A. That's correct.

15 Q. If we look at the first paragraph then on page 17, just to contextualise the work of the Commission, here your evidence to the Committee was that the Commission is an independent non-departmental public body with a budget in the region of £600,000, comprising a chair and 16 sessional commissioners. Presumably in addition to that, there were also the staff that you have just referred to? 10:44

A. Yes.

16 Q. And yourself as Chief Executive?

A. Yes.

17 Q. In the second paragraph then, you describe the role of commissioners, and we'll come to that in some more detail in a moment. You say the Commission formed multidisciplinary teams who visit individuals in hospital to check on services provided and to meet and talk with them and their relatives about their experiences. You go on then in the next paragraph to say that this is a very important starting point because the Commission focuses on the individual rather than general, and it focuses on how the service has been delivered to specific individuals.

So, in terms of the focus on the individual rather than general services, is the point that you were trying to get across there that this was in contrast to the focus in RQIA? 10:45

A. No, I wouldn't say that. The concern that the Commission members had was that the RQIA was a large organisation with a wider range of responsibilities, and that the role or the function of the Mental Health Commission could be subsumed within that and may not be given the sole focus that the Commission gave as an independent standalone organisation. 10:45

18 Q. We're going to come to some of those concerns in just a moment. If we continue to move through the document as best we can. 10:46

A. Okay.

19 Q. You then go on to say that within the statutory requirements, the Commission can bring to the department, to Trusts or to any body, any important issues that have arisen during visits. You raise an issue there of under 18s being admitted to adult wards. Then you continue in your evidence to say that if the Commission feels it is necessary, it can refer particular cases to the Mental Health Review Tribunal, for example in relation to detention or guardianship? 10:46

A. Yes.

20 Q. You say very specifically, the Commission has the power to gain access to any facilities if required and can medically examine patients and also examine documents

and medical notes.

In the fifth paragraph then, you indicate that the Commission appoints doctors who, at the end of the Mental Health (Northern Ireland) Order 1986 assessment process, can detain individuals; and you also have the ability to appoint doctors to provide second opinions.

In the following paragraph then, you refer to the Commission reviewing legal documentation in relation to detention, which was a very important function, to ensure that the legislation has been applied properly or appropriately.

At paragraph 7 then, you refer to the fact that if an individual has been detained for more than three months, the Commission was required to see the drug treatment plan - and we'll come to that - for that individual.

In terms of the reviewing of legal documents and reviewing of the drug treatment plans, there is some focus there on the Mental Health Order?

A. Yes.

21 Q. Did that also apply to learning disability patients?

A. Anyone who was detained under the legislation would have had to have had the documentation provided. There may well have been individuals who had mental health problems under learning disability who had to be

detained and therefore the legislation would apply in that way. Simply because somebody has a learning disability doesn't necessarily mean to say that they would be detained under the Order, as I understand it.

22 Q. In terms of the work of the Commission with patients with a learning disability who may not have been detained, how did the Commission engage with them? 10:48

A. There could be issues of guardianship could arise in such matters, and they would still fall within the remit of the Commission and the requirement to check on their condition, their situation, the way in which they were living and so forth. 10:48

23 Q. If we then go to the top of page 18 and scroll down, please. Here you outline broadly some of the concerns that the Commission had in relation to the transfer, and you've already referred to that in your evidence this morning. Some of the recommendations to address some of those concerns are then outlined in the rest of that page? 10:49

A. Yes. 10:49

24 Q. Those include, for example, that the Commission's budget should be given to RQIA but ring-fenced or protected for a period of time to enable functions to be embedded. That there should be someone senior within RQIA who had specific Mental Health Order knowledge or experience. 10:49

If we go to the following page then on page 19, you raised as a concern a lack of lay and professional

involvement in the RQIA format, as it was then, that it wasn't a significant as it was in the Commission. So there appears to have been some concern, if I can put it in this way, that some of the focus on mental health may have been lost, or there was a risk of dilution with functions moving from the Commission to RQIA. Could you tell us a little bit more about the concerns? I know you have already touched upon it.

A. I think the specific concern in relation to the number of lay members is that lay members brought a different perspective to the Mental Health Commission. These were individuals who either had experienced mental health problems in the past, or the facilities, or indeed had family members who were experiencing, who had learning disability problems or mental health problems. They could influence, I suppose is the best way to put it, or inform the Commission in respect of any findings they would have in the facilities that it went to see, and indeed in the way in which it carried out its visits.

25 Q. Do you consider that the concerns that the Commission raised were listened to and were acted upon?

A. I cannot say specifically because I did -- the moment I left the Mental Health Commission, I was a retired individual and I couldn't, I had no access to RQIA. Certainly I had the impression that RQIA had taken very seriously the issues that the Commission had raised, but they themselves had to consider how they, as an organisation, would deliver that function.

I'm not aware of -- I knew -- I'm aware of Board members within RQIA, and I was aware that some discussion had taken place - had taken place - about the potential to extend the number of lay members within RQIA on the Board to cover the like of mental health and learning disability. I do not know whether that happened. 10:51

26 Q. Before we move on from this report for now, if we could scroll just up to the last paragraph on page 18, please. Here you refer, just at the middle of the paragraph, to some of the functions of the Commission, including scrutinising documents and visiting patients. You specifically say: 10:52

"This included examining serious incidents including suicide, self-harm, violent incidents and abuse from staff, which sadly sometimes happens, or abuse from another patient." 10:52

Can you recall at all in what circumstances the reference there to abuse to staff had come to the attention of the Commission?

A. No, I cannot.

27 Q. If we move then to page 2 please, question 2. The next question, Mr. McBrearty, you were asked was to explain the system of inspection carried out by the Commission from 1999 until April 2009. I appreciate you were only in post for a limited period at the end. You answer 10:52

this question from paragraph 6. In respect specifically of the Commission developing lines of inquiry, you say that during your time at the commission, "Inspections followed a pre-existing inspection format." 10:53

At paragraph 7, you say:

"Correspondence was sent to Muckamore informing them of the date of the visit, and a notice was posted throughout the hospital to notify patients and relatives that they could meet with commissioners." 10:53

At paragraph 8 then, you refer to the Commission expressing concern to the minister about 18 year olds being admitted to adult wards in mental health facilities, and there being a lack of acute psychiatric admission beds, and that's we've just referred as something that you raised in the Hansard note? 10:53

A. That's correct, yes. 10:54

28 Q. In terms of the concern about the lack of acute mental health beds, can you recall if that's something that applied to Muckamore in particular?

A. I can't say it applied to Muckamore in particular; I think it was a regional issue that had caused concern for Commissioners. I have to say at this point in time, we went to see the Health Committee at an early stage of my time within the Commission, and I was asked to specifically do the presentation. So, I would not 10:54

necessarily have had all of the detail behind the thinking in terms of the presentation but I was certainly asked by those who -- because there was other commissioners with us at that presentation who had input into the presentation that was made to the Health Committee at that stage, and in some ways I was just simply highlighting a number of issues that they themselves had expressed concern about.

29 Q. Further down at question 2, you were then asked about the effectiveness of the Commission in following up on recommendations and then in responding to patient concerns identified at inspections. Now, we're going to come on to some of the forms that you have provided, the exhibits, in just a moment, but I am just going to refer to them briefly now before we go to them. 10:55

At exhibit 4, you provide a report from an announced visit to Muckamore on 5th February 2008. Exhibit 5, you provide a post-visit evaluation form. You've referred to those documents in the context of those being tools -- 10:56

A. Yes.

30 Q. -- for following up on visits. You also then refer to, and exhibit, an unannounced inspection report from December 2008, and we will come to it. That contains recommendations. You say that this type of report would be issued to Muckamore senior managers for follow-up? 10:56

A. Yes, that's correct.

31 Q. And all visit reports would be tabled for consideration by the Commission Untoward and Complaints Committee, which you say was made up of commissioners who met once per month to review any correspondence received and to make decisions about scheduled visits. 10:56

If we pause there, could you tell us a bit more about the Untoward and Complaints Committee?

A. The UTEC Committee met monthly, and it met specifically to ensure that issues that had been raised were being responded to. When I arrived, I looked at the UTEC committee format and was satisfied that it was meeting, but what I wasn't satisfied about was the length of time sometimes responses were coming back from hospitals and facilities. 10:56 10:57

Because of my time within the health service, I undertook to review every single piece of correspondence that was going to a UTEC committee meeting, and if we had not received a response from our last communication to the Trust or the hospital management committee or whatever, because I knew a number of the people who would have been there, I would make direct contact with them. I would have had a friendly conversation with them to say that the Commission were about to discuss this particular item, we had asked for a response, we didn't appear to have received that response yet and if it was not with us by the time the UTEC meeting took place, there would be a 10:57 10:58

correspondence with the Chief Executive of the Trust expressing dissatisfaction. So, the point behind that was we were making sure that we would quickly double-check on the issues that had been raised, and seek answers to the issues that the commissioners had raised.

32 Q. We're going to come to some examples in the documents in a moment and I am going to ask you about escalation, if there were issues, but just to understand the governance within the Commission. We know already from your evidence that there were members of staff office-based; there were then commissioners, and we'll come to their role. There was the Chief Executive and the Chair. We know, you've just discussed, the Untoward and Complaints Committee, and we'll also come to the Visiting Committee. 10:58 10:58 10:59

A. Yes.

33 Q. Could you explain the governance structure within the Commission? Were there any other committees that sat?

A. Oh, yes. We had a Finance Committee, for example. We had a Visiting Committee who would determine the rota for the visits. The UTEC Committee itself, which was particularly for untoward incidents and complaints. I also would have met with -- I'm trying to think now, my head is spinning here at the moment. 10:59 10:59

The committees were made up of the commissioners and the Chief Executive and the Chairman. The administrative staff were only there to take minutes in

that respect. There was also a meeting of the Board on a quarterly -- of the whole Commission, on a quarterly basis. At that meeting, reports from each of the subgroups would have been issued to them for discussion.

34 Q. If we then move to page 4, question 3. You were asked if the Commission carried out inspections focused on individual patients or individuals wards, or whether it inspected Muckamore as a whole. At paragraph 12 you say that during your time at Muckamore, there were two inspections -- apologies, during your time at the Commission there were two inspections of Muckamore which took place, and those were an announced visit on 5th February 2008 and an unannounced visit on 17th December 2008? 11:00 11:01

A. Yes.

35 Q. Now, if we look first of all to the February 2008 inspection. If we could go to page 12, please, exhibit 1. Here you've provided a pro forma for announced visits. This document outlines a range of issues that the commissioners had planned to examine? 11:01

A. Yes.

36 Q. They are listed, as we go through the document, as admission, transfers, discharge, serious incidents and complaints and special observation procedures. It is also notable that within that document, there is reference to there being a significant number of patients and relatives who wanted to speak with the commissioners? 11:01

A. Yes.

37 Q. Those issues that I've just listed, were they repeat or standing issues that would be looked at at every inspection or visit as a baseline?

A. Yes, that would be correct. 11:01

38 Q. Then presumably if there were other issues in particular that were drawn to the Commission's attention, would they also form part of that inspection or would there be separate issue inspections?

A. If there was a planned visit within a short period of time, it is quite possible that they would be added in as part of the pro forma to look at. If there were issues that were considered to be serious, or the visit had just been recent and it was going to be some time before the next visit took place, then you could get a situation where the UTEC committee would say to the Visiting Committee, well, we think we need an unannounced visit here, and they would go and do that. 11:02 11:02

39 Q. The second line down on the screen in front of you, you can see the team leader is stated as being Molly Kane. The Inquiry has received evidence from another witness, Patricia Cullen, which names Molly Kane as a nurse consultant with the Public Health Agency. 11:02

A. Yes.

40 Q. Do you know the reference here to Molly Kane here being a team leader, was that in her capacity with the PHA or is that in an entirely separate capacity as a commissioner? 11:03

A. Oh, that's as a commissioner.

41 Q. I have referred you previously to your statement to the Select Committee as the Commission being non-departmental and independent. Would it be correct to say then that any of the commissioners who would ever be involved in inspections to Muckamore, would there have been anything in place to prevent them having been connected to Muckamore, either by way of being staff or lay members, having relatives at Muckamore? 11:03

A. I wouldn't -- in my time there was no-one who would have been on a Visiting Committee who was a member of staff of the facility. 11:03

CHAIRPERSON: Could I just ask what the term "commissioner" means, because it can mean different things, I think, in different jurisdictions. Sometimes "commissioners means it is actually a crown appointment. How do you mean it or how was it used? 11:04

A. The commissioners were the primary members of the Mental Health Commission. They were the individuals who were professional, who had specific areas of interest, who, under the role of the Commission, had power to go into a facility either on an announced basis or an unannounced basis. 11:04

CHAIRPERSON: Yep. So they were inspectors effectively? 11:04

A. They were inspectors in that respect, yes.

DR. MAXWELL: And how were they recruited?

A. Most of the commissioners, I have to say - in fact all of the commissioners - were there already. It was

through the Department of Health, as I understand it, that the commissioners were -- through advert. There would have been an advert in respect of, as I understand it, in respect of seeking individuals who were interested in becoming commissioners.

DR. MAXWELL: So it is the Department of Health who appointed them?

A. The Department of Health were involved in the appointment of commissioners.

DR. MAXWELL: When you say involved, were they the people who appointed? 11:05

A. I cannot answer that because I did not sit on any of the panels for appointment of commissioners.

CHAIRPERSON: And they were employed by the Department?

A. They were employed by the Commission. They were appointed by the Department. 11:05

CHAIRPERSON: And you are an arm's-length body effectively, were you?

A. Yes. Yes.

CHAIRPERSON: So your funding comes from the Department of Health if you are arm's length? 11:05

A. It does. It does.

CHAIRPERSON: Sorry, Ms. Bergin.

42 Q. MS. BERGIN: If we scroll down to page 30, please, and we look at exhibit 4. This is then the report from the February 2008 visit. If we scroll down, the third paragraph of that report refers to a high demand for interviews from patients or relatives with the commissioners. 11:05

Now, at page 31 under the heading "Patient and Relatives", here we can see that 10 relatives and 18 patients were spoken to. Now, within this report there doesn't appear to be a summary of their views?

A. No.

43 Q. Do you know if the commissioners would have recorded the views of the patients and relatives and specifically fed that back within the Commission?

A. I, in my time, did not see anything that was a recorded interview with a patient. What I would have been looking for would be recommendations from the commissioners in respect of issues raised during the discussions but I did not and have not seen any written notes of meetings with patients. 11:06 11:07

44 Q. Would it be the case though that the commissioners would have been required to take a note during the inspections to record --

A. Not to my knowledge.

45 Q. No? 11:07

A. Not to my knowledge.

46 Q. And on the same page then under the heading of "Occupational Therapy", it states:

"There is no occupational therapy service in the hospital." 11:07

Without going to it now, I can say that that is also reflected in the December, following December 2008

visit.

Then if we look at "Other Therapies", here it states:

"Psychology and speech and language services are also limited." 11:07

If we then look at page 32, please, under "Staffing", we see here that there were 30 nursing vacancies, and below "Medical Staff", there were two consultant vacancies. So as far back then, for the Inquiry's purposes, as 2008, there was a lack of occupational therapy services and there was also a lack of a full staffing complement at Muckamore. 11:08

When we look then at page 33 to the recommendations of the report, those two issues of lack of specialist professionals and also lack of particular staff don't appear to be included in the recommendations. Can you assist us with why that might have been; why would those not have been issues that would have been flagged as concern? 11:08

A. I can't. I don't know.

47 Q. Page 32 then. Again, I appreciate we're going back and forth somewhat. Here under the heading "Children", it states that there is 296-bed complement in Muckamore, of which 241 were delayed discharges. Long stays is also something that features then in the 2008 December visit. 11:09

Now, if we look back to the recommendations again at the end of that document at page 33, please, we can see that, in fact, delayed discharge issues are listed as being something that should continue to be given priority rating. Now, you've already referred in your evidence this morning to the Untoward and Complaints Committee, can you talk us through when a recommendation like that is received, is that something that goes to that committee? 11:09 11:10

A. That's correct. That is how the issues get raised, and UTEC would then consider what actions, if anything, it would want to -- or it would want to pursue such matters.

48 Q. And beyond that is there a further chain of escalation? 11:10

A. Well, beyond that they could decide to write to the Minister and raise concerns, if it's a regional issue and one that is consistent; as it did. As you saw from the discussion at the Health Committee, those matters were raised at that point as being a regional issue and one of concern. 11:10

49 Q. If we look then at page 26, please. This is exhibit 3 and this is the note of the Visiting Committee, which we have already referred to. At page 27 then, scrolling down then, under "Issues arising from MHC Visiting Programme 2008-2009", we can see under subheadings I and J, that: 11:11

"Long stay detained patients and regular reviews by

Mental Health Review Team" and "Resettlement of long stay learning disability and mental health patients".

So, those are two issues that are flagged of concern at that stage? 11:11

A. Yes.

50 Q. There is reference there at I to saying:

"This matter of the long stay detained patients is covered under the internal audit report and will be subject of a separate discussion with RQIA." 11:11

Can I ask you about that. Do you have any recollection of what those concerns were more specifically than has been stated? 11:12

A. No, I can't. It would be wrong of me to say I do; I cannot recall the specific detail of it. But that note was specifically for RQIA, as I remember, to be sure that they, as part of their processes, would undertake to take those matters forward. 11:12

51 Q. We spoke earlier about governance. Can I ask you then particularly about the internal audit report; that differs from the report on accounts that we're looking at; is that correct?

A. The internal audit report is finance. I'm slightly confused about the way that's... The internal audit report is a finance one. 11:12

DR. MAXWELL: Isn't internal audit about risk controls?

A. Yes.

DR. MAXWELL: So it's beyond finance.
A. Yes. The annual report, the annual report, covered some of those issues, as I would be looking at it.
DR. MAXWELL: We understand that for the Trusts, the Health and Social Care Trusts, the internal audit function is carried out by BSO? 11:13
A. That's correct.
DR. MAXWELL: According to a programme of work that the organisation gives to them?
A. Yes. 11:13
DR. MAXWELL: So who in the Mental Health Commission would have decided the programme of internal audits?
A. Well, arguably it would be me but my function at that time was about shutting the organisation down rather than planning a further programme of internal audit. 11:13
DR. MAXWELL: Okay.
A. The issue then for me was how do, or how will, RQIA take a lot of these matters forward when they get a hold of them.
DR. MAXWELL: But presumably your predecessor had agreed a programme of internal audits? 11:14
A. I believe so.
DR. MAXWELL: Would the BSO internal audit team have delivered those reports to you or to somebody else?
A. I cannot -- I mean I seriously cannot recall specifically having. I recall having discussion with the auditors in relation to the shutdown of the organisation -- 11:14
DR. MAXWELL: Okay.

A. But not necessarily in terms of internal audit reviews.

DR. MAXWELL: Okay. Thank you.

52 Q. MS. BERGIN: If we could then go to page 38, please, and this is exhibit 5. Here you have provided the preliminary report form. 11:14

A. Yep.

53 Q. The description at the top is "Desk immediate, Chief Executive". So, that was a form that went to you?

A. Yes.

54 Q. Now, could you tell us first of all a little bit about the mechanism of you receiving this form and what's meant to occur? 11:15

A. The whole point behind it is were there any serious issues that had been raised that required to be discussed by the Commission with the Trust and hospital management team. Or, from an untoward incident issue, were there things that required immediate further action. 11:15

55 Q. Who was responsible for completing the forms after the visits? 11:15

A. The team leader.

56 Q. This may seem an obvious question but the copy that we have here is blank; are you able to explain why that is?

A. No, I can't. I asked to see the reports that had been produced and that's what came with it. I don't know whether that is the actual report that came through or indeed whether it is just a copy of a report that would have been held on file. 11:15

CHAIRPERSON: When you say you asked, you asked who, the DoH?

A. I asked though the commission, the Inquiry.

MS. BERGIN: The Inquiry.

CHAIRPERSON: So this is what we had? 11:16

MS. BERGIN: Yes, yes.

57 Q. In terms of any type of checking to make sure that these reports were periodically submitted to you, did you have any system in place to make sure that after every visit, such a report was, in fact, sent to you? 11:16

A. Well yes, because the reports went to the Visiting Committee panel, so that they would see that. I would also have reference to the UTEC Committee in terms of any issues that would have come up from the visits. So, the reports did come through. 11:16

58 Q. If we can then move on to the December 2008 inspection. We are looking now at page 41, please. That's exhibit 6. This is a report from the 17th December 2008 unannounced visit to Muckamore. This visit was focused on the Forensic Unit and Intensive Care Unit? 11:17

A. Yes.

59 Q. So in terms of the types of visits, certainly during your time at Muckamore there was a visit which was focused on one unit?

A. Yes. 11:17

60 Q. In terms of the parts of the Hansard report I brought you to earlier, some of the focus of that was around the work of the Commission being individual patient focused rather than more general?

A. Yes.

61 Q. Was there ever any specific patient visits as opposed to a general ward visit or a general unit visit?

A. Not that I'm aware of.

62 Q. Now at page 44, if we can scroll down, of this report, under the heading "Intensive Care Unit", the second line here states that: 11:17

"There is a seclusion room. The protocol for using this room was reviewed by the Commission and found to be within acceptable guidelines." 11:18

It goes on to state:

"When occupied by a patient, the room is observed every 15 minutes. If they are there for more than four hours, the medical officer must interview the patient." 11:18

I appreciate you have said in your evidence this morning you are not a clinician but I wonder can you assist the Inquiry. The reference to the Commission having reviewed the use of the room and that this being in acceptable guidelines, do you know if this was intended to mean that there wasn't a set time period or a set guideline for checking the use of the room and that there were actually different margins that could be applied for different settings? 11:18

A. I cannot answer that.

63 Q. If we then move to question 4, and we are now back to

page 5, please. We've touched on this already but you were asked here if inspections were ever focused on specific topics. Now, I have already asked you about specific patients but here you are asked if it was topic-specific, for example finances or detention. At paragraph 13 you refer to the February 2008 inspection focussing on those specific areas that we have already dealt with. You then say: 11:19

"The areas for inspection and the reason for the visit were determined by the Visiting Committee". 11:19

You have referred to that already. Can you assist the Inquiry any further, even if it wasn't during your time with the Commission, even any of the previous reports you might have reviewed, are you aware if there were any topic-specific inspections or visits? 11:19

A. No, I cannot.

64 Q. Question 5 then, moving on. You were asked how many inspectors were generally involved in an inspection, and about their disciplines and professional backgrounds. At paragraph 16 then you describe how the number of commissioners involved in visits depended on the size of the facility. So, some that were large, like Muckamore, could range from two to six commissioners, depending on availability. You say that during the February 2008 visit that we've just looked at there were four commissioners comprising a medical member, occupational therapist and two nurses, and 11:20 11:20

there were also lay members who you have referred to who did attend other visits?

A. Yes.

65 Q. At question 6 then, you were asked about the duration of inspections. At paragraph 17 you say that these either lasted a half day or a whole day depending on the size of the facility. In the following question then, question 7, you were asked about how the Commission decided on announced or unannounced inspections. You have already indicated in your evidence that that would be a matter often for the Visiting Committee to decide? 11:21 11:21

A. Yes. Yes.

66 Q. Can you tell us anything more about that, apart from the specific issues being raised? How would it be that the Visiting Committee would decide, for example, that a certain type of inspection was required? 11:21

A. Well, that could come about, as I have already said, I think, either through untoward incidents that had been reported. It could have been through communication from a party to the Commission raising an issue possibly. It could also be because the commissioners themselves from previous visits had issues that they wanted to ensure had been resolved, and therefore they would want to go back and have a look at them and see that they were. 11:21 11:22

67 Q. Apologies. I didn't mean to cut across you.

A. No, you are okay. I think that's probably the best way of putting it. The rota for the visits was determined

on a rolling basis, and at the Visiting Committee and at the UTEC Committee, issues would be raised. That in itself could be a prompt for them to either say we should go back and have a look, or we are content to wait until the scheduled visit comes up again. 11:22

CHAIRPERSON: Could I just ask, because you are coming in obviously at the back end of this organisation when it was closing, but what was the ability of the Commission? You said you might react to, I think you said to a communication; does that sometimes mean a 11:23 complaint?

A. Yes.

CHAIRPERSON: So what was the ability of the Commission to react to complaints in terms of the manpower that you had? 11:23

A. It could react quickly enough because if a letter of complaint came in, it would have gone to the UTEC Committee, and that's the point at which someone may well have said, well, let's do a visit. It would then be for the chairman of the visiting panel would be 11:23 asked can we put a team together to go and see. But you are going then, if that's the case, you're doing an unannounced visit.

CHAIRPERSON: Yes. But you didn't have, as I understand it, your staff weren't permanent? 11:23

A. The commissioners were sessional; many of them were employed.

CHAIRPERSON: Which means they are pulled in?

A. They were pulled in but they were committed to a

certain number of sessions a year.

CHAIRPERSON: I see.

A. Sometimes they would do additional sessions if there was something happening that was required. Although there -- the indications were if somebody couldn't do a visited which had been planned and dropped out, we would approach another commissioner to see could they fit in to do that. So, on that basis we did use commissioners as a pool, even though they were contracted to a certain number of sessions. 11:24

CHAIRPERSON: I understand.

A. And if they were available, then we would use them.

CHAIRPERSON: Just to give some idea, how big was the pool?

A. We're talking about 16 individuals. 11:24

CHAIRPERSON: Of different disciplines?

A. Of different disciplines. Well, there would have been maybe several psychiatrists, for example, two GPs, occupational therapy, so it wasn't necessarily just one individual from one discipline. There were several 11:25 nursing members, if I recall, for example.

CHAIRPERSON: Yes. Thank you.

68 Q. MS. BERGIN: If we move then to question 11 on page 8, please. Here you were asked if the Commission medical panel ever reviewed drug treatment plans for patients 11:25 who had been detained at Muckamore for three or more months, and you have referred to that already in your evidence.

Now, say at paragraph 28 you say:

"Each hospital provided a list of patients who had been detained for three months and their drug treatment plans were then reviewed by the medical panel." 11:25

Could you tell us a little bit more about that process? Would they periodically review -- the medical panel, would they periodically review drug treatment plans when a timeframe of three months was triggered, or was 11:26 this connected in some way to the inspections of hospitals? Could you tell us a little bit more about that?

A. No, it was not related to the inspections. It was a requirement under the Order that drug treatment plans 11:26 be reviewed after three months, and we would receive -- the hospitals had to send a list in every three months. When they came in, that would be referred straight to the drug treatment, the medical panel, to review the cases. 11:26

69 Q. Some of the powers we have already discussed of the commissioners on behalf of the Commission included reviewing medical documents and gaining access to facilities and so on. So, independent of the process you have just described, if commissioners were visiting 11:26 a hospital and reviewing patient notes and records, could they then have carried out a review of drug treatment plans --

A. Yes.

70 Q. -- if it was triggered by an assessment or a visit?
A. Yes, they could. Yes.
71 Q. You were then asked as part of this question whether the Commission ever had concerns about patients' drug treatment plans. You say then in the following paragraph that in the Commission's 12th annual reports and accounts, seven were queried. In the 13th annual report, that's 2008, nine, five were queried. You say at paragraph 30 that the treatment plans were queried with the Trust medical officer and thereafter found to be acceptable by the Mental Health Commission medical panel member. 11:27 11:27

If we just go to one of those. If we go to exhibit 7 on page 62, please. Here, the document in fact outlines what you have just described, which is the requirement to review those plans. We see then in the table below the figure of seven queried plans that we've referred to. Can you say at all whether those refer or would include Muckamore patients? 11:27 11:28
A. I would presume it included Muckamore patients if there was anyone who had fallen within that timeframe. I cannot say whether specifically they were Muckamore patients included in that.
72 Q. There is a reference here, and also in the document above the table, which says when they were reviewed then - if we could just move up, please. Thank you - that the seven treatment plans were queried with the relevant Trust's responsible medical officer and were 11:28

thereafter found to be acceptable to the members of the Commission medical panel.

Can you tell us anything about the process of reviewing that or querying that? What did that engagement between the Commission and the Trust medical officer look like? 11:29

A. I cannot answer that.

DR. MAXWELL: Do you know, because there is a possibility in what's written here that there was a query, that there was a discussion, with the patient's consultant and then the medical panel said 'oh yeah, that's okay then', and no changes were made to the medication, or there is the possibility that the patient's consultant said 'oh yeah, perhaps that is wrong, I'll change it'. 11:29 11:29

Would the Mental Health Commission collect any data about which it was that caused the resolution?

A. Not to my knowledge. 11:29

DR. MAXWELL: Okay.

A. Not to my knowledge.

73 Q. MS. BERGIN: Staying with this 2007-2008 report, then if we can scroll up to page 55, please, and the heading of "Patient Monies". Here you outline that the Mental Health Commission had ceased requiring Trusts to provide an annual report on patient monies. There had been a requirement under legislation that the Commission provide consent to Trusts to hold patients' 11:29

valuables or money in excess of £5,000, and that when you learnt of this then, when you became Chief Executive, you reinstated this happening.

Do you know how long this requirement had been in abeyance? 11:30

A. I cannot say accurately. Certainly it was at least a year but I cannot say the full...

74 Q. Can you recall anything further in relation to that at all? 11:30

A. No, no. Not in relation to Muckamore Abbey, no.

75 Q. You were then, at page 9, please, asked some further questions which you have addressed, and I won't go through all of those. You have addressed them and everyone has a copy of your statement. At paragraph 16 11:31 in particular, you were asked if there was anything else you wanted to draw to the attention of the Panel. I think you have already answered that at the beginning of your evidence in relation to some of the issues that you encountered when you came to the Commission? 11:31

A. Yes.

76 Q. Is there anything further you want to add in relation to your time with the Commission relevant to the Inquiry?

A. Only in a very general sense to say that the 11:31 commissioners that I came across were extremely dedicated to ensuring that the rights of individuals were protected, and brought to the operation of the Mental Health Order a knowledge from not only their

work situation but also from their own family experiences as to what they would have liked to have seen and heard from whenever they went to visit a facility. I was impressed by the dedication that the commissioners gave to delivering the functions of the Mental Health Commission. I understood why they were disappointed that its functions were being transferred to another organisation. They were proud of the fact that they did focus on individuals where they could, and they were -- they just had an anxiety that a much larger organisation may not be able to do that. 11:32 11:32

77 Q. The final question I have for you, subject to any questions from the Panel, is were made aware by the Inquiry this morning of an equality impact assessment which was prepared by the Commission in March 2009. I just wanted to ask you if you have any recollection of that? 11:33

A. I have to say I was quite taken aback when you produced the document for me because I looked at it and I thought I know we were involved because we mentioned it again at the Health Committee, I think. It was part of the transfer we were looking to make sure that equality and whatever was going to be dealt with. I had attended when I arrived at the Commission, with the chairman, several meetings around the country -- 11:33 11:33

78 Q. Sorry, I am going to interrupt you there. Just for the benefit of everyone else, just if you could bring the Equality Impact on up on the screen. We are not going to refer to it in detail, it is just to anchor. Thank

you.

Sorry, please continue, Mr. McBrearty.

A. But I have to say when I saw the document, I could not remember it at all, to be perfectly honest. 11:34

79 Q. Thank you. I have no further questions.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 11:34

PROFESSOR MURPHY: I'm still worried about the February 2008 visit because, you know, 296 patients in Muckamore of which 241 were delayed discharges. Now, that seems to me to be the most enormous failure on the part of a hospital. Plus the lack of OTs, consultant 11:34
psychiatrists, psychologists et cetera et cetera.

Now, from what you're saying, you would have written, as the Mental Health Commissioners, to the Trust about this, but did that not trigger anything else? Because 11:35
it seems to me that it's reflecting a failing hospital.

A. I think throughout the -- in the short time that I was there, I was aware that moving patients into the community and delayed discharges had been an issue for some considerable time, and that the Commission 11:35
themselves had raised the matter with ministers in the past. This was just a further confirmation of the fact that it was still ongoing and that they wanted the matter to be resolved as quickly as possible. But I

agree with you, it certainly is an indication that things were not happening as well or as quickly as should have been. There was no request to me to write to the Minister or to do anything else in relation to that. It was certainly raised as an issue with the RQIA as they were taking over that they probably, quite possibly, would have been in a better position and a stronger position to raise these issues than the organisation that was being disbanded. 11:36

DR. MAXWELL: You say you weren't asked to write a letter to the Minister. Who would you have expected to ask you to write? 11:36

A. The commissioners.

DR. MAXWELL: The commissioners. So you wouldn't have thought you had the authority independently? 11:37

A. Well, again I go back to what was -- how did I see my function at that point in time. At that time, we were coming very close to transfer dates and I was focused on making sure that the Commission itself was still able to operate as a commission; that we had people in post who were going to be able to do what was expected of them come 1st April 2009. In that respect - and I think I did reference it, it's somewhere in one of the documents - we actually made an agreement between the Department of Health, RQIA and the Commission, for RQIA to employ staff which would then be seconded to us, and these would be the individuals who would be doing the work from 1st April. 11:37 11:37

That in itself was a significant issue of making sure that knowledge was being transferred. My focus would have been on that.

DR. MAXWELL: I understand that your role was to manage the transition and I know that's a big job, but it sounds as though there was a bit of a gap because the commissioners are sessional workers -- 11:38

A. Yes.

DR. MAXWELL: -- and for all the accountability to lie with sessional workers would be unusual. You've talked about concerns about moving from the Mental Health Commission to the RQIA. I am struggling to know if the substantive staff of the Mental Health Commission weren't raising concerns, why you thought moving to the RQIA would be a bad thing? 11:38

A. Well, I am not saying that they didn't raise concerns because clearly they did in the past. They clearly had.

DR. MAXWELL: At the point you were there, you weren't raising the concerns because you were focusing on the transitions; the commissioners are sessional so that's a bit of a risk? 11:39

A. But the commissioners were putting in reports, the commissioners were meeting on a quarterly basis to discuss issues arising from the visits, the Complaints Committee, the UTEC Committee, whatever issues had been raised, and the commissioners had the facility to express concerns as and when they felt it was necessary. 11:39

Certainly in terms of that report, I can only accept what you say in terms of it. I did not raise it as an issue; I did not write to commissioners or to the Minister or to others on that.

DR. MAXWELL: So who had sight of the commissioners' reports?

A. The visiting panel, the Visiting Committee itself, and UTEC.

DR. MAXWELL: And who was on the Visiting Committee? 11:40

A. There were several members of the Commission would have been on that particular --

DR. MAXWELL: Commissioners?

A. Commissioners.

DR. MAXWELL: So, these sessional workers? 11:40

A. Yes.

DR. MAXWELL: So, sessional workers were doing a report that was going to other sessional workers. Were there any substantive staff on the Visiting Panel or Committee? 11:40

A. No, not that I am aware of. I would have attended --

DR. MAXWELL: Okay.

A. -- in that respect to facilitate the meeting. Admin staff would only have been there for taking minutes.

DR. MAXWELL: Okay. 11:40

MS. BERGIN: I think in your evidence previously, if I may, Mr. McBrearty, you also indicated that the Chair would have attended those meetings?

A. Oh, the Chair would certainly have been. I was

thinking of him as a commissioner in that respect, Mr. Chair.

80 Q. MS. BERGIN: It might assist the Panel if you could explain then along the same lines that you've been asked what function would the Chair have fulfilled in terms of receiving these complaints or issues and escalating them? 11:41

A. Well, the chairman and I would have met on a regular basis, and certainly prior to any of the committee meetings that would be taking place, so that he would know what issues were there, he could raise concerns or whatever with me as he felt were necessary, but he would certainly be very much aware. And he had given me a lead in terms of the Commission's mental health issues that they as commissioners would want to express concern about. 11:41

But again, I come back to how I felt I was -- what I was required to do, and my requirement was to ensure that there was a smooth transfer of the function, and I was working along the lines that had been established for many years within the Commission. 11:41

DR. MAXWELL: I understand. So arm's-lengths bodies usually have an accountability meeting with their sponsor at some point. 11:42

A. Hmm-mm, yes.

DR. MAXWELL: So who was the Mental Health Commission's sponsor?

A. Well, it was the Department of Health.

DR. MAXWELL: But there is usually a named individual?
A. Well, there was an undersecretary there that I spoke to occasionally. There was also an individual who was assigned to the group, whose name, I have to say to you I cannot remember, who was there to facilitate again the transfer. He didn't have -- I didn't have -- 11:42
DR. MAXWELL: You didn't have a named?
A. I personally did not have meetings with anyone in the Department of Health in relation to the operation of the Commission, specifically about its concerns or whatever. The chairman, I would have said, would be the person who would be able to go to the Department and go to the Minister, as he was appointed by the Minister, to raise concerns if he had any. 11:42
DR. MAXWELL: So we have a statement where the Chief Medical Officer explains that he is the responsible officer for RQIA at the moment, so it sits within a senior position. You weren't aware of anybody, Chief Social Worker, Chief -- 11:43
A. No. 11:43
DR. MAXWELL: -- Medical Officer who was the sponsoring. You didn't have any accountability meetings with anybody at the Department of Health about the performance of the Mental Health Commission?
A. Not about the performance of the Mental Health Commission. I had meetings with the Department about the progression in relation to the transfer. 11:43
DR. MAXWELL: No, I understand that you were there to manage the transfer.

CHAIRPERSON: Could I just understand a bit more about your powers to escalate. We have spoken a bit about escalation within the Mental Health Commission. If you found something, if one of your inspectors found something very wrong with a hospital, and I don't know if you have read a statement of Mr. McKenna?

A. No, I haven't seen it.

CHAIRPERSON: No. Well, he describes an inspection at Muckamore which found things in a very, very poor state indeed. The RQIA now can, for instance, issue an Improvement Notice. 11:44

A. Yes.

CHAIRPERSON: How would you escalate it to the hospital? Have escalated it, sorry.

A. Well, you write to the Chief Executive of the Trust. 11:44

CHAIRPERSON: You make a telephone call first, you told us.

A. Well, I might. I did not have to in terms of that particular serious sort of issue, but the simple matter is I would most certainly have expected that there would be direct contact with the Trust and the Chief Executive of the Trust in regard to any significant serious matter that required immediate attention or discussion and concerns raised by the Commission. 11:44

11:45

The Commission also had the opportunity following a visit to meet with the senior management team of that facility and express their concerns about any issues that they had seen on their visit. That again would

have become part of the report that would have been submitted as well. So, the commissioners themselves could say directly to the hospital or the Trust we are not happy about this or whatever.

11:45

But in a formal matter, a letter to the Chief Executive would have been what you would have expected.

CHAIRPERSON: Right. And then what?

A. Depending on their responses, well... We had no other powers to issue notices to stop.

11:45

CHAIRPERSON: No. I mean, you must have been interested, I suppose, in the development of the RQIA and the powers that they were given --

A. Yes.

CHAIRPERSON: -- if you were asked to make a comparison?

11:46

A. RQIA's powers are way beyond the Commission's powers.

CHAIRPERSON: Yep.

A. I have -- if I might say outside of this particular situation, I had worked with RQIA in relation to inspections in nursing homes, and I know their powers are considerable. The Commission did not have such power.

11:46

CHAIRPERSON: I know that you were troubled by the transfer, as it were, from your commission to the RQIA, and particularly obviously concerned about mental health inspection services et cetera.

11:46

A. Yes.

CHAIRPERSON: But if you were to be asked to make a

comparison between then and now, would you be more comfortable to be a patient in a mental health hospital now than you would have been under your own commission?

A. Well, I can only say - and I did say to you - that I was impressed by the dedication of the commissioners and how they carried out their functions.

CHAIRPERSON: Nothing you say will reflect upon that.

A. But I do think RQIA have power that the Commission did not have.

CHAIRPERSON: All right. 11:47

A. And that makes a difference.

CHAIRPERSON: All right. Can I thank you very much for pulling these matters back out of your memory and assisting this Panel as far as you can. Thank you very much indeed for attending this morning. 11:47

I think, in fact, the next witness is here but we will obviously take a break of 15 minutes now and then we'll try and start Mr. Dillon a bit early. Thank you very much. Okay, 15 minutes. 11:48

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

COUNSEL OVERVIEW OF ORGANISATIONAL MODULE 9:

11:58

CHAIRPERSON: Thank you. Mr. Doran.

MR. DORAN: Good afternoon, Chair and Panel members. This afternoon we are going to hear from the first witness in Organisational Module 9, Trust Board. The

witness is Martin Dillon, who is a former Chief Executive of the Trust. I will hand over in a moment to Ms. Kiley, who will be taking the evidence.

The module is described in suitably brief terms as follows in the summary of the organisational modules that is posted on the Inquiry's website. 12:10

"The evidence of persons in positions of responsibility for MAH past and present at BHSCT Board level." 12:10

The module extends right across the issues and the timeframe of the Inquiry's Terms of Reference. The Inquiry has received statements from 13 individuals with knowledge and experience of the Board and its work. Those individuals were asked to address specific questions put to them by the Inquiry. The statement-makers are as follows: 1. Peter McNaney, who was Chair of the Belfast Health and Social Care Trust from 2014 to 2023. 12:10 12:11

Pat McCartan, who was Chair of the North and West Belfast Health and Social Services Trust from 2001 to 2006, and Chair of the Belfast Trust from 2006 to 2012. 12:11

Third, Cathy Jack, Chief Executive Officer of the Trust from 2020 to 2024, and Medical Director of the Trust from 2014 to 2020.

Fourthly, Martin Dillon, Chief Executive Officer of the Trust, as I've said, from whom the Inquiry will hear today. His period as Chief Executive Officer was from 2017 to 2020. 12:11

Fifthly, Colm Donaghy, Chief Executive Officer of the Trust from 2010 to 2014.

Sixthly, Brenda Creaney, Executive Director of Nursing and User Experience at the Trust from 2010 onwards. 12:12

7. Cecil Worthington, Executive Director of Social Work and Children Communities Services at the Trust from 2012 to 2017. 12:12

8. Dr. Robin McKee, Director of Medical Services Community in the North and West Belfast Health and Social Services Trust from 2000 to 2007. 12:12

9. Jacqueline Kennedy, Director of Human Resources and Organisational Development at the Belfast Trust from 2018 to 2023.

10. Claire Cairns, Co-Director Risk and Governance at the Trust since July 2014. 12:12

James O'Kane, a nonexecutive director and Chair of the Audit Committee at the Trust from 2007 to 2016.

The twelfth statement is from Gordon Smyth, a nonexecutive director and Chair of the Audit Committee of the Trust from 2016 onwards.

12:13

Then finally, the thirteenth statement is from Tony Stevens, who is a former Medical Director. He was in office prior to Ms. Jack taking up the post in 2014, and he was Chair of the Patient and Client Safety Operational Group at the Trust.

12:13

All of those statements are publicly available on the Inquiry's website. Having considered the various statements, some of which are particularly detailed, the Panel wishes to hear oral evidence from the following six witnesses: First, as I've mentioned, Martin Dillon. Second, Brenda Creaney, who will give evidence next Monday, 14th October. The Panel will recall that Ms. Creaney previously gave evidence for the Ennis module in June. Third, Gordon Smyth, from whom the Panel will hear next Monday afternoon. Fourth, Cecil Worthington, who will be coming to give evidence next Tuesday afternoon. Fifth, Cathy Jack, who is in the schedule for Wednesday, 16th October. Sixth and finally, Peter McNaney who will attend on Thursday, 17th October.

12:13

12:14

12:14

Now, in keeping with the approach to these later organisational modules, Chair, I do not proposing to

through the content of the statements. As I've said, they are all publicly available on the website. The Panel will be hearing from the six witnesses who I've mentioned.

12:15

I should, however, make one point that has been made before but that I think is worth repeating. Even though the Panel has not asked a witness to attend to give oral evidence, that does not mean in any way that their evidence is unimportant. The Inquiry is, of course, grateful for all of the many contributions to its evidence, whether that be by written and oral evidence or by written statement only.

12:15

Following on from that very brief introduction, Chair, we can now move on to hear the oral evidence of Mr. Dillon. As I've said, I am going to hand over to Ms. Kiley for that purpose.

12:15

CHAIRPERSON: Thank you very much for that. It's also just worth mentioning that, of course, Cecil Worthington, who is giving evidence on Tuesday afternoon, we haven't forgotten that in the morning we are reverting back to Module 7.

12:15

MR. DORAN: That's correct.

CHAIRPERSON: And Esther Rafferty will be giving evidence that morning.

12:16

MR. DORAN: And her evidence will complete the evidence for Module 7.

CHAIRPERSON: Exactly. So that deals with next week

entirely. Thank you very much indeed.

Okay, Ms. Kiley.

MS. KILEY: Chair, thank you. I see the secretary has gone to get the witness who is ready to be called. 12:16

CHAIRPERSON: We'll probably sit through to about a quarter past one and then take a break.

MS. KILEY: Yes.

MR. MARTIN DILLON, HAVING BEEN AFFIRMED, WAS EXAMINED BY MS. KILEY AS FOLLOWS: 12:17

CHAIRPERSON: Good morning, good afternoon just. Thank you for coming to assist the Inquiry. What we are going to do is sit a little bit longer than we normally 12:17 do in the morning until about 1.15 and then we will take a break, and then we will carry on this afternoon.

Thank you for your statement, which is 46 pages long, and the multiple exhibits that you have produced. 12:17 Ms. Kiley will be taking you through some of those. If you need a break at any stage, will you just say so?

A. I will of course, Chairman. Can I thank the Inquiry for accommodating me date wise? I just want to put that on the record. 12:18

CHAIRPERSON: Thank you. Yes, Ms. Kiley.

MS. KILEY: Thank you, Chair.

MR. MARTIN DILLON WAS EXAMINED BY MS. KILEY AS FOLLOWS:

81 Q. MS. KILEY: Good afternoon, Mr. Dillon. We met just a few moments ago. As you know, my name is Denise Kiley, I am one of the Inquiry counsel team and I will be taking you through your evidence today.

12:18

You have made three statements to the Inquiry at this stage over the course of various modules. Just to remind everyone of those, your first statement was made for the purpose of Module 5 of the evidence modules. That was where the Inquiry looked at regulation RQIA and other agencies. For everyone's reference, that is statement number STM-100. Then the second statement you made was for the purpose of Module 6 of the evidence modules, where the Inquiry looked at a number of reports concerning Muckamore Abbey Hospital. Again for everyone's reference, that is STM-107.

12:18

12:18

Then your third statement was made for the purpose of Organisational Module 9, which is the module the Inquiry is looking at now relating to the Trust Board. The reference for that statement is STM-272. It's that final statement that we will focus on today, Mr. Dillon, in your evidence, but can I check do you have copies of all of those statements in front of you?

12:19

A. Not the former two, not in front of me.

12:19

82 Q. Okay, but you have a copy of your third statement?

A. I do.

83 Q. In respect of all three, would you like to adopt all three as your evidence to the Inquiry?

A. I would.

84 Q. But as I say, we will focus primarily on your final statement.

If we turn then to the third statement, STM-272. I should say, Mr. Dillon, you will see now, although you have a copy, a hard copy of your statement in front of you, you can see that we will be bringing up electronic information on the screen, so you can follow along there if you wish? 12:19 12:20

A. Yes.

CHAIRPERSON: I was going to say just to reassure the witness, if you do refer to the earlier statements, then we will bring up those paragraphs so you can see what you have said. 12:20

A. Thank you.

85 Q. MS. KILEY: Yes. We have your statements and exhibits for all of your statements available, so if there is anything that you wish to refer to, even if I don't direct you to it, please feel free to let us know and we can bring that up. Okay. 12:20

A. Thank you.

86 Q. Now in this statement, which I am calling your third statement, you were asked to address a number of questions on various different themes. Firstly, you were asked questions in relation to your role on the Trust Board. Then you were asked some more specific questions about the A Way to Go Report, and about the Trust's response to the A Way to Go Report. I am not 12:20

going to take you through all of those question by question.

There are about four broad themes that I want to touch on with you today arising from what you have said in your statement, Mr. Dillon. The first is your role and the role of the Board more generally. The second is the Board structures and the various ways in which issues relating to Muckamore Abbey Hospital might be brought to the Board. The third is the Board's knowledge of issues relating to Muckamore Abbey Hospital, looking specifically at the period before 2017. Then fourth and finally, the Board's knowledge and response to the allegations of abuse which emerged in 2017. Now, inevitably there will be overlap between all of those issues, but that's the course that we will take. 12:20 12:21 12:21

So, if we start then with your role, first of all. You detail this at paragraph 6 of your statement, if we could have that up on screen, please. At paragraph 6 you set out the various roles that you have had over the years. You were Chief Executive of the Belfast Trust between February 2017 and February 2020; is that right? 12:21 12:22

A. Correct.

87 Q. Before that you were Deputy Chief Executive and Executive Director of Finance between January '15 and January '17?

A. Correct.

88 Q. Before that you were Interim Chief Executive in the period June 2014 to December 2014; is that right?

A. Correct.

89 Q. Then prior to that, you were Executive Director of Finance, and that was during the period October 2010 to June 2014? 12:22

A. Correct.

90 Q. Is it the case that in all those roles, you were a member of the Trust Board? 12:22

A. That's correct. In all of those roles I was a member of the Board, yes.

91 Q. Were you also a member of the Executive Team in all those roles?

A. I was a member of the Executive Team in all of those roles, and in the Chief Executive role would have chaired the Executive Team. 12:22

92 Q. Yes. So the period that you were on the Trust Board in total then spans between October 2010 and February 2020? 12:23

A. Correct.

93 Q. When you were Deputy Chief Executive during that period, January '15 to January 2017, who was the Chief Executive at that time?

A. At that stage the Chief Executive of the organisation was Dr. Michael McBride, who was also at that stage carrying on his role as Chief Medical Officer. So, an arrangement had been struck with the Department of Health whereby, although I was Deputy Chief Executive, 12:23

I had responsibilities for some elements of governance such that Dr. McBride's Chief Medical Officer role didn't conflict with his role as Chief Executive of the Belfast Trust.

94 Q. Okay. So, during that period you were exercising more than the role of Deputy Chief Executive might ordinarily have exercised? 12:23

A. Yes. To the best of my recollection, the Department had issued a second accounting officer level to cover the uniqueness of the circumstance. 12:23

95 Q. So you were also an accounting officer during that time?

A. Yes, for certain aspects of the organisation while Dr. McBride was the accounting officer for other aspects of it. 12:24

96 Q. You describe the Trust itself in detail in your statement. If we could turn to paragraph 13, we can see what you say there. You describe it as a huge organisation. I want to read what you say just to put your evidence in context. You say: 12:24

"The Trust was and is a huge organisation with circa 22,000 staff and a current budget of circa £1.9 billion. My recall is that during my time in the organisation, it was one of the biggest provider Trusts across the United Kingdom. It had a huge span of control to be managed covering a huge range of services across many directorates, ranging from very complex regional hospital services in acute hospital services, 12:24

including transplant services, to mental health and learning disability services, which ranged from complex regional services, including secure forensic units, to local services, to domiciliary practical and personal care services provided to people in their own homes. The Belfast Trust provided services and support services from over 700 buildings.

From recall during my time as Finance Director, Muckamore Abbey Hospital would have accounted for about on average 1% to 1.5% of the total Belfast Trust budget."

It sounds like a vast organisation even from that description alone, Mr. Dillon. In your experience across all of your roles whenever you were on the Trust Board, what difficulties did the size of the Trust pose for the Board in carrying out its oversight operations?

A. I think the way in which I can best answer that is when you have such a vast organisation, you will need complex governance structures, and they are set out in the Board Assurance Framework. And you will need a robust system of delegated and distributed leadership throughout the organisation. And the structure below Chief Executive in terms of number of directors and so on will need to be commensurate with the size of the organisation so that is effectively managed.

CHAIRPERSON: Could I just ask you to keep your voice up just because this is being sent out over the

website. So if you just keep your voice up nice and loud.

A. Thank you, Chairman.

97 Q. MS. KILEY: Does that mean in reality the Trust Board relied heavily on delegation of functions to other parts of the organisation, and reporting up from those parts? 12:26

A. Yes. The Board, within the parameters of the Board Assurance Framework, would have been reliant on effective, almost summary level performance, information coming across to the Board so that it could assure itself that the organisation was being effectively run and that the statutory duty of quality was being met at all times. So, the Board was very reliant on its subcommittee structure and the distributed and delegated leadership within the organisation to assure itself that those primary functions were being met. 12:26 12:27

98 Q. I am going to come on and look at the Assurance Framework with you. One of the statistics you give in the portion of your statement that I have just read out was that the Trust was delivering services from over 700 buildings. For example, taking your time as Chief Executive, would you have been familiar with the services delivered at every one of those buildings? 12:27 12:27

A. No, not from every one of those buildings. Some buildings would have been for the purposes of estates and supplies and support services. But in both my time as Deputy Chief Executive and Chief Executive, I

endeavoured to get out across the organisation as much as I possibly could. One of the things I wanted to do as Chief Executive -- if I could just go back one step. When I took up the role of Chief Executive, each and every Trust always has a very strong focus on 12:28
continuous improvement, always wanting to improve patient and user service safety, because whether you like it or not, each and every day in the health service, incidents, accidents, near misses occur. So it is very important that staff feel able to report all 12:28
of those so that we can look at those as appropriate, take the learning from them and continually to improve.

One of the propositions that I had for the organisation was that we would redouble or re-energise our focus on 12:28
patient and service user focus and aim to be in the top 20% of top performing Trusts across a range of performance metrics by 2020. So I was very keen personally to make myself visible to carry that message out to as many staff as I possibly could to make them 12:29
understand that the organisation had, as one of its first order priorities, patient and service user safety.

One of the things I did every time I was out with 12:29
staff -- and my purpose in going out was not to have some sort of empty Chief Executive visit, it was more about walking in staff shoes for a few hours, accompanying them out on domiciliary care visits, going

into hospital wards, going into operating theatres, meeting with as many staff as I possibly could to understand the challenges that they faced at the coal face, at the frontline, to familiarise myself with as many services as I possibly could.

My career in the health service spanned some 35 years. So in previous jobs and previous roles, I was very familiar with the breadth of the services and always made an effort, even in the Director of Finance roles, to get out and about the organisation and see services and service delivery at first hand.

99 Q. You refer later on in your statement to some of the visits that you made to Muckamore, which we will come to. But is it fair to say that whilst that was your intention, as you have described, the fact that the Trust was so vast meant that naturally you were dividing your time between a number of services and so that impacted on how familiar you could be with an individual service and individual members of staff; is that fair enough?

A. I would put that in context to say that within our Board Assurance Framework, and with our directors and assistant directors and service managers who would be very, very familiar with the services that they were overseeing and running, there would be a limit, yes, to what I could do and see throughout the organisation. Because, I mean, the role of Chief Executive is like any job in the health service, be that a nurse or a

domiciliary care worker, very challenging. So I could only do what I could do in terms of freeing up the time to get out there to see services at first hand.

100 Q. Yes. Can I ask you about the final sentence in the paragraph that I read out where you give some statistics about your time as Finance Director, and you say Muckamore Abbey Hospital would have accounted for on average about 1% to 1.5% of the Trust budget at that time. Can you say or are you aware of what the figure was whenever you retired? 12:31

A. To the best of my recollection, it would have been about 14 to 16 million; something of that order.

101 Q. Are you able to give a similar percentage of the Trust budget?

A. Well, the Trust budget was so big it would have taken a big shift to change that percentage, to the best of my recall. 12:31

102 Q. So, in fact, whilst that refers to your time as Finance Director, the statistic there as to the amount of percentage of the Trust budget that was allocated to Muckamore is probably correct for the entirety of your period? 12:31

A. To the best of my recall, yes, it would be.

103 Q. You have referred to the Assurance Framework, so I want to turn now to look at that to look at the role of the Board. Could we turn up page 67 of the statement, please. This is one of your exhibits. You have exhibited a number of versions of the Assurance Framework. It was an annual document; isn't that 12:32

right?

A. Yes.

104 Q. So it changed annually. For our purposes, we only need to look at one version and you can tell me if there were significant changes in what we are discussing. If we can scroll down, we're looking at the version of the Assurance Framework for 2010-2011. It sets out here the role of the Board. 12:32

"The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trust affairs. It provides active leadership of the organisation within a framework of prudent and effective controls which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance by setting the Trust's values and standards. The Board ensures that Trust's obligations to patients, the community and staff are understood and met." 12:32 12:33 12:33

That's the role of the Board as it was stated in the 2010-11 Framework. Is it fair to say that that is an accurate summary of the Board's role throughout the time that you were on the Board? 12:33

A. I think that is a fair representation, yes.

105 Q. The language in the different assurance frameworks may

have altered but, in summary, that's what the Board was attempting to do?

A. Yes. To the best of my recall, the changes to the Assurance Framework from one year to the next would have been fairly minimal. Sometimes the Department of Health would somewhere changed something and it was updated to reflect that. On other occasions, the organisation itself may have slightly changed its subcommittee structure or introduced a new committee so the Assurance Framework would be updated to reflect any changes in the governance arrangements. 12:33 12:34

106 Q. If we could move down to page 68, please, we can see the role of the Chief Executive explained. If we can just look at that then. It says: 12:34

"The Chief Executive through his leadership creates the vision for the Board and the Trust to modernise and improve services. He is responsible for the statutory duty of quality. He is responsible for ensuring that the Board is empowered to govern the Trust, and that the objectives it sets are accomplished through effective and properly controlled executive action. His responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives, and to the Department of Health and Social Services and public safety as accountable officer. 12:34 12:34

As accountable officer, the Chief Executive has

responsibility for ensuring that the Trust meets all of its statutory and legal requirements, and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses elements of financial control, organisational control, clinical and social governance, health and safety, and risk management."

Is that an accurate description of how you understood the role of Chief Executive? 12:35

A. I believe that to be an accurate description, yes.

107 Q. The Chief Executive role, did it also encompass a duty to protect patient safety?

A. Yes. That comes under the statutory duty of quality.

108 Q. So whilst not specifically defined there, was your understanding that whenever you held the role of Chief Executive, or whenever you were on the Board and others held it, that the Chief Executive was accountable for patient safety throughout the organisation? 12:35

A. Responsible for the statutory duty of quality, which would have encompassed that. 12:35

109 Q. Okay. In respect of Muckamore, the Chief Executive is the named responsible individual for the Muckamore Abbey Hospital service; is that right?

A. Certainly the Chief Executive would have been named as the responsible officer in relation to regulated services. 12:36

110 Q. Yes.

A. But I am not sure I would put it in the way you just

have in relation to Muckamore. I had the overall responsibility; I was the overall accounting officer, yes.

111 Q. Say, for example, whenever RQIA went out to inspect Muckamore Abbey Hospital, if they were to deliver an inspection report or a Quality Improvement Notice, would they have been delivered to the Chief Executive? 12:36

A. They would have been delivered to the Chief Executive's office in line with arrangements struck with the Governance Department, and those reports then would have been disseminated back out to the relevant directorate and directorate teams to take forward the recommendations, if any, on any of the RQIA reports. 12:36

The Chief Executive would not normally see an RQIA report. There is too many of them by volume that come into the organisation across such a broad range of regulated services. So, we had a model in place where those inspection reports got to where they needed to get to address the recommendations. 12:37 12:37

Very rarely RQIA might write to the Chief Executive to issue Improvement Notices. Something of that order of magnitude would be drawn to the attention of the Chief Executive, and I have had experience of that. So, whenever the RQIA inspection reports went out under the delegated distributed leadership model to the relevant directorate or sub-directorate to deal with it, the Governance Department would have been logging the RQIA 12:37

report, making a note of the recommendations, and then providing summary information through the subcommittee structure about how many reports there were, how many recommendations there were, how many recommendations were now judged to have been met; and in relation to those not being met, what corrective action was being taken.

112 Q. You mentioned recommendations there, what recommendations --

DR. MAXWELL: Sorry, just before you go on to that. As the accountable officer, you were accountable for services. The fact that you delegated it because of the size of the Trust doesn't diminish the fact that accountability still lay with you. You just delegated the collection of data and management of any recommendations but you remained accountable for it?

A. Yes, correct.

DR. MAXWELL: So it remained your responsibility, therefore you had responsibility to make sure the system of delegation you put in place was effective?

A. Correct.

113 Q. MS. KILEY: Just on that, for example if RQIA carry out an inspection - you mentioned recommendations - they might put in place a quality improvement plan. You are familiar with that document?

A. Yes.

114 Q. And the Inquiry has seen some quality improvement plans relating to Muckamore Abbey Hospital, and we have seen quality improvement plans where recommendations have

been signed off by the Chief Executive. Do you recall taking that action as Chief Executive, signing off on improvements?

A. At this remove, no.

115 Q. Okay. Notwithstanding that, you accept that whilst there was delegation of the responsibility through the committees, the buck stopped with the Chief Executive ultimately? 12:39

A. Oh, absolutely the buck stops with the Chief Executive as accounting officer and responsible officer, yes. 12:39

116 Q. You mentioned some of the committees. I think if we could scroll down to page 73, please, we can see how they interact with each other. This is again the part of the Assurance Framework from 2010-11. Can we zoom in on the top half of that page, please, just so it's 12:40 clearer. This is the Assurance Committee subcommittee structure. We can see at the top there that the Trust Board sits at the top. There are four committees that feed into the Trust Board - the Remuneration Committee, the Charitable Funds Committee, the Audit Committee and 12:40 the Assurance Committee. Throughout your time at the Board, would it broadly have remained that way, those four main committees?

A. Yes. There was subsequently established - and at this remove I can't recall which year - a Social Care 12:40 Committee.

DR. MAXWELL: I think that's in there, reporting to the Assurance Group. Social Care Steering Group; the first grey line.

A. I'm struggling to remember at this remove the exact year. I hope I am not wrong but I believe at a point in time, a Social Care Committee, a formal subcommittee of the Board was established.

DR. MAXWELL: So we've heard various things about that and it's not clear. Some people have suggested there was a subcommittee of the Board for social care. 12:41

A. Yes.

DR. MAXWELL: And this suggests that there is a Social Care Steering Group that reported to the Assurance Group that reported to the subcommittees. Do you recall whether there was a social care committee that had a direct line to the Board bypassing the Assurance Group and Assurance Committee? 12:41

A. I stand to be corrected, and it's difficult at this remove, but my recollection is that at a point in time, a social care committee was established that reported directly back to the Board, had a direct line back to the Trust Board. 12:41

DR. MAXWELL: So bypassed the Assurance Group, the Assurance Committee and the Audit Committee? 12:41

A. Well, it had a direct line back to the Trust Board, yes.

DR. MAXWELL: Okay.

117 Q. MS. KILEY: And if that was the case, Mr. Dillon, we would see that in the -- 12:42

A. You should see that --

MS. KILEY: -- later reiterations of the Assurance Framework?

A. Indeed.

CHAIRPERSON: Because this is 2011.

MS. KILEY: Yes.

118 Q. So if the annual versions of the framework were to be analysed, we would be capable of ascertaining of the dates that that happened; is that correct? 12:42

A. Indeed.

119 Q. And we would see a document like this with the --

A. With it updated to reflect that.

120 Q. Sticking with this one and thinking about the four committees that we can see there, is it right that the committees had minutes which were reported to the Trust Board meetings? 12:42

A. Yes. Each Board subcommittee's minutes would have went to the next available Trust Board. 12:42

121 Q. Was that for noting or was the Trust Board approving those minutes?

A. I believe approving those minutes.

122 Q. Do you recall the Trust Board interrogating the minutes of the committees in a detailed way? 12:43

A. From memory, the way in which it operated was that the chair of the relevant committee would present the minutes and draw to the attention of the Board any matters that he wished to escalate to the Board. So on occasions I can recall the Chair of Audit Committee saying over and above these minutes, we, as an Audit Committee, have concerns about the following and that we would like the Board to specifically know about; and here's the assurances we, as Audit Committee, have been 12:43

given about how these matters will be rectified but it was just to let the Board know. So that would happen on occasion where, as opposed to the minutes simply being adopted, it was up to the chair of a relevant committee to escalate anything or raise anything or ask the Board to discuss anything that they wanted to have discussed.

123 Q. If that sort of escalation or raising of issues did occur, we would expect to see that in the minutes of the Trust Board meeting; is that right? 12:44

A. You would, you would, yes. I think there will be minutes of Trust Board. I can't remember the year in which were some of the internal audit opinions, their overall opinion, was such that the Chair of the Audit Committee felt he needed to raise this at Board level. 12:44

124 Q. Okay. Returning to the structure on your screen then, underneath the committees we can see the executive. So the executive feeds into the Audit and Assurance Committee, and then they in turn feed up to the Trust Board. Did the Executive Team meet separately to the Board? 12:44

A. Yes, the Executive Team met weekly.

125 Q. And were its minutes presented to the Trust Board?

A. No. Executive Team minutes would not have been presented to the Trust Board. 12:44

126 Q. Why was that treated differently to the committees?

A. Because the Executive Team is not a formal subcommittee of the Board. It's the executive arm of the organisation, you know, charged with the effective

running and management of the organisation, it's not a formal subcommittee of the Board.

127 Q. So the Executive Team then, if they wanted to raise something with the Board, would have to do that verbally rather than the Board getting information from a reported minute; is that right? 12:45

A. Yes. Now, I was in the custom and practice of meeting with the chairman once a week.

128 Q. This is when you were Chief Executive; is that right?

A. Yes. With that type of frequency, and I would have kept the chairman informed of anything from exec team that I believe he needed to be aware of. 12:45

129 Q. So the Chief Executive then is the arbiter of what makes it from the Executive Team discussions to the Board; is that fair enough? 12:45

A. I wouldn't characterise it like that. You know, the Board secretary and the chairman were responsible for the Trust Board agenda and could have on that agenda anything that the chairman wanted. The fact that exec team minutes didn't come to the Board wasn't a limitation in any way. Before each Board meeting, you know, I would have been with the Chair and the Head of Governance preparing the agenda for the Trust Board, so there was no limitation or in no way was anything circumscribed that could make its way up to the Board. 12:46 12:46

DR. MAXWELL: But the chairman, who was ultimately setting the agenda, was getting a lot of his information from the Chief Exec?

A. From the Chief Executive, from his subcommittees, and

from the -- and from the groups set out below which were feeding up to both Assurance Committee and to Trust Board, yes.

DR. MAXWELL: The chairman, as a non-executive, was getting information from the Chair of the Audit Committee and the Chair of the Assurance Committee, who were non-executives, but he went getting any direct operational information except through you? 12:47

A. Well, he was getting -- he would have been getting lots and lots of operational information through the Trust Board, through the various finance, performance, planning. All the various performance metrics that would have came to Trust Board, the chairman would have been getting lots of information through the -- 12:47

DR. MAXWELL: These are standing items on the agenda? 12:47

A. Yes.

DR. MAXWELL: So there's standing items, and he would be seeing the reports of those coming through?

A. Yes.

DR. MAXWELL: That are on every month? 12:47

A. That are on every month.

DR. MAXWELL: And he would be getting feedback from the non-executive directors, either from activities they had been doing in general or from the Audit Committee and the Assurance Committee. But actually, concerns about operational processes or risks that weren't on the standing items he was getting through you as the Chief Executive? 12:47

A. Or any other avenues he had. I wouldn't characterise

myself as being a filter in some way. I mean, the chairman had access to whatever he wanted in the organisation.

DR. MAXWELL: But if he doesn't know what he doesn't know, he doesn't know to go and look for it. 12:48

A. Yes, but I was in the custom and practice of making sure that the chairman was involved of all emerging issues as they arose when we met every week.

DR. MAXWELL: Yeah, I'm not disputing that but I'm just saying the route is through the Chief Exec primarily. 12:48

A. Yes. It would be unusual, I think. But it was equally open for any other director, if they had wanted to see the chairman about something, to see him.

CHAIRPERSON: And you would give that information verbally? 12:48

A. Yes. He and I would have a meeting once a week when he was available, so they were fairly frequent, when he would be in the organisation to do his work as chair. So he and I had the custom and practice of where I would say 'here are some things you would need to be 12:49 aware of'.

CHAIRPERSON: Those obviously wouldn't be minuted?

A. No, no. They weren't formal meetings, they were kind of catch ups to make sure. Like myself, the chairman operated on the basis of no surprises. So I wanted to 12:49 make sure any emerging issues, anything I felt he as chair needed to be aware of, he should be made aware of. So, there were no limits or circumscription of anything that could be brought to him. The only thing,

of course, is in such a vast organisation, you cannot overburden someone, or you cannot bring them irrelevant or extraneous information that they don't need to have.

130 Q. MS. KILEY: Can I just pick up on one of the things you said in answer to Dr. Maxwell's question, which was it would be open to any director to bring a matter to the Chair. How would that practically have been done; at a Trust Board meeting? 12:49

A. No. A director, if they so wished, could have asked to see the chairman. I do know the chairman on occasion would pop his round the door of directors when he was around, just to have a conversation. But the normal route would be up through the executive, the director would say there is something I want to escalate to exec team. Then we decided that this is where they have been escalated up to Trust Board. 12:50 12:50

131 Q. Okay. The possibility of a director raising something directly with the chair was exceptional; is that right?

A. Exceptional, but a route nonetheless available to any director. 12:50

132 Q. If we could return then to the diagram. Just beneath the executive is the Assurance Group and the Assurance Group feeds into the Executive. We can see underneath there the number of groups which feed into the Assurance Group: The Governance Steering Group, the Safety and Quality Steering Group, SAI Review Board, Social Care Steering Group, Equality Engagement and Experience Steering Group. 12:50

If we can just scroll down to see the bottom of the page there. Just pause there, please. We can see coming out to the right of the Assurance Group, there is a line down to the directorates. So the directorates fed directly, as it were, to the Assurance Group; is that right?

A. Sorry, I am struggling to see that line.

133 Q. If you focus on the Assurance Group box.

A. Yes.

134 Q. And then you look to the right of that - excellent, it is being helpfully highlighted there - there seems to be a direct line to the directorates. Does that mean that the directorates directly reported to the Assurance Group? 12:51

A. That's going back to 2011, during a time that I was not Chief Executive, so I can't answer that question fully. My instinct is that what that's trying to show is there were safety improvement teams with various associated work teams within the directorates. So, it's a specific reference to the safety improvement teams then which could provide information directly to Assurance Group. 12:51 12:52

135 Q. I'll come back perhaps to the Assurance Group. If we can return to your role and how you fitted into this at various times, and we turn to your statement, please, at paragraph 9, you refer particularly to the subcommittees. You explain that you sat on the Charitable Funds Committee of the Board. Then at paragraph 11 you say that whilst you were not a member, 12:52

you were in regular attendance at meetings of the Audit Committee and the Assurance Committee.

"This was for the purposes of presenting or speaking to papers, answering committee members' questions and queries, and ensuring follow-up, where that fell to me, of agreed actions on behalf of the committee."

So it's right, is it, that the Audit Committee and the Assurance Committee were chaired by non-executive directors? 12:53

A. Yes.

136 Q. Then you attended as part of the Executive Team to present papers to those non-executive directors; is that how it worked? 12:53

A. Correct.

137 Q. Then the Assurance Group I said I would return to. I want to ask you to look at paragraph 64 of your statement just to make sure that we all understand the nature of the Assurance Group, because there is the Assurance Group that we have seen just on the diagram that we looked at. Then at paragraph 64, this is the portion of your statement where you refer to some actions that were put in place post 2017 CCTV revelations, and you refer to the establishment of an Assurance Group chaired by the Deputy Chief Executive and Medical Director. That is something different to what we saw on the diagram; isn't that right? 12:53 12:54

A. That is something entirely different, yes.

138 Q. Even though they have the same name?
A. Indeed.
139 Q. So what you are talking about in paragraph 64 only took place in response to post 2017?
A. Indeed. 12:54
140 Q. But the Assurance Group that we saw on the diagram was part of the Board's structures throughout your time on the Board; is that correct?
A. Correct.
141 Q. You've touched on it a little bit but it might be helpful if you could explain in summary what the role of the Assurance Group was. If we can bring the diagram at page 73 up again, please, so you have it in front of you. The Assurance Group sits in the middle there. We can see that it seems to have an important role in the structure; is that a fair summary? 12:54 12:55
A. Correct.
142 Q. Could you explain in layman's terms briefly what the role of the Assurance Group was?
A. To the best of my recollection, I think the Assurance Group would have met four or five times a year. It was comprised of all of the executive directors, who would have been joined by the governance manager and other members of staff from the Governance Department. The Assurance Group would have considered a whole range of reports from those various subgroups, a whole range of performance metrics, and would have reviewed all of those very carefully for any outlying performance or issues of concern. The Assurance Group, as well as 12:55 12:55

fulfilling that role and function, also acted as a preparation then for Assurance Committee, which was a subcommittee of the Board.

143 Q. When you say it acted as preparation, is it right that it set the agenda for the Assurance Committee meetings? 12:56

A. Well, the agenda was prescribed for Assurance Committees. This was a full review of all the reports and information that would be going to the Assurance Committee in order that directors who would be presenting at Assurance Committee could be fully 12:56 prepared and have all the right information and be in a best position to answer non-executive questions and queries when it came to Assurance Committee.

144 Q. What sort of matters would the directors have reported on to the Assurance Group? 12:56

A. To the Assurance Group? There would have been individuals who would have been chairing some of those various steering groups who then would have walked members of the Assurance Group through the various metrics, talked about performance, talked about any 12:57 matters of concern, anything they felt needed escalated, anything that was outlying, for example.

For example, SAI Review Board would have been examining summary level information about the number of SAIs, how 12:57 many SAI review reports were now complete, how many were outstanding, how many recommendations from previous SAIs reviews had been implemented; had appropriate learning letters emerging from SAIs review

been properly disseminated in the organisation; had other regional bodies like the Public Health Agency and the then Health Board been kept fully up-to-date.

So, it was examining a whole range of performance metrics across all of those domains. 12:57

145 Q. Just sticking with the example you have given there for the SAI Review Board for the purposes of illustration, you have described there receiving information about SAIs. Would, for example, the Assurance Group have routinely received SAI reports? 12:58

A. No. The Assurance Group would have been examining information to do with the number of SAIs, the level of the SAI, the nature of the incident, progress with an SAI review and progress with implementation of recommendations and learning from previous SAIs. Individual SAI reports would have been considered at the appropriate level within a directorate. This was more summary level governance information to highlight trends or emerging issues and so on and so forth. You know, for example, if any one directorate was behind with SAI review reporting, that would have been highlighted and understanding gained of why that was, and a planned outline for corrective action and so on. 12:58 12:58

CHAIRPERSON: Could I just understand. With the SAI, you have the SAI Review Board but would an SAI also be considered by Safety and Quality Steering Group? 12:58

A. I'm not sure at this remove whether I can answer the Safety and Quality Steering Group would have considered

individual SAI reports. I would have to come back on that.

CHAIRPERSON: Or by Governance Steering Group which was responsible for risk management?

A. Yes. I think it was primarily for the SAI Review Board to look at those trends in relation to SAIs and to be able to assurance the Assurance Committee and assure the Assurance Group that all appropriate learning that could be gleaned from serious adverse incident reviews was being elicited and applied across the organisation. 12:59

DR. MAXWELL: Can I just add to that? Sometimes it isn't learning, sometimes it's gaps that are identified, which you might call risks. So, if the SAI Review Board identified one or more SAIs where the investigation identified gaps that made this more likely to happen again, how would that SAI be dealt with? 13:00

A. You couldn't repeat the question? I am not sure I have grasped it.

DR. MAXWELL: So sometimes when there is a review of an SAI, you find that actually there is a gap in control or assurance -- 13:00

A. Yes.

DR. MAXWELL: -- and this is why the SAI happened. So yes, there is the generalised learning but that's a real significant risk that has been identified? 13:00

A. Yes.

DR. MAXWELL: How does that then feed into the other committees to be monitored? Because once the SAI is

closed, it's closed, but you might have identified some real risks that require ongoing monitoring?

A. Yes.

DR. MAXWELL: So where would that ongoing monitoring be picked up? 13:01

A. At SAI Review Board or even Safety and Quality Steering Group because, as you say, sometimes the gaps might have become because of some design flaw. So I can recall SAI learning leading to pumps that delivered insulin being redesigned so that the patient could 13:01 never again have an overdose. Then in line with departmental circulars, the organisation would have made something like that a never event; something that we as an organisation wanted to never happen again so that no other patient could come to harm. So again, we 13:01 produced information then on never events if and when they happened.

DR. MAXWELL: If an SAI identified that some action had to be taken and had to be taken fairly quickly and it was within the control of the Trust, it wasn't a design 13:01 fault with a medical device, who would decide who was responsible for that? Would that be the Chair of the SAI Review Board, would it be the Assurance Group, would it be the Assurance Committee, would it be the Board? How would you make sure the ball wasn't dropped? 13:02

A. It would be for the directorate in the first instance who were the recipients of the SAI review to take forward the recommendations, and then relay their progress up to those various review boards.

DR. MAXWELL: But some of the concerns would cross different directorates, wouldn't they?

A. Yes.

DR. MAXWELL: So I'm just wondering about the relationship between the directorates. I fully understand the distributed leadership, but distributed leadership only works if you've got redundant systems and stopgaps to make sure that you haven't got a single point of failure; the whole James Reason safety Swiss cheese model. 13:02

A. Sure.

DR. MAXWELL: So I'm not clear in this system - and I understand it's a big Trust - how you make sure the ball doesn't get dropped.

A. Again through the oversight coming from the Governance Department and the Review Board, where if something was of fundamental importance or there was a piece of learning that might even have regional application. 13:03

DR. MAXWELL: Forget regional, I am just talking within the Trust because that's the area that you are accountable for. 13:03

A. Yes. So through the Governance Department then, a learning letter or the action to be taken in response to a review findings would have been issued to the relevant department, or across departments if it was of a crosscutting nature. 13:03

DR. MAXWELL: So one of the things that might happen out of an SAI Review Board is that the Governance Department, the operational arm as opposed to the

committee arm, would be monitoring this issue?

A. Yes. You know, we would have frequently issued learning letters across directorates that we felt had wider applicability within the organisation.

DR. MAXWELL: I suppose it's the feedback I am interested in rather than the pushing down. How do you know that action is being taken? So you're saying the Governance Department would be monitoring that; who would they be reporting that to? 13:04

A. They would be reporting that up through some of the subgroups and up through Assurance Group, but it is a very good question. One of the questions I frequently asked at Assurance Group when advised about previous learning and advised of the fact that learning letters would have gone out, one of the questions I would asked as Chief Executive, in the same way as a non-executive might have asked, how can we as an organisation assure ourselves that that learning has been fully applied and is working such that something like this can never happen again. 13:04

Other than assurances from the director or the assistant director to say, yes, that learning has been disseminated to all the right clinical or other staff and we've had no recurrence of that since, or if it does happen again because it's now a never event, you know, we will have a firmer grip on this. 13:05

DR. MAXWELL: So if that happened, would it always result in the Governance Department doing some

monitoring or would you sometimes just be relying on a single person from the directorate to reassure you rather than assure you that it was all learnt?

A. Again at this remove, you would be to some extent reliant on the directorate assuring you that the learning had been applied. 13:05

DR. MAXWELL: But with no evidence to back it up?

A. Well, evidence coming forward that there was no recurrence of the root cause that gave rise to the original incident. 13:06

146 Q. MS. KILEY: Is that true, Mr. Dillon, for other issues - so thinking beyond SAIs now - really was the Board and the structures at the top, the committees, the Assurance Group, the Executive, were they heavily reliant on the directorate doing the heavy lifting, as it were, and giving/feeding information up to them? 13:06

A. Yes, but the directorates were supported by a range of corporate functions, Planning and Performance, by Finance, by the Medical Director's Office, by Corporate Governance to assist them, producing for them a whole range of performance metrics and helping the directorate manage their performance such that any outlying performance or adverse performance could come up through the structure. 13:06

147 Q. You say a little bit more at paragraph 19 about how that worked, so I think it's an appropriate time to turn there. Back to your statement. You say there: 13:06

"In summary, given the size, scale and enormous scope

of the Belfast Trust, it was primarily for the Director of Adult Social and Primary Care"...

Do you have that, Mr. Dillon? It should be on the screen in front of you. Paragraph 19. 13:07

A. Okay, yes.

148 Q. You have that?

A. Thank you.

149 Q. "...it was primarily for the Director of Adult Social and Primary Care to have in place the structures and 13:07 processes for the effective oversight of Muckamore Abbey Hospital in line with the Belfast Trust's overall assurance and governance arrangements. Those arrangements made provision for matters of concern to be raised to Trust Board level. As with the other 13:07 directorates within the Belfast Trust, the directorate would have accounted for and provided assurance on the effective management and oversight of services operating within the directorate by a variety of means, including through internal senior leadership meetings, 13:07 Trust level and external accountability meetings, and from the inspection reports from regulatory and other bodies."

Then if we can move to paragraph 21 and picking up just 13:08 halfway down there. You say:

"Whilst it was expected that areas of significant concern would be specifically raised through Executive

Team Assurance Committee and Trust Board, other parts of the Belfast Trust and external organisations had functions which were capable of triangulating information, thereby highlighting problems or other issues which could be picked up at Board level. This included the presentation of Key Performance Indicators, information in Trust-wide reports on finance and performance tabled at Executive Team and at Trust Board Assurance Committee reports, which included information or trends on SAIs, complaints, process measures, early alerts, incidents. Progress with implementation of RQIA inspection findings would also have helped identify concerns at ward service level. Furthermore, during my time as Chief Executive I regularly told individuals I met when I was at ward level that I was available to discuss any serious concerns raised at that level." 13:08 13:08 13:09

In terms of the directorates' role in all of those, you describe, I think you say from memory you think there were eight directorates during your time on the Board -- 13:09

A. Yes.

150 Q. -- whenever you were Chief Executive, did you meet with the eight directorates, the directors of the directorates, regularly to discuss these sorts of matters? 13:09

A. We came together as an Executive Team every week, myself and the directors, along with the corporate

communication's head, yes. Our Executive Team agenda was structured very much like the Board agenda. Our first agenda item was always around patient and service user safety. There would have been various reports, performance metrics in relation to that. Then we would have worked down through the agenda, including performance against our Trust delivery plan. I mean, we had levels of activity in terms of patient and service user activity to deliver to the Health Board, who were commissioning our services and paying us for our services. So all of those would have been discussed at Exec Team. 13:10 13:10

But I think what I'm trying to describe here is, if I take complaints as an example, while it's first and foremost for the Director of Adult Social and Primary Care to look after complaints in her directorate, and like every other Trust we would have attempted to resolve complaints as informally as we could and as close to service level as we could so as not to put someone through the burden of having to make a formal complaint. Whenever formal complaints came in, they would have went to the Central Complaints Department. They would have been logged there, the nature of the complaint, type of complaint, was it about tone or attitude on the part of a staff member, was it about diagnosis, was it about some aspect of their care. Then, that would have went out to the director and the sub-directorate team for the compilation of a response. 13:10 13:10 13:11

Progress with that response would have been tracked by the Complaints Department and, when it came back, they would have issued the complaint response to the complainant and there would have been a judgment made then, depending on what the complainant said, whether the complaint was considered closed or resolved at that juncture.

That's summary level information about the number of complaints, the type, their nature, whether they were considered resolved or not would have been coming up through Exec Team, through Assurance Group and up to Assurance Committee.

MS. KILEY: But...

DR. MAXWELL: Can I just ask about -- it is maybe the point you were going to make and I am sorry if it is. You said you had meetings weekly with the directors of the directorate where you were looking at high level information. How often did you have a one-to-one with the directorate to do a more deep dive?

A. Over the course of a week, it would be very rare for me not to have conversations with each and every directorate.

DR. MAXWELL: But did you ever have a scheduled performance accountability meeting?

A. Over and above that then we would have had - I can't remember the frequency now - our formal one-to-ones in which we would have talked about range of issues, including the individual development, their feedback to

me of my performance and my feedback to them of their performance. As well as that then, twice a year we had a formal accountability meeting. I would have had a formal accountability meeting with each of the directors as well. So we had those one-to-one meetings, yes.

DR. MAXWELL: So if I was the director of a directorate and I had some ongoing concerns that hadn't quite made it to the top level, so weren't getting the attention at the high level summary but I had a niggly feeling about them and I wasn't happy, I would have the chance to go through that with you.

A. Absolutely. There were no limitations to anything any director could raise with me at any time and, in fact, I positively encouraged that all the time.

Equally as well, I mean some of the issues were maybe to do with nursing staff levels or the number of nurses being brought into training, and directors also had a range of avenues back to the Health Board and back to the Department of Health in relation to issues like that. Both the Health Board and the Department would have had regular meetings as well with directorates, normally on a programme of care basis as opposed to directorate, at which directorates had every opportunity to raise any issues or concerns directly with the bodies who were commissioning the services and funding the services.

151 Q. MS. KILEY: Earlier on in your evidence, you had

accepted that, as Chief Executive, it was impossible for you to have -- there were limits to what you could learn and understand about individual facilities. So, was there not a need for the Chief Executive to have an even greater interaction than what you have described with the directors, to exercise a probing function and to allow the time and space for a director to raise other issues so that you could get a feel for what was actually going on in directorates separate to the things that were being escalated to you, so that you could really have an understanding of what was going on and the issues in the directorate? 13:14 13:14

A. I genuinely believe in terms of the formal one-to-ones, the informal meetings, the nature and style of my leadership, that directors had every access they would have needed to me to raise or escalate any concern whatsoever. I have absolutely no doubt about that. Knowing the directors that I worked with, their values, their principles, their integrity, I believe if they had any major issue of concern, they would have had no hesitation in escalating that to me or raising that to me. 13:15 13:15

MS. KILEY: I am going to come on to look at some specific reports that the Board received or perhaps did not receive. I think it might be an appropriate time to break now. 13:15

CHAIRPERSON: Certainly. Okay. We will take an hour as I think the stenographer and all of us will need it. We will sit promptly at 2.15, and then we will see how

we go this afternoon.

THE LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS: 14:16

CHAIRPERSON: It's got warm in here again, it was freezing before lunch. Sorry, thank you. Right.

152 Q. MS. KILEY: Mr. Dillon, just before lunch we were looking at the Board structures and how issues might be brought to the Board's attention. One of the things that you were asked to do when making your statement for the Inquiry was to comment on whether the Board actually received specific reports which were put to you. 14:21 14:22

Can we turn to look at page 15 of your statement please? You'll see this is question 5, it just trims the bottom of that page. You were asked, "Did the Trust Board receive reports on the following and, if so, please indicate how often," and a number of matters were listed. One is safeguarding of patients at Muckamore. Two, seclusion rates at Muckamore. Next page, please. Three, complaints relating to Muckamore. Four, resettlement of patients from Muckamore. Five, staffing, both establishments and vacancies at Muckamore. 14:22 14:22

You answer this at paragraphs 44 to 51 of your statement. In respect of each of those, in respect of the safeguarding, seclusion, complaints and staffing, you say to the best of your recollection, prior to 2017 no reports were tabled at Trust Board. 14:23

At paragraph 50, if we could move down, you address resettlement reports specifically. You use slightly different language in respect of that, so rather than saying no reports were received, you say no specific or 14:23 detailed reports were received. It might just be a non-deliberate choice of language but I wondered was it deliberate. Does that mean that some reports on resettlement were received but they weren't specific or detailed? 14:23

A. Thank you. No, I suppose what I was trying to tease out there that in relation to resettlement, whenever the Health Board had set the Trust, as indeed all Trust targets in relation to this, they tended to do that on a programme of care basis as opposed to an individual 14:24 facility basis. They would have been monitoring performance in relation to mental health and learning disability.

True, the Trust delivery plans performance reports, the 14:24 Board might have been getting reports on how the Trust was doing against resettlement targets but not specifically related to facilities. However, if performance was adverse or outlying, it may well have

been that the facilities that were outlying or the nature of the service that was outlying would have been referenced or mentioned. Now, I can't recall at this remove any specific examples but that's the distinction I was trying to draw there.

153 Q. Okay. Just so we're clear, you were receiving reports about resettlement and whether the Trust was meeting resettlement targets but that was on a high level and a wider level, not just related to Muckamore Abbey Hospital; is that what you're saying? 14:24

A. Yes. Initially those would have been on a programme of care basis, for example, mental health, learning disability, although there was probably the ability to drill down then by facility beneath that. But the Board would have been considering summary level information against targets and receiving explanations as when performance was off. 14:25

154 Q. But there was a drive specifically to resettle patients from Muckamore Abbey Hospital so that no learning disability patient had their home in a long stay hospital; isn't that right? 14:25

A. There was. That was the ultimate intention, of course. Over the years, and even in the time I was with the Belfast Trust, there were very many successful resettlements but towards the end of the process, the way it was explained to me was that many of the remaining patient population were some of the most vulnerable patients, patients with the greatest need, and that we, as a society and as a health care system, 14:25

were struggling to put in place the alternative community placements for some of these very vulnerable and those patients in greatest need. And so I hesitate to use the word 'stalling', but obviously resettlement over time became more difficult. It wasn't, you know, it wasn't necessarily that money was the limiting factor here, that was not the rate limiting factor, it was trying to encourage the independent and third sector, and again the statutory sector, to come up with the alternative community provision that would best meet these vulnerable patients' needs. 14:26 14:26

155 Q. Yes. Resettlement was complex issue, I think it's fair to say?

A. Indeed.

156 Q. But in terms of data and reports, are you saying then that despite the policy drive which was specifically to resettle patients from Muckamore, setting aside other services and institutions, specifically to resettle patients from Muckamore, the Trust Board was not receiving regular reports on the number of patients actually being resettled from Muckamore as compared to the targets? 14:26 14:27

A. To the best of my recollection, the Trust Board reports were probably in the context of a programme of care basis. That's not to say that there wouldn't have been references to the challenges related to resettlement of the remaining patient population at Muckamore. 14:27

157 Q. But the Board wasn't receiving simple figures saying here's our target, this is the number we're meant to

resettle from Muckamore this year and this is the number that we have achieved?

A. No. I stand to be corrected but I think it would have been in the context of the overall summary reports on how resettlement was going across the organisation. 14:27

PROFESSOR MURPHY: When you say by programme of care, do you mean learning disability?

A. Yes.

PROFESSOR MURPHY: So, there were no other big facilities for learning disability that required resettlement, were there? 14:27

A. No, but there would have been --

PROFESSOR MURPHY: Does that mean most of the figures would have been in there?

A. There would have been patients maybe needing other form of care and leaving their homes to go to care as well. 14:28

PROFESSOR MURPHY: I see. I see what you mean. Okay, so not just leaving hospitals.

158 Q. MS. KILEY: Given the complexities of the resettlement programme, and the challenges, some of which you have described, on reflection do you think that it would have been useful for the Board to have received that specific data on the number of resettlements from Muckamore as compared to targets? 14:28

A. On reflection, yes, for information and for the Board maybe to seek assurances that everything that could be done was being done. However, I say that in the context that the Department and the Health Board would have been very aware of the challenges and issues that 14:28

were frustrating resettlement of the remaining patient population, and there would have been a number of regional meetings at which this would have been raised by the Director and her team, and equally by the Health Board and the Department of Health, asking the Trust about its performance and indeed asking all Trusts who were involved in this and making sure that the drive to do this could be continued. 14:29

As I've said, money wasn't always or very rarely the rate limiting factor within the overall parameters of the health settlement. It was trying to stimulate and encourage alternative community placements for these very vulnerable patients. 14:29

DR. MAXWELL: Can I just ask a comparison? So, you've said that it was known that there were challenges with the resettlement target. Whilst I accept your point that people were being resettled from home, there wasn't a target for that, there was a very specific target for resettling from Muckamore, and you were saying that wasn't being addressed on a monthly basis by the Board. 14:29

If I gave you another example, A&E waiting times, hugely challenging, hasn't been achieved for many years, well known by the Department and the HSCB, and yet I think that was probably being reported on a monthly basis to the Board? 14:30

A. Yes.

DR. MAXWELL: So why is the A&E waiting time target, even though it's a complex issue that hasn't been met for years, being reported to the Board monthly but resettlement from Muckamore, which is a challenging problem that hasn't been met for years, not being reported monthly to the Board?

A. Leaving aside the issue or question of frequency of reporting because, you know, A&E performance is measured daily, weekly, monthly and can therefore be reported, but sometimes there might be a long high hiatus between, you know, resettlement taking place.

DR. MAXWELL: But that figure should be zero then, you can still report it?

A. Yes. You know, because I have been away for sometime now, I can't at this remove recall or recollect what information might have been coming forward to the Board when you drill down into some of the performance reports.

DR. MAXWELL: But you can see that potentially it looks like some targets were more equal than others in the eyes of the Board and possibly the HSCB?

A. I think it would be pointless me speculating on that. I mean, all targets were given a priority and I wouldn't elevate one target over another. Yes, I accept as an organisation sometimes when there was public pressure and political pressure, some targets may well have had the sense that they were being elevated over others and organisations asked to address those over other things at a point in time.

CHAIRPERSON: Could I just ask what other targets would have appeared on the Board agenda regularly apart from A&E waiting times?

A. There would have been a whole range of performance metrics. 14:32

DR. MAXWELL: Elective surgery waiting times?

A. Yes, again dealt with in the context of performance against the Trust delivery plan, which is the levels of activity that the Health Board commission from the Trust and pay for. But towards the top of every 14:32 agenda, and certainly I insisted on it as Chief Executive, as did the Chairman, was the patient experience, patient safety metrics.

CHAIRPERSON: Yes, but those aren't targets, are they?

A. No. 14:32

CHAIRPERSON: I am asking specifically about targets that are set.

A. No. But, well, I mean there are targets set for the time in which you must respond to a complaint --

CHAIRPERSON: I see. 14:32

A. -- the time in which an SAI review might be reported. But this was information more to do with trends, analysis, so you could spot emerging issues, spot trends.

CHAIRPERSON: It comes back to Dr. Maxwell's question, 14:33 how do you decide what targets are going to appear on the Board agenda? Is it because they are most in the press or is it politically high agenda? What is it?

A. No. There was a whole suite of performance metrics,

including performance against the Trust delivery plan. And where -- and often that would be presented by different directors at Trust Board. Ordinarily what they would do, as you would expect given the business of Trust Board, they would say there is nothing that I wish to highlight this month in particular over on what I have highlighted previously, or here is some new emerging issue in relation to performance that I wish to highlight this month for the Board's attention. 14:33

DR. MAXWELL: Did you not have a dashboard, a performance dashboard? 14:33

A. At the Board? Yes, that was coming through the performance against Trust delivery plan and a range of other things. And over time, governance, as you know, is continuous journey. If you ever think you have cracked governance, you haven't; it is a continuous improvement journey. Over time we were adding through the subcommittee structures performance metrics, with a particular focus on those related to patient safety and service user experience. 14:34

DR. MAXWELL: I understand that but going back to Mr. Kark's question about targets that were in your delivery plan, was there a dashboard which had the targets the delivery plan and the performance each month presented, whether or not it was discussed? 14:34

A. Yes.

DR. MAXWELL: Was resettlement for Muckamore, which was a delivery plan target, included on that dashboard?

A. Yes. Other than I say -- I mean, I can take this away

and come back with further written explanation.

DR. MAXWELL: It would be interesting to see the dashboard.

A. Yes, you know resettlement would have been there on the dashboard but on a programme of care basis. 14:35

159 Q. MS. KILEY: At what point in time was that, Mr. Dillon?

A. I think from my recollection, and again I stand to be corrected, but in most years.

160 Q. Returning to the other matters that you were asked about in respect of specific reports - safeguarding seclusion, complaints and staffing - you say that to the best of your recollection, prior to 2017 no such reports were tabled at the Board. Would the Board have expected directors to be looking at those sorts of reports? 14:35

A. Yes. Again if I put it in context, individual safeguarding reports, individual seclusion reports, individual complaint responses, none of those things are things that ordinarily come to a Trust Board. What will come to a Board so it can assure itself is summary level information around trends, emerging issues. Yes, each directorate would have had on their performance dashboards a range of metrics that the corporate functions would have been contributing to and collating for them. For example, the Director of Adult Social and Primary Care and in the Learning Disability sub-directorate, they would have had on their performance dashboard seclusion, SAIs, complaints, safeguarding, and they would have been monitoring those 14:36 14:36

metrics. It was open at any time, either through the summary level information coming to the Board which the Board can interrogate, or indeed for a director, to escalate anything at any point in time in relation to concerns relating to any of those. There were no limitations to that, no barriers to that whatsoever. 14:36

161 Q. Do you recall such issues being escalated to you from the directors?

A. No. In relation to, you know, complaints, complaints performance on the part of directors would have been discussed through the governance framework. Likewise, issues in relation to seclusion and safeguarding I believe probably would have been referenced in the annual statutory functions report. 14:37

14:37

You know, primarily a Board is always looking to say in relation to safeguarding is our policy in line with best practice, fully aligned with regional policy? Is it working effectively; are safeguarding issues taken seriously; are the right of protection plans and the right responses to safeguarding taking place? Primarily where that happened was at the level of the directorate, with them having the ability to escalate any concerns, and with the corporate functions and others with their oversight spotting anything there that... 14:37 14:38

As well as that you had, you know, RQIA, for example, who may well have been coming along and saying we think

safeguarding is an issue for your organisation arising out of our latest inspection report; or we don't think it's in line with policy and so on and so forth.

But going back to the question, the Board would not have ever considered, nor any Trust Board as far as I -- have considered individual reports of that nature. It was the summary level information that the Board can interrogate, constructively challenge and satisfy itself that those things were being properly discharged and done throughout the organisation. 14:38 14:38

162 Q. But you would expect the directors to be looking at the granular detail and the Trust Board to be looking at the high level summary; is that --

A. Yes. The individual reports on safeguarding would be dealt with at the appropriate part of the directorate. So, the safeguarding incident led to a safeguarding review and it led to a protection plan. I mean, the relevant part of the directorate was responsible for putting that in place but as you went higher up, then the directorate and the Learning Disability team would have had as part of their performance dashboard how it was they were monitoring trends in relation to safeguarding, seclusion, complaints, SAIs, all of those things. They would have been assisted in their endeavours through the provision of information that helped them monitor all that by corporate function departments. 14:38 14:39 14:39

163 Q. In your answer to your questions in your statements,

you preface all your answers with 'prior to the events that surfaced in 2017', and you say prior to that, those events, the Board wasn't receiving reports. Is the --

A. Not the individual reports. 14:39

164 Q. Yes.

A. But summary information through the subcommittee structure on, you know. Like, for example, through the Assurance Committee, Board members would have been aware of the number of SAIs in any one year; what 14:40 directorate they were happening in; the nature and type of the SAI; what learning was being elicited; how was that learning being applied. Likewise with complaints. So, the Board would have been -- would have known how many complaints the organisation was receiving; the 14:40 nature and type of the complaint; whether they were considered resolved, and being able to discern or spot any trends or patterns that were emerging in any of that. You know, for example was there one department or ward that was attracting a disproportionate volume 14:40 of complaint; was there any one individual who was attracting a disproportionate share of complaints. All of that was carefully monitored.

165 Q. And despite the careful monitoring, the Board didn't actually identify any such issues related to Muckamore 14:40 Abbey Hospital; isn't that right?

A. No. If the director and the directorate and the relevant teams within the directorate believed that all of those performance metrics were within control

limits, well then, they wouldn't escalate. Only if they felt something had emerged that they needed to escalate to the Board to say there is now -- we consider there to be a real issue with safeguarding at Muckamore, or anywhere else for that matter, yes, they would escalate. But if, based on their performance dashboard, the individual metrics were within control totals, well then, they wouldn't be raising it or escalating it. 14:41

Whenever the incidents surfaced in 2017 and the viewing of the CCTV test footage began to reveal more instances of neglectful and abusive behaviour, I do recall the director telling me at the time that all of the things that were being considered by the Learning Disability Directorate on its performance dashboard in relation to seclusion, the use of seclusion, in relation to safeguarding, complaints et cetera, were all within control totals. 14:41

166 Q. So in respect of the reports that were specifically received by the Board, your evidence is that prior to 2017 there were no specific reports of the kind that we have discussed tabled albeit there were different routes to get information of that kind to the Board. But I just want to clarify, after the events surfaced in 2017 did the Board start receiving specific reports on seclusion, safeguarding, complaints, staffing, resettlement? 14:42

A. To the best of my recall at that stage, what the Board 14:42

was receiving was updates on all the actions that were being taken by the Trust to ensure patient safety at Muckamore; all the actions that were being taken to enrich the daily lives of the remaining patient population. It was more to do with that than looking at any individual safeguarding incident report or any individual seclusion report. 14:43

167 Q. It was closer oversight?

A. It was making sure the improvements we were making to seclusion practice in the form of an updated policy, any improvements we were making to safeguarding, all of those action plans were being monitored at the Board, with lots of constructive challenge at the Board in relation to all of that. So it wasn't again about bringing about individual reports on seclusion or safeguarding, it was about the Board being provided with all the information it required to track progress with all the various action plans that were being put in place at that point in time so it can assure itself about that but, more importantly, constructively challenge the executives about the fulsomeness of the plans and were they working and were they achieving their desired aims. 14:43 14:43 14:43

168 Q. I am going to come to that post 2017 period shortly. Just to complete this picture about the various ways in which issues could be brought to the Trust Board, you do mention some other avenues in your statement. If I could ask you to look at paragraphs 74 and 75, you reference the Delegated Statutory Functions Report or 14:44

Corporate Risk Register.

Now, the Delegated Statutory Functions Report, I think that is what you are also describing just as the statutory functions report; isn't that right? 14:44

A. Yes.

169 Q. It is one and the same thing. You were asked specific questions about those here and you say that you don't recall at this remove whether issues relating to Muckamore were included in the Delegated Statutory 14:44 Functions Report or the Corporate Risk Register.

Taking the Delegated Statutory Functions Report first, that was something that was reported to the Trust Board annually; isn't that right? 14:44

A. Correct.

170 Q. It was presented by the Executive Director of Social Work; is that right?

A. That's correct.

171 Q. Do you recall the Board ever having robust discussions 14:45 about the contents of the Delegated Statutory Functions Report or was the Board's role more simply to note the report?

A. A number of responses to that. Apologies for not being able to recall earlier the exact timing of the creation 14:45 of the Social Care Committee, but whenever it was established, one of its part of its terms of reference would have been to scrutinise and constructively challenge the statutory functions report and question

and challenge the Executive Director of Social Work before the statutory functions report would come to Trust Board for adoption or approval.

The second part of my response is in my experience in the Belfast Trust, and hopefully the minutes would reflect this, whenever the statutory functions report would come to Trust Board, there would be a number of questions, queries, challenges from non-executive directors about it. 14:45 14:46

172 Q. But your overall evidence, and you say this elsewhere in your statement, is that you don't recall the Board being made aware of any serious concerns in relation to Muckamore Abbey Hospital?

A. No. In the annual statutory functions report, which was a report in which the Trust, the Belfast Trust, would set out how it had effectively managed those functions delegated to it in relation to vulnerable children, children in need and vulnerable adults' deprivation of liberty, there would have been lots of summary information in that report about how the Board had effectively -- sorry, the Trust had effectively discharged its statutory functions, those that had been delegated to it from the Health Board. 14:46 14:46

PROFESSOR MURPHY: But wasn't the Social Care Committee set up precisely because people were worried that those kinds of social care issues didn't get properly considered at the Trust Board, that they were always overshadowed by Acute Services? 14:47

A. I suppose there was a fear on the part of some in the organisation that such were the big issues in acute hospital services and services like that that community issues or the community voice wouldn't be heard as loudly as it should. I know I never had any particular concerns about that because around the Executive Team table, we had the Director of Social work, we had the Director of Adult Social and Primary Care, we had the Director of Children's Services, and these people were fantastic advocates for the services they managed. But it may well be that given the background of at least one of the non-executive directors, they wanted to see a bigger focus and profile given to this at Trust Board, although I had no sense -- and while that is very good, I had no sense that there was not the right focus et cetera before that. But anything that can be done to improve governance, augment governance, because it's a continuous journey, that's a good thing in my view. 14:47 14:47 14:48 14:48

PROFESSOR MURPHY: Thank you.

173 Q. MS. KILEY: I want to move on to what I said was my third topic, Mr. Dillon, which is the Board's knowledge, actual knowledge, of Muckamore's issues. We talked about the various routes that a Muckamore issue, if I can put it that way, could get to the Board. I want to turn to look at the actual knowledge. 14:48

Can I ask you to turn to page 24 of your statement, please. Sorry, I think I said page but I meant

paragraph, if we could bring that up, sorry. Paragraph 24. It's on screen in front of you.

A. Yes.

174 Q. You say:

"To the best of my recollection, which I accept may be impaired with the passage of time, until the serious adult safeguarding concerns surfaced in 2017, during my time in the Belfast Trust I do not recall any significant or major concerns about the management or oversight of Muckamore Abbey Hospital, or patient safety issues from MAH being escalated to or raised at Executive Team or Trust Board level." 14:49

Then at paragraph 25, you do go on to say: 14:49

"To assist with preparing this witness statement, I sought from the Belfast Trust and received access to Trust Board documents that I would have had access to during my employment. This was to refresh my memory of what matters were being discussed at Trust Board. While I do not have any recall of this matter at this distance in time, I note that in the minutes of the Trust Board in confidential session on 11th April 2013 under the reference 09/13F, the then Director of Adult Social and Primary Care briefed Trust Board members that the PSNI had investigated an alleged case of ill-treatment of patients at Muckamore Abbey Hospital by two members of staff, and that they had recommended 14:49 14:50

prosecution to the Public Prosecution Service. This would be in keeping with what I would expect to happen on the thankfully reasonably rare occasions when staff of the Belfast Trust faced criminal prosecution. The relevant director of the Directorate in which the staff worked would inform the Trust Board. It would not have required the Trust Board to do anything, rather it was for information. The expectation of the members of the Trust Board would be that the issues that gave rise to the matter were being addressed in the relevant Directorate, unless the relevant director considered that some specific issue required the attention of and assistance of the Trust Board." 14:50 14:50

That issue that you refer to in respect of the minute of 11th April 2013, that relates to the safeguarding investigation that took place on Ennis Ward; isn't that right? 14:51

A. I believe so. I mean, I wasn't in the Chief Executive role at that point in time. 14:51

175 Q. But you were on the Board?

A. I was on the Board, yes.

176 Q. Whenever you checked the minute to refresh your memory, were you in attendance at the meeting?

A. Yes. 14:51

177 Q. So you were in attendance at the meeting and it was reported to the meeting that members of the PSNI had investigated an alleged case of ill-treatment of patients at Muckamore Abbey by two members of staff and

they had recommended prosecution to the Public Prosecution Service.

Was the Board made aware that there was a safeguarding investigation that related to the issues? 14:51

A. I mean, I can't recall at this remove whether or not that was said at that point in time.

178 Q. Do you recall a safeguarding investigation into matters arising from Ennis Ward?

A. I don't. 14:52

179 Q. Is the lack of recall that you have about this solely attributable to the passage of time or might it also suggest that the Board wasn't fully cited on the Ennis issue?

A. One is the passage of time, but I genuinely don't recall the Board being briefed on the Ennis Report. That's not to say it was but I genuinely don't recall it. 14:52

180 Q. Do you now have some knowledge of the Ennis Report?

A. Limited knowledge from other statements, yep. 14:53

PROFESSOR MURPHY: Was it rare for there to be prosecutions of staff by the police and the PPS?

A. I don't have statistics on that.

PROFESSOR MURPHY: But your general impression. I mean, did it come up very often or was this like really unusual? 14:53

A. In my experience this would be pretty unusual.

181 Q. MS. KILEY: And you say that it would not have required the Trust Board to do anything, rather it was for

information. But while the Trust Board might not have been required to do anything when alerted to that rare and serious issue, would it not have wanted to do something to find out more?

A. I can't speak to the specifics of that particular instance but what I can say is ordinarily when something like this would come up at Trust Board in confidential session, my experience has always been that non-executive directors would ask for further information and seek assurance that whatever gave rise to this had been properly investigated, that all appropriate actions were being taken and pursued. It would be very unusual if that type of discussion didn't take place in response to something like this. 14:53 14:54

182 Q. To be clear, are you saying that you can't recall whether that happened but your firm expectation is that whenever presented with this type of information, the response would usually have been as you've described? 14:54

A. Yes. As you say, I can't recall, specifically recall, but my experience of working with non-executives over a long period of time, and the integrity of those on the Belfast Trust Board was they would have interrogated and challenged this and asked for assurances about the robustness of any action plans associated with this. 14:54

183 Q. That step, might it have also included a request to receive any safeguarding report that had been conducted into the allegations? 14:54

A. Possibly, but that would probably be unusual if a safeguarding report had been concluded. I think one of

the things that non-executives and a Board tries to avoid is second-guessing reports or opening up something that has been resolved and dealt with. Rather they would focus on is there an appropriate action plan in place; is it being delivered, and can we see the evidence that it is being delivered upon.

DR. MAXWELL: Wouldn't they have to see the report in order to satisfy themselves that an appropriate action plan had been put in place?

A. I'm not sure about that. Ordinarily in my experience, what would come forward would be an explanation and the associated action plan. 14:55

DR. MAXWELL: So we are back to single point of failure and reassurance.

A. As opposed to the individual safeguarding report per se. 14:55

CHAIRPERSON: Do you actually recall this?

A. No.

CHAIRPERSON: So it wasn't startling to you that two members of staff had been arrested for abusing patients? 14:56

A. It probably would have been startling to me, yes, I have no doubt about that. But probably in the way in which the then director, Catherine McNicholl, probably would have been to assure us that all appropriate action was being taken. You would have been -- after, you know, being startled, you would want, as a Board member, assurance that all of this was being appropriately dealt with. 14:56

CHAIRPERSON: Exactly. If you had been Chief Executive at the time, would you have wanted further information?

A. I mean hindsight, it's very difficult to say and I wasn't Chief Executive. Certainly if not individual safeguarding reports, I probably would have expected to see an Ennis Report or something like that come to the fore. 14:56

CHAIRPERSON: It's just the way you put it in your statement so that you have an opportunity of dealing with it. You say "it wouldn't have required" -- sorry, this is just after dealing with the issue having come to the attention of the Board. "It would not have required the Trust Board to do anything, rather it was for information." 14:57

14:57

That rather sounds as if it is a rather passive approach to this and the information received is received and then you move on. Is that unfair?

A. I would maybe characterise it as slightly unfair. I think what was happening was the Director was informing the Board that prosecution had been recommended to the Public Prosecution Service. What you would expect after that is an assurance that this was an isolated thing, had been examined, investigated, that there were no further concerns. 14:57 14:58

CHAIRPERSON: So you would certainly want to see the investigation report?

A. Yes.

CHAIRPERSON: Right. If you were Chief Executive?

A. Yes. I think yes, absolutely. I think the Board should have, would have needed to have seen that, something like an Ennis Report.

CHAIRPERSON: Yes. Thank you.

184 Q. MS. KILEY: One of the things you say later in your statement whenever you're reflecting on the issues that emerged in 2017 - this is at paragraph 86 - you're discussing what a Board ought to do. You say: 14:58

"We need to find a way through increased vigilance of nipping in the bud any culture or behaviours that run contrary to the values of the Belfast Trust. This should be a feature of specific leadership training for leaders in environments caring for patients who lack capacity where the leader's antennae must always be up through a frequent on the ground presence and through promoting a zero tolerance culture in respect of poor behaviour to patients, and by truly listening to the patient family voice." 14:58 14:58

Whilst that reflection is made thinking about the issues which emerged in 2017, is it equally applicable to the issue which we have just looked at, should the Board's antennae have been up having been told there were two members of staff being prosecuted? 14:59 14:59

A. Yes, and I think what the Board would be looking for at that point in time was assurance that whatever incidents gave rise to possible prosecution had been thoroughly examined, and that all the appropriate

action plans and improvements to safeguarding or whatever else was required was in place.

185 Q. But you don't recall the Board actually doing that?

A. I genuinely don't recall the Board doing that but I stand to be corrected. 14:59

186 Q. Does that suggest that radical action was not taken? The fact that you can't recall the Board doing that and you can't recall any action surrounding that, does that not suggest that the radical action wasn't taken and that the antennae weren't up? 15:00

A. I wouldn't suggest that. You know, knowing what I know now in terms of, you know, the response to the allegations that gave rise to the Ennis Report was a very long multiagency approach with the Health Board and all the other RQIA and everyone else involved in 15:00 that, leading to the various action plans that had been put in place. So even at this remove, knowing what I know now, I believe all appropriate actions were being taken in response to those particular incidents and allegations et cetera by the organisation, by the 15:00 Directorate, by the Health Board, by RQIA, you know. So therefore, even if it had have come to the Trust Board, they would have getting assurance around the involvement of this multiagency -- they would have been getting information about this multiagency response, 15:01 how robust, how comprehensive it was, and the various action plans that were flowing from that to assure patient safety on the site.

187 Q. If they were, in fact, getting that information, one

would expect to see it in later Trust Board minutes; is that right?

A. I believe so.

188 Q. Moving away from the Ennis episode and the minute that you have pointed out, the Inquiry has heard more general evidence about staffing at the hospital. You deal with this at paragraph 68 of your statement in answer to question 8. Question 8 asked what you arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix and thereby to ensure safe care at MAH. 15:01 15:02

You describe at paragraph 68 how that would have been done. You say: 15:02

"With regard to workforce monitoring generally, throughout the huge organisation that the Belfast Trust was, the Trust Board would have been made aware at a high level through finance, performance and HR reports, and through the Directors of Nursing and Social Work and the Medical Director of general workforce concerns." 15:02

Now, the Inquiry, as you know, has heard from a number of witnesses and has heard from a number of witnesses who describe issues with staffing at the hospital. That has been described as there being a staffing crisis at Muckamore Abbey Hospital. Was the Board 15:02

aware that there was a staffing crisis at the hospital at any point?

A. I'm not sure it was ever characterised to the Board as a workforce crisis. The Trust Board would have been aware of the impact on the organisation of unfilled vacancies across a whole range of services, the impact, for example, it was having on child protection services and the need to prioritise there, and the impact it was having on the organisation's ability to deliver a range of commissioned services. So, the Board would have been aware of the issues. The Board also would have been aware that money wasn't the rate limiting factor here, that it was a supply of staff that was the main issue here. So, there would have been discussions going on between relevant directors, the Director of Nursing, the relevant directors and the service directors with colleagues in the Health Board and the Department of Health if it was an issue whereby training places needed to be increased or something like that to ensure an adequate supply of nurses. 15:03

But I know that there were times when every Trust was struggling, particularly in the areas of nursing, and were very reliant on staff coming forward to go onto the nursing banks, on agency staff to fill these vacancies to ensure services were safe. So, I have no doubt this was a huge issue for the relevant directors and the Board being aware of the impact on the organisation of unfilled vacancies. But I don't recall

the workforce sustainability challenges at Muckamore ever being characterised as a crisis.

189 Q. If there was a crisis at Muckamore, or any of the areas for which the Board had responsibility, would the Board expect to be specifically told and for it to be characterised in that way? 15:04

A. Yes. I mean, a good example for me is the challenges we had in Children's Services, particularly in child protection services, children in need services, where the supply of new social workers was very constrained at a point in time. This was a pressure being felt right across Northern Ireland, and indeed nationally. So the Trust Board would have been updated on the impact this was having on the delivery of those services, what mitigation or remediation steps the organisation was taking in terms of maybe stepping some services down and having the priority on the most critical services et cetera. 15:05

So those sort of discussions, to the best of my recall, would have happened at Trust Board in response to the Board being told about acute workforce shortages in some areas. 15:05

190 Q. If there was a staffing crisis, would the Board have expected the directorate to take responsibility for managing that, or would it have expected the directorate to escalate that up to the Board? 15:05

A. The Board would have been expecting the relevant director working with colleagues in HR, working with

colleagues in Corporate Nursing and with colleagues in the Health Board, and indeed the Department of Health, to understand the impact workforce shortages were having and what could be done by way of mitigation in relation to that, and escalating that up to the Trust Board as appropriate so the Trust Board could understand what steps the organisation was taking to ameliorate the problem, what it was doing to protect critical services, and what the action plan going forward was. 15:06

DR. MAXWELL: So would this have come up through the risk registers?

A. Yes. Well, a combination of coming up through the risk registers and the impact this was having on the effective performance in the organisation coming up through the subcommittee structure as well. 15:06

DR. MAXWELL: We've heard from a number of witnesses that staffing was red rated risk on the directorate -- or staffing at MAH was red rated risk on the Directorate Risk Register, and then some witnesses have said it didn't make it onto the Corporate Risk Register. Can you help me understand if the directorate is raising this as an issue, who decides what guess onto the Corporate Risk Register and therefore why the Board didn't know that the directorate had been raising it. 15:07

A. I think it would be better for the Trust governance manager to answer that question because at this remove I can't recall the specifics or what the particular

criteria were for elevating a risk from a directorate risk register onto the Corporate Risk Register.

DR. MAXWELL: But you do recognise that directorates do raise things that don't get to Board?

A. Yes, but might-- 15:08

DR. MAXWELL: Even though we have to ask somebody else what the process is, you recognise there could be a situation where the directorate had raised it but it still didn't get to the Board?

A. Yes. I mean, I was aware of situations where something 15:08 was fairly high on the Directorate Risk Register and they were finding ways of managing it, because, you know, by rating or grading something as red risk obviously means you need to be doing something in respect of it and managing that risk and doing your 15:08 best to ameliorate that risk in the interest of patient safety and so on and so forth. At this remove I can't recall the mechanism then that got you from your Directorate Risk Register onto the Corporate Risk Register. 15:08

DR. MAXWELL: The principle of risk registers is they are only red if they are unmitigated.

A. Sorry? I couldn't...

DR. MAXWELL: The principle of risk registers is that they are only rated red if the risk is unmitigated. 15:08

A. Yes.

DR. MAXWELL: So the fact that they had been made red meant that they hadn't been able to resolve it?

A. Yes.

191 Q. MS. KILEY: I want to return, Mr. Dillon --
A. Sorry, just again to put that in context. The only thing I want to add to that was I can recall in my time as Executive Director of Finance in the organisation, the Muckamore spend would considerably exceed budget, with a principal reason for that being the number of unfilled posts, some of which was associated with the lack of regional supply of newly qualified learning disability nurses et cetera, and we were turning to bank, to agency, to help plug the gaps. 15:09

In addition to that, in response to safeguarding issues and incidents and various protection plans that were being put in place, there was very often a prescription for one-to-one, two-to-one and sometimes three-to-one nursing. So all of that was generating a very significant overspend, but on each and every occasion, to the best of my recall, the Health Board would have stepped in and funded that on the basis that this was a necessary spend to mitigate or ameliorate the impact of unfilled vacancies. 15:09 15:10

DR. MAXWELL: So there was at least two members of the Board who know that there are problems: The Director of Nursing, because we've heard lots of evidence that she was involved in reviewing staffing, and as Finance Director you were aware of the overspend because of the problems with recruiting staff and the demands of the patients. So if at least two executive members of the Board are aware of things, how is it that -- how would 15:10

that get communicated to the rest of the Board?

A. Well, every member of Exec Team, I think, would have been aware because I think every director had examples in their directorate of the impact of unfilled vacancies, not just in Northern Ireland but nationally across a whole range of staff groups, sometimes owing to the fact that we haven't been very successful in the NHS or the HSC at very robust workforce planning so as to avoid this type of thing happening. 15:11

So Exec Team would have been aware because directors would have had their own examples of this; would have been aware from the Director of Nursing and other directorates of the issues around workforce issues right across the organisation. So, it wasn't unique to Muckamore, it was a real challenging issue across a number of directorates and services, including emergency departments. 15:11

DR. MAXWELL: And were the non-execs aware of this?

A. I can't say with certainty, but I would be very surprised if they weren't because of the discussion that would have happened at various Trust Boards when the performance of the organisation was being discussed and that the impact that unfilled vacancies was having on performance. 15:11 15:12

192 Q. MS. KILEY: Mr. Dillon, we moved away slightly from paragraph 24 so I want to return to it. This was the paragraph I took you to first. You said there that until the serious adult safeguarding concerns surfaced

in 2017, and with the caveat of the Trust Board minute of 11th April 2013, which we have discussed.

"I do not recall any significant or major concerns about the management or oversight of Muckamore Abbey or patient safety issues." 15:12

Is the Inquiry to take it that you don't recall serious concerns being raised about safeguarding specifically at Muckamore Abbey Hospital? 15:13

A. You know, apart from the discussion we just had about awareness around the challenges associated with workforce and workforce stabilisation and the reference in 2013, I think it was, to that --

193 Q. Yes. 15:13

A. -- I don't recall any concerns about abusive or neglectful behaviour at Muckamore being escalated.

194 Q. I want to ask you to look at a document which is exhibited to a statement which the Inquiry has received. It's a statement made by a Sean Clarke, who is a PSNI analyst. This is statement STM-322. 15:13

Mr. Clarke has provided some statistical breakdown of staff-on-patient complaints prior to and including Operation Turnstone incidents in respect of 2017. I want to look at the table at page 7, please. Now, I know that you haven't seen this before today. I gave you a copy of it just before you came in to give your evidence, and there is a hard copy in the black folder in front of you, if you prefer to use that. You can 15:14

see there, to orientate yourself, that there is a table which runs from 1991 to 2023. It is organised by date and there are annual numbers presented. You can see the first substantive column just beside the dates says "Turnstone", so that relates to incidents arising from the 2017 CCTV revelations. Then there is Muckamore only, and there is a series of numbers below there. Then there are totals.

As I have said, Mr. Clarke says this is a statistical breakdown of staff-on-patient complaints. So, there are a number there. If we scroll down to start to look at 2010, which is the first period you were on the Board. Can you see beside 2010-11, the first figure there is 56, so 56 issues of staff-on-patient complaints made to PSNI?

CHAIRPERSON: Do you mean staff on patient complaints or assaults?

MS. KILEY: Complaints to PSNI is how Mr Clarke puts it.

So there are 56 in 2010 and then we can see in 11-12 it moves up to 228. 12-13, it moves up to 618. 13-14, it moves up to 589. 15-16, it reduces to 84. 16-17, 100. If we pause there.

This, I think today, is the first time you have seen this table; isn't that right?

A. Yes.

195 Q. Setting aside the table, were you, in your capacity as a Board member, ever aware of the number of incidents, the number of complaints made to PSNI in respect of Muckamore Abbey Hospital? Was this sort of information ever delivered to the Board? 15:16

A. I think it would be pointless for me to try and speculate at this point in time, only having just seen this. As I said earlier --

196 Q. Well, if I can just pause you there.

A. -- this type of statistic would have been on the performance dashboard of the directorate and up to them then to escalate anything they wanted to be made visible at Trust Board or anywhere else. 15:16

197 Q. Yes. To be clear, I am not asking you to speculate, I am not asking you whether the specific figures were ever given to you, but what I'm asking is did the Board ever receive figures about the number of staff-on-patient complaints that the PSNI were dealing with in respect of Muckamore Abbey Hospital? 15:16

A. I would say no, but in the context of any reports on the number of safeguarding incidents, nature and type at summary level what had been coming through the subcommittee structure. 15:17

198 Q. Do you agree, looking at these figures now, that some of those seem like large numbers? For example, if we look at the 2012-2013, number 600 and... 15:17

CHAIRPERSON: Can we just stop? There is somebody either leaving the room or...

MR. AIKEN: No, I am definitely not leaving the room,

sir. This is being put a number of times as a table showing staff-on-patient incidents that have been reported to police. Now, you have heard some evidence about these statistics and you had some further questions to ask about them, but my understanding is this is not a table showing staff-on-patient incidents being reported to police. These are incidents that have been reported to police and they will encapsulate all incidents, including patient-on-patient incidents. There is a representative from the Police Service here who can speak to that, but it's been repeatedly put in a way that doesn't appear to be accurate. 15:18 15:18

CHAIRPERSON: Okay, Mr. Aiken, thank you.

Ms. Kiley?

MS. KILEY: (Inaudible) before that, but it is put in that way because it is an exhibit to Mr. Clarke's statement and that is what Mr. Clarke says he is providing. At paragraph 5 he says: 15:18

"I have provided statistical breakdown of staff-on-patient complaints." 15:18

Now it may be that the Inquiry will want to take --

CHAIRPERSON: If the Trust want to give further explanation of this, they can do so. 15:18

MS. KILEY: Yes, and it may be that the Inquiry wants to look at that, but as to what is being put --

CHAIRPERSON: Let's put the figures aside because the figures, in some sense, don't matter; it is a question

of whether this type of information was given to the Board.

199 Q. MS. KILEY: Exactly, exactly. So in terms of the general proposition, the Board was not receiving statistical information about the number of staff-on-patient complaints that were made in respect of Muckamore Abbey Hospital? 15:19

A. That information would have been considered by the Director and sub-directorate teams, with the ability or capacity to escalate anything of note or concern in relation to anything up to the Trust Board. 15:19

MS. KILEY: Yes.

DR. MAXWELL: Can I just clarify that because there are two ways of reporting. One is internal staff reporting, which the Director would have access to. This is information from the police. My question would be were you ever aware of the police sharing information with you about the number of calls they had had? 15:19

A. No, I wasn't aware of the police sharing information. Again, it's pointless for me to speculate, and it may well be these figures are actually coming from the Trust in terms of, you know, patient-on-patient allegations, staff-on-patient allegations, so I don't know. I mean, this would need to be taken away and we can come back with further written explanation. 15:20

CHAIRPERSON: Okay.

A. But these figures may well have been what was notified by the organisation to the PSNI.

DR. MAXWELL: You weren't getting anything directly from PSNI?

A. Not that I am aware of.

200 Q. MS. KILEY: And if there were concerns about the figures at directorate level, you would expect those to be escalated up to the Board? 15:20

A. Indeed.

201 Q. And how; through which route?

A. Either directly through me by the Director, or up through the subcommittee structure. 15:20

202 Q. Setting aside these figures then, and it may be that clarification is provided in respect of them, I want to look at an extract of the review of Leadership and Governance Report. The review of Leadership and Governance Report is exhibited to your second statement, and we can bring it up on screen. If we could bring up, please, page -- this is STM-107 page 1611. Just pause there. This is the first page of the review of Leadership and Governance Report dated 31st July 2020. Have you seen that report before or do you recognise it? 15:21

A. I had left the organisation, I had retired before that report was produced.

203 Q. Yes, but this is a report which you exhibit to your second statement. 15:21

A. Yes.

204 Q. So have you seen that report before?

A. Yes. As part of that statement preparation, yes.

205 Q. But what you are saying is you had left post before the

report came to the Board?

A. Was finalised, yes.

206 Q. Can we move down, please, to paragraph 8.83?

CHAIRPERSON: Have you got a page number?

MS. KILEY: I'm afraid not; paragraph 8.83. If you look at the internal page numbers at the bottom, it's internal page 125. 15:22

CHAIRPERSON: So it would be around 1731.

MS. KILEY: We are not quite there yet; if you just keep scrolling down to 8.3. That's it, thank you. 15:23

This is part of the report where the Review Team look at the history of CCTV in the hospital, and they look at the installation and emergence of CCTV. You can see there at paragraph 8.83, it records: 15:24

"In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the core hospital. The business case proposed that CCTV would be installed in communal areas 15:24 used by patients and staff in Six Mile and Cranfield male, female and Intensive Care wards. The overall purpose was CCTV is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012-13 there were 15:24 667 reported assaults to the PSNI from Muckamore Abbey Hospital. Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80,000 on

13th January 2014. This allocation was approved in principle by the Trust's Executive Team on 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services." 15:25

If we just see the next paragraph, please, and just pause there. "Funding became available in the later part of 2014 -2015 financial year." The report does then go on to analyse the timeline in relation to the 15:25 procurement and contractual development of the CCTV and its operation, but if we just pause there for now and bring into view 8.83 and the top of 8.84 on the screen, please.

15:25

Now at this time, whenever the business case was developed - and we can see the date given there for the approval in principle by the Trust's Executive Team was 22nd January 2014 - at that time you were Executive Director of Finance; is that right? 15:26

A. Correct.

207 Q. And so do you recall having received the business case?

A. No. My recall of the process in operation at that point in time was that the directorates were allocated a share of available capital funding for their priority 15:26 projects and so on, and a number of assistant directors and others would have met as a capital evaluation team and come to an agreement about what each directorate's priorities were in line with whatever criteria we had

at that point in time. That capital evaluation team then would have, at each of its meetings, approved a list of the bids that would go forward for funding. That would then come forward to Executive Team; the minutes of the Capital Evaluation Team would come 15:27
forward to Executive Team for approval which gave the approval to the allegation of funding. Ordinarily what that would be would be a long list of a large number of projects, some ranging from some very smaller amounts of money to slightly bigger amounts of money that was 15:27
simply noted. People wouldn't be drawing attention at Exec Team to individual lines within that because that would have been sorted out by individual directorates and their priorities, and sorted out at the Capital Evaluation Team. 15:27

So, the Executive Team endorsing the long list or whatever was coming through from the Capital Evaluation Team because the Capital Evaluation Team had agreed, if you like, on the list of priorities for that quarter, 15:27
or whatever it was, was then simply approved at Exec Team. It wasn't a line-by-line, to the best of my recall, examination of each of the bids, or trying to second guess the process of what had going on at Capital Evaluation Team. If you had a particular 15:28
interest or you wanted to drill down to something, at Exec Team directors would have already known from their representative at the Capital Evaluation Team which of their bids had been accepted, and this was, if you

like, a final approval coming from Exec Team.

208 Q. So someone on the Exec Team would have been on the Capital Evaluation Team?

A. Again, I can come back with written clarification at some point. My understanding was directorates sent individuals at the level of Assistant Director or Co-Director, and or sometimes even before that when the Co-Director wasn't available. Somebody in their Directorate who was au fait with business cases, capital development and so on went to the Capital Evaluation Team, made their case for funding and then decisions would have been made at that particular evaluation team meeting. 15:28 15:28

DR. MAXWELL: From Finance, it would have been an Assistant Director as well? 15:29

A. Yes. Holding the ring, reminding people of their respective allocations, how much was available. A big part of their role would have been ensuring that the relevant, the business case proportionate to the size of the investment, was in place. 15:29

DR. MAXWELL: Because this was a normally delegated budget already, there would be no executive directors at the meeting? They were previously delegated?

A. No, no. They would have been obviously kept informed after the meeting by their participant here was the outcome, we are getting money for the following five things. So it was simply a long list then coming to Executive Team that was the final step in the approval process. 15:29

209 Q. MS. KILEY: So are you saying as Director of Finance, you wouldn't have routinely reviewed the detail of all business cases?

A. No. One of my assistant directors had responsibility for doing that, to make sure the business cases (one) had been prepared; that they were in line with best practice; that they, for want of a better expression, ticked all the boxes, and it was okay then to approve the funding in line with the directorate's wishes. 15:29

210 Q. But the Executive team did then approve in principle what was brought to them from the Capital Evaluation Team? 15:30

A. Yes.

211 Q. Do you have a recollection of approving the installation of CCTV? 15:30

A. None.

DR. MAXWELL: Sorry, can I just clarify that point. Because there was delegated authority, did it have to go back for sign-off by execs, or was it just agreed at the capital group and didn't go back for sign-off by the execs? 15:30

A. It was more or less fully agreed at the Capital Evaluation Team that that was the best place for people to argue their case in relation to very limited funding. 15:30

DR. MAXWELL: That would be normal in most Trusts.

A. That would be normal. Obviously I probably inherited, as part of the governance process, where it came back to Exec Team in the form of a long list of what had an

approved just for, I suppose, compliance, maybe with a departmental circular or some other aspect of best practice governance, that Exec Team had signed these off. Unless you had a specific interest, for example, for me, if I had been making a bid for funds for something in my Directorate, then you wouldn't probably run down through that list. Each of the directors would have already known in advance what bits -- which of their bids would be on the list and had been approved. So it was just a collective agreement to sign off what had previously been through a governance process and agreed at Capital Evaluation Team. 15:31 15:31

212 Q. MS. KILEY: So what is being described here in terms of the Executive Team's function is really an administrative process; is that right? 15:31

A. Well, a final step in the governance process in terms of compliance, I imagine, with Departmental guidance.

213 Q. Would there have been detailed discussion at Exec Team level of the proposal?

A. Not of the individual proposals because the individual business cases would have been prepared by the relevant people in the Directorate; they would have went to the Capital Evaluation Team; the bids would have been adjudged. As I say, my representatives would have made sure everything was in place in terms of the quality of the business cases and so on, and then it just came for this final, if you like -- I hesitate to use the expression "rubber stamp", but this final rubber stamping. There would be no need at all for the Exec 15:31 15:32

Team to scrutinise this or go down through this because there would be no surprises in it. Directors would already know from their representative what had been approved for their directorate.

15:32

My recollection at this remove is the single biggest lament of the Exec Team in relation to this was, as was common with so many services, there simply isn't enough capital funding for us to be doing all the things we would like to do. That was a very popular refrain from directors at that point in time, but that was just a reality of the funding envelopes they had to work within.

15:32

214 Q. Once this issue was signed off, approved in principle by the Executive Team, is it the type of issue that the Executive Team reported on to the Board? Would the Exec Team have said to the Board this is new information, there is going to be CCTV in Muckamore Abbey Hospital?

15:33

A. No. I mean, I can't at this remove remember the limits, but, you know, you might argue that £80,000 isn't an insignificant sum of money but when you went up the thresholds, things got reported to the Board, you know, things over a quarter of million, half a million. I can't remember at this remove the various thresholds that were in place but that's how it operated.

15:33

215 Q. Was it just a financial threshold or were there other factors? For example, the installation of CCTV on

wards was an unusual measure; isn't that right?

A. Sorry, you couldn't repeat that?

216 Q. The installation of CCTV on hospital wards was an unusual measure; is that fair?

A. I'm not sure I can comment on that because I'm not sure... Yes, probably, yes. 15:33

217 Q. It was new to Muckamore Abbey Hospital anyway?

A. Yes. Yes.

218 Q. So, given that it was a new measure, would that not have factored into any decision as to whether it should be brought to the attention of the Board? 15:34

A. I don't believe so because, as I say, the process was directorates would have been notified of their proportionate or share of the money, or in line with what the organisation maybe viewed as some priorities, and it was for the directorate to decide how it was they were going to spend their money. I mean, the role of the Capital Evaluation Team and my representative is to make sure the proportionate business case was in place that we could comply with Departmental guidance and best practice in terms of best use of public funds, discharging our duty to the taxpayer. 15:34 15:34

CHAIRPERSON: So it's all to do with financial thresholds really as to whether it gets to the Board or not? 15:35

A. Yes. You know, the Board would be aware of very major business cases and their purpose, you know, like new hospital development, significant ward redevelopment, you know, where very major amounts of money were

involved. But this was a matter primarily for the directorates to decide how to spend their share of the allegation.

CHAIRPERSON: I understand. Ms. Kiley, I'm just thinking about timing. 15:35

MS. KILEY: I just have one more question on this and then I think it would be an appropriate time.

219 Q. I wonder, Mr. Dillon, after the Executive Team approved this, whether it would have expected to receive updates on the installation of CCTV and that process, or 15:35 whether the Executive Team's involvement was purely financial?

A. Mainly financial because it was then for the directorate who had prepared the business case to work with Estates, to work with our procurement specialists 15:35 and so on and so forth, to enact their business case and do that. The Exec Team, from memory - and again I stand to be corrected - would have received information on how well directorates were getting on in spending the allegation, because in health at that time there 15:36 was a system at that time whereby if you hadn't spent it by the end of the financial year, potentially it was lost. So there would have been some level of scrutiny in relation to how well were the directorates getting on in spending their allocation, and a system whereby 15:36 if their view was we haven't progressed as much as we would like and we probably need to hand some money back, it was more of that ilk.

220 Q. Okay, thank you. I have nothing further on that topic

so I think that's an appropriate time.

CHAIRPERSON: Thank you. Shall we take a break there? Do you think you are going to finish this afternoon?

MS. KILEY: I think so. We have finished all topics bar the last. 15:36

CHAIRPERSON: Thank you very much indeed. We will take the usual 10-minute break.

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

15:48

CHAIRPERSON: Thank you.

221 Q. MS. KILEY: Mr. Dillon, we have now reached our fourth and final topic that I referred to you at the outset. That's the Board's knowledge and response to the allegations of abuse which emerged in 2017. 15:53

Can I ask you to look at paragraph 53 of your statement. Again, it will be on the screen if you would prefer. This is where you first set out your recollections of how you came to know about that incident and the actions that were taken. 15:53

So, starting with the second sentence in paragraph 53, you say:

15:53

"My recall is that I was first made aware of a specific safeguarding concern relating to MAH on 20th October 2017 when I received correspondence from the Chief Social Work Officer and the Chief Nursing officer in

the Department of Health about a safeguarding incident at Muckamore Abbey Hospital. A copy of that letter, together with its response and subsequent correspondence, is exhibited at tab 4."

15:54

We will turn to that document shortly. I just want to be clear about the dates, first of all. Are you saying then that this letter from the Department dated 20th October 2017 was the first time that you became aware about the safeguarding incidents at Muckamore Abbey Hospital? 15:54

A. Yes, to the very best of my recall and recollection. I don't recall before 20th October and receipt of that correspondence being briefed on the 12th August incident at Muckamore Abbey Hospital. 15:54

222 Q. But as you say, the incident had taken place on 12th August. Would you not have expected to be briefed, for example, by your Director of Nursing before having heard from the Department on 20th October?

A. Yes. I mean, like everyone else and as Chief Executive, you would like to operate on the basis of no surprises. As I said, I mean I can't point to anything specific where I might have been briefed on this before receipt of that letter. I do know -- the Trust no longer as access to my electronic diary but I do know, 15:55 looking at my own records, that I was on annual leave from about mid August to early September and then again on leave mid September, during which periods of absence the Deputy Chief Executive would have been deputising

for me. I don't know what internal briefings there might have been in my absence, but certainly I wasn't briefed on my return.

Again, I stand to be corrected but to the best of my knowledge and recollection, the first I became aware of the 12th August incident was on 20th October 2017 on receipt of the correspondence from the Department of Health. 15:55

CHAIRPERSON: If the Deputy Chief Executive had been briefed, you would certainly have expected to be briefed as soon as you got back? 15:55

A. Indeed.

CHAIRPERSON: And you weren't?

A. Not to my recall. 15:56

CHAIRPERSON:

DR. MAXWELL: That raises some concerns about your confidence in the governance systems because we know that the Director of the directorate knew in September, and we know the Director of Nursing knew, and you are saying they didn't brief you which raises some wider concerns about what you were being briefed about beyond this, and what they would have thought would have been reasonable to brief you on? 15:56

A. Can I say quite honestly, I don't have any wider concerns because I have to say the directors I worked with knew my leadership style; they knew the tone and style of my leadership; they knew they could bring anything to me and my behaviour would be consistent. 15:56

They may well have a different recollection and may -- I don't know, maybe think that there had been a briefing. I certainly don't recall being briefed in relation to this prior to 20th October.

DR. MAXWELL: So this is actually three people. This is the directorate director knew; we know the Director of Nurse knew; we've had some evidence that, I think Cathy Jack was the Deputy Chief Executive at the time, wasn't she? 15:57

A. Correct. 15:57

DR. MAXWELL: We have had some information about when she knew, but I think it was certainly before 20th October, and none of them brought this to your attention before you had a letter from the Department?

A. Not to the best of my recall. Now -- 15:57

DR. MAXWELL: Which raises concerns about how well informed you were.

A. -- something might turn up that suggests I was briefed, but I certainly don't remember it.

223 Q. MS. KILEY: And if you weren't briefed until 20th October, would that not indicate that there had been a failure in governance systems? 15:57

A. Well, in my response to the Department's letter of 20th October, I mean I apologised for the fact that an Early Alert had gone in late, and in the view of the Department, there had been insufficient information on that, and I resolved that the organisation would take learning from that. 15:57

I suppose for me, when I was fully briefed and the timeline explained to me - and I don't take away one iota from the importance of the Early Alert system and the Department receiving the information it requires, that is a fundamental importance, we need to operate on the basis of no surprises - I suppose after that short delay between 12th August and 21st August when a member of staff, I was briefed, was on leave, the appropriate actions were all being taken on the ground in terms of the safeguarding referrals, the relevant agencies being notified, precautionary suspension put in place and so on and so forth. So, at least when did I get the timeline, I was assured that all the relevant appropriate actions were being taken. 15:58 15:58

It would be pointless for me to speculate as to why I wasn't briefed at this stage. It may well have been that the Director and the Director of Nursing believed that they were dealing with a very serious but isolated incident, and that perhaps, you know, I didn't need to be briefed taking into account leave and so on and so forth. It may well be that something turns up to suggest I was told, but I genuinely don't recall it until I got that correspondence. 15:59

DR. MAXWELL: Does that also mean that the non-executives weren't briefed? 15:59

A. To the best of my knowledge and recall, because as soon as I had received that correspondence and had asked the Director of Nursing and Director of Adult and Social

Primary Care to provide me with a full briefing, a full timeline and an update on all the actions being taken, to the best of my recall I told the chairman almost immediately and shared the Departmental correspondence with him, and told him of the steps that we were taking in response to this. My recall is that at this point then, and I think it is in my statement, he asked for a full briefing on all of this to be provided to the next meeting of the Assurance Committee, which was upcoming in early November, from recall. 15:59 16:00

DR. MAXWELL: So in your risk management strategy and also in the regional SAI policy, risk to reputation is one of the issues that escalates concerns. Certainly, even if this was not as widespread as it turned out to be, there would be a risk to reputation that evidence had been found on CCTV, that the police had been involved; in those scenarios would you not normally inform non-executives outside of formal meetings? 16:00

A. No. My role, I suppose my formal line of accountability was back to the Permanent Secretary but, you know, in reality and on a day-to-day basis back to the Chairman of the Trust, so it was to the Chairman of the Trust that I turned initially to brief him. Ordinarily then, it would be for the Chair to decide what he does with that at that stage and in what way he informs the non-executive directors. I don't know at that stage whether the Chairman arranged phone calls or how he might have disseminated the information to the non-executives at that point in time, but I do know one 16:00 16:01

of his immediate requests was for a full briefing to come to the next -- I think the Trust Board was a wee bit away but to the next Assurance Committee meeting.

DR. MAXWELL: And when was the next Assurance Committee meeting? 16:01

A. I think it was 4th November, from memory.

DR. MAXWELL: Sorry?

A. 4th November, from memory.

DR. MAXWELL: So two weeks.

224 Q. MS. KILEY: An Early Alert was issued on 7th September. 16:01 Would it have been expected that the Chief Executive would have been informed of all early alerts?

A. No, not all early alerts because there would have been quite a few of them, and the Governance Department, working with the appropriate directorate, would submit 16:01 the early alerts, and then it would be a director exercising their judgment about the nature of it as to whether the Chief Executive needed to know or not.

225 Q. So we have the director exercising the judgment about whether to bring the Early Alert to you, whether to 16:02 bring the incident to you, there are a number of --

A. Not in their discretion. The Early Alert would have been coordinated between the director's staff and the corporate governance function. The way in which the Early Alert system works is an initial phone call goes 16:02 into the Departmental health official followed up by the pro forma form goes in, and at that juncture then if the Department want any further information at that juncture about it. It is primarily an information

giving process at that stage.

226 Q. But whenever you say that your recall is that this letter of 20th October, which we'll turn to look at, was the first time you were made aware of it, can you tell the Inquiry how you felt, your reaction whenever you received the correspondence from the Department? 16:03

A. Yes. Obviously I believed it was a matter that I probably should have been briefed on, and again something might turn up to suggest that something about this was mentioned to me. 16:03

227 Q. Well, can I just pause you there?

A. I don't recall.

228 Q. Can I just ask you, though, on receipt of that correspondence of 20th October, did you ask anyone, any of your directors, why am I only hearing about this now? 16:03

A. To the best of my recall, I did say to the Director of Adult Social and Primary Care this seems to be the first I am aware of this. I can't remember the response at the time. I hadn't spoken directly to the Director of Nursing at that point because my focus at this point in time was getting a full explanation, a full timeline, but probably most important of all, making sure all appropriate actions were being taken in response to this. 16:03 16:04

229 Q. Let's turn to look at the letter. It's at page 335. It is from the Department addressed to you dated 20th October, as we can see. Can we see the second half, please. Pause. Let's go up to just see that first

paragraph. Pause there, thank you.

"We are writing to you in order to raise a number of significant issues around the recent allegations of abuse made against staff working in Muckamore Abbey Hospital and the related suspension of staff. You should take our decision to raise this directly with you as a measure of our growing concern as to the handling by your Trust of this very serious issue. This relates both to the way we became aware of the incident and the partial and imprecise nature of information provided in response to a number of requests for information from Departmental officials. As you will be aware, there is a clear procedure in place for the reporting of incidents such as this". 16:04 16:04 16:05

There is a reference to a Departmental circular and a quote which says:

"Immediate suspension of staff due to harm to patient, client, and further stipulates that such incidents should be notified to the Department promptly within 48 hours of the event in question. In light of this very clear guidance, it is wholly unacceptable that the Department was not made aware of these allegations through an Early Alert notification until 7th September. Indeed, this alert seems to have been raised only after the Department had been prompted to make inquiries following a phone call on 30th August to 16:05 16:05

a senior official by an elected representative acting on behalf of the father of the patient in question. It was further troubling to learn that there were also delays in the reporting of the incident within the Trust. Based on the information in the Early Alert received on 7th September, an adult safeguarding concern had been raised on 21st August regarding the alleged assault of a patient in the psychiatric Intensive Care Unit in Muckamore Abbey Hospital which had actually occurred some nine days earlier on the 12th August. This delay was separately explained to Departmental officials as due to a combination of a staff member who witnessed the incident going on leave and some subsequent confusion over who was responsible for the reporting of the incident in their absence." 16:05 16:06 16:06

Then if we just scroll down. I won't read the entirety of this. If we scroll down, please, there is further reference to the Early Alert. Keep going down, please. Pause there. We have skipped through some analysis of the Early Alert but then the final paragraph says: 16:06

"Again, we are profoundly disturbed that this further incident was not formally reported to the Department through the Early Alert notification system. Indeed no such report has been made at the time of writing." 16:07

Then move to the next page, please.

"To be clear, the lack of comprehensive, accurate and timely information to date as outlined above has made it difficult for the Department to be assured that the relevant adult safeguarding policy and procedures have been appropriately implemented in relation to these incidents. This is a situation which we find both unacceptable and unsustainable. We ask now that as a matter of urgency you provide comprehensive written accounts of both of the incidents in question, the actions of the Trust in managing them, and provide an explanation of the apparent noncompliance with the relevant guidance."

Reading that, it sounds like whenever the Department is using language such as "significant concerns", "profound concerns", that sounds like a serious letter from the Department that might cause one to pause and realise that one was dealing with a very significant incident. Is that how you reacted to the correspondence? 16:07 16:07 16:08

A. Absolutely.

230 Q. And had you received correspondence of that gravity and tone from the Department often, or was the nature of this correspondence and the concerns that the Department were raising unusual? 16:08

A. I think we were in a period in Northern Ireland where there was no Assembly or sitting Executive, and I think possibly civil servants - and I think they refer to this in a later letter - felt an extra burden in terms

of holding organisations to account in the absence of a minister, and holding organisations to the same standard that a minister had. I do know other people will have had letters from the Department of that tone and nature. Yes, I absolutely agree that this is a very serious letter which is why, in my response, I acknowledged the failures on the part of the organisation in relation to the Early Alert and providing information to the Department; committed the organisation to learning from this because of these very clear failures in internal and external communication. 16:09 16:09

But as I said earlier, and I would like to go back to this, I separate out two things here. One is the business of providing the Department with the early alerts and the information they require, which is of fundamental importance and I don't mean to take away from that at all. But I separate that out from what actions were actually being taken on the ground in response to 12th August incident, and that those are being properly -- all appropriate actions are actually being taken on the ground. 16:09 16:09

231 Q. I think if we can go back to your statement, at paragraph 55 you summarise what you did after receiving this correspondence. You've mentioned a response that you issued which we'll turn to, but this, I think, describes what you did in the interim period on receipt of the correspondence. You say: 16:10

"I requested a full briefing from the then Director of Adult Social and Primary Care including an update on all the actions being pursued to investigate the complaint and of the engagement with affected families and actions being taken to ensure the safety of all patients. As part of this briefing, I was advised that the contractor which had installed CCTV at Muckamore Abbey Hospital had advised that CCTV footage in relation to 12th August 2017 incident was available to view because although the system was not due to go live until 11th September 2017, recording for trialing and testing purposes had been going on for a number of months in 2017." 16:10 16:10

Then if we can move down, please, to 56. You say that you then briefed the Trust Chairman on the issue "just as soon as I became aware of it", and provided him with a copy of the DoH correspondence referred to earlier. 16:11

"Subsequently a full verbal update was provided to the Trust Board in confidential session on 2nd November 2017." 16:11

Just pausing there then. Is that date, 2nd November 2017, the first time then that the Trust Board was formally made aware of these issues? 16:11

A. If I may, just a small correction. I had it in my head that it was an Assurance Committee that we were

providing the briefing to, which subsequently happened after the Board meeting. So there was the verbal update given at the Board meeting on 2nd November, but I had briefed the chairman before that, given him the copy of the correspondence. As I said earlier on, I don't know the detail but it would normally fall to a Chair then to either ring the non-executives or find a mechanism of making them aware, but I can't speak to that because that was a matter for the Chairman.

16:11

232 Q. Is there a facility to have an urgent meeting of the Trust Board?

16:12

A. There is the facility to call an extraordinary meeting, yes.

233 Q. The confidential Board session that you refer to, 2nd November 2017, was just over two weeks after the letter from the Department of Health?

16:12

A. Yes.

234 Q. Do you know why there was a delay in calling the meeting?

A. No. It would have been a prescheduled Board meeting with a public notice issued about it and so on. So I have informed the chairman, he's also got a copy of the correspondence. I can't say at this remove, I can't remember at this remove, what he did by way of informing the non-executives. I imagine he found some way to contact them and provide assurance about the actions being taken to date and that a full update would be provided then on 2nd November.

16:12

16:12

CHAIRPERSON: Could I just ask --

A. Only the Chairman can speak to that then.

CHAIRPERSON: Finish your answer.

Just going back to that letter that you received that was signed off by Sean Holland and Charlotte McArdle, and you made a comment and I just want to understand it, that possibly civil servants felt an extra burden to hold organisations to account because there was no minister. Are you suggesting, just so that we have it clear, that the tone of letter wasn't justified? 16:13

A. Unjustified?

CHAIRPERSON: Yes.

A. Oh not at all. I think actually later on in another letter from the Chief Social Work Officer and the Chief Nursing Officer, they made an attempt, if you like, to explain the tone by making the point I have just made. So that's in a subsequent letter, I believe, from them as well. No, this letter --

CHAIRPERSON: You are not suggesting it was inappropriate? 16:14

A. No, not at all. This letter was wholly justified, which is why I, in my response, made a complete unreserved apology to the Department for our failings in communication - that's what I did - and acknowledged that we had failed and that we would learn from it. 16:14

CHAIRPERSON: Thank you.

A. So not unjustified in any way.

CHAIRPERSON: I just wanted to understand the context in which you were suggesting because there wasn't a

minister.

A. No. It was really, I suppose, in relation to the content wholly justified. It was maybe just a comment on tone, which they subsequently acknowledged themselves.

235 Q. MS. KILEY: Let's turn now to your response. It is at page 338. You responded on 3rd November. Is this the response that you have just been referring to? Can you see that on the screen in front of you?

A. Yes.

236 Q. So you reply to Sean Holland and Charlotte McArdle and you reference the letter of 20th October. If we could move down, please, to the next paragraph. Pause there. In the second paragraph, you say:

"The incidents reporting timeline has been subject to detailed scrutiny and challenge and it is evident that there were clear failures both internally and externally in respect of these requirements. Incident reporting in Learning Disability Services is a key quality indicator, and the management and leadership behaviours in this area will be subject to further investigation and action. Please accept my unreserved apology for our shortcomings in this regard, and for the concern this has raised about patient safety and the quality of service provided to these most vulnerable individuals in our care. I will ensure that learning from our scrutiny of the timelines around reporting, both internal and external, is applied in

the future."

Just pausing there. As you have described, and as it is stated there, it is an unreserved apology, does the apology given there and your response indicate that there was a failing in the internal and external reporting governance systems in respect of this incident? 16:16

A. Yes. The directorate had not raised an Early Alert with the Department in a timely fashion, and I think there had also been a delay in this coming up the line management chain to the Director in the directorate as well. 16:16

237 Q. You give a timeline - if we scroll further down - in your letter. You say, you can just see it at the bottom of the screen "I have provided a summary timeline of incidents and actions below". If we can scroll down, I won't take you through all of those, but you give a summary timeline of the incidents and how they made their way through internal systems. 16:16

One of the issues that we saw in the Departmental letter of 20th October was a specific issue that was raised about the timeliness of an Early Alert. You will forgive me but in reading this letter, it wasn't immediately apparent to me that there was a specific explanation of the delay in respect of the failure to submit an Early Alert. Did you get to the bottom of what that failure was? 16:17

A. At this remove, I can't recall. I do know that the Belfast Trust and other Trusts from time to time were unable to meet the 48-hour reporting timeline for early alerts because sometimes it took a little bit of time to consider whether an incident actually met the criteria for that. So at this remove, I can't remember the explanation for the delay in getting the Early Alert to the Department. Sometimes at some levels in the organisation, people would be less aware of the need for that than others, even though training is provided, you know, the circular is on the website and directors and their senior team should be aware of this. Sometimes I think maybe the further down the organisation you go, staff's first instinct will be to make sure they are taking the appropriate actions and may not be fully aware of the importance of notifying the Department through the Early Alert system. 16:17 16:18 16:18

I am not suggesting this is an explanation or a mitigation but sometimes staff are focused on making sure they are taking the right actions in response to an incident, with reporting up to the Department following on from that. It's not an excuse, it is simply an attempt to explain how it sometimes happens. 16:18

238 Q. But you don't now recall -- 16:18

A. No.

239 Q. -- the specific reason for the delay in the Early Alert?

A. No.

240 Q. There was then a further letter from the Department on 30th November in response to yours. If we could move down to page 342, please. You can see there again addressed to you, dated 30th November. Then if we can scroll down, please, to just below "Muckamore Abbey Hospital". Thank you.

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

So we are to take it from this that there was a meeting then between the Department and Marie Heaney and Brenda Creaney on 17th November to discuss the issues raised in your letter that we have just looked at; is that right?

A. Correct.

241 Q. And do you recall that?

A. I recall the directors telling me that I think it was they who had arranged a meeting with the Department to update the Department face-to-face on all the ongoing actions that were taking place at this point in time.

242 Q. Did you attend that meeting?

A. No.

243 Q. Given the gravity and tone of the Departmental correspondence and the seriousness with which it was received, did you not think that it was appropriate to

meet with the Department to explain for yourself the detail of your letter on 2nd November?

A. Well, these are very high level ranking directors meeting with the Chief Social Work Officer and the Chief Nursing Officer. Had the Permanent Secretary requested a meeting with me, obviously I would be in attendance, but this was the appropriate representation and attendance from the Trust at this juncture. This is whom the Chief Social Work Officer and the Chief Nursing officer would have expected to meet with them at this juncture. 16:20 16:20

244 Q. But in terms of your own expectations, having received correspondence of the nature that we have looked at which expresses grave and profound concerns, did you not feel that it was necessary as Chief Executive to meet with the Department to provide them with your personal assurance? 16:21

A. No. I mean, I had provided my personal assurances in the full apology in my correspondence. I have no doubt, not that I recall now, there would have been other phone calls, meetings, conversations between the Adult Director of Social Care and the Director of Nursing with the Department. So again, whenever this meeting was arranged and set up, that, in my view, was the appropriate representation to go from the Trust. 16:21 16:21

245 Q. Just to complete the correspondence picture - I won't go through this entire letter - but we can see there, the second paragraph, that the Department seeks further written assurances on a range of issues which were

raised. I won't read them all out but the Inquiry Panel and all parties have the document and it's published online as an exhibit to your statement. But if we just scroll down, a number of specific issues are raised. Then if we keep scrolling down to the end of this letter, please, you can see the list of a number of issues. Then if we turn to the next page, please, we can see there is a response to this on 22nd December 2017 where you respond to the Departmental letter, and you say there that you are writing to provide the further written assurances requested therein. 16:22 16:22

Again I won't go through it all but that's the correspondence that you have exhibited to your statement? 16:22

A. Indeed.

246 Q. Was there further correspondence between you and the Department after this stage or did it rest here?

A. I think the major formal correspondence, to the best of my recall, rested here. 16:23

247 Q. If we return then to your statement, please, at paragraph 58. You give some more detail about the Trust actions following the emergence of the CCTV footage. I'll just read paragraph 58 and part of paragraph 59. "Since we". The "we" there, is that we the Trust or we the Trust Board? 16:23

A. The Trust.

248 Q. Okay.

"Since we (the Trust) had learned that CCTV footage was available to view, this led to other recent incidents being viewed and further examples of unacceptable practice surfaced. My recall at this remove from events of the key initial and subsequent actions taken is set out below. It was largely based, given the passage of time, on re-reading Trust Board minutes. I should say that it was primarily the responsibility of the executive arm of the Belfast Trust to develop and implement the appropriate actions to safeguard patients in response to the unfolding events at Muckamore Abbey Hospital, and to keep the Trust Board fully cited on these matters so that it could exercise its challenge on assurance functions. The role of the Trust Board was to provide oversight and challenge and to scrutinise actions for their comprehensiveness and appropriateness, or to highlight any other actions the Trust Board wished to see taken. It would not be the Trust Board itself taking the actions." 16:23 16:24 16:24 16:24

Then if we just move down to paragraph 59.

"From November 2017 onwards, Trust Board members were updated every month, either by means of a verbal or written update, of the various actions being taken to ensure the safety of all patients at Muckamore Abbey Hospital and to improve their daily lived experience." 16:24

Then you say the Trust Board minutes record questions, follow-up actions and assurances asked for by the Chair and non-executive members following these updates.

Then from paragraph 60 onwards, you do describe a number of groups which were set up in response to the allegations, and a number of key actions. I am not going to take you through all of those but I want to pick up on what you said about the Executive Team at paragraph 58, if we could move back up, please. What you said there was that it was primarily the responsibility of the executive arm of the Belfast Trust to develop and implement the appropriate actions to safeguard patients in response to the unfolding events. 16:25

Whenever you say "the executive arm", is that a reference to the Executive Team?

A. It is, yes.

249 Q. Whenever you say it was primarily their function to develop and implement the appropriate actions, you are referring to the post 2017 period? 16:25

A. Yes.

250 Q. But is the fact that these issues emerged in 2017 evidence that the Executive Team was not properly carrying out that function before that time? 16:26

A. I am not sure I grasped the question.

251 Q. What you are saying there, you are asked to respond and to tell us about what was done after the 2017 CCTV

allegations emerged?

A. Yes.

252 Q. You say:

"It was primarily the responsibility of the executive arm of the Belfast Trust to develop and implement the appropriate actions to safeguard patients in response to the unfolding events at Muckamore Abbey Hospital." 16:26

The fact that the incidents occurred, was that evidence itself that the Executive Team had failed to implement appropriate actions to safeguard patients prior to that time? 16:26

A. No. I mean, my response is in response to the specific question about the action taken by the Trust Board. I hope I haven't misled in any way. What I was saying was in response to the specific incidents that were emerging from August 2017 onwards, it was the Executive Team and the relevant directors who were formulating the appropriate action plans for challenge and scrutiny at the Trust Board. Prior to that, everything we discussed earlier on this afternoon in terms of the directorates' management and oversight of Muckamore Abbey Hospital, the performance and other information coming through the committee and subcommittee structure all applied. But at this time what I was simply trying to point out was that I, as Chief Executive, and the relevant directors on the Executive Team were exercising a very tight grip on the situation with very 16:27 16:27 16:27

focused action plans and making sure the Board was fully up-to-date with the detail of those action plans so that the Board could exercise its function of are these plans sufficient, are they robust enough, are they working et cetera. I was simply trying to make that pint so I hope I haven't misled in any way.

253 Q. In other parts of your statement, you do specifically comment on the effectiveness of Trust Board systems prior to 2017. It might be an appropriate time to look at that. If we can look at paragraph 26, please. We're seeing here your reflections on the structures and processes that were in place prior to 2017, which is what we were just discussing. You say:

"Prior to 2017 I had no reason to believe that the structures and processes for the management and oversight of Muckamore at directorate level were other than effective. Governance structures obviously require staff to use them appropriately. Now, with the benefit of hindsight and through the findings of the likes of the Level 3 SAI Review Report A Way to Go, it seems clear to me that the governance system was not being used appropriately by some staff, in that staff who were aware of their responsibilities their training, job description, through Trust codes of conduct and associated values and behaviour statements, and through their professional codes of conduct, and who would or should have been aware of the Trust's focus on seeking continuous improvement on patient

safety were not speaking up and out either to line or professional management about unacceptable behaviours of some staff at Muckamore Abbey Hospital."

Are you saying, Mr. Dillon, then that the structures themselves were fine but the issues that arose in Muckamore in 2017 were a result of staff at Muckamore Abbey Hospital not using the structures effectively? 16:29

A. As I said earlier on, no system of governance is perfect, and any system of governance is only as strong as its weakest link, which is the staff who use it. Prior to this, to the best of my knowledge and recall, the directorate and the learning disability team monitoring/responsible for the oversight of Muckamore Hospital, were saying that the performance metrics were within control limits, and there was nothing to suggest anything like this coming forward. 16:30 16:30

I suppose what I was saying was that, you know, if it hadn't been for the CCTV, which was revealing instances of neglect and abuse which were being witnessed by staff, and those instances of neglect and abuse were not being reported to safeguarding or in line with individual, particularly members of staff's professional codes of conduct, or in line with the Trust's policies regarding notification or whistle-blowing. So I'm not saying governance was perfect but I think, with the benefit of hindsight, my reflections is that because CCTV viewing revealed staff 16:30 16:31

witnessing things which were unacceptable and neglectful practice but were not, for whatever reason, choosing to report those so that the appropriate action could be taken. Does that make sense?

254 Q. It does, and I have this question in response. Would you accept that whilst individual incidents of abuse or non-reporting might slip through governance systems, the volume and nature of abuse that was uncovered to have been taking place at Muckamore Abbey Hospital was such that it should not have been able to slip through the governance systems by way of individual failures such as the kind you have described? 16:31 16:31

A. Well, I mean, as I say, no system of governance is perfect --

255 Q. But it ought to be able to detect difficulties in the system, should it not? 16:32

A. Yes, but staff working together who collude together can defeat any system of governance. So if there were certain staff on certain shifts on certain wards who were either indulging in or witnessing unacceptable practice or neglectful behaviour but failing to report that to those who would take direct and immediate action about that. 16:32

So, going back to the point I made, if the Director was coming up through the governance structure saying the monitoring of safeguarding, the monitoring of seclusion, the monitoring of complaints et cetera is all within control totals, this is one mechanism that 16:32

could have alerted us to what was going on, and it was being kept hidden from those who would take action.

PROFESSOR MURPHY: So do you think it was staff colluding with each other and not reporting it, even though they recognised what was going on; or do you think that a culture had developed in which they didn't acknowledge even to themselves that it was abuse? 16:33

A. I am far from an expert in this field but if I were to give a view, it would be in relation to the latter.

DR. MAXWELL: You said, and you've said repeatedly, about governance evolving. It's been clear for quite a long time in corporate governance, in clinical governance and safety science that you can't rely on one line of reporting because, like the Swiss cheese model, it can happen in many places. There have been a number of red flags about Muckamore and in, as you've said, other parts of the Trust; that actually we have seen evidence about increased incidences within Muckamore. You know, we can debate what they were but we have certainly seen that from your Datix system, quite apart from the PSNI evidence. We know that there were huge problems with staffing, whether you want to call it a crisis or not. We know there were safeguarding incidents, and Ennis wasn't the only one. 16:33 16:34 16:34

In what way did your governance system triangulate all the different systems? You seem to be saying you were only taking what was being reported up through the Directorate, whereas most governance systems would have

a number of ways of checking that?

A. Yes, and apologies if I misled in that way, that it was simply what was coming up through the Directorate. As I said earlier on a number of times in my oral evidence, a range of corporate functions would have helped the Directorate by producing performance information. Certainly in my time, I remember efforts to triangulate SAIs with complaints and potentially safeguarding. So, the organisation was very conscious of the need to look at the whole picture and not just one individual stream of governance or one line of governance. 16:35 16:35

But I suppose the point I was trying to make here was that while things were being triangulated and, you know, it suggested that things were within control limits, there was nothing coming through to suggest neglect and abuse on the scale that subsequently emerged through that. 16:35

DR. MAXWELL: So what were your control limits; what do you mean by that? 16:35

A. I imagine by that what the Directorate meant was we are looking at the number of SAIs in relation to learning disability as a whole, and in relation to Muckamore. We're looking at the complaints and the information that's been provided to us is about the number and nature and type of complaints, and also then looking at the safeguarding incidents. I suppose at least in relation -- going back to the point I was trying to 16:36

make, at least in relation to safeguarding, once an incident is reported, it can then be a safeguarding investigation can take place and the appropriate agencies can be involved. But if staff are not reporting incidents that should really be reported.

DR. MAXWELL: But a good governance system would get ahead of the curve and it would identify problems before they happen. You seem to be saying there was nothing we could do until abuse happened and then we were reliant on staff reporting it. The Inquiry has heard a lot of evidence about red flags; the increase in incident reporting; the number of patients who were inappropriately in hospital, it wasn't the right environment for them; the staffing crisis, and you're saying it was being triangulated at Directorate level. You have also told us the Board weren't looking at the safeguarding reports. So there was --

A. Not the individual reports.

DR. MAXWELL: So who outside the Directorate was actually triangulating the information to say, okay, the Directorate is telling us everything is fine but actually have we got information that suggests that's not quite true?

A. Firstly, sincere apologies if I gave the impression that we were being passive and we were suggesting that there was nothing could be done. You know, we were constantly updating our governance arrangements to make sure they were in line with best practice. The Corporate Functions Department, particularly the

Governance Department, the Complaints Department and others were working to triangulate information. I suppose the point is in the future does that need improved even further, that type of triangulation, so that short of staff reporting abuse and neglect, we have another mechanism of picking up on it. So sincere apologies if I gave the impression that we were being passive in any way, or not triangulating. 16:38

DR. MAXWELL: My concern is the reason you have non-executive directors is to give scrutiny outside the Executive Team. 16:38

A. Absolutely. Couldn't agree more.

DR. MAXWELL: And yet they didn't seem to be getting the information that we know the Trust held that would have allowed them to say to the Directorate, hang on, there seem to be some problems here? 16:38

A. Well, the relevant committees would have been getting information on complaints, safeguarding and so on and so forth. But unless, unless something was being highlighted and the information going to the non-executives to suggest that something was awry here, and even before it would have got to the level of, you know, putting non-executives in a position, I mean we would have gripped the situation. 16:39

DR. MAXWELL: So you don't think a huge increase in incidents -- so, Chris Hagan presented evidence that there was almost a quadrupling of the reporting of assault by patients on staff, which might suggest that it might be going the other way. That doesn't seem to 16:39

have been discussed at the Assurance Committee with the non-execs. You don't think -- you think quadrupling would be inside control limits?

A. Well, I suppose what I am referring to was as we worked our way through this and I was asking the Directorate and others about potential red flags, and in the briefing paper that came to the Assurance Committee, you know, the Director was outlining everything that was on the performance dashboard, including that information that was being triangulated provided by corporate functions, and making the point that at her level and Assistant Director level, this was all within control limits. That was the point made in the briefing paper to the Assurance Committee on whatever date in November that happened. 16:39 16:40 16:40

PROFESSOR MURPHY: Can you tell me was there this kind of thinking going on, that these levels are creeping up, they are creeping up, they are creeping up, but it's because we're resettling people from Muckamore Abbey and the people who are left are more challenging and it's just down to the population we're serving? Was there that kind of thinking going on? 16:40

A. I'm not in a good position to answer that at this remove, and I don't know what element of this also related to changes in thresholds relating to incident reporting. I just simply can't recall at this remove, but I grasp the point you're making. 16:41

CHAIRPERSON: Just before we hand back the floor to Ms. Kiley, she asked you about paragraph 26 and I just

want to make sure we understand your evidence. In paragraph 26, you say, "It seems clear that the governance system wasn't being used appropriately by some staff." Then in paragraph 85, you say, you

16:41

"... hope this Inquiry is able to gain insight through its work as to why staff were either unable, unwilling or both to speak up and to escalate concerns and incidents despite the means being available to them, and the MAH Inquiry is able to gain insight as to why staff go 'rogue'."

16:41

Now, just taking those two paragraphs together, again it might give the impression that you feel that the governance systems were all fine but you've got a few bad apples and no governance system can prevent that. Do you mean to give that impression at all?

16:42

A. Not at all, far from it. As I said earlier on, governance, improving governance is a continuous improving journey. You will never fully crack governance but you must maintain your focus on continually improving it. I suppose the point I was trying to make was - and I hope it hasn't come across the wrong way in any way - was that whenever this was all being investigated and the PSNI became involved et cetera, there were limits to what we could find out at that time as to why, in particular, that aspect of governance wasn't working in terms of the proper reporting of incidents.

16:42

16:42

CHAIRPERSON: That was looking back, of course?

A. Yes. Why that particular aspect of governance wasn't working in the way in which we would have hoped. I think the Trust made reference to this in its opening statement and so on and forth. 16:43

So no, not at all am I trying to suggest that the governance system was perfect and wholly robust, save for this one thing: I'm simply saying that, you know, we certainly would have been much helped in uncovering 16:43 the type of abuse and neglect that was going on had staff spoken up, particularly where it's seen on CCTV where staff see things but then choose not to report those incidents.

CHAIRPERSON: I do understand that but in your 16:43 statement when you're asked about question 5, which is "Did the Trust Board receive reports...", and you go through each, the safeguarding of patients, seclusion rates, complaints, resettlement and staffing, pretty much none of that actually came regularly to the Trust 16:44 Board. I think you had some equivocation, as it were, on resettlement --

A. Not individual reports at the level of the individual patients; more summary information on trends, analysis and so on. 16:44

CHAIRPERSON: Sure. Do you think there is an issue that this Trust was so vast, is so vast, that actually the right information wasn't getting to the Board because there was just... You had 700 buildings, you

had a massive economy, but the sort of core material that the Board might want to know in relation to keeping patients safe wasn't able to get through to it. Is that an argument at all or not?

A. Well, I go back to the point I made a few times in the evidence. Yes, you've got a vast organisation so then you invest in management commensurate with the scale of the organisation in terms of the number of directors, directorates and so on and so forth. What was coming to the Board through its subcommittee structure was lots of information on complaints, SAIs and the range of things we've talked about earlier. Somehow what wasn't coming through was that there was neglect and abuse going on at Muckamore, and that information wasn't going to the Trust Board because we didn't have it. 16:44 16:45 16:45

CHAIRPERSON: And you don't put that down to the size of the organisation; a smaller Trust and a smaller Board might have picked that up? You don't think so?

A. It's always a possibility but, you know, when you're scaling up or scaling down organisations, I think it is fundamentally important that you invest in the right level and depth of management to allow you to manage a vast organisation and so on. But I have no doubt that is a moot point whether sometimes the span of control is simply too great. 16:45 16:46

CHAIRPERSON: Ms. Kiley.

256 Q. MS. KILEY: Just finally from me, Mr. Dillon, one of the things you say in your statement - if we could

scroll up to paragraph 82, we will see it - you refer to having had an opportunity to meet families of patients at Muckamore Abbey Hospital on 18th February 2019. You can just see that at the bottom of the screen. Scroll down a little bit, that's it. We will see that whole thing.

"I was very grateful to have had the opportunity on 18th February 2019 to be able to humbly and unreservedly apologise in person to families at a meeting the Trust Chairman and I attended to hear the views of families as to how the recommendation of the "A Way to Go Report" might be taken forward. This personal apology followed up on previous unreserved and unequivocal apologies to patients and their families made by the Belfast Trust."

I just wanted to pick up on your reference to a personal apology and give you an opportunity, if you wish, to explain to the Panel what you said to the families on that occasion?

A. Yes, thank you very much. I mean, when the scale of abuse began to emerge, I have to say I was shocked, angered, ashamed that this had happened on my watch. I felt a personal responsibility but, most of all, my feeling, and because I have close family members who work in learning disability, was the devastation this would have for families. My first and foremost feeling was of that for the families and the devastation this

would have on them because, as I say, I know family members who work in Learning Disability Services. Once again, on my own behalf and behalf of -- I can't really speak for Belfast Trust now that I am not a person, but again that same humble and unreserved apology for what happened to those patients. I mean, their loved ones entrusted those vulnerable people to our care; we let them down in unacceptable ways. I hope for the sake of the patients, I hope for the sake of the families, that much learning comes out of this Inquiry to the betterment of Learning Disability Services in the future. I myself are much humbled by what happened, devastated for the families, and can't apologise enough for what happened, and look forward to the Inquiry's recommendations and the learning that will come for the betterment of services in the future. 16:48 16:48 16:48

257 Q. Okay. Mr. Dillon, I have no further questions for you. If you just remain where you are, the Panel may have some follow-ups.

A. Thank you. 16:48

CHAIRPERSON: Mr. Dillon, we have asked our questions as we have gone along, quite obviously. Can I thank you very much for attending the Inquiry and assisting us as you have.

A. Thank you very much, Chairman. 16:49

CHAIRPERSON: Okay. We don't need to meet tomorrow now. We are sitting on Monday at 10 o'clock. Thank you very much indeed.

THE INQUIRY ADJOURNED TO MONDAY, 14TH OCTOBER AT 10:00 A.M.