MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 23RD OCTOBER 2024 - DAY 120

120

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WITNESS PAGE

THE INQUIRY RESUMED ON WEDNESDAY, 23 OCTOBER 2024, AS FOLLOWS:

CHAIRPERSON: Thank you very much. Just before you start, Ms. Briggs, can I just deal with this. 10:02
Yesterday Ms. Anyadike-Danes KC made a request for a normal hearing to discuss in the chamber further evidence which her clients believe the Inquiry should hear. I don't accept that an oral hearing is necessary and I want to explain why. 10:02

The Inquiry has been in receipt of correspondence from Phoenix Law on behalf of its clients to seek further evidence in relation to a number of issues. Those include the evidence of a member of a staff whose 10:03
evidence it is suggested requires further exploration, more specific evidence from the PSNI in relation to statistics relating to offences for victims and offenders and other issues, further evidence in relation to resettlement in which context a further 10:03
letter was received from Phoenix Law just yesterday. Correspondence on matters of evidence do not always lend itself to an immediate substantive response, usually they will require consideration by the Panel to ascertain what further measures may be needed to be 10:03
taken for the purposes of the Inquiry. But I can say that each of these matters will be taken forward in an appropriate way to assist the Inquiry in addressing the Terms of Reference and the Inquiry will write to

Phoenix Law early next week setting out the Inquiry's plans in relation to each issue, including how it proposes to receive further information in relation to the issue of resettlement.

10:04

In relation to the issue of resettlement, Phoenix Law and others will then have the opportunity of making written representations in relation to the Inquiry's proposals. In my view, therefore, it would be unhelpful to hear submissions at this stage before that correspondence has been considered. 10:04

Although today is the last formal evidence hearing day, the Panel will always consider requests that it should receive further material in any suitable format. None of this will interfere with the preparation of closing submissions starting on 26th November but, of course, further written submissions will be allowed should any additional material be received which could effect those oral or written submissions. 10:04

So that deals with that. Ms. Briggs are we ready for --

MS. ANYADIKE-DANES: Sir, it is not a replying submission please, don't concern yourself with that, it is just a point of clarification. When you, Sir, refer to formal submissions on various matters, and I understand that and we are grateful for it, I think if we are going to do that it may be very helpful given the public hearing nature of this investigation and for 10:05

that matter, my clients, if formal submissions were put up on the website. We will ensure that when we do that we will not include anything that could possibly be covered by a Restriction Order. But I think that would help everybody to understand how some of these matters are being dealt with, certainly on behalf of my clients and it may be true also of others.

CHAIRPERSON: Well I'll certainly consider that. As you know the submissions were going to be cross-served on all CPs on any event. 10:05

MS. ANYADIKE-DANES: That is true.

CHAIRPERSON: I take your point about the public nature and that is one of the reasons why we have made it clear that no submission should include restricted material. So certainly I will give careful consideration to that request. Thank you. Right, Ms. Briggs. 10:06

ROUND UP STATEMENT - MS. BRIGGS

10:06

MS. BRIGGS: Chair, members of the Panel, this morning's session is a round up exercise to address a number of statements received by the Inquiry through its various phases of evidence. As Mr. Doran indicated last Thursday when referring to this week's schedule in his introduction to Organisational Module 10, the purpose of this round up exercise is to acknowledge for the record a range of statements that have not to date been referenced in the public hearings. 10:06

The round up will not, for the most part require detailed treatment of the various statements but it is important that all of this material should be fully acknowledged in public session. There is a document now on the screen. It details the statements that I am going to address in the order that I am going to address them. 10:06

It can be seen from that list, Panel, that I will be starting with statements received in relation to the patient experience phase of the Inquiry's evidence. I'll then move on to the staff phase, followed by the evidence modules 2023, then the organisational modules 2024 and finally I will address some other statements which fall broadly within the remit of the organisational modules 2024. 10:07 10:07

If I start then with the patient experience phase Panel, there are four statements to address in that regard that you can see. You will recall that on the 12th October 2023 I presented a round up of patient experience statements that had been provided to the Inquiry. Those statements did not fall directly within the Inquiry's Terms of Reference or provided information which was too limited to require oral evidence or to be read into the record. 10:07 10:07

The first statement on your list, Panel, is one which

ought to have been included with that group of statements. That statement is made by Marvin, the father of patient P59, but I can call him Graham and it's at Inquiry reference 70. Marvin told the Inquiry that his son? 10:08

CHAIRPERSON: Mervyn or Marvin.

MS. BRIGGS: Mervyn, I'm sorry Chair. Mervyn told the Inquiry that his son, Graham, who was ciphered P59 is diagnosed with autism, cerebral palsy, epilepsy and behavioural issues. He has limited vocabulary. He was 10:08 admitted to Muckamore as a voluntary patient on three occasions due to the difficulty of managing his behaviours. The first occasion was in 1994 when Graham was 14 years of age. The second was in 1995-1996. The third occasion was for one week in 2012. 10:08

It will be appreciated that, aside from the final very brief admission in 2012, Graham's time in the hospital was outside the Inquiry's Terms of Reference. Mervyn helpfully provides the Inquiry with his recollections 10:09 of his son's time at the hospital, particularly with regard to the earlier periods prior to the Terms of Reference.

I do not intend to recite the details of the statement. 10:09 It is, however, important to record the Inquiry's thanks to Mervyn for sharing his account of his son's stays at the hospital and indeed about other aspects of Graham's life and experiences elsewhere with the

Inquiry.

Panel, the next three statements on the list are second statements made by witnesses who gave live evidence to the Inquiry as part of the patient experience phase. 10:09
As can be seen from the, list Panel, those statements are P16's mother, at Inquiry reference 80. P28's mother, known to the Inquiry as Helen, at reference 99. P60's sister known to the Inquiry as Angela, at reference 189. 10:10

After their live evidence each of those witnesses provided second statements to the Inquiry. Those statements each exhibit documentation or correspondence which was referred to during the witness's oral 10:10
evidence. Whilst it was not necessary to recall those witnesses to give oral evidence, Chair, it is important that they are referred to this morning in order to form part of the Inquiry's public record.

10:10
For completeness and for the record I will confirm the date that each of those witnesses gave their live evidence to the Inquiry.

P16's mother gave evidence on 20th September 2022. 10:10
P28's mother, Helen, gave evidence on 28th September 2022.
P60's sister, Angela, gave evidence on 20th September 2023.

Finally, it is worth stating that each of those four patient experience statements on the list are available for Core Participants and the Panel to read in their entirety. 10:10

The Inquiry team again wish to record its thanks to all of those who came forward to provide accounts to the Inquiry as part of the patient experience phase of evidence. 10:11

Chair, members of the Panel, if I can now turn to the staff phase of the Inquiry's evidence.

Like the patient experience phase of evidence some of 10:11
the individuals that have contacted the Inquiry have provided accounts that do not fall directly within the Inquiry's Terms of Reference. Others have provided information which is too limited to require oral evidence or to be read into the record. 10:11

There are two statements in that regard, those statements are of course available to the Panel and Core Participants to read in full. 10:11

The first on your list, Panel, is the statement of Ronald Mackey at Inquiry reference 50. Mr. Mackey worked at Muckamore Abbey Hospital between 1963 and 2004 as a nurse. He did his LD nurse training there

and became a Staff Nurse, then a Charge Nurse and finally a Nurse Manager. Mr. Mackey said that he got in touch with the Inquiry because he was puzzled by the media coverage about the hospital and he had heard of over 100 people being suspended. He said that if any allegation was made at Muckamore there was a thorough investigation and, if necessary, a disciplinary hearing. He said that he would have been involved in a reasonable number of investigations, albeit not many of a very serious nature, and he said that they did not lack for investigation. He provided details to the Inquiry about the investigative process. 10:12 10:12

He also said that over the years he has heard from many appreciative relatives, both verbally and in writing, and he said that he often meets former patients in the local area. He said if systemic abuse existed during this time then people would not be as pleased to see him and talk to him about Muckamore and other members of staff. 10:12 10:13

The second statement on your list then is Declan Callan at Inquiry reference 39. Mr. Callan told the Inquiry about his relative who was an employment officer at Muckamore from some time in the 1960s to approximately 2000. Mr. Callan referred to a culture of nepotism at Muckamore. Mr. Callan is a teacher but he did spend a short time working at Muckamore in 1983 working in the female workshops. While outside the time frame of the 10:13

Inquiry's Terms of Reference, he said that he did not witness abuse but had concerns regarding the supervision of patients.

Mr. Callan told the Inquiry about some pupils he taught who were former or current patients of the hospital. He told the Inquiry about the service arrangements between a school he worked at and the hospital and he detailed some of the difficulties faced by the school in that regard. 10:13

Mr. Callan also raised other issues that he perceived with Muckamore and the facilities available to people with learning disabilities including what he says was an apparent lack of supervision over patient finances. 10:13

Before I move on to the next statements on your list, Panel, which are a series of second statements made to the Inquiry, there is one further matter to mention in relation to the staff phase generally. 10:14

Given the scale of the Inquiry and the outreach work that the Inquiry conducted to encourage engagement with its work, the Inquiry was contacted by others offering to assist the Inquiry. As I said in my previous round up to the Panel in October last year, in most cases those contacts did not result in formal accounts being taken by the Inquiry and the information provided is not reasonably capable of assisting the Inquiry Panel in its work. 10:14

Nonetheless, once again Panel, the Inquiry team do think it is important to record the Inquiry's thanks to all those who have made contact, even though their information will not ultimately feature in the Panel's consideration of the issues.

Next on your list then, Panel, is a series of second statements that were made by staff phase witnesses after they gave oral evidence to the Inquiry. The evidence provided in those second statements did not require the witness to be recalled to give further live evidence. The statements are or shortly will be available to Core Participants and the Panel to consider in full. There are six such statements and they are ordered by the date of their receipt starting with the oldest first as follows:

Firstly Mr. Clinton Stewart who gave oral evidence to the Inquiry on 10th June 2024. His second statement at Inquiry reference 305 exhibits two documents in relation to his actions regarding Ennis.

Secondly, Dr. Clare Byrne who gave oral evidence to the Inquiry on 8th May 2024. In her second statement at Inquiry reference 314, Dr. Byrne refers to questioning by the Panel and provides some further information about two issues in that regard. The first is the use and mechanics of the DBT diary card, the second issue

is the number of patients who underwent therapy on Six Mile Ward.

Thirdly then, A12's second statement at reference 327. A12 gave oral evidence to the Inquiry on the 13th May 2024. A12's second statement exhibits a number of documents, mostly correspondence, which she refers to in her first statement but she had not exhibited those documents at the time of completing her first statement. 10:16

Next is A7's second statement at reference 328. A7 gave oral evidence to the Inquiry in restricted session on 20th February 2024. Restriction Orders 38 and 39 refer, Chair. That statement is being finalised for disclosure and will be shared with Core Participants in due course. 10:17

Next then, Panel, Gillian Traub's second statement at Inquiry reference 329. She gave oral evidence to the Inquiry on 10th June 2024. Ms. Traub's second statement was made at the request of the Inquiry to provide a copy of any reply to an e-mail from Liz Moore, Bryson House, to Ms. Traub dated 27th November 2019 and advised as to how the issues raised in that e-mail were addressed. Ms. Traub's second statement duly does that. Her statement exhibits, among other things, her responses to that e-mail. It should be noted in relation to that statement that DLS have 10:17 10:17

confirmed that there is an error in the statement in that a patient's initials are incorrectly ordered in places in the statement making it seem as if more than one patient is being referred to by Ms. Traub, when in fact it is a single patient. Accordingly the Inquiry has applied one cipher to that patient's initials which is P600.

The final statement then is A5's second statement. A5 gave oral evidence to the Inquiry in restricted session on 7th and 8th 2024. Restriction Orders 35 and 37 refer, Chair.

If I can thank those witnesses for the provision of their second statements on behalf of the Inquiry team.

There is one final matter to attend to in relation to the staff phase before I move on, Panel. You will recall that H284 gave evidence on 14th May 2024 following on from her statement dated 19th February 2024, which is at Inquiry reference 204. In her statement H284 states that she was an approved social worker at Muckamore from November 2017 to July 2019. H284 contacted the Inquiry after her live evidence and said that she had meant to correct her statement to say that she was a social worker rather than an approved social worker. H284 stated that, while she is an approved social worker, she was not employed as an approved social worker at Muckamore. That correction

is now on the Inquiry record.

CHAIRPERSON: Well that's very accurate of her, right, thank you.

MS. BRIGGS: If I can now turn to the evidence modules 2023, Panel. Following on from the live evidence heard by the Inquiry in that phase it was necessary to revert to some of the witnesses to ask them to provide materials or information that had been referenced during the course of their oral evidence. A number of witnesses provided supplementary statements of this kind. There was no need for the witnesses in question to be recalled to give further oral evidence to the Inquiry. 10:19 10:19

You will see from the list, Panel, that there are eight witnesses whose additional statements are to be acknowledged today in order that they properly appear on the public record. Those statements have been posted in the appropriate location on the Inquiry's website and they have been shared with Core Participants. 10:20 10:20

The first five witnesses on your list, Panel, gave evidence in relation to Evidence Module 2, Healthcare Structures and Governance. If I go through those statements then in the order that they appear on your screen. 10:20

Dr. Elizabeth Brady has provided second and third

statements to the Inquiry at references 128 and 160 following her oral evidence to the Inquiry on 18th April 2023.

Lynn Preece has provided a second statement to the Inquiry at reference 125 following her oral evidence to 10:20
the Inquiry on 18th April 2023.

Mark McGuicken has provided three more statements to the Inquiry in relation to the evidence modules 2023. He gave oral evidence in that regard on 3rd April 2023 10:21
and 19th April 2023. He has provided three further Module 2 statements at references 118, 129 and 228 respectively. And as Mr. Doran stated in relation to Organisational Module 10 last week, Mr. McGuicken has also provided a fifth statement in relation to 10:21
Organisational Module 10 which, for completeness, Panel, is at reference 333.

Aidan Dawson has provided a fourth statement to the Inquiry at reference 179 following his oral evidence to 10:21
the Inquiry on the 3rd April and 28th June 2023 in relation to his first three statements to the Inquiry.

Brendan Whittle has provided a second statement to the Inquiry which is at reference 184 following his oral 10:22
evidence on 17th May 2023.

The next witness on your list is Briege Donaghy who was a witness in relation to evidence Module 5, regulation

and other agencies. Ms. Donaghy gave her oral evidence to the Inquiry on 3rd May 2023. Since then she has provided two further statements to the Inquiry at references 185 and 187 respectively.

10:22

Margaret Flynn is the next witness on your list, Dr. Flynn gave evidence in relation to Module 6, MAH Reports and Responses, on the 25th May 2023 in relation to her first two statements. She has since provided a third statement to the Inquiry at reference 130.

10:22

Finally in relation to evidence Module 6(b) the Ennis Ward Report of 2013, there is one final statement to address. The Panel will recall that the Belfast Health and Social Care Trust provided the Inquiry with two

10:23

bundles of material shortly before Ms. Brenda Creaney gave evidence for the purpose of Evidence Module 6(b) on 11th June 2024. She was asked to provide a short statement exhibiting those bundles. That statement is at reference 319 and is available on the Inquiry's

10:23

website to view and has been shared with Core Participants.

CHAIRPERSON: Just to mention all of these statements I think are going to be published, save the Ennis statements or including the Ennis statements? No, save

10:23

the Ennis statements. I think some are already up in fact.

MS. BRIGGS: Yes, Chair, they are published as you say Chair, yes.

CHAIRPERSON: Okay.
MS. BRIGGS: Finally, Chair, the Inquiry Team wishes to express its thanks to all of those witnesses who have assisted the Inquiry with the provision of additional statements. 10:24

If I can now turn to the Organisational Modules 2024. There are four additional statements received from witnesses who gave evidence in relation to the Organisational Modules 2024 which should be put on the 10:24 Inquiry record.

Firstly the second statement of Professor Neal Cook. Neal Cook had provided a statement to the Inquiry in relation to Organisational Module 2, Professional 10:24 Education which is at Inquiry reference 221. As was stated by Inquiry counsel in the introduction to Organisational Module 2 on 28th May 2024, Mr. Cook was not called by the Inquiry to give oral evidence but instead a request was made of him to provide a second 10:24 statement. That second statement is Inquiry reference 284 and is available on the Inquiry's website along with the other organisational module 2024 statements.

Secondly, the statement of Charles Massey. Mr. Massey 10:24 had provided a statement to the Inquiry in relation to Organisational Module 3, Professional Regulation, which is at Inquiry reference 210. As was explained by Inquiry counsel in the introduction to Organisational

Module 3 on 29th May 2024, Mr. Massey was not called by the Inquiry to give oral evidence but a request had been made of him to provide a second statement. That second statement is at Inquiry reference 303 and is also of course available on the Inquiry's website. 10:25

Thirdly, the third statement of Andrea Sutcliffe also in organisational Module 3. Ms. Sutcliffe provided two statements to the Inquiry and then Sam Foster and Lesley Maslan gave evidence in relation to Ms. 10:25
Sutcliffe's written evidence on 29th May 2024. A third statement was then provided by Ms. Sutcliffe and is at Inquiry reference 304. It is also available on the Inquiry's website.

10:26

Fourthly in relation to Organisational Module 6, resettlement, Ms. Fiona Rowan who gave oral evidence on 24th June 2024 has provided a second statement to the Inquiry which is at Inquiry reference 278. It too is available on the Inquiry's website. 10:26

Before I move on, Panel, there are two matters in relation to Organisational Module 7 and 9, MAH Operational Management and Trust Board.

10:26

Firstly, in relation to Organisational Module 7, MAH Operational Management, you may recall, Panel, that an exhibit to the statement of Catherine McNicholl, reference 293, was put by Inquiry counsel to Jackie

Austin, specifically the ASP governance dashboard of April 2016 to March 2017 at page 42. Ms. Austin stated during her evidence to the Inquiry on 18th September 2024 that the exhibit contained numerical errors. DLS have confirmed that a supplementally witness statement will be furnished to the Inquiry regarding that particular issue. Once received this statement will of course will be circulated to Core Participants. 10:27

Secondly in relation to Organisation Module 9, Trust Board, the Panel will recall that Martin Dillon gave oral evidence in relation to that module on 9th October 2024. Following his oral evidence DLS contacted the Inquiry to explain that Mr. Dillon wished to correct his evidence in relation to the date of his knowledge of concerns at Muckamore. Senior counsel, Mr. Doran, had already raised this with you, Panel, on Monday last week, the 14th October, during the evidence of Brenda Creaney, and he set out the correction that Mr. Dillon wished to make in that regard. 10:27 10:27

As Mr. Doran said on that occasion, the Inquiry has asked Mr. Dillon for a short supplementary statement to address that matter. The Inquiry awaits receipt of that statement and it will be circulated to Core Participants once received. 10:28

Before leaving the organisational modules I should mention one further statement that doesn't appear on

the list as it was in fact referenced in the introduction to Organisational Module 5 on 19th June 2024. This is the third statement of Lynn Long on behalf of RQIA to which Ms. Long exhibited a large number of documents relating to Ennis. That statement is subject to RO 91 made on 18th October 2024. Preparation of the statement and exhibits for publication on the website is on the verge of completion and the statement will be published and shared shortly. 10:28

If I could again take the opportunity to thank all of the witnesses who have assisted the Inquiry with the provision of statements and additional statements for the Inquiry. 10:28

If I can move on then, Panel, to the final section on the list. There are other statements that have been received by the Inquiry which may be considered as falling broadly within the territory covered by the organisational modules but they were not received as part of the evidence gathering process for those modules, rather they are from individuals who have assisted the Inquiry by providing statements which contain information that may be of assistance but that do not require to be examined in oral evidence. Those statements are available to Core Participants and the Panel to read in full. I will however provide a relatively brief summary of those statements for the 10:29 10:29

purpose of the public record. They are listed in the order in which they were received by the Inquiry starting with the oldest statement first.

Firstly Mr. Seamus Logan, the statement reference is 53. Mr. Logan has a professional background in social work and held a range of posts in the Northern Health and Social Services Board, the Department and the Regional Health and Social Care Board. Mr. Logan provides his experience of the organisational culture between the commissioning boards and Trusts in Northern Ireland, in particular the Belfast Trust. He says that there were organisational and cultural problems brought about by various reorganisations, all of which contributed to accountability problems within the system. 10:29 10:30 10:30

His statement includes discussion of the delegated statutory function scheme which provided an unbroken line of accountability from those staff on the ground through to the Board and ultimately to the Minister through the Department. He said that until this was clarified it was a commonly held view that Trusts were almost completely independent, answerable only to their own management boards and their local populations. He described leading a review, prior to the time frame of the Inquiry's Terms of Reference in 1997, of the way in which the Northern Board dealt with untoward events. 10:30 10:30

Mr. Logan said that there was no clear under understanding within Trusts at Board or departmental level as to what incidents should be reported, how they were to be reported or when. Mr. Logan proposed a new policy which was approved and he described the resistance he met to the proposed changes. Mr. Logan also described being invited to join the Mental Health Commission and he described his experience with that body. 10:31

He described the transfer of functions from the Mental Health Commission to the RQIA in 2008 to 2009 and provided his view on that change. 10:31

Mr. Logan went on to provide detailed information to the Inquiry about his professional involvement in and experience of the resettlement process, including by the establishment of a project board to oversee completion of the resettlement process. 10:32

He referred to difficulties with some Belfast Trust staff in achieving resettlement.

Mr. Logan also described his involvement in the Bamford Review in 2005. He formed the view that there was no shortage of resource within the Department to plan and deliver change. He expected that a new bill reforming mental health and learning disability law would be introduced shortly after 2008 to 2009 and refers to the 10:32

delay in bringing forward that legislation.

Mr. Logan also provided three exhibits to his statement including the Aras Attracta Review Report from the Republic of Ireland dated July 2016, the transfer of functions from the Mental Health Commission to the RQIA and a research paper presented to Northern Ireland Assembly in June 2008. 10:32

The second statement on your list, Panel, Wilfred Mitchell at reference 54. Mr. Mitchell was Chief Executive and Principal at a specialist further education college. In his statement he provides information about nine past and current students of the college who have a history and link with Muckamore Abbey Hospital. He described some of those students or patients, their treatment and their experiences in his statement. Mr. Mitchell said that it is his opinion and experience that provision in Northern Ireland is inadequate and under funded. He also referred to presentations made to the Stormont Committee for Communities and a visit made by Robin Swann to a college in Manchester. He also referred to Mr. Farry MP's launch of a five year strategy to address what he describes as the outstanding and longstanding issues. 10:32 10:33 10:33

The third statement is Maureen Piggot at reference 177.

CHAIRPERSON: I'd just like to welcome Ms. Piggot to the room who has attended to listen to this short

summary of the statement, but also to repeat that the Panel have of course read or will read all of these statements.

MS. BRIGGS: Thank you, Chair. Ms. Piggot told the Inquiry about her work in the learning disability sector in Northern Ireland from 1980 to 2014. In September 1980 Ms. Piggot became the Divisional General Manager of Mencap in Northern Ireland, a position she held for 23 years. She provided the Inquiry with information about her roles advocating for patients, her involvement in and knowledge of government policies, her interactions with individuals working for the Trust and the Minister for Health over a period of many years. 10:34 10:34

She told the Inquiry that Muckamore played an important part in developing the capacity of community services to support people with more complex needs.

She also said that the future of Muckamore was one of her concerns in her position with Mencap. She described the resettlement of patients out of Muckamore and other learning disability hospitals as a major challenge. She described her work in this regard. 10:34 10:35

Ms. Piggot also provided accounts of some patients and families she met who had experience with Muckamore, some positive, some negative.

Ms. Piggot described how she eventually formed the view that there needed to be an escalated closure of MAH and she described her interactions with parents, officials and media in this regard and the actions she took to achieve resettlement and closure of the hospital. 10:35
She told the Inquiry that in her view most of the resettlement from LD hospitals whilst she was in Mencap were positive for individuals, albeit not all resettlement was perfect.

10:35

She described her interactions with and experience of the Human Rights Commission and she described Mencap's support of a judicial review taken by a patient.

Ms. Piggot said that the numbers of patients who 10:35
remained in hospital beyond their need for treatment is a failure in health and social care, housing, education and the commissioning of services. She said that Muckamore should be closed as it is the wrong service in the wrong place and her vision continues to focus on 10:36
policy and funding for people with learning disabilities to live in the community and she endorses a human rights based approach for future policy and strategies.

10:36

If I could thank those three witnesses for providing their accounts to the Inquiry.

CHAIRPERSON: Thanks from the Panel.

MS. BRIGGS: In addition, Panel, for completeness the

Inquiry has also received a statement from another witness who has no direct connection with Muckamore Abbey Hospital but who worked in the school of Nursing and Midwifery at Queen's University, Belfast. That statement is at Inquiry reference 181. She offers some reflections on the education and training of nurses. The statement has been provided to the Panel and Core Participants and the Inquiry is grateful also for her contribution. 10:36

Chair, Panel, while this round up has attempted to be as comprehensive as possible, it is not the final word on statements received by the Inquiry. The Inquiry has just yesterday received further statements from PSNI that are being prepared for disclosure to CPs. There may also be other evidential matters in respect of which further statements will be required. I hope, however, that the round up will have been of assistance in updating the Panel, Core Participants and public on evidence received by the Inquiry in addition to the statements that have been addressed in hearing to date. Panel, unless there is anything further that concludes my presentation and I will hand over to senior counsel, Mr. Doran. 10:37 10:37

CHAIRPERSON: No, thank you, that has been very comprehensive. Mr. Doran, are we ready to go straight into Mr. Pengelly or do we need a break? 10:37

MR DORAN: Yes, Chair, we are.

CHAIRPERSON: Thank you. Can we get Mr Pengelly in

please.

MR. RICHARD PENGELLY, HAVING BEEN SWORN WAS EXAMINED BY MR. DORAN AS FOLLOWS:

10:38

CHAIRPERSON: Welcome, Mr. Pengelly.

A. Thank you.

CHAIRPERSON: Thank you for coming to assist the Inquiry and thank you for your statement. I expect you have seen how these things are done by watching at least some of the televised hearings. We normally take a break in about an hour, maybe -- yes, about an hour today. But if you want a break at any earlier stage just obviously let us know and I'll hand you over to Mr. Doran.

10:39

1 Q. MR. DORAN: Mr. Pengelly, thank you for attending to give evidence. I am Sean Doran, senior counsel to the Inquiry. We met very briefly this morning to discuss procedure. It's correct to say, isn't it, that you made a statement for the Inquiry that's dated 14th June 2024?

10:39

A. 28th June.

2 Q. Oh, my apologies. The reference, Chair, is MAHI STM-299. And you prepared the statement in response to specific questions that the Inquiry wanted to address, isn't that right?

10:39

A. That's correct.

3 Q. And I think you say in paragraph 5 of the statement that you prepared the statement with the assistance of

former colleagues in the Department?

A. Yes.

4 Q. And whilst these questions were directed globally at department witnesses, you make the point that where a question related to matters that you weren't routinely involved in and had nothing to add to the statements of the other departmental witnesses, you would say so in the statement and you have done that, isn't that correct? 10:40

A. That's correct, yes. 10:40

5 Q. There are two very brief corrections that we need to deal with at the outset and the Department has provided a helpful note on this. Let me just go through those very briefly. The first one relates to page 6 at paragraph 21 and where you say: "I exhibit at exhibit 14 the MDAG action plan from April 2022" you make the point that in fact the attached document is the August 2022 version and not the April 2022 document? 10:40

A. That's correct, yes.

6 Q. And then at page 11, paragraph 39, you say: "I exhibit at exhibit 16 a copy of the letter establishing this forum." But as you say, this letter is not in fact at exhibit 16? 10:41

A. That's correct.

7 Q. Exhibit 16 is a separate document. Now it's correct to say, isn't it, that both of those documents have been furnished separately to the Inquiry? 10:41

A. They have, yes.

8 Q. Thank you. And, Chair, for the reference they appear

in the bundle, additional documents for M10 departmental witnesses, the reference is MAHI DoH OM bundle and the action plan appears at page 52 of the bundle, that's the April version of the action plan referred to in the statement. And then the letter that is referenced as being exhibit 16 in paragraph 39 of the statement now appears at page 99 of that additional bundle. 10:42

CHAIRPERSON: Okay, so we've got it in a different bundle, not just in Mr. Pengelly's bundle. 10:42

9 Q. MR. DORAN: Yes indeed. So, Mr. Pengelly, subject to those amendments and additions you have had the opportunity to read through your statement again?

A. Yes, I have.

10 Q. And are you content to adopt the statement as your evidence for this part of the Inquiry? 10:42

A. I am indeed.

11 Q. As with all statements in this part of the Inquiry, your statement is published on the website and I'm not going to go through it paragraph by paragraph as such, I want to focus on questions that you might be able to assist the Panel with in addressing the Terms of Reference and it may be that as we go along the Panel will also have questions for you. 10:43

A. Okay. 10:43

12 Q. Now, dealing first with your role, you say at paragraph 2 that you took up the post as Permanent Secretary in what was then the Department of Health, Social Services and Public Safety back in July 2014 and you remained in

the post until the 4th April 2022, isn't that correct?

A. That's correct.

13 Q. And of course the Department was renamed the Department of Health then in 2016?

A. Mhm-mhm. 10:43

14 Q. Can I just ask, is it correct to say that was purely a change of name and didn't involve any reconfiguration of the Department's areas of responsibility?

A. In terms of the Department that's correct, at that stage there was some reconfiguration across some 10:44 departments. Originally, with us being DHSSPS, the "PS" being public safety which was the Fire Service, it had been anticipated that the Fire Service might relocate to the Department of Justice, in the end that didn't happen. It was largely just a name change as 10:44 far as the Department was concerned.

15 Q. So it didn't materially impact on your areas of responsibility?

A. No, not at all.

16 Q. Now, you say in your statement that you're an 10:44 accountant by training and you talk about your previous experience in the Department of Finance and the Audit Office. For those of us who aren't fully familiar with how career paths work in the Civil Service, can I ask, was the move towards health one that you were 10:44 particularly interested in or did it just so happen that your career went in that direction?

A. It happened that it went in that direction. Although I was, I am a chartered accountant by background, I spent

a considerable part of my career in the public expenditure side of the Department of Finance. I was classified as a generalist civil servant. So as a consequence I had a couple of promotions there. While I was in the Department of Finance I was promoted to Permanent Secretary and at that stage it's a completely mobile grade so my first appointment was to the then Department For Regional Development which became the Department for Infrastructure and the then Head of the Civil Service about 18 months in decided on summary shuffle of Permanent Secretaries so there was a few moves. I replaced Andrew McCormick who at that time moved to the Department for the Economy so there was a general reshuffle. 10:45 10:45

17 Q. Indeed the Inquiry has heard from Mr. McCormick as you are aware. You were in the post for almost eight years. That must be considerably longer than average for a period for a Permanent Secretary one would thing? 10:45

A. It is considerably longer than the average, excluding Health. Dr. McCormick was in post for around nine years, so it seems that Permanent Secretaries to the Department of Health seem to stick a little longer than in many other departments. 10:46

18 Q. In any case you were in the post prior to and at the time at which the allegations relating to Muckamore emerged in 2017, isn't that right? 10:46

A. That's right, yes.

19 Q. And also then through the subsequent reactions to that through the Way to Go Report and leadership and

governance?

A. That's correct.

20 Q. We'll come on to deal with those in due course. You give more detail about your roles and responsibilities later in paragraphs 26 to 32 of the statement. I want to ask you a few questions about that. If we go to paragraph 26, please, you provide a snapshot of your role. You say: 10:46

"My role within the Department was as Permanent Secretary from the 1st July 2014 to 31st March 2022. In this role I was responsible for providing advice to the Minister and for ensuring the effective implementation of policy. I provided strategic leadership in developing and planning the role of the Department in a regional, national and international context." 10:47 10:47

And you go on then to provide some further information about your duties within the statutory scheme for health and social care. And at paragraph 29 you say you were: 10:47

"....the Principal Accounting Officer responsible for the stewardship of the Department's resources including its allocated annual budget of approximately 6 billion." 10:47

A. That's correct.

21 Q. I wonder if you could just clarify this, I think Mr. McCormick touched on it, but is the 6 billion simply based on a set figure on X pounds per head of the total population or is it adjusted to reflect levels of social deprivation, for example between Northern Ireland as compared with the rest of the UK? 10:48

A. I'll try to describe it as best I can but please if I dive into too much detail, please stop me or ask me to go into more. Essentially the overall allocation is essentially a matter of political judgment by the Executive. Through the national spending review process, and there's a budget coming up at the end of the month nationally, that will determine a total amount, one figure that is available to the Northern Ireland Executive to fund public services that are the responsibility of the Executive. 10:48 10:48

22 Q. Yes?

A. Through advice provided through the Finance Minister to the Executive, that will be broken down into nine individual amounts, one for each of the nine departments. The deprivation aspect that you refer to, well the global amount comes to the Health Minister, the Health Minister of the day will allocate that between certain priorities within the health portfolio. There is, what's called capitation formula. That looks at the equitable distribution of the amount that is determined to flow through the Trusts as opposed to determining the amount that flows through the Trusts. So it will take into account relative deprivation 10:49 10:49

factors between Trusts and issues like rurality and the fact that it costs a bit more to provide services in a rural location versus an urban location. Those factors go to the distribution as opposed to the quantum.

23 Q. So matters of deprivation feed into distribution once the money has been allocated so to speak? 10:49

A. Yes, that's correct.

24 Q. Are health and social care entirely separate funding streams or are they fully combined?

A. They are fully combined in the Northern Ireland context, which is unique across these islands at the moment. 10:50

25 Q. Now, I'm not expecting a definitive answer on this but there have been some suggestions that funding for mental health and learning disability in Northern Ireland compares unfavourably with elsewhere in the UK. Do you feel that you can comment on that perceived differential? 10:50

A. I'm not sure, having been away from health for two and a half years, I'm not sure of the current position. But certainly I was aware that that was the sense. Part of the issue is the fragmentation of the resources and I think this is a theme that I may return to in other aspects of today because we talk at great length about the need for transformation of health and social care across Northern Ireland; one of the flaws in our system is that we have quite a lot of fragmentations. We have too many services in too many places and that means they cost a bit more money and they are 10:50 10:51

relatively expensive in comparison to a model that had more aggregation of demand. Now that is not to suggest that anyone feels the optimum model is one centre for everything in Northern Ireland because of its regional services. That skews the comparison in terms of there is an issue about how much money is available versus the efficient spending of it. But the sense, and it was a common feature in many ways, the likes of Mental Health and Learning Disability Services were the poor relation, particularly in the context of an integrated service where certainly public discussion about acute services tends to dominate the narrative. 10:51 10:51

26 Q. That is a theme that perhaps we can return to later but you wouldn't disagree with the general suggestion that there is a differential then between the funding available for public services in this jurisdiction and elsewhere? 10:52

A. I would be reluctant thinking on my feet to try and quantity that or be absolute about it, but certainly I recognise the sense that that is the case. I think the point that Michael McBride made yesterday that in terms of priorities for the system there is no differentiation, that somehow Mental Health and Learning Disability are seen as lower priority, but in terms of looking out into the system the narrative does always seem to focus on -- and again not seeking to attribute blame to the media but stories about acute services, cancer delays, those issues dominate the dialogue about it which may make it seem that is where 10:52 10:52

all the energy and attention goes but there is a broad portfolio of priorities.

27 Q. Do you not think the narrative meets the reality then?

A. I think at times the narrative reflects where people see problems as opposed to within the system there are people who are dedicated to deal with issues like Learning Disability and Mental Health Services. So they are not distracted by when there is a narrative focusing on acute services. 10:53

DR. MAXWELL: Could I just ask, so this perception that there is a lower funding for LD services in Northern Ireland than other parts of the UK, would that funding gap be higher or wider for Learning Disabilities than for other services or is there a funding gap between services for all health and social care in Northern Ireland and the rest of the UK? 10:53 10:53

A. Again, with the caveat that numbers may have drifted on in the two and a half years, we were always acutely aware that when you factored in what we called relative need in Northern Ireland, because of greater health needs and the rurality of the population it cost more to run services. So while, if you measured funding on a per capita basis, Northern Ireland always had a lead over England. 10:54

DR. MAXWELL: A lead over England. 10:54

A. A lead over England in pure pounds but when you factored in relative need our argument was we were underfunded by reference to relative need.

DR. MAXWELL: And would that be equal across all

services or is it more pronounced in services that aren't predominantly provided in one place i.e. an acute hospital?

A. I think it is present in all services, I'm not sure about the amount of the gap, whether it would be bigger or larger in some areas because, as I say, I haven't re-visited the figure in quite a period of time. 10:54

28 Q. MR. DORAN: Moving on slightly, in this part of your statement, that is paragraphs 26 to 32, you talk about your leadership and directional role both before and after the collapse of power sharing in January 2017. Presumably your role became somewhat more onerous after collapse? 10:55

A. It did, essentially while Ministers are in post my role was very much to provide advice to Ministers, Ministers were the decision makers, Ministers had a policy agenda so there was advice in terms of the formulation of policy and then leading the implementation of policy once Ministers had settled on that. Post the collapse of the Executive with no Minister in post, there was the Bewick judgment at an early stage in the collapse which in short form basically concluded that the power of Permanent Secretaries was restricted to issues that would normally have been dealt with at official level. Things that routinely would have gone to Minister would have been outwith our power. That meant in some cases we just couldn't act. The EFEF Act, Executive Formation and Execution, I can't remember the exact, the long title, that was November 2018 it received 10:55 10:55 10:55

Royal assent. That basically said that we could exercise powers subject to the application of a public interest test so it gave us a little bit more power. But rather than the authority, if your question is specifically about busyness there was, I tried to step into the place about more visible leadership of the system and doing things that normally a Minister would have done, just to try and maintain coherence and leadership across the organisation.

29 Q. Yes and indeed in the context of this case, you essentially acted in the Minister's role when delivering the apology? 10:56

A. In December 2018 very much so, that was very much the case that had a minister been in place that would have absolutely been a ministerial role. 10:57

30 Q. I am not going to explore the legal niceties of your powers at the time following on from the collapse of the arrangements, you give a thumbnail sketch of that in paragraph 31 of the statement. But, I suppose without getting into those legal niceties about what could be done and couldn't be done in the absence of a Minister, can I just ask you a broad question, do you think the absence of a Health Minister at the time had any adverse impact on the immediate response of the health authorities to the news that was emerging from Muckamore in 2017? 10:57 10:57

A. I think I would seek to answer that in two ways. On the one hand I think it is important to state that short of calling a public Inquiry, which we clearly

concluded was outwith my power and in the absence of a Minister it would have been for the Secretary of State to do that, but certainly it wouldn't have sat within my power, I can't recall any definitive issue that landed on my desk where the advice was here is something we want to do but in the absence of a Minister we can't do it. So I don't think, short of a public Inquiry point, we felt that we were running into a brick wall in terms of the absence of Ministers. The bit that is more difficult to answer is what would the ministerial reaction have been had a Minister been in place. I've always found throughout my career that Ministers have a much greater antennae in terms of the public mood and the sentiment of the public and that connectivity at community level. Sometimes they bring that to the conversation which influences a response in a way that the advice from the Civil Service and public officials just doesn't have that colour and flavour to it. It is hard to say what would or wouldn't have happened but there may have been things a Minister did that we didn't do. 10:58 10:58 10:58 10:59

31 Q. I suppose that is an imponderable issue given there wasn't a Minister in place at the time. In paragraph 32 you explain that you didn't have any direct role in the oversight of services at the hospital and you explain that would you have relied on others for information to come to you with any significant emerging concerns about healthcare services? 10:59

A. That's correct, yes.

32 Q. And I think you refer to the possibility of early alerts or submissions from departmental officials?

A. Yes.

33 Q. You also then refer to the possibility of receiving communications verbally from Sean Holland? 10:59

A. Yes.

34 Q. Now I wonder, looking back at your time as Permanent Secretary, do you actually recall at this remove any concerns about the hospital arriving with you through any of those various channels of communication prior to 11:00 2017?

A. I mean, I've given this some thought in preparing for today and I can't recall any discussion or dialogue about any issues at Muckamore prior to Gavin Robinson approaching the Department in August of 2017. 11:00

35 Q. And we'll come on to deal with that?

A. Yep.

36 Q. In due course. Now, you then refer to Chairing mid and end year accountability and assurance meetings with the Chair and Chief Executive of the Belfast Trust and I 11:00 want to deal with those meetings. You say in paragraph 32:

"These meetings were intended to be a forum for addressing strategic issues which had been identified 11:01 in advance of the meeting. Issues relating to Muckamore were raised on three occasions at these meetings during my time in post and minutes of these meetings have been exhibited to Mark McGuicken's

statement of 26th May 2023 at MMcG 300, MMcG 301 and MMcG302."

We are going to have a look quickly at those now. If I could, and just to stress again, Muckamore was mentioned at those meetings but they are all post 2017? 11:01

A. Yes.

37 Q. And if we can have a look please at MAHI STM-118-3305. Sorry, Chair, I did ask for these documents to be at the ready, it may not take too long to have them prepared. It's STM-118-3305. All of this material of course appears on the Inquiry's website? 11:02

CHAIRPERSON: CPs in the room will be able to get them through their own system but it is important obviously for the witness to be able to see it. Does he have the bundle that would include this? 11:02

38 Q. MR. DORAN: This is obviously a reference, Mr. Pengelly, to documents that have been exhibited to another statement, that is the statement, the second statement of Mark McGuicken. Do you have a copy of that? 11:02

A. I think I do actually. This is the December, the first one the December 2017, the minutes of the accountability meeting?

39 Q. There are three minutes, one is 21st December 2017, the second then on 24th January 2019 and third on 2nd July 2019? 11:03

A. I have them.

CHAIRPERSON: Can we pause for a second. We have got

them, brilliant, it makes it easier for me. 118-3305.

MR. DORAN: 118-3305.

CHAIRPERSON: If the witness has got it, and everybody else can access it I think we might move on.

MR. DORAN: It may put me at a disadvantage of course, but I think I can manage that. 11:04

CHAIRPERSON: Don't worry about that, Mr. Doran.

40 Q. MR. DORAN: I'd thought you say that, Chair. What I can do is to ask the witness to read in the relevant entries relating to Muckamore which are in fact relatively short. I wonder, Mr. Pengelly, we'll go to the first meeting and that's on 21st December 2017? 11:04

A. Yes.

41 Q. And, as you've said, these are assurance meetings with the Chair and Chief Executive of the Belfast Trust and I think it's at page 3308 at paragraph 6.2? 11:04

A. Yes.

42 Q. There is a reference to Mr. McNaney's assurance to the meeting. I wonder could you possibly read that into the record? 11:05

A. Yes, of course. This is 6.2:

"Peter McNaney gave an assurance that in relation to the issue at Muckamore Abbey Hospital the Trust has introduced additional measures and is confident of the ongoing safety and care of the patients in the hospital." 11:05

43 Q. Thank you for that. I think it's fair to say that is

the only reference to Muckamore in the course of that meeting?

A. It is.

44 Q. And just for completeness if I can move on to the meeting of the 24th January 2019. That is at STM-118-3310. The relevant reference is at page 3311 and that's paragraph 5 at which you yourself I think make certain observations? 11:05

A. Yes.

45 Q. Could you read that into the record please? 11:05

A. "Richard referred to Muckamore and while recognising that the service had fallen well below acceptable standards, acknowledged the significant effort by Trust staff in responding to the issues emerging. Martin Dillon thanked Richard saying it is a testament to the 11:06 dedication and resilience of Trust staff that they have coped and remained at their posts through very difficult times. Richard said in terms of Muckamore he appreciated the extreme challenges involved in removing the remaining Muckamore service users out of the 11:06 hospital environment."

46 Q. And then finally on the 2nd July 2019, that's at STM-118-3313. I think again there is a reference to yourself and it's at paragraph 4.1 and the issue 11:06 discussed there is one that we'll come back to later and that is resettlement.

A. Mhm-mhm. It says:

"Richard asked whether the target date of December 2019 to resettle patients is still achievable. Martin replied that it was hugely ambitious and had focused minds and efforts but that it would take longer to have all the specialist community infrastructure required in place as well as the additional staff required."

47 Q. Yes, we'll come back to look at that point later. Just admittedly these are only minutes and they may not, therefore, capture all that was discussed at the meeting. But would you agree that from the minutes the meetings appear to be more of a reporting forum than an accountability forum? 11:07

A. They do, but I think it's important to understand the architecture of the accountability forum. The arrangements that were in place at this time, the issue of the accountability forum was primarily to focus in depth on issues where there wasn't a parallel forum or interface in terms of dealing with the issue. So certainly in terms of the second two issues, by the time we got into -- so the 2nd January '19 and July '19, at that stage there was very significant ongoing dialogue. January '19 I think there was monthly update meetings between the Trust and the Department and by the time we get to the middle part of the year, I think MDAG was coming on stream at that stage. 11:07 11:08

48 Q. Yes?

A. At December '17, that was just when the issue was emerging and the SAI was being initiated. The

accountability meeting that the minutes reflect comes on top of a ground clearing meeting where issues can be discussed in more depth if required, so there is some architecture underpinning this. And I think it's important to reflect too the overall guidance and accountability would also emphasise that accountability isn't the set piece event, it's prevalent in every and all discussion that takes place between the sponsored department and arms length body. I want to be clear that this isn't the only place that these issues are discussed. 11:08 11:09

49 Q. And of course relating to the first meeting, the backdrop to that was a series of correspondence between the Department and the Trust?

A. Yes. 11:09

50 Q. In which the Department was seeking assurances as to what was being done, isn't that right?

A. Yes, that's where Sean Holland and Charlotte McArdle had written to Martin Dillon in quite strident terms in terms of the reporting and response to the issue, yes. 11:09

51 Q. Is it fair to say that in terms of calling to account, the work on that front was being done elsewhere than at these particular meetings?

A. To some extent, yeah, but in terms of managing the issue, because this wasn't an issue just where something has happened and the only conversation now is to hold you to account for that. Holding to account is about actually driving behaviour and performance and a response. So the heavy lifting on that was certainly 11:09

being done in terms of the very frequent and detailed dialogue that was happening separately between departmental colleagues and the Trust. In terms of the accountability meeting, there is also a point sometimes in the minutes, and certainly I have a recollection, and again when I was re-reading this, the discussion that took place in December 2017 there was a bit more back and forth in it. The minutes just summarise the assurance from the, because it was important to capture the assurance that the Trust was formally putting that services were safe going forward. But there would have been more of a dialogue that, you know, I am aware of the previous letters, you know, there is an issue about improving the response and the handling of this. Maybe in hindsight they could have been recorded but that would have been part of the conversation. 11:10 11:10 11:10

52 Q. Yes, and in your recollection did the assurance letters, if I can put it like that, feature in the discussion at the meeting?

A. My memory is that there wasn't -- I am not trying to suggest there was a very long and detailed discussion about the letters but they certainly were referenced, you know because it was important that I referenced I was aware of the letters and that I was very much with Sean and Charlotte in terms of their frustration about the handling of the issue. 11:10 11:11

53 Q. I think the Trust, the next Trust assurance letter came on 22nd December which is the day after that particular meeting?

A. Yep.

54 Q. I also have a specific question about those meetings, Mr. Holland said in his statement that he attended Belfast Trust mid and end year assurance and accountability meetings with departmental colleagues up until around 2014 when new arrangements for those meetings were introduced. It seems that the practice of the Chief Professional Officers attending at those meetings ceased in or around 2014. Can you recall how and why that came about? 11:11

A. Yeah, and I think in terms of -- I think it's exhibit 5 to Sean Holland's statement.

55 Q. Yes?

A. There is a note that actually puts in place the architecture for the new approach. The approach prior to 2014 was that there were two parts to the accountability meeting, part A and part B. One part involved the Professional Officers and other departmental colleagues and the wider Executive Team from the Trust. And the other part just involved the Chair, Chief Executive the Permanent Secretary and the lead sponsor. The new arrangements were essentially, instead of that being part A and part B to one meeting, there became two separate meetings, a ground clearance meeting and the guidance that is exhibited to Sean's statement --

56 Q. Sorry to interrupt but for the record, Chair, that's exhibit 5 to the statement of Mr. Holland and it's MAHI 297-81. I am not going to ask for that to be brought

up. Sorry for interrupting.

A. It referenced a ground clearing meeting that would happen a few weeks before the main accountability meeting. There is a couple of lines, just to read from that letter to clarify. 11:13

57 Q. Certainly?

A. "It is envisaged that it will become normal practice for sponsor branches, policy leads and professionals as appropriate to hold a ground clearing meeting with their arm's length body prior to the Permanent Secretary meeting." 11:13

So that engagement of policy leads, sponsor leads and professional officers, that engagement at senior level with the Trust was still part of the accountability process. And your question about what drove the change, certainly when I came into the Department in terms of my introductory meetings, both with Trust Chief Executives and senior colleagues and the senior team in the Department, there was a sense of 11:13 frustration that these meetings, although there was certainly a value proposition in them, sometimes it was getting a bit lost in the noise of a very, very long meeting with lots and lots of participants. There was big chunks of the meeting that maybe only a very small 11:14 number of those in the room were particularly interested in and there was large numbers that were there. So this was a way of trying to maintain the good bits of that interface but lose some of the noise

around it. But I think, as exhibit 5 to Sean's statement shows, the core components remained in place so it wasn't a dilution of the accountability mechanism, it was just doing in a slightly different way.

DR. MAXWELL: But when we heard evidence from Charlotte McArdle yesterday she said when those arrangements changed it wasn't, the professional officers were not routinely asked if they had clinical and quality issues that they wanted raised, it was them raising it on an exception basis. How did you make sure, because I'm sure finance wasn't dealt with on exception basis, how did you make sure that clinical and quality issues were front and centre of that accountability meeting?

A. The process that was in place specifically required the lead sponsor to reach out to all relevant colleagues in the Department to say are there issues.

DR. MAXWELL: What do you mean by the lead sponsor?

A. So there is a Directorate that had, each arm's length body had a sponsor lead. So --

DR. MAXWELL: But the Chief Nursing Officer isn't an arm's length body?

A. No, sorry, so each arm's length body has a sponsor lead in the Department. So if we take the Belfast Trust, the sponsor lead in the department in preparing for the ground clearing meeting, the requirements were that they would reach out and engage with all other policy leads and professional officers in the Department to say the ground clearing meeting is coming up, are there

any issues that you want to be raised or touched on in this meeting or do you want to attend the meeting?

DR. MAXWELL: Can you explain what a ground clearing meeting is? It's not a term I've come across before?

A. It was a meeting of potentially, I'm just trying to -- that extract I read: "It will be normal practice for sponsor branches, policy leads and professionals to hold a ground clearing meeting". The purpose of these meetings was to go through the long list of issues that might feature in the shorter accountability meeting that I was having. But it was part of the accountability mechanism and it was with colleagues in the Department and senior colleagues from the relevant arm's length body to go through those issues. If those issues were resolved to the satisfaction of all participants they didn't need to be carried forward to the accountability meeting and if not, they did. 11:16 11:16 11:16

DR. MAXWELL: So your expectation is that the lead sponsor for Belfast Trust within the Department would actively seek out the professional officers and say do you have any concerns? 11:16

A. Yes.

DR. MAXWELL: But we heard that that didn't happen, certainly Charlotte and Sean inferred that as well?

A. My recollection, and I don't have any of the papers in front of me at the moment, as part of my briefing for the meeting I would have received a briefing about the ground clearing meeting and, from memory, there would have been reference that the sponsor area had reached 11:17

out and no other issues were identified. So the sense I was getting was that was being done.

DR. MAXWELL: Who was giving that briefing to you?

A. That would have come from the sponsor area and the individual in that changed over time because when I took up the role in 2014, the sponsor lead, it would have been at director level, it was Catherine Daly was in post, I think that moved. 11:17

DR. MAXWELL: What was the title of the post?

A. I think it was, it might have been the Secondary Care Directorate, but it moved I think from I can't remember, Catherine Daly to Debra -- 11:18

DR. MAXWELL: Secondary care implies hospitals, not primary care.

A. That was one Directorate, I can't remember the group name. 11:18

58 Q. MR. DORAN: You referred there to briefing papers, you exhibited a number of those to your statement, but presumably the specific briefing papers that proceeded the meetings to which we've just referred would be available if required? 11:18

A. Yes, they would. And the paper that came to me for the accountability meeting, there would have been a briefing paper and there would have been minutes of the ground clearing minutes meeting as well for my review. 11:18

59 Q. That's what I was going to say so those ground clearing meetings were minuted also?

A. Yes.

60 Q. Before moving on completely from your roles and

responsibilities, part of your portfolio is to provide leadership and direction to the health and social care system as a whole. Perhaps worth asking you about a matter that has been raised with other relevant witnesses and that's about the size and scale of the Belfast Trust. Obviously a huge organisation responsible for delivering a very wide range of services across many individual facilities. I just wonder, first of all, did you ever have any specific role from your position of providing leadership and direction to the system of examining the corporate governance structures of the Trust? 11:19 11:19

A. Not examining in detail the corporate governance structures within the Trust. Certainly as part of the routine accountability mechanisms, that was based on statements of assurance that were coming from the Trust, that their corporate governance procedures were sufficient and robust. But I think the question is, I didn't undertake a detailed deep dive review of those corporate governance arrangements within the Trust. 11:19 11:20

61 Q. You were never involved yourself in a specific review of those matters?

A. No.

62 Q. In your experience, and I appreciate it is quite a broad question, but did the sheer size of the Trust pose difficulties for the Department in overseeing its operations? 11:20

A. I don't recall the size of the Trust specifically caused difficulties for the Department. I think

certainly there was a recognition in the Department that the Belfast Trust was a very large and complex organisation. From time to time, and I can't off the top of my head recall a specific example, but there may have been frustration sometimes maybe about the speed of response to a question from the Trust in the context of knowing the size and scale of the organisation. If I can maybe come at the question -- if the question is, if I may, sorry. 11:20

63 Q. Well it's very much in the context of oversight, did the size of the Trust cause difficulty for the Department in exercising its oversight functions? 11:21

A. No, it didn't cause us in terms of the oversight function. As I say, from time to time maybe the speed of response. And certainly in many ways you can see elements of that in the correspondence between Sean and Charlotte and Martin Dillon at the tail end of 2017, that the Trust, there was a view that the Trust wasn't responding quickly enough or in a comprehensive way. There would have been acknowledgment that that may have been an issue about the size and scale of the Trust. But I think, and I'll just touch, I'll not go into it now, I think there are two issues. There is the size and scale of the Trust and then there is the Trust response to that complexity and size and scale and how it is configured. I think some of Charlotte's comments, yesterday particularly when she benchmarked the position in Leeds were very interesting just about the differential structures which we'll come on to. 11:21 11:21

64 Q. I am just wondering from your leadership perspective looking at a field such as Learning Disability Services, I mean would you accept that within the context of such a large structure it can tend to be overshadowed by other services? 11:22

A. I couldn't push back against that, I think it's a fair assertion.

65 Q. I wonder if you were charged with the responsibility for designing the healthcare framework at Trust level, might it benefit from being reconstituted with smaller individual parts? For example, one might have a Mental Health and Learning Disability Services within a smaller unit. Is that an attractive option do you think? 11:22

A. I think it would require some careful analysis, but particularly in a context where we have very constrained resources. Certainly one of the frustrations that I have in, we talked earlier about the financial allocation process, we have been in the depths of a financial crisis I think now for nearly as long as I can remember, particularly in the health service and broader public services. There is always an understandable cry to protect the frontline and put money towards the frontline. I think this issue and some other issues that we have dealt with highlight that sometimes we can do that at cost to the overall governance and oversight. So whether the answer is to fragment the system by creating smaller units or, and I think it was why I was drawing the link to some of the 11:22 11:23 11:23

points that Charlotte made yesterday, in other places it strikes me that maybe they have larger comparable units to us but they put in place more management and oversight structures so it's not necessarily the frontline. I always take the view you can't have an effective frontline unless you a very effective back office doing all the important things, including governance oversight and accountability. I think at times we have hollowed out that function a little bit. So it is maybe not a structural issue as opposed to an investment issue in terms of areas that are seen not as being on the front page but are absolutely essential if you want world class services. 11:24 11:24

66 Q. You refer to governance oversight and accountability. Of course one of the questions that the Inquiry is looking at is whether the actual governance structures in place at the relevant time were actually effective in ensuring safe and effective care. You touch on this in paragraphs 33 to 39 of your statement. You talk about the evolution of the oversight arrangements over the years, but I just wanted to bring you to the observations that you make in paragraph 38. You say: 11:24 11:24

"The HSC governance arrangements as they were structured during my time in post were in line with the relevant requirements for public sector bodies in Northern Ireland. There were clear and well established lines of accountability in place for the HSC system as a whole which are described in section 6 11:25

of the HSC framework document which was exhibit MMcG31 to Mark McGuicken's statement of 13 February 2023, para 4.6. Exhibit MMcG1 to the same statement sets out the specific oversight arrangements for MAH."

11:25

I am not going to take you specifically to those. You then go on to say:

"While this is ultimately a matter for this Inquiry, I had no evidence during my time in post to indicate 11:25
these oversight arrangements were not effective. I was aware that the report of the Leadership and Governance Review in 2020 did identify some shortcomings in the oversight arrangements for those specific social care functions which are reported on through the delegated 11:26
statutory functions arrangements and in response I understand the Department is carrying out a review of these. However the risk of abuse to vulnerable individuals, whether through neglect, incompetence or malign intent remains persistent in all healthcare 11:26
settings and efforts to eradicate and minimise these continue to evolve. It remains the responsibility of the relevant arm's length body to escalate any concerns appropriately through the established structures and the effectiveness of the extant governance arrangements 11:26
is dependent on all stakeholders recognising their obligations and taking the appropriate steps to assure themselves that they have appropriate and proportionate measures in place to meet these obligations."

Now, is it fair to say that you're talking primarily about the oversight of the Trust at departmental level?

A. Yes but that would ripple in, I think -- I'm reading it there and forgive me if the wording is perhaps a little clumsy. I think I'm trying to differentiate there between the architecture of oversight and the practical application of those oversight arrangements. When I refer to the arrangements, I mean the oversight of the Trusts and how that ripples down through it. I think the second half of paragraph 38 is making the point about it's the responsibility to escalate concerns and the effectiveness of arrangements is dependent on all stakeholders recognising their obligations. I think it's a point that came out in the Leadership and Governance Review, that in shorthand terms the architecture seemed sound but maybe the practical application of that was less than it should have been.

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67 Q. That's what I was going to ask about. I want to hone in on that phrase you used: "No evidence during my time in post to indicate these oversight arrangements were not effective". But given the knowledge that we now have of what was occurring at the hospital, evidenced by the CCTV footage, doesn't that actually bring into question dramatically the effectiveness of the oversight arrangements?

11:27

11:28

A. Absolutely, clearly and unequivocally something was happening that should not have been happening and should have been detected. But I think I'm just trying

to differentiate between the arrangements and the practical application of the arrangements. My sense is that it was a practical application of the arrangements where the greater issue arose, but I would also just have to acknowledge the points that I think Dr. Maxwell, I heard you make in earlier sessions, about fundamentally it's a model based on responding to problems as opposed to a model that proactively looks for comfort and assurance that positive things are happening. I mean that struck me as a very, very interesting point and one that I think, you know, needs a lot of closer examination and how could we develop and implement such a position. 11:28 11:28

CHAIRPERSON: Mr. Doran, we have been going an hour and a half, complete that question but I think we ought to break. 11:29

68 Q. MR. DORAN: I am coming to the end of this topic in fact. Given what we know now, and of course we're operating with the benefit of hindsight, could and should the Department's oversight arrangements have picked up on what was occurring within the hospital? 11:29

A. If we park the issue about the evolution of the arrangements to one that looks for, proactively looks for positive assurance, in terms of the arrangements we had, short of the Department moving into the position of reperforming, virtually reperforming some of the work of the Trust or being beside the Trust in real time when this was happening, which would require a massive increase in resourcing for the Department to do 11:29

that. Unfortunately with governance and oversight sometimes there is trade over between the resources you have available to do it and what you do. I think with the framework that we had and the resources that we had, I can't point to a definitive place where the mechanism, and by that I mean more the architecture than the application, slipped up and we should have identified something from a departmental perspective as opposed to should it have been escalated up to us at an earlier level. 11:30

69 Q. What about the Early Alert that was received in respect of Ennis, and obviously the well recorded difficulties in discharge and delays in resettlement? I mean presumably those issues were on the Department's radar?

A. Sorry, forgive me, in terms of the Ennis issue we are talking about 2012/2013? 11:30

70 Q. Yes?

A. I was focussing in this paragraph in terms of my time. I would accept Ennis clearly, I think there was the 2013 submission to the then Minister which indicated that an SAI had been initiated which turned out not, but there was clearly a flag there that there was something amiss and I think more curiosity and follow up by the Department at that stage would have been appropriate. I think that's an absolutely fair point. 11:31

71 Q. That is essentially what I am getting at.

CHAIRPERSON: Could I just test something you said a bit earlier in relation to you can't really have the Department sitting in the Trust as it were or taking

over the Trust and I think everybody understands that. But doesn't it depend on what information you, the Department, ask for. If, for instance, the Department is particularly interested in ambulance waiting times outside Accident & Emergency, that's something you can ask for, daily or weekly updates, is that right?

A. Yes, absolutely.

CHAIRPERSON: And that happens?

A. Yes.

CHAIRPERSON: So in acute services there is all sorts of information I imagine that you want regular updates about because otherwise you're going to get an Early Alert and something is going to hit the press, is that a fair point?

A. It's a fair point but it is also, using that example, for example ambulance waiting times just to differentiate between -- I am referring more to my time when the Health and Social Care Board was a separate entity from the Department, that was in transition. Some of that fall within the performance management aspect that was the Board's responsibility to over -- now, just to say the performance management in itself is a very legitimate and important entry point into accountability mechanisms that if there are recurring issues of performance.

CHAIRPERSON: Yes.

A. That should come up into the accountability conversation.

CHAIRPERSON: And is one of the difficulties that in

areas such as mental health and learning disability, assessing performance is actually rather harder?

A. Yes, but that's particularly --

CHAIRPERSON: It needs to be done.

A. That's particularly true in those areas but I think that's a real problem that we have, not just across health and social care, but across public service in Northern Ireland. We fixate on counting things that are easily counted as opposed to counting and measuring outcomes and I think certainly patient experience is a hugely important outcome measure. 11:33 11:33

CHAIRPERSON: I think we'll probably be coming back to this but we better take a break. We'll take our 15 minute break now. Take a break, you will be looked after and we'll be back here in 15 minutes, thank you. 11:33

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

MS. ANYADIKE-DANES: Sir, I am conscious that we are in the middle of the witness's evidence. 11:51

CHAIRPERSON: Does this relate to this witness?

MS. ANYADIKE-DANES: If you would afford me a few minutes after the witness's evidence is closed, I have instructions. I don't want to interrupt the witness's evidence. 11:51

CHAIRPERSON: I'll consider that but please take a seat now and let the witness continue.

MS. ANYADIKE-DANES: I understand that, Sir, but what you have said is you will consider it. You haven't

said that you will at least allow me to speak.
CHAIRPERSON: At the moment I am not allowing you to speak. We are in the middle of an important witness.
MS. ANYADIKE-DANES: Not at the moment. I haven't asked do it at the moment, Sir, I have asked to do it after his evidence. 11:51
CHAIRPERSON: Ms. Anyadike-Danes, will you take your seat, please. Right, let's carry on with the witness and I'll hear any application in due course.
72 Q. MR. DORAN: Now, Mr. Pengelly, in the next paragraph of your statement, that's paragraph 39, you mention a specific initiative that you introduced when you took up the post of Permanent Secretary and you say: 11:52

"One of my early decisions was to instigate regular meetings with the Chief Executives of key ALBs through the establishment of a HSC senior manager's forum which sought to take a strategic view of the challenges and opportunities the HSC system was facing. I exhibit at exhibit 16 a copy of the letter establishing the forum." 11:52

As we established earlier that's not actually at exhibit 16 but it appears in the additional DoH organisational module bundle at page 99, if that could be brought up, please. So it's MAHI DoH OM bundle at page 99, thank you. So, one sees there a letter from the Permanent Secretary and HSC Chief Executive to various other high level officials within the other, 11:52

within the Trusts and the HSCB, PHA, BSO, NIAS.
If you scroll down please. You refer there to a proposed HSC Senior Managers forum. You say at the outset:

11:53

"I have been struck by the multiple layers of engagement within and between our respective organisations. While much of this is of course necessary and value adding the current approach inevitably requires us to wear our organisational hats when together. This is often appropriate, however I feel we are perhaps missing an opportunity to take a more strategic view of the challenges and opportunities before us."

11:53

And then you go down to talk about the proposed meetings. Just at the second bullet point there you say:

"The meeting would absolutely not be an accountability forum, it would be a space for the senior team to discuss issues of common concern and to do some horizon scanning to better prepare for the future."

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11:54

Can I just ask did this senior managers forum meet throughout your time as Permanent Secretary?

A. That group of individuals, its name changed. It started as the senior managers forum. It eventually largely through the period of Covid transformed into I

think it was called the Rebuilding Management Board, RMB. At one point in time it was called, a dreadful title, TIG, the Transformation Implementation Group. Is it helpful for me to say the genesis of why I moved to this? 11:54

73 Q. Yes, please?

A. It may have come out before, but uniquely the Permanent Secretary role of the Department of Health has two job titles, which isn't the case in any other department. So it is Permanent Secretary of the Department of Health plus Chief Executive of Health and Social Care, Health and Social Care being the Northern Ireland equivalent of the NHS. In England, for example, there is a separate stand alone NHS with a Chief Executive and the department is purely policy. I struggled a little bit with this upon my arrival in July, because I was Chief Executive of an organisation that in legal terms didn't exist because Health and Social Care in Northern Ireland is a loose confederation of all the individual 17 arm's length bodies. 11:55

74 Q. I see.

A. But I also found it odd that there was no dialogue at that strategic level. I would speak frequently and regularly to each individual organisation. So this was just about trying to bring what I called the senior leadership team together. This wouldn't have been on my radar by the time I wrote that note. But over the coming months issues, for example, I remember one issue, Daisy Hill Hospital in Newry had a crisis in

terms of trying to keep the Emergency Department open. It couldn't recruit emergency department consultants. It went on a very aggressive campaign of recruitment external to Northern Ireland. It stabilised and about two months after it got stability another Trust advertised for EMERGENCY DEPARTMENT consultants and took -- so it was about saying to the Trusts let's take a holistic Northern Ireland strategic approach and, for example, if you are going to advertise for a consultant speak to the other Trusts before you do it, make sure that by solving your problem you don't create a bigger problem in another Trust. So eventually those conversations took place, they didn't need to take place in this forum but for me it was a very important way. My mantra throughout my time leading the health service was trying to create what I called a one system approach where people talked more about I work in the health service in Northern Ireland rather than I work in a specific Trust, and to get that collaboration and integration across, that was the basis for that. 11:56 11:56 11:56 11:57

75 Q. But your reference to Daisy Hill is interesting because the question I was going to ask was, given the nature of the forum, I take it that it would not typically involve discussions around individual facilities?

A. No, it wouldn't talk about individual facilities but it would talk about system-wide solutions to problems that manifested in individual facilities. Sorry, I used Daisy Hill as an illustration of the point. What I would have said in this environment was there needs to 11:57

be dialogue between Trusts when you are getting into consultant recruitment, it doesn't need to happen here and we don't need to talk about individual cases, but we have to avoid the situation where one Trust does a thing which causes other Trusts difficulties. 11:58

76 Q. And do you recall did Muckamore ever feature in the context of this body's work?

A. I don't recall it ever. It may have been mentioned at some point but I can't, at this remove I can't recall that happening. 11:58

CHAIRPERSON: Sorry, what's the time span for this body? I haven't got a grip on --

77 Q. MR. DORAN: Is it 2014 onwards?

A. This was established in 2014 and this forum, although the title changed, it existed right up to the point I left in 2022. 11:58

CHAIRPERSON: But the reason I ask that, and you may not be able to comment, is that some of the evidence that we've heard was in relation to when Muckamore hospital was being denuded of staff because so many were being suspended, that there was a call on other Trusts to provide I think it was six learning disability nurses from each one. Well, that's precisely what this is talking about because what you're doing actually is raising a difficult issue for other Trusts. Mr. Doran, were you going to go to that? 11:58 11:59

78 Q. MR. DORAN: I was going to ask. It is arguably a somewhat analogous situation to that that you have described in respect of Daisy Hill?

A. That's correct. But I think this forum was more about trying to create the culture and attitude at a very senior level to allow those discussion to happen at the granular level about individual sites. This wouldn't have been the place to talk specifically about a problem at one facility.

CHAIRPERSON: No, I understand that.

A. In parallel with this there was a separate issue, I'll not go into the detail, but there was a performance issue in a Trust in terms of clinical performance. This was early in my tenure. When I spoke to the individual Trust the answer to that was that two very senior clinicians had fallen ill and were off for a period of two months and it was performance against one of the red flag cancer issues. I, as it turns out naively, asked the question of the Trust but in this period when you were down two key resources, what help did you get from other Trusts, how many of your patients did they take or how many clinics did their consultants take for you. The answer was none because the Department holds each Trust to account for their own performance so why would anyone else help someone else? So we quickly, and it very much mirrors what we were trying do here, we moved to the point with Trust Chief Executives where we emphasised accountability was more about your contribution to wider system performance rather than individual organisational performance. Something just to be clear that Trusts were exceptionally responsive to, that struck me this

was something they had been wanting permission do for a long time as opposed to driving change. That's just an important contextual point.

PROFESSOR MURPHY: Another reason why it is a bit surprising though that Muckamore didn't come up is that, you know, it had a big resettlement programme and it needed the help of the other Trusts for that to happen and we have heard sometimes that there were debates between Trusts. 12:01

A. Yes. 12:01

PROFESSOR MURPHY: About resettlement but did that never come up at this forum?

A. It never came up. And, sorry, I don't have the minutes of all the meetings. In the early stages there wouldn't have been a detailed record. As this group transformed into what became the Rebuilding Management Board there would have been more granular minutes so someone can look at that. As time moved on, particularly when we get into the resettlement phase post-2019 and the challenges that endure, this group throughout '20 and '21 was very much focused on the Covid, it became absolutely focused on firstly the Covid response and then rebuilding the health and social care system after Covid. So the ordinary business issues like that wouldn't have necessarily been on the agenda. 12:01 12:01 12:02

79 Q. MR. DORAN: Chair and Panel, we can of course follow up by ensuring that the minutes of the meetings of that particular group are checked to see if there is in fact

a reference to Muckamore, but that is a separate exercise, Mr. Pengelly. Just a question actually in relation to the group, was that the forum that was used for the summit meeting to discuss the Way to Go Report that we will look at later? 12:02

A. No, no, it was separate.

80 Q. It was especially convened for that particular matter?

A. Yes.

81 Q. Now, before we look at 2017 and afterwards, I want to ask you briefly about prior events and specifically the 12:02 Ennis episode that we mentioned earlier on which obviously occurred in 2012, which was before your time as Permanent Secretary. But Ennis obviously resulted in a fairly lengthy adult safeguarding process and I'm interested in how ultimately the report made its way to 12:03 the Department. You deal with this in paragraphs 8 and 9 of your statement on page 2. You've also exhibited a series of e-mail, a series of e-mails between the Trust and the Department that led to the production of the report to the Department, isn't that right? 12:03

A. Yes, that's right.

82 Q. And it seems as though the report was provided to Marie Redmond at the Department in an e-mail from Marie Heaney at the Trust on the 17th October 2017. That's at page 94 actually if we can have a quick look at 12:04 that. So, the e-mail is basically attaching the report "Dear Myra, as questioned Marie". The date is 17th October 2019. If one scrolls down obviously there has been a request for the report.

"Thanks Marie, I can't find any trace of the report in the Department and some who were around at the time don't recall seeing the report itself. It would be helpful if you were able to get a copy to us." 12:04

And if you go on to page 95 then we are going backwards in the e-mail chain. If you just scroll down please, you can see the message from Marie Redmond to Marie Heaney: 12:04

"Marie, would you be able to share a copy of the Ennis Ward Adult Safeguarding Report with us. We do not appear to have received a copy into the Department at the time of the report being finalised or since and it would be helpful to see it now in light of the ongoing investigation at Muckamore." 12:05

I don't need to go through the whole chain but it shows that the Trust alerted the Department to the Ennis Investigation Report after being contacted by the Irish News to say that they had the report? 12:05

A. Mhm-mhm.

83 Q. Now, just stepping back from this for a moment, so it seems that although this matter had been the subject of an Early Alert, the actual Safeguarding Report didn't find its way to the Department until a much later date, in fact a couple of years after the CCTV -- yes, a couple of years after the CCTV revelations. In 12:05

retrospect does that surprise you that the report hadn't been received by the Department earlier?

A. In the context of what I know now, absolutely it does. I mean I think even a few days ago my response to that question would have also been a very resounding yes, it does surprise me. But, listening to the evidence of Sean Holland, the point he made, which I think is relevant, is that lots of safeguarding issues are taken forward by Trusts on a regular basis and they don't all need to come to the Department, so I think that's something that would cause me to pause. I think pausing on it and reflecting the subject matter of this, on balance I think my instincts still are this should have been something that was the subject of much more dialogue with the Department, at the time it should have been put on the Department's radar at the time as opposed to in 2019. 12:06 12:06 12:06

84 Q. When you say the subject of much more dialogue, I take it you mean not only the Trust informing the Department, but the Department actually asking the Trust what was happening? 12:07

A. Yes, because I think, and as you've said it predates my time, but this is a Safeguarding Report as distinct from an SAI report. But at the point in time there was a 2013 submission to the Minister that referenced an SAI report was being taken forward. 12:07

85 Q. Yes?

A. That it turns out now, the individual who wrote that submission I suspect was told that. Notwithstanding

the fact that that is incorrect, I think it's a fair and reasonable conclusion to say there was knowledge that something was happening and --

86 Q. And something that involved the Public Prosecution Service? 12:07

A. Yes.

87 Q. Taking forward a prosecution?

A. So I don't want to get hung up on the fact of whether it was an SAI or a Safeguarding Report, I'm not sure -- but the fact, and notwithstanding the fact that, you know, maybe if I asked a colleague at the time they would say, well, we were told by the Trust that it was an SAI report and the mechanism that the SAI would be escalated through the Health and Social Care Board to us, there was a natural trajectory for that to come in so it didn't need to be followed up. Then maybe with the passing of time it slipped off the radar but I think there was a red flag there and we can't escape that. 12:07 12:08

88 Q. You wouldn't resist the proposition that the Department could have been more inquiring about the ultimate -- 12:08

A. I think that's a very fair comment.

89 Q. Moving on then to the September 2017 revelations and the initial reaction of the Department to the emerging allegations has been dealt with by other witnesses. You provide an early briefing that you received on the matter from Sean Scullion in the Learning Disability unit on the 29th of September 2017. You mention that in paragraph 45 and it's exhibited at page 278. If we 12:08

go to page 278, please. So I don't need to go into this particular note in detail but it suggests that the Department -- Chris Matthews, was he an individual within the Department?

A. Yes, Chris would have worked directly to Sean Holland.

90 Q. Yes and he heard about the breaking story from Gavin Robinson MP on 30th August?

A. That's right, yes.

91 Q. Formal notification had been given by the Trust to the Department through the Early Alert system on the 7th of September 2017?

A. Yes.

92 Q. Now, as we've discussed briefly earlier the Department then was seeking assurances from the Trust as to the measures that were being taken to address the matter?

A. Yes.

93 Q. Isn't that right?

A. Yes.

94 Q. I am not going to take you to the correspondence but there was correspondence from the Chief Nursing Officer and Chief Social Worker addressing these matters directly with the Trust. And indeed, the Panel has heard the Department had concerns about the reporting and handling of the matter by the Trust and was seeking further assurances?

A. Yes, I think that's fair. I just add it was interesting, it's maybe unfair to read too much into it but the call from Gavin Robinson, I think it was 30th August, that triggered an Inquiry from Chris Matthews

to a counterpart in the Belfast Trust to ask for more information. It's an obvious conclusion that it was the reaching into the Trust from the Department that nearly prompted the Early Alert to us.

95 Q. Which followed on 7th September? 12:11

A. Where the reality is the Early Alert system is designed to bring to the Department's attention swiftly issues like this. So, I don't think it would be an unfair conclusion to say in normal times the Early Alert maybe should have predated the Gavin Robinson phone call. 12:11

96 Q. Yes and that presumably is the Department's view on this matter?

A. And that's the intention of the Early Alert system, yes.

97 Q. Now, is it fair to say, though, that the approach of the Department then was to seek assurances and to give a fairly strong steer as to what was expected of the Trust? 12:11

A. Yes, very much so.

98 Q. But, the approach of the Department appears to be, and correct me if I'm wrong, ultimate responsibility remained with the Trust to deal with the matter and central to that was the commissioning of a Level 3 SAI? 12:11

A. Yes.

99 Q. Now, just so that the Inquiry and indeed the public can understand, given the serious nature of this matter, could even more robust intervention have been contemplated by the Department if it had viewed the Trust's response as inadequate? 12:12

A. Well, I mean I think the answer has to be yes to that. If we've -- I mean clearly, and you can see from the tone of the letter that there was, there was much concern on the part of the Department about the way the Trust had handled this issue. I think for there to be a further escalation it would have required us to conclude that the failure in handling this issue was evident of a wider problem and that that would require some further intervention from the Department as opposed to here is this very specific problem, you know, the ball has been dropped in terms of the Early Alert system, the response to information, the way this has been taken forward. You know, there was a very, very clear signal sent from two senior colleagues in the Department to the Chief Executive of the Trust that we are concerned about this, this needs to be addressed. So, the specific issue, I'm not sure there was a further escalation but if the view had been it was -- 12:12 12:13 12:13

100 Q. I am wondering is there a mechanism, for example, whereby the Department could have said no, sorry, we are not happy about how this is being handled, we are actually going to take over the strategy moving forward or would that be completely out of step with the governance arrangements that are in place? 12:13

A. You would have to conclude that all options would have to be in play, depending on how seriously we viewed the issue. I'm trying to think while I speak. If your proposal was had the Department -- if your question was

if the Department at that time was so concerned that the Trust was incapable of dealing with this, did we feel our hands were tied and we still had to let the Trust get on with it? Absolutely not. All options would have been in play for us to consider escalation.

DR. MAXWELL: What other options would have been available?

A. Well, I think that would have required senior colleagues sitting down to try and identify those options but we could have directly, either with colleagues in the Health and Social Care Board or through other organisations, commissioned some work separately and independently rather than ask the Trust to take the lead on the initial work on this.

CHAIRPERSON: Would you have the power to put the hospital into special measures?

A. Yes.

CHAIRPERSON: But can you do that with one individual hospital as opposed to with the whole Trust?

A. I don't think special measures are, you know, defined in legislation and we can intervene. We certainly have the power to direct Trusts and health and social care bodies. Obviously that would be subject to a more informed legal view.

CHAIRPERSON: Sure.

A. My instincts are -- I would also at this point, I think it is very important to differentiate between what I would call hard power and soft power. There is the question would we have the legal basis to intervene

and do something, maybe in the context where the Trust was resistant to it. I would argue that the relationship that we had with all our arm's length bodies was such that we should be able to intervene and the sheer fact the Department is saying this needs to happen because here is a coherent case that it is the right thing to do in the public interest, that we wouldn't need to test all the legalities of that, there is a way do that. And certainly, just to add, that was my experience throughout. I can't ever recall -- there was an issue towards the tail end of, I think it was 2018 where there was a lot of public concern about the ongoing use of seclusion and there were some media stories that photographs were available about the seclusion facilities and they weren't being able to see them. I phoned the Chief Executive of the Trust and said publish the photographs, there is clearly no reason. So I had no experience where something that using soft power we asked Trusts or other arm's length bodies to do where they resisted that. 12:15 12:15 12:16 12:16

CHAIRPERSON: Yes.

101 Q. MR. DORAN: But ultimately then the response essentially was that of the Trust in commissioning a Level 3 SAI?

A. Yes. 12:16

102 Q. And as we know that review began its work in January 2018 and ultimately reported in 2018 through the Way to Go Report. And that of course directly led to the apology which you gave, to which we will return later

on. So I wanted to ask you now about the Department's reaction following on from Way to Go, and this was late 2018. It seems that the key element of the response was the action plan that features prominently in your statement and exhibits. 12:17

A. Yes.

103 Q. Now, can I just ask you some general questions about the plan, you provide early drafts of an action plan at Exhibit 6, page 140, and then Exhibit 9, page 158. I don't need to look at those in detail. Can I just ask 12:17 generally, are those early drafts of the same document that we ultimately see in a more developed form at exhibit 14 from August 2022?

A. Yes, just looking at them, yes, they are. This was an evolving document and I think the point is I formally 12:18 approved the document from recollection in about October 2019.

104 Q. October 2019. You explain that I should say at paragraph 17.

A. But in approving it I think we specifically made the 12:18 point it was a live document which is Civil Service speak for this document will continue to morph and change. I think the recommendations of the Leadership and Governance Review when they were available in 2020 were added to the action plan. 12:18

105 Q. Yes I'll come on to that?

A. Yes.

106 Q. It is fair to say that not only was it a live document then but it remains a live document today?

A. Yes.

107 Q. And in fact, Chair, for the record, the Department has provided a bespoke version to the Inquiry that shows the current state of play regarding the open actions and that's been shared with Core Participants. I may return to that briefly later. 12:18

But let's just look at the early gestation of the plan, Mr. Pengelly. The key moment appears to be the summit meeting on the 30th January 2019, isn't that right? 12:19

A. Yes.

108 Q. You provide a note of that meeting at exhibit 4, that's page 132. One sees the list of attendees. There is yourself, Mr. Holland, the Chief Social Worker, Dr. McBride, the Chief Medical Officer, Rodney Morton 12:19 Deputy Chief Nursing Officer, Jerome Dawson, Director of MHDOP DoH. David Gorcan, Director of Communications, DoH and Alison McCaffery then taking the note. Then further down Lourda Geoghan, Director of Improvement and Medical Director, RQIA, Marie 12:20 Roulston, Director of Social Care and Children, HSCB, Paul Cummings, Director of Finance, HSCB. Then you have representatives of the Trust, Northern, Southern, South Eastern, Mr. Dillon from the Belfast Trust and there is also a representative by phone from the 12:20 Western Trust.

I mean in fairness presumably you would say that the seniority of the attendees reflects the seriousness

with which the Department was treating the matter at that time?

A. Yes.

109 Q. I won't go through the note in detail because it's there for the record, I just want to pick up on a couple of points. If we scroll down to page 133 at paragraph 5. Paragraph 5 reads: 12:20

"At this point in the discussion Richard also stressed that he was not concerned with symbolic or token gestures being mooted around, for example, the closure of Muckamore and that the focus should be on moving forward on the basis of evidence based and co-produced options for the future." 12:21

Now I wonder can you explain what you mean by symbolic or token gestures, were there other possible initiatives being discussed at the time that you would have regarded as a symbolic gesture? 12:21

A. No, I think this paragraph is just simply reflecting that I was trying to convey the sense that this must be the trigger for real and meaningful intervention on our part to drive real improvement. It's not about trying to give the appearance of reacting to it. So, I wouldn't want to make too much of this paragraph that, you know, it's not that I had a list of things that I was wanting to rule out. What I was saying is nothing is ruled out, nothing is ruled in, whatever we do must be evidence based and co-produced, let's not jump to 12:21

doing something because we think it sounds good in terms of a sound bite, that was effectively the point.

110 Q. When you refer to closure did you mean immediate closure, is that something that was being mooted at the time? 12:22

A. Well, I think, this was early 2019, the SAI reports had touched upon the issue of Muckamore and I can remember, I can recall some discussions around this. There was also at the time I remember the point that some family members were making was that we should remove the title 12:22 of "hospital" from Muckamore because, I think their language was it's not fit to be called a hospital given what happens in it. What we had concluded, particularly in terms of the focus on resettlement and avoiding delayed discharges, for the short-term we 12:22 actually want to get it back to actually being a hospital as opposed to removing the title and accept that it is something else. Make it a hospital, a place where people go where they require treatment and intervention and when that treatment and intervention 12:23 has run its course, they move on. That's not to say that this should suggest that there was any attempt to rule out closure as a medium to long-term option. And I think, this point, I can't specifically remember it so I'm trying to join dots, there was reference to an 12:23 e-mail that Charlotte sent me in December where she was raising professional concerns about closure. I think that was, that would have played into the context that at this stage there was no contingency if there was an

immediate closure of Muckamore, there was professional concerns from the Chief Nursing Officer who was hugely respected across the Department. But we certainly weren't ruling that out as an option for the medium to longer term but for now it was about stabilisation, make sure what happens within Muckamore is safe and of sufficient quality. Focus on the resettlement progress, focus on addressing the delayed discharge process and then return to that issue in more calmer times. 12:23 12:24

111 Q. This was all in response essentially to the Way to Go Report?

A. Yes.

112 Q. One issue also that you raised concerns about at the meeting, if we scroll down to page 134, paragraph 9, you say: 12:24

"Richard also took the opportunity raise concerns about the wider cultural issues exposed by the report and the need to learn lessons and ensure they are also addressed in the action plan. He mentioned a recent whistle-blowing letter in relation to another unit that has recently been drawn to his attention." 12:24

There is also then, I should go on the next line: 12:24

"There was general consensus around the table that addressing these issues would perhaps be the most challenging aspect of the work that lies ahead."

Now, I suppose if one were critiquing the action plan which contains a lot of practical measures and targets, one might ask, how exactly does the action plan address this cultural issue to which you refer? 12:25

A. I think that's a very fair question. The action plan doesn't specifically address it. I think the point here, and again in hindsight maybe it's something we should have had a more granular focus on. Given the attendee list at this meeting fundamentally the 12:25 cultural point was a leadership challenge for all of us in the system and ultimately that would flow, as we took forward in 2018 we had published a workforce strategy, there was also, I can't just off the top of my head recall the specific date for it, but there was 12:25 a collective leadership strategy. At the heart of this, and I believe some of the cultural issues at play here were, I need to be -- I am not offering this in any way as an excuse or an alibi for what happened, but getting the culture right starts with recruiting the 12:26 right people, treating people in our system in terms of employees with respect and dignity and ensuring that they treat everyone they come into contact with with the same respect and dignity. I think large elements of our workforce felt that they weren't getting the 12:26 respect and dignity they deserved but we were demanding that of them.

So, as I say, I see this fundamentally as a leadership

challenge for all of us but I think the point is maybe with the benefit of hindsight some more granular measures within the action plan, just in terms of as opposed to articulating as a leadership challenge, as leaders what specifically are we going to do as a collective to deal with it might have been helpful.

113 Q. So cultural issues could conceivably be dealt with within the context of the action plan, although they also require leadership initiatives alongside?

A. There is absolutely no reason they couldn't be within the -- anything could have gone into the action plan. It was the action plan in response to the A Way to Go Report. So any issues of concern that were triggered by that report, whether specifically mentioned in it or not, that was absolutely a legitimate entry point into the action plan. 12:27

114 Q. Another question arises from the questions the Chair had before the break and I think just before the break you said "patient experience is a hugely important outcome measure." 12:27

A. Mhm-mhm.

115 Q. Looking back at the action plan now do you think it caters for providing mechanisms to ensure that the patient experience is in fact recorded and given due priority within reform of the system? 12:28

A. Again, I think it's fair to say, that's maybe another area for the benefit of hindsight the action plan could have been improved. There was other work going on in the system. I say at this remove I can't remember

either the timing or the specific granularity but there was the 10,000 Voices project that Charlotte McArdle was leading on in terms of capturing -- so whether there was a sense that that generic piece of work would have addressed this, given the specifics of this, again with hindsight, maybe including something specific on the patient voice in action plan would have been a helpful addition to it.

116 Q. Yes. Just kind of moving on chronologically, you had the summit meeting in January 2019 and then you have the first drafts of the action plan circulating in the early part of 2019. But it's fair to say, isn't it, that the concerns about the hospital weren't subsiding? 12:28

A. They weren't subsiding but they were being managed through some very specific interaction between senior colleagues in the Department. I wasn't part of that specific dialogue but there was an ongoing process of engagement that was happening and then was formalised in the Assurance Group later in 2019. 12:29

117 Q. Which we will come on to but as you note at paragraph 18, the RQIA carried out unannounced inspections in February and April 2019? 12:29

A. Mhm-mhm.

118 Q. And the RQIA then set out its continuing concerns directly to the Department in a letter to the Chief Medical Officer on the 30th April 2019 and that's in Exhibit 12 at page 203, if we can go to that please and I want to ask you a few things about that letter. I'm not going to go through it in detail but just on a 12:29

general level, were you surprised that the RQIA still had serious concerns about the hospital in April 2019, given that such focused attention had been brought to the hospital from September 2017 onwards?

A. I can't recall specifically my reaction in real-time when this was brought to my attention. But, you know, sitting here now I wouldn't have been surprised because this was a complex problem with no easy solution. I think the devil is in the detail in terms of that because, and there was a little bit as we get into the dialogue with the RQIA and the Belfast Trust, the one very specific point is Belfast Trust, and I think the reference in the submission, it talks about, I can't remember the exact term but some disconnect between the Belfast Trust and RQIA. RQIA were saying they had concerns about staffing levels but Belfast Trust were saying but the staffing levels are higher and the patient numbers are lower than a previous inspection when RQIA was content with it. So I think I was surprised that in some elements of it there was a suggestion on the part of RQIA that the Trust could have been doing more to deal with the issue. That would have surprised and disappointed me. The fact that, you know, if RQIA were saying despite the absolute best efforts and endeavours of the Trust the complexity of the problem means it is not perfectly resolved, that that wouldn't have been a surprise. But I think the RQIA concern was maybe there's more could be done by the Trust, it's not just about the

12:30 12:31 12:31 12:31 12:32

complexity of the issue.

119 Q. And that's something you were, well, you've said surprised but perhaps concerned about?

A. Frustrated and concerned and certainly it was a point that I think in discussion at the time with Sean Holland he was sharing and it was feeding back into the dialogue that was happening with the Trust. 12:32

120 Q. Yes. And I'm not going to ask you about the details of the particular issues that the RQIA was looking at, but there is one detail of the letter that I want to ask you about. And if we go to page 206 please. At the bottom of the page the letter reads: 12:32

"Given that we have been able to demonstrate limited progress only in relation to assurances previously provided and in light of recent contacts by staff to RQIA as above, we are now recommending that DoH implements a special measure for Belfast Trust in relation to MAH." 12:33

And then over on page 207 at the top: 12:33

"We recommend the establishment of two task forces, one, a task force to stabilise the hospital site in support of patients currently receiving care and of staff delivering that care. And, two, a task force to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community. I would highlight a pressing need to 12:33

ensure that senior operational nursing leadership is provided in the hospital as soon as possible. It is essential that frontline nursing staff now receive appropriate support as they continue to deliver care in the most complex and challenging environments." 12:34

Now, just on that final point, presumably it would have been a matter of concern that senior operational nursing leadership was lacking in the view of the RQIA over a year and a half after the revelations had emerged? 12:34

A. Mhm-mhm, yeah.

121 Q. And I mean, looking back, does it seem very surprising that that matter hadn't, in the view of RQIA, been tackled head on by that stage, given the time that had elapsed since the revelations? 12:34

A. In those stark terms, yes. What I just can't recall at this stage is the Belfast Trust position because I know there was some elements of the RQIA analysis that they felt they had a counter narrative to. I just, I can't recall the specifics of whether this was, you know, a 12:35 contested view. But ultimately, and I think again this came out in earlier evidence sessions, there was a move to put Francis Rice in to provide some additional support. The fact, and Charlotte emphasised this, that was very much welcomed by senior nursing leadership in 12:35 the Belfast Trust. I think that in itself reflects the fact that maybe there was an acknowledgment in the Belfast Trust that this was a legitimate point from RQIA so in those terms it would be a surprise.

DR. MAXWELL: But actually we heard from Charlotte that it was her requirement that Francis Rice go in. It was accepted by Brenda Creaney but the Trust were not saying we've got a problem, can you provide us with extra senior nursing support.

A. No, sorry, and I wasn't meaning to suggest. I think the point Charlotte made was she concluded as Chief Nurse that this was required.

DR. MAXWELL: Yes.

A. When she put it to the Belfast Trust there was no push back and it was welcomed, not that they were invited to do that.

DR. MAXWELL: At this stage, two years after the CCTV, there is a recurring story of Belfast Trust accepting when people bring things to their attention, but were you not concerned that two years after this it still required the Chief Nursing Officer to make these suggestions, that Belfast Trust weren't being more proactive?

A. Yes, it is a matter of concern. The point I'm just slightly hesitant on, and I can't recall any -- Francis Rice was an exceptionally experienced and competent individual who made a huge difference when he went in. I'm not sure whether Charlotte reached towards Francis because of his skill set and experience or was the view that there was no one in Belfast Trust. I'm clumsily trying to make the point, was this an issue that Belfast Trust had the capability and capacity to put more resources towards Muckamore but choose not to or

they simply didn't have the resources.

DR. MAXWELL: Even if they didn't have the resources would you not have expected them to reach out and say we don't have the resources?

A. That was the point I was coming on to make. If the answer was the resources weren't there, that is a conversation they should have been prompting, firstly with the Health and Social Care Board in terms of the resourcing point and equally with other Trusts in terms of reaching out for help to other Trusts, formally through the Health and Social Care Board and ultimately to the Department and clearly it is a concern that that wasn't happening. 12:37 12:37

DR. MAXWELL: But given the concern that has been expressed, the delay for the Early Alert, only came after the Department had reached out after the MLA had contacted the Department. There seems a recurrent theme of the Department going back to the Trust and saying this is an issue, we need to do this. Did that not affect your confidence in the Belfast Trust's ability to manage the situation, notwithstanding that it was complex? 12:38 12:38

A. Yeah, I mean at the time it did and we had concerns. But the earlier questions about should we or did we consider other alternative forms of intervention. I think, and as I say, I can't recall a very specific conversation on this but I think our options, and whether they were being formally considered or they were being thought about in real-time, I'm not sure 12:38

there were a huge amount of other options for us other than continuing to work with the Trust and seeking to provide support.

DR. MAXWELL: One of the things that happens in England is that sometimes, it was monitored at the time, would appoint an improvement director from outside the Trust to work with the Trust if they thought they had concerns about performance. Did you not ever consider getting somebody very senior to come in as an improvement director? 12:39

A. It wasn't an issue that was ever discussed with me. I'm not sure if it was ever discussed at other levels within the Department and ruled out and not brought to me but it wasn't brought to me.

DR. MAXWELL: Because of course you have a very large pool of associates with senior experience through the HSC Leadership Centre so you would have had access to people with a lot of experience? 12:39

A. Yes, we would have had access. I'm just not so sure the pool is desperately large and experienced. And I say that because one of the issues that certainly I noticed in my time in health was that for senior posts at director and Chief Executive level the candidate pool was diminishing rapidly over the eight years of my tenure. The last couple of senior competitions we ran we were getting one applicant. 12:39 12:40

DR. MAXWELL: But I think there are a lot of retired directors who work for the HSC Leadership Centre as associates?

A. There may be. I am not sure of the details of those individuals.

CHAIRPERSON: Can I just ask whether you have ever, to your knowledge, used that system of bringing in an improvement director from outside the Trust? 12:40

A. Not that I am aware of at all. I can't recall certainly in my time.

122 Q. MR. DORAN: Yes, I want to bring you back to the RQIA recommendations in the letter specifically relating to the task forces. Now, those recommendations are then 12:40 addressed in the briefing paper from Sean Holland to which that letter is annexed and that you also exhibit at Exhibit 12, that's page 196, if you have a look at that please. So this is a briefing paper following on from the RQIA report. Can I ask, is this essentially 12:41 how MDAG came about?

A. Yes.

123 Q. And can I ask this, was MDAG expected to perform the work of the two task forces recommended by the RQIA? Just to remind you of those, the RQIA was saying that: 12:41

"We recommend the establishment of two task forces, one to stabilise the hospital site in support of patients currently receiving care and, two, a task force to manage, deliver and govern a programme to relocate 12:42 patients."

I mean was MDAG essentially intended to perform the role of those task forces?

A. My understanding is that MDAG was performing the role of stabilisation. The task force to manage, deliver and govern a programme of relocation and discharge was a thing called the Regional Learning Operational Delivery Group which was a separate group that was established under the auspices of MDAG and I think reported through to MDAG.

124 Q. Essentially MDAG and that subsidiary group were the Department's response to those recommendations made by RQIA? 12:42

A. Yes.

125 Q. MDAG then is obviously jointly chaired by the CNO and CSW?

A. Yes.

126 Q. As for your own role it seems that you gave it the go ahead. After it was established did you play any part in its operation? 12:42

A. Not in the operation of MDAG. I didn't attend MDAG. I mean I would have received updates from both Charlotte and Sean and that would have been more in the context of sort of regular monthly stock take sessions I had with each of them, just keeping me aware of it. And, you know, any issues that they needed to escalate for anything that they required my input or action on, but I wasn't routinely part of that process at all. 12:43

127 Q. So you're speaking at a bit of a distance but do you have a view on whether the structure has in fact reinforced and strengthened the existing arrangements as you put it in paragraph 19?

A. I think they have and I think the credit for that goes to Charlotte and Sean because of the intensity they brought to this. They are two of the most respected and competent colleagues we have in our health and social care system so I think the work they did and their leadership of MDAG did bring that to it. 12:44

128 Q. Now, you also mention, at paragraph 48 of your statement, other meetings that you attended later in September 2019. So this is moving on from A Way to Go, the summit meeting, the RQIA concerns, the establishment of MDAG. So we turn to September 2019 and these were meetings with Sean Holland and Charlotte McArdle and the Trust to address ongoing concerns about the stability of the services being provided at the hospital. I think they were called Department and Belfast Trust Liaison meetings, is that right? 12:44 12:44

A. Yes.

129 Q. And you refer to meetings that took place on the 6th and the 13th September 2019 and you exhibit those at exhibits 18 and 19. So those are basically high level meetings between the Department and the Trust, isn't that correct? 12:45

A. That's right, yes.

130 Q. We look at the first meeting, I just want to ask you a few questions about the content of the minutes. The first meeting was on 6th September 2019 and that's to be found at page 284. You can see there the list of attendees. I wanted to look specifically at paragraph 6, and this is something we touched on briefly earlier. 12:45

"In discussion it was suggested that Muckamore's status as a hospital could be removed, given only two patients were under active treatment, which might allow a different staff mix to be deployed under a social care style model. The Department would check the process for removing hospital status however it was noted it was likely that significant input from doctors and nurses would still be needed to manage the risks which came from having such a significant number of challenging individuals together in one place. " 12:46 12:46

I am just wondering, it's a reference to a suggestion. Do you recall where the suggestion came from?

A. I'm honestly not sure whether this is a vague recollection in my mind or whether this is just me trying to rationalise this. I think it was more a suggestion from the Trust and that removing that designation from it might help, because staffing ratios and staffing levels was a core issue for them and changing the descriptor might have offered some assistance in terms of the staffing ratios. 12:46 12:46

DR. MAXWELL: But it wouldn't have helped the patients. If you are saying the patients need these staff, we can't recruit them so we'll change the status so we don't have to worry about the fact that we haven't got them. 12:47

A. It wasn't accepted as a way forward. The minutes recorded it was going to be looked at. The minutes

recorded significant input from doctors and nurses in terms of managing risks which is about ensuring that --

DR. MAXWELL: Do you think it was appropriate for it even to have been discussed?

A. It would have been appropriate for it to be discussed if it was done in the context of improving patient care. 12:47

DR. MAXWELL: How would it have been? How would reducing the number of staff, therefore not meeting patient's needs have improved the quality of their care? 12:47

A. If the risks were properly -- sorry, as I say, I think this was a suggestion that was tabled so, you know, in the course of these meetings you can't stop people raising suggestions. 12:48

DR. MAXWELL: Okay.

A. But I absolutely take your point, that the guiding principle has to be does it improve the care that was being provided.

PROFESSOR MURPHY: Also presumably by that stage one of the reasons there was such a staffing problem is that Muckamore had got a really bad reputation, so changing it into social care wouldn't have helped that either. 12:48

A. Yes.

131 Q. MR. DORAN: Presumably then it's not an idea that was pursued? 12:48

A. I'm not sure what further analysis was done by colleagues but certainly it never progressed as an issue and the designation of "hospital" was never

removed from it.

CHAIRPERSON: On the other hand, Mr. Pengelly, it wasn't ignored because an action was created out of it for the Department to check the process?

A. Yes. 12:48

CHAIRPERSON: So it wasn't that people said no, of course we can't do that, there was actually a process to find out if it could be done?

A. But I think the action in terms of checking the progress, the final three lines "significant input from 12:49 doctors and nurses would still be needed" so I think that was the way of acknowledging those points.

CHAIRPERSON: Yes.

MR. DORAN: And obviously again, we can check whether any note was recorded in respect of the checking. 12:49

CHAIRPERSON: Well we may have enough in that single paragraph I would have thought.

132 Q. MR. DORAN: Now, the second specific point then that I wanted to ask you about in the context of these meetings is on page 286 and it's in the middle of 12:49 paragraph 9. There is a reference to:

"Other jurisdictions would also have approaches we could consider including crisis response teams and panels who have to agree any admission to an learning 12:50 disability hospital."

And it's just simply to ask, do you recall if that idea ever gained any traction?

A. I don't recall the specifics of how that played out. I see the action was captured at the bottom but I don't recall how it played out.

133 Q. And going back to paragraph 8, that's on the previous page, page 285. It's recorded that: 12:50

"The Trust were able to provide a reasonable assurance of safety in Muckamore at the moment and confirmed that it was safer than it had ever been. Nonetheless, it was agreed that a stocktake of current safeguarding 12:50 measures should take place and that a process map for existing safeguarding process should be completed. One additional action would be to consider requiring all HCAs working in Muckamore to be registered with NISCC, this would allow their removal from the register if 12:51 necessary."

Now it's really the first part of that paragraph that I wanted to ask you about because the proposition there is that the hospital was safer than it had ever been. 12:51 And obviously the backdrop to this meeting was the ventilating of ongoing concerns by the RQIA and there were ongoing exchanges between the Department and the Trust about that?

A. Mhm-mhm. 12:51

134 Q. About how the Trust was dealing with the RQIA's correspondence and notices.

A. Mhm-mhm.

135 Q. Now, can you recall whether or how the proposition that

the hospital was safer than it had ever been was actually evidenced at the meeting itself?

A. I can't recall the discussion at the meeting, but reading the way the minutes are drafted, the minutes don't record any concern or push back expressed by my professional officer colleagues who were at the meeting.

136 Q. Yes.

A. And I am assuming there would have been some very forthright articulation of concerns and push back had that existed because this was a live issue that MDAG was operating in parallel with this, and those issues, there would have been granular exploration of them. The fact that that is recorded as an assertion by the Trust and unchallenged by colleagues suggests, suggests or implies -- sorry, I am not saying that as an absolute statement of fact -- that there would have been that granular, more granular evidence base had been discussed at MDAG.

DR. MAXWELL: We are back to the point that you raised that I have made before, the presence the safety is not the same as not having raised any concerns of harm. The fact that professional officers didn't have to hand any evidence to contradict this statement doesn't negate the fact that the Trust should have provided evidence to support that statement?

A. I'm not, but what I'm saying is in the context of this meeting the fact that my two professional officers weren't pushing back against this.

DR. MAXWELL: I hear what you are saying.

A. I am assuming that that evidence was presented in the MDAG context where there was much more granular discussion.

DR. MAXWELL: But it doesn't say that in the minutes, you are making an assumption. 12:53

A. I am absolutely making an assumption.

DR. MAXWELL: I suppose my point is at Departmental level, with so much concern, with RQIA still concerned, would you not have expected the Trust to provide some evidence to support such a claim or do you just assume the claim is true if the professional officer didn't contradict it? 12:53

A. But knowing my two professional officers, they would not have allowed a statement like that to go unchallenged. 12:53

DR. MAXWELL: So your answer is yes, you were happy with the Trust providing a statement without evidence.

A. I think what I am saying is I am relying on my professional colleagues for a question about professional competence. 12:54

DR. MAXWELL: But you didn't expect the Trust to provide any evidence to support the claim?

A. I am presuming, perhaps erroneously, that that would have been provided in the different format where the granular discussion was taking place. 12:54

137 Q. MR. DORAN: So the granular discussion of that particular issue wouldn't have occurred at the meeting which is minuted?

A. No, because this was supplementary to MDAG where there was much more detailed discussion of these issues.

138 Q. Just when you say "supplementary to MDAG", how did those two processes work alongside each other?

A. Well, MDAG continued uninterrupted, this was a supplementary process. I can't remember what was the precise trigger for -- there is minutes of two meetings there. I understand there was a third meeting on 25th September of largely this attendee list, although I wasn't present at it, that's why I haven't exhibited the issue. I can't recall the specific trigger, whether that was a very specific issue that triggered it or whether there was a view from Charlotte and Sean at the time that it would be good to create a forum where I had some sit down time with the Trust in terms of this issue, just to emphasise the departmental interest and ongoing perspective on it. 12:54 12:55 12:55 12:55

139 Q. Well in your recollection of the meeting there was no detailed discussion of the background evidence that might need to be presented to support a claim of that nature?

A. I have no recollection of that being the case, no.

140 Q. Now, this leads onto the final point I wanted to ask you about these meetings and it relates to the next meeting on 16th September which is at page 287. And if we scroll down, please, to page 289. And the paragraph I wanted to look at is paragraph 9. "RP" that's your initials presumably: 12:55

"RP asked if MAH is only perceived safe because of the CCTV in the hospital although he recognised for privacy reasons this does not cover bedrooms and bathrooms. MD agreed this was the case..."

12:56

MD presumably is Martin Dillon.

"MD agreed this was the case and that there was a need to increase the contemporaneous viewing of the CCTV at MAH which is currently one shift per week. MD agreed that there is no doubt that there has been a change in staff behaviour since CCTV was introduced. RP was concerned about this reliance on CCTV given it did not cover all areas and that it was arguable as to whether it prevented any incidents as opposed to simply recording them."

12:56

12:57

So just from that final sentence is it fair to say that you were somewhat sceptical about the effectiveness of CCTV as a preventative measure and would you like to expand on that?

12:57

A. I'm not sure I would say sceptical of it as opposed to I was recognising that there were some limitations because the fact that CCTV is present, I absolutely accept that that acts as a deterrent to any such incidents but it doesn't act as an absolute and guaranteed deterrent, it still may take place and then be recorded. But what we all want is these incidents don't ever take place as opposed to they happen, we

12:57

have a record of them, we can pursue them and take action. I just think CCTV is an important deterrent but not a complete one. It needs to be part of a basket of measures to change the culture in any institution.

141 Q. So you accept it's an important aspect of overall strategy or regime that is designed to improve patient safety?

A. Yes, yes, absolutely.

12:58

142 Q. Now I am going to move onto the Leadership and Governance Review Chair, I note that it's 1 o'clock. Should we perhaps have a break?

CHAIRPERSON: Yeah, certainly. You have got about another hour to go?

MR. DORAN: Probably less.

12:58

CHAIRPERSON: That's fine, okay. We will take our lunch break now, one hour and we will be back at 2 o'clock. Thank you very much.

LUNCHEON ADJOURNMENT.

12:58

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Yes.

14:03

143 Q. MR. DORAN: Now, Mr. Pengelly, we move on to the Leadership and Governance Review. The report was published, as you are aware, in August 2020. We know that that review was initiated by the Department, the

Department requested the Health and Social Care Board and the Public Health Agency to commission an independent review on the effectiveness of leadership, management and governance arrangements in relation to the hospital. As matter of interest had you any input into the determination that a further review should be conducted following on from A Way to Go?

A. Not in the determination of it. I think it was conclusions that were reached through the work of MDAG and taking forward A Way to Go there was a missing piece of the jigsaw. So I was kept informed that that's where the thinking was crystalising but certainly it wasn't prompted by me or dramatically steered by me.

144 Q. Did you have to give the final seal of approval in respect of that work moving forward?

A. I don't recall it ever coming formally to me to sign off on it, but I think it was certainly mentioned. So there was an opportunity if I wanted to raise any objections to it, which I didn't, in terms of conclusions that had been reached at the Department.

145 Q. And the upshot of the review was 12 recommendations and as you've said earlier they were then incorporated into the action plan, isn't that right?

A. That's right.

146 Q. And three of those recommendations were specifically for the Department to bring forward?

A. That's right.

147 Q. I just want to look at those at page 260, please. This

is the August 2022 iteration of the action plan but I just wanted to look at the detail of those three particular points that were for the Department to bring forward. The first one:

14:05

"The Department of Health should review the structure of the discharge of statutory functions reporting arrangements to ensure that they are fit for purpose."

So that's one of the three. Can we scroll down please. 14:05

Secondly then:

"The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission in regulating and inspecting all 14:06 hospital provision."

And scrolling down please, to 3:

"The Department of Health, in collaboration with 14:06 patients, relatives and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can be best delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future." 14:06

Just looking at those three specific recommendations, can I just ask about their incorporation within the action plan, from the Department's perspective was that

an automatic process so to speak? Were they accepted without question?

A. Yes, they were. I mean I think there was, I don't have the exact dates to hand but I think there was a fairly prompt submission that went up and they were accepted quite rapidly. 14:07

148 Q. So from your point of view it wasn't really an issue over whether the recommendations would be taken up but simply one of timing?

A. Yes. 14:07

149 Q. And you've mentioned that the progress of the action plan is generally overseen by MDAG?

A. Mhm-mhm.

150 Q. And it's also a live document, as you say?

A. Yes. 14:07

151 Q. Now, as I mentioned earlier, the Department's representatives have furnished the Inquiry on request with a bespoke version of the action plan that brings us up-to-date in 2024 and of course there may well be further iterations of the document moving forward. And 14:07 I know that you're no longer in post but I did want to look briefly at the current state of play as regards those three recommendations. If we just look at that briefly please, it's at page 30 to 31 of the new action plan that was furnished to the Inquiry as a separate 14:08 document. So it's the live edition of the action plan and it's at page 30?

CHAIRPERSON: And Core Participants have access to this? Have they?

MR. DORAN: Yes indeed, that was received and circulated yesterday, Chair.

CHAIRPERSON: Thank you.

152 Q. MR. DORAN: If we look then at the recommendation that is numbered A44 there and it arises from Leadership and Governance Review. 14:08

"By March 2022 complete a review of the accountability arrangements for Delegated Statutory Functions Reports." 14:09

Then one looks at the August 2024 update:

"Time table for the issue of the revised circular has been delayed. A workshop is being planned for October." 14:09

So obviously there has been a lot of work going on in the background. The recommendation isn't quite brought home at that stage. 14:09

A. Sure.

153 Q. If we scroll down then, please, to the next one which relates to the powers of the Care Quality Commission being aligned, or RQIA being aligned with the powers of the Care Quality Commission. The August '24 update is: 14:09

"No further developments since May 2024 update included below. The Department is currently operating within a constrained budget and is required to make decisions in

relation to the work that can be delivered within current resources. In that context, while it remains an important identified priority, work on the review of the regulation is currently paused to allow for other priority projects to progress." 14:10

So again that recommendation remains outstanding and it seems is stalled partly due to budgetary constraints?

A. Mhm-mhm.

154 Q. If one scrolls down then to the next recommendation which relates to the partnership with patients, relatives and carers. The update in August 2024 is: 14:10

"The BHSCT submitted an initial implementation plan for the closure of MAH to the Department on 3rd November 2023. The Department continues to liaise with the Trust on the content and implementation of the plan. Work continues through the regional resettlement oversight group to ensure that all patients have firm resettlement plans in place. Given the Minister's announcement of a short extension to the anticipated closure date for MAH the Department issued a letter via the Belfast trust to families of current patients outlining the reason for the delay and reaffirming the commitment to the closure of the hospital once all remaining patients had been resettled. The letter also contained an offer for a further meeting with departmental officials should any patients' families wish to discuss directly. To date no requests have 14:10 14:11

been received. As previously outlined, development of future service provision needs and structures are being taken forward as part of the wider work on the learning disability strategic action plan and associated T and F Group and a draft LDSM is being prepared for consultation in the coming weeks."

So again the live picture, if you like, from August 2024 is that we're not there yet and work continues on various fronts to achieve the objective. Now, I am not going to go through the history of each of those recommendations or indeed the plan generally, and I appreciate that this is a big question, but what if a member of the public or a patient relative were to ask look, we're now seven years on from these revelations breaking, there is still a live document called the MAH HSC action plan. As we've just seen actions remain to be completed, why do these initiatives take so long to implement? 14:11 14:11 14:12 14:12

A. I think there is a number of strands to that. In the context of this specific action plan, I absolutely take the point about we are seven years on from the issues emerging in 2017. This was an action plan that was created in the course of 2019.

155 Q. Yes? 14:12

A. So I think in terms of delivering the specific actions, they didn't exist until then. I think there is two real components, one comes out in the update there. The sad and unfortunate reality is much of 2020 and

2021 were lost to the pandemic. That was just a dominating factor throughout health and social care. That's not to say that no work was taken forward, but the skewing of resources and the intensity of effort, that inevitably caused a delay. 14:13
The point that comes through in terms of the August 2024 update, and I am not close to the detail of it.

156 Q. I understand that?

A. There is a clear sense about resource constraints and again the reality is taking forward work requires that 14:13 work to be resourced. And certainly at the point I was leaving, and nothing that I have seen or heard in the public domain since then is changing, the health and social care system, in line with many other public services, is under the most intense financial pressure 14:13 that it is ever been under so it is deeply regrettable that more progress hasn't been made but I think there are some very real constraints on the pace that that can move forward with.

157 Q. I hope you can see where I'm coming from? 14:14

A. Of course.

158 Q. Should an action plan take so long to implement, is the effectiveness of the action plan undermined by the period of time that it has taken to implement it?

A. Of course there is some degree of undermining an action 14:14 plan when it takes so long and in a perfect world it would be taken forward with much more pace. But no-one could have planned for the pandemic. And having been there through it, I wouldn't underestimate the energy

and intensity that that absorbed for two full years. You know, as an illustration, we talked earlier this morning about the governance and oversight arrangements. All those systems across all public services for all public bodies, issues like that were effectively paused for a couple of years because there was just no capacity to take them forward. As I say, the constraints of Covid, that is deeply unfortunate, and it's always uncomfortable to say that the availability of resources gets in the way of doing the right thing and putting in place high quality care and addressing action plans to address what are real and deeply regrettable issues that have arisen in the past. So it's far from ideal and we are all uncomfortable with it. But, you know, I would be much more uncomfortable if there was a sense that the system was simply dragging its feet in this. That doesn't leap out at me from the update that's given there. As I said, having been away from it for two and a half years, I don't know whether that's a fair or unfair point to make but, these issues are getting in the way of it. 14:14 14:15 14:15 14:15

159 Q. Although the indication given in respect of the second proposal in relation to the Care Quality Commission alignment does, it seems to have been stalled simply on a resource basis, isn't that right? 14:15

A. Yes, but equally with very, very constrained resources, if the resources aren't there to take forward, because pieces of work need to be resourced. If the resources

aren't there I'm not sure what the answer is, there is certainly no easy answer to it. There needs to be prioritisation. But I think the real question is, and as I sit today I can't answer this question, if there is a resourcing constraint about taking this action forward, the legitimate question to pose is, is everything else that is happening in the Department currently assessed as being a higher priority than delivering on this action. I think that's a legitimate -- I can't offer an answer to that question. 14:16

DR. MAXWELL: The Risk Register should contain all the unmitigated risks and I completely take your point about, you know, Covid overtaking everything and I take your point about lack of money. I think the question is was this still within eyesight? Was the Minister aware that there were some high profile things that couldn't be done, weren't being done? 14:17

A. I can't answer that question over the last two and a half years.

DR. MAXWELL: But in your time, did the actions arising from Muckamore and from the various reviews, did they make it on to the Departmental Risk Register? 14:17

A. I don't have the definitive answer to that in front of me. I would doubt very much that issues from this made it onto the Departmental Risk Register which tends to focus more on risks at a system level that cut across all areas as opposed to individual areas. It may well have sat on a Risk Register at a Directorate for the Directorate that was taking this work forward but not 14:17

necessarily just in terms of the Departmental Risk Register.

DR. MAXWELL: So we've heard a lot about things getting escalated system wide and maybe that's one of the problems for the governance system that something has to be system wide to get up there. But given, you know you've given a good explanation about why things couldn't be done but how were these very important things for a very vulnerable group of people kept at the top of people's minds? 14:18

A. I would need to look at the detail of how they were kept in people's minds. I suspect issues like this would have featured on a Directorate Risk Register which would have prompted a conversation at a level within the Department, not -- your fundamental point is the issues that we're talking about today were serious enough that there should have been some ministerial engagement. 14:18

DR. MAXWELL: Well I think the issue is it can be dealt with at a lower level if it can be managed at a lower level but the whole principle of Risk Registers is that you escalate the unmitigated risk and this is an unmitigated risk. What you are telling me, what other people are telling me is it doesn't matter how extreme the risk is and how unmitigated it is if it isn't a system issue so I am wondering where you put very high risks that aren't system wide that are unmitigated? 14:19

A. But I think the point I'm making is there is a graduated level of escalation of risk. The point about 14:19

system wide risks applies to the Departmental Risk Register.

DR. MAXWELL: I understand.

A. But there would be Risk Registers at a lower level.

DR. MAXWELL: I understand. 14:19

A. Where it would be appropriate for this to sit and that in itself should prompt a conversation.

DR. MAXWELL: I understand that but what you have said is the reason you couldn't take some of these forward, part was Covid and that's reasonable and part was 14:19 funding, so if you have got a persistent unmitigated risk over a number of years, how does it get to the attention of the people who decide the money, who are essentially the Minister, the Assembly, potentially the Treasury, if it's on a Directorate Risk Register that 14:20 they never see?

A. But issues like this would flow through into the discussion about funding and financial issues.

DR. MAXWELL: How would they have done that if they weren't on the Departmental Risk Register? 14:20

A. Because the initial conversation at departmental level, I mean ultimately when the Department of Finance commission a financial exercise, a budget exercise, they commission bids from departments for resourcing.

DR. MAXWELL: But when you are deciding, because there 14:20 will be bids for more money than you can afford, that's a fact of life.

A. Yes.

DR. MAXWELL: So then is there not some assessment of

the risks when deciding how to allocate money?

A. Yes, but the process would be that the Department of Finance commission inputs from all departments about a budget exercise. Each department would then commission inputs from all relevant directorates and groups within the Department. This would be sitting on, and sorry, I was going to say sitting on the Risk Register at Directorate or group level, I can't assert that as a matter of fact because I don't know it to be true, I suspect it may be the case. That would influence the bids that the director at group level would put through and that would be part of a holistic conversation at departmental level, how do we prioritise the bids we put forward. 14:21 14:21

DR. MAXWELL: When you are having that discussion about prioritising the bids that have been put forward because you can't afford all of them, how are you comparing the risks between them when you make that decision about which to fund? 14:21

A. Well that's part of the dialogue that would take place amongst -- 14:21

DR. MAXWELL: If you don't have an overview of the most extreme risks, how can you have an informed discussion about it?

A. But there is no easy metric to compare risks other than when the senior team of the Department come together to discuss the paperwork that is in front of them with all bids and associated risk analysis, there is a conversation. 14:22

DR. MAXWELL: You don't use the Departmental Risk Register to inform the allocation of funds then?

A. The Departmental Risk Register would be the risks at a system level but I am talking about this very specific issue which, as was said, it isn't a system wide issue. 14:22

DR. MAXWELL: No, no but if you have got bids from a range of different services and they come forward for a decision by a senior group are looking at them and, as we've said, this wouldn't make it onto the Corporate Risk Register so those people making the decision may 14:22 not be fully informed about this risk, surely you would use the Corporate Risk Register, otherwise what's the point of it, to inform your decisions.

A. The Corporate Risk Register informs decisions but it tends to capture risks at the highest level. The 14:23 financial risk would be that there is insufficient finance to address all key priorities across the Department and then it would set out mitigating factors. It doesn't build up the individual financial risk in every individual area. 14:23

DR. MAXWELL: No, I understand and I am suggesting that is a limitation of it.

A. It's a limitation but if you take it to the other extreme, I am not suggesting is your implication, if you were to take it to the other extreme you would have 14:23 a Risk Register for a system in excess of I think now £8 billion, 65,000 people, it would be too unwieldy to be of value.

DR. MAXWELL: But there is something in the middle.

160 Q. MR. DORAN: Let's move on to an issue that one might says defies action plans or time tabling and that is resettlement. You deal with this at paragraphs 55 to 64 of the statement. Could we go back to the statement, please. In the statement you go through the history of resettlement right back to the publication of Equal Lives in September 2005. Obviously that was well before your time in post as you say in paragraph 57, but the issue obviously came into sharp focus after 2017, isn't that right? 14:24

A. That's right, yes.

161 Q. Of course it featured in your public statement which we'll come on to in December 2018. But I was just wondering about your awareness of this issue prior to 2017. Was it a matter that came specifically to your attention after you became Permanent Secretary in 2014 and if so, how? 14:24

A. I don't recall it coming specifically to my attention other than the development of papers in and around 2015 and 2016 when the proposition was evolving and there was the evaluation of the second action plan. The conclusion that came out of that was that this was under the heading now of business as usual and the various structures could be stood down. That didn't go to the Minister because by that stage the executive had collapsed and there was no Minister in post. 14:25

162 Q. Did it go to you then?

A. Well my understanding of the position, the dialogue that I had with colleagues that submissions were in the

course of being prepared for it to come to me but then there was a decision taken that it was an issue that would have been outwith my powers because at that stage my recollection, and this is just a caveat that I would just need to double check this, prior to the EFE Act receiving royal assent towards the end of 2018, the position determined by the Bewick judgment was that things that would normally go to a Minister were outwith the power of Permanent Secretaries and officials to take decisions. So there was a view that I wouldn't have had the power to take a decision, so a submission was being drafted but didn't ultimately come to me for consideration. 14:25 14:26

163 Q. That was at a later stage, I thought you were referring to 2015 or in or around that period? 14:26

A. I think the evaluation was undertaken in 2015 and 2016. The time it would have gone to a Minister was into 2017. I think the Executive collapsed around the tail end of February 2017 but the evaluation was under way and I think it was particularly late 2016 that crystallised and that concluded that the architecture around Bamford could be stood down and it was more business as usual. The analysis was the resettlement programme had largely been concluded because the numbers were fairly small at that stage. 14:26 14:26

164 Q. Did that evaluation process come to you attention so to speak?

A. It would have been copied to me in terms of its evolution but it didn't come to me for a decision.

165 Q. Just generally where did the matter of resettlement fit within your sphere of responsibility as Permanent Secretary?

A. In terms of Permanent Secretary sitting at that apex of the pyramid there is oversight of everything, but things didn't routinely come. I mean in normal times with the Minister there would have been a lot of issues where the work would have been progressed at a group level and there isn't necessarily a form of clearance process that I have to see everything before it goes to the Minister. Material would go to the Minister and in parallel be coped to me offering me, where things were assessed as being not particularly controversial or an issue that I didn't need to get involved or colleagues weren't naturally looking for some specific input from me, so this would have been very much in that sphere given the legacy of Bamford that started well before me. 14:27 14:27 14:27

166 Q. Is it right then to say prior to 2017 you wouldn't have had any specific input to decisions around resettlement? 14:28

A. That's correct, that's correct.

167 Q. Now, you set out in paragraph 62 a number of barriers to meeting targets over the years. And you say: 14:28

"These have included a reluctance on the part of some patients and their families to relocate from a hospital setting, a lack of appropriate community placements to meet the needs of complex individuals and difficulties

in recruiting appropriately skilled staff and a reluctance by some hospital staff to fully support the resettlement concept."

A. Mhm-mhm. 14:28

168 Q. Now looking at the middle two there, lack of appropriate community placements and difficulties in recruiting appropriately skilled staff, those are factors that could, on the face of it, be tackled by direct action, most obviously an injection of 14:29 resources. I mean we've heard of investment in the programme, for example in the evidence of Brendan Whittle on behalf of SPPG. Do you have any views on why, notwithstanding the investment, the difficulties in delivering the resettlement programme have seemingly 14:29 been intractable?

A. I don't think I have a huge amount to add because the specific issues here weren't issues that I was dealing with on a very regular basis, they are more issues that through the passage of time were brought to my 14:29 attention as some of the inhibitors of actually successfully delivering the full resettlement programme, so I wouldn't claim to understand all the nuances of these issues.

14:29

The funding issue, again, there is an issue about the totality of funding available to take forward resettlement. There was a very particular problem, again it wasn't one I was involved in but I think there

was an interface issue between the Department of Health and what was then the Department for Social Development in terms of the Supporting People because some of the budget, particularly for capital investment, sat with that department, whereas the ongoing costs sat with us so there was an issue about positioning resource as well as totality of resources issues. The staffing issue has been a perennial and long standing issue. Now in saying that, I'm not seeking to dismiss it into the "too difficult" box, it is an issue of such fundamental importance that we need to take forward. 14:30 14:30

169 Q. And it's a fixable issue?

A. All things should be fixable given the right will and time. The workforce strategy that was launched in 2018, there was to be three action plans launched over sequential periods of time to address that so there are measures in place to seek to address that. The particular difficulty in terms of when we look at the social care workforce is, there is undoubtedly a need for greater investment in that workforce and again that circles back to the resourcing problem because at one level its easier to identify solutions than it is to deliver them because of the scale and magnitude of the workforce. 14:30 14:31

170 Q. I want to look at that deliverability issue because you did in fact intervene directly in respect of the resettlement issue in the context of your apology in 2018? 14:31

A. Yes.

171 Q. And we'll look at that in a bit more detail shortly, if we go to page 129 one sees that, and this is in the context of, as I've said of your apology to families in December of 2018. And reading the text:

14:31

"Mr. Pengelly said he expects the resettlement process to be completed by the end of 2019. That means finding suitable alternative accommodation for patients who have been living at Muckamore on a long term basis despite not requiring in-patient hospital care. 14:32
The separate issue of delayed discharge will also be addressed as a top priority with the HSC system tasked to provide an action plan to the Permanent Secretary in January. Delayed discharges involve patients staying longer than medically required due to difficulties 14:32
securing appropriate alternative arrangements. Mr. Pengelly added "I fully recognise that the December 2019 deadline for the resettlement process will be challenging but the Department owes it to patients and their families to be demanding"." 14:32

Now, presumably when you made that commitment you were fully satisfied that it was achievable?

A. No, absolutely not. I made that commitment a number of days after delivery of the A Way to Go Report. The 14:33
system needed to respond. I'm certainly not suggesting at the time I made that certain I was certain it couldn't be delivered, but equally it would be wrong to sit here and suggest that at the time I made that

commitment I was fully confident. This was a call to action across the system. This was about giving this priority and energy. And, you know, we talked earlier this morning about the accountability meetings and I think the July 2019 meeting, Martin Dillon is recorded as saying that the commitment certainly focused minds and focused efforts, that's what the commitment was absolutely intended to do, to try and get the system energised into focusing on the resettlement agenda. But we didn't have the time to do a full assessment about deliverability and be 100% confident that it would be delivered by December 2019. 14:33 14:33

172 Q. So it wasn't a commitment to delivery so much as an encouragement to those responsible to get on with the process? 14:34

A. I would say it was a commitment to seek to deliver it but it wasn't, there was no guarantees of success. I mean it wasn't impossible to do this, it was going to take a huge amount of energy to even start and put in place the building blocks of it. And I think, you know, forgive me, I'm talking from memory, I think if we look at 2019, the resettlement commitment focused on was, from Bamford, the priority target list. I think there was about 12 individuals on that at the time the commitment was given. By December 2019 I think the assessment was there had been two resettlements, one I think that resettlement hadn't worked and individual came back to Muckamore. There was four cases where there were coherent plans for it to be delivered by the 14:34 14:34

following March and I think there were two cases where the family had indicated strongly that they wanted to remain in Muckamore. So there was progress and there was movement but it didn't deliver everyone.

173 Q. Do you regard the failure to meet the commitment as a failure on the part of the system? 14:35

A. Well, I mean in the sense that it was a commitment to finish resettlement, in those terms it has to be classified as a failure to deliver on the wording of that commitment. I would prefer -- targets, the reason we set targets is to encourage and improve performance and I would always far rather set a challenging target that drives high performance than a very easy to attain low target where people just hit the target and decide not to do more. This was a demanding stretch target. My view is targets should be challenging. I think that only becomes problematic when you set a target that is so out of reach that the response from the system is look, we are never going to achieve that so why bother. That certainly wasn't the sense of the response from the system, in Martin Dillon's words that it focused minds and effort. So I think it was a demanding stretch target that incentivised behaviours in the system. 14:35 14:35 14:36 14:36

174 Q. Do you think it might have been achievable with more intensive effort and greater resourcing? 14:36

A. Possibly but in terms of the challenges that you touched on, in terms of the staffing issues, the investment issues and very importantly the views of

some of the families, it was always going to be incredibly difficult to deliver. Arguably it was possible but, it was a big ask.

175 Q. I want to look in a bit more detail at the apology, this obviously was made back in December 2018 and I want to read some of this into the Inquiry record. I'm not going to read the full text. It begins at page 128 if you could scroll up please. 14:36

"Department of Health Permanent Secretary Richard Pengelly today apologised to families of Muckamore Abbey Hospital patients at a meeting with them at the country Antrim facility. Mr. Pengelly also made a series of firm commitments to the families as regards future care provision. He was accompanied at the meeting by Chief Social Worker, Sean Holland and Chief Nursing Officer, Charlotte McArdle. Commenting after the meeting Mr. Pengelly said "it was important to me to apologise to families face to face for what happened to their loved ones while in the care of Muckamore Abbey Hospital, rather than through a press statement. I am both appalled and angered that vulnerable people were let down. At the same time action is urgently needed by the HSC system as a whole in response to the recommendations of the Serious Adverse Incident review. I fully endorse the view of the SAI Panel that no-one should have to call Muckamore their home in the future when there are better options for their care. I am now confirming to the families that this will be the case. 14:37 14:37 14:37

That means Muckamore returns to being a hospital providing acute care and not simply a residential facility. To make that happen will require investment in both specialised accommodation and staff training to meet the complex needs of people who no longer need to be in hospital." 14:38

And then you deal with the resettlement issue.

"The Permanent Secretary continued: "I also know that while this report has highlighted appalling behaviours that fall well short of what is acceptable, there are many working in the HSC who work tirelessly to deliver high quality and safe services to families and people with learning disabilities and will rise to this challenge. We have seen this as recently as this weekend in the actions of those staff who have provided much needed support and flexibility to ensure the safe and effective care of our most vulnerable patients in Muckamore. It is important in the midst of this not to overlook the dedicated and compassionate care that families have also experienced. I will be holding the HSC system to account in closely monitoring progress"." 14:38 14:38 14:39

Then you deal with the possibility of a public Inquiry or the call for a public Inquiry and police investigations. If one scrolls down then to the next page, please, and scrolling down further: 14:39

"Mr. Pengelly expressed his thanks to the families for taking the time to meet with him and for sharing their concerns and issues. He also thanked the SAI independent Panel for their work. He added "I remain very concerned about the HSC's systems, current structures and attitudes regarding concerns and complaints from service users and their families. All too often it seems the onus is on citizens to persuade the system that something is wrong"."

14:39

14:40

You then refer to advocacy rights and the Patient Client Council.

"Finally Mr. Pengelly stated that it was his intention to have regular meetings with the families to keep them updated on developments and to listen to any new concerns that they may have."

14:40

I just wonder did those meetings to which you refer take place following on from your apology?

14:40

A. There was a meeting in, I think, February 2020, follow up meeting. I reviewed the minutes of MDAG and colleagues on my behalf raised, because there were family representatives at MDAG, the minutes in 2019 record that colleagues were pressing for another meeting but the families had pushed back a little bit on the basis that they wanted to wait until there was coherent progress to report for another meeting, given understandably the obligations on their time and

14:40

energy, they didn't want a meeting for the sake of a meeting, that would have been wasting their time. So, I think aside from that meeting in February 2020 I can't specifically recall another engagement but as I say there was the offer there. 14:41

176 Q. I wonder if almost six years on as we move towards the closing stages of the Inquiry, is there anything that you would like to add to what you said at the time?

A. Not to add. I certainly want to reiterate the comments made on that day. This simply should not have happened. And certainly reflecting on some of your points, to the extent that there is frustration in terms of the rate of progress and responding to some of the important learning that came out of these events, I think to the extent that during my tenure I would also take the opportunity to apologise to the families that the pace hasn't been as rapid as we all would have wanted but I just completely re-emphasise the points that were made back in December 2018. 14:41 14:41

177 Q. Thank you, Mr. Pengelly. My questions are done, the Panel may have more but just before I hand over is there anything further that you wish to say that might assist the Panel in its work? 14:42

A. No, not from me, thank you.

14:42

MR. PENGELLY EXAMINED BY THE PANEL:

178 Q. PROFESSOR MURPHY: I've just got one for you. There is a lot of mentions of the New Service Model For Learning

Disabilities in various places in your statement and I am just wondering what stage that's at because as I understand it has not been approved yet by the Department of Health?

A. My understanding is it hasn't been approved yet but having been away for two and a half years, I don't know the detail of where it is at the moment. 14:42

PROFESSOR MURPHY: You don't know when it might be finalised because it seems to have been in process for a very long time. 14:43

A. It does, it does.

CHAIRPERSON: I think we're done. Mr. Pengelly, we've asked some questions as we have gone along but can I thank you very much indeed for giving us your time this afternoon. So thank you. 14:43

MR. DORAN: That completes today's evidence, Chair.

CHAIRPERSON: All right. Now, Ms. Anyadike-Danes, I am not inviting to you reopen the submission, if you want to tell me that that is unfair you are entitled to do so but I am not going to hear you on the same 14:43 submission that I have already effectively given a ruling on.

SUBMISSION OF MS. ANYADIKE-DANES: 14:43

MS. ANYADIKE-DANES: Yes, thank you very much. Well I am going to say that on instructions from my clients that they think it is unfair and it's not really appropriate simply to make that bald statement without

explaining why they think it's unfair, that doesn't really help you. But the first point to notice is that you made a decision as to whether you would have an open hearing or a hearing in this chamber that would be on the record and capable of listened to by the public as well as CPs without really having submissions from me or anybody else who might have been supportive of a procedural hearing. So they do think it's unfair. And some of what you have explained as to how you are going to address matters, which I suspect was your way of trying to deal with the question of whether it was or was not unfair, they equally think are unfair and so it's only appropriate to get into that a little bit. The first rationale as to why they think it's unfair is that they had specifically -- in fact only two things that I was asked to say in support of having a public hearing and having a procedural hearing was that they didn't want to have any correspondence, they have actually been corresponding on a range of issues of which we set out five categories of them since about, since before the summer of this year and none of that correspondence has actually produced a reasoned decision or a reasoned explanation of the Inquiry's position. So that's one reason why they didn't want any more correspondence, they rather feared they would be getting much of the same.

14:44 14:44 14:45 14:45 14:45

The second point was they didn't want a private meeting, you certainly haven't offered that, but they

wanted whatever was going to happen to be in the public domain because they are very conscious that this is a public Inquiry and it should be in the public domain. In fairness to you, Sir, right at the beginning of all of this and in fact throughout, not just at the beginning, you have been at pains to say how important it is that it is, so far as you can do it without trespassing into the areas covered by the memorandums of understandings, that it is held in public and you have made that point and that point has been taken on board. 14:46 14:46

So they consider when we now get into a very serious issue from their point of view as to whether evidence is going to be heard, whether it's going to be called, how evidence is going to be treated, that is something that should be in the public domain and the public should be able to understand you, Sir, your reasoning for that; it is important for a whole host of things to do with public confidence. 14:46 14:46

So that is one aspect of why they think it's unfair. If we then go to the arrangements that you, Sir, have set out, what effectively you have said is that for all the correspondence that falls within those five categories of things that we set out, that's all going to be -- a response to that is a way of putting it, is all going to be with us in the early part of next week. 14:47

CHAIRPERSON: Beginning.

MS. ANYADIKE-DANES: I beg your pardon, beginning of next week, even better, so the beginning of next week. And that if in relation to the particular aspect of resettlement then we can make written submissions as for that matter can other CPs. The difficulty about that is in that category of non-resettlement issues, but some of the issues that do form part of that evidence, if there is anything there that when we respond, which we are committed to do, to your explanation for how you are going to deal with that evidence, if there is anything there that you should be persuaded about that suggests that there actually should be some oral evidence of that, we effectively have passed the point when that could happen. And it's not that you have actually ruled that out because you, in fairness to you, you haven't ruled that out.

CHAIRPERSON: If I may say so, this is why I thought you should wait to see what the proposal is.

MS. ANYADIKE-DANES: I understand that.

CHAIRPERSON: I suspect the proposal is going to meet many of your concerns.

MS. ANYADIKE-DANES: But if I may, Sir, really, and thank you for that, but if I may. So what you, Sir, said this morning, and my clients were listening to it as I'm sure others were, that whatever is going to be dealt with in that period next week will not impact upon the preparation for closings, that's the first thing you said. And second of all, nobody has for one minute suggested that the dates for when the written

skeletons, I think you called them, Sir, have to be with you, which I think is the 22nd, and then for our purposes anyway our closing is being delivered on 26th. So if we have got that as one bookend and then we have got the explanation coming next week, in practical terms if, and I am going to use an example so you see what I am talking about, if you were to say that we'll call a witness in practical terms that doesn't seem to be feasible if it's also not going to affect what we say in closing. Now I come to the example that my clients very much wanted you to have, and that's to do with ministers. That's one of -- 14:49 14:49

CHAIRPERSON: Ministers?

MS. ANYADIKE-DANES: Yes, that's one of those categories of the evidence and calling of Ministers. It also speaks to the value of these things being done in the public domain. Now you, Sir, had reached a view in relation to the evidence from the Chief Medical Officer that you didn't really think that he should be called to give oral evidence but you acceded to that. 14:49 14:50

CHAIRPERSON: That was a Panel decision.

MS. ANYADIKE-DANES: I beg your pardon, I don't mean to isolate you from the rest of your Panel members. One of the reasons that happened was because a view was taken that he had provided a very full and detailed statement which could be accessed on the website, and I understand that. But the fact of the matter is that the Chief Medical Officer, who is currently the Chief Medical Officer for everybody here in Northern Ireland, 14:50

when he came to give evidence and made certain statements in terms of recognising accountability and responsibility but went slightly further than he had in his written statement, that evidence was reported in detail on the BBC News Northern Ireland and in fact hit the evening news. That's how much it was considered to be a matter of potential interest to the public in Northern Ireland that their Chief Medical Officer said that about a period of time when he happened to be also Chief Executive of the Belfast Trust in respect of which all this arises. So that is the difference that my clients see and the accessibility of that to the public. 14:50 14:51

Now, if I get into the point about why I'm using the Minister as an example. The Minister of course bears statutory responsibility and you know that, Sir, and we have made the point in our correspondence, I am certainly not going to get into all of that. But the significance of that is you, Sir, will have heard from the Perm Secs, the limitation of what Perm Secs can do, Permanent Secretaries I should say, and you have heard that from Andrew McCormick and now from Richard Pengelly and there are elements that are dealt with by the Minister. They are a Minister's decision making exercise of judgment for how the Department for who he or she is responsible discharges their statutory obligations. And if I may just give you two examples of that -- 14:51 14:51 14:51

CHAIRPERSON: Can I just point out that you are actually making the very application that I told you, you couldn't make.

MS. ANYADIKE-DANES: I am explaining why they say it's unfair because none of this happened. 14:52

CHAIRPERSON: Okay.

MS. ANYADIKE-DANES: So why they say it's unfair is that you have Andrew McCormick, for example, saying:

"We had to set targets that were stretching, yes, but 14:52
if they were, if you set a target that is totally unachievable then the Trust will just shrug its shoulders and say that's impossible. I wasn't the one making those judgments personally. I was approving and then putting to the Minister for approval." 14:52

So they say that if a decision is going to be made about whether a Minister can or cannot be called then that decision ought to be in the public because it impacts upon evidence that the Inquiry has already 14:53
heard. Only this morning Mr. Pengelly says that, through advice provided through the Finance Minister to the Executive, that will be broken down into nine individual amounts and so forth, one to each of the nine departments, the deprivation aspect, which is an 14:53
important one, certainly for my clients, that you refer to while the global amounts comes to the Health Minister. The Health Minister of the day will allocate that between certain priorities within the health

portfolio. And these are not the only references to what the Health Minister does. We have all heard about the Health Minister's eagerness to get into the double jobbing issue. So this is why they think it is unfair that if you are going to make a decision that relates to that kind of evidential point that that decision should not be in the public domain so that the public can know and hear about it. 14:53

CHAIRPERSON: Okay. Thank you.

MS. ANYADIKE-DANES: Thank you very much. 14:54

CHAIRPERSON: I will consider those remarks and decide whether to take that forward. Mr. Aiken, I have had no written submissions from you at all. What are you going to speak about?

14:54

SUBMISSION OF MR. AIKEN:

MR. AIKEN: I am going to raise three issues with you, Sir. The first is a matter of fairness to Dr. David Robinson. You heard evidence on Monday, you will recall the pace of the evidence on Monday about the Ennis Early Alert. 14:54

CHAIRPERSON: Sorry, why does this need to be dealt with now as opposed to by correspondence?

MR. AIKEN: Well because I am putting it on the record now. 14:54

CHAIRPERSON: It's on the record if you send a letter and you want it published, we can publish it.

MR. AIKEN: No, I am here and making a submission that

was dealt with in the chamber in evidence and I am drawing attention to a matter that needs to be corrected.

CHAIRPERSON: I simply don't understand why that can't be dealt with by correspondence. 14:55

MR. AIKEN: Because this is the entirely normal way that we do these matters. They are not done --

CHAIRPERSON: Sorry, at the very beginning of this, some two years ago, this Inquiry, I said that I would not allow oral submissions unless they were preceded 14:55 two days in advance by a skeleton and it was only in relation to really urgent matters affecting the evidence that day that I would allow oral submissions. Now you may have forgotten that, but that's what was said. Is there anything urgent that you need to raise 14:55 with the Inquiry that needs immediate correction?

MR. AIKEN: We'll put it in writing to you then, if you won't take the correction orally, we will put it in writing.

CHAIRPERSON: I think that is best because then we get 14:56 it accurately and if you would like us to and it is appropriate to do it, we will publish it.

MR. AIKEN: So the second issue, I sat through what was described as a round up. There were some 28, if my calculation is right, 28 statements that were 14:56 referenced in quick succession. Some of those had been disclosed before yesterday or the day before yesterday, but many of them were new and there was reference in the round up to further statements that are to come

and is it possible to receive clarity from you as to how many further statements are still to come?

CHAIRPERSON: Well I'll turn to my counsel for the Inquiry. I know there is something that has only just been received, I think from the PSNI, that is going to be disclosed very shortly but let's just see if we can get assistance from Mr. Doran. 14:57

MR. DORAN: That's correct, Chair, there have been a couple of statements received and they will be processed for disclosure as soon as possible. 14:57

CHAIRPERSON: And will we be able to do that by next week or is there a lot in them that needs consideration?

MR. DORAN: I would hope that they will be disclosed to Core Participants next week. 14:57

CHAIRPERSON: That's that, Mr. Aiken.

MR. AIKEN: Now there was then reference to further statements, I had written down "will be required", it may be the transcript says "may be required", I am not sure, but what I'm trying to understand isn't two PSNI statements, it is are there more witness statements to come and, if so, can you tell us that fact and indicate when they will be available? 14:57

CHAIRPERSON: Again, Mr. Doran?

MR. DORAN: Well, Chair, there may be matters to be followed up in the evidence that we have heard. For example, there might have been a reference to a particular paper in the course of a witness's evidence. The Inquiry -- 14:58

CHAIRPERSON: Evidence we have very recently heard, and this is what we have been doing all the way through.
MR. DORAN: Absolutely, and there may indeed be questions arising from individual witness sessions that would lend themselves to follow up statements from the relevant witnesses, so that was the reason for including that line in the round up session this morning. Obviously one cannot say definitively at this point in time that all statements to be received by the Inquiry have in fact been received. 14:58
CHAIRPERSON: I suspect, Mr. Aiken, what you're concerned about or may be concerned about is once you've made your submissions at the end of this, next month, will you have the opportunity of addressing issues that have arisen late. Is that one of the issues that you are concerned about? 14:59
MR. AIKEN: No, the primary issue, as with anyone in my position and I expect everyone else, you want to have in front of you the totality of the evidence when you take instructions from your client -- 14:59
CHAIRPERSON: Yes.
MR. AIKEN: -- about what it is should be said in the closing of a public Inquiry, particularly of this nature. And respectfully, sir, it is perfectly legitimate for every one of us to want to understand how many more witness statements are coming. And it seems to be, notwithstanding that apparently today the evidence is closed, there is not going to be any more hearings, it can't even be said how many more witness 14:59

statements there are going to be. And I won't have an opportunity to address you again about the effect of continuing to receive further evidence, even though the hearings are closed, and that's unfair.

CHAIRPERSON: All right. 15:00

MR. AIKEN: That's my second point.

CHAIRPERSON: Oh, I thought it was your third.

MR. AIKEN: Yes, I have three points. You have received a detailed letter from us of 23rd October I trust. 15:00

CHAIRPERSON: Do you mean the one that came in at 1.30 this morning?

MR. AIKEN: Yes.

CHAIRPERSON: I haven't read it yet.

MR. AIKEN: That's perfectly fine, I will take you to the salient point. 15:00

CHAIRPERSON: No, I'm sorry, but why; if you send something at 1.30 in the morning you cannot expect any Inquiry to have read it or dealt with it. We will deal with it in due course as is appropriate with correspondence. 15:00

MR. AIKEN: Sir, we have all had to deal, including my clients, with material from the Inquiry on the morning that they are giving evidence. We responded overnight to submissions that you received yesterday from Ms. Anyadike-Danes. We joined with those submissions, having reflected on them, and the Belfast Trust's position is as set out in the correspondence, you have just been hearing submissions about the issue so I am 15:01

going to make the submission as well, which is that you should have a procedural hearing where all the various issues that the Core Participants are raising with you can be transparently and openly dealt with and you can indicate your position on all of the issues. We have given you 15 by way of example. 15:01

CHAIRPERSON: Sorry, 15 in the letter this morning at 1.30?

MR. AIKEN: Yes. You can criticise us for the timing, it doesn't change the issues. You have had the correspondence setting out the issues for a prolonged period and like, it turns out, Ms. Anyadike-Danes, I have to acknowledge that many responses don't directly answer the question that we have asked or answer a different question than the one that we have asked and we are continuing to ask the questions and we are asking that they be addressed in an open, transparent way in a public hearing and then you can explain the position. 15:01 15:02

CHAIRPERSON: Right, are those your submissions? 15:02

MR. AIKEN: Well my invitation to you then is to rule --

CHAIRPERSON: I am not going to make a decision now until I have read the extensive correspondence you tell me you've sent today. It would be absurd for me to make a decision, wouldn't it, without having read your correspondence? 15:02

MR. AIKEN: I am not asking you to make a decision. You are being asked to have an oral hearing. The

Belfast Trust is joining with the family groups in respect of that issue. As I understand it you've ruled you won't have an oral hearing and you were then hearing submissions about the unfairness of that so I am now joining with those submissions that it's completely unfair not to allow legal representatives of the Core Participants to openly raise with you in a public session the issues that arise from the state of the evidence and the approach of the Inquiry. 15:03

CHAIRPERSON: Mr. Aiken, I need to read your correspondence before I can make a decision, all right. That's all that I am saying at this stage. 15:03

MR. AIKEN: Thank you, sir.

SUBMISSION OF MR. DORAN: 15:03

MR. DORAN: Chair, can I make a few brief remarks. I just wanted to say first of all its perhaps somewhat unfortunate that the close of this evidence session is being marked by representations of this nature. It has been, if I may say, a very intensive session in which the Inquiry has heard from many individuals in key positions of responsibility for the hospital and indeed the system of health and social care in this jurisdiction. 15:03 15:04

It will come as no surprise, Chair, that I do not accept the representations that have been made in respect of fairness and, in my respectful submission,

there is no basis whatsoever for suggesting that the Inquiry has acted unfairly on the basis suggested.

In relation to the issue of correspondence, I also wish to say that I do not accept on behalf of the Inquiry teams that correspondence is not being answered. What I will say about that is that the representations that have been made, and are being made, to the Inquiry are always the subject of thorough and comprehensive scrutiny by your legal team with a view to assisting the Panel to address those issues as we move forward. 15:04 15:04

So, insofar as there is any criticism of the counsel team, the solicitor team and the administrative teams working on this Inquiry, I do not accept those criticisms and I repeat again that it is unfortunate that at the close of this very important evidence session my learned friends have taken the opportunity to make those representations to you. 15:05

CHAIRPERSON: Thank you. Right, Mr. Aiken, would you like to take your seat. 15:05

MR. AIKEN: That's a response to --

CHAIRPERSON: These aren't submissions. You've made some comments, senior counsel to the Inquiry has made some comments. I am going to deal with your -- we will deal with your correspondence. But unless you are asking me to do something now at this moment, I am not sure you can assist. 15:05

MR. AIKEN: I was asking you to hear me in response in

the normal way because I made a submission to you. Your counsel has now responded to it and I was going to reply to that. But if you don't wish me to, I can't help -- the point has just been made to you that it's deeply regrettable that Core Participants for patients and families as well as the Trust that ran the hospital are making submissions to you at this juncture --

CHAIRPERSON: That's not what Mr. Doran is saying and I don't think that's fair.

MR. AIKEN: That is what he said and it's on the transcript. 15:06

CHAIRPERSON: Okay.

MR. AIKEN: And the point I am making is it ought not to be lost on you why both senior counsel for patients and families groups and senior counsel for the Belfast Trust, all on instructions, felt it necessary to make these submissions. And I recognise you don't want to hear them, that's clear to me, but in my respectful submission we are entitled to make them and it's unfair to characterise the need to make them as somehow inappropriate on the last day of your oral hearing. 15:06

CHAIRPERSON: Just one point, Mr. Aiken. You say it's on instructions, can I ask on instructions of whom? Who is the current -- is it the Deputy Chief Executive of the Trust? 15:07

MR. AIKEN: There are a series of people that I take instructions from within the Trust.

CHAIRPERSON: And are they the directors of the Trust?

MR. AIKEN: What's the purpose of that question, Sir?

CHAIRPERSON: I would like to know, you said that on instructions, I just want to know on whose instructions?
MR. AIKEN: The instructions of my client.
CHAIRPERSON: Well who is your client? 15:07
MR. AIKEN: The Belfast Trust is my client.
CHAIRPERSON: So the Belfast Trust generally?
MR. AIKEN: Sir, it's extraordinary that you want to ask behind who my client is and why are you doing that?
CHAIRPERSON: Mr. Aiken, you have said "on instructions" and I want to know, I am entitled to ask who you mean by that. 15:07
MR. AIKEN: You know who I mean, I act for the Belfast Trust.
CHAIRPERSON: I see, okay, thank you very much. 15:08

Now, putting aside that slightly bad tempered exchange, I think it is right to record that today is day 120 of the oral hearings and Mr. Pengelly was our 235th witness and this year alone we have called or read 98 witnesses. 15:08

Now first, it's right to thank every witness who has contributed to the work of the Inquiry. We all know that attending a Public Inquiry to give evidence is not always pleasantly anticipated but every witness, I hope, has been treated courteously and in the Panel's view tested appropriately. 15:08

There will always be other witnesses who Core Participants may have wanted, but the approach of a Public Inquiry has to be proportionate and there comes a point in relation to any particular topic or issue where the Panel is satisfied that further evidence, even if from a different source, will not add to the sum total of its knowledge. 15:09

It's also worth bearing in mind throughout that we have been running this Inquiry contemporaneously with a huge police investigation and a criminal trial. But I want to reiterate that there is no witness who we felt were critical to the Inquiry, whom we were not able to interview. And it is testament to the care that has been taken by the Inquiry that we've actually got to this point without any significant delay or disruption. 15:09 15:09

I do want to thank the Core Participants, all the Core Participants, their representatives and all those who have submitted questions. Not every question, of course, has been asked, but the central themes have always been explored by counsel to the Inquiry. 15:10

It's right that I should record again our thanks to Cleaver Fulton Rankin for the efforts they made preparing the staff witnesses. 15:10

We particularly want to acknowledge the efforts of our own teams, first of all the solicitors team led by

Lorraine Keown and with the assistance of Stephanie Kennedy, Orla Henderson and Rachel Nethercott. As some of you may have realised at this stage as we enter a different phase of the Inquiry, Lorraine Keown has decided to step down and return to her practice and I am very pleased to announce that the new solicitor to the Inquiry will be Stephanie Kennedy who I would like to warmly welcome to the post. I do want to thank Lorraine for everything she has contributed to the Inquiry and obviously we all wish her well for the future. 15:11 15:11

The effort of getting the statements ready, redacting them and preparing them for hearing has been a massive effort by the Inquiry staff and that includes all three teams, counsel, solicitors and administration. The fact that we've had as few errors in terms of redaction as we have shows the care that has been taken. 15:11

The efforts of the administrative team led by Jaclyn Richardson and her team Steven, Finola, Claire, Daniel, Laura, and Catherine-Ann, to bring all of this about has been a massive feat of work involving many weekends lost and midnight oil being burnt and that's not often appreciated by those sitting in the room. 15:12

I want to thank again the PI team who ensure we are streaming when and where we should be and always seem

to have the right document on the screen, despite the occasional technical challenge as we saw this morning.

We especially want to thank Paula, our regular stenographer, who has put up with quite a number of long days recently and more than that, has shown a skill that no-one else in this room could possibly match, dealing particularly brilliantly with the speed of some witnesses speech, which if I may say so, particularly in this jurisdiction, is an extraordinary feat. 15:12

Davy and Rab, our security staff, have been constantly helpful and on occasion have proved to be experts of their own in deescalation. 15:13

And finally we want to acknowledge the work of our counsellors Mairead, Sean and Niall who have assisted and calmed countless nervous and occasionally distraught witnesses and helped them to get through their evidence. 15:13

Now, we will meet again next on 26th November at 10.00 a.m. I remind you that written submissions in skeleton form must be submitted by 4 p.m. on 22nd November and, because all of those submissions are going to be crossed-served for all CPs, that has to be a hard deadline and I am afraid failure to meet it will have consequences on the time allowed to make oral 15:13

submissions. In other words, 4 p.m. please.

Can I thank you everybody for their attendance today. I will take into account the submissions that have been made by Ms. Anyadike-Danes and Mr. Aiken and I will provide a decision on whether there needs to be a further oral hearing in due course. Thank you all very much.

MR. DORAN: Thank you, Chair and Panel.

15:14

15:14

THE INQUIRY ADJOURNED UNTIL TUESDAY, 26th NOVEMBER AT 10.00 AM.