MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 16TH OCTOBER 2024 - DAY 116

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1 THE INQUIRY RESUMED ON WEDNESDAY, 16 OCTOBER 2024 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Ms. Tang.
5 MS. TANG: Good morning, Chair and Panel. This 09:33
6 morning, the Inquiry will be hearing the evidence of
7 Mr. Cecil Worthington, who is the former Director of
8 Social Work at Belfast Health and Social Care Trust.
9 That is as part of the organisational Module 9 focusing
10 on the Trust Board. The statement page is STM-309 and 09:33
11 other than the Inquiry correspondence to
12 Mr. Worthington, there are no exhibits. There are no
13 restrictions or considerations with regard to the
14 statement so unless there are any issues the witness
15 can now be called. 09:34
16 CHAIRPERSON: Okay, thank you.
17
18 MR. CECIL WORTHINGTON SWORN:
19
20 CHAIRPERSON: Mr. Worthington, thank you very much for 09:34
21 your statement, thank you for coming along to assist
22 the Inquiry. Thank you. Ms. Tang, hold on, Mr. Aiken
23 is on his feet. It would be better to raise issues
24 before the witness comes in perhaps, Mr. Aiken.
25 MR. AIKEN: No, I raised the issue, Sir, and I made it 09:35
26 clear I would make the submission I have to make in
27 front of the witness.
28 CHAIRPERSON: I see.
29 MR. AIKEN: There are two issues that I wish to raise

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1 with you, the first is that on the 14th October,
2 Mr. Worthington, a letter was sent to DLS in respect of
3 Mr. Worthington asking that he be given access to a 418
4 page bundle, that contained extracts from various
5 delegated statutory function reports. 09:35
6 CHAIRPERSON: This is the same bundle that we were
7 talking about the other day?
8 MR. AIKEN: There was a reference to it the other day.
9 CHAIRPERSON: Yes.
10 MR. AIKEN: And there is a detailed letter from DLS, 09:35
11 which I'm not going to go through this morning but
12 which if you haven't seen I would invite you to
13 consider it of the 15th of October. Having received
14 the correspondence on the 14th afternoon while we were
15 sitting, arrangements were made, and in fairness to 09:36
16 Ms. Templar, she took the bundle and personally
17 delivered it to Mr. Worthington at a quarter past six
18 on Monday evening. You'll be aware it was anticipated
19 that Mr. Worthington was giving evidence yesterday, for
20 reasons unconnected to the bundle that didn't occur. 09:36
21 CHAIRPERSON: Yeah.
22 MR. AIKEN: The correspondence makes clear that
23 Mr. Worthington would do all he could to consider the
24 content of that bundle to assist you with whatever
25 issues there are in respect of the material that it 09:36
26 contains which weren't identified, other than providing
27 him with the bundle itself. What he isn't able to
28 address, steps will be taken after his evidence to
29 either gather or respond to issues, because obviously

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1 the report, as you will be aware --
2 CHAIRPERSON: Yes.
3 MR. AIKEN: Is a stand alone document but will be based
4 on a series of work underneath with colleagues that
5 resulted in its production in the first place. 09:37
6 CHAIRPERSON: Yes.
7 MR. AIKEN: So he will do what he can to deal with any
8 issues that arise.
9 CHAIRPERSON: Well I'm sure he will be able to tell me
10 that himself. Yes. 09:37
11 MR. AIKEN: I am making the submission on behalf of the
12 core participant that I represent.
13 CHAIRPERSON: Yes.
14 MR. AIKEN: The second issue is that in paragraph 16 of
15 the statement from -- 09:37
16 CHAIRPERSON: His statement?
17 MR. AIKEN: Yes, from Mr. Worthington, he refers to a
18 period of time when he held two directorships and
19 consideration was being given to both the director, the
20 portfolio of Social Work and potentially Adult Social 09:37
21 and Primary Care being together, and that midway
22 through that year long exercise he was to provide a
23 report on his views on the wisdom of that course. We
24 identified that report and wrote to the Inquiry on the
25 30th September, it was sought on the 1st of October. 09:38
26 It has been provided, I understand it has not been
27 circulated to anyone. Mr. Worthington has it with him
28 and can address you on any of the issues that it covers
29 and then it can subsequently, if you consider it

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1 appropriate, be provided to everybody else. But it is
2 an issue he addressed in his statement, we have given
3 you the report to which it relates.
4 CHAIRPERSON: Well obviously if anything arises in
5 relation to that report, all CPs will have to have it 09:38
6 and we will ensure that is circulated.
7 MR. AIKEN: Thank you Chair.
8 CHAIRPERSON: Thank you Mr. Aiken. Right, Ms. Tang.
9
10 MR. CECIL WORTHINGTON EXAMINED BY MS. TANG: 09:38
11
12 1 Q. MS. TANG: Thank you Chair. Good morning again,
13 Mr. Worthington. We met a short time ago but, just to
14 remind you, my name is Shirley Tang and I am going to
15 be taking you through your evidence this morning. I 09:39
16 have got some questions for you and the Panel may have
17 some questions as well they may ask in the course of my
18 questions or they may keep some to the end. Can I
19 check first of all, I am often told I speak too
20 quietly, can you hear me okay? 09:39
21 A. I can hear you fine, thanks.
22 2 Q. Please stop me if for any reason you need me to speak
23 up, I'm happy to do that. Can I ask you, you have a
24 hard copy of your statement in front of you. Are you
25 content with the statement, you don't need to make any 09:39
26 amendments or make us aware of anything?
27 A. No, I'm content with the statement.
28 3 Q. So in view of that, can I ask if you are content to
29 adopt the contents of your statement as your evidence

1 to the Inquiry?
2 A. I am.
3 4 Q. Thank you.
4 INQUIRY SECRETARY: Apologies, can we just pause, I
5 think maybe one of the TVs isn't working properly. 09:39
6 CHAIRPERSON: Okay, thanks. Is that now on, right,
7 okay, so we need to turn the television on. Okay.
8 Right, carry on, Ms. Tang.
9 MS. TANG: All good, thank you. Sorry about that.
10 A. You're okay. 09:40
11 5 Q. MS. TANG: I want to go to paragraph 5 of your
12 statement first of all, please. It should come up on
13 the screen in front of you, if that's of any assistance
14 to you, or you are welcome to use your hard copy if you
15 prefer. By way of introduction, you tell us you were 09:41
16 Director of Social Work and Children's Community
17 Services of the Belfast Trust between September 2012
18 and September 2017. And in addition you were also
19 Interim Director of Adult, Social and Primary Care
20 Services from August 2016 until August 2017. And can I 09:41
21 take it that you retired after August 2017?
22 A. Yes, I retired in the September of 2017.
23 6 Q. September, okay. So when you were Executive Director
24 of Social Work what would you describe as your main
25 areas of focus? 09:41
26 A. Well, as I say for most of the period that's in that
27 paragraph I was Executive Director of Social Work which
28 covered all social work activities across the Trust,
29 but I also had operational responsibility for

1 Children's Community Services as well.
2 7 Q. So when you said you had operational responsibility for
3 that, how hands on would that have been?
4 A. Children's services?
5 8 Q. Yes? 09:42
6 A. As Director there was a whole structure underneath me
7 there, there would have been three co-directors and a
8 layer of service managers under that. But I was head
9 of that Directorate during that five year period.
10 9 Q. You describe having operational responsibility for that 09:42
11 particular bit, did you also have operational
12 responsibility ultimately for other elements of the
13 social work service?
14 A. Not up until 2016, it would have been a professional
15 input. So, for example, if there were difficulties 09:42
16 with recruiting social workers in a particular area,
17 even though I wasn't operationally responsible, I might
18 be asked for advice from a professional point of view
19 and that would have been done through my Co-Director
20 who was the governance lead for social work. But in my 09:42
21 last year I did have an operational input into the
22 adult side.
23 10 Q. Okay.
24 DR. MAXWELL: Can I just clarify, so there was a
25 discrete Directorate of Children's Community Services? 09:43
26 A. Yes, basically the Children's Community Services would
27 have covered children's disability, fostering, looked
28 after children, child protection, early years, all of
29 the various services in the community for children.

1 All the children's homes and there was a regional
2 service also came into my remit during that five year
3 period at Glenmonagh.
4 DR. MAXWELL: That was separate from the Paediatric
5 Directorate. 09:43
6 A. I wasn't responsible for Paediatrics, it sat in another
7 Directorate. Autism and those sorts of areas would
8 have been covered elsewhere.
9 DR. MAXWELL: In your role as Executive Director you
10 had co-directors and you had a Co-Director who was 09:43
11 responsible for governance in social work?
12 A. Yes.
13 DR. MAXWELL: But you were still ultimately the
14 responsible person?
15 A. Yes, he reported to me. 09:44
16 DR. MAXWELL: So ultimately you were responsible for
17 those processes through him?
18 A. Yes.
19 11 Q. MS. TANG: Can I ask you, were you also responsible
20 ultimately for the safeguarding processes? 09:44
21 A. Yes, I mean the adult safeguarding would have been
22 something that the Director of Social Work in each of
23 the Trusts would have had the ultimate responsibility
24 for, yes.
25 DR. MAXWELL: But you had the responsibility for making 09:44
26 sure that the processes and systems they were using
27 were effective?
28 A. Yes.
29 12 Q. MS. TANG: Can you explain to me how the safeguarding

1 reports that the Trust received would have been
2 reviewed and lessons learned if an Adult Safeguarding
3 Investigation was completed?
4 A. Well in each of the adult sections within the Adult
5 Directorate there would have been a lead in learning 09:44
6 disability, older people, mental health and physical
7 disability so there would have been probably about four
8 fairly senior managers leading on adult safeguarding
9 and they would have reported into a monthly meeting
10 with the co-director for governance and leadership. I 09:45
11 mean they covered a whole range of things but one of
12 the aspects that they would have looked at in that
13 forum would have been adult safeguarding. I had felt
14 very strongly during my time, we had some very good
15 systems in place for child protection and child 09:45
16 safeguarding and we had forums. I think around 2015,
17 about halfway through my time, we did start to develop
18 a forum that brought all those different people
19 together as well In terms of what you said, to look at
20 policy, any learning from cases and, you know, whether 09:45
21 the procedures were being followed.
22 13 Q. And can I clarify that forum, was that an adult
23 safeguarding focused forum or all types of
24 safeguarding?
25 A. No, it was adult safeguarding. 09:46
26 DR. MAXWELL: Can you explain what the process was in
27 other parts of the Trust, because people with learning
28 disabilities don't just receive care through adult and
29 social and primary care, they come into the acute

1 hospitals for care. How did all the safeguarding get
2 integrated?
3 A. Well, I mean the various leads would have linked,
4 that's what I was saying, I was trying to mirror what
5 was happening in children's with the Directorate there 09:46
6 where you would have had Paediatrics involved in that
7 group so you would also have involved senior nurses who
8 maybe had responsibility in the hospitals as well so
9 they were getting information about policy changes or
10 anything of that nature. I did feel it was a bit loose 09:46
11 up until 2015 and that's why we decided to form a
12 forum, a Trust-wide forum that could cover that.
13 DR. MAXWELL: And you said that that was an opportunity
14 to share learning but was it also an opportunity to
15 share concerns about whether the process was actually 09:47
16 working to the patients' best interests?
17 A. Yes, obviously the leads would have linked in to the
18 governance lead around making sure there was adequate
19 resources to do investigations, to do, you know
20 protection plans and so on and those would have been 09:47
21 reported through the stat functions, not individually
22 but figures. You know, it would tell you how many
23 investigations were done in the year, how many
24 protection plans were made and, you know, whether the
25 things were done in a timely fashion or not. 09:47
26 DR. MAXWELL: And did you attend that forum?
27 A. Which one?
28 DR. MAXWELL: The Trust-wide adult safeguarding forum.
29 A. I chaired that one.

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1 DR. MAXWELL: Thanks.
2 14 Q. MS. TANG: I want to go to paragraph 12 of your
3 statement now, it should come up on the screen for you
4 shortly. Thank you. Just looking down through towards
5 the end of that paragraph and you indicate that during 09:48
6 the time that Muckamore fell under your remit, I would
7 say even in your time as Director of Social Work, were
8 you aware of any abuse going on at Muckamore from the
9 time whenever you commenced in post in 2012?
10 A. I had no knowledge of any abuse, that's right. 09:48
11 15 Q. And were you aware of the investigation into
12 allegations made about the Ennis Ward?
13 A. Not at the time but I'm aware of it now because
14 obviously of events that have taken place.
15 16 Q. Can you recall when you first became aware of that 09:48
16 investigation?
17 A. I actually became aware of it when I was interviewed as
18 part of the independent review, I think which took
19 place around 2020.
20 17 Q. Okay, so some time after? 09:49
21 A. Yes.
22 18 Q. Given that two members of staff were arrested by PSNI
23 for abusing patients associated with those allegations,
24 did that not make -- did that news not reach the Trust
25 Board? 09:49
26 A. I think that as far as I, from what I know of the
27 situation the adult safeguarding process was followed
28 in that. I think it was two nurses that were subject
29 to disciplinary proceedings, as I understand it. And

1 obviously there would have been a forum to look at the
2 whole action plan around that. And presumably, for
3 whatever reason, those that led on that certainly
4 didn't feel the need to come and consult me or the
5 Trust Board on it. 09:50
6 DR. MAXWELL: Would you have expected that to stay
7 within the Directorate or would you have expected your
8 Co-Director for social work governance to have been
9 aware?
10 A. Well I don't know whether the lead for the 09:50
11 investigation, I presume may well have consulted my
12 governance lead.
13 DR. MAXWELL: Well I'm asking you about your
14 expectation rather than what happened?
15 A. No, I mean it would have been very rare that I would 09:50
16 have been consulted or made aware of individual cases
17 and I think probably because it involved nursing staff,
18 if it had have been social work staff, possibly my
19 governance lead might have said to me you need to be
20 aware that two of our social workers are going to be 09:50
21 subject to disciplinary procedures.
22 DR. MAXWELL: I think it was a nurse and a healthcare
23 assistant but they were interviewed by PSNI, you don't
24 think allegations of safeguarding concerns that
25 involves the police is serious enough to escalate to 09:50
26 the professional lead for social work?
27 A. I would imagine over the five years there would have
28 been other cases where the police were heavily involved
29 and certainly I was never privy to those, so it wasn't

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1 unusual that I wouldn't have been made aware of them.
2 DR. MAXWELL: No, I understand that, but I'm saying as
3 the professional lead for social work, and I think you
4 have already agreed you were responsible for the
5 oversight of safeguarding. 09:51
6 A. Yes.
7 DR. MAXWELL: As the professional lead you are content
8 that you weren't made aware of cases that involved the
9 police?
10 A. I am because my Co-Director was a very experienced 09:51
11 social worker and governance lead and if he was
12 consulted, I'm quite sure if he had any concerns he
13 would have brought them to me.
14 DR. MAXWELL: So you would expect the divisional social
15 worker, or whatever they were called at that time, to 09:51
16 have told your Co-Director, even if you don't know if
17 they did, your expectation is that they would have
18 done?
19 A. Well, as I said to your colleague, all leads in adult
20 safeguarding would have had a link to the Co-Director 09:52
21 should they need any professional advice. So I don't
22 know whether the individual did go to the Co-Director,
23 I am just assuming that might have happened.
24 DR. MAXWELL: So it's discretionary, they can go if
25 they want, they don't have to. 09:52
26 A. They have to make a judgment call as to whether they
27 need to go and seek further advice. Depending on the
28 complexity of the case.
29 DR. MAXWELL: So you're content that the social worker

1 in the division makes a judgment call about whether to
2 tell anybody else about a safeguarding issue?
3 A. Well, as I say, there was a whole range of agencies
4 involved in that case as I understand it.
5 DR. MAXWELL: Yeah. 09:52
6 A. And, as I say, the lead was a very experienced lead as
7 well so judgment calls have to be made.
8 19 Q. MS. TANG: Can I take it that you weren't aware then of
9 the investigation that happened into Ennis at the time?
10 A. No, I wasn't. 09:52
11 20 Q. And would it concern you that in the course of that
12 investigation the lead investigator was unable to say
13 for sure that there was no institutional abuse
14 happening?
15 A. Well, I think that from what, as I say I can only pick 09:53
16 up from what I've gleaned since. I understand it was a
17 very difficult case to make a judgment on and I
18 understand there were some differences of opinion and
19 that's the difficulty with this area. There is
20 professional judgment and evidence gathering and I 09:53
21 understand there was a difficulty in determining
22 whether it constituted institutional abuse or not.
23 21 Q. I want to go up to paragraph 9, please, and pick up on
24 something there. This talks about the structures and
25 processes at Trust Board level for oversight of 09:54
26 Muckamore and you mention that those were the same
27 structures as applied elsewhere in the Trust. Can I
28 ask you, in your recollection was there any recognition
29 that patients at Muckamore would have been particularly

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1 vulnerable and that there might be a need for some
2 enhanced monitoring, something over and above what
3 happened in other parts of the Trust?
4 A. Well, I think within my sphere of operation, we had
5 many clients, both children, older people, both with 09:54
6 physically disability and obviously mental health and
7 learning disability. There was a whole range of
8 clients and residents who would have been vulnerable.
9 I'm not suggest in any way that Muckamore wasn't
10 vulnerable or was more vulnerable, but there was always 09:54
11 vulnerability in learning disability but that would
12 also go for the community as well as Muckamore. So I
13 don't think there was any particular thinking around
14 enhancing, are you thinking about reporting or
15 something of that nature? 09:55
16 22 Q. Yes?
17 A. Or oversight, I'm not aware there was any other
18 discussions around strengthening that in any way.
19 23 Q. I want to go down to paragraph 12 again, please. An
20 interesting sentence that you use there, you say: 09:55
21
22 "It often felt like there was a more immediate focus on
23 acute services at the Trust Board itself."
24
25 Can I ask you why you feel that was the case? 09:55
26 A. Well, I think I need to put it into some sort of
27 context maybe. I think it was around 2014, there were
28 huge pressures on the Trust to comply with the various
29 standards and targets in accident and emergency, for

1 example. And we did actually, I think, I think while
2 there was patient waiting for a bed the Royal Victoria,
3 they passed away and it was major media news. It was
4 such an event that -- and it's the only time, I had a
5 40 year career but it's the only time in my career that 09:56
6 the Health Minister came to the Executive Team because
7 of the event and made it very clear what he expected in
8 terms of meeting targets. And I mean, it was no
9 coincidence that in that year the Chief Executive and
10 the Medical Director both went and sought other jobs 09:56
11 because there was a lot of pressure on the Executive
12 Team at that time. That heightened the focus on 12
13 hour breaches, four hour targets. So I can well
14 understand why my colleagues were so focused on acute
15 events. But in fairness to Trust Board, I also in 09:57
16 individual conversations with non-execs, they often
17 said to me we do hear a lot about acute, we would like
18 to hear more about social care, and Social Services.
19 And that was one of the reasons why I suggested to the
20 Chairman to start a Social Care Committee that would 09:57
21 relate directly to the Trust Board that would give a
22 bit more focus to the area of work that I was
23 responsible for and that was very well received by the
24 Chairman and the Trust Board.
25 24 Q. Did you attend that Social Care Committee or -- 09:57
26 A. Yes, it was basically there, in the run up -- I mean,
27 the Delegation of Statutory Functions reports is about
28 250 pages so I had to present that. So you can imagine
29 the ability to go in to interrogate that and look at it

1 in great detail was difficult and I felt that if there
2 was a subcommittee chaired by a non-executive, they
3 could spend more time challenging and going into it in
4 a bit more rigor. I attended it, as did my governance
5 lead, as did the authors of the various sections of the 09:58
6 delegation of stat functions. I felt that was some way
7 to address a little bit the balance between acute and
8 community services.
9 PROFESSOR MURPHY: Did you feel they were better
10 interrogated then after the Social Care Committee was 09:58
11 set up?
12 A. Well I certainly felt the Committee had more time and
13 actually was able to talk directly to the authors of
14 the various sections. I did not write the report, as
15 was said at the start, I presented it. So there was an 09:58
16 opportunity for better interaction and a better
17 understanding for non-execs to understand Children's
18 Services, Learning Disability Services, Mental Health
19 and so on, I think it was well received. There were
20 three non-execs that were on the Committee. They were 09:58
21 able then to go to Trust Board and actually speak to
22 it, as well as myself.
23 25 Q. MS. TANG: So, was that Subcommittee quite instrumental
24 in picking out the bits of the DSF report that you
25 would then focus on whenever you were presenting to the 09:59
26 Trust Board?
27 A. Yes, I mean obviously with a report that size, part of
28 my job was to obviously tell them where things were
29 going well, but also tell them where we had concerns

1 and what we were trying do about those concerns, so it
2 was a mixture in trying to present a picture. So that
3 was probably the focus in the Committee.
4 DR. MAXWELL: And did the Committee report to the
5 Assurance Committee or was it going straight to the 09:59
6 Trust Board?
7 A. It would have been to the Trust Board.
8 DR. MAXWELL: Because there was already a subcommittee
9 looking at social care that was reporting to the
10 Assurance Committee, wasn't there? 09:59
11 A. Yes, that was broader issues. This Committee was
12 focussing really on two reports, the bi-annual
13 Corporate Parenting Report and the annual delegation of
14 statutory functions.
15 DR. MAXWELL: So it was very focused on those two 10:00
16 things?
17 A. It was very focused on those. So it met twice a year
18 just, the Committee.
19 DR. MAXWELL: And was the Social Care Committee that
20 was brought in with the Assurance Committee still 10:00
21 continuing.
22 A. Yes.
23 DR. MAXWELL: So you had two committees at this stage?
24 A. Yes.
25 DR. MAXWELL: What was the relation between them, or 10:00
26 were the two separated and never the twain shall meet?
27 A. Well, as I say, because the focus was on the reports
28 that went to Trust Board, they were two very separate
29 agendas but it was mainly the same personnel.

1 DR. MAXWELL: My concern is was scrutiny given to the
2 Corporate Parenting Report and DSFs at the social care
3 committee and therefore the Assurance Group and the
4 Assurance Committee, or did it just fall off their
5 agenda? 10:00
6 A. No because the Social Care Group, that's where my
7 governance lead would have pulled together the
8 Statutory Functions Report, I mean that's where the
9 work went on, he worked with the various leads each
10 year on getting the information together and making 10:01
11 sure if there were any problems they were dealt with.
12 DR. MAXWELL: I understand he was attending both or
13 producing reports for both, but the process by which
14 those reports are scrutinised is different if it goes
15 through the Assurance Group and the Assurance Committee 10:01
16 than it just goes through the Social Care Committee to
17 the Board.
18 A. I would imagine if there had been any problems about
19 the production of the report or issues, they could
20 still take some of those matters to the Assurance 10:01
21 Committee as well.
22 DR. MAXWELL: But I think the issue about assurance is
23 not people taking concerns, that's reassurance.
24 A. Yes.
25 DR. MAXWELL: It's about people saying I'm concerned 10:01
26 about this or why haven't you reported this, so it
27 might have been an opportunity for a non-exec to say
28 actually, we have been told because the Directorate,
29 the Service Directorate Director has told us that

1 police have arrested staff but it isn't mentioned
2 anywhere in any of the reports, can you tell me more
3 about it. So it's a scrutiny of the process whereas
4 you seem to be describing staff working very hard,
5 seeking advice if they want it, and that's not at all 10:02
6 the same as non-executive directors saying tell me more
7 about this, I think there's a bit missing?
8 A. Well, you know, in terms of staff seeking advice, those
9 staff also had line managers, you know, it's also to
10 remember there was a whole operational line as well as 10:02
11 professional advice.
12 DR. MAXWELL: I understand.
13 A. They would have had monthly supervision so they could
14 have raised, they would be raising whatever work they
15 were doing at the time within that Directorate. 10:02
16 DR. MAXWELL: My concern is not about that, it's about
17 how well the non-execs were able to discharge their
18 independent scrutiny function.
19 A. Well I would have thought the Social Care Committee
20 actually strengthened that arrangement because you had 10:03
21 face to face contact between non-execs and the authors
22 of the document and they could ask whatever, and they
23 did ask whatever questions, asked some very hard and
24 searching questions about why was this and why was that
25 and, you know, and so on and so forth. So I mean, and 10:03
26 it was exposure for those leads to non-execs that they
27 wouldn't normally have. So I personally felt it really
28 did strengthen governance arrangements.
29 DR. MAXWELL: Okay.

1 26 Q. MS. TANG: Mr. Worthington, the Inquiry has heard
2 evidence on a number of occasions about significant
3 staffing shortages that impacted Muckamore and the
4 Inquiry has heard that those feature across the Trust.
5 Can I ask you, do you recall staffing shortages at 10:03
6 Muckamore ever being escalated to Board level in your
7 time as Director of Social Work?
8 A. I am aware there were staff shortages, certainly, but I
9 don't recall them being discussed at Trust Board. I do
10 know that in working with my Director of Nursing 10:04
11 Colleagues and so on, I know these were matters that
12 were looked at within nursing forums as well as in the
13 Directorate itself in terms of how they could recruit
14 more appropriate staff. It may well have gone through
15 some of the assurance meetings as well, but I couldn't 10:04
16 recall which ones it had been, but I don't recall them
17 being discussed at Trust Board as such.
18 27 Q. Do you recall any conversations or discussions with
19 your professional colleagues within Social Work about,
20 given there were staff shortages, were there 10:04
21 potentially adult safeguarding risks within that?
22 A. Well I think certainly, I mean my linkage into
23 Muckamore in the last year would have been through the
24 Head of Service and certainly, you know, I would be
25 left in no doubt if there had been any concerns around 10:05
26 patient safety because of staffing, they certainly
27 would have notified me and we would have rectified it.
28 I don't recall ever anyone coming to me and saying the
29 service is unsafe. They certainly said the service is

1 being stretched and we are having to move staff around
2 and there are difficulties and those would have been
3 the way in which I would have been made aware of any
4 staffing issues within Muckamore. Prior to 2016 I
5 wouldn't have been involved in those sort of 10:05
6 discussions because they were largely again about the
7 nursing workforce and it was only when I became
8 operationally involved in my last year I would have had
9 much more exposure to that.
10 28 Q. You've mentioned that these sorts of issues, in your 10:06
11 recollection, wouldn't necessarily have made it up to
12 the Trust Board and we've talked already about the big
13 focus on acute targets which we understand, given the
14 high profile of those. Do you feel that acute services
15 inevitably overshadowed Learning Disability and Mental 10:06
16 Health Services because of all of that?
17 A. Well, I mean -- and I mean I think it's been referred
18 to, the double job if you like I had in my last year.
19 My appointment to that was seen with great concern,
20 hopefully not on a personal basis, but because it 10:06
21 seemed to further erode the status of Learning
22 Disability and Mental Health within the Trust. And the
23 feeling was that they wouldn't ask a director to manage
24 two acute directorates, that would be too much, but
25 they could ask a director to manage all of community 10:07
26 services which, if you think about it, meant within an
27 Exec Team of maybe 10 directors there was only one
28 director speaking for the community, which was me. So
29 there did seem to feel an imbalance in terms of voice

1 and speaking out.
2 29 Q. Can I ask you, when you say there did seem to feel, did
3 you feel that or was there someone else felt that?
4 A. I certainly did in the sense that when I took on the
5 post the plan was to merge learning disability and 10:07
6 mental health and I felt that that was not the right
7 way to go, I felt the two services needed to be kept
8 separate and needed to be managed appropriately. So I
9 was opposed to that merger and I certainly, as my year
10 went on, I did not see the merging of the two 10:07
11 Directorates to be appropriate either because I think
12 it did erode confidence in Learning Disability and, I
13 suppose, Mental Health at that time.
14 30 Q. And how did you come to be in the situation where you
15 were effectively doing those, both jobs? 10:08
16 A. In 2016 I was intending to retire but the Director for
17 Adult Services got in before me and retired in July
18 2016 and the Chief Executive asked me would I stay on
19 for a further year and manage both my substantive post,
20 which was Children's Services as I've mentioned 10:08
21 earlier, and take on the adult brief. So I, I did so
22 with a certain amount of trepidation because it
23 essentially was about a quarter of the budget of the
24 Trust and almost a third of the staffing of the Trust.
25 And it had been tried before, many years ago, before my 10:08
26 time, and I was told that in no uncertain terms by some
27 of the staff I met with once I was in post. So I
28 suspect the reason that I was asked to do it was
29 because of my social work background and the many

1 problems there were at that time in older peoples'
2 services. So I wasn't appointed because of Learning
3 Disability or Mental Health, so I think that was the
4 focus. So I took on the role and assisted and after
5 six months I presented a report saying this is what 10:09
6 needs to happen. It was an interim job and I tendered
7 my resignation in June to give them three or four
8 months to appoint someone permanently into the role,
9 which is what they did.
10 31 Q. The person who you took over from on that interim basis 10:09
11 presumably certainly had to give some notice as well.
12 Do you know why the Trust didn't go out and try and
13 fill that post, rather than asking someone to try and
14 do both?
15 A. This is speculation on my part, but I mean the Trust 10:09
16 was under severe pressures at that time in terms of
17 annual savings, it was somewhere around 3% annually.
18 So I suspect my predecessor in not filling the
19 Co-Director post and Service Manager post in Learning
20 Disability, because they were going to merge, was to 10:10
21 find savings and I think then also by having one
22 director instead of two, that was going to be a further
23 saving. So I suspect that that was part of the
24 thinking at the time. But as I said, the Trust did
25 change that after a year following my involvement. 10:10
26 32 Q. And you made a recommendation in the course of your
27 time as to what they should do?
28 A. Yes, I do feel it was the right decision because I feel
29 that certainly Learning Disability and Mental Health

1 requires proper managed structure and oversight and I
2 think what they were proposing would have eroded that
3 to the detriment of Learning Disability and Mental
4 Health.
5 33 Q. You had mentioned, I think, if I picked you up 10:10
6 correctly that you didn't think that Mental Health and
7 Learning Disability should be merged as well?
8 A. That's right.
9 34 Q. What were your concerns about the potential merger of
10 those? 10:11
11 A. Well they were two very different services. I suppose
12 the one thing they had in common was resettlement,
13 because there were resettlement issues in Mental Health
14 as well as in Learning Disability but they were
15 distinctly different, okay there might have been 10:11
16 similar legislation in relation to some of it, but the
17 skills and requirements of working with someone with a
18 learning disability as opposed to someone with a mental
19 health condition, they were just different services,
20 and required different structures, different planning 10:11
21 and different oversight. I can understand why the
22 thinking was, you know, the Co-Director was retiring so
23 we'll not replace him, we will ask the Co-Director for
24 Mental Health to manage both, and when I met with him
25 he said he didn't want the job. So there were people 10:11
26 already opposed to it, even from the day and hour I
27 went into post.
28 35 Q. So these people were, as you say, opposed to it, you
29 had concerns. What happened to those concerns?

1 A. Well basically the first thing I did was I went and
2 said the Co-Director post has to be reinstated.
3 36 Q. Co-Director for Learning Disability?
4 A. It would have been John Veitch, who I'm sure you've
5 heard from here, he retired in the September and the 10:12
6 plan was not to replace him, a very experienced
7 learning disability manager. So I was deeply
8 concerned, given the spread of span and control I had
9 to suddenly lose that position. So I immediately said
10 to the Chief Executive, this post needs to be 10:12
11 reinstated. But of course it was given up to savings
12 so I had to call it something else, I called it Head of
13 Service which was basically the same thing. And to be
14 fair, the Chief Executive supported me in getting it
15 reinstated. And I think we appointed a Head of Service 10:12
16 within a few months after the Co-Director retired. I
17 also, it was a Service Manager below that retired and
18 they weren't replacing that person which meant that the
19 Service Manager in Muckamore had extra duties on top of
20 their already duties, so I felt that was also wrong. 10:13
21 And that post was reinstated. Now it took a bit longer
22 but the Head of Service did get that post reinstated.
23 So I spent most of the year trying to rebuild what was
24 being lost, if you understand, particularly in Learning
25 Disability. 10:13
26 37 Q. Yes. So who was it that decided to offer those posts
27 up to savings, I get the sense it wasn't you?
28 A. My predecessor.
29 38 Q. Your predecessor. And would that have been part of the

1 Trust Board's considerations about savings plans that
2 they could have looked through and said there's a post
3 we are going to get rid of, or whatever, how much would
4 the Trust Board have seen of that plan?
5 A. There were different forums, there was a special group, 10:13
6 I think it was the called the More Group, I can't
7 remember what more stood for, essentially it was about
8 efficiency savings and all the services would have been
9 at that. So these proposals would have been tabled at
10 fairly senior management and were approved. 10:14
11 39 Q. So this was, do I understand you correctly, was this a
12 subcommittee or something like one of the Trust Board
13 that would review savings plan or have I misunderstood?
14 A. It was set up specifically to look at the financial
15 savings, I don't know whether it would have been a 10:14
16 subcommittee. Obviously reports would have went to the
17 Exec Team as well, the Director of Finance would have
18 given a report and also would have given a report at
19 Trust Board. And I'm quite sure Trust Board, certainly
20 the savings plans and how the Trust was managing 10:14
21 towards meeting its targets would have been tabled.
22 DR. MAXWELL: It would have been more than tabled, it
23 would have to be formally agreed by Trust Board?
24 A. Yes, yes, yes.
25 DR. MAXWELL: Because the authority and ultimately 10:14
26 responsibility lies with the Trust Board to agree
27 whatever plan had been produced?
28 A. It had to be signed off.
29 DR. MAXWELL: And this was to meet a savings target

1 that had been imposed on the Trust I presume, so you
2 were instructed by HSCB or the Department of Health?
3 A. It probably came from the department but came through
4 HSCB and it was across the Board. If it was 3%,
5 everybody had to find 3%. I think, again, when I came 10:15
6 into post, there was an eight million deficit already
7 in because there hadn't been sufficient savings in the
8 previous year. A lot of it was in older peoples', it
9 wasn't necessarily in Learning Disability, because you
10 can imagine the pressure on domiciliary care and all 10:15
11 the other things in Older People.
12 DR. MAXWELL: So what did you expect would happen if
13 the Trust went back to the HSCB and said no, we can't
14 meet this full 3%, it would be unsafe?
15 A. Well I think there was representation made on a regular 10:15
16 basis about the savings plans. But the attitude, I
17 think, of the Board was the organisation was I think
18 what, 1.2 billion, 1.3 billion, you know, if you can't
19 find it from here, find it from somewhere else. It's
20 your call, if it's unsafe to take it from here, take it 10:16
21 from somewhere else. So they left it back to the Trust
22 to make those decisions. Obviously if we came forward
23 with plans that the Board, Health Board didn't like,
24 they would then maybe not support it because they also
25 had to support it as well. 10:16
26 DR. MAXWELL: Yes.
27 40 Q. MS. TANG: I just want to check one detail on what you
28 told me about the vacant post, the very senior ones,
29 the Co-Director?

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1 A. And Service Manager.
2 41 Q. And Service Manager and the fact that you were then
3 double jobbing effectively in covering the ASPC
4 Directorate?
5 A. Yes. 10:16
6 42 Q. That would have generated a certain amount of savings
7 as you've indicated, was that, do you recall that
8 decision to not fill those very senior posts discussed
9 at Trust Board when you were the Director of Social
10 Work? 10:16
11 A. You mean in terms of losing them or subsequent to --
12 43 Q. In terms of them losing them?
13 A. Yes, I think going back to your colleague, those
14 matters would have been tabled at Exec Team and signed
15 off at Board level. 10:17
16 44 Q. And would you have raised any concerns at that point
17 about your Co-Director presumably not being replaced?
18 A. At that time I wasn't director, that would have
19 happened prior to me coming in as director.
20 45 Q. You were Director of Social Work on the Board at that 10:17
21 point, that's what I mean. Did you raise concerns
22 about the loss of a very high profile social work post?
23 A. I don't recall me raising it. I didn't know what was
24 being put in place to mitigate, I presumed there were
25 going to be mitigations in terms of how they were going 10:17
26 to manage it because it was an operational issue. They
27 weren't necessarily cutting social work posts, as such,
28 they were cutting management posts. So I don't recall
29 ever raising issues about it. Obviously when I became

1 director and I assumed, there is another assumption I
2 made, that there had been consultation in the
3 Directorate about it and when I met with staff they
4 said there hadn't been any consultation about the
5 withdrawal of both the posts, which I was astounded 10:18
6 about because I can tell you now, if I was going to
7 take out, in children's services if I was going to take
8 out a Co-Director post, there would be a wide
9 consultation about the ramifications of that and how we
10 were going to mitigate it. So I assumed the same thing 10:18
11 had happened in adult services which was probably the
12 wrong thing to do because it hadn't happened.
13 46 Q. It hadn't happened?
14 DR. MAXWELL: Can I ask, in some NHS Trusts,
15 non-executive directors are nominally associated with 10:18
16 the particular client group or Directorate, did that
17 happen at Belfast Trust? Would there have been a
18 Champion for adult, community and social care and
19 primary care who actually was visiting and talking to
20 staff and had a better understanding of what was 10:18
21 happening?
22 A. I can't recall if it was down to that level of detail.
23 I know the non-execs did walk arounds and some
24 expressed more interest, I know that Ann O'Reilly, who
25 was a non-exec, I worked with her very closely because 10:19
26 she was very interested in social work, social care and
27 the various -- she was Chair of the committee I
28 mentioned earlier. But I don't know whether there was
29 non-execs assigned to different client groups, if

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1 that's what you're maybe asking.
2 DR. MAXWELL: So I am wondering, you were saying that
3 you were on the Board when the decision to disestablish
4 the Co-Director for Learning Disability post came up,
5 and to merge the two director posts into one, and you 10:19
6 didn't question it because it wasn't your area of
7 expertise. I am wondering who on the Board would have
8 been able to challenge that, because if everybody said
9 it's not my area then I'm not sure what the point of
10 the Board looking at it is? 10:20
11 A. I mean, the Board would have considered all of the cost
12 savings, if you like, that were being presented to
13 them.
14 DR. MAXWELL: Yes.
15 A. And obviously they depended on the directors who were 10:20
16 signing off.
17 DR. MAXWELL: Service Directors?
18 A. Service Directors signing those off, that essentially
19 if you remember these savings are about efficiencies,
20 so they should not affect the service, if they are just 10:20
21 about efficiency. So that was the basis on which these
22 papers were written. And therefore, you know, I
23 wouldn't have taken a post out of somewhere where I
24 thought it was going to have a detrimental effect. But
25 I would have taken a post where I thought it was an 10:20
26 efficiency, that would be covered in other ways. So
27 that's the basis on which these reports were presented.
28 DR. MAXWELL: I understand that that gives you a single
29 point of failure, the Service Director because if they

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1 make the wrong call, which you clearly thought they did
2 when you went in --
3 A. Yes.
4 DR. MAXWELL: Nobody knows, you have to take on faith
5 that the Service Director has done this properly and 10:21
6 reached the right decision. There's no second checking
7 system, it's all a single point of failure. So if you
8 have got a good Service Director, happy days, but if
9 you haven't then things can go wrong.
10 A. The Service Director would also have been discussing 10:21
11 this with the Chief Executive in their one-to-ones.
12 There would have been several discussions, I would have
13 thought, before it got to the length of the Trust
14 Board. So there would have been checks and balances in
15 there but I take your point. It would be very hard for 10:21
16 a non-exec sitting on a Board every couple of months to
17 suddenly be presented -- and remember it was again
18 another huge document because it was a savings for
19 across the whole Trust and this was one small part of
20 it. So it would be very difficult for them to have, as 10:22
21 you say, the wherewithal to challenge something.
22 Sometimes people would ask are you sure this isn't
23 going to be detrimental to the service, and the Service
24 Director would try to explain what the mitigation would
25 be in order to meet that saving. I wouldn't 10:22
26 underestimate how difficult it was and how much it
27 dominated the thinking from one year to the next in
28 trying to find the savings without wrecking the service
29 basically.

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1 47 Q. MS. TANG: I want to move down to paragraph 15 and look
2 at some detail that you provided between paragraphs 15
3 and 17. You talk about visits to Muckamore?
4 A. Yes.
5 48 Q. And I want to ask you, when did you first visit 10:22
6 Muckamore and have a look around the wards, if you can
7 remember?
8 A. I think the first time I would have visited there were
9 two visits, I think there was one around -- it would
10 have been March, April and then another one, June, 10:23
11 July. There were two visits I did with the Head of
12 Service. I mean I had been to Muckamore and spoke to
13 people but actually doing a ward round, it was probably
14 into 2017.
15 49 Q. 2017, so in your capacity as Executive Director would 10:23
16 you have visited the site before that, before you
17 became ASPC director?
18 A. I think there was a Trust Board held, I think it might
19 have been around 2015, the Trust Board wanted to get
20 out and about and be more visible rather than sitting 10:23
21 in one place to meet. And I think after that we were
22 each, including the non-execs were each taken for
23 visits, I think I saw the day care facilities and a few
24 other wards back in about 2015.
25 50 Q. And was that the first time that you had been to 10:23
26 Muckamore at that point?
27 A. In my current role, I mean I had been to Muckamore many
28 times in the past.
29 51 Q. In the past, in previous jobs?

1 A. Well, mainly I had a brother who was a resident for 25
2 years in Muckamore from when he was nine through to he
3 was 34 and he was discharged from Muckamore in the
4 early 90s, so I would have been a regular visitor from
5 a family perspective to Muckamore. So I had knowledge 10:24
6 of Muckamore, put it that way.
7 52 Q. That's interesting. Whenever you were going around the
8 wards then when you arrived there as Executive Director
9 of Social Work, what was your impression of the wards?
10 A. I think my impressions were mixed, the new wards looked 10:24
11 great, I mean in terms of the decor, the environment,
12 the furnishings. The older wards looked tired and in
13 some cases I was quite concerned, you know, poor
14 settees or whatever. So there was discussion about,
15 through the Ward Sisters, about ordering what they 10:25
16 needed. And I understand there was a running down of
17 some of those wards so maybe there was less investment
18 in them but I felt that every ward was entitled to the
19 same service. I thought that -- obviously it was
20 announced so I presume everybody was on their best 10:25
21 behaviour when you were arriving, it wasn't
22 unannounced. And the officer in charge or charge
23 nurse, whoever it was in any of the wards I was in was
24 very forthcoming in the issues that were around, around
25 staffing, around I suppose uncertainty about the 10:25
26 future. Around just good -- sometimes poor
27 communication in terms of what was happening. So I
28 picked up, I obviously picked up that -- and there were
29 staff who had been injured in incidents, so there was a

1 number of things that were discussed in both the first
2 visit and the second visit. I did one set of wards the
3 first visit and I did the rest on the second visit as I
4 recall, as much as I can remember.
5 53 Q. So is it your sense that you got around the entire 10:26
6 hospital campus?
7 A. Yes.
8 54 Q. Over the course of those two visits. So that would
9 have included the resettlement wards?
10 A. Yes. 10:26
11 PROFESSOR MURPHY: Did you feel there was a big
12 contrast between the so-called core hospital wards and
13 the resettlement wards?
14 A. I felt that obviously a new building is a new building
15 and I mean some of the New Buildings in Muckamore I 10:26
16 thought were top rate buildings. I thought some of the
17 older buildings that were being marked for closure were
18 tired buildings and were clearly needing closed and
19 replaced. But I mean I think there is no excuse.
20 PROFESSOR MURPHY: The atmosphere, did the atmosphere 10:26
21 differ between the two?
22 A. No, I think the quality of the staff across, from what
23 I could see and talking to people in terms of how
24 caring they were and what they were trying do and some
25 of the challenges they were facing was no different 10:27
26 from I could tell, it was more the environment that did
27 feel different. And, you know, if you were a family
28 member, I was trying to think of it because having been
29 a family member, walking into somewhere, how did I, if

1 my brother was in there or my son or daughter,
2 whatever, did it look as if it was well kept? Was it
3 clean? Was the furnishings good? I mean those were
4 things that I would have wanted and I was trying to
5 look at it from the eyes of a family member. And I 10:27
6 think some of the older units did fall a little bit
7 shorter than I would have expected and we did encourage
8 then, and the Head of Service did encourage, if there
9 was something needed get it. Because, let's face it,
10 if the ward closed, that settee or whatever it was 10:28
11 could be transferred somewhere else, it wasn't going to
12 be, it wasn't misuse of money. And I understand money
13 was tight but at the end of the day there were some
14 things just had to be bought.
15 PROFESSOR MURPHY: We have heard witnesses say that 10:28
16 they felt the core hospital was more clinical and more
17 hospital-like.
18 A. Yes.
19 PROFESSOR MURPHY: And the other wards were more
20 homely. 10:28
21 A. Yes.
22 PROFESSOR MURPHY: Did you feel that?
23 A. I understand that too because, you know, new wards can
24 seem a little bit more clinical and some of the old
25 wards were more sort of like, as you say, were more 10:28
26 homely, so I understand those comments. But at the end
27 of the day the staff, the abilities of the staff or
28 their skills, as far as I understood, was similar
29 across the various wards. I know they had to move

1 people about at different times and all the rest of it
2 but, by and large, the workforce was the same across
3 the wards, as I understood it.
4 PROFESSOR MURPHY: Thank you.
5 55 Q. MS. TANG: You had said that the visits that you made 10:29
6 were preannounced?
7 A. Yes.
8 56 Q. And the staff therefore knew you were coming and I
9 think you used the phrase everybody was on their best
10 behaviour. Can I ask you, did the visits get told to 10:29
11 family members so that they could meet you when you
12 were on-site as well?
13 A. I didn't meet with any family members. I mean it was
14 mainly to meet staff and see round. I think the Head
15 of Service was meeting family members, so I'm quite 10:29
16 sure -- I mean, part of my thinking was, I picked up
17 very early on when taking on the role, since the
18 inception of the Trust, which was in 2007, so we're
19 talking best part of 10 years, that there was a feeling
20 that Muckamore was a place alone, that it was separate 10:29
21 almost from the Trust, that senior management was
22 remote and that basically, I suppose 'who cares about
23 us' type of attitude. So, one of my reasons for
24 wanting to do walk arounds was to be visible, to let
25 people know that senior management was interested, that 10:30
26 it was part of the Trust and that if people had any
27 concerns, they had an opportunity, either when I was
28 there to voice them, or subsequent to that they could
29 speak to the Head of Service and know that we were in

1 listening mode. So that was part of my agenda at that
2 time, because I was aware there were some tensions
3 between professions, there were communication issues,
4 there was some things around. So I did feel, along
5 with my Head of Service, we had to be more visible. So 10:30
6 that was part of the thinking. But Head of Service
7 tended to work more directly with the families.
8 PROFESSOR MURPHY: So you felt you were doing your
9 best, by the sounds of it, to mitigate the feelings of
10 staff in MAH that they were kind of forgotten by the 10:31
11 Trust, not attended to by the Trust because they were a
12 long way out of Belfast, et cetera?
13 A. Yes.
14 PROFESSOR MURPHY: Did you feel there were genuine
15 reasons for them feeling that? 10:31
16 A. Yes, I think it's not all one side. I think -- I don't
17 believe that the Trust was neglecting Muckamore, it
18 probably felt that way to them. I mean they were
19 geographically quite apart from the Trust, as you know
20 as well, which didn't really help. And I probably 10:31
21 think that they probably saw less of senior management
22 than maybe some of the community services and other
23 services in the city of Belfast. So, you know, there
24 was probably some truth in that. But, I do feel that,
25 you know, if you are going to get staff to talk they've 10:32
26 got to feel they can Trust senior management, they'll
27 not speak up if they don't feel they can Trust senior
28 management. And if they don't see senior management
29 it's going to be hard for them to trust them.

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1 PROFESSOR MURPHY: Thank you.
2 57 Q. MS. TANG: Moving down to paragraph 16, please, thank
3 you. When you became acting director of the ASPC
4 Directorate in 2016, 17, would you at that point have
5 reviewed the Learning Disability Risk Register? 10:32
6 A. Yeah, well I mean, as Director I think we had
7 quarterly, quarterly governance meetings in each of the
8 directorates. So, you know, the Risk Register would
9 have come up in those meetings and obviously in the
10 Statutory Functions Reports, any areas where we were 10:33
11 maybe not doing as well as we would like, it usually
12 said how the risk was categorised, low, medium, high,
13 so therefore it would have been in those reports as
14 well.
15 58 Q. We're going to come on to those shortly? 10:33
16 A. All right.
17 59 Q. Can I ask you, were you aware of the installation of
18 CCTV at the time of you being the Interim Director of
19 ASPC?
20 A. No. 10:33
21 60 Q. At what point would you have become aware of CCTV being
22 at Muckamore?
23 A. When I came back from holidays in August when the whole
24 exposure, if you like, occurred, that's when I became
25 aware. 10:33
26 61 Q. Do you mean August 2017?
27 A. Yes.
28 62 Q. And you retired?
29 A. September 17.

1 63 Q. So just as you were about to retire?
2 A. Yes.
3 DR. MAXWELL: So, are you saying, we've heard that the
4 policy for the use of CCTV was going through multiple
5 committees. 10:34
6 A. Yes.
7 DR. MAXWELL: And wasn't finally agreed until June
8 2017.
9 A. That's right.
10 DR. MAXWELL: Are you saying that that was never 10:34
11 discussed at Directorate meetings?
12 A. I don't recall it, I do not. I mean I understand that
13 there was maybe something lodged back as far back as
14 2015 with the Exec Team. That's not something that
15 stuck in my mind at the time. So, you know, and I mean 10:34
16 when I took on the role nobody said to me oh, by the
17 way, we've got CCTV and it's going to be switched on at
18 some stage in the future, we are going through due
19 process, I don't recall having of those discussions.
20 DR. MAXWELL: You weren't involved in agreeing the 10:34
21 policy for its use?
22 A. No.
23 64 Q. MS. TANG: Would you have attended the Directorate's
24 governance meetings whenever you were in that interim
25 role? 10:35
26 A. Yes, I would ordinarily if I was available I would have
27 chaired them and in my absence the Co-Director would
28 have chaired them.
29 65 Q. Would those governance meeting have reviewed incident

1 data or Datix information or what was considered?
2 A. It would be fairly high level. I mean there was
3 obviously within each of the service areas, I know in
4 Muckamore there was weekly meetings that went into
5 detail on things like seclusion, complaints, adult 10:35
6 safeguarding, whatever the areas were. I think by the
7 time it came to the Directorate governance meetings
8 there was collation of reports because it was quarterly
9 so you were looking at data over maybe a three-month
10 period, comparing it with the previous three months and 10:35
11 so on and so forth.
12 66 Q. Can you recall any change in trends in incident data,
13 for instance, number of violent incidents that were
14 being reported or --
15 A. I really, my memory of trying to remember that detail, 10:35
16 all I can say is I know in the year that I was involved
17 I was struck by how many injuries that staff, you know,
18 there were incidents. One that sticks out in my mind
19 is I think there was staff member ended up with a
20 broken hip or a broken pelvis and that one obviously 10:36
21 sticks in my mind. So I know that there were an
22 increase in aggressive incidents towards staff, but I
23 don't recall seeing any abuse or aggression. There
24 might have been some from resident to resident, but not
25 from staff to resident if you understand what I mean. 10:36
26 67 Q. I'm just trying to recall, did you say you noticed
27 there was some increase in the violence or just that
28 you remember a particularly dramatic one?
29 A. I had no knowledge of what went before but certainly I

1 was struck, compared with other parts of the business,
2 you know, managing a whole range of children's homes
3 there wouldn't have been the level of injuries to staff
4 going on there as what seemed to be happening on the
5 Muckamore site, from what I could pick up. 10:37
6 68 Q. Were there any mitigations that you recall put in at
7 that time to try and reduce that or to challenge it?
8 A. Well I do recall having conversations with my Head of
9 Service who had taken up post and she had a governance
10 background and a nursing background and I felt she was 10:37
11 the perfect fit for the role. She felt that there were
12 things that could be done, both in terms of behavioural
13 support to the staff -- but also I think there was a
14 concern that not enough stimulation was going on for
15 the residents in Muckamore, because I think there had 10:37
16 on occasions, the day care services had been closed
17 because of staff shortages and also there wasn't any
18 in-reach to Muckamore. I mean I remember years ago
19 there was music therapy, there was various other things
20 provided in Muckamore to try and stimulate residents 10:37
21 and, you know, things that calmed them down. So I
22 think there were, I think the Head of Service, once she
23 got into post, she did try to look at various ways to
24 try to, as you say, mitigate. Because it was looking
25 at ways that would seek to calm residents, to make 10:38
26 residents feel more at ease and therefore less likely
27 to strike out as I understood it.
28 CHAIRPERSON: Where did you hear about that from, the
29 lack of --

1 A. When I appointed the Head of Learning Disability, she
2 liked -- she was a hands-on type of person and she did
3 a lot, I asked her to take an office up in Muckamore,
4 spend more time up there. And she, one of the things
5 she said to me was that she felt there were things that 10:38
6 had been lost. Because I think she knew Muckamore over
7 a 10 year period so she was aware of things that were
8 available.
9 CHAIRPERSON: I understand, but it was a concern
10 expressed by her? 10:38
11 A. It was a concern expressed by her and not only did she
12 express it, she told me what she was going to do about
13 it, she was actively trying to pursue ways of trying to
14 if you like de-escalate some of the issues that were on
15 the Muckamore site. 10:39
16 DR. MAXWELL: You said that she felt these activities
17 had been lost.
18 A. Yes.
19 DR. MAXWELL: Did she tell you when they were lost, so
20 how long had the patients not had stimulation? 10:39
21 A. Well I think that, I think she found it difficult to
22 get the right way of the -- there was a very good day
23 care facility, for example, on the site, I think there
24 was a swimming pool on the site and I think at various
25 times because of staff shortages they were temporarily 10:39
26 closed but I couldn't tell you when or how long.
27 DR. MAXWELL: Okay. So she was of the view that this
28 loss of activity was to do with staffing?
29 A. She felt certainly the day care, but she couldn't

1 understand because there were groups that would have
2 come in and volunteered to, say, to do various sort of
3 therapies with some of the residents and she couldn't
4 understand why some of those had been stopped. Yes,
5 the day care probably was do with staffing, but she 10:40
6 wasn't sure why those other initiatives hadn't been
7 maintained. And I think she did succeed in getting
8 Extern and a few other groups to come in and do work
9 on-site with residents.
10 69 Q. MS. TANG: Chair I'm conscious I have about 20 minutes 10:40
11 more of questions to go and I just wonder --
12 CHAIRPERSON: If the witness is all right to carry on I
13 would actually rather carry on but would you like a
14 break now?
15 A. No, I'm quite happy to continue. 10:40
16 70 Q. MS. TANG: Thank you. I want to move down to paragraph
17 30 of your statement, please. As you'll see, paragraph
18 30 is where you discussed the Delegated Statutory
19 Function Reports and the Inquiry understands these
20 reports covered a very broad range of services, whether 10:41
21 they be older peoples', physical disability, mental
22 health, learning disability, children's services. And
23 you've told us already about the tier of scrutiny that
24 applied to those reports effectively with the
25 subcommittee, the social -- 10:41
26 A. I only came in around 2015 so it was in the latter
27 couple of years of my time at the Trust, yes.
28 71 Q. So in terms of the, I'm going to call them DSF reports
29 if I can?

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1 A. Yes, that's good.
2 72 Q. Can you just clarify for me what was the essential
3 purpose of the DSF reports in your mind?
4 A. Well, the DSF report was essentially social work
5 activity and social care services in terms of the 10:41
6 content, that's what the focus was, and it was
7 obviously, the Department was ultimately responsible
8 for the statutory functions. They handed those to the
9 Health and Social Care Board who, in turn, delegated
10 them to the Trust, the five Trusts. And it was really 10:42
11 to assure the Health and Social Care Board and the
12 Department that all the legislation, the regs and
13 guidance that went with them, that they were being
14 adhered to and followed by the social work workforce
15 and the social care services, so it was very much 10:42
16 focused. And it was, not a sort of a live document.
17 You know, by the time I viewed it, it was probably May,
18 June of the next year of which the activity was from.
19 So say, for example, if the '23, '24 year that has just
20 passed in March, I would have been viewing that 10:42
21 material in say June of this year. So some of the
22 activity and the issues that were raised were from
23 maybe six, 12 months previously. They were presented
24 first of all to the Committee in the latter years but
25 then presented to the Trust Board. And once the Trust 10:43
26 Board approved them, I then met in the August with the
27 Health and Social Care Board, as did all five Trusts,
28 and each of the sections was, you know, we brought in
29 the authors of each of the sections to that meeting and

1 the Health Board had their experts in learning
2 disability and mental health and they were interrogated
3 and discussed. And finally I would say in September,
4 you are now a year and a half on from the start of the
5 previous year in which these things were compiled from, 10:43
6 it went to the Department. The Health and Social Care
7 Board would have went to the Department with consummate
8 report from the five Trusts. And I think it was
9 broadly used by the Department and Health and Social
10 Care Board to compare, for example, how is Belfast 10:44
11 doing against the Western Trust, the Western Trust
12 seems to be doing better here, why is this other Trust
13 not doing that. So there was a bit of compare and
14 contrast and learning going on at that level. But it
15 was very much, it was a piece that was done from the 10:44
16 previous year. It was not live data as such.
17 CHAIRPERSON: What was the point of you looking at is
18 so much later on, was it simply for the preparation of
19 the next one?
20 A. The problem, Chair, was once you got to the end of say 10:44
21 March of this year, it took a couple of months to
22 compile everything. There wasn't a lot of resource.
23 And again, I'm going to sound like I'm griping about
24 acute and community, but community did not have the
25 same IT and data systems that our acute colleagues. I 10:44
26 was very envious at times of the live data. I had an
27 app on my phone that could tell me how many patients
28 were waiting in A&E today and how long. I didn't have
29 access to that sort of data on the social care side.

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1 So it was always lagging behind. So if you had a
2 problem in July of last year, you weren't going to say
3 you know what I am going to do, I'll save that and put
4 it in a stat functions report. You would find other
5 ways of discussing that problem because it wasn't going 10:45
6 to be looked at by the Exec Team or the Trusts Board or
7 the Health and Social Care Board until the following
8 year.
9 PROFESSOR MURPHY: So nobody ever suggested that these
10 should be monthly, for example, with an annual summary 10:45
11 at the end?
12 A. Well the five Trusts, and I don't want to speak for the
13 five Trusts, but I know it wasn't just Belfast, all
14 five Trusts weren't happy with the make up of the DSF
15 report, they felt it was a number crunching exercise. 10:45
16 It didn't tell you anything about outcomes. When I
17 looked at that report, yes, I could see there was 20 of
18 this and 40 of that, but it didn't tell me what the
19 patient experience or the client experience was,
20 whether the right people were involved and so on. 10:46
21 There were definitely things missing. We had been
22 lobbying, all five Trusts, I would say from 2013, 2014
23 to say look, with the way things are changing and the
24 better focus on outcome measures that are around,
25 surely we can do better than this, surely you would 10:46
26 want a different type of report because if any of you
27 had taken the time to look at it, there is a lot of
28 repetition in these reports. And, you know, while
29 there is some good stuff in there, don't get me wrong,

1 there is a lot of repetition and therefore we started
2 to question whether they were fit for purpose
3 essentially. And I don't know whether they are still
4 being produced in the format because I am seven years
5 away. That lay mainly with the department and to a 10:46
6 certain extent the Commissioner as to whether they
7 wanted different data and a different report.
8 DR. MAXWELL: Who did you raise that with, did you
9 raise it with the office of the Chief Social Worker?
10 A. It was raised both with the Health and Social Care 10:47
11 Board and Chief Social Worker. And, don't get me
12 wrong, there was no disagreement. I think there was a
13 feeling it needed revised but it was getting round to
14 revising it seemed to be the problem.
15 DR. MAXWELL: Would that have required new legislation? 10:47
16 A. No, I don't think it needed new legislation. I think
17 because the legislation is all there, it was just a
18 different framework or reporting mechanism that was
19 probably needed with maybe different questions being
20 asked. 10:47
21 DR. MAXWELL: If the Chief Social Worker was aware and
22 didn't disagree, why didn't it change?
23 A. You would have to ask -- I'm sorry, you have probably
24 heard that a lot.
25 DR. MAXWELL: We will. 10:47
26 A. And there was no disagreement, but, you know, to
27 overall something like that, I can understand they
28 would have had to put time and a lot of effort into it
29 and for some reason other priorities, I guess, I can't

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1 answer for it, you know.
2 A. MS. TANG: If you had been able to make the changes
3 that you wanted, what kind of things would you have put
4 into the DSF reports?
5 A. If you had asked me that seven years ago I might have 10:48
6 been able to answer it.
7 73 Q. Okay?
8 A. I think it's just, you know, if you look at it, it
9 obviously did I suppose try to report on whether things
10 happened, in when I say a timely manner, in a manner in 10:48
11 which they were supposed to happen. If there was a
12 case conference that needed to be called in 15 days,
13 that it happened, how many weren't called in 15 days.
14 But it didn't tell you were the right people there,
15 what was the outcome, was the family consulted, were 10:48
16 they happy with it. You know, it would have required a
17 different -- it would have been a much more qualitative
18 report, it was very much a quantitative report. There
19 was some good narrative in there so I'm not wanting to
20 say, it wasn't all bad, there was some very good, you 10:49
21 know, commentary in there but it did need an overhaul.
22 But I think there would have been more focus on client
23 patient experience in some shape or form with outcomes.
24 I mean those were being developed in the latter years I
25 was there. So there was things they could have maybe 10:49
26 drawn on.
27 74 Q. Do you feel that there was space within the DSF reports
28 for concerns about safeguarding or for issues around
29 patient care to be ventilated?

1 A. Well I think again, as I say, you have a 250 page
2 document with a number of appendices. So, you know, a
3 certain amount is probably going to be lost in the
4 sheer volume of that. But, as I said before, I think
5 there were ways and means of raising concerns. I mean 10:49
6 latterly they did produce I think an adult safeguarding
7 separate report, it used to be in the body of the
8 report. And I mean that was really to try and look at
9 the numbers across, you know, Mental Health, Learning
10 Disability, Older People. And there were differences, 10:50
11 I mean I can vaguely remember there being a very small
12 number of mental health investigations against learning
13 disability and older people and people were saying is
14 that because the interpretation is different or they
15 haven't enough staff to do things. So there were 10:50
16 opportunities at times for people to, as you say,
17 discuss and interpret figures. But they were basically
18 large number crunching, there was nothing there about
19 individual cases as such. That wasn't the place they
20 were discussed. 10:50
21 75 Q. So whenever you were at the subcommittee that would
22 have been scrutinising the reports that came in from
23 the different service areas, do you recall those
24 committees drilling down into some of the issues that
25 were being flagged up, whether it be resettlement 10:51
26 targets being difficult to meet or --
27 A. Are you talking about the Social Care Committee?
28 76 Q. Yes, well the Committee, you described a committee at
29 the start, forgive me, I'm not sure I remember the name

1 of it, but it's the one that looked at the DSF reports
2 on behalf of the Board effectively, is that the Social
3 Care Committee?
4 A. Yes, I can remember my last one.
5 77 Q. Okay? 10:51
6 A. And it was my only one covering the adult side from an
7 operational point of view. Yes, professionally I
8 covered social work. And I do remember, because I
9 reflected on the fact that I think resettlement has
10 featured in the DSF reports as far back as 2009 in 10:51
11 terms of the challenge and the issues surrounding
12 meeting targets and getting, you know, residents out in
13 a timely fashion. And my only observation, and it's
14 easy when you're leaving to make some observations as
15 you probably imagine, but my sense was that the 10:52
16 statutory side had given this over to the voluntary and
17 private sector basically to provide housing, support,
18 whatever it is. Obviously the Trust had to provide
19 maybe psychological support, social work support,
20 nursing support. But largely, the whole housing of the 10:52
21 residents who were in Muckamore depended on the
22 independent sector to cover the whole thing. There was
23 a part of me, I had a conversation with the Chair and I
24 said one of the things that maybe needs to be
25 reconsidered is whether the statutory side needs to 10:52
26 take ownership in the community of some of this and
27 actually manage some of these services again. Because
28 can clearly to me one of the reasons why there were,
29 ongoing for a number of years, resettlement problems

1 was that there were issues about having sufficiently
2 trained people. It wasn't just the money, it was
3 having the right staff to actually support some very
4 vulnerable and highly complex individuals who were in
5 Muckamore who weren't going to just need a visit here 10:53
6 and there, they were going to need round the clock
7 support. So I think, I think that some of the
8 voluntary sector and independent sector providers were
9 really struggling with this, and understandably so,
10 because sometimes they just didn't have the expertise. 10:53
11 And that's why I think, I think there were a number of
12 placements broke down and the individual had to come
13 back to Muckamore and that was probably because they
14 just couldn't put the right package of support around.
15 10:53
16 There was a part of me thought why isn't the Trust
17 maybe reconsidering it's role here. That was just on
18 an observation on being involved for the 12 months that
19 I was, more directly with it.
20 78 Q. Did you raise those concerns at the time with your 10:54
21 executive colleagues?
22 A. I raised it both with the Committee and presented it at
23 Trust Board as well, that was my last DSF report.
24 79 Q. And how was that received?
25 A. I know that the Chair, Ann O'Reilly, and she had a 10:54
26 background in the voluntary sector so she understood a
27 lot of what I was talking about and she very much
28 supported that view. And, you know, there was a
29 feeling that the Commissioner needed to relook at that

1 and the Trust maybe needed to relook at that, you know.
2 I would have said there was the same problem, it wasn't
3 just a problem for Belfast, I think it was a problem
4 across all the Trusts.
5 80 Q. Is it the case that this move towards community and 10:54
6 voluntary sector provision of those services was very
7 much policy direction?
8 A. Yes and, don't get me wrong, it worked very
9 successfully with older people but older people mostly
10 weren't as complex as those in Learning Disability, 10:55
11 certainly the residents at Muckamore. So the model was
12 there, there was just an expectation that well it's
13 working really well here because they were closing
14 older peoples' home, they were getting more domiciliary
15 care and it was working really well and they 10:55
16 transferred that model into Learning Disability and
17 Mental Health. But the costs, I think the minimum cost
18 for a support at that time was may be 85,000 or 90,000.
19 You could you probably support nine older people for
20 that in the community. So the costs were vastly 10:55
21 different as well. So the model, I think, didn't
22 translate as well as maybe they thought it would. So I
23 think it was a policy driven and I think there was a
24 feeling it needed to be relooked at.
25 81 Q. So whenever you raised your concerns that perhaps, if I 10:56
26 interpret you correctly, one size didn't fit all, that
27 this model might not be quite as easily transferable to
28 Learning Disability, you mentioned the Trust Chair was
29 supportive of your outlook?

1 A. Yes.
2 82 Q. Did it go beyond that, did you raise that directly with
3 HSCB or the Department?
4 A. Yes, it would have been raised with the Health and
5 Social Care Board and who in turn, I presume, raised it 10:56
6 with the Department who obviously were those, they set
7 the policy, the Board commissioned the Department
8 policy makers and then we delivered. I mean that was
9 the way it worked. So, I mean, I am under no illusion
10 that changing these things are not simple, it takes 10:56
11 time and effort. And I don't know whether any other
12 Trusts would have supported that view, but that was
13 certainly a view that I was coming to as to why things
14 had stilted up and were being so difficult. Now again,
15 if you look at the DSF report, it is not all bad news. 10:57
16 There was a percentage who got out each year, got into
17 placements and it worked, but they never actually hit
18 their target each year fully, maybe 50% one year, 60%
19 another year, 30% another year, it was always difficult
20 to meet whatever the target was set for the Trust. And 10:57
21 largely it was because the provision wasn't there, it
22 wasn't because of the individual, it wasn't because of,
23 it wasn't Muckamore's fault. They were left holding
24 the situation but it was because there wasn't the
25 infrastructure there to safely, and it was about being 10:57
26 safe, safely transfer someone who is very high complex
27 into a community situation and feel that their needs
28 are being met and that they are protected and they are
29 safe. You know, that's a big ask.

1 83 Q. Is it your analysis that it was very difficult or
2 impossible for the community and voluntary sector or
3 the independent sector, whichever we want to call them,
4 to meet those needs and only the Trust could do that or
5 was it a timing issue? 10:58
6 A. I think we are talking about a percentage of residents.
7 I think there were many residents that the voluntary
8 and independent sector were able to manage. Obviously,
9 slightly more able-bodied, higher ability, less maybe
10 physical needs, mental health needs. So I'm talking 10:58
11 about, I wasn't saying we shouldn't, I think it had to
12 be if you like a mixed economy. I think the Trust
13 needed to decide what services it could provide, what
14 services the voluntary sector could provide and the
15 housing sector and what independent private sector 10:58
16 could provide. So I think it was a mixture of those
17 things. All I'm saying is it seemed to me that the
18 Trust had stepped back from a lot of that and it left
19 those other sectors to try and find ways of managing
20 those highly complex cases. 10:59
21 84 Q. You've made reference to some of that detail being in
22 the Delegated Statutory Functions Report?
23 A. Yes.
24 85 Q. And that there would have been some reference, I get
25 the sense from what you say, to Muckamore and the 10:59
26 resettlement targets particularly. I want to, if I
27 can, just pull up just one page from the DSF bundle
28 which is page 285, that should come up on the screen if
29 you wish?

1 A. Okay.
2 86 Q. Use your hard copy if you prefer?
3 A. No, no, that's fine.
4 87 Q. I just want to look down towards the second half of
5 Section 3 there, and it talks about: 10:59
6
7 "Remaining 16 unfunded Belfast Trust delayed discharge
8 patients."
9
10 And it talks about the arrangements that are being put 10:59
11 into place for those. Then looking across to the next
12 column:
13
14 "The service areas presented a cost pressures paper to
15 the Board for £1 million which includes the pressures 11:00
16 created by unfunded delayed discharges to date."
17
18 I don't expect you to recall the detail of those
19 delayed discharges, but the concept of such a large
20 amount of funding not being in place, can you say 11:00
21 anything about that?
22 CHAIRPERSON: What's the date of this?
23 A. Is this the '15, '16.
24 MS. TANG: It is '15, '16, yes.
25 CHAIRPERSON: 15, 16, right, thank you. 11:00
26 A. All I can say is that when they say the Board there, I
27 am assuming they mean the Health and Social Care Board,
28 I would have thought it was to the Commissioner rather
29 than to the Trust Board, although this would have went

1 through the Trust Board. Well it's just what I said
2 before, the level of an individual cost to some of
3 these packages was huge in some cases compared to the
4 model that was in use with older people. I think the
5 average package in older people is maybe £10,000, 11:00
6 you're talking here maybe £100,000, you know.
7 DR. MAXWELL: It says it is a cost pressure to the
8 Trust which includes pressures created by unfunded
9 delayed discharge.
10 A. Yes. 11:01
11 DR. MAXWELL: Which sounds as though it is a cost
12 pressure at Muckamore of a million pounds, is that
13 right?
14 A. Basically the cost pressure would have landed in the
15 Adult Directorate, yes, I mean as part of -- I think 11:01
16 what is being said there is we are going ahead with
17 this but we are going to be overspent.
18 DR. MAXWELL: It reads as though the fact that you
19 didn't discharge patients meant you were spending a
20 million more in Muckamore, rather than you need a 11:01
21 million pounds to resettle people. Can you just
22 clarify which it refers to?
23 A. I would read it that you would have needed to spend
24 that money on the community packages in order to allow
25 the discharges to take place on the basis of just 11:01
26 looking at that now, as much as I can remember. I
27 don't think it was a cost pressure to Muckamore itself.
28 Obviously it would have delayed presumably the running
29 down of wards and so on that Muckamore was trying do,

1 if there were individuals still sitting in Muckamore
2 maybe it then delayed whatever the plans were to pull
3 money out of Muckamore.
4 DR. MAXWELL: That's what I'm wondering about, because
5 we've to'ed and fro'ed about did you have to close 11:02
6 wards at Muckamore to release the money to resettle
7 people, this chicken and egg thing.
8 A. Yes.
9 DR. MAXWELL: If the assumption had been that a ward
10 was going to close and so it wasn't funded, I could see 11:02
11 you could get to one million plus, there were staff
12 shortages so you were getting temporary workers --
13 A. There may have been a discussion about bridging, you
14 know yourself, you are running two services, it is
15 going to be over budget once the second service closes 11:02
16 you can repay or reduce your outgoing. I think the
17 Trust was always trying to advocate that the process
18 was complex and therefore it needed bridging on
19 occasions and you would then have cost pressures if you
20 didn't have the bridging. 11:03
21 PROFESSOR MURPHY: It looks as though from the first
22 column as though that million pounds refers to funding
23 needed for four patients to be resettled?
24 A. Yes.
25 PROFESSOR MURPHY: Which would have been roughly 11:03
26 250,000 per patient, which is a lot, but they were
27 obviously complex people.
28 A. Mhm-mhm.
29 PROFESSOR MURPHY: So it's not unheard of. Is that how

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1 you interpret it?
2 A. Yeah, no I think it is more to do with delayed
3 discharges rather than Muckamore itself, certainly
4 would be my interpretation looking at it today.
5 DR. MAXWELL: So they had been discharged at this 11:03
6 point, they are not delayed at this point, they are
7 discharged?
8 A. Well, I suppose I would never like to say funding
9 secondary because, you know, we were under the kosh in
10 terms of our budgets but we were trying to do the right 11:04
11 thing by patients and clients. And if we could get
12 somebody out, if the money wasn't there then you would
13 have went and looked for it after the event, you know,
14 but there was a financial risk to the Trust in doing
15 that, obviously. 11:04
16 CHAIRPERSON: Ms. Tang, you said 20 minutes. We have
17 imposed a few questions. How many more topics do you
18 have to deal with?
19 MS. TANG: I think probably about five minutes we'll
20 finish. 11:04
21 CHAIRPERSON: Okay, let's keep going.
22 88 Q. MS. TANG: I want to probe with you some of the links
23 between risk registers and what was in the DSF reports?
24 A. Yes.
25 89 Q. And can I ask you, were you or can you recall issues 11:04
26 being lifted directly from DSF reports and put onto the
27 Corporate Risk Register?
28 A. I can't recall specifically. But, I mean I do remember
29 there was the matrix in terms of the frequency versus

1 the impact if you like. I think the risk had to be
2 high or red or something like that before it moved from
3 a Directorate register on to the corporate or principal
4 register, whatever it was called, that's just my
5 recollection of that. 11:05
6 90 Q. So in terms of what was listed on the Directorate Risk
7 Register, severe, moderate, et cetera?
8 A. Presumably all of it would have been there, yes.
9 91 Q. So would you have expected the Directorate Risk
10 Register to generate a certain amount of risks that 11:05
11 then went across to the Corporate Risk Register, I
12 think that's what I'm asking you?
13 A. I suppose if the risk was deemed to be high impact or
14 red or whatever it was, I would expected that to be
15 placed on the Corporate Register, I would imagine so. 11:05
16 DR. MAXWELL: So if you saw something in the Risk
17 Register that wasn't rated red on the Directorate.
18 A. Yes.
19 DR. MAXWELL: Risk Register would you raise that?
20 A. Well, I mean it would be obviously monitored, that 11:05
21 would be something that would have went to the
22 Directorate Governance meeting on a quarterly basis so
23 it would have been looked at at that level within the
24 organisation. And obviously you were always trying to
25 move Reds down to ambers and ambers down to greens and 11:06
26 so on, you were always trying to work at mitigation and
27 ways of reducing it. My sense of resettlement,
28 resettlement was always seen as a high risk because the
29 Trust knew it wasn't going to be able to meet its

1 targets. And I don't think, I don't think the Trust
2 was complacent in any way, but you could understand
3 because it's been there a long time that it sort of
4 taken as red. I'm not saying things weren't being done
5 to improve it, but it wasn't suddenly something that 11:06
6 happened and you thought right, we've got to do
7 something about it. But if it's been there for 10
8 years, it is a work in progress essentially.
9 MS. TANG: Thank you. Mr. Worthington, you've covered
10 the questions that I wanted to ask you, I want to hand 11:07
11 over to the Panel now to see if there are any issues
12 that they want to raise with you.
13 CHAIRPERSON: No, thank you very much indeed. We've
14 asked our questions as we've gone along. So can I just
15 thank you very much for coming along to assist the 11:07
16 Inquiry to the best of your recollection, which you
17 obviously have, so thank you.
18
19 We will take our 15 minute break now and then we'll
20 start with the next witness, Dr. Jack. 11:07
21
22 THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:
23
24 MR. DORAN: Good morning, Chair and Panel members, this
25 morning's next witness is Cathy Jack and again her 11:26
26 evidence is for the purpose of organisational Module 9.
27 If Ms. Jack could be called please.
28 A. Good morning.
29 CHAIRPERSON: Good morning.

1 MS. CATHY JACK, HAVING BEEN SWORN, WAS EXAMINED BY
2 MR. DORAN AS FOLLOWS:
3
4 CHAIRPERSON: Dr. Jack, can I just welcome you to the
5 Inquiry, thank you very much for your statement which 11:27
6 is quite lengthy and detailed.
7 A. Thank you.
8 CHAIRPERSON: And thank you for your attendance today
9 and I'll hand you over to Mr. Doran. I don't know if
10 you have watched any of these proceedings. 11:27
11 A. I have.
12 CHAIRPERSON: I expect you have, but if you want a
13 break at any stage, just let me know but otherwise
14 we'll probably try and go to around lunchtime. If you
15 do need a break, as I say, please just say, okay. 11:27
16 A. Thank you.
17 CHAIRPERSON: All right, Mr. Doran.
18 92 Q. MR. DORAN: Dr. Jack, I'm Sean Doran, senior counsel to
19 the Inquiry. We met very briefly this morning isn't
20 that correct? 11:28
21 A. Correct.
22 93 Q. And we had a brief chat about the procedure to be
23 followed today. Now, you've made a statement for the
24 purpose of this module dated the 14th June of this
25 year, isn't that right? 11:28
26 A. That is correct.
27 94 Q. And for the record, the reference is MAHI STM-287. And
28 you prepared that statement, I think it's correct to
29 say, in response to specific questions that the Inquiry

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1 wanted you to address?
2 A. Exactly.
3 95 Q. And I understand at the start that there are some
4 corrections and clarifications that you want to make to
5 the statement and I think we'll start by getting that 11:28
6 out of the way. Helpfully, Chair, Dr. Jack's
7 representatives have provided us with a note of the
8 corrections and clarifications and that note has been
9 circulated to --
10 CHAIRPERSON: And the Panel have had it as well, so 11:29
11 thank you.
12 MR. DORAN: Yes indeed, but I do think we ought to go
13 through.
14 CHAIRPERSON: Yes, absolutely.
15 A. Can I just apologise for that, it was written just 11:29
16 after two weeks of our Encompass go live, and I was in
17 the full-time role of the Chief Exec, so please forgive
18 me for these.
19 CHAIRPERSON: Don't worry at all. As long as we get it
20 correct now it is absolutely fine. 11:29
21 A. Thank you.
22 96 Q. MR. DORAN: Yes indeed. Let's go to the note, have you
23 got a copy of that yourself?
24 A. Yes, I have printed that this morning.
25 97 Q. Obviously you have a copy of your statement as well? 11:29
26 A. Mhm-mhm.
27 98 Q. I think you have some notes that you made in respect of
28 your statement?
29 A. On my statement, here and --

1 99 Q. On your statement?
2 A. And having watched some of the evidence and read some
3 of the transcripts, things that I thought the Inquiry
4 might be interested and that I might, we might discuss
5 further in detail. 11:30
6 100 Q. Well, thank you for that. Can you just confirm for the
7 record that those are your own notes?
8 A. They are absolutely all my own notes.
9 101 Q. Thank you. So let's go to the corrections then. The
10 first one is page 5, it's paragraph 18, and it's three 11:30
11 lines down from the top of the page, should read "five"
12 not "six". So the sentence: "I returned to the Royal
13 Group of Hospitals Trust in Belfast as a consultant in
14 September 2004 and continued in that role when it
15 merged with six other Trusts in 2007 to become the 11:30
16 Belfast Trust", should read five other Trusts?
17 A. Yes, Belfast Trust came into being with the merger of
18 six Trusts in entirety, but the Royal Group was a Trust
19 in itself, which is why it is five.
20 102 Q. Indeed the Inquiry has heard some evidence about that. 11:30
21 Then at page 7, paragraph 26, and six lines down, there
22 is a sentence which begins: "Corporate risks were also
23 included" and you say that should read "during my time
24 on Assurance Committee an extract of corporate risks
25 was also included"? 11:31
26 A. Yes, that's correct, it wasn't the full corporate risk
27 document, it was just an extract.
28 103 Q. We will perhaps come back to discuss that a little bit
29 later. And then as regards paragraph 85, which appears

1 at page 26, the note provided to the Inquiry on your
2 behalf reads:
3
4 "Dr. Jack wanted to make it clear that when she refers
5 in paragraph 85 to no concern being raised with her 11:31
6 prior to September 2017 about the treatment or safety
7 of patients at MAH, Dr. Jack was referring to no
8 concerns about patients being maltreated or abused by
9 staff. Dr. Jack has elsewhere in the statement given
10 examples of concerns about various issues in MAH being 11:32
11 raised with her prior to September 2017 such as those
12 raised by Dr. Milliken. But not any concern that
13 patients were being abused."
14 A. That's right, so the statement probably should change
15 to say, it's four lines from the bottom: 11:32
16
17 "I can say that no concern was ever raised with me as
18 Medical Director about the maltreatment or abuse of
19 patients in Muckamore Abbey Hospital until September
20 2017." 11:32
21
22 104 Q. Thank you for that. Then we move to page 27 and it's
23 paragraph 87, and you say that paragraph 87 should
24 read:
25 11:32
26 "My first visit to MAH was probably in 2015 when a
27 Trust Board workshop was held there."
28
29 Is that correct?

1 A. Yes, I was definitely at that Trust Board workshop but
2 I cannot be certain if I made a visit to Muckamore
3 before it. So for the purposes of absolute honesty
4 this will read that way. Can I be clear that in
5 November 2014 when I met with Dr. Milliken, and I did 11:33
6 meet, it was a series of specialty meetings just after
7 I had taken up post as Medical Director with the
8 clinical directors, the medical leads of each service,
9 that meeting when I checked my diary as to where it
10 actually occurred, did not occur in Muckamore. 11:33
11 105 Q. And I think it's right to say, isn't it, Dr. Jack, that
12 helpfully you have provided to the Inquiry the e-mail
13 from Dr. Milliken?
14 A. With the briefing.
15 106 Q. That was sent to you in advance of the meeting and also 11:33
16 a briefing paper?
17 A. Yes, and when I met with each Clinical Director what I
18 wanted to do, having just taken up the post, was to
19 understand their challenges and their concerns from a
20 medical point of view in each of the areas and 11:34
21 Intellectual Disability and Dr. Milliken was treated
22 like every other Clinical Director.
23 107 Q. Chair, if I may flag up, this document will be prepared
24 for disclosure to Core Participants. And just on that
25 note actually, a number of documents have arisen in the 11:34
26 course of the organisational modules that haven't at
27 the moment got specific Inquiry references. What we
28 will do is compile a bundle of all of those materials
29 at the close of the organisational modules for

1 circulation to Core Participants.
2 CHAIRPERSON: Right, okay.
3 108 Q. MR. DORAN: It's just sometimes not possible to process
4 material for disclosure at the last moment. And I
5 think just in that briefing note I think it's fair to 11:34
6 say, isn't it, that Dr. Milliken mentioned to you
7 issues around resettlement?
8 A. Yes.
9 109 Q. The delayed discharge problem?
10 A. Mhm-mhm. 11:35
11 110 Q. And indeed RQIA inspections that were ongoing at the
12 time?
13 A. I certainly remember the GP support for physical health
14 screening and in fact I've noted the comments that he
15 raised when we met, mixed wards, delayed discharges and 11:35
16 GP support for physical health checks. So some of this
17 paragraph is correct but it didn't answer the question
18 that actually was put to me.
19 111 Q. And by way of further clarification in respect of
20 paragraph 87, your note goes on to say: "The rest of 11:35
21 the paragraph should be deleted".
22 A. Yep.
23 112 Q. "On further consideration Dr. Jack is clear that the
24 November 2014 meetings she was referring to in
25 paragraph 87 was not a speciality meeting, speciality 11:35
26 meetings began in 2015, but a one-to-one meeting with
27 Dr. Milliken as a part of a series of one-to-one
28 meetings organised by Dr. Jack to meet all of the
29 clinical directors across the Belfast Trust. The

1 November 2014 one to one meeting did not happen in MAH.
2 DLS wrote to the MAH Inquiry yesterday, 15th October
3 2024, offering to produce to the MAH Inquiry the
4 briefing document Dr. Jack has found that was provided
5 by Dr. Milliken to Dr. Jack ahead of the November 2024 11:36
6 meeting."
7
8 And as I've indicated that note will be circulated in
9 due course. Then we move on to page 27, paragraph 28.
10 CHAIRPERSON: Sorry, paragraph? 11:36
11 113 Q. MR. DORAN: I think that is an error, I think that
12 should be paragraph 88?
13 A. Yes.
14 114 Q. So page 27, paragraph 88 should read:
15 11:36
16 "My first specialty meeting at MAH occurred on the 1st
17 of March 2016."
18
19 A. Mhm-mhm.
20 115 Q. Then on pages 48 and 49 paragraphs, 154 to 158, the 11:36
21 note reads in relation to that:
22
23 "As per the DLS letter of 11th October 2024, these
24 paragraphs are based on an error. As set out in the
25 letter of 11th October 2024..." 11:37
26
27 And I should clarify that is correspondence from DLS to
28 the Inquiry.
29

1 "Dr. Jack would be grateful for the opportunity to
2 correct what is an error in her witness statement at
3 paragraphs 154 to 158. Dr. Jack's evidence to the MAH
4 Inquiry will be, in answer to the question posed, that
5 prior to 2017 it appears there were no issues relating 11:37
6 to MAH elevated to the corporate level of the Belfast
7 Trust Risk Register on Datix and consequently no such
8 risks relating to MAH were considered at the Assurance
9 Committee for inclusion on the Principal Risk Register,
10 now the BAF risk document." 11:38
11
12 A. Board Assurance Framework.
13 116 Q. Board Assurance Framework, thank you. I think we come
14 to that a little bit later because I want to look at
15 those entries on the Risk Register very briefly, but is 11:38
16 it fair to say your basic point is that those, contrary
17 to what you first supposed when provided with the
18 information, those were not actually included on the
19 Corporate Risk Register?
20 A. On the extract of the Corporate Risk Register that came 11:38
21 to the Board Assurance.
22 117 Q. Yes?
23 A. The Assurance Committee would always get the principal
24 risk document and we would get any new corporate risks
25 or any corporate risks that were stood down for 11:38
26 consideration and discussion, but we would get an
27 extract of the high corporate risks.
28 118 Q. Yes?
29 A. If they weren't covered on the principal risk document

1 and this came out of an internal audit finding and
2 recommendation.
3 119 Q. As I say, we will maybe return to that a little bit
4 later?
5 DR. MAXWELL: Can I ask how many risk registers there 11:39
6 are in the Trust.
7 A. There are numerous risk register, because they actually
8 should go from ward to Board, but what came to the
9 Assurance Committee was the principal risk Register,
10 now known as Board Assurance Framework. 11:39
11 DR. MAXWELL: Is that different from the Corporate Risk
12 Register?
13 A. Because Belfast was so big, there was a principal risk
14 and below that there was corporate risk where all the
15 directorates would have put everything but that didn't 11:39
16 come, only the very high risks on the corporate would
17 have been flagged.
18 DR. MAXWELL: You've got ward, division, directorate,
19 corporate and principal, now called BAF.
20 A. And actually unit service level. So ward, service, 11:39
21 division, Directorate.
22 DR. MAXWELL: Thank you, okay.
23 MR. DORAN: I should say that the Inquiry team is
24 hoping to compile a set of entries on the risk
25 registers at various levels that relate to the hospital 11:40
26 for the assistance of the Inquiry and Core
27 Participants.
28 CHAIRPERSON: Yes.
29 MR. DORAN: Rather similar to the exercise that was

1 conducted in respect of the DSF reports but it is a
2 work in progress.
3 CHAIRPERSON: No I understand.
4 MR. DORAN: We may come back to these distinctions
5 between different levels of register at a later stage. 11:40
6 A. I'm sure we probably will in the course of today,
7 because the Principal Risk Register is a very high
8 level document and I know you're interested in staffing
9 and staffing in the Trust was on that high level
10 Principal Risk Register, although it did not name 11:40
11 specifically Muckamore, but it was known at the Trust
12 Board to be a significant risk, as many Trusts, I think
13 across Northern Ireland or indeed the UK will find with
14 challenges with staffing.
15 120 Q. We will return to that matter but finally, let's deal 11:41
16 with the last correction in the list and that is a
17 pretty straightforward one, it's at page 73, paragraph
18 244 you indicate that there is a missing I in the first
19 sentence, it should read:
20 11:41
21 "I can see from communications available to me that I
22 was asked if I was content with the Royal College of
23 Psychiatrists nomination for the Level 3 SAI Panel, Dr.
24 Ashok Roy, and I confirmed on 21st December 2018 that I
25 was content." 11:41
26
27 So the insertion of the word "I" in that sentence is
28 the final correction?
29 A. It might be December '17.

1 121 Q. Oh, that's another correction then. So that's duly
2 noted, Dr. Jack. Thank you for that.
3
4 I wanted to flag up also, Chair, that at an earlier
5 stage there was some necessary revision of the various 11:42
6 exhibits to Dr. Jack's statement and there was
7 correspondence from the 1st October from DLS relating
8 to that matter. That correspondence was shared with
9 all Core Participants. The irregularities have been
10 fixed in the version of the statement that appears on 11:42
11 the Inquiry's website. I don't want to dwell on it
12 because it doesn't materially affect the issues that I
13 am dealing with today, but just to record, there were
14 some alterations made to the exhibits to the statement.
15 CHAIRPERSON: So the one that the CPs have got is 11:42
16 slightly different to the one on the website at the
17 moment?
18 MR. DORAN: I would hope that the revised version was
19 circulated to CPs also.
20 CHAIRPERSON: That is fine, thank you. 11:43
21 122 Q. MR. DORAN: But as I say, Chair, it's not something
22 that we need to worry about for the moment.
23
24 Now, that we've dealt with those formalities, Dr. Jack
25 -- 11:43
26 A. Forgive me, I think on page 10, paragraph 37, because
27 this is my sworn statement.
28 123 Q. Absolutely?
29 A. Because of the busyness of the correspondence, we

1 wanted to make the change from seven previous Trusts to
2 six again, I'm not sure we covered that in this session
3 just there now.
4 124 Q. Can you say where that appears?
5 CHAIRPERSON: Is it out of the merger of seven. 11:43
6 A. Yes, it should be six.
7 CHAIRPERSON: Four lines up from the bottom.
8 A. I'm not sure we mentioned that.
9 MR. DORAN: I'm sorry, this is page 37?
10 A. It's page 10, paragraph 37, four lines from the bottom. 11:43
11 It's item No. 3 in what Mr. Aiken sent you last night.
12 MR. DORAN: I see?
13 CHAIRPERSON: It should be six, not seven.
14 A. I just don't think we covered that in this discussion
15 and it is my statement. 11:44
16 125 Q. MR. DORAN: The reference to seven should be six.
17 Thank you very much for that.
18
19 Now that we've dealt with those formalities, Dr. Jack,
20 are you content to adopt the statement as your evidence 11:44
21 for this part of the Inquiry?
22 A. I am, thank you.
23 126 Q. Now, as you know, all statements for this phase of the
24 Inquiry are published on the website. I don't need to
25 go through the statement paragraph by paragraph with 11:44
26 you, but what I do want to do is focus on matters that
27 might assist the Panel in addressing the Inquiry's
28 Terms of Reference and I'm sure you have had the
29 opportunity of considering the Inquiry's Terms of

1 Reference yourself. It is a very lengthy statement.
2 Can I maybe suggest that it can helpfully be broken
3 down into five segments?
4 A. Mhm-mhm.
5 127 Q. Paragraphs 1 to 18, first of all, paragraphs 1 to 18, 11:45
6 you talk about your working background and you give us
7 some general information about the Trust?
8 A. Mhm-mhm.
9 128 Q. Then from paragraphs 19 to paragraph 237, this is the
10 main body of the statement, if you like, you address 11:45
11 the specific Trust Board questions that were put to you
12 by the Inquiry and you provide a fairly detailed
13 description of the relevant governance structures and
14 how the hospital fitted within those structures. Just
15 pausing there, is it fair to say on a very general 11:45
16 level that the broad picture is that prior to 2017,
17 Muckamore was scarcely to be seen at the higher levels
18 of governance, but post 2017 it features prominently.
19 Is that a fair general characterisation?
20 A. So it's probably a little bit too simplistic. I think 11:46
21 you'd have to look at how the Trust overall functioned.
22 So Muckamore, like any other site, didn't come up in
23 that way to Trust Board or Assurance Committee.
24 129 Q. Yes, that's what I'm talking about of course when I say
25 high levels? 11:46
26 A. Because it wasn't an area of concern and in an
27 organisation the size of Belfast Trust, the only way to
28 manage and govern is through a proper system of
29 delegated and distributed management and governance

1 with the expectation that all staff at every level will
2 do the right thing. It's built on a foundation of
3 Trust and then demonstrating and then superimposed the
4 checking whether that's internal audit, RQIA, regulated
5 inspections, et cetera. 11:47
6 130 Q. Yes, now I don't want to interrupt the flow at this
7 stage but if I can say, Dr. Jack, I will come back
8 specifically to deal with those issues. I was simply
9 making the suggestion that on a very general level
10 pre-'17 when it comes to consideration at Board level 11:47
11 and higher levels of governance, the hospital isn't to
12 be seen significantly, but post 2017 it features very
13 prominently?
14 A. Post-'17, because it was such a concern, there were
15 regular reports. You are absolutely right, I would say 11:47
16 there is 38 reports or something. But before that,
17 like some other sites, it was not a place of concern
18 and therefore, did not need to come and that was the
19 director's assessment, it did not need to come to Trust
20 Board. 11:48
21 131 Q. And I am going to explore that point in due course.
22 Let me come back to this overview of the statement.
23 The third section then is at paragraphs 238 to 252, and
24 at those paragraphs you give your responses to the way
25 to go questions, if I can put it like that. And for 11:48
26 the most part I think it's fair to say you can't really
27 assist with those questions?
28 A. Yes, I think there is individuals that would be much
29 better and best placed to assist the Inquiry with those

1 questions.
2 132 Q. And you've made that point in the statement. And then
3 the fourth segment of the statement is at paragraphs
4 253 to 281 and in those paragraphs you provide answers
5 to questions about the Safety and Quality Steering 11:48
6 Group. You provide a description of how that group
7 works and you answer the questions that were posed to
8 you by the Inquiry. But again, is it fair to say that
9 in your recollection, the hospital didn't really
10 feature in the work of that group? 11:49
11 A. So the work of that group was informed by the Quality
12 Improvement Plan, by the Safety Forum, by the
13 indicators of quality improvement that the HSCB, now
14 SPPG, wanted and laid out. And, like any other area I
15 think across the UK, quality improvements, patient 11:49
16 safety largely focused on secondary acute care at those
17 times, hospital acquired infections, VTE, early warning
18 scores, pressure sores or the skin bundle and falls
19 assessment and our Safety and Quality Steering Group
20 was no different. And I think the quality improvement 11:49
21 indicators and the work on quality improvement and
22 moving into social care perhaps lagged slightly right
23 across the UK.
24 133 Q. Is it fair then to say that in your recollection
25 Muckamore didn't feature in the deliberations of that 11:50
26 group?
27 A. I think it would be fair to say that we focused
28 improvement work on health first and, not just
29 Muckamore, but social care and aspects of social care

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1 were harder in the quality improvement world and were
2 not in our quality improvement plan until later and
3 that's why we did the work around the core metrics on
4 building the patient experience, the staff engagement
5 and then with the SitRep and what happened, you know, 11:50
6 about seclusion, restrictive practices, et cetera.
7 It's not just Muckamore, it would be other non-acute
8 hospital sites.
9 134 Q. But did Muckamore as an institution feature in the work
10 of that group? 11:50
11 A. Not as an institution but then no hospital site
12 featured on that --
13 CHAIRPERSON: The short answer I think is no.
14 135 Q. MR. DORAN: I see. Now then the final section of your
15 statement at paragraphs 282, to 285, in that section 11:50
16 you refer to apologies that were made following on from
17 the revelations at the hospital and you repeat those
18 apologies. Dr. Jack, we'll come back to that towards
19 the conclusion of your evidence.
20 A. Thank you. 11:51
21 136 Q. So I just wanted to put the statement broadly in
22 context and you made the statement on 14th June as we
23 have said. At that time you were the Chief Executive
24 of the Trust and you had been the Chief Executive, I
25 think it's right to say, since 13th January 2020, isn't 11:51
26 that right?
27 A. Correct.
28 137 Q. Since making the statement you've left your role as
29 Chief Executive?

1 A. That is correct.
2 138 Q. But when you were making the statement itself in June,
3 you were doing so from the perspective of Chief
4 Executive of the Trust at that time?
5 A. That is right. Just for the record to be clear, my 11:51
6 resignation was unrelated to the events that happened
7 in Muckamore or this Inquiry. My resignation related
8 to events in a different area of the Belfast Trust when
9 matters were brought to my attention and I raised these
10 up to and including Trust Board, it was how these 11:52
11 matters were dealt with that caused me to resign.
12 139 Q. Thank you, Dr. Jack. I'm not going to be returning to
13 that matter. Just to complete the picture as regards
14 your working background, in paragraph 12 at page 3 you
15 say that before taking up your appointment as Chief 11:52
16 Executive you were the Medical Director of the Trust
17 from the 1st August 2014 up to your appointment as
18 Chief Executive in January 2020, isn't that right?
19 A. That is correct.
20 140 Q. And from the 1st August 2017 until January 2020 you 11:52
21 were the Deputy Chief Executive of the Trust?
22 A. I carried that portfolio in addition to the Medical
23 Director.
24 141 Q. Thank you. So basically you were on the Trust Board
25 and the Executive Team for a decade? 11:53
26 A. That is correct.
27 142 Q. 2014 to 2024?
28 A. Mhm-mhm.
29 143 Q. And at paragraph 18, that's on page 4 you provide an

1 outline of your career before 2014. I think in fact
2 you say you had been deputy Medical Director since
3 2008; is that right?
4 A. That is correct.
5 144 Q. Presumably that wouldn't have entitled you to sit on 11:53
6 the Board?
7 A. No, no. I did on occasion perhaps attend if Dr.
8 Stevens, the then Medical Director was unable to make
9 it, and I would have deputised for him.
10 145 Q. And prior to your management roles then you explain you 11:53
11 worked as a doctor and a consultant?
12 A. That's correct, in care of the elderly medicine,
13 geriatrics.
14 146 Q. In fact I was going to say, you make it clear in your
15 statement that you yourself have never worked in the 11:53
16 mental health or learning disability fields?
17 A. No.
18 147 Q. So those areas were within your very broad portfolio as
19 Medical Director, but you yourself had no specialist
20 knowledge of or practical experience in those areas? 11:54
21 A. That is correct.
22 148 Q. Now, you explain in paragraph 16 that in your Medical
23 Director role you had a key role in patient safety and
24 clinical governance?
25 A. Mhm-mhm. 11:54
26 149 Q. As regards patient safety, the primary roles were your
27 role, that of the Executive Director of Nursing and
28 User Experience, and the Director of Social Work?
29 A. Yes.

1 150 Q. So those three roles really were the key roles in the
2 context of patient safety?
3 A. Yes, the Executive Director of Finance would have had
4 some input but it's the three key professional
5 executive directors that are required to give 11:54
6 assurances that our services, both in health and social
7 care, are safe and our governance systems are
8 effective.
9 151 Q. And we referred to the meeting that you had with Dr.
10 Milliken when you became Medical Director and you were 11:55
11 meeting him, I suppose, to introduce yourself to those
12 who were involved within the various areas that your
13 portfolio covered and you were becoming familiar with
14 the kinds of issues that were presenting themselves to
15 the relevant individuals in the field? 11:55
16 A. That's correct. I mean, you know, what we need in an
17 organisation the size of Belfast is to get a sense, not
18 just from the balcony, but also from the stairs and the
19 dance floor. And so, whilst I had a very able
20 associate Medical Director in Maria O'Kane, it was also 11:55
21 important for me to familiar rise myself with the
22 individual clinical areas. And the best way of doing
23 that was meeting with the clinical directors. And then
24 further into my role, strengthening re-validation, I
25 actually met with every single member of the medical 11:56
26 staff that were employed by Belfast at their time of
27 re-validation to understand, you know, what were their
28 challenges, what were they proud of, what did they want
29 to see developed in their services. It was also a very

1 good way to engage the medical profession, but it was
2 equally a good way to sense problems and foster an
3 organisation of openness so that people could feel they
4 could just e-mail me about issues.
5 152 Q. Interestingly as we discussed earlier, at that first 11:56
6 meeting, Dr. Milliken raised with you the issues of
7 resettlement?
8 A. He did.
9 153 Q. Problems with delayed discharges and RQIA related
10 issues. That was right at the outset of your tenure as 11:56
11 Medical Director?
12 A. That is correct.
13 154 Q. Can you recall issues such as that or other Muckamore
14 related issues featuring in discussions throughout the
15 remainder of your time as Medical Director? 11:57
16 A. So the delayed discharges or the delay in resettlement,
17 because they are actually two of the same, was a
18 recurrent theme. And let's be very clear, Bamford,
19 back in the early 2000s, if those recommendations from
20 the Bamford Review had of been delivered in a timely 11:57
21 way, Muckamore would not have existed in the format
22 that it did in 2014. All those resettled patients, the
23 delayed discharges, should have been discharged much
24 earlier. So this was very much a chronic problem and
25 the whole system, myself, the director, Trust Board, 11:57
26 the HSCB and the Department were well aware of it and
27 indeed the Department adjusted their targets year on
28 year about resettlement because they knew they weren't
29 delivering. So it was very much a chronic problem, it

1 wasn't an acute problem, the same way as staffing was a
2 chronic problem with acute crises in between that we
3 dealt with. But it was well known to the system, it
4 wasn't a new problem.
5 155 Q. You say that the Trust Board was well aware of it and I 11:58
6 suppose, going back to your analogy, was it aware of it
7 from the balcony, did it really get down and grapple
8 with the issue of resettlement? I'm talking about the
9 Trust Board now.
10 A. It was aware of the targets. It was aware of the 11:58
11 Bamford Review. It came up in the care delivery
12 performance. It wasn't just Muckamore, it was all of
13 the delayed discharges in Intellectual Disability, the
14 same way as all of the delayed discharges in Mental
15 Health. And, you know, back in June this year the 11:59
16 Trust still has a number, not just of patients delayed
17 in Muckamore, but right across the system we have large
18 numbers of patients who are delayed and that causes
19 concern both for timely admission of patients that need
20 to come in, and also being in a hospital environment 11:59
21 when you no longer need to be there has consequences.
22 156 Q. But, I suppose it's fair to say, isn't it, that, given
23 the size of the facility at Muckamore and the extent of
24 the resettlement programme, the issue arose perhaps
25 more acutely in the context of Muckamore than 11:59
26 elsewhere?
27 A. I think, you know, if you think back when I joined the
28 Trust as a geriatrician, we had Wakehurst with a large
29 number of longer stay wards. We had Elliot Dynes in

1 the Royal, a large number of long stay wards.
2 Knockbracken Health Care Park was known as Purdyburn, I
3 mean right across the system there has been changes to
4 reduce the number of longer stay hospital wards and
5 make hospitals much more acute, Muckamore was no 12:00
6 different than that, just because of the extraordinary
7 supports that were needed to provide ordinary lives in
8 the community.
9 157 Q. That is a differentiating feature of course, isn't it?
10 A. It took longer. But Muckamore, actually if the Bamford 12:00
11 recommendations had have been delivered, should not
12 have existed in 2014.
13 158 Q. I suppose the point I'm getting at is that when one
14 looks at the issues that were being considered by the
15 Trust Board in those years prior to 2017, there is no 12:00
16 evidence of the specific issue of delayed discharge and
17 resettlement at Muckamore being considered by the
18 Board; is that fair to say?
19 A. It was considered in the programme because there would
20 have been extra-contractual referrals. We had patients 12:01
21 with intellectual disability outwith Northern Ireland.
22 We still do as far as -- we did in June, sorry, we
23 definitely did in June. There were patients delayed in
24 Iveagh and we may have had patients maybe perhaps in
25 Blue Stone other environments. It's not so much the 12:01
26 site, the way our services are delivered, it is the
27 services in its entirety.
28 DR. MAXWELL: I suppose one of the questions is you did
29 have targets for different types of patients in your

1 care --
2 A. Correct.
3 DR. MAXWELL: So the Board would be getting on its
4 dashboard when you were going to achieve this year's
5 target. I suppose the question is did the Board ever 12:02
6 ask for a paper going into more detail about why this
7 target wasn't being achieved? And I perfectly accept
8 your point that resettlement is a major issue in other
9 services so I'm not saying that Muckamore should be
10 treated any differently to the others, but did the 12:02
11 Board ever request a more detailed report explaining
12 why the target was consistently missed?
13 A. So not in my time from 2014 to '17, perhaps earlier. I
14 mean this was so well known. I think everybody in the
15 system, everybody that worked in health and social care 12:02
16 across Northern Ireland were aware.
17 DR. MAXWELL: If I can put to you a question I put to
18 Mr. Dillon that you may have seen, was missing A&E
19 targets was a chronic problem that hadn't been met for
20 years and was a performance target on your care 12:03
21 delivery plan, but I think it had more attention than
22 resettlement?
23 A. So I would, in 2014 when I became Medical Director,
24 there was a lot of focus on the emergency departments,
25 there still is a lot of focus on our emergency 12:03
26 departments. That wasn't just within Belfast Trust,
27 that was system wide. People may recall the Human
28 Rights Commission coming down about the care in our
29 emergency departments. And you may also recall the

1 task force set up by the Department of Health in 2014,
2 I think, and I can get you the details on that, but
3 that was chaired by both the Chief Medical Officer and
4 the Chief Nursing Officer around ED performance and the
5 four hour targets. So I would absolutely accept there 12:04
6 was greater focus, greater focus on the ED performance
7 targets than there was on some of the cancer targets in
8 2014 and on some of the resettlement targets. So I do
9 accept that premise, but I think it was not just within
10 Belfast, I think it was the system at large in Northern 12:04
11 Ireland and I can furnish you or we can get the papers
12 for that furnishing. Because one of the first tasks
13 that I was given when I became Medical Director was to
14 actually set up a group looking at how do we improve
15 patient flow, what we call impact, I think I have 12:04
16 referenced it in my statement, and I was asked to lead
17 on that work with Ms. Owens, the then Director of
18 Unscheduled.
19 159 Q. MR. DORAN: What year was that?
20 A. That was 2014, 2014. So the whole of the HSC had a 12:04
21 special regional task force --
22 DR. MAXWELL: And this was to look at the flow of
23 patients so that you could release capacity to admit
24 people from A&E?
25 A. Yes. 12:05
26 DR. MAXWELL: Which as you say actually isn't even
27 confined to Northern Ireland.
28 A. No.
29 160 Q. MR. DORAN: We may return to those themes. I wanted to

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1 ask you quite a specific question about your roles. As
2 Medical Director you would have attended the Assurance
3 Committee, isn't that right?
4 A. Oh, absolutely, yes.
5 161 Q. The Assurance Committee reports to the Board? 12:05
6 A. Yes.
7 162 Q. I just wondered did that not place you in a position of
8 potential or actual conflict, because on one view you
9 are providing reassurance by yourself in your Medical
10 Director role to yourself in your Deputy Chief 12:05
11 Executive role?
12 A. Can I just be clear, the Medical Director is in
13 attendance at the Assurance Committee. Assurance
14 Committee is not just to provide assurance but it is
15 also to identify gaps in assurance that need to be 12:06
16 addressed. So when you go into an Assurance Committee
17 it is not just to look at and seek assurances, but it's
18 actually also to problem sense and --
19 163 Q. But is it, sorry to interrupt, Dr. Jack, but is it also
20 to provide assurance to the Board? 12:06
21 A. Where appropriate or to identify and highlight areas
22 where you are not assured, and I have done that.
23 164 Q. And did you never feel that there was some conflict
24 there between your role on the one hand as the person
25 providing reassurance, and your role on the other body 12:06
26 to which the reassurance was being provided?
27 A. Can I talk about Assurance Committee? Assurance
28 Committee is a committee that had the non-exec
29 directors and we attended to be held to account. And

1 it was all members of the non-execs that made up the
2 Trust Board, all seven, until the Social Care Committee
3 started and Ann O'Reilly then excused herself from
4 that. Trust Board is a body of 12 in its purest sense
5 which has seven non-exec directors and the five, the 12:07
6 Chief Exec and the four executive directors. So my
7 role would have been no different than the Executive
8 Director of Finance, Nursing and User Experience or
9 Social Work or indeed the Chief Exec. But Trust Board
10 always has a greater number of non-execs because they 12:07
11 carry the weight of decision making, that is how they
12 test us and they challenge us.
13 DR. MAXWELL: But the information going to the
14 Assurance Committee comes from the Assurance Group
15 which is the Executive Team, and the Assurance 12:08
16 Committee doesn't know what it doesn't know, it's
17 dependent on the information presented to it. Is there
18 a potential in that model for the Executive Team to
19 present them with good news?
20 A. In my experience we have never done that. I have 12:08
21 striven to deliver an open and honest organisation that
22 will become much more problem sensing, and I hope I
23 will get the opportunity to talk about our journey.
24 DR. MAXWELL: So I recognise that you made a lot of
25 changes when you came in as Chief Exec but we've had 12:08
26 people, including Mr. Worthington this morning, tell us
27 that the Assurance Framework was based on assuming that
28 the Service Director had raised everything of
29 significance and that there wasn't actually any -- well

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1 I know you've studied a lot of safety science and you
2 will know about redundant systems.
3 A. Yes.
4 DR. MAXWELL: So you need at least two ways of
5 information to come forward in case one of them isn't 12:09
6 working properly. But Belfast Trust appears, certainly
7 up to 2017, to be relying on the Service Directors
8 raising the concerns, the Executive Team filtering that
9 to decide what went to the Assurance Committee, because
10 as you rightly say it is a large Trust and you couldn't 12:09
11 put everything. Was there a potential that the
12 non-execs and the Assurance Committee weren't seeing
13 everything warts and all, and I am asking about
14 potential rather than actual?
15 A. So I would say that the non-execs got to see everything 12:09
16 that Exec Team got to see.
17 DR. MAXWELL: Okay.
18 A. When I joined the Executive Team. Certainly I have
19 tried to drive forward changes and include a culture of
20 supportive challenge and, indeed, the more recent, and 12:10
21 I know you are probably not interested in this and
22 forgive me, but the more recent QMS system and
23 insisting that the directors become much more problem
24 sensing and triangulating and the work on training our
25 co-directors and chairs and divisional nurses in the 12:10
26 Scottish Improvement Leaders Science and the King's
27 Fund to be constantly curious. How I describe RQMS is
28 when I put as myself as Chief Executive and the
29 executive directors when they come in for their

1 accountability and assurance, it is a bit like going
2 through an RQIA inspection. That is our job to be
3 curious and scrutinise so we can identify the issues --
4 DR. MAXWELL: That was not in place pre --
5 A. That was not in place in 2014. 12:10
6 DR. MAXWELL: Or in 2017?
7 A. No, it was growing, there were changes. As you know we
8 introduced Safetember and we were investing in the
9 capability and the capacity to do the work but there is
10 no point in doing that work if you don't have the 12:11
11 skills and the expertise and the knowledge. And an
12 organisation the size of Belfast Trust takes time. And
13 the work is not yet done, the work is not get done.
14 165 Q. MR. DORAN: Following on from Dr. Maxwell's question
15 and relating specifically to the Directorate structure, 12:11
16 clearly prior to 2017 there was an awful lot of
17 reliance placed on the Director to escalate risks
18 specifically?
19 A. Correct.
20 166 Q. Looking back do you think that was actually a weak 12:11
21 point in the governance structures that existed at the
22 relevant time?
23 A. So, I mean, I think it's a clear improvement around
24 assurance, because assurance is built on three levels,
25 trust, demonstrate and check. So our Assurance 12:12
26 Framework was built on trusting and perhaps on audits,
27 but the checking and the scrutiny certainly has
28 improved and strengthened. And along with that, to be
29 fair, to be fair to the individuals that carried those

1 portfolios, those portfolios were huge. Belfast is and
2 was an enormous organisation.
3 167 Q. Yes?
4 A. There were four Service Directors. Since taking up
5 post I have not only split the portfolio of the 12:12
6 Executive Director of Social Work and Children's
7 Community, I also split the portfolios of each of the
8 Service Directors so that they are responsible for two
9 divisions. I did that in conjunction and with
10 agreement with them so that they would have more time 12:12
11 to work with Exec Team. Just, you know, as I said,
12 what I expected from them when they got two divisions
13 is in a five day working week you would spend one day
14 working as an Exec Team and corporate body, you would
15 spend one day working on regional portfolios, half the 12:13
16 time on one division and half the time on the other,
17 and the remaining three days you would split between
18 them. The whole idea of that was so they could get
19 out, visit some of the wards, work with their teams and
20 do the mile dive deep because I could only do the mile 12:13
21 wide.
22 CHAIRPERSON: Sorry, Mr. Doran, I just need to get an
23 idea; we have heard consistently from several witnesses
24 about how huge the Trust was. You've got a population
25 in Northern Ireland of about 1.7 million and you were 12:13
26 one of the Trusts. Now how does your Trust compare to
27 a London Trust say like Guy's and Tommies.
28 A. Guy's and Tommies would be, I'm speaking now from
29 history.

1 CHAIRPERSON: I am trying to get a sense of it.
2 A. It would be an acute trust. I mean Belfast Trust is
3 the largest health and social care trust in the United
4 Kingdom when it was formed, I think close to Leeds.
5 Now Glasgow, Greater Glasgow would be a very large 12:14
6 trust, but we also have the social care dynamics and
7 when you look at our budget compared to the budgets of
8 other Trusts in Northern Ireland, we would be about
9 double or more the size because we carry a lot of the
10 regional work, we have the majority of the regional 12:14
11 work.
12 CHAIRPERSON: It's difficult to compare you I suppose
13 to an English Trust because of the social care side?
14 A. In preparation I looked at the size I think Avon and
15 Wiltshire Mental Health Trust which is a high 12:14
16 performing trust, or was referenced in one of the
17 safety briefs as an area of good practice. It has
18 4,000 staff. Belfast Trust has 21,500.
19 DR. MAXWELL: But it is a small Trust compared with
20 English Trusts, you are large but you are certainly not 12:15
21 the largest Trust.
22 A. Not now, but I think in 2007 we -- forgive me if I'm
23 wrong, but we were one of the largest.
24 DR. MAXWELL: You are large.
25 CHAIRPERSON: When you say large you are talking about 12:15
26 the population that you serve, your staffing, your
27 budget, your services.
28 A. So the population for the likes of unscheduled care or
29 for some of the more core services would be 340,000 for

1 Belfast and greater Belfast, but then we have all the
2 regional services so it would be a population now of
3 1.7, 1.8 million.
4 CHAIRPERSON: Covered solely by your Trust?
5 A. Yes. So if you needed a vascular surgery, if you had 12:15
6 abdominal or aortic aneurysm, if you need a
7 neurosurgery, if you needed the cancer centre.
8 CHAIRPERSON: It would go through Belfast, right.
9 DR. MAXWELL: But there would be a small number of that
10 1.9 million that were accessing those tertiary 12:16
11 services.
12 A. Those tertiary services probably account for 60% or
13 more of everything we do.
14 DR. MAXWELL: No I understand but in terms of
15 population it is still not a huge population base, but 12:16
16 what you have got I think is a large number of tertiary
17 services and that's probably what makes you different
18 from English Trusts.
19 A. Okay.
20 CHAIRPERSON: Thank you, I just wanted to get an 12:16
21 understanding. Mr. Doran.
22 A. The Trust was huge and I think if you think of smaller
23 Trusts, they had a Trust Board, they had an executive
24 team, they would have had more service directors. So I
25 doubled the number of service directors to allow to go 12:16
26 deep.
27 168 Q. MR. DORAN: I am going to return to the size of the
28 Trust in a moment. I want to go back to this issue
29 that I was asking you about in relation to the reliance

1 on upward reporting by directors. Now a lot of the
2 initiatives that you have talked about, and indeed
3 describe in detail in your statement, are fairly recent
4 and relate to your period as Chief Executive. But, I
5 just want to go back for a moment to pre-2017? 12:17
6 A. Yes.
7 169 Q. What would you say to the proposition that at that
8 point in time there was excessive dependence on upward
9 reporting from Directorate level without a sufficient
10 mechanism for downward scrutiny? 12:17
11 A. So --
12 170 Q. Do you accept that proposition?
13 A. I think there was a greater reliance on upward
14 reporting. I'm not sure about excessive, but I think
15 there was greater reliance on upward reporting. And 12:17
16 indeed that was what the Leadership and Governance
17 Review pulled out in 2020, that the size of the Belfast
18 Trust means that directors should be held to account
19 more.
20 171 Q. Yes? 12:18
21 A. And we accepted those so, yes.
22 172 Q. And coming back to this issue about the size of the
23 Trust, you actually provide fairly detailed description
24 in paragraphs eight and nine of the scale of the
25 Trust's operation and where the hospital fits within 12:18
26 that operation. And if we can just skip back, skip
27 forward a little bit as well to paragraph 37 on page
28 10, you talk about the Trust Board being responsible
29 for the strategic direction and oversight of governance

1 of the Trust:
2
3 "In my time the Trust Board met bimonthly between 2014
4 to 20178 with a workshop held on alternative months.
5 However from 2018 onwards, although Trust Board 12:19
6 meetings continued bimonthly, confidential Trust Board
7 meetings occurred monthly, in addition to the bimonthly
8 workshops."
9
10 Just in passing, why confidential Trust Boards, what 12:19
11 were they and why were they necessary?
12 A. Basically what we found in 2018 was that we would have
13 had Trust Board workshops, but the Trust Board
14 workshops would never have had minutes et cetera
15 recorded. And so we would have brought confidential 12:19
16 issues to the Trust Board workshop but there would have
17 been no recording of that and that was a weakness in
18 our governance. So we rectified that so that every
19 Trust Board workshop also had a confidential workshop
20 were issues of escalation could be brought. It also 12:19
21 merged at the time when we were going live with our
22 live governance and sharing our SAIs and our governance
23 report with the Trust Board, it merged with the events
24 of Muckamore. It merged with the publication of the
25 IHRD report, the hyponatremia deaths, and of course the 12:20
26 neurology recall for the patients of Dr. Watt.
27 173 Q. When you say confidential, presumably all fully
28 minuted?
29 A. All fully minuted from 2018 for the remainder of that

1 time.
2 174 Q. In the remainder of that paragraph you go on again to
3 talk about the size, complexity and scale of the
4 Trust's operation. I mean, correct me if I'm wrong,
5 but it seems to me that two key points you make when 12:20
6 you refer to the size of the Trust's operation is,
7 first of all, the Trust is a massive organisation
8 covering many facilities, huge structure?
9 A. Yes.
10 175 Q. The second point is Muckamore wasn't treated any 12:20
11 differently than any other facility under the Trust's
12 wing. Is that a fair summary of the two points you're
13 making?
14 A. Yes, that is absolutely correct.
15 176 Q. Now, looking back on your work within the Trust and 12:21
16 drawing on your own professional experience, is there
17 an argument to be made that it is in fact too big an
18 organisation, particularly to deal with the particular
19 demands of a discipline such as learning disability?
20 A. So it is a huge organisation and at any one time across 12:21
21 the size of that organisation things will and do go
22 wrong. But there are other very large organisations
23 and indeed across the UK, the view has been more and
24 more mergers of trusts such as Guy's and Tommies that
25 we mentioned earlier, or Greater Glasgow or Lothian. 12:21
26 And I think more importantly is having adequate
27 structures where individuals that are in the correct
28 position of the Trust can go a mile deep. I mean, you
29 know, you need to be able to go the mile deep as well

1 as have the mile wide. Our Trust Board could only have
2 the mile wide, could only have the mile wide, but
3 that's not to say we didn't expect others to go down
4 that mile deep. And we've become much more explicit
5 and we've become much more curious and inquisitive 12:22
6 about what goes on and we've split the portfolios to
7 allow that to happen. So there are pros and cons of
8 large organisations because there is also transferable
9 learning. And indeed there is debate currently going
10 on in Northern Ireland at the moment at the moment, 12:22
11 should they have one massive Trust, I mean that has
12 been discussed. And RPA in 2007 was all about multiple
13 small trusts merging into a large trust. Any change
14 takes years to form. Any change, there are pros and
15 cons. There are certainly pros and cons, but the 12:23
16 expectation was that that, the director and that
17 division was expected to do those functions as if they
18 were nearly a chief exec in mental health and learning
19 disability.
20 PROFESSOR MURPHY: Isn't the problem really not so much 12:23
21 the size of it overall but the diversity of what it
22 covers, so that topics like learning disabilities,
23 mental health, community care will never get the
24 attention that acute services get?
25 A. So that, I think, is a really important point and you 12:23
26 may be aware of the Ray Jones' work that is currently,
27 the consultation that was currently ongoing in Northern
28 Ireland about children's community services because we
29 are also the corporate parent. His view is that in

1 fact children's community services should be pulled out
2 and be a separate regional entity, managed differently.
3 Equally there is a new mental health overarching board
4 being proposed and there has been discussion about
5 should we have a mental health and learning disability 12:24
6 trust for Northern Ireland. I mean, my statement is
7 written as a Chief Exec of the Belfast Trust. I don't
8 really want to get into speculation about pros and
9 cons. But I do think social care is very different to
10 health and the pressures in 2014 and '15, and '16 that 12:24
11 were in health around the emergency departments, around
12 the flow, the focus that was coming from the region
13 caused us to focus in that area. I mean the system
14 sometimes is designed to get the results it gets.
15 DR. MAXWELL: Can I just make one point about large 12:25
16 organisations; so you expect the Directorate to manage
17 a lot. The difficulty is you don't have the
18 independent non-executive scrutiny and what's happened
19 in a number of large English conglomerations is that
20 actually they set up sub areas with a managing director 12:25
21 and their own mini board with non-execs on and it seems
22 to me that one of the big challenges for Belfast Trust
23 was, although you had an operational structure, there
24 was no independent non-executive scrutiny until you got
25 to the Board, would you agree with that? 12:25
26 A. So to an extent because in our Assurance Framework, and
27 it's going to be from 2017, we did put a non-exec
28 director in each of the steering groups to try and
29 address, but that was --

1 DR. MAXWELL: But pre-2017 you weren't getting that
2 independent non-executive scrutiny because you were
3 relying on the operational directorates to do it.
4 Whereas a Trust Board that has deliberately been up
5 with the execs and non-execs, you didn't have that 12:26
6 level in the organisation?
7 A. The only committees that had a non-exec were the likes
8 of the Fostering Committee, or indeed our complaints,
9 our Service User Committee when I joined Trust Board.
10 That was chaired by a non-exec -- 12:26
11 DR. MAXWELL: You didn't have any Directorate level
12 governance meeting.
13 A. Correct.
14 CHAIRPERSON: So why was it thought sensible to bring
15 in non-exec directors in those areas but not in others? 12:26
16 A. That was in place in 2014 and predated me. Whenever I
17 became Medical Director and we were changing the
18 Assurance Framework, we worked towards putting a
19 non-exec director in each of the pillars of the
20 assurance committees below it. 12:27
21 CHAIRPERSON: And you don't know why originally the
22 decision was made in 2014 to limit it?
23 A. I don't even know if the decision predated '14. When I
24 came in, that was the structure that they were on, they
25 chaired the Committee. 12:27
26 CHAIRPERSON: Oh, I see. Understood.
27 A. Sorry if I wasn't clear.
28 177 Q. MR. DORAN: I just want to keep to the theme of
29 oversight and look at oversight of Muckamore

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1 specifically and how effective the governance
2 structures were in ensuring adequate oversight of the
3 hospital at the relevant time. You address this in
4 some detail from paragraphs 36 to 62 of your statement.
5 I'm not going to delve into all the detail, you will be 12:27
6 glad to know, but again the emphasis is on governance
7 being managed and addressed at divisional level. As
8 I've said already, the reality is that with those
9 structures in place the hospital itself didn't feature
10 regularly in discussions at Board level prior to 2017? 12:28
11 A. That's correct, that's correct.
12 178 Q. Just from your own perspective, looking back now,
13 particularly when you think about the issues that were
14 arising around resettlement and discharge and also the
15 very difficult staffing issues at the hospital, does it 12:28
16 surprise you that Muckamore didn't feature at Board
17 level when it came to discussion of individual
18 facilities as such, or were individual facilities
19 routinely discussed at Board level?
20 A. Individual facilities were not routinely discussed at 12:28
21 Board level. And I think the thread you're trying to
22 pull is because delayed discharges and staffing issues
23 can be one of the many risk factors that, you know, are
24 in a myriad of risk factors that can result in abuse,
25 should we have been more problem sensing towards that, 12:29
26 correct me if I'm wrong.
27 179 Q. Well that's correct but of course one can add to that
28 the Ennis episode which was specifically brought to the
29 attention of the Board in 2014?

1 A. 2014?
2 180 Q. 2013, sorry?
3 A. I first became aware of Ennis just at the end of 2019
4 when it was raised. I was not aware of it before.
5 181 Q. So during your time on the Board from 2014 to 2019, you 12:29
6 had never been made aware of the --
7 A. Ennis Report?
8 182 Q. The prosecutions and the Ennis Report?
9 A. No. And I do think, you know, there were other areas
10 of the Trust that had delayed discharges. There were 12:30
11 multiple areas of the Trust that had short staffing.
12 Those areas didn't necessarily lead, and I would hope
13 they would never lead, to the issues of abuse that we
14 have seen here. And there are multiple, multiple risk
15 factors and Collins and Murphy actually describe all 12:30
16 the risk factors that could come in and, you know, I am
17 a geriatrician.
18 183 Q. You'll have to clarify who Collins and Murphy are
19 please?
20 A. Professor Murphy was one of those authors and that 12:30
21 paper came to Trust Board, it's come to Exec Team, we
22 have looked at all those risk factors, we have sense
23 checked that across, I think it was 2020 the paper that
24 I am --
25 PROFESSOR MURPHY: I think it was 2020 or 2021, yes. 12:31
26 A. Can I say I wish we had had that paper in maybe 2012.
27 But nevertheless we have done that piece. We are
28 trying to learn from this. But, I'm a geriatrician,
29 when I came to work in Belfast, when I worked in the

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1 Royal Liverpool there were long stay wards, they had
2 nurse shortages too. That doesn't automatically mean
3 that the abuse, and certainly some of the abuse that I
4 witnessed on CCTV, should happen. And in fact, some of
5 the items of abuse that I witnessed were deliberate 12:31
6 acts of force or taunting to trigger vulnerable
7 patients, and there is no place for that and there
8 never will be. And that same CCTV in some of those
9 instances captured sufficient staffing. And so lack of
10 staffing and delayed discharges is no excuse for those 12:32
11 episodes that I saw on CCTV and to do so would be
12 wrong.
13 184 Q. MR. DORAN: Could you let the Panel know in what
14 context you yourself viewed the CCTV?
15 A. I was Chief Exec of an organisation, I was Medical 12:32
16 Director. I want to see for myself some of the
17 instances of what had happened here because you can be
18 told it, but actually to see it.
19 185 Q. So did you arrange for a special viewing of the
20 material? 12:33
21 A. Yes, yes.
22 186 Q. When was that?
23 A. So I certainly saw some I think in 2019 and perhaps I
24 went again in 2020.
25 187 Q. So that was a couple of years after the -- 12:33
26 A. There was a view that if we were sitting on
27 disciplinary panels we couldn't because it might affect
28 who could sit on disciplinary panels. But I believed
29 it was more important that I saw some of the instances

1 of what actually happened and excused myself from the
2 disciplinary panels.
3 188 Q. Now, we'll come back to the revelations a little bit
4 later. Again, some of the matters that you have
5 described draw a distinction between what was happening 12:33
6 then and what would happen now. Discussion of an
7 individual facility, such as Muckamore, wouldn't have
8 been common prior to 2017. You refer in your statement
9 to the recent initiatives such as the QMS system. Did
10 you introduce that system yourself? 12:34
11 A. As Chief Exec I led the introduction. Clearly our
12 Performance and Planning Director, Charlene Stoops, our
13 Medical Director, the Executive Directors and whole of
14 the Exec Team were involved in that. But the concept
15 came from me. I visited, had the opportunity to visit 12:34
16 Virginia Mason back in September 2019, that is when we
17 brought in the safety huddle.
18 189 Q. Again for us of us who are uninitiated in these matters
19 who is Virginia Mason?
20 A. Virginia Mason in a large healthcare organisation based 12:35
21 in Seattle, I also visit -- children's. It is grounded
22 and merged in a safety culture, in a ward to board
23 assurance, in rapid cycles of change, in the chief exec
24 being very visible. It's basically, Toyota, in the
25 lean system, stop the system if you see something going 12:35
26 wrong, rapid workforce changes to introduce
27 improvement. So myself and a number of other
28 directors, because it's a collective team, and indeed
29 Sharon Gallagher who was in the Department of Health at

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1 that time, we went because I arranged the tour to learn
2 from different systems.
3 190 Q. Yes. You will have to forgive my ignorance, Virginia
4 Mason is an institute then rather than a person,
5 presumably named after an individual. 12:36
6 DR. MAXWELL: Virginia Mason is the name of the
7 healthcare organisation. Actually Jeremy Hunt paid
8 quite a lot of money for them to come and coach some
9 English trusts.
10 A. They actually took five trusts in England -- we had 12:36
11 actually wanted, but Northern Ireland is separate, yes,
12 there is lots to be learned looking at best practice.
13 DR. MAXWELL: But they are a delivery organisation,
14 they are not an institute, they actually run hospitals.
15 191 Q. MR. DORAN: I am learning as we proceed. Now, you 12:36
16 describe the system that you introduced in paragraphs
17 48 and 49 of your statement. I'm not going to read
18 those details in, but can I ask, has this new system
19 brought to light risks that the Board had previously
20 been unaware of at care delivery unit level? 12:36
21 A. Yes, because at the end of each QMS in the
22 accountability and assurance we have a standard
23 question which is 'which area of the service causes you
24 to stay awake at night?' It's a very simple question
25 but it's a very telling question. That being the case, 12:37
26 then the Executive Directors and the Service Director
27 meet and do a deep dive into all the metrics and that
28 problem sense making. And when we go into our
29 Assurance Committees now, not only do we have those

1 standard reports that you will have seen, but there is
2 also an opportunity for the service, there is also a
3 standing item for the Service Director to present on
4 their QMS and identify their key risks and talk through
5 it. So there is now line of sight between what happens 12:37
6 in each care delivery service and the Trust Board or
7 the Assurance Committee.
8 192 Q. I appreciate this may be difficult to answer and of
9 course we are all operating with the benefit of
10 hindsight, but in your professional assessment would 12:38
11 this new QMS system have been capable of picking up on
12 the issues at Muckamore at an earlier stage?
13 A. So that's, that is the question. Having thought about
14 this, I think the sea change in picking up the issues
15 in Muckamore was the CCTV, was the CCTV that we put in. 12:38
16 Because when you look at the paper Marie Heaney
17 presented to the Assurance Committee on the 14th
18 November 2014, you will see the range of metrics that
19 her Directorate considered. You'll see a run chart of
20 the incidences that she reported on where she said they 12:39
21 were out not, they were all within process control.
22 You will see her sense making of those indices. But
23 what clearly wasn't visible, you know, is what, where
24 people who could not, or who struggled to advocate for
25 themselves and what came to light on that CCTV. So as 12:39
26 I sit here today I think the biggest change in bringing
27 the abuse that happened in Muckamore into the light was
28 the CCTV.
29 CHAIRPERSON: But the question is whether the QMS would

1 have picked it up. The problem with CCTV is it's
2 backward looking?
3 A. Yes, it is. And I think you could detect the risk
4 factors and you could ask for a deep drill, but
5 somebody has to go into those wards and actually 12:39
6 independently observe.
7 MS. ANYADIKE-DANES: The feed seems to have stopped.
8 CHAIRPERSON: That is important. Sorry, nothing do
9 with your evidence. Thank you. Can we just check,
10 it's the public feed. It's important that Core 12:40
11 Participants, some of whom can't get here, are able to
12 watch and others so we will just stop.
13 A. It will give me time to think.
14 INQUIRY SECRETARY: I'll just check. It seems to be
15 working for our staff. 12:40
16 CHAIRPERSON: Okay. Is it one individual who has
17 reported that or is it global?
18 MS. ANYADIKE-DANES: One first but I'm just checking
19 how widespread it is.
20 CHAIRPERSON: Thank you. Sorry but it is obviously 12:41
21 important.
22 INQUIRY SECRETARY: It seems to be working.
23 CHAIRPERSON: I think it's one individual. I am going
24 to ask that we continue. There is a transcript of
25 course and counsel are here to advise their clients in 12:41
26 due course, but because we're slightly pressed for
27 time. If it's a more widespread problem please let me
28 know. Okay, right, let's carry on. We're on QMS.
29 193 Q. MR. DORAN: We are back to the issue of whether QMS

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1 might have picked up on warning signs, had it been in
2 place at the relevant time?
3 A. So it may have been better at identifying the risk
4 factors and certainly the skills of not just having the
5 data, but actually analysing the data and being curious 12:42
6 because data is data until you start asking questions.
7 But I have to come back that a lot of trust in
8 demonstrate -- our checklists, our audits, and what
9 happened, I mean what happened with the CCTV is what
10 the information systems were saying, was saying one 12:42
11 thing, but actually that wasn't what was happening on
12 the ward. And even when RQIA went in, there appeared
13 to be a change in practice so it might have better
14 sensed, but you are asking me would it have
15 definitively found that level of abuse and that's a 12:42
16 very hard question. And if I digress, and forgive me,
17 when we look at things like the surgical checklist, we
18 ensure the checklist has been done. It makes people
19 undergoing surgery much safer, you sign in, you sign
20 out, you check you've got all the right instruments, et 12:43
21 cetera. But if you look at the reliability of that
22 system, that clinical system and the reliability of the
23 human behaviour in it, it's very clear that that
24 reliability will slip over time and you need to then go
25 in and observe it in practice to check it's actually 12:43
26 happening. I think it's the reliability that we would
27 need to go in and check. And when RQIA went in,
28 because these wards were -- people knew it was RQIA and
29 the behaviour was not the same. So I think it would

1 have been better at sensing many of the risk factors.
2 Do I think absolutely it would have captured the abuse,
3 I can't say that, it would be me speculating. But I do
4 think the big change was when the CCTV was on and when
5 the staff knew it was on. 12:44
6 DR. MAXWELL: Can I ask you some questions? So I think
7 you've said in your statement, certainly the Chairman
8 has, that you were the Health Foundation's Measurement
9 and Monitoring Safety Framework which is based on
10 higher reliability organisations, as is Virginia Mason, 12:44
11 and there are a number of principles, one of which is
12 anticipating --
13 A. And preparedness.
14 DR. MAXWELL: And preparedness taken from NASA and
15 various other organisations, and I am going to mess up 12:44
16 Mr. Doran's questions, I'm sorry, but Winterbourne View
17 had happened and other scandals actually going back to
18 the Ealy Report, we knew --
19 A. The very first public Inquiry.
20 DR. MAXWELL: Yeah, we have known for a long time that 12:45
21 people with learning disabilities in hospitals are at
22 high risk of abuse, or Professor Murphy's work. Was it
23 not possible, certainly after Winterbourne, to
24 anticipate that Muckamore was a high risk environment
25 and build that into the system? And then the second 12:45
26 point, your point about the World Health Organisation
27 surgical checklist, the main thing of that was about
28 the power gradient. It was about could the medical
29 student or the student nurse say hang on a minute, I

1 think you're operating on the wrong side. Was there
2 anything to look at whether staff felt they could speak
3 up at Muckamore? Both of those things could have been
4 used to anticipate rather than wait, as Mr. Kark says,
5 to wait until finding it after the event, it would be 12:46
6 better to prevent abuse than to identify it after it
7 happened.
8 A. I absolutely agree it would always be better to prevent
9 abuse than to find out any incident happened, let alone
10 it perpetuated, which is what happened in Muckamore. 12:46
11 From my recollection and that from some of the exhibits
12 that I know will be shared with you if they haven't
13 already, do demonstrate that Winterbourne was
14 considered by the Muckamore team, they did review it,
15 they did look at that and they took that sense -- 12:46
16 DR. MAXWELL: Did the Board look at it though and think
17 oh, we have a high risk area --
18 A. I wasn't on the Board over Winterbourne.
19 DR. MAXWELL: Okay.
20 A. I don't know if the Board -- because that predated 12:47
21 2014. But I know that the team within Muckamore did
22 look at it and there is bundles to show you that. It
23 was one of the things that actually Dr. Milliken in
24 2014 mentioned.
25 194 Q. MR. DORAN: In the meeting? 12:47
26 A. To me and then again when the abuse came to light in
27 2017 that they had done this piece of work. The second
28 point you talk about is the power.
29 DR. MAXWELL: Power gradient to report things.

1 A. I think if you look at Margaret Flynn's A Way to Go
2 Report, she talks about new staff, visiting staff and
3 their ability to not have unfettered loyalty I think is
4 her phrase that she uses for some staff that worked
5 there, so I absolutely agree that that -- 12:48
6 DR. MAXWELL: And the staff survey I think includes a
7 question about would you feel safe to report things.
8 So you had the data?
9 A. So the staff satisfaction, because in 2016 and 2017 it
10 is actually in the stat function report, page 406 of 12:48
11 the bundle you shared with me at the weekend, in the
12 stat function report for 16/17 which finished the end
13 of March '17, we benchmarked our LD services with
14 England, Scotland and Wales. It showed two interesting
15 points, I don't know if you can pull up page 406. 12:48
16 195 Q. MR. DORAN: That's the compilation of Delegated
17 Statutory Functions Reports from 2010 to 2017, they are
18 contained in a separate document that has been
19 circulated to all the Core Participants?
20 A. So Northern Ireland didn't automatically -- 12:49
21 196 Q. I'm sorry, Dr. Jack, could you just give us the page?
22 A. It's 406. You can see that we started to benchmark
23 with England, Scotland and Wales and I just wanted to
24 highlight two things in this, first of all the NHS
25 staff survey satisfaction scores aren't routinely used 12:49
26 every year the way they are in England. We have done
27 that in Belfast. We would do it maybe once every four
28 years, we haven't done it since 2020, apart from in
29 Belfast because we linked with Annie Laverty and the

1 patient experience network. So in 2018 we started to
2 seek real-time staff feedback in the Trust and then we
3 also then linked it with the staff survey. So we've
4 been doing that.
5 DR. MAXWELL: So my question is, did you ask the 12:50
6 question, the specific question how --
7 A. Safe.
8 DR. MAXWELL: -- how safe do you feel in reporting
9 concerns?
10 A. We have done but I don't know if we ever did that 12:50
11 before 2017. But I wanted to highlight point four
12 there, the staff satisfaction scores, because we talk
13 about demoralised staff, chronic shortages, poor
14 training, you know, but the staff satisfaction scores
15 for Belfast in intellectual disability were actually 12:50
16 higher than the national average. And the nursing
17 skill mix in intellectual disability or learning
18 disability showed a higher proportion of qualified in
19 Belfast than the national average. So I'm not saying
20 there wasn't staff shortages. I am not saying training 12:50
21 was as good as it should and could be, I am never going
22 to say that, okay. But what I'm saying is because the
23 CCTV just started recording around, well the captured
24 -- this was at a snapshot in time and those two items I
25 think are important to note, that those couldn't be the 12:51
26 only reasons that the abuse happened, sorry.
27 PROFESSOR MURPHY: We've also seen evidence from some
28 witnesses about exit interviews from staff in MAH and
29 actually their exit interviews are very different from

1 this. They say that they would not recommend MAH as a
2 working environment. They think the Trust is okay, but
3 not MAH. So, you know --
4 A. That's so interesting and I didn't know that and thank
5 you for sharing. That might be a much more -- that is 12:51
6 a really important indicator. And were they staff that
7 turned round rapidly that maybe came and left quickly?
8 PROFESSOR MURPHY: I can't honestly remember.
9 CHAIRPERSON: It was a very small number.
10 PROFESSOR MURPHY: It was a small number. 12:52
11 197 Q. MR. DORAN: And presumably coming back to the DSF
12 report, that is global percentage figure relating to
13 learning disability and mental health staff across the
14 board --
15 DR. MAXWELL: It is community staff as well as MAH -- 12:52
16 A. It's no different than the reports we would have --
17 DR. MAXWELL: No, I understand but we have to bear in
18 mind this is community as well as MAH, not just MAH.
19 A. Although it says community team case loads were at
20 national average. I mean I am not the expert to drill 12:52
21 down into it but I did think that was an interesting --
22 198 Q. MR. DORAN: Just importantly for the record, Dr. Jack,
23 those are global statistics as opposed to percentage --
24 A. Percentage for the learning disability service --
25 MR. DORAN: If you just let me finish, and I say that 12:52
26 for the purpose of the transcript because obviously the
27 stenographer is taking a full record of what is said
28 and it is important that two individuals in the room
29 don't speak at the same time. Just for clarification

1 those are global statistics as opposed to statistics
2 that relate specifically to the staff experience at
3 Muckamore, isn't that right?
4 A. These are statistics that relate to the entirety of the
5 learning disability service within Belfast. 12:53
6 199 Q. Yes?
7 A. And not specifically to Muckamore. But they are not
8 global for the whole of Belfast Trust staff.
9 200 Q. Thank you for that clarification. Now, you've touched
10 on the Leadership and Governance Review and you refer 12:53
11 to the report in paragraph 63 and 64 of your statement.
12 I just want to read those in and ask you some things
13 about that. The 2020 Leadership and Governance Review
14 when speaking of 2017 concluded:
15 12:53
16 "Governance structures were in place at Board and Trust
17 level to enable the Trust to assure itself of the
18 quality of the services it provided at MAH. I agree
19 with that assessment. I hope the governance structures
20 in 2024, particularly after the introduction of QMS and 12:54
21 the assurance map which covers each care delivery unit
22 are in fact better today than they were beyond five
23 years ago. However, I also acknowledge that the
24 provision of health and social care carries significant
25 inherent risk. It can be very difficult. It is 12:54
26 unfortunately inevitable, despite the best efforts of
27 systems and people, that things can and will go wrong.
28 Depending on the extent of what has gone wrong, it can
29 be very difficult to remedy. MAH is certainly an

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1 example of that. It does not follow that because the
2 Trust Board or Executive Team or Directorate level
3 staff or hospital level staff did not know that
4 patients were being abused in MAH in 2017, this
5 therefore means there were not effective structures and 12:54
6 processes in place capable of ensuring adequate
7 oversight of MAH or other similar facilities by the
8 Trust Board. Any governance system, no matter how well
9 developed and comprehensive, relies on individuals
10 doing the right thing. If, for whatever reason, this 12:55
11 does not happen, then the governance system will fail.
12 Each time an individual nurse, doctor, manager or
13 colleague failed to further inquire or escalate a
14 concern they should or did have when they could and
15 should have, then that also unfortunately means that 12:55
16 the governance systems of the Belfast Trust failed as a
17 consequence."
18
19 Now, you express agreement with that selected quote
20 from Leadership and Governance which says: "Governance 12:55
21 structures were in place at Board and Trust level to
22 enable the Trust to assure itself of the quality of the
23 services it provided." But of course the Leadership
24 and Governance Report went significantly further than
25 that, I think you'll accept? 12:55
26 A. Absolutely.
27 201 Q. I'm not going to go right through the report, the
28 Inquiry has heard quite a lot of evidence about it.
29 But, for example, the report made the point that there

1 was limited evidence of executive or Board engagement
2 with MAH prior to the events identified in August 2017.
3 At paragraph 7.36, and I don't think we need to bring
4 this on screen, the review said:
5 12:56
6 "The Review Team considered leadership at a range of
7 levels across the Belfast HSC Trust in respect of MAH.
8 An examination of the Trust Board and Executive Team's
9 minutes showed that MAH rarely featured on the agenda.
10 There was no reference to it in the Trust's Annual 12:56
11 Quality Reports or within the Discharge of Statutory
12 Functions Reports. The Review Team considered the
13 repetitiveness of the DSF reports and the general
14 absence of assurance regarding the degree to which
15 statutory functions were discharged should have 12:56
16 resulted in challenges at Trust Board and HSC Board
17 levels."
18
19 And at paragraph 7.37:
20 12:57
21 "Neither the vulnerability of the patients cared for at
22 MAH, nor an awareness of the likely risks associated
23 with institutional living, brought MAH into focus at
24 any level at Trust Board or Executive Team levels. The
25 Review Team concluded that for a number of reasons MAH 12:57
26 was perceived, as one Co-Director noted, as a
27 self-contained community with its own culture and
28 identity. It's geographic distance from the Trust and
29 the resettlement plan for the hospital led in the

1 Review Team's opinion to it being viewed as a place
2 apart. MAH had no champions at either the Executive
3 Team or at Trust Board levels with a curiosity about it
4 and those for whom it cared."
5 12:57
6 And then that paragraph concludes by saying:
7
8 "The Review Team concluded that the Trust's values and
9 the objectives established in the Belfast Way..."
10 12:58
11 Which is a strategic document issued in 2007 I think
12 after the Trust was established.
13
14 "...were not guiding principles at MAH. The Review
15 Team identified a cultural divide between the Trust and 12:58
16 MAH."
17
18 So while one might say that the structures are in place
19 and they were capable of ensuring adequate oversight,
20 the reality is in this instance that they didn't work, 12:58
21 isn't that correct?
22 A. I think that is actually what paragraph 64 says, that
23 there were structures and there were processes and they
24 were capable of working.
25 202 Q. Yes? 12:58
26 A. But, you know, what happened in Muckamore, what
27 happened in Muckamore shouldn't have happened and was
28 unacceptable and it was, when people come to harm the
29 governance structures and processes fail. And if

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1 everybody at every level did everything right and
2 escalated it, we would have had a chance. But there
3 were people that harmed others and there were people
4 that saw it and for whatever reason did not raise it.
5 And we've discussed some of the reasons about why they 12:59
6 might not and that paragraph you've read out about
7 culture, et cetera, and a place apart and maybe not
8 wanting to be integrated in Belfast, is all very
9 important into the mix that causes issues like this.
10 203 Q. But you accept that the system failed? 12:59
11 A. I accept the system failed because -- not because we
12 didn't have the structures, but if the structures
13 relied on everybody doing everything right at every
14 time, clearly it failed because we didn't, it didn't.
15 204 Q. But if you were asked to pinpoint exactly how and at 12:59
16 what level the governance system failed, what would you
17 say, who should have done what?
18 A. I think when you really look at this in detail, and
19 I'll take it right back because it is, you know, for
20 me, it's the level that stops it being escalated, and 13:00
21 there will be risks and there will be problem sensing,
22 but when an individual came to harm and either that was
23 reported or people witnessed it and didn't report it,
24 that's where it stopped at the first level. Then if
25 somebody did escalate it and nothing was done, and we 13:00
26 see that, a delay in reporting in August '17, that
27 could be another level. And then if there were
28 decisions taken not to escalate at a higher level. So
29 it could be at anyone of many levels that the

1 governance breaks down.
2 205 Q. Including the Board?
3 A. Up to and including the Board. But what we do know,
4 what we do know is when events came to the attention of
5 the Directors, that was raised at the very next 13:01
6 Executive Team, it was brought to the attention of the
7 Trust Board at the very next Board on 2nd November I
8 think, 2nd November '17. Then a detailed paper came to
9 the 14th November '17 and between that, between the 2nd
10 November and 14th, and you can read it in the minutes 13:01
11 of that, that Miriam Carp, one of the non-exec
12 directors was so concerned that she arranged to meet
13 Marie Heaney herself.
14 206 Q. This was after the revelations?
15 A. This was after, yes. 13:01
16 DR. MAXWELL: But you think that's quick, do you? We
17 heard from Esther Rafferty yesterday that I think she
18 said she informed you on 21st September.
19 A. Esther Rafferty didn't inform me, Colin Milliken
20 informed me on the 20th September. 13:02
21 DR. MAXWELL: So you knew on 20th September, I think
22 Brenda Creaney knew.
23 A. And Marie Heaney.
24 DR. MAXWELL: And it wasn't escalated, the Board
25 weren't informed until 2nd November? 13:02
26 A. That was the next meeting of the Board.
27 DR. MAXWELL: There are ways of communicating outside
28 Board meetings?
29 A. Absolutely, Professor Maxwell, and it may well have

1 been that we spoke to the chairman or that we, Martin
2 Dillon spoke to the chairman, all I can tell you is the
3 next minutes where the formal Board met, just --
4 DR. MAXWELL: Okay, that's the minuted evidence, not
5 necessarily what happened. 13:02
6 A. Yes, this is an Inquiry, you know, the evidence, the
7 next opportunity that the formal Trust Board met, that
8 was discussed.
9 DR. MAXWELL: Okay.
10 A. Sorry for my clumsy way. I can't tell at this recall 13:03
11 whether I spoke to the chairman myself or whether Marie
12 Heaney or whether Martin Dillon. I believe that we
13 would have, but I have no evidence.
14 DR. MAXWELL: We can ask him.
15 A. To stand over that. 13:03
16 207 Q. MR. DORAN: But, Dr. Jack, what you're talking about
17 now is the Board's reaction to what occurred in 2016,
18 2017, sorry. What I'm trying to get at is this: When
19 you talk about the failure to escalate and you say in
20 paragraph 64 that: 13:03
21
22 "Each time an individual nurse, doctor, manager or
23 colleague failed to further inquire or escalate a
24 concern they should or did have, then that also
25 unfortunately means that the governance systems of the 13:03
26 Belfast Trust failed as a consequence."
27
28 But is that not perilously close to placing
29 responsibility on individuals at lower levels of the

1 system rather than accepting that the ultimate
2 responsibility for failure in a governance system lies
3 at the top?
4 A. Sorry, I thought you asked me what level did the
5 governance system fail and I think the governance 13:04
6 system, and I tried maybe in my clumsy way to say that
7 if an incident happened and it went unreported, then we
8 couldn't have known about it. But when we did know
9 about it, we acted. I'm not saying that our governance
10 systems didn't fail here. I'm saying that at every 13:04
11 level, for it to work everybody needs to be doing
12 everything consistently that they should and could do.
13 208 Q. And you make that point in paragraph 66 you say:
14
15 "Everyone needs to consistently and at every level be 13:04
16 curious, triangulate the information and act
17 appropriately on any concern."
18
19 But do you accept that there was not only a failure to
20 escalate issues from below, but also a failure to 13:05
21 inquire and scrutinise from above?
22 A. So, that's talking about the curiosity and the problem
23 sensing, trying to pick it up before.
24 209 Q. Yes?
25 A. As I have said that, you know, when I came into the 13:05
26 Trust Board in 2014, we did rely on directors bringing
27 these issues and we have built an increasing scrutiny
28 and an increasing culture of challenge and an
29 increasing hold to accountability. We are not, I don't

1 believe that we are there yet, I don't believe you will
2 ever be there yet. I think it's been a challenging
3 journey at times because you have had directors used to
4 one way of working and moving into a different way and
5 the vast majority would welcome that but some have 13:06
6 struggled more with that. So, yes, I do believe that
7 with the benefit of hindsight, if we had known all the
8 risk factors, could there have been more scrutiny? Of
9 course there could and this Inquiry hopefully will pull
10 that out in the lessons and recommendations and if it 13:06
11 is about having a non-exec or a lay person as part of
12 our QMS Panel, then you know, that's a really helpful
13 suggestion to take forward.
14 PROFESSOR MURPHY: Isn't one of the problems that
15 governance systems are not good at picking up culture. 13:06
16 A. No.
17 PROFESSOR MURPHY: You have ever tried measuring
18 culture?
19 A. So we did, I think it's in one of the minutes that you
20 provided actually with me over the weekend, is it June 13:07
21 2019, the Executive Team minutes. That exhibit
22 actually has the regional HSC culture and we were the
23 test case. We were the Trust that went forward with
24 that and you'll see Brendan McConaghy came to present
25 it, I'm sorry I don't have that. 13:07
26 DR. MAXWELL: This was 2019 you think?
27 A. So there was a whole big HSC strategy on leadership and
28 culture and indeed there is more work ongoing around
29 being open. And, again, we were the First Trust to

1 invite Peter McBride in to our being open culture. But
2 I think that was the first sort of pieces of work that
3 the HSC system or the Trust did.
4 PROFESSOR MURPHY: I mean culture means a lot of things
5 obviously. But what I'm thinking about is the culture 13:08
6 in relation to people with learning disabilities in MAH
7 and the extent to which they were treated as human
8 beings would want to be treated, that kind of culture.
9 I think you're saying you didn't ever measure, you
10 didn't ever -- 13:08
11 A. So my understanding is that we, from 2014, to '17, we
12 tried to do patient experience and staff experience
13 after that, as you'll see from the SitReps. I don't
14 recall any report about the culture coming but neither
15 do I recall a report coming about the culture in the 13:08
16 likes of Muckamore or in our mental health institutions
17 or our acute wards. But I absolutely agree that
18 culture eats strategy and policies et cetera for
19 breakfast, dinner and tea and I do think, as I reflect
20 on, you know, what happened in Muckamore and how it 13:09
21 should never have happened, culture must be one of the
22 big risk factors in that. And it pulls on your thread
23 that some of the exit interviews showed alarms or high
24 risks or red flags about things to go down and explore
25 further. 13:09
26 MR. DORAN: Chair, I am on the verge of finishing my
27 treatment of the Leadership and Governance Review. Can
28 I have a couple of minutes more just to complete that
29 topic before lunch?

1 CHAIRPERSON: Yes, then we'll take lunch.
2 210 Q. MR. DORAN: I wanted to bring you to a minute of a
3 Trust Board meeting on 3rd December 2020, it was
4 exhibited to the statement of Brenda Creaney. The
5 reference is MAHI STM-291-75. It's just Board meeting 13:10
6 on 3rd November 2020. If you scroll down, please, to
7 the next page, page 76. And I think I'm right in
8 saying that these are official answers, if you like,
9 given to questions that were posed by a member of the
10 public? 13:10
11 A. Yes.
12 211 Q. I just wanted to get back to this theme of failings and
13 accepting responsibility for failings. If you scroll
14 down please. Yes, it's the paragraph beginning "while
15 the Board". 13:10
16
17 "While the Board acknowledges its failings as made
18 clear in the review into leadership and governance at
19 Muckamore Abbey Hospital dated August 2020, it also
20 recognises, as highlighted by the review, that 13:11
21 appropriate governance procedures were in place at
22 Muckamore Abbey Hospital and that the Board was unable
23 to act because there was a regrettable failure to
24 escalate serious issues to the Board. The Board fully
25 acknowledges the review's comment that there was a lack 13:11
26 of curiosity shown by the Board which contributed to an
27 environment which enabled the serious maltreatment of
28 vulnerable people to go unnoticed for so long. This is
29 a matter of profound regret to each member of the Trust

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1 Board."
2
3 Now, I just wanted to ask you about the language
4 because there is somewhat of a contrast between saying
5 there was a regrettable failure to escalate and then 13:11
6 the statement that the Board fully acknowledges the
7 review's comment.
8 A. Mhm-mhm.
9 212 Q. Acknowledging a comment is one thing but did the Board
10 and do you accept the point that the Board was making 13:12
11 about lack of curiosity?
12 A. So, I think what we have strived do since this coming
13 to light, Mr. Doran, counsel, is to improve curiousity,
14 to improve the scrutiny. I had a presentation that I
15 gave to every single director when they joined 13:12
16 Executive Team of what I expected from them.
17 Curiosity, focus, courage, honesty is all part of that.
18 So I do accept that we could and should have been more
19 curious, particularly about the risk factors that could
20 have added to the situation and the factors where abuse 13:13
21 can occur. I think the first bit of that paragraph is
22 when abuse did occur, how quickly was it detected, how
23 was it escalated so that it didn't perpetuate, if you
24 see the difference for me.
25 213 Q. But you do accept that the Board could have and should 13:13
26 have been more curious?
27 A. Yes, I do.
28 MR. DORAN: Chair that may be an appropriate moment to
29 pause for lunch.

1 CHAIRPERSON: We have got a way to go as it were, I
2 think we will sit at 2 o'clock I am afraid. You will
3 be looked after. Please don't speak about your
4 evidence to anybody and we will see you back at 2
5 o'clock, thank you very much. 13:13
6
7 LUNCHEON ADJOURNMENT.
8
9 THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS
10 FOLLOWS: 13:56
11
12 CHAIRPERSON: Thank you. Mr. Doran.
13 MR. DORAN: Thank you Chair, Panel members. The Trust
14 representatives have flagged up an issue with me
15 arising from this morning's evidence, there was some 14:03
16 discussion around the Staff Satisfaction Survey to
17 which reference was made I think in the 2016 Delegated
18 Statutory Functions Report and then an issue arose as
19 to the exit interviews that the Inquiry heard about at
20 an earlier stage. Now, the Trust's understanding is 14:03
21 that those exit interviews related to a later point in
22 time, that's 2018, 2019.
23 CHAIRPERSON: They might have done, okay.
24 MR. DORAN: The matter is dealt with in the statement
25 of Monica Molloy, and that's STM-285, page 8 and 32. 14:04
26 CHAIRPERSON: Okay.
27 MR. DORAN: Obviously those are matters that we can
28 check separately from today's evidence.
29 CHAIRPERSON: Let's crack on. Thank you.

1 214 Q. MR. DORAN: Dr. Jack, let's look briefly at the actual
2 consideration of the hospital by the Trust Board before
3 2017, because you deal with this at paragraph 72 to 85,
4 starting at page 23. I just wanted to look, first of
5 all, at paragraph 73. And you say: 14:04
6
7 "From the material presently available to me it appears
8 that prior to September 2017 MAH was discussed by Trust
9 Board on three occasions between 2012 and September
10 2017. Before my time on Trust Board there was a report 14:04
11 about the prosecution of staff by Catherine McNicholl
12 on..."
13
14 It possibly should read, "a report by Catherine
15 McNicholl about the prosecution of MAH staff", 14:05
16
17 "...on 11th April 2013. Following my joining of the
18 Trust Board in August 2014, the first occasion there
19 was a specific reference to MAH was on 2nd April 2015.
20 I was not present for that Trust Board meeting. From 14:05
21 the available papers, the reference was in the context
22 of a savings plan required of the Belfast Trust which
23 had support in principle from the HSCB, LCG and PHA and
24 also had been informed by legal advice and discussions
25 with the then Department of Health, Social Services and 14:05
26 Public Policy. The minutes record members expressed
27 concern regarding the proposal to withdraw the
28 financial reward system for day centre clients in
29 Muckamore Abbey Hospital and the impact on very

1 vulnerable people. Following discussion it was agreed
2 that this proposal should be removed from the draft
3 plan."
4 Now I don't want to get into the details of those
5 mentions, but you've said the hospital was discussed on 14:06
6 three occasions, and I think there are only two
7 occasions in that paragraph --
8 A. I think if you --
9 215 Q. Sorry, if you let me finish for a moment. The first
10 one I think relates to Ennis, isn't that correct? 14:06
11 A. I believe it's the prosecutions resulting from Ennis.
12 216 Q. From Ennis, yes indeed, and the second one relates to
13 that very specific matter that arose in respect of the
14 savings plan, isn't that right?
15 A. Mhm-mhm. 14:06
16 217 Q. Can you think of what the third occasion was?
17 A. My understanding is the workshop and I talk about it in
18 paragraph 80.
19 218 Q. I see.
20 A. On page 25, which is the workshop, I think July 2015 14:06
21 that happened in Muckamore and there is an agenda.
22 219 Q. Yes and that refers to the service user story presented
23 by the Trust Board by the then Learning Disability
24 Service Manager, Aine Morrison. And obviously Ms.
25 Morrison led the Ennis Safeguarding Investigation. 14:07
26 Presumably that was separate from the whole Ennis
27 episode then, a separate issue?
28 A. At this remove I believe it was although I don't have
29 any documentary evidence for that.

1 220 Q. That's something obviously the Inquiry can check. That
2 leads you then to say:
3
4 "It is the case that up until September 2017 MAH was
5 not a place of concern for the Trust Board or the 14:07
6 Executive Team."
7
8 I think you make that point at paragraph 78 and you
9 made that point earlier today.
10 14:07
11 I just want to look briefly at two other routes through
12 which concerns about the hospital could arguably have
13 come onto the Board's radar, if I can put it like that,
14 that's through the Delegated Statutory Functions
15 Reports and through the Corporate Risk Register? 14:08
16 A. Yes.
17 221 Q. First of all the Delegated Statutory Functions Reports,
18 I know you have had the opportunity to look at those
19 and indeed you referred to one of them earlier on. And
20 in your statement, I think at paragraph 59, you refer 14:08
21 to the reports being presented annually?
22 A. Mhm-mhm.
23 222 Q. And in that paragraph you say:
24
25 "This is a significant opportunity to draw to the 14:08
26 attention of the Trust Board matters that have arisen
27 in social care including in learning disability and
28 including MAH."
29

1 A. Mhm-mhm.
2 223 Q. So it's a significant opportunity if you like to put
3 those matters before the Board?
4 A. Yes, it's a standing item on the Trust Board.
5 224 Q. Yes, by way of annual report? 14:09
6 A. Mhm-mhm.
7 225 Q. And then you go on to say towards the bottom of the
8 paragraph:
9
10 "I invite the Inquiry Panel to consider those specific 14:09
11 sections in each DSF report as providing a snapshot of
12 what social work within the Trust considered needed to
13 come to the attention of Trust Board and the Department
14 of Health at those particular points in time."
15 14:09
16 Now, it's fair to say, isn't it, without going into too
17 much of the detail, that the issues relating to
18 discharge and resettlement were actually raised on a
19 number of occasions in the context of those reports?
20 A. Resettlement delays were raised in each of the reports 14:09
21 up to 2015/16, and 16/17, from my review this weekend.
22 But they weren't raised in 15/16 and 16/17, but every
23 other report predating that they did raise the
24 resettlement, although in some of those reports they do
25 acknowledge that the targets set were met. But in 14:10
26 other reports they don't actually even indicate the
27 targets that the Board set for us.
28 226 Q. Yes, well let's just have a brief look at one of them,
29 it's in the Delegated Statutory Functions extracts and

1 I think this is from 2015 to 2016 which is a point in
2 time at which you would have been on the Board; isn't
3 that correct?
4 A. 15, 16, yes.
5 227 Q. And it's at pages 335 to 336 so that's the Delegated 14:10
6 Statutory Functions extracts. And, yes, 335, if you
7 scroll down please to the paragraph beginning "the
8 HSCB". That says:
9
10 "The HSCB will be aware of the ongoing difficulties the 14:10
11 service area has encountered in achieving the PTL
12 (Priority Target List) resettlement target for this
13 year. The target for the year 2015 was 16. One of
14 these patients died and one patient completed a first
15 overnight but then chose not to continue with the 14:11
16 process. Three others have completed or commenced
17 their trial resettlements. This leaves 12 patients to
18 be resettled during 2016 to 2017. Each of these
19 patients have plans for a move into their new homes
20 pre-March 2017 and four have plans for a new supported 14:11
21 living scheme in the Belfast Trust scheduled for
22 completion in June 2017."
23
24 If you scroll up again, please. If we look to -- I
25 won't read the middle column for now but the right-hand 14:11
26 column reads:
27
28 "The issue is on the service area Risk Register and is
29 categorised as a high risk."

1
2 Could you scroll down please to the next page. If we
3 scroll down a little bit further please. At No. 4:
4
5 "The service area is experiencing pressure on the 14:12
6 availability of acute admission beds due to the numbers
7 of delayed discharged patients in admission wards."
8
9 On the right-hand side:
10 14:12
11 "This issue is not on the service areas's Risk Register
12 but is monitored very closely for ongoing trends."
13
14 The point I want to make is that there is a reasonable
15 degree of detail there, isn't there, about the current 14:12
16 position regarding discharge and resettlement. That
17 obviously relates to the specific facility at
18 Muckamore?
19 A. Yes.
20 228 Q. And yet it didn't lead to focused discussion of that 14:12
21 matter at Board level?
22 A. Not as I recall. And interestingly if you look at the
23 Executive Director's summary at the start of the
24 section where they highlighted where they haven't met
25 their delegated statutory functions. 14:13
26 229 Q. Yes?
27 A. The resettlement process was not highlighted in that.
28 230 Q. But is it fair to say then that whilst an issue such as
29 resettlement discharge at a specific facility like

1 Muckamore might feature in the report, that won't
2 necessarily lead to it being considered at Board level?
3 A. It won't lead to it necessarily being discussed and you
4 will see it was on the service area Risk Register so it
5 doesn't even say the Directorate Risk Register, it's 14:13
6 ward, service, so this was an area that the service was
7 managing.
8 231 Q. Yes. But if you like, I suppose it's information
9 that's on the Board's radar, but isn't necessarily
10 being subjected to focused attention by the Board? 14:13
11 A. So, as I previously said, counsel, resettlement delays
12 were well known across the whole system and they were
13 well known from 2011 onwards.
14 DR. MAXWELL: Is that a good enough reason not to
15 discuss them when they are ongoing? 14:14
16 A. Well I think if you looked at every single target in
17 Trust Board we would never have got through the agenda.
18 It's not an excuse but I would have expected the
19 Directorate and the service to have done that detailed
20 discussion. 14:14
21 DR. MAXWELL: But it says here for item 3: "The
22 service have identified it as high risk."
23 A. Yes and then they could have escalated that to our
24 corporate or Principal Risk Register. It was seen that
25 they had mitigations no doubt in place that they were 14:14
26 content.
27 DR. MAXWELL: Well it's not seen, is it, you're
28 assuming?
29 A. I am, but this was a paper that was tabled and the

1 Executive Director responsible for the delegated
2 statutory function didn't even draw it out in their
3 conclusions and summary.
4 DR. MAXWELL: So you didn't see that they had
5 mitigations, you assumed? 14:15
6 A. We didn't see it, but it was certainly there in the
7 report.
8 232 Q. MR. DORAN: Now, we've just referred to the fact that
9 it's categorised as high risk in the service area Risk
10 Register, does that mean it will be elevated 14:15
11 automatically to the Directorate risk level or sorry,
12 risk register?
13 A. So the Directorate will have considered that risk to
14 see whether it meets the level to go on higher or onto
15 the corporate, that would be their decision. 14:15
16 233 Q. So is it right then that an item being categorised as
17 high risk on a service area Risk Register doesn't
18 automatically result in inclusion on the Directorate
19 Risk Register?
20 A. So -- 14:16
21 234 Q. You may not be able to answer that question?
22 A. I am probably not the best and I think in '15, '16
23 Mr. Worthington was probably the Service Director, he
24 was also the Executive Director of Social Work, I think
25 this question would have been better asked of him. 14:16
26 235 Q. He has given his evidence this morning. He has given
27 us quite a lot of detail about Delegated Statutory
28 Function Reports and their purposes. But coming back
29 to the Risk Registers with which you would have been

1 more familiar --
2 A. I was familiar with the risk registers that existed
3 within the Medical Director's office because I had my
4 own Risk Registers and --
5 236 Q. Yes? 14:16
6 A. And I would have been familiar with the extract, the
7 Board Assurance principal risk Document or as I would
8 call it the principal risk Document and then the
9 extract from the corporate.
10 237 Q. Yes? 14:16
11 A. I would not have seen anything below that.
12 DR. MAXWELL: You are saying you had your own Risk
13 Register within the Medical Director's office?
14 A. Yes.
15 DR. MAXWELL: Would that be true for the other 14:17
16 Executive Directors, would the HR Director have their
17 own Risk Register.
18 A. Well again yes, I would assume. I can't give you the
19 evidence for that but the expectation is that every
20 Directorate is responsible. So even in the medical 14:17
21 education facilities, there were risks. In our
22 research and governance there were clearly risks. So I
23 had my own Risk Register.
24 DR. MAXWELL: And so how did your Risk Register feed
25 into the Corporate Risk Register? 14:17
26 A. So if I had a risk that existed within the Medical
27 Director's office, maybe I'll give an example, it was a
28 combined risk. So at a point in time the GMC placed
29 the anaesthetic department in the Royal Victoria

1 Hospital, as it was then known, under enhanced
2 monitoring, that was on our Corporate Risk Register.
3 DR. MAXWELL: Because there was a risk they would
4 removed trainees.
5 A. If they removed trainees and not only did that involve 14:18
6 the anaesthetic department, it would have caused a risk
7 to other services and our delivery, so it was both my
8 risk and the Service Director's risk.
9 238 Q. MR. DORAN: But is it correct to say that everything
10 that appears on the Corporate Risk Register will have 14:18
11 appeared on a Directorate Risk Register?
12 A. Again I am probably not the best to answer that, Claire
13 Cairns who was the Risk and Governance Lead and sat on
14 the Risk Register Management Group would have been the
15 best to tell you how that extract was extracted and 14:18
16 whether all the directorate risks made up the
17 corporate, all I know is what came to assurance.
18 239 Q. Yes?
19 A. And none of mine made the corporate extract.
20 240 Q. The Inquiry does have other information about this and 14:19
21 I don't want to press you on matters in which you're
22 not expert or with which you're not familiar. But, can
23 you just give us a basic outline from a lay perspective
24 of what the difference is between the Principal Risk
25 Register and the Corporate Risk Register? 14:19
26 A. Yes, and I think I do cover it in some of my --
27 241 Q. You do mention it in your statement, yes?
28 A. Earlier paragraphs. So in an organisation the size of
29 the Belfast Trust, the principal risks are those really

1 high level risks that if we don't mitigate and address
2 will cause us to fail to deliver our corporate plan.
3 So they are the highest level risks and the strategic
4 risks for the organisation. The corporate risks that
5 sit below that -- no, let me just finish with the 14:20
6 principal risk document, there are some key points.
7 The principal risk document every risk is considered at
8 every Assurance Committee. But in detail on a rolling
9 programme, because you have to discuss these at regular
10 intervals and no less than every bi-annually, two or 14:20
11 three risks would have been picked to be dissected and
12 challenged and scrutinised.
13 DR. MAXWELL: Is that -- in your statement you refer to
14 an extract, in fact in your corrections you refer to an
15 extract of the corporate? 14:20
16 A. This is the principal risk document, I'll get onto the
17 extract later.
18 DR. MAXWELL: The principal risks are discussed on
19 rotation?
20 A. Any new risk was discussed, any risk before closure was 14:20
21 discussed because it had to be agreed at Assurance
22 Committee. And then the ongoing risk would have been
23 discussed on rotation. So, for example, an area that I
24 think the Inquiry will be interested in is the nursing
25 vacancies across the risk went on the principal risk 14:21
26 document, I think it was April '17 and remained on it
27 until 2021. I think Brenda Creaney, Director of
28 Nursing, talked about the international nurse
29 recruitment and how, with the Director of Finance, we

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1 led that work. But that's a very high level right
2 across the organisation.
3 DR. MAXWELL: Just before you move on, who decided what
4 became a principal risk rather than a corporate risk?
5 A. So any new corporate risk was also highlighted in my 14:21
6 time to the Assurance Committee for discussion and to
7 make sure it didn't need to go onto the principal risk.
8 DR. MAXWELL: Is the answer the Assurance Committee
9 decided what transferred from corporate to --
10 A. It was proposed by, proposed by the Risk Management 14:22
11 Committee this was the level, but the Assurance
12 Committee had the opportunity to challenge and
13 scrutinise. And what made up the corporate risks were
14 risks that were critical to a service but not
15 necessarily -- 14:22
16 DR. MAXWELL: No, I understand.
17 A. The delivery of the corporate plan and there is a
18 difference in that, and could have affected more than
19 one Directorate. So if I can, and I think there is one
20 of the Assurance Committee's that we talk about, there 14:22
21 is something like paediatric pathology. So paediatric
22 pathology, we didn't have enough paediatric
23 pathologists so we had to link to Alder Hey. That was
24 on the Corporate Risk Register because it didn't just
25 affect pathology but it would affect a wider issue, it 14:23
26 wasn't on the corporate plan but it was a critical
27 service. And you can see that from our assurance
28 minutes where that comes up and where it comes off as
29 we stabilise the service, which isn't provided here

1 anymore, but we have a good service level agreement
2 with Alder Hey.
3 242 Q. MR. DORAN: You refer to the fact that risks on the
4 Principal Risk Register are reviewed?
5 A. They are. 14:23
6 243 Q. I think you say in your statement they are reviewed on
7 a two year basis?
8 A. No less than two year. My statement is they were
9 minimally reviewed on a two year.
10 244 Q. Presumably if there are particularly pressing risks, 14:23
11 they would be subject to review on a more regular
12 basis?
13 A. Absolutely and each risk, each risk on the Principal
14 Risk Register is always updated for the Assurance
15 Committee. 14:23
16 245 Q. Let's come back then to the risks that you have
17 identified in outline at paragraph 154 to 158 of your
18 statement, and these were risks prior to 2017. Now I
19 appreciate that you have corrected this part of the
20 statement in the sense that it appears that whilst they 14:24
21 are described as corporate risks identified for
22 Learning Disability, it doesn't appear that they were
23 on the Corporate Risk Register, is that correct?
24 A. They were never discussed at the Assurance Committee
25 for the extract. 14:24
26 246 Q. I see?
27 A. I don't know if they were discussed at the Risk
28 Management Committee that sat below that.
29 247 Q. I see. So is it correct to say then that they were on

1 the Corporate Risk Register, but they didn't appear on
2 the extracts from the Corporate Risk Register that was
3 considered by the Assurance Committee?
4 A. So again I think this questions better to Clare who
5 chaired that meeting. There were definitely on the 14:25
6 Directorate risks, they didn't appear on the extract of
7 the corporate. But I can't and I don't want to give or
8 say anything that may or may not be true, I am not the
9 expert. And, you know, if I had still been, you know,
10 I did consider contacting Clare but she's also retired 14:25
11 so I can't answer that fully.
12 DR. MAXWELL: The Trust will have the Corporate Risk
13 Register for that time.
14 A. I would suggest that that is where you would get that
15 definitively. 14:25
16 248 Q. MR. DORAN: As I flagged up earlier, the Inquiry team
17 is conducting an exercise in compiling the various
18 risks at various levels so I am not going to pursue
19 that now. But I do, however, want to talk about the
20 risk that was recorded on the Principal Risk Register 14:25
21 in January 2019. This was obviously after the CCTV
22 revelations and you say at paragraph 159, that's page
23 49:
24
25 "In January 2019 a new risk was added to the Principal 14:26
26 Risk Register: SQ44 ongoing risk of harm to vulnerable
27 patients in Muckamore Abbey Hospital especially in
28 regard to historical incidents. The actions required
29 to address the risk were detailed:

1 (A) review of the following policies: Seclusion,
2 special observation, personal alarms, admission and
3 discharge by March 2019.
4 (B) To find better way of presenting and analysing data
5 by February 2019. 14:26
6 (C) staff training and reflective practice ongoing.
7 (D) implementation of day care review by January 2019.
8 (E) set up live governance forum by January 2019.
9 (F) work with other Trusts re discharge of patients
10 January 2019. 14:27
11 (G) work with independent providers and statutory
12 sector to map needs of delayed discharges January 2019.
13 (H) and ongoing reduce bed numbers in hospital
14 ongoing.
15 (I) develop purpose and function of March 2019." 14:27
16
17 And then at paragraph 160 you say:
18
19 "This risk has remained on the Principal Risk Register
20 ever since as we manage the hospital site to closure. 14:27
21 At the time of writing despite best efforts the
22 hospital still has 23 in-patients."
23
24 Now, presumably that was included on the Principal Risk
25 Register directly as a result of the CCTV revelations? 14:27
26 A. Absolutely correct.
27 249 Q. Those revelations emerged in Autumn 2017 and were
28 ultimately serious enough to give rise to this public
29 Inquiry, arguably one of the most serious issues to

1 arise in the health and social care system ever in this
2 jurisdiction?
3 A. Yes.
4 250 Q. My question is then how come it was not escalated to
5 the Principal Risk Register for over a year? 14:28
6 A. I think this is because it was about the ongoing risk
7 of harm to patients that remained in Muckamore as a
8 consequence of what was emerging. And if my
9 recollection is correct, the increasing challenges of
10 staffing the hospital, and if you recall in December 14:28
11 2018, because of the increasing suspensions and staff
12 leaving or going off with ill-health, we had to do a
13 contingency plan to close the PICU Ward just on
14 Christmas eve. So my understanding is this came out
15 because of a contingency issue that caused a ward 14:29
16 closure precipitously and our struggle to make sure the
17 site was viable, safe and sustainable. Nobody would
18 close a PICU Ward lightly and we did it in conjunction
19 with RQIA, the Department of Health and the Board. And
20 so, you're going to ask me why didn't you think of 14:29
21 doing this earlier.
22 251 Q. What I have asked is why didn't the matter merit
23 inclusion on the Principal Risk Register at an earlier
24 stage?
25 A. And, again, I would suggest that I'm perhaps not the 14:29
26 best Director to have asked that to. I'm sure it was
27 considered by the Director and, you know, it's easy to
28 sit back in hindsight and look at this but I do think
29 in 2017, whilst there were incidences of abuse seen,

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1 the extent and the extent of the precautionary
2 suspensions and the impact of that on staff and the
3 morale was difficult to judge. That's not to say that
4 it shouldn't have been on earlier.
5 DR. MAXWELL: But we're back to acting after the event 14:30
6 and, as I understand it, you were quite involved in the
7 response to, you chaired some of the groups looking at
8 the response to the CCTV?
9 A. So I took on as the assurance in February '19.
10 DR. MAXWELL: Not before then? 14:30
11 A. I did in '17 go to two meetings.
12 DR. MAXWELL: Yes, that's what I thought.
13 A. But then I stood back from that because the IHRD report
14 came out in January '18 and of course there was the
15 Muckamore, not the Muckamore, there was neurology and 14:31
16 managing Dr. Watt and the recall of patients. So I did
17 not remain on the Directorate Oversight Group in 2018.
18 I came back in and the Assurance Committee of January
19 '19 will show you that.
20 DR. MAXWELL: I appreciate you were busy but you did 14:31
21 say in answer to one of Mr. Doran's questions earlier
22 that the three professional Executive Directors, Social
23 Work, Medicine and Nursing were responsible for the
24 oversight of safety, so would you agree that three of
25 you had as much responsibility as the Service Director 14:31
26 to make sure that the safety of the patients was being
27 addressed?
28 A. I would say that we all collectively, and Trust Board
29 collectively, had a responsibility. But I was not

1 close to that detail and I'm not sure even the Director
2 of Social Work was close to that detail until 2019. In
3 2018, what happened in 2018 after April, no, in April
4 2019 Marie Heaney was pulled off hers to give full
5 focus. So up until then it was the Director of HR, the 14:32
6 Director of Nursing and the director of the service
7 that were the Core Participants on the Director's
8 Oversight.
9 DR. MAXWELL: Given you have told us that the three
10 professional Directors, Nursing, Medicine and Social 14:32
11 Work were responsible for safety and the Director of
12 Nursing was quite heavily involved, did the three
13 professional directors ever meet to discuss
14 professional issues around safety?
15 A. Did we meet separately to that? 14:33
16 DR. MAXWELL: Yes, to discuss as the heads of
17 profession are there safety issues for our patients?
18 A. We didn't meet separately to Executive Team or Trust
19 Board but we will have met in those forums.
20 DR. MAXWELL: So you would have known from the Director 14:33
21 of Nursing, who was quite heavily involved, that there
22 were a lot of issues in 2018?
23 A. We knew there were issues but we understood they were
24 being managed safely and it wasn't until there was a
25 number of further suspensions and annual leave over the 14:33
26 Christmas period that it became precipitous. And I
27 certainly engaged in that regional call about the
28 contingency plan and the decision. And then I was
29 asked by the Chairman and the Chief Exec to go in and

1 provide an extra layer of assurance.
2 252 Q. MR. DORAN: Thank you. I hope you understand where my
3 question about timing was coming from because when one
4 thinks, as a lay person, about a Risk Register,
5 particularly a Principal Risk Register, one would 14:34
6 assume that an issue so serious as that to emerge from
7 the hospital in September 2017 would find itself almost
8 immediately on a Risk Register so to speak at Board
9 level within the Trust. And what I'm trying to get at,
10 I am depersonalising this issue, whatever your role may 14:34
11 have been, how does it take that long for such a
12 serious issue to be escalated to the Principal Risk
13 Register at Board level within the Trust?
14 A. This Principal Risk Register was again about the
15 overall corporate risks and could we deliver the 14:34
16 corporate plan. In January '19 it became is the
17 hospital going to be viable. You could argue should we
18 have anticipated and prepared for that further and
19 should it have been on the corporate risk maybe before
20 then. But, the sustainability of the hospital did not 14:35
21 emerge until that December '18.
22 253 Q. So it was the sustainability issue specifically that
23 led to inclusion on the Principal Risk Register.
24 Before I move on from this theme of what material finds
25 its way to the Board. I want to mention Serious 14:35
26 Adverse Incidents?
27 A. Yep.
28 254 Q. At paragraph 163 of the statement you say that before
29 2018 SAIs were not routinely escalated to the Board.

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1 They were only escalated if the Director escalated
2 them. And after 2018, a monthly summary of SAIs was
3 given to the Board. And you give Iveagh I think as the
4 only example of that occurring.
5 A. Before? 14:36
6 255 Q. Before, yes. Sorry, before the change. In looking
7 back can you understand from a governance perspective
8 why SAIs were not routinely reported to the Board, what
9 was the rationale for that?
10 A. So certainly when I joined Trust Board in 2014, we had 14:36
11 about 100 and -- over 150 SAIs per year, so that is
12 just over three a week, I think there is 1,500 from
13 when I joined in August '14 until this statement. So
14 there was no routine reporting, otherwise it would have
15 been much more noting. But we did, having visited 14:37
16 Wigan, Brighton and Lee Trust back in early '17, we
17 then started to do a weekly live governance summary and
18 that went to Executive Team, I think it was March,
19 April '17 and that had issues like high risk
20 complaints, SAIs, Ombudsman's critical incidents. And 14:37
21 thereafter, after a confidential Trust Board in October
22 I think did I say, October '18 here, yes, not only did
23 the non-execs and the whole of Trust Board get the
24 weekly live governance report which had a summary of
25 each SAI and each critical incident, they then also got 14:37
26 the opportunity with the list of SAIs every Trust
27 Board. So they had an opportunity to go back and
28 challenge us or scrutinise us again. Obviously every
29 week they could put in an e-mail, can you just give me

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1 a ring about this.
2 256 Q. So it's information that would now be escalated through
3 the governance reports?
4 A. Since 2023 in the new changes on Trust Board, we have a
5 different Trust Board now. That report no longer comes 14:38
6 to Trust Board. But it did from 2018 to 2023. Instead
7 non-exec directors get a very short summary of the live
8 governance report every week, but they do not get the
9 list. They have been doing some work around the
10 workings of Trust Board, doing some workshops and it is 14:38
11 not one of the standing papers. Although as I
12 highlight, it was one of the recommendations from
13 O'Hara, Mr. Justice O'Hara's Inquiry about deaths, and
14 if you put every SAI up then it will automatically
15 capture. 14:38
16 257 Q. Do you think going back that it was a gap in the
17 governance arrangements that such reports weren't
18 routinely reported to a higher level?
19 A. Given we introduced this, we thought governance would
20 strengthen by having that. It is not just would the 14:39
21 scrutiny happen, but it was the opportunity to
22 scrutinise that I think is equally important, so the
23 live governance report and then the list of SAIs coming
24 to every Trust Board allow the opportunity for
25 scrutiny, for challenge. 14:39
26 DR. MAXWELL: You said that's now stopped?
27 A. Yes.
28 DR. MAXWELL: Do you know why?
29 A. Because it's not part of the standing orders that needs

1 to come.
2 DR. MAXWELL: Who sets the standing orders?
3 A. That's in the How the Board Runs and obviously the
4 Chairman and the non-execs and they are having a series
5 of workshops as to what needs to come and what doesn't. 14:39
6 DR. MAXWELL: So the Board sets its own standing
7 orders, it's an internal decision to stop that going to
8 the Board?
9 A. There is standing orders that must come and then, like
10 every year I would have had a professional governance 14:40
11 report, a bit like the delegated stat functions, not at
12 all as detailed, didn't have to go to the HSCB or the
13 Department of Health but it is good governance do that.
14 So there are some things that the Board must do and
15 there are other things that are in Board -- 14:40
16 DR. MAXWELL: But it is an internal decision that from
17 2023 it no longer -- it went from '17 to 2023 and then
18 a decision was made within the Belfast Trust that they
19 didn't feel they needed it and they weren't required to
20 have it by HSCB, so it stopped going. Is that correct? 14:40
21 A. Correct, that's correct.
22 258 Q. MR. DORAN: I wanted to talk about these various
23 reporting mechanisms in the round, one has the
24 Delegated Statutory Functions Reports, the Risk
25 Register system, the system of SAIs and of course there 14:41
26 is the Early Alert System?
27 A. Yes.
28 259 Q. I wonder was there any process within the Trust for
29 assessing this kind of material in the round, let's say

1 for example, an individual facility was featuring
2 regularly in the DSF reports, there was also evidence
3 of an increase in safeguarding concerns within the
4 facility. Was there any mechanism for ensuring that
5 all of that information was considered in the round 14:41
6 and, if necessary, flags picked up?
7 A. So I think that was, that triangulation as an
8 integrated governance report came later. And certainly
9 you can see from some of our assurance committees how
10 we went about piloting integrated governance reports 14:41
11 and how we then piloted triangulation of data at a
12 divisional level. But before 2017 it probably would
13 not have been at all in that way and probably was more
14 siloed.
15 260 Q. I want to ask about the response to the revelations in 14:42
16 2017. You obviously were the Medical Director at the
17 time and you became Chief Executive in 2020 and we have
18 explored this with the Chief Executive at the time,
19 Mr. Dillon. You talk in some detail about the various
20 initiatives that were taken after the events of 2017 in 14:42
21 paragraphs 110 to 120 of your statement. I wanted to
22 ask you about a number of things within those
23 paragraphs, that's back at page 34, please. In
24 paragraph 114 you mention the RQIA Improvement Notices?
25 A. Mhm-mhm. 14:43
26 261 Q. And you talk about how the Chief Executive advised the
27 Permanent Secretary that action plans had been
28 developed in relation to those. I apologise, you say
29 earlier in the paragraph:

1
2 "The fact these Improvement Notices were considered
3 necessary demonstrates the extent of the difficulty
4 continuing to be experienced at MAH in that from
5 November 2017 there had been an ongoing focus on MAH 14:43
6 but, notwithstanding this, the problems were
7 persisting."
8
9 But is the fact that those problems were persisting not
10 somewhat to the discredit of the Trust because 14:43
11 obviously one had, this was August 2019, one had Ennis
12 in 2012, the CCTV revelations in 2017, well documented
13 staffing issues in the hospital through the years. I
14 mean, looking back as Medical Director and subsequently
15 Chief Executive, what would you say to the suggestion 14:44
16 that really those issues that featured in the
17 Improvement Notices ought to have been resolved at an
18 earlier stage?
19 A. So, I would say that what happened in Muckamore and
20 what came to light was huge, absolutely huge, and very 14:44
21 difficult to manage and it was multi-faceted. So we
22 had a historic safeguarding incidence of abuse, we had
23 linking with the PSNI, we had difficulties in sharing
24 the information because the PSNI investigations had to
25 take precedence, that's one element. We had to manage 14:45
26 the hospital safely on a day-to-day basis. We had to
27 develop the community infrastructure that we know
28 struggled to be developed from early 2000s because the
29 solution wasn't in the model of care that was in

1 Muckamore, it was actually in a different model of care
2 altogether. And then we had our own disciplinary. And
3 whilst the Trust Board and the Exec Team took a number
4 of measures and if I can, back in April 19, and you
5 will have it in your document folders, the RQIA were 14:45
6 considering issuing a lot more Improvement Notices and
7 I'm sure you have those evidences, not just
8 safeguarding and staffing and the financial audits, but
9 they talked about physical health checks. They talked
10 about seclusion. They talked about live governance. 14:46
11 And so, you know, even at that stage where we freed up
12 a director from all her other portfolios apart from
13 focusing on learning disability, and to pay tribute to
14 Marie Heaney who worked incredibly hard at trying to do
15 this, but she was pulled backwards and forwards. You 14:46
16 know, those Improvement Notices, whilst they weren't --
17 I think it was six but it might have been seven that
18 were suggested in April, were reduced to three, it
19 gives you a level of complexity and work that arises
20 out of an issue like this where, in fact, what came to 14:46
21 light nobody wanted to work, staff went off sick, we
22 couldn't get the wrap around support from other Trusts.
23 We had experts in but we were still struggling. I mean
24 it's one of the most difficult things, you know, that
25 we have ever had to manage. Covid of course being an 14:47
26 absolute other one. But Muckamore, the size and scale
27 and the implications and the impact on that, on every
28 aspect, was enormous.
29 262 Q. Well on the staffing issues specifically you say at

1 paragraph 115:
2
3 "Staffing at MAH was becoming increasingly precarious
4 and there was a real risk that individuals would become
5 increasingly torn between ensuring adequate staffing 14:47
6 and acting appropriately when a historic complaint came
7 to light."
8
9 I wonder can you explain what you mean by that?
10 A. I can. I think it's very difficult, no matter whenever 14:48
11 you're charged with ensuring that the safety and the
12 staffing of the hospital is safe and then having to
13 make decisions about historic CCTV, about does this
14 individual need precautionary suspended, because one
15 directly impacts on the other. And over September and 14:48
16 August, you know, I am aware that individuals were
17 really coming very close to the sharp end and it was a
18 very difficult position and nobody should have been in
19 that and it would have been safer to put clear blue
20 water into those that were managing the hospital and 14:48
21 those that were managing the historic CCTV viewing.
22 And the police were very clear that, whilst these were
23 historic, they were abuse, they were seen as current
24 abuse instances and therefore adult protection and
25 adult safeguarding kicked in. It would have been in 14:49
26 defensible to leave someone who is visibly seen as
27 abusing someone on a CCTV camera to remain in work.
28 263 Q. Would you accept there was a real risk that the
29 response in 2017 with the large scale suspension of

1 staff could potentially have been to the detriment of
2 patients at the hospital?
3 A. So my understanding is in 2017 the numbers that were
4 precautionary suspended were actually much smaller and
5 it became greater. 14:49
6 264 Q. As time went on?
7 A. As time went on and not only that, but staff then left,
8 they left. Staff didn't want to come and work and a
9 number of staff went off sick. So I don't think it's
10 just the precautionary suspensions, I think there were 14:49
11 a number of other factors. I mean staff will have no
12 doubt told you that they were embarrassed to say they
13 worked in Muckamore. They would have been stopped in
14 the supermarkets, they would have been challenged. We
15 needed to put extra protection, extra security on the 14:50
16 site. So this, this was not easy to manage.
17 265 Q. Yes?
18 A. And it was out of that, and out of those that I decided
19 to decouple the various workstreams so that each
20 workstream could get appropriate focus. 14:50
21 266 Q. You deal with that in some detail at paragraph 118 of
22 the statement I think. Did you regard that
23 reorganisation as effective?
24 A. So I could answer from my own personal opinion but I
25 also think it would be important that we look at the 14:50
26 evidence of effective outcomes and the fact is that in
27 December 19 RQIA released and removed most of those
28 Improvement Notices. They did await for the formal
29 financial independent audit, et cetera.

1 267 Q. That was December 2019?
2 A. 2019. Within a couple of months of October '19 when
3 the changes actually occurred.
4 268 Q. But the core problem of staff shortages at the hospital
5 persisted, it's fair to say? 14:51
6 A. Indeed, if you look at the paper that was presented, I
7 think, to the Trust Board in November '19, and I don't
8 have it in my bundle I think Mrs Owens had it in her
9 bundle, you will see a table around the staffing and
10 the, you know, what was deemed and then what was 14:51
11 available and all the absences, et cetera, and then the
12 24% headroom which is something that is always built-in
13 to nurse staffing. That demonstrates that even in that
14 position on that metric the staffing requirements were
15 just, they were just being met. 14:52
16 DR. MAXWELL: With a large agency compliment?
17 A. Yes, with a large, absolutely.
18 DR. MAXWELL: Which brings its own challenges?
19 A. It does bring it's own challenges, absolutely. But,
20 let's be clear, when we had our stable workforce, when 14:52
21 they were skilled intellectual disability nurses and
22 support staff, that's when the abuse happened and there
23 was no way that we could leave those members of staff
24 still caring for vulnerable adults, because one of the
25 highest risks for abuse happening again is when someone 14:52
26 has already abused someone. There is no place for that
27 in the adult safeguarding protocols within Northern
28 Ireland. So I accept that these were stable agency, we
29 recruited them for six months a year. They went

1 through an accreditation programme so that they then
2 could become in charge of a ward and that was one of
3 the key changes in September and October 2019 that
4 actually released some of the pressure. Some of the
5 pressure on ward staffing is when the agency nurses 14:53
6 could not be left in charge of a ward. But with the
7 work that Francis Rice and Mrs. Owens and the team did,
8 we could do that. And then a further development was
9 actually not using the Telford Model, and I am not a
10 nurse expert, okay, so please don't -- but looking at 14:53
11 the number of enhanced observations and what the needs
12 of the patient was on that day and in that week, we
13 could then manage. And interestingly when East London
14 came to visit in June '19, they did highlight that a
15 large resource for the nursing staff was actually tied 14:53
16 up in the enhanced observations and that is certainly
17 in my bundle. The staff on the ward themselves said
18 look, if we could release this staff, and they did say
19 we need to be reviewing it more regularly, then
20 actually would lead to better staffing, more positive 14:54
21 behavioural support time, therapeutic interventions,
22 taking patients off the ward, reducing boredom and
23 indeed reducing restrictive practices which is what
24 enhanced observations were seen by East London as.
25 269 Q. Even at a slightly later stage you then convened the 14:54
26 risk summit, isn't that right, to address specifically
27 the staffing issue?
28 A. This was a staffing issue that had been raised by some
29 of the families in Muckamore. You could say is this

1 part of the learning, so this is a risk factor that was
2 raised and I wanted to make sure that I and my
3 colleagues in the Belfast Trust had done absolutely
4 everything. And that wasn't just a sense check within
5 the organisation it was a sense check of the system. 14:55
6 270 Q. Well, you've provided the minutes of the summit meeting
7 at page 333 I think, if we can go to that. As you have
8 said, the summit was convened as a result of concerns
9 reported by family members, isn't that right?
10 A. Mhm-mhm. 14:55
11 271 Q. If we go to page 333, please. And I'm not going to go
12 through the detail but, it's obviously titled
13 "Stakeholder summit 29 April 2021."
14 A. Mhm-mhm.
15 272 Q. It's a meeting of the various stakeholders, one can see 14:55
16 the various Trusts, RQIA, the Department and HSCB were
17 all represented. As I say, I won't go through the
18 details and the various presentations that were given.
19 Just a very straightforward question, were any families
20 invited to attend that event? 14:56
21 A. No, they weren't. The families did attend the
22 Departmental Assurance Group.
23 273 Q. Yes?
24 A. They were a standing member on that, but they were not
25 included in the risk summit. I have held a number of 14:56
26 risk summits with the Chief Exec when I was Medical
27 Director. It's something that we brought in, it was
28 deemed to be good practice. It came in actually with
29 the enhanced monitoring in anaesthetics, so we would

1 basically get everybody providing education. We've
2 never had a service user or carer there. So this was
3 no different. Would it have been better?
4 274 Q. Would it have been better to invite families?
5 A. At this remove I, you know, I can't say definitely it 14:56
6 would or it wouldn't, it was just something that we
7 hadn't done. You know, I have no problem involving
8 service users and carers and in fact you'll see that in
9 my Safety Quality Steering Group where we put service
10 users and carers on. But we didn't do that at the time 14:57
11 and that's probably because if you look at the guidance
12 for safety summits, it's all the key organisations
13 involved need to meet and look at a range of data. So
14 it wasn't in the good -- it wasn't in the guidance but
15 I can get the guidance for you, it would be quite old 14:57
16 now.
17 275 Q. Obviously the families themselves are key stakeholders,
18 if I can put it like that?
19 A. I would be confident that this safety summit would have
20 been discussed at NDAG, they were there. 14:57
21 276 Q. Yes, I wanted to ask you about a specific report that
22 you made to the Executive Team meeting in June 2019,
23 that's exhibited to the statement of Brenda Creaney.
24 The reference is MAHI, STM-291, page 100. You will see
25 that's an Executive Team meeting on Wednesday 26th June 14:58
26 2019 at 3.30. And can we scroll down to page 102,
27 please.
28 A. Just to be clear before you ask me another question,
29 just to say that QI presentation was about the cultural

1 survey. If you want to just read those minutes for a
2 wider issue about bringing in our culture, there it is,
3 I knew I had seen it recently in some of the papers.
4 277 Q. Sorry which one is that you are referring to, Dr. Jack?
5 A. It's that page, you see item No.4, I can't really read 14:58
6 it very well but this is about our organisational
7 culture.
8 278 Q. That's the presentation by Joan Peden and Brendan
9 McConaghy, it is the one right before that actually
10 that I wanted to focus in on and that's paragraph 3.5 14:59
11 where we have a reference to the Annual Quality Reports
12 18/19, SAIs per Directorate and learning. And this is
13 you obviously reporting to the meeting. Now admittedly
14 this is simply a minute of the meeting so it's
15 obviously not representative of the full report 14:59
16 necessarily. But what the text says is:
17
18 "C Jack reported that B Godfrey had written to the
19 Trust requesting standard wording."
20 14:59
21 I'm sorry, I am afraid that is not, it's not the
22 extract that I'm looking for, it's page 102. Scroll
23 down, please. That's it. And keep scrolling down. I
24 may have got the page wrong. Terribly sorry about
25 this. 15:00
26 A. Is it about East London?
27 279 Q. I can't find the text in the report on screen but it
28 was a report to the Executive Team meeting in June 2019
29 and the report read:

1
2 "C Jack reported that the CCTV showed evidence of good
3 practice and the audit reports were 100%. The vast
4 majority had activity plans and will be reported on in
5 the future." 15:00
6
7 A. Mhm-mhm, it is this, if you go up.
8 280 Q. Could we scroll up again please?
9 A. There it is, the SitRep.
10 281 Q. Yes, thank you for spotting it. So it's at 5.1 it is 15:01
11 the Muckamore Abbey Hospital SitRep report and there is
12 a reference to the SitRep report being reviewed.
13
14 "There were positive messages and all restrictive
15 practices were well within the working practice. The 15:01
16 major challenge currently was securing discharge into
17 the community. There were three discharges this week.
18 C Jack reported that the CCTV showed evidence of good
19 practice and the audit results were 100%. The vast
20 majority had activity plans and will be reported on in 15:01
21 the future. More work will be done within the nursing
22 team regarding morale. The Trust will have access to
23 the CCTV following the PSNI interviews, this will be
24 reported at the Trust Board workshop."
25 15:02
26 I just wonder what point were you making when you say
27 the CCTV showed evidence of good practice. You will
28 understand perhaps this could be capable of being
29 misunderstood?

1 A. Okay, so basically when the CCTV policy, when the
2 events of harm came to light and abuse on CCTV, the
3 policy said it couldn't be used for routine screening
4 and monitoring which caused some consternation.
5 Obviously we put in contemporaneous viewing in late '17 15:02
6 early '18 and then every week, and we did increase it,
7 every week every ward was randomly sampled. And
8 whenever I took up as assurance in February or March,
9 we wanted to share what we found on the CCTV. So what
10 we did is we got that viewed and we took some comments 15:02
11 and we then shared that with the staff because we
12 couldn't actually share the CCTV because the policy
13 didn't have it in it. So what I was reporting there
14 was that the CCTV contemporaneous sampling for that
15 week demonstrated areas of good practice. I'm not sure 15:03
16 the audit results are 100% related to that or did it
17 relate to psychotropic medication, because there was an
18 audit going on, or did it relate to the physical health
19 checks. But the CCTV bit, I can say that it was
20 related to the contemporaneous sampling and, you know, 15:03
21 we would get a snapshot and we can share with you those
22 that would say staff appear to be interacting well,
23 helping individuals, you know, with activities, playing
24 cards, you know, the sort of things would you
25 automatically expect that should happen. 15:03
26 282 Q. So you were talking about the viewing of
27 contemporaneous CCTV in or around June 2019, you
28 weren't talking about the historic viewing of CCTV?
29 A. No, not at all, not at all.

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1 283 Q. Thank you, thank you for clarifying that. I want to
2 ask you about another specific issue now that arose in
3 the evidence of Moira Mannion on 23rd September. She
4 said in her evidence that she had alerted you in or
5 around winter 2018 to the fact that the Collective 15:04
6 Leadership Team at the hospital was not working. Now
7 you were Chief Executive, sorry you were Medical
8 Director at that time?
9 A. And Deputy Chief Executive.
10 284 Q. And Deputy Chief Executive. In fact Dr. Maxwell asked 15:04
11 her to clarify. I will paraphrase slightly:
12
13 "But you are clear that Cathy Jack was aware that these
14 dysfunctional relationships was quite intense and they
15 were impeding a proper response to the allegations?" 15:04
16
17 And Moira Mannion said yes. I don't want to dwell on
18 this but I want to make sure your response is on
19 record, because the Inquiry received correspondence
20 from DLS on 8th October on behalf of the Trust in 15:05
21 relation to this matter. I am not going to go into the
22 detail but is it fair to say that the gist is you do
23 not recollect Moira Mannion notifying you of this
24 matter?
25 A. It was one of the points I wanted to clarify at the end 15:05
26 counsel, thank you for raising it.
27 285 Q. Please do that now?
28 A. Moira Mannion is a person that I have a huge amount of
29 respect and regard for but I do believe with the

1 passage of time her recollection may not be fully
2 accurate. She did state that she believed it was
3 Autumn 2018 that she reported there was a dysfunctional
4 team in the division of Learning Disability. My
5 understanding is that Moira went in in August, just 15:06
6 after the Divisional Nurse left the team, and the team
7 then was Colin Milliken, H425 and Mairead Mitchell and
8 I think Brenda O'Rawe as the service user. Moira was
9 in as the Deputy Director of Nursing to provide
10 additional assurance and there was no Divisional Nurse 15:06
11 at that time. I was not closely involved in that and
12 we've already discussed that here today because in my
13 own portfolio I not only had the Medical Director, I
14 also had IHRD and all the concerns around those medical
15 staff that came out of Justice O'Hara and the Neurology 15:06
16 recall. And if you remember we launched that recall in
17 May 2018 and that was a significant piece of work that
18 myself and Mrs Owens were doing in the Autumn of 2018,
19 so I was not closely involved in Muckamore. That
20 changed in '19. 15:07
21 CHAIRPERSON: Can we just stop the feed for one second,
22 a name was used who has actually been ciphered. Can we
23 change that in the transcript.
24 MR. DORAN: I wonder perhaps if we ensure I'm not sure
25 how much of the feed is cut, if we can perhaps ensure 15:07
26 that the last couple of minutes aren't played.
27 CHAIRPERSON: Three minutes.
28 MR. DORAN: It's three minutes.
29 CHAIRPERSON: It's a good chunk.

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1 286 Q. MR. DORAN: Thank you. We are ready to go. So you
2 were explaining what you were involved in, in or around
3 Autumn 2018 and?
4 A. So I have no recollection. I have also checked my
5 notebooks, I have notebooks from 2014 up until 15:08
6 September 2024, and my emails. I do have on 24th
7 December 2018 the concerns regarding staffing in PICU
8 and joining the regional call. Then in March '19, at
9 the end of March '19 I do have in my book where Moira
10 Mannion raised the issue about staffing within 15:08
11 Muckamore shortly after an RQIA visit and my notes
12 recall that I immediately flagged that to the Chief
13 Executive and to the CMO and the Chief Executive was
14 going to discuss that with the Permanent Secretary and
15 we closed Muckamore over that weekend because we were 15:09
16 inducting some staff that hadn't got into post. And
17 then over the summer when I was in the Assurance
18 Framework as an extra pair of scrutiny and eyesight, we
19 continued to have, you know, staffing issues. But on
20 the 4th September 2019 Moira Mannion came to me again 15:09
21 and it was about the thresholds about decision making
22 because at that time she was then in the decision
23 making around precautionary suspension and working
24 closely with the PSNI and RQIA. On the back of that I
25 held a multiagency meeting on 6th September with the 15:09
26 PSNI and RQIA and we set up a new process where, whilst
27 the Trust made the decision, it was verified then and
28 assured by RQIA and the PSNI and we can share those
29 minutes with you. That was a multiagency meeting. And

1 given Moira's concerns, I then met with the HR Director
2 and the individual directors and Exec Team about how we
3 managed this portfolio going forward. And that was a
4 decision, because Mr. Dillon was off on annual in
5 September, that I made to decouple and to really make 15:10
6 Muckamore into four different streams, manage the
7 hospital safely day-to-day, build up the community,
8 look at the safeguarding and then manage the
9 disciplinary.
10 287 Q. But is the basic point that you can't recollect Moira 15:10
11 Mannion alerting you to that?
12 A. Not in 2018.
13 288 Q. 2018?
14 A. But definitely she did raise concerns with me in 2019
15 and my books and some emails, I think she emails me 15:11
16 back in April '19 thanking me for all my support, you
17 will see that. So I don't know, but the passage of
18 time, it may be it's not entirely accurate.
19 289 Q. I wanted to give you the opportunity --
20 A. I need to tell you I have the highest regard for Moira 15:11
21 Mannion and anything she did tell me, I would have
22 acted on.
23 290 Q. Now, I wanted to ask you about some resettlement issues
24 and the closure of the hospital. Specifically I wanted
25 to ask you about something you raise at paragraph 134 15:11
26 to 135 of the statement which is at page 41. This
27 relates to costings and individual patients. You say:
28
29 "Cost is not seen by the Belfast Trust or HSCB or SPPG

1 as an impediment to resettling patients from MAH per
2 se. However, the Belfast Trust is required, as with
3 all its services, to carry out a financial evaluation
4 of any bids submitted by potential providers of care to
5 ensure these provide value for money for the tax 15:12
6 player. In terms of community packages, prospective
7 suppliers will provide staffing and cost requirements
8 based on the care needs of the individual as advised by
9 appropriate clinical staff in the Trust. Belfast Trust
10 staff will then assess the financial requirements 15:12
11 identified by providers, including the grade of staff
12 and rates of pay involved, on the assumption that these
13 should be more or less in line with NHS rates of pay
14 for comparable work along with any other clinical or
15 facilities costs." 15:12
16
17 Then at paragraph 135 you say:
18
19 "There is currently a shortage of providers willing to
20 offer appropriate community packages for learning 15:13
21 disability people with complex needs. The Belfast
22 Trust cannot be definitive about the reasons for this
23 but a lack of suitable facilities and long lead in
24 times to build or refurbish facilities and difficulties
25 in recruiting an appropriate workforce are certainly 15:13
26 factors."
27
28 Firstly as regards paragraph 134, and it's normally,
29 and I suppose at the risk of generalising, it's

1 normally going to cost less to keep patients with
2 complex needs in a hospital than to put in place the
3 individually tailored arrangements that one requires in
4 a community setting, as a general proposition?
5 A. If you just consider the financial costs. 15:13
6 291 Q. Yes. But how does one assess, and I appreciate it's a
7 difficult question, how does one assess the benefit to
8 the patient against the other cost pressures on the
9 Trust? I mean you say that cost isn't seen as an
10 impediment by itself, but presumably the cost 15:14
11 implications can, in individual cases, militate against
12 a particular package being adopted for a patient?
13 A. So can I, just before I answer that, be clear that you
14 will note in paragraph 124 how I highlight I have had
15 the assistance of Maureen Edwards, who was the then 15:14
16 Director of Finance and is now the Interim Chief Exec,
17 in preparing these paragraphs. So I am answering to
18 the best of my knowledge but I am not the Executive
19 Director of Finance.
20 292 Q. Yes, that's noted? 15:14
21 A. So, I mean I think overall, whilst cost is not seen as
22 an impediment, it is certainly a delay because of the
23 complex process that we have to get, go through. And
24 the Commissioners, the Department gets a block grant,
25 the Commissioners get a section of that, they then 15:15
26 divide it up to the different Trusts. Nobody would not
27 be resettled eventually on the basis of need, and I
28 think that's what it is saying but we have to put the
29 bid in, they look at it, they scrutinise it. But

1 obviously if the commissioners don't have the money,
2 and you will have seen that in Marie Heaney's evidence
3 where she talks about the savings plan and the Board
4 saying we only have money for this, so I just want to
5 be clear, that that is what I believe it is saying, 15:15
6 that's why it says per se.
7 293 Q. Yes?
8 A. But these are expensive care packages because these
9 individuals need extraordinary support to live ordinary
10 lives in the community and that's only as it should be. 15:15
11 You know, you can think about right across domiciliary
12 care in older people, et cetera, et cetera, exactly the
13 same, we are not means tested in Northern Ireland for
14 our domiciliary care of our older people.
15 CHAIRPERSON: You say they will all be resettled 15:16
16 eventually, but the reality is some of these patients
17 have been waiting a very, very long time.
18 A. Some of them have been waiting decades.
19 CHAIRPERSON: Yes and part of that, presumably, is
20 because the structure that is needed in the community 15:16
21 is extremely expensive and nobody wants to bear that
22 expense?
23 A. So again I think you need to discuss that better placed
24 to the Department or the Commissioners, but for us, we
25 were very clear we wanted to resettle all those that no 15:16
26 longer needed or required or had the benefit of a
27 hospital. And can I just say, I'm not an expert in
28 intellectual disability at all, but I do and have since
29 this struggled to think about the role of an

1 intellectual, of a purpose built large intellectual
2 disability hospital on its own. If a patient, if a
3 person with a learning disability develops an
4 appendicitis they come into an acute hospital. If they
5 develop an acute mental health illness would they not 15:17
6 be better served coming into an acute mental health
7 service with a wraparound support from the learning
8 disability team? So, is the purpose of a large
9 learning disability hospital, and this goes way back,
10 is it to manage dysregulated behaviour, because if it 15:17
11 is, then it's completely the wrong model because when
12 an individual with learning disability or an older
13 person with acute confusion who happens to have a
14 background of dementia, the best chance of recovery,
15 the quickest chance of recovery is for the Crisis 15:18
16 Response Team to go into their environment and support
17 and protect them there and then. And you can see in
18 East London, and there is emails where I write to Ian
19 Hall and he summarises what I say, I am not an advocate
20 nor have I ever been for a large learning disability 15:18
21 hospital that sits alone and hasn't got one or two
22 mental health assessment beds attached to a pod in a
23 mental health, or has the learning disability team that
24 that person is familiar with come into hospital with
25 them. And that's not Belfast Trust because this 15:18
26 service, this hospital was commissioned long before my
27 time and I think it's something that actually the
28 people in society in Northern Ireland need to ask
29 themselves why, why did we not close quicker after Ely

1 when the whole of the UK were actually, you know,
2 taking away these large institutions, the Republic of
3 Ireland were also taking away the large institutions
4 and yet Northern Ireland lagged behind.
5 DR. MAXWELL: Yet you made a very important point there 15:19
6 about the best thing to do is to have a wraparound
7 crisis intervention team at home, my understanding is
8 Belfast Trust does not have a learning disability
9 crisis intervention team to support people in the
10 community? 15:19
11 A. We have tried to develop that, and you will see in some
12 of the statutory function reports it talks about that
13 and it talks about behavioural support, but it was 9 to
14 5 at points in time is my understanding from reading
15 those reports. We've also talked about Blue Light and 15:19
16 Panel admissions, but we have a lack, you know. People
17 do not necessarily want to work in Belfast.
18 DR. MAXWELL: But Belfast Trust Board could have
19 discussed, as you so passionately demonstrated, a
20 different model and could have made creating a 24/7 15:20
21 crisis response team a high priority, and yet there
22 doesn't seem to be any evidence that the Board did
23 discuss that.
24 A. So East London did discuss that.
25 DR. MAXWELL: Yes, but your Trust Board. 15:20
26 A. The Trust Board did consider that but you've got to
27 understand the commissioning model for us. So the
28 commissioning model in Northern Ireland.
29 DR. MAXWELL: I'm talking about discussing it at Board

1 because then you can go back to the commissioners and
2 say you are not commissioning what we need. I have
3 read the Board minutes, I can't see any evidence that
4 the Board did discuss that.
5 A. I've certainly discussed it with the stakeholders and 15:20
6 time and time again and even in the risk summit, I do
7 talk about we're only treating one patient, it's the
8 wrong model.
9 DR. MAXWELL: Do you remember taking a paper to the
10 Board on that. 15:21
11 A. I didn't, it would have been the director and I think
12 it's one of the things that Colin Milliken flags that
13 he wants to do.
14 CHAIRPERSON: And can you shortly, you're saying there
15 is an issue with the commissioning model, specifically 15:21
16 in a nutshell if you can, what is it?
17 A. For me it's been very clear that we are only allowed to
18 start or stop services that the commissioners have
19 approved.
20 CHAIRPERSON: Okay but you can start that conversation. 15:21
21 A. We don't have the freedom of a foundation trust.
22 CHAIRPERSON: You have to start that conversation with
23 commissioners, yes?
24 A. Yes.
25 CHAIRPERSON: Yes, sorry Mr. Doran. I am aware that we 15:21
26 have been going quite a while. How much longer do you
27 think?
28 MR. DORAN: I would say approximately 40 minutes.
29 CHAIRPERSON: I think we ought to take a 10 minute

1 break and we will try and finish this witness. You
2 have been going a good while this afternoon and I think
3 everyone should have a break. 10 minutes and we will
4 carry on. Thank you.
5 15:22
6 THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:
7
8 294 Q. MR. DORAN: Now, before the break we were discussing
9 ways of dealing with individuals with complex and
10 serious needs? 15:34
11 A. Mhm-mhm.
12 295 Q. Whether in hospital or in the community or both. And
13 at paragraph 194 on page 59, you discuss the
14 consideration by the medical team at Muckamore of the
15 Winterbourne View scandal in England and you say there, 15:35
16 you were aware in late 2017 that the medical team in
17 MAH had previously discussed the findings of
18 Winterbourne and considered the systems in place at
19 Muckamore to protect patients. And then you exhibit
20 e-mail communications about that at page 449, and I 15:35
21 wonder if we could go to that please. Page 449.
22 Scroll down, there is an e-mail. There is an e-mail
23 from you to Colin Milliken sent on 16th November 2017,
24 and it's to Colin Milliken and others within the
25 hospital. Colin Milliken, Janet McPherson and Ken Yoe. 15:36
26
27 "Dear Colin, Janet and Ken, thank you so most sincerely
28 for meeting yesterday with Marie and myself. It is
29 clear you are all dedicated and committed to provided

high quality, safe and compassionate patient care. There continue to be challenges in delivering this including significant delayed discharges, staffing levels, both medical and nursing, increasing complexity of case mix and traditional practices including mixed child/adult service provision. It is reassuring that after the media coverage of Winterbourne that you met as a group and discussed and considered the systems in place to protect patients in Muckamore. It is also reassuring that none of you were aware of any safeguarding or inappropriate behaviour until the recent incidents on CCTV. Rest assured, Marie and myself are available to discuss any issues or concerns as they arise.

We also acknowledge the many excellent practices and ward accreditation that has occurred over the past couple of years."

And then this is what I wanted to ask you about:

"We discussed several changes that you as consultant medical staff would like to introduce and I summarise these below:

1. Redesign community in-patient interface.
2. Develop intensive support unit to align to the crisis response team delivery model in mental health.
3. Develop an autism service in LD and consider a separate in-patient facility."

1
2 Now I wanted to ask you particularly about that third
3 suggestion. Do you recall if and how that suggestion
4 was developed?
5 A. That would have been by the medical staff and the 15:37
6 experts in that field. I'm not an expert, I've never
7 claimed to be, my background is in care of the elderly.
8 But I think learning disability, at a point in time
9 autism was, is a diagnosis that becomes more and more
10 prevalent and needs a different approach and we did not 15:38
11 have an autism service.
12 296 Q. Yes, but you're unable to assist as to any developments
13 beyond the suggestion made in the e-mail?
14 A. So, well Marie Heaney and the management team
15 responsible for that service would be the ones that 15:38
16 would normally take on the service development. Not
17 everything is developed by the Medical Director. The
18 Medical Director develops education, training,
19 re-validation, research, you know, we all have our own
20 separate portfolios. Many of these directors, there'll 15:38
21 be planning and performance managers, et cetera, who
22 would write the business cases and propose those. And
23 indeed Janet Macpherson comes back to me saying "thanks
24 we will take these forward" if you notice.
25 DR. MAXWELL: Are you aware whether they did? I 15:39
26 recognise it wasn't your job to write the business case
27 or develop the service but as Medical Director and then
28 as Chief Exec, presumably you would have had sight of
29 any business case that was written?

1 A. So not necessarily every business case.
2 DR. MAXWELL: Okay.
3 A. Not necessarily, just because of the scale --
4 DR. MAXWELL: But that would be a new service, that
5 would be a big business case. 15:39
6 A. Yes and it might be mentioned but you wouldn't
7 necessarily have sight of the full business case.
8 PROFESSOR MURPHY: But would it be part of the learning
9 disability service model that we have been told several
10 times is being revised but isn't out yet? 15:39
11 A. That would have been a bid that they would have
12 prepared and taken it to the Commissioners with the
13 Director of Planning and Performance because they were
14 responsible for planning and performance. And then the
15 Commissioners would have had a dialogue and maybe had 15:39
16 some revisions. I am not aware of the individual
17 business case. I am aware in June '19 Chairing a
18 regional meeting where we invited the Commissioners and
19 the PHA to come to talk about admissions and -- because
20 there was a concern that some of the admissions maybe 15:40
21 weren't best served in being admitted to a learning
22 disability hospital now. The jargon for that in health
23 terms is "inappropriate admissions", it doesn't mean
24 the patient or the service user is inappropriate, it
25 means there was a better model to support that 15:40
26 individual. And so, I did host a meeting on behalf of
27 the Belfast Trust with a number of other Trusts to try
28 and say we need Blue Light Panels, it's part of the
29 admissions criteria because really people should only

1 be admitted to hospital if the hospital will benefit.
2 To have someone with dysregulated behaviour being put
3 out of their normal environment and being placed into
4 an area with multiple other vulnerable people who may
5 also have dysregulated behaviour is actually completely 15:41
6 the wrong model. And so, I have to tell you though,
7 that that was difficult. We did secure agreement, but
8 again, I think at a point in time Marie Rolston was
9 charged with developing the community infrastructure.
10 And I know the Panel wondered, you know, was how I 15:41
11 split the services in September/October '19 the best
12 model. Marie Heaney, who had a community background
13 and social care background, was absolutely the best one
14 to work with Marie Rolston and develop that. But we
15 had to develop it with the Department of Health and 15:42
16 with the Commissioners because they are responsible for
17 the regional policy, the directions.
18
19 I mean, even if you think about the Bengoa and the
20 recent coverage about the future hospital services, 15:42
21 that comes from the Department down. So yes, we would
22 influence up but we are also, as a Trust Board, given
23 parameters that we work in.
24
25 So for me, I know about that but that's because it 15:42
26 struggled to get off. I know about the crisis response
27 teams and the fact it's not 24/7. Autism, you know,
28 people with autism, the hospital was the wrong,
29 completely the wrong model, even more so than some. I

1 know that the hospital today, we have far fewer
2 patients in. I think when I last checked before I came
3 down it was 16. We have been able to have sort of
4 independent areas, so there's less dysregulated
5 behaviour with other, you know, and we have been able 15:43
6 to even reduce some of the pharmacology, the
7 pharmaceuticals to try, and people who might have been
8 labelled as, you know, dysregulated behaviour, their
9 behaviour is less dysregulated now because it's -- I'm
10 not saying it's perfect, please, I'll never say it's 15:43
11 perfect, no hospital system is. But it has an improved
12 environment, despite all its challenges.
13 MR. DORAN: Now, I am coming towards the end of my
14 questions. The Panel may have some other matters to
15 pick up with you, but I want to move to the closing 15:44
16 section in your statement and that's at paragraphs 282
17 to 285 and I am going to read those in.
18
19 You say at the end of your statement:
20 15:44
21 "As the leader of an organisation that unfortunately
22 get things wrong with sometimes dreadful consequences,
23 it is important that when that happens I, on behalf of
24 the organisation, apologise. I have apologised for the
25 abuse of some patients perpetrated by some staff at 15:44
26 MAH. This is not confined to just a period in 2017 but
27 whenever it occurred, some of which was reported and
28 addressed and some of which may not have been reported.
29 Such abuse should never have occurred. By their

1 conduct those staff who abused patients in their care,
2 have tarnished the reputations of the many dedicated
3 staff, some of whom gave all of their working lives to
4 caring to the best of their abilities for those with
5 learning disabilities living in MAH and often in very 15:45
6 difficult circumstances.
7
8 I have also apologised for the conduct of some staff
9 who walked by what occurred, and by that means failed
10 in their duty to patients and the Belfast Trust. Those 15:45
11 individual failures and the systems failures they also
12 represent, meant that more senior individuals within
13 the Belfast Trust were deprived of the opportunity to
14 act appropriately and decisively.
15 15:45
16 I repeat those apologies. It is also clear that the
17 Belfast Trust has not got everything right in response
18 to what occurred at MAH in 2017 and since. Responding
19 to what emerged at MAH has had a damaging effect on
20 many people. We were dealing with an extraordinarily 15:45
21 difficult situation for which we had no precedent. So
22 whilst I am not surprised that we did not get
23 everything right, I am nonetheless sorry for that too.
24
25 I cannot undo what has occurred but I can do all I can 15:46
26 with others to try to improve the systems and
27 mechanisms with the Belfast Trust to make the provision
28 of learning disability care as safe and as high quality
29 as possible. I concluded that part of that effort

1 involved ensuring that MAH is closed, and that the
2 patients and service users in our care no longer live
3 in a hospital. It will be evident to the MAH Inquiry,
4 notwithstanding the extreme efforts that have been
5 engaged in to make that a reality, just how hard it is 15:46
6 to achieve. I will continue with others to try to make
7 that happen."
8
9 Now Dr. Jack, as a former Chief Executive of the
10 Belfast Trust, is there anything that you wish to add 15:46
11 to those remarks before the Inquiry today?
12 A. I think it's just to recognise again that when our
13 systems and processes failed that we also failed, and
14 on behalf of the Trust Board I'd like to apologise for
15 that. This abuse should never have occurred. 15:47
16
17 And on a personal level can I make an apology, because
18 I no longer represent the Belfast Trust, but I just
19 want to recognise at the very heart of this Inquiry
20 there are vulnerable people who, through no fault of 15:47
21 their own, have been harmed. The patients who were
22 harmed in Muckamore were sons or daughters and brothers
23 and sisters and they and their families deserved
24 better. What happened was unacceptable. It should
25 never have happened and I personally am truly sorry 15:47
26 that it did.
27 297 Q. Thank you, Dr. Jack. I have no further questions.
28
29 DR. JACK EXAMINED BY THE PANEL:

1
2 CHAIRPERSON: I just wanted to ask this really arising
3 from that comment that when your systems and processes
4 failed, we also failed. And, as you know, if you
5 followed this Inquiry we heard, a long time ago now 15:48
6 admittedly, from many, many, many relatives about
7 seeing their patient relative bruised or in the wrong
8 clothes or apparently over-medicated. You describe
9 various levels of the governance system, but what part
10 of the systems and processes and governance should have 15:48
11 picked up that something was happening which should
12 have been a warning sign?
13 A. So, I think there's two different parts to that, it is
14 the risks and the anticipation and preparedness before
15 it happens, which would be the curiosity and the 15:48
16 scrutiny, and then there would be when an incident did
17 happen, how was it allowed to happen again. And so
18 when an incident did happen, that is about the
19 reporting and the escalation, but the curiosity and the
20 scrutiny. And, you know, healthcare and social care is 15:49
21 really complex and we've committed to learning and
22 improving. So, you know, as I sit here now there were
23 many things that we could and should, there's a myriad
24 of risk factors. You know, you need to do nearly a
25 risk matrix right across the organisation looking at 15:49
26 this and looking at adult safeguarding and the same way
27 we need to do that in children's safeguarding right
28 across our children's homes and in our family support
29 workers. And I don't think governance ever is sorted

1 or ever ceased because healthcare and social care
2 become more and more complex.
3
4 So at the top of the organisation we should have been
5 more curious and we should have been problem sensing 15:50
6 and we, in the Trust Board, have been trying to grow
7 that and myself as Chief Exec have been trying to grow
8 that. And I'm not sure you will ever finish it but
9 there's always more you can do. From my point of view
10 it is about the problem sensing. It is about looking 15:50
11 at data, it's about analysing it, it's being curious,
12 it's pulling on that thread. It's about building a
13 culture where we can challenge constructively and
14 really drill down and wrap around each other and there
15 should have been more of that. 15:50
16 CHAIRPERSON: You've mentioned culture, do you think
17 that there was, therefore, a culture in your Trust of,
18 in certain areas and obviously we're talking about
19 Muckamore, a failing to report bad behaviour?
20 A. Within Muckamore? 15:50
21 CHAIRPERSON: Yes.
22 A. I believe there was a failure to report unacceptable
23 standards in care. I do think Belfast Trust is made up
24 of many, many different cultures. When we rolled out
25 the real-time patient feedback every ward has sort of 15:51
26 its own culture and I know that, you know, even within
27 Muckamore different wards had different cultures. For
28 example, PICU was one of the best staffed wards and yet
29 had the highest incidents of abuse. Other wards might

1 have been, you know, not as well staffed and yet had
2 lower incidents. How do you explain that? Four other
3 wards won awards. We do our staff survey anywhere that
4 has ten or more staff members reporting gets an
5 individual report now. And the culture across our 15:51
6 organisation varies hugely, and I think it probably
7 does in any large organisation. What I have done in
8 recent times is really go in and listen to those that
9 were in the top 10% and ask them why are you like that
10 and then gone into the bottom 10% of service areas with 15:52
11 culture and saying, right, what can we do to help you
12 more, how can we help, because it's not necessarily
13 their fault, it's about learning and improving. So
14 that is a piece of work that I know the Trust has
15 started and I'm sure it will continue. 15:52
16 CHAIRPERSON: I don't have anything else. I think
17 we're all done.
18 MR. DORAN: Nothing further Chair.
19 CHAIRPERSON: Dr. Jack, can I thank you for coming
20 along to assist the Inquiry. It was obviously 15:52
21 important that somebody from your level came to the
22 Inquiry and did so. I am grateful.
23 We are sitting tomorrow at 10 o'clock I think.
24 MR. DORAN: Yes, Chair.
25 CHAIRPERSON: Not an early one tomorrow. 10 o'clock 15:53
26 tomorrow. Thank you very much indeed.
27
28 THE INQUIRY ADJOURNED UNTIL THURSDAY, 17 OCTOBER 2024
29 AT 10.00