Muckamore Abbey Hospital Inquiry

Module 6b – Ennis Ward Adult Safeguarding Report

FURTHER WITNESS STATEMENT OF BRENDA CREANEY ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, Brenda Creaney, retired Executive Director of Nursing and User Experience within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This is my third witness statement to the MAH Inquiry. I provided my first witness statement dated 22 February 2024 on behalf of the Belfast Trust, corporately, in relation to Evidence Module 6b about the Ennis Ward Adult Safeguarding Report. My second witness statement dated 19 June 2024 relates to Organisational Module 9 about Trust Board.

2. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "BC3".

3. This statement is made on behalf of the Belfast Trust corporately in response to a request by the MAH Inquiry dated 10 July 2024 for an addendum or additional statement relating to Evidence Module 6b and the Ennis Ward Adult Safeguarding Report. It was to exhibit additional documentation. A copy of the 10 July 2024 MAHI letter can be found behind Tab 1 of the exhibit bundle.

4. On 7 December 2023, the Belfast Trust was requested by the MAH Inquiry to make an organisational statement in respect of the Ennis Ward Adult Safeguarding Report and its outworkings (Evidence Module 6b). (The Belfast Trust had

originally addressed the Ennis Ward Adult Safeguarding Report through the Evidence Module 6 Belfast Trust corporate statement provided by Martin Dillon dated 26 April 2023.) With the 7 December 2023 request from the MAH Inquiry the Belfast Trust was provided with a bundle of documentation entitled *"Module 6b: Ennis Ward Adult Safeguarding Report - Bundle for Witnesses"* (the first bundle) for the purposes of making the statement. This first bundle, of initially 804 pages, was comprised of only those documents that were assessed by the MAH Inquiry as necessary for statement makers to have the opportunity of considering for the purpose of assisting the MAH Inquiry Panel. I have not exhibited the first bundle to this witness statement.

5. Unlike the previous Evidence Module witness statements, witness statements provided in relation to Module 6b, were not limited to informing the MAH Inquiry of the legal and regulatory framework, organisational structures, policies, procedures and practices or reports. The MAH Inquiry Panel wished, through the provision of the Module 6b witness statements, to examine the adequacy and effectiveness of systems and processes that were in place as well as the actual response by the Belfast Trust to the 2012 allegations relating to Ennis Ward.

6. I made my first witness statement in response to this request on behalf of the Belfast Trust corporately dated 22 February 2024.

7. In preparing the witness statement it became evident to me that there were documents that had previously been provided by the Belfast Trust to the MAH Inquiry that were relevant to the issues addressed in my witness statement, but which had not been included in the first Bundle for use by witnesses. I referred to those additional documents in my first witness statement and either exhibited them (where I considered that necessary and helpful - four documents), or referred to their disclosure reference in the statement so they could be easily identified by the MAH Inquiry. For instance, the first bundle did not contain the applicable vulnerable adult/adult safeguarding policies that applied to the Ennis investigation, and with which those conducting the investigation would have been obliged to comply (I note in paragraph 8 of the witness statement of Ms Morrison (who was the Designated Officer for the relevant investigation) of 2 February 2024 that she was actually looking for the policy documents that I considered should be exhibited to my first statement because they were not in the MAH Inquiry's first bundle). By exhibiting those documents to my first witness statement I was trying

to assist the MAH Inquiry. I was disappointed to learn I was subsequently criticised, amongst other things, for having engaged in what was described as *"an unnecessary duplication of materials which the Inquiry sought to avoid."*

8. On 28 May 2024 the MAH Inquiry notified Core Participants that it had uploaded a supplementary bundle of documents (amounting to 43 pages) onto Box. This supplementary bundle (the second bundle), which can be found behind Tab 2 in the exhibit bundle, was intended by the MAH Inquiry (according to paragraph 12 of the MAH Inquiry Note to Core Participants of 17 May 2024) to be the documents referred to in my first witness statement, but which were not exhibited, and which were otherwise not contained within the first Bundle. The same paragraph of the Note to Core Participants also said that the documents to which I had referred (but not exhibited) to my first witness statement would in any event not assist the MAH Inquiry Panel in addressing what were said to be *"the key issues arising from the Ennis report"*. I do not know what the *"key issues arising from the Ennis report"* are said to be, but the documents I either exhibited or referred to in my first statement were the documents I considered necessary to answer the questions posed to the Belfast Trust by the MAH Inquiry, and through which I was trying to assist the MAH Inquiry. The supplementary or second bundle uploaded by the MAH Inquiry was called *"MAHI Creaney B, Supplementary Bundle"*.

9. Unfortunately, the supplementary or second bundle of 43 pages did not contain all of the documents I had referenced in my first statement. I therefore had prepared, for the assistance of the MAH Inquiry, a third bundle of documents, consisting of 46 pages, entitled *"Documents referred to in statement (that are not in the MAHI Bundles)"*. It was provided to the MAH Inquiry on behalf of the Belfast Trust under cover of a letter of 7 June 2024. The 7 June 2024 letter, the index to the third bundle, and a copy of the third bundle can be found behind Tab 3 in the exhibit bundle. The italicised index commentary for each document was my effort to assist the MAH Inquiry by giving a very short summary of the import of each document in the third bundle.

10. Separately, after submission of the Belfast Trust corporate statement (my first witness statement dated 22 February 2024), the Belfast Trust continued to try to identify documents that may bear on the Ennis issues it understood were being considered by the MAH Inquiry Panel. Some further documents were identified. Had these documents been identified prior to the filing of my first witness

statement, they would have been included as exhibits to my first witness statement. I therefore had prepared, for the assistance of the MAH Inquiry, a fourth bundle of documents, consisting of 38 pages, entitled *"Documentation not referred to in statement or in bundles"*. This fourth bundle was also provided on behalf of the Belfast Trust with the letter of 7 June 2024. The index to the fourth bundle, and a copy of the fourth bundle can be found behind Tab 4 in the exhibit bundle. The italicised index commentary for each document was my effort to assist the MAH Inquiry by giving a very short summary of the import of each document in the fourth bundle.

11. On 11 June 2024, I gave oral evidence to the MAH Inquiry on behalf of the Belfast Trust in relation to Evidence Module 6b. In the course of that evidence, Sean Doran KC, Senior Counsel to the MAH Inquiry, explained that he was not going to ask about the third bundle and was not going to display it on screen. He explained that the material in the third bundle was going to be processed for disclosure in an appropriate way to Core Participants. He asked that if I needed to refer to any of those documents, that I did so in general terms.

12. Mr Doran KC went on to explain that the fourth bundle, containing the additional relevant documents identified by the Belfast Trust since the provision of my first witness statement of 22 February 2024, could safely be displayed on the screen that day, that no redaction issues arose in relation to those materials and the MAH Inquiry had labelled that bundle "Creaney B, New Bundle". This is the fourth bundle I refer to above, found behind Tab 4, and entitled *"Documentation not referred to in statement or in bundles"*

13. Post my oral evidence, on 10 July 2024, the Belfast Trust received a letter from the MAH Inquiry asking that I make a further Module 6b Ennis witness statement exhibiting the third and fourth bundles referred to above. For completeness and for the reasons set out above, and so that all documents either exhibited to or referred to in my first witness statement, or which would have been exhibited or referred to in my first witness statement (had they been identified) are before the MAH Inquiry exhibited to a witness statement, I have exhibited the second, third and fourth bundles to this witness statement behind Tabs 2, 3 and 4.

Declaration of Truth

14. The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which I believe are necessary to address the matters on which the MAH Inquiry Panel has requested the Belfast Trust to give evidence.

Signed:

Dated: 30 August 2024

Belfast Trust Module 6b Supplementary Statement Exhibit Bundle "BC3"		
INDEX		**PAGES**
Tab 1	Letter from MAH Inquiry to DLS dated 10 July 2024.	7
Tab 2	The second bundle entitled "*MAHI Creaney B, Supplementary Bundle*" prepared by MAH Inquiry said to contain the documents referenced in the first statement of Brenda Creaney dated 22 February 2024.	9
Tab 3	The third bundle entitled "*Documents referred to in statement (that are not in the MAHI Bundles)*" provided by the Belfast Trust under cover of 7 June 2024 letter, containing those documents referenced in the statement of Brenda Creaney dated 22 February 2024, but which had been missed out of the second bundle, together with the covering letter of 7 June 2024.	52
Tab 4	The fourth bundle entitled "*Documentation not referred to in statement or in bundles*"provided by the Belfast Trust under cover of 7 June 2024 letter containing those documents that would have been exhibited to the statement of Brenda Creaney dated 22 February 2024 had they been located by that date.	98

MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

10 July 2024

By Email Only
Mr John Johnston
Solicitor Consultant
Directorate of Legal Services
2 Franklin Street
Belfast
BT2 8DQ

Dear Mr Johnston

Re MAH Inquiry: Witness statement – Brenda Creaney

I refer to your correspondence of 07 June 2024 in relation to Belfast Trust witness Brenda Creaney.

The correspondence I refer to attached two bundles. The first bundle contained materials that were mentioned in the witness statement but that did not appear in the documentation that had been provided to Core Participants. The second bundle contained documents that were not identified at the time the witness made her statement but would have been exhibited if they had been identified at that time.

As you are aware Inquiry counsel addressed this documentation during Ms Creaney's oral evidence on 11 June 2024, however for completeness I would be grateful if the documents within the additional bundles could be provided to the Inquiry by way of exhibit to a short second statement, in the order and manner previously provided to the Inquiry.

Please note, the second statement is for the purpose of exhibiting this material and also needs confirmation by the witness that she endorses the description of the documents in the covering indices. The second statement should not revisit any previous issues.

Should you require any assistance please do not hesitate to contact me, and I thank

you and Ms Creaney for your continued assistance.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

This exhibit duplicates the Inquiry bundle “MAH-Creaney,B-Supplementary bundle” which has already been published on the Inquiry website [link]

DOCUMENTS REFERRED TO IN STATEMENT (THAT ARE NOT IN THE MAHI BUNDLES)			
	Document Name	**Para of Statement**	**Page in Bundle**
1	**Nurses in Difficulty Table for 1 April 2013- February 2014** BHSCT - II - 00045 - 2013.04.01 - 2014.02_Meeting with the Executive Director of Nursing_Summary Document (33 pages) - (02373) *This document shows that* H197 *(pg 2, 4, 5) and* H198 *(pg 3) were included in the consideration by the Nurses in Difficulty Meeting.*	42.	1 - 5
2	**Email on 13 Feb 2013 showing that John Veitch updated Catherine McNicholl in 1:1 meetings.** BHSCT - A - 00016 - LD Governance Lead - Various Records - Box File (572 pages) Redacted Copy - (00958) *Email showing Catherine McNIcholl put Ennis on agenda of 1:1 meeting with John Veitch.*	43.	6
3	**Email on 11 February 2013 showing John Veitch shared minutes of Joint Strategy Investigation meeting with Catherine McNicholl.** BHSCT - A - 00016 - LD Governance Lead - Various Records - Box File (572 pages) Redacted Copy - (00958) *Example email showing John Veitch provided Catherine McNIcholl with minutes from Ennis Strategy Meeting.*	43.	7
4	**Email on 15 May 2013 showing John Veitch shared minutes of Joint Strategy Investigation meeting with Catherine McNicholl.** BHSCT - A - 00016 - LD Governance Lead - Various Records - Box File (572 pages) Redacted Copy - (00958) *Example email showing John Veitch provided Catherine McNIcholl with minutes from Ennis Strategy Meeting.*	43.	8
5	**Email on 11 February 2013 showing John Veitch shared minutes of Joint Strategy Investigation meeting with Catherine McNicholl.** BHSCT - A - 00016 - LD Governance Lead - Various Records - Box File (572 pages) Redacted Copy - (00958) *Example email showing John Veitch provided email updates to Catherine McNIcholl.*	43.	9
5	**Interim Delegated Statutory Functions Report** BHSCT - I - 00011 - 2012-2013_DSF_Interim (40 pages) - (02061)	56.	10-11

	There was an issue in 2012/2013 about the interpretation of an incident under the Joint Protocol. The Belfast Trust was thought by the PSNI to be over reporting incidents. Section 8 shows that this issue was captured in the Interim DSF Reports. The tenor of the DSF report can be seen to include general issues rather than incident – specific information.		
6	**Board Assurance Framework 2011/2012** BHSCT - D - 00004 - 2011-2012 Board Assurance Framework Revised Nov 2011 (18 pages) - (00032) *This sub-committee structure shows the structure as it existed at the time the Ennis allegations were made. It shows the SAI Review Board sitting as it's own Steering Group. This changed in 2013-2014 (See 'New Material index') when the SAI Group became a sub-committee of the Learning From Experience Group. This may not have been accurately captured at page 30 of the L&G Review. It is useful as a compare and contrast exercise of how the structure changed.*	69.	12-13
7	**Email on 19 November 2012 from Aine Morrison to Catherine McNicholl noting Aidan Murray, of HSCB, wanted minutes from the strategy meetings.** BHSCT - A - 00024 - Ennis Investigation - Aine Morrison File 1 (353 pages) - (02452) *In this email, Aine Morrison informs Catherine McNicholl that "Aidan Murray from the Board has asked for copies of the strategy meeting minutes?". We do not know whether they were provided to him, but it shows that HSCB, who was a recipient of the Ennis Early Alert, along with DoH, were engaging with the Belfast Trust in November 2012.*	114.	14
8	**Email chain between Esther Rafferty and Aine Morrison in September 2013 about disciplinary investigation.** BHSCT - A - 00017 - LD Governance Lead - Various Records (Folder 1 of 3) (816 pages) Redacted Copy - (00959) (Pg 1 and 2) *This email chain shows Aine asking for clarification over the purpose and need for a separate investigation. Esther clarifies it is a disciplinary investigation.*	122.	15-16
9	**Email on 17 December 2012 from Colette Ireland to Aine Morrison which details the conversations with relatives during telephone contact.** BHSCT - A - 00024 - Ennis Investigation - Aine Morrison File 1 (353 pages) - (02452) (pg 280) *This is an email from Collette Ireland to Aine Morrison which lists the NoK that she had contacted and summarises the content of the conversation.*	131.c.	17
10	**A Memo by Barry Mills which details the communication with next of kin as of 9 November 2012.** BHSCT - A - 00018 - LD Governance Lead - Various Records (Folder 2 of 3) (322 pages) - (00960) *This memo dated 9 November 2012, records that Barry Mills all relatives had been contacted and informed of the allegations, the staff suspension and ongoing investigation.*	131.b.	18

11	**Written Account by Aine Morrison of her experience during the Ennis Investigation.** BHSCT - A - 00010 - 2020.02.06_AM_AccountofEnnisExperience (10 pages) - (00952) *This is a written Account that Aine Morrison provided to the Belfast Trust on 6 February 2020 of her experience during the Ennis Investigation. She provided this when she was not happy with the note that Marie Heaney and Carol Diffin provided in relation to the Teleconference they attended with her (and attended in a supporting role by Jackie McIlroy) on 16 January 2020.*	193.	19-28
12	**Esther Rafferty's Response to Aine Morrison's written account.** BHSCT - H - 00014 - File 14 of 2020 Leadership & Governance Review materials - BHSCT L&GRFile v3 (334 pages) - (00081) *This is the written statement of Esther Rafferty responding to the issues raised by Aine Morrison. This was provided at the request of BHSCT to the L&G Review Team.*	196.	29-30
14	**Moira Mannion's Response to Aine Morrison's written account.** BHSCT - H - 00014 - File 14 of 2020 Leadership & Governance Review materials - BHSCT L&GRFile v3 (334 pages) - (00081) *This is the written statement of Moira Mannion responding to the issues raised by Aine Morrison. This was provided at the request of BHSCT to the L&G Review Team.*	196.	31-43

Belfast Health and Social Care Trust

PRIVATE & CONFIDENTIAL - Nurses/Midwives in Difficulty 'Clinic'

CENTRAL NURSING & MIDWIFERY RECORD - SUMMARY OF REFERRALS TO NMC

FOR THE PERIOD: 1 April 2013 to February 2014

Nurse/ Midwife	Directorate and ADN/M	Referral date to NMC	Reason for Referral	Update

The Exhibit at pages MAHI-STM-319-55 to MAHI-STM-319-59 is a Nurses in Difficulty Table for 1 April 2013 - February 2014. The redacted text contains information about nurses employed by the Belfast Health and Social Care Trust who were unconnected with the Ennis Ward Adult Safeguarding Investigation. It contains summaries of referrals made to the Nursing and Midwifery Council (NMC) in respect of those nurses, including details of investigations and outcomes.

1

Belfast Health and Social Care Trust

PRIVATE & CONFIDENTIAL - Nurses/Midwives in Difficulty 'Clinic'

CENTRAL NURSING & MIDWIFERY RECORD - SUMMARY OF REFERRALS TO NMC

Nurse/ Midwife (initials)	Directorate and ADN/M	Referral date to NMC	Reason for Referral	Update
[redacted]				
H197	Soc & Prim Care - Learning Disability - Esther Rafferty	Tue 13/11/2012	Alleged abuse of patient	6/12/13 Email from DR to A Badger, NMC: As we discussed yesterday evening with Mrs Esther Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast HSC Trust: H197 remains on precautionary suspension following an allegation of physical abuse. The case has been investigated by the Police Service of Northern Ireland (PSNI). The PSNI have concluded that there is a case to answer. H197 appeared in court on 26th November 2013 and pleaded not guilty to charges of ill treatment and common assault. It is anticipated that the court hearing will be in April 2014.
[redacted]				[redacted]
				[redacted]

2

Belfast Health and Social Care Trust

PRIVATE & CONFIDENTIAL - Nurses/Midwives in Difficulty 'Clinic'

CENTRAL NURSING & MIDWIFERY RECORD - SUMMARY OF REFERRALS TO NMC

CURRENT EMPLOYEES - FOR THE PERIOD: 1 APRIL 2013 TO FEBRUARY 2014

[redacted]

H198	Esther Rafferty	Children and Vulnerable Adults	No case to answer.

[redacted]

Belfast Health and Social Care Trust

PRIVATE & CONFIDENTIAL - Nurses/Midwives in Difficulty 'Clinic'

CENTRAL NURSING & MIDWIFERY RECORD - SUMMARY OF REFERRALS TO NMC

EX-EMPLOYEES - FOR THE PERIOD: 1 APRIL 2013 TO FEBRUARY 2014			
Nurse/ Midwife (initials)	Directorate and ADN/M	Reason for Referral	Update
[redacted]			
H197	Esther Rafferty	Alleged Abuse of Patient	Existing interim suspension order confirmed
[redacted]			

2

Belfast Health and Social Care Trust

PRIVATE & CONFIDENTIAL - Nurses/Midwives in Difficulty 'Clinic'

CENTRAL NURSING & MIDWIFERY RECORD - SUMMARY OF REFERRALS TO NMC

Key: Former Employee

Nurse/ Midwife (initials)	Directorate and ADN/M	Referral date to NMC	Reason for Referral	Update	CNO ALERT
H197	AS&PC / Adult Learning Disability Community & Hospital Services directorate - Esther Rafferty	Tue 13/11/2012	Alleged abuse of patient Safeguarding	ER reported at the quarterly NMID meeting with ExDoN in March 2014, that a court hearing will take place in April, the information for which is currently being collated. Letter from dated NMC 24 April 2014: Outcome of recent IO review meeting before IC on 17/4/14. Panel decided to confirm existing interim order. (Feb 2014 for 12 months)	9/11/12
[redacted]					

FOR THE PERIOD: February 2013 – June 2014

5

016

Haywood, Patricia

From: Mannion, Moira
Sent: 25 February 2013 08:06
To: Veitch, John; Rafferty, Esther
Cc: Harris, Lesley; Clarkin, Una
Subject: RE: Unannounced Inspection Ennis Ward

Moira – This is only to draft response to RQIA letter so don't think I need to be involved in meeting.
J

Can we set time aside to begin this proactive approach please
Uan and Lesley could we start by attempting to get us together ie the folk included in this email
Many thanks
Moira

From: Veitch, John
Sent: 14 February 2013 15:29
To: Rafferty, Esther
Cc: Mannion, Moira; Harris, Lesley
Subject: FW: Unannounced Inspection Ennis Ward

c.c. Esther
25.2.13.

Just to confirm that Catherine has requested we formally respond to rqia following meeting on Monday. I know Moira is very willing to assist with this.

Thanks

John

✓ JV 25/2/13 @1139

From: Kerr, Hayley **On Behalf Of** McNicholl, Catherine
Sent: 13 February 2013 09:13
To: Veitch, John
Cc: Harris, Lesley
Subject: FW: Unannounced Inspection Ennis Ward

This will be on the agenda for your next 1:1 with Catherine.

Hayley

From: Veitch, John
Sent: 11 February 2013 16:26
To: Kerr, Hayley; McNicholl, Catherine
Cc: Harris, Lesley; McNeany, Barney
Subject: FW: Unannounced Inspection Ennis Ward

Attached internal briefing paper from Esther for information.
John

From: Rafferty, Esther
Sent: 08 February 2013 11:29
To: Veitch, John
Cc: Milliken, Colin
Subject: Unannounced Inspection Ennis Ward

John
Password for letter is ennis01022013

024

Harris, Lesley

From: Veitch, John
Sent: 11 February 2013 16:20
To: Kerr, Hayley; McNicholl, Catherine
Cc: Harris, Lesley
Subject: FW: Ennis Ward Investigation Meeting 09 01 13#2
Attachments: Ennis Ward Investigation Meeting 09 01 13#2.docx

For info.

John

From: Hanna, Debbie
Sent: 06 February 2013 17:14
To: Morrison, Aine; McKnight, Yvonne; Hegarty, Deirdre; Mannion, Moira; Veitch, John; Rafferty, Esther; McNeany, Barney; Murray, Geraldine
Cc: Ireland, Colette; Drysdale, Carmel
Subject: Ennis Ward Investigation Meeting 09 01 13#2

Please see attached minutes of the Ennis Ward Investigation Meeting held on 9th January 13.

Kind Regards

Debbie Hanna
Personal Secretary
For

Aine Morrison
Operations Manager

Harris, Lesley

From: Veitch, John
Sent: 15 May 2013 09:06
To: McNicholl, Catherine; Kerr, Hayley; Creaney, Brenda
Cc: Harris, Lesley
Subject: FW: MINUTES/please circulate
Attachments: Ennis Ward Investigation Meeting held 29 March 2013.doc

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From: Hanna, Debbie
Sent: 13 May 2013 16:46
To: Drysdale, Carmel; Hegarty, Deirdre; Ireland, Colette; Mannion, Moira; McKnight, Yvonne; Morrison, Aine; Rafferty, Esther; Veitch, John
Subject: FW: MINUTES/please circulate

Please find attached minutes of Ennis Investigation Meeting Held on 29th March 2013

Kind Regards

Debbie Hanna
Personal Secretary
For
Aine Morrison
Operations Manager

From: Morrison, Aine
Sent: 10 May 2013 15:45
To: Hanna, Debbie
Subject: FW: MINUTES/please circulate

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No 90566038/90566034

Yvonne McKnight, TASS
Adult Safeguarding
1st Floor, Admin Building
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9504 6896
email: pauline.stewart@belfasttrust.hscni.net

Kerr, Hayley

From: Veitch, John
Sent: 11 February 2013 16:17
To: Kerr, Hayley; McNicholl, Catherine
Cc: Harris, Lesley
Subject: FW: Ennis Staff Interviews

For information- I will keep you appraised.

John

From: Morrison, Aine
Sent: 11 February 2013 12:21
To: McNeany, Barney; Veitch, John; Rafferty, Esther
Subject: Ennis Staff Interviews

Hi,
Just to let you know interviews with H197 [redacted] and H159 [redacted] by the PSNI did not proceed as H159 was ill and H197 had not arranged for a solicitor.
The interviews have been rearranged for the 20th and 22nd of February,
Aine

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No 90566038/90566034

Belfast Health and Social Care Trust

Interim Delegated Statutory Functions Report

1 April 2012 – 30 September 2012

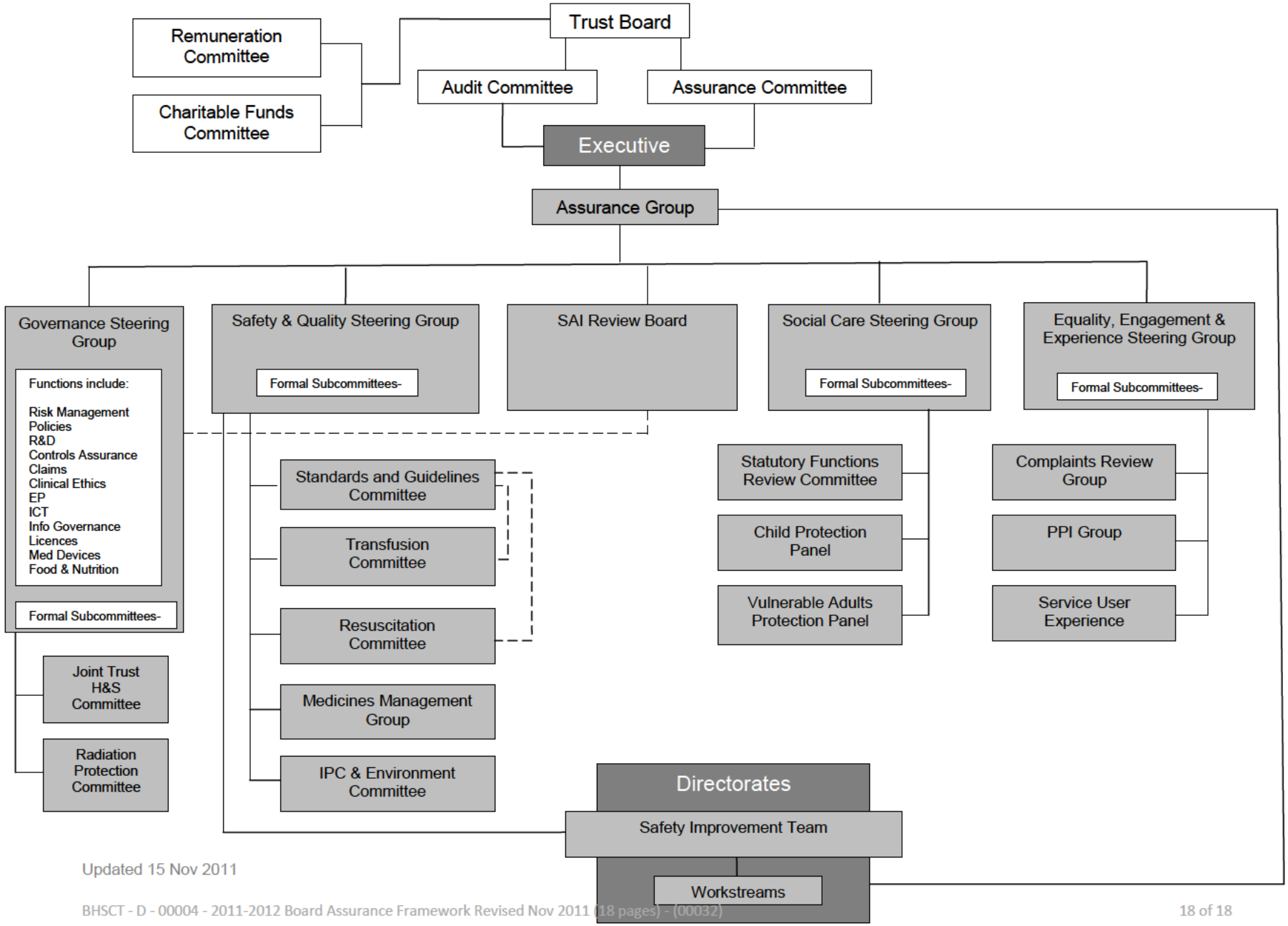
	Last year, the Service Area conducted an audit of community team staff distribution of time and tasks. This is currently being analysed. It is planned that this will lead on to further analysis of capacity and demand.
5.	**Difficulty in Increasing direct payments uptake**
	Service Area staff are due to attend regional training in the implementation of the HSC circular making arrangements for direct payments for persons who lack capacity to consent. It is hoped that once these new procedures are established, people with learning disabilities will have much greater access to direct payments again. The Service Area will continue to promote their use.
6.	**Deprivation of Liberty Safeguards**
	(see Audits and Reviews)
7.	**Promoting Quality Care Guidance**
	The Service Area continues to find the 28 day target for completing a comprehensive risk management plan largely achievable. The Service Area notes the large degree of consensus reached at the regional learning disability PQC forum about necessary changes to the Guidance and would hope to see these implemented as soon as possible.
8.	**PSNI/Social Services Interface in Vulnerable Adult Processes**
	Working relationships with the PSNI are good and there is generally a positive approach to co-ordination and joint working. The Trust has raised its concerns about the timely implementation of vulnerable adult procedures as a result of resource and capacity pressures being experienced by the PSNI. Difficulties remain about differences in interpretation of the current Joint Protocol. The Service Area welcomes the revision of the Joint Protocol and would be hopeful that an agreement between all parties on this would resolve some of the current concerns. The Service Area awaits the new regional DHSSPSNI Adult Safeguarding Policy.
9.	**Financial Position**
	The Trust's financial position continues to have a significant impact on the availability of service provision. The volume and complexity of need in people with learning disability creates a demand for high cost care packages which causes significant financial pressure. The Service Area is currently awaiting the outcome of consultations with the HSCB about two requested high cost domiciliary case packages. The Service Area also awaits the development of regional procurement policy and guidelines which it hopes will aid decision making in these cases. The Service Area will introduce in November a new process for assessment, categorisation and prioritisation of need. This system will mean that only those deemed to have needs that are having a critical or substantial impact on their health or wellbeing will receive a care managed service. The Service

Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

2011/12

ASSURANCE COMMITTEE
SUB-COMMITTEE STRUCTURE



Updated 15 Nov 2011

Hanna, Debbie

From: Morrison, Aine
Sent: 19 November 2012 12:14
To: Hanna, Debbie
Subject: FW: Ennis Ward/please print
Attachments: InitialInvestigationPlan19.11.12.doc

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No 90566038/90566034

From: Morrison, Aine
Sent: 19 November 2012 12:08
To: McNicholl, Catherine
Subject: Ennis Ward

Catherine,

Please see attached the suggested initial investigation plan. Most of this was agreed at the last strategy meeting. I have added some elements and formalised it into a written plan. I would intend circulating it to those present at the strategy meeting for agreement.

I'll also forward a draft email I was planning on sending to Esther asking for information from the hospital.

I'll also forward the guidance I agreed on Friday for the supervising staff on the ward.

RQIA have asked for a minor change to the agreed press statement which I will circulate to all parties.

Aidan Murray from the Board has asked for copies of the strategy meeting minutes ?

There have been 7 interviews carried out by Trust staff with Bohill staff. Of these, 3 made statements which might suggest criminal physical abuse. These staff were unsure of staff names. In addition there are two staff who came forward with potential criminal concerns previously as well as the initial person. The other four staff all raised concerns about the culture on the ward and poor care practice. Some of these were similar to my own observations of concern when I visited the ward.

Would appreciate a bit of guidance on a few things.
When you say you intend to put a senior, external team together, is it your intention that I'm included in that ?
Also, do you want me to proceed with the suggested investigative actions above or wait until those who will be becoming involved are on board ?
Would also suggest that there should be a fairly urgent discussion about the need for more independent monitoring on the ward and if this is agreed, discussion about how we might source this.
I've also fed back to the police on our discussions and they await our response,

Aine

Aine Morrison

Harris, Lesley

From: Rafferty, Esther
Sent: 19 September 2013 18:13
To: Morrison, Aine
Cc: Veitch, John
Subject: RE: Ennis

Yes

From: Morrison, Aine
Sent: 19 September 2013 18:04
To: Rafferty, Esther
Cc: Veitch, John
Subject: RE: Ennis

Esther,
Do you mean a disciplinary investigation ?
Aine

Aine Morrison
Service Manager Community Treatment & Support Services for Learning Disability

Belfast Health and Social Care Trust

Address: Fairview 1
Mater Infirmorum Hospital
47-51 Crumlin Road
Belfast
BT14 6AB
Telephone: 028 9504 7490
Email: aine.morrison@belfasttrust.hscni.net

From: Rafferty, Esther
Sent: 19 September 2013 15:49
To: Morrison, Aine
Cc: Veitch, John
Subject: RE: Ennis

Aine
A full internal investigation will now take place to look at what action and learning the Trust needs to undertake in relation to any staffing concerns raised from the original complaint on 8th November
This is normal practice
Esther

From: Morrison, Aine
Sent: 19 September 2013 15:17
To: Rafferty, Esther

Cc: Veitch, John
Subject: FW: Ennis

Esther,
I wasn't aware that there was to be an internal investigation. Are there issues that haven't been dealt with by the safeguarding investigation ? We are currently finalising the report and will be organising another case conference shortly,
Aine

Aine Morrison
Service Manager Community Treatment & Support Services for Learning Disability

Belfast Health and Social Care Trust

✉ Address: Fairview 1
Mater Infirmorum Hospital
47-51 Crumlin Road
Belfast
BT14 6AB
☎ Telephone: 028 9504 7490
@ Email: aine.morrison@belfasttrust.hscni.net

From: Scott, Rhonda
Sent: 19 September 2013 14:56
To: Morrison, Aine
Cc: Rafferty, Esther
Subject:

Aine
You may be aware G Hamilton and myself have been requested to carry out the internal investigation in Ennis re the alleged abuse within the ward in Nov 12. I know your team interviewed a lot of the staff and I am requesting that Geraldine and myself could have access to these interview notes To aid us in our investigation This may save us having to re-interview staff as you will appreciate this can be extremely stressful to staff Please let me know if this is possible
Many thanks
Rhonda

Hanna, Debbie

From: Morrison, Aine
Sent: 17 January 2013 12:19
To: Hanna, Debbie
Subject: FW: list of NOK who I had contacted/please print

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No 90566038/90566034

From: Ireland, Colette
Sent: 17 December 2012 10:02
To: Morrison, Aine
Subject: list of NOK who I had contacted

[redacted] spoke to mum, she had no worries about the ward and felt [redacted] is content. Her concern is about the uncertainty for the future of the ward and is worried about it closing.

[redacted] spoke to [redacted] sister. She has no concerns. [redacted] is content.

[redacted] spoke to her mother who said [redacted] hasn't been affected.

[redacted] spoke to her brother [redacted] His main concern was the proposed move fo[redacted] has been contacted by Catherine O'Callaghan about possible placement [redacted] old him that the nurse in charge [redacted] Had got her by the scruff of the neck and took her to her bed room [redacted] felt that [redacted] wouldn't tell lies and may not want to say anything that would get her into trouble.

[redacted] spoke to her sister [redacted] who asked that any correspondence is sent to her and not to her mother's address. She had no concerns and talked about the proposed move for [redacted] to Bowhill.

[redacted] spoke to her brother. No concerns

[redacted] spoke to her brother who had no concerns and wanted to talk about his unhappiness about re-settlement as his sister has been in hospital for 30 yrs and has been content there.

[redacted] spoke to father who talked very positively about the improvement in [redacted] since she moved to Ennis. They take [redacted] every weekend and have never had any concerns. They were concerned that this should be passed on.

[redacted] just getting voice mail for mum's number, didn't leave a message

[redacted] number provided is unobtainable.

At this stage I contacted Ester to clarify [redacted] sister contact details and was told not to proceed with the letter being sent.

Colette.

2.052

Friday 9th November 2012

Ennis Notification of Next of Kin

All relatives of patients not directly connected to recent allegations contacted and advised of allegations, staff suspension and ongoing investigation. Also advised how to raise any concerns they may have had or currently have.

No relatives at the time of calling had any concerns and most stated they were more than satisfied with the standard of care.

However, all would like to be updated on the investigation.

I advised should the investigation identify any areas of concern directly affecting their relative they would be contacted immediately.

One relative when being contacted raised concerns regarding the taxi service– P583's NOK next of kin of P583

I will advise Senior Nurse Manager Mr C Stewart of the matter.

BARRY MILLS
CLINICAL AND THERAPEUTIC SERVICE MANAGER

12th November 2012

This is a written account of some of my experience in acting as Designated Officer (DO) into allegations of abuse on Ennis Ward, Muckamore Abbey Hospital.

In writing this account, I have had access to the safeguarding investigation report which was completed at the end of the investigation although I am not totally sure that the version received by the Dept. of Health is the final version. The writing of the report was led by me but the contents agreed with the two Investigating Officers (IOs) who worked with me during the investigation.

However, I have not had access to any other written documentation about the investigation so much of my account is based only on my memory of what occurred at the time.

I am writing this account at the request of the BHSCT following a number of conversations with the Trust about my experience.

In December 2019, I made the Trust aware that I had experienced difficulties in my role as DO in the Ennis investigation.

My decision to do so was prompted by two factors.

Firstly, I was conscious that some of my experiences were potentially relevant to the MAH leadership and governance review which was commissioned following the disclosure of allegations of abuse at Muckamore Abbey Hospital. I thought it likely that any conversations I might have with the review team would involve my discussing these experiences and therefore wanted to make the BT aware of them also.

Secondly, the leak of the Ennis report to the Irish News had set in train a number of actions which resulted in an agreement at the MDAG that I along with a BT representative would be involved in briefing the family representatives on the MDAG as well as the families of Ennis patients. I felt that I could not give an open and honest briefing without mentioning some of the difficulties I experienced and therefore wished to share this information with the Trust in advance of briefing families.

At the time the allegations were made, 8.11.12, I was an Operations Manager in BT Learning Disability Services with responsibility for community multi-disciplinary learning disability teams.

B Mc N was my line manager although I believe he was on sick leave at the time the allegations were made. JV was the Co-Director for both hospital and community learning disability services at the time. My memory is that he was on annual leave and out of the country when the allegations were made.

I was appointed to a service manager role on 1.7.13 and continued with some aspects of the Ennis investigation then.

MAH informed me of the allegations, I don't remember who in particular informed me but I stepped in to take on the role of Designated Officer under the September 2006, Safeguarding Vulnerable Adults Policy.

The nature of the allegations and the fact that it was alleged that the abuse had happened openly in front of external staff made me immediately concerned about potentially widespread abuse on Ennis Ward rather than single, isolated incidents.

I immediately contacted the PSNI and a joint protocol investigation was agreed with a strategy meeting organised very quickly.

I experienced my first difficulty before this initial strategy meeting. ER who was Service Manager for Hospital Services had invited Dr.CM who was Clinical Director for MAH but also the Consultant Psychiatrist for the ward to the strategy meeting. When I realised this, I spoke to ER stating that I did not think it was appropriate that CM or any other staff from Ennis Ward be involved in planning an investigation strategy or in agreeing a protection plan which were the two main items for consideration at the meeting. This was because I was conscious that there was a need to consider the possibility of widespread abuse on the ward.

ER disagreed vehemently with this approach and tried to overrule me, stating that she was the more senior manager. While accepting this, I was insistent that as the DO, I had the lead responsibility for immediate protection planning and agreeing a joint investigation strategy and that I was not prepared to involve any ward staff in this meeting. We were unable to resolve the issue between us and ER decided to contact CMcN,

Director for Adult Community Services. I was not involved in that phonecall but following the phone call, ER asked me to ring CMcN. I did this and CMcN told me that she had agreed with ER a position whereby no MAH staff would attend the strategy meeting. This resolved the issue of CM's attendance but did mean that there was no one from the hospital present to answer queries or take on responsibility for any actions.

At a later point, ER did rejoin the meetings but I do not remember at what point. I do not believe that CM attended any future meetings but am not sure on that point.

A further difficulty arose when making protection plans to ensure the patients were safe while an investigation was underway. While a number of staff had been suspended, I believed that the concerns were such that 24 hr monitoring of the ward by external staff was also necessary.

The Bohill staff who had made the allegations were very clear that they had had no concerns about staff conduct on other wards that they had also spent time in and indeed had observed very compassionate care on the other wards so we had no reason to suspect at that stage practice in other wards.

It was agreed that the 24 hour monitoring would largely be provided by Band 8A senior nursing staff from MAH. I believe that MM, Co-Director for Nursing also did some monitoring herself, she also made unannounced ward visits and I think she also arranged for other staff external to MAH to participate in some of the monitoring. I think that over time, Band 7 staff from other areas both within and outside MAH also provided monitoring but I cannot remember all the details.

From the outset, I experienced significant opposition from hospital staff to the part of the protection plan that required 24 hour monitoring. There were some initial difficulties with ensuring that it was happening as stipulated. RQIA found on at least one occasion that the agreed arrangements were not in place when they visited the ward. I needed to restate the expectation of 24hr monitoring on a number of occasions. Then, there were repeated requests made to me to stand down the monitoring. These requests started at an early stage of the investigation and continued for quite some time. I was repeatedly told that the presence of a monitoring member of staff was causing disruption and

distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion. I believed that the presence of one unfamiliar member of staff amongst a team of familiar staff who were doing most of the hands on care was unlikely to be so significant that it outweighed the need to protect from the possibility of wider abuse on the ward. I did not accede to any of the requests to step down the monitoring. I do not remember who exactly voiced the opposition to the protection plan but my memory is that it came from MM, ER and other hospital management staff. The minutes of various meetings may record the details of this.

During one of the earlier meetings where MM and ER were both present. MM was extremely hostile towards me. She berated me for daring to suggest that nurses would be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own professional practice. The level of hostility and confrontation was such that a number of people external to the BT who were present at the meeting contacted me afterwards to see if I was ok. While this incident was the most direct and confrontational, I continued to feel that I was not receiving adequate support from ER and MM. During much of the investigation, I felt like an unwelcome outsider. I did not get any sense of a collaborative approach between myself and hospital management, instead feeling that I was having to regularly challenge.

While it was not unusual for a Designated Officer to experience some resistance from a service under investigation, this was beyond the norm.

There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was criticism of their level of experience, expertise, perception of events and in particular their failure to speak out at the time of witnessing the alleged abuse. This was portrayed as poor practice on their part and used as an argument to doubt their credibility. While a lot of this criticism came from ward level staff, my memory is that it was also voiced by ER and MM. There appeared to be a lack of understanding about the difficult position the Bohill staff were in, the power differentials, the lack of immediate support for them in that setting and the fact that at least two of them had reported their concerns very soon afterwards.

MM and I had very different views on the care plans for individual patients on the ward. While acknowledging that I was not familiar with nursing care plans, they appeared to me to be lacking detail, particularly in relation to managing challenging behaviours. MM's view was that the care plans were satisfactory.

I also experienced very significant pressure from JV, the Co-Director for both hospital and community learning disability services.

JV repeatedly challenged me both privately and publicly in meetings about what I had determined to be evidence of abuse. My response was that I had weighed up all the information available to me and that I gave weight to the number, credibility and consistency of reports and that where these factors were sufficiently persuasive, I counted this as evidence. JV repeatedly characterised this as one person's word against another and therefore unreliable. I responded by accepting the inherent difficulties in having conflicting accounts but stated that many issues both in criminal cases and safeguarding relied on witness evidence which was challenged by the person accused and that the safeguarding task was to make the best judgement possible on the balance of probabilities.

I was also challenged repeatedly by JV to state that I had found no evidence of institutional abuse. I had not used the term "institutional abuse" up until this point. My understanding of the term was about routines, systems, regimes which created the conditions for abuse or were in themselves abusive. I felt that what I was investigating in Ennis was allegations of physical abuse and ill-treatment which were potentially widespread and potentially happening openly. My aim was to describe what was alleged and to describe what the investigation found.

However, when JV used the term, I understood him to mean whether there was or wasn't widespread or endemic abuse.

One of the major difficulties in the investigation was in identifying individuals as described by Bohill staff.

There were also a number of individual allegations which were potentially a matter of interpretation, such as "how tight was too tight in relation to a belt?".

There were also a number of instances where all we had were two different accounts, one by the person making the allegation and one by the person accused of it.

So while,the investigating team were very clear about the weight of the evidence against two named individuals, we also believed there was an absence of concrete evidence against other individuals that would be deemed sufficient evidence for disciplinary action.

However, we did believe that there was enough evidence to warrant suspicion about wider-spread abuse and for that reason, I was not prepared to say that we had found no evidence of institutional abuse. In the debates with JV about this issue, I said that while I did not feel that I could say that there was conclusive evidence of institutional abuse, I felt that equally, I could not say that there wasn't institutional abuse.

JV disagreed with this position and while I felt pressurised by him to state that I had not found institutional abuse, I maintained my own position both in the investigation report and in meetings. I was not challenged on the final wording of my report by JV or any of the other people involved.

At one point in the investigation, when we were struggling to get identification of individual MAH staff members from Bohill staff members, I explored the possibility of showing MAH staff photos to Bohill staff. I explored the possibility of getting staff photos from their staff identity cards but was advised that this would not be technically possible. I discussed the issue with JV who was very opposed to this and not willing to consider it at all. He said that it would be most unfair to staff given the risks of misidentification and that staff could legally challenge it.

I would have welcomed a discussion on it but did have significant doubts about the appropriateness of it myself, feeling that there were risks of misidentification in it and also that such a process would more properly sit with the PSNI if they thought it was necessary. For those reasons, I accepted JV's determination on that issue and did not pursue this further.

All of the investigatory actions were planned and reviewed with the PSNI throughout the process.

JV also emphasised to me that I could not make disciplinary recommendations, that all I could do was recommend someone for disciplinary investigation. Policy at the time supported two separate processes and I was unconcerned about this advice as I believed the disciplinary process would take account of what the safeguarding investigation had found.

Towards the conclusion of the investigation and in recognition of the possibility that the abuse had been more widespread than we had been able to prove, I suggested that the investigating team would meet with the Ennis staff team to discuss the allegations, the outcome of the investigation including the fact that we had been unable to identify some staff against whom allegations were made and the recommendations we had made. I felt that raising awareness of this and stating clearly what was acceptable and unacceptable would serve as a protective factor in the future. ER set up and attended this meeting. Staff presented as very angry during the meeting, repeatedly challenging what the Bohill staff had said. During the meeting, I felt very unsupported by ER who largely just observed the meeting. I felt that this created an unhelpful impression that hospital management did not have the same level of concern as community staff.

Following the end of my investigation, at some point, I was made informally aware that a disciplinary investigation into the two people I had recommended for disciplinary action was underway. I was concerned that I had not received a request for either the investigation report or any of the other documents, including in particular the records of the interviews with Bohill staff. Nor had I been contacted in relation to my reasoning for recommending a disciplinary investigation. I raised my concern about this with JV and he arranged for the two disciplinary investigating staff to get a copy of the investigation report and asked them to meet with me. During this meeting, I became concerned that they did not wish to review all my records although they had received and read the investigation report. I felt that their focus was to re - investigate whereas I felt that the investigation had been done and that they should rely on the evidence that I had already gathered. I think it

was at that meeting that I was informed that some of the Bohill staff were unwilling to be re – interviewed by them and unwilling to give witness statements in a disciplinary investigation. I argued that these were unnecessary as I already had their statements.

At a later point, again I heard informally that neither of the two staff had been dismissed. On hearing this, I raised my concern with JV, stating that the safeguarding investigation had very clearly found significant evidence of abuse and that the ongoing protection plan was that these two staff members should not have any contact with vulnerable adults. I pointed out the difficulty of two contradictory decisions being made by two separate Trust systems. JV arranged a meeting with a HR senior manager to discuss this. He and I both attended and I raised my concern about what had occurred. While JV was not dismissive of my concern, he did not express any shared concern. The HR senior manager stated that there was nothing that could be done, that the disciplinary process had to come to its own conclusion and that there was no route of challenge to this. I was told that neither of the two individuals concerned were actually working, that one had retired and one was on sick leave which assuaged my concern to some degree.

While I did experience what I believed to be unacceptable opposition and pressure as described, I also believed that I had withstood the pressure and had been able to carry out the investigation that I wanted to carry out and that the investigation report reflected what I felt able to say. The uncertainty of some of the conclusions were reflective of a lack of concrete provable evidence in some cases and not as a result of any pressure.

My report was not challenged and I believed that my conclusions and recommendations were accepted. At one of the final meetings, I was assured that all the recommendations I had made had been acted upon.

At the time, I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced to a range of possible factors including professional defensiveness on the part of nursing and as a reflection of some community/hospital and social

work/nursing tensions. I also believed there was a reluctance, perhaps unconsciously, to accept the possibility of widespread abuse.

However, at a recent meeting with the Trust on 21.1.2020, I was made aware of an email sent by JV to Human Resources stating that the investigation had found no evidence of institutional abuse and indeed had found evidence of good practice. I have not had access to this email when writing this report so am unsure of the exact wording.

I was unaware of this email or indeed of any discussion with HR about the outcome of the safeguarding investigation. Had I been aware, I would have challenged it as I consider it to be very misleading and in no way representative of either the verbal or written conclusions that I had drawn.

The existence of this email now makes me question whether there were other discussions and decisions about Ennis that I was not party to and was unaware of. The email has also led me to question my belief that I had overcome opposition and that my report had been accepted in good faith and acted upon.

During and following the investigation, I did seek some support from the Trust's adult safeguarding specialist and from JG, Co-Director for Social Work & Social Care in relation to the difficulties I experienced. Both people were very personally supportive. It was relatively informal support but I did suggest in a conversation with JG that where there were future major concerns about wide spread abuse, that it would be better to appoint a DO who did not belong to the programme of care which managed the service. My rationale for this was to avoid the position where I had to challenge my own senior managers. I also had a conversation with the Trust's adult safeguarding specialist about ensuring that safeguarding and disciplinary processes were more joined up.

- .

14.031
ER + MM

Statement in relation to Complaint by AM

I took up post as Service Manager in January 2012 for Muckamore Abbey Hospital, I was also designated as Associate Director of Nursing. On taking up these roles I worked closely with the management team in learning disability services and central nursing to deliver on the care and treatment of patients in MAH.
The hospital consisted of a range of new wards for assessment and treatment of patients with a learning disability with mental health and behavioural challenges alongside a number of resettlement wards which were historical to the site and assessed as no longer fit for purpose. On taking up post I noted and shared my views that these wards were outdated, characterised by poor environmental standards, lack of privacy and overcrowding. Staffing in all wards was limited and the qualified nurse ratio was not appropriate for the acuity levels of patients. These issues I highlighted and a range of actions were identified to support staged improvements to areas of the hospital which also included changes to the community integrated programme to expedite appropriate discharges and provide easement to some of the challenges. As MAH a large institution a number of improvements were introduced alongside planned discharges.

One of these actions was placing staffing of the hospital on the risk register.

During my initial tenure in MAH I addressed incidents whereby safeguarding events were reported, these were proactively addressed using safeguarding processes with PSNI, and followed up with Trust disciplinary processes holding staff to account as appropriate.

In early November 2012 RQIA notified me directly of safeguarding concerns in Ennis ward to which I immediately actioned a protection plan of precautionary suspension of two staff. I ensured the matter was communicated to the co-director and Director of AS& PC as well as Director of Nursing. This involved communicating with key personnel in central nursing and Hr to progress the precautionary measures and early alerts. I undertook all tasks in relation to this complaint and allegations seriously and responded promptly and professionally to implementing a robust immediate protection plan for patients.

In line with adult safeguarding AM undertook the role of Designated officer and she coordinated the multi agency meeting. AM expressed her view that the hospital management team should not be involved in the strategy meeting or anyone from the ward. AM expressed her view that widespread abuse was present. In discussion and consultation with the Director of AS& PC the hospital management team stood back as requested. I was included in this action however I met with AM after the strategy meetings and actioned all agreed plans in a timely manner. At no time was I unco-operative or unprofessional and in all instances I considered the safe care of all patients in all wards.

This included 24 hour monitoring of the ward by identified staff supernummery to the ward team and who were of band 6 and above internal or external to the hospital. The monitors were provided with guidance which AM and I agreed upon and shared with the staff undertaking this role. Ward staff were issued with separate guidance. The monitors from the beginning were band 6 and above and were not only band 8 a staff as referred to in the complaint. My recollection of the monitoring is that on only a small number of shifts were covered by non MAH staff as few were identified as willing to assist with same.

MM coDirector was identified to support the investigation process, and learning from the processes and this also included supervision in Ennis ward, engagement in improvement methodologies in the ward and support for myself as Service Manager. MM attended the strategy meetings and represented nursing on same providing her expert view and opinion on situation and progress.

At no time did my non involvement in the strategy meeting impact on protection planning for the patients in Ennis ward. AM requested further suspensions which I actioned as well as lifting of suspensions.

Providing 24 hour monitoring on a supernumerary basis to the ward was very challenging and impacted on a range of available services to this ward as well as the hospital. This protective measure which was reviewed every month continued until July 2013 almost 9 months. Feedback from professional staff involved in the ward indicated that the new staff deployed in the wake of those suspended alongside the monitors did have an impact on patients who due to their known presentations did not respond well to transition or abrupt changes to routines.

During this period and afterwards the hospital management team and other wards continued to work proactively with Bohill private nursing home staff owned by Priory group and managed to progress discharges from other wards to their facility. Unfortunately the patients in Ennis did not eventually move to Bohill however the hospital management team continued to work with Priory group to discharge the patients to one of their facilities in Armagh.

During the investigations of both safeguarding and disciplinary I have continued to support improvements to this ward and the hospital using learning from the incident to continue to monitor the service provided and proactively manage safeguarding on site including where possible to minimise the risk of reoccurrence.

When AM requested a meeting to provide feedback to the nursing team in Ennis I made all necessary arrangements for same.
Staff present were distressed being informed by AM that she believed there was likely more abuse than she had evidence for or could prove.
In my role I attended the meeting and reiterated that learning must come from the incident. I had commissioned an Trust disciplinary investigation into the allegations following completion of the adult safeguarding investigation and this was a live investigation at the time of the meeting.

I finally would like to express concern at the 8 year delay in AM raises her concerns having ample opportunity to do so with the Co director JV who attended the strategy meetings at the time of the investigation as well as being appointed Associate Director of Social Work for learning disability in the intervening years.

14.032

Statement

Name: **Mrs Moira Mannion**

Job title: **Senior Nurse Advisor to HR. (prev. Deputy Director of Nursing)**

Professional address: HR Dept, McKinney House, Musgrave Park Hospital

Subject of statement:
Statement of response to allegations contained in the document titled "Excerpt in relation to MM" at the request of Carol Diffen, Executive Director of Social Work

I am employed by Belfast HSC Trust. I qualified as a nurse in 1980. My previous experience includes working in the HSC as an enrolled nurse, RMN, Specialist CAMHS Nurse, CAMHS Clinical Lead, Co-director and Deputy Director. I have also worked for Royal College of Nursing as Practice Development Fellow and Interim Head of Education. I was seconded to the Department of Health as a Nursing Officer.

I retired from my substantive position as Deputy Director of Nursing on 31st October 2019 after 12 years service with BHSCT. I am on the BHSCT Nursing Bank and had been retained by the BHSCT HR Dept as a Senior Nurse Advisor from November 2019 to support Muckamore Abbey Hospital (MAH) investigations. I voluntarily stood aside from this work as a result of these allegations. I have been told that had I not stood aside, I would have been required to do so.

This statement is based on my personal recollection. I have not been facilitated access to documents, emails or files which I would have created and used in the course of my employment as Deputy Director to allow me to give a more detailed response. I note that the allegations relate to events seven to eight years ago. I have not been advised of which process or policy these allegations are being investigated under so as to shape this statement.

I am responding to allegations contained in the document "Excerpt in relation to MM" made by a person unidentified in that document.

The potential allegations appear to be;

A. *"I believe that MM, Co-Director for Nursing also did some monitoring herself, she also made unannounced ward visits and I think she also arranged for other staff external to MAH to participate in some of the monitoring. I think that over time, Band 7 staff from other areas both within and outside MAH also provided monitoring but I cannot remember all the details."*

B. *"From the outset, I experienced significant opposition from hospital staff to the part of the protection plan that required 24 hour monitoring."*

C. *"RQIA found on at least one occasion that the agreed arrangements were not in place when they visited the ward."*

D. *"Then, there were repeated requests made to me to stand down the monitoring. These requests started at an early stage of the investigation and continued for quite some time. I was repeatedly told that the presence of a monitoring member of staff was causing disruption and distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion."*

E. *"I do not remember who exactly voiced the opposition to the protection plan but my memory is that it came from MM, … and other hospital management staff."*

F. *"During one of the earlier meetings where MM and … were both present. MM was extremely hostile towards me. She berated me for daring to suggest that nurses would be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own professional practice."*

G. *"The level of hostility and confrontation was such that a number of people external to the BT who were present at the meeting contacted me afterwards to see if I was ok.*

While this incident was the most direct and confrontational, I continued to feel that I was not receiving adequate support from ... and MM."

H. *"During much of the investigation, I felt like an unwelcome outsider. I did not get any sense of a collaborative approach between myself and hospital management, instead feeling that I was having to regularly challenge."*

I. *"There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was criticism of their level of experience, expertise, perception of events and in particular their failure to speak out at the time of witnessing the alleged abuse. This was portrayed as poor practice on their part and used as an argument to doubt their credibility. While a lot of this criticism came from ward level staff, my memory is that it was also voiced by ... and MM. There appeared to be a lack of understanding about the difficult position the Bohill staff were in, the power differentials, the lack of immediate support for them in that setting and the fact that at least two of them had reported their concerns very soon afterwards."*

J. *"MM and I had very different views on the care plans for individual patients on the ward. While acknowledging that I was not familiar with nursing care plans, they appeared to me to be lacking detail, particularly in relation to managing challenging behaviours. MM's view was that the care plans were satisfactory."*

Statement of Response

Context

I have a track record of being deployed to many contentious situations across the BHSCT over the last 12 years. I have experience in many improvement projects, enabling and supporting staff who had needed to use whistle blowing. I know such work does not make me popular but I have acted openly in a framework of high challenge / high support with

integrity. I practice with a strong personal value base, the values of the NMC and the Trust. This has meant I have often needed to take action and bring forward information to the executive team. My experience is that such projects are fluid and need revised strategies throughout their duration, but such strategies are not always the easy option. I have always focused on the safety and care for patients first, staff next.

I have extensive experience as a psychotherapist (behavioural, individual, family and group), with advanced communication skills, extensive knowledge of systems and functionality, analysis of behaviour interactions across teams, along with facilitation, mediation and coaching skills. I have prior experience with assurance mechanisms to support investigations, governance frameworks and ensuring that such is proportionate and in line with Trust guidance and policy.

I have worked in mental health services and in Child and Adolescent Mental Health Services (CAMHS). I have extensive experience in safeguarding and have led on safeguarding interventions in previous employment in SHSCT at great personal risk and in the face of threat from those who may have been involved in subversive activities. My work in CAMHS and mental health has involved challenge of the "status quo" where this has been needed to empower the disadvantaged. I do not stand up for poor practice and have led on many initiatives to promote good practice. I have maintained good standing for professional education and trust mandatory training, including safeguarding.

Involvement

I recall that when Ester Rafferty (ER) took up post in MAH in spring/summer 2012, she placed the site on the BHSCT risk register and would have had a discussion with the then workforce lead Nicki Patterson (NP).

I recall that David Robinson and I were updated by ER that she had precautionary

suspended two staff and required an early alert to Chief Nursing Officer in November 2012. The Director of Nursing was also briefed about these concerns. Around this time, I had been requested by the Director of Nursing to take charge of the BHSCT nursing workforce portfolio (as NP had moved to SEHSCT) and ER had been advised to seek guidance and support from myself.

In mid to late November 2012, I was requested by Director of HR, the service Director and the Director of Nursing to provide assurance to the executive team on the Muckamore Abbey Hospital (Ennis Ward) investigation. I was informed that staff from an external agency had reported abuse of patients in Ennis ward to RQIA. At that time, I was advised by the Directors that there were dysfunctional working relationships in the ward under investigation and in the service team. They reported a need for full multi-disciplinary team working. I was advised that an investigation had already been commenced, led by the DAPO and their team. I was informed that a follow-up RQIA visit had occurred, which noted further concerns with adherence to the management plan in Ennis. I was deployed to MAH to provide assurance (in addition to my other duties).

When I arrived, it was evident that there had been conflict in Ennis ward in MAH. I recall that ward staff reported concern with the approach that had been adopted by the investigation team. I recall that staff reported that they had received no communication of the context or nature of the investigation by the investigation team. There also appeared to be difficult working relationships between and within the service management and clinical teams.

I was requested by the Directors to mediate and support resolution in the relationships to enable the investigation to be completed. I am not sure if this had been communicated to the investigation team. I informed the co-director and the investigation team why I was there. My recollection is that the DAPO did not respond in a positive manner to my becoming involved in the process. I recall she had concerns about membership of the strategy group progressing the investigation.

I had regular supervision with the Director of Nursing over the duration of my deployment. I raised any issues of concern and discussed strategies, policies and interventions. I would have discussed issues, attitudes, behaviours and culture encountered.

The Nursing and Improvement Model applied during this work was the Productive Ward Methodology. The First Fifteen Steps were used to complete the initial assessment of the ward. The Nursing Model of Critical Companionship (A Titchen) was also used. This model is helpful in understanding fractured relationships and promoting resolution. The NI safeguarding framework had recently been updated and not all staff across the team were as familiar as the Trust would have wished them to be.

There was little evidence of adequate induction for staff who were joining the ward team. This was urgently addressed by ER. The student nurse environment learning audits required to be updated and the student placement and learning outcome be addressed which were actioned by ER.

A review of staffing, care planning and audits of monitoring were undertaken. Staffing was enhanced. Supervision, appraisal and training were reviewed with remediation as required.

RQIA noted a poor ward environment. An environmental review was undertaken. The ward area was overcrowded, cluttered, outdated and posed a fire risk. Patient areas had been converted for the use of staff reducing care space. A wide range of remedial actions were undertaken as result of this.

Response to Potential Allegations

Allegation A

> *"I believe that MM, Co-Director for Nursing also did some monitoring herself, she also made unannounced ward visits and I think she also arranged for other staff external to MAH to participate in some of the monitoring. I think that over time, Band 7 staff from other areas both within and outside MAH also provided monitoring but I cannot remember all the details."*

I did not undertake the monitoring.

I did engage in the clinical supervision of staff on the ward alongside **review** of the monitoring process which had been agreed to be completed by a range of staff, from the band six, seven and the assistant service managers, internal and external to MAH.

I led leadership visits, planned and also unannounced, to the ward across the shift patterns to observe practice, review documentation and operational practice / processes that registrants and HCSW were delivering. Staff **were** expected to adhere to the management / protection plans.

I completed an analysis of the completed monitoring forms and processes. This was presented to the MAH Strategy group and to the MAH Improvement group.

Allegations B, D and E

B. *"From the outset, I experienced significant opposition from hospital staff to the part of the protection plan that required 24 hour monitoring."*

D. *"Then, there were repeated requests made to me to stand down the monitoring. These requests started at an early stage of the investigation and continued for quite some time. I was repeatedly told that the presence of a monitoring member of staff*

was causing disruption and distress to the patients and that it was having a detrimental impact on staff morale as they felt they were under suspicion."

E. *"I do not remember who exactly voiced the opposition to the protection plan but my memory is that it came from MM, … and other hospital management staff."*

I am unable to confirm or refute Allegation B with regard to hospital staff.

I am unable to confirm or refute if there were repeated requests to stand down monitoring from early in the investigation by others (Allegation D).

I was not a member of the hospital staff. I held no opposition the protection plan nor to the part of the protection plan that required 24-hour monitoring. In fact, much of my work was to assure compliance with the protection / monitoring plan. I did however ensure that the need for 24-hour monitoring was reviewed.

As I have stated above, I led leadership visits to the ward to observe practice, review documentation and operational processes that staff were delivering. I expected staff to adhere to the management / protection plans.

I completed an analysis of the completed monitoring forms and processes. This was presented to the MAH Strategy group and also to the MAH improvement group. The monitoring activity was continued over a period of a minimum of six months, maybe more. I and other members of the team would have made requests for review as would be expected as part of improvement planning. At no time did I request the monitoring to be stood down. I did question the rationale for continuing 24-hour monitoring after some months given the large proportion of new staff and the outcome of monitoring to that date. I fully facilitated the continuation of monitoring when the decision was taken.

Allegation C

"RQIA found on at least one occasion that the agreed arrangements were not in place when they visited the ward."

I can confirm that I was made aware of the RQIA visit prior to my involvement in MAH. This, in part, led to my deployment to provide assurance to the executive team.

Allegation F

"During one of the earlier meetings where MM and ... were both present, MM was extremely hostile towards me. She berated me for daring to suggest that nurses would be involved in abuse, pointing to their professional registration, their professional codes of conduct, their duty to uphold their code of conduct and accountability for their own professional practice."

I was not hostile to the DAPO.

I recall that the precautionary suspension (which I fully supported) of the alleged perpetrators of abuse (reported by Bohill staff) had taken place prior to my involvement. I recall that, I would have appropriately challenged any expressed views of abuse by significant numbers of additional staff **in the absence of evidence** from investigation and/or monitoring (so as not to prejudge the findings). Such constructive challenge is a normal part of assurance and intervention in circumstances such as this. As part of this deployment, I was also involved in constructive challenge of the management team, clinical staff, ward staff and support staff where appropriate.

I completely refute that I would have suggested that nurses could not be involved in abuse. Historically there have been high profile cases of health and social care staff (including nurses) who abused others and abused the positions they held. I have a track record of addressing and reporting practice that was poor / wilful neglect / abuse across the 40 years

of my professional practice.

I am fully aware of my professional duty to report misconduct, support investigation and be held accountable for practice in accord with NMC requirements, Nolan principles and HSC/Trust values. I am also familiar with regulatory standards applying across the HSC staff family and have supported the investigation, remediation, mediation and practice improvement involving staff of various professional groupings.

I, as Co-Director and Deputy Director, have ensured that staff were held to account for misconduct. I have overseen investigations and disciplinary sanctions involving nursing staff on behalf of the Director of Nursing. I have ensured the involvement of regulatory bodies where indicated. I have had oversight of a wide range of disciplinary actions involving staff.

Allegation G

> *"The level of hostility and confrontation was such that a number of people external to the BT who were present at the meeting contacted me afterwards to see if I was ok. While this incident was the most direct and confrontational, I continued to feel that I was not receiving adequate support from … and MM."*

I am unable to confirm or refute if a number of people external to the trust contacted the individual making the allegations to see "if they were ok".

My role was to provide assurance to the executive team. I have an established track record of supporting and of working well with others, even in circumstances of significant challenge. Where I am made aware of a need for further support, I endeavour to provide it or to see that it is provided. I however do fully recognise the need for appropriate supervision, this is normally provided by professional line management.

Allegation H

"During much of the investigation, I felt like an unwelcome outsider. I did not get any sense of a collaborative approach between myself and hospital management, instead feeling that I was having to regularly challenge."

I was not a member of the "hospital management" team. I recall actively trying to work collaboratively with the DAPO, the investigation team, service management and clinical teams.

I would however note that it has been my experience that individuals undertaking investigations, overseeing remediation or trying to bring about change are often initially seen as outsiders. I have found, that in these situations, I have been able to overcome this distance, to develop a collaborative approach. I also recall that, in this deployment, I initially was an unwelcome outsider though this changed over time. I did receive active support from the Directors and ER throughout the deployment.

Allegation I

"There was a lot of criticism of Bohill staff voiced to me and the two IOs. There was criticism of their level of experience, expertise, perception of events and in particular their failure to speak out at the time of witnessing the alleged abuse. This was portrayed as poor practice on their part and used as an argument to doubt their credibility. While a lot of this criticism came from ward level staff, my memory is that it was also voiced by … and MM. There appeared to be a lack of understanding about the difficult position the Bohill staff were in, the power differentials, the lack of immediate support for them in that setting and the fact that at least two of them had reported their concerns very soon afterwards."

I did not and do not criticise staff who whistle blow. Across my many years of practice, I have

been involved in enabling staff to raise concerns early, thereby reducing the opportunity for neglect, poor or abusive practice. I have undertaken interventions for the BHSCT to facilitate staff at all levels to bring forward concerns. These include RVH Emergency Dept, RVH ICU and RVH Paediatric ICU, RVH Orthopaedics, Neurology, Iveagh (review by the children's commissioner), and CAMHS services.

I can state that at no time have I berated staff who took the courageous action of whistle blowing the concerns they have had. I would not be hostile toward staff who felt unsafe to have such discussions.

I have been a whistle blower on a number of occasions and know the personal and professional cost of raising concerns. These experiences have shaped my career and informed my approach in improving professional practice. I also seek feedback and expect to held to account for any work that I have engaged in.

Allegation J

> *"MM and I had very different views on the care plans for individual patients on the ward. While acknowledging that I was not familiar with nursing care plans, they appeared to me to be lacking detail, particularly in relation to managing challenging behaviours. MM's view was that the care plans were satisfactory."*

I **did not** regard the care plans as satisfactory.

I recall that the wards were using a nursing model of care with uni-disciplinary notes. There was a desire to introduce a full multi-disciplinary model of care. This had not been implemented or resourced at the time. I also recall that there were limitations on multi professional involvement. The model of care planning in use was Roper–Logan–Tierney Activities of Living (for Intellectual Disability). When completed appropriately, with

individualised activity plans, this results in a positive care experience. PARIS electronic record (which facilitates multi-disciplinary recording) had not been implemented at this time.

I recall that I was not satisfied with the care planning record on the ward. The assessments were incomplete. They had not been regularly reviewed by the nursing and medical staff. All patients did not have activity plans to enable them to participate fully in meaningful activity. I undertook a random sample review of charts, none had been updated. Record keeping was poor and needed to be improved by all involved in the provision of care. Staff where held accountable for this. Accurate and timely recording being an essential part of nursing practice (NMC Standard 10; 2015). An action plan to redress and improve this was put into place by ER. The medical staff were also required to review their records. This led to a project to review care planning across all wards in line with the regional project for acute hospitals.

This statement is true to the best of my knowledge and belief, based on the information available to me at this time.

Name: Moira Mannion

Job title: Senior Nursing Advisor

Signature: M Mannion

Date: 6th April 2020

	Document Name	Date of Upload	Page in Bundle
1	**Trust Board Minutes 11 April 2013** BHSCT - V - 00021 - 2013.04.11_Minutes_Confidential (5 pages) - (00982) (Pages 1, 3) *This document shows that the Trust Board were aware of Ennis allegations. Catherine McNicholl briefed the Trust Board on the Prosecutions.*	16 June 2023	1-2
2	**Trust Board Minutes 05 March 2020** BHSCT - V - 00107 - 2020.03.05_Minutes_Confidential (8 pages) - (01068) (Pages 1,3,4) *Dr Jack briefed the Trust Board on the Ennis Report after it was raised at MDAG.*	16 June 2023	3-5
3	**Exec Team Meeting 09 October 2013** BHSCT - H - 00023 - File 17 of 2020 Leadership & Governance Review materials - BHSCT L&GRFile17 v3 -Redacted (631 pages) - (01783) (Page 42) *This document shows that the Exec Team were aware of Ennis allegations. Catherine McNicholl updated the Exec Team on the Prosecutions.*	11 October 2023	6
4	**Core Group Meeting 28 October 2014** BHSCT - U - 00167 - 2014.10.28_Minutes (5 pages) - (00807) (Page 1,2) *This document shows that the Core Group were made aware of Ennis Report and went through the conclusions and recommendations. Ms Morrison attended on that occasion for that purpose.*	1 February 2023	7-8
5	**Core Group Meeting 15 September 2015** BHSCT - U - 00182 - 2015.09.15_Minutes (4 pages) - (00822) (Page 1,4) *This document shows that Mrs Rafferty kept the Core Group informed of developments with the Ennis allegations. On this occasion it was a staffing update.*	1 February 2023	9-10
6	**Board Assurance Framework Sub-Committee Structure 2013-2014** BHSCT - D - 00006 - 2013-2014 Board Assurance Framework Revised Jun 2013v4f (19 pages) - (00034) (Page 19) *This document shows how the Sub-Committee structure changed in 2013-2014. The SAI Group changed from being a Steering Group of its own to being a sub-committee of the Learning From Experience Group. This may not have been accurately captured at page 30 of the L&G Review.*	26 September 2022	11
7	**Email that refers to Joyce McKee** BHSCT - A - 00024 - Ennis Investigation - Aine Morrison File 1 (353 pages) - (02452) (Page 222) *This document is referred to at paragraph 114 of the witness statement. It shows that HSCB, who was a recipient of the*	22 February 2024	12

	Ennis Early Alert, along with DoH, were engaging with the Belfast Trust in November 2012.		
8	**Ennis Internal Inspection Report/Action Plan** BHSCT - H - 00003 - File 12 of 2020 Leadership and Governance Review materials - relating to Ennis - BHSCT L&GRFile v2 (431 pages) - (00062) (Page 394- 410) *This document from 12 December 2012 and updated 19 February shows the various pieces of environmental work that were planned for and actioned in respect of the Ennis Ward.*	26 September 2022	13-29
9	**Email on 1 September 2015 from Belfast Trust to HSCB re SAI** BHSCT - J – 00039 – Communications relating to Ennis Ward EA (552 pages) - (00843).pdf *This is an email chain between the Trust and HSCB about whether Ennis should have been reported as an SAI. It shows the last email that the Trust can find that was sent from BHSCT to HSCB was on 1 September 2015.*	1 February 2023	30-35
10	**Email on 9 September 2015 from HSCB to Belfast Trust re SAI** BHSCT - J – 00039 – Communications relating to Ennis Ward EA (552 pages) - (00843).pdf *This is an email from HSCB to the Belfast Trust in response to the above email on 1 September 2015. This email together with those referred to at 9. above suggests there may have been a misunderstanding that resulted in the content of footnote 79 of the L&G Review.*	1 February 2023	36

1.218

Belfast Health and Social Care Trust

Minutes of the Confidential Trust Board Meeting
Thursday 11 April 2013 at 10.00 am
Lecture Rooms, Elliott Dynes, Royal Victoria Hospital

PRESENT:

Professor Eileen Evason	Chairman (Acting)
Mr Colm Donaghy	Chief Executive
Mr Les Drew	Non-Executive Director
Mr T Hartley	Non-Executive Director
Mr J O'Kane	Non-Executive Director
Dr Val McGarrell	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mr Martin Dillon	Director of Finance
Dr Tony Stevens	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Women's Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mrs Marie Mallon	Deputy Chief Exec/Director of Human Resources
Ms Catherine McNicholl	Director Adult Social and Primary Care
Mrs Jennifer Welsh	Director Cancer and Specialist Services

APOLOGIES:

Ms J Allen	Non-Executive Director
Mr Charlie Jenkins	Non-Executive Director
Mrs Patricia Donnelly	Director Acute Services
Mrs June Champion	Head of Office of Chief Executive (Acting)

Professor Evason welcomed everyone to the meeting with special welcome to Shane Devlin who had recently taken up post.

06/13 Minutes of Previous Meeting

The minutes of the previous meeting held on 14 February, 2013 were approved subject to the following amendment:

Min. 05/13 a. 4th paragraph replace the word "Sandown" with "Sydenham".

09/13 (Contd.)

d. Arms Length Bodies Board Governance Self Assessment 2012/13

Mrs Mallon advised that a draft of the Trust's Arms Length Bodies Board Governance Self Assessment 2012/13 would be presented to the May workshop for members consideration and approval prior to being submitted to the DHSSPS.

e. Bogus Orthopaedic Surgeon

Mr Barry briefed members on case that had received media coverage recently regarding a PSNI investigation into a bogus Orthopaedic Surgeon who had used a Trust address on correspondence with patients.

f. Public Prosecution Cases

Ms McNicholl briefed members on two imminent public prosecution cases which may be the subject of media coverage.

Members were advised that in March 2011 a member of staff from a residential home for people with learning difficulties had been suspended in response to alleged ill treatment of a client. Following a lengthy investigation the Public Protection Unit of the PSNI had handed the file over to the Public Prosecution Service (PPS) who had confirmed they were proceeding to court to seek a prosecution under Article 121 of the Mental Health (NI) Order. The PSNI had also investigated an alleged case of ill treatment of patients in Muckamore Abbey Hospital by two members of staff and they had recommended prosecution to the PPS. It will take some considerable time for the PPS to confirm their decision regarding this incident.

In response to a question from Mr Hartley, Miss McNicholl advised that the Trust had policies and procedures in place in respect of safeguarding vulnerable adults. She further advised that the Trust had to wait for the PSNI to complete their investigations before implementing disciplinary proceedings.

Decision: report of Chief Executive noted

The directors withdrew from the meeting at this stage.

10/13 Report of the Deputy Chief Executive/Director of Human

a. Report of Remuneration Committee Meeting – 11 April 2013

Professor Evason advised members that the Remuneration Committee had met prior to the confidential Trust Board meeting and invited Mrs Mallon to present a report of the meeting.

3.018

Belfast Health and Social Care Trust
caring supporting improving together

Minutes of the Confidential Trust Board Meeting held on 5 March 2020 at 9.00 am in the Boardroom, Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Mrs Nuala McKeagney	Non-Executive Director
Professor David Jones	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Mrs Maureen Edwards	Director Finance, Estates and Capital Development

IN ATTENDANCE:

Mr Steve Austin	Deputy Medical Director (on behalf of Mr Hagan)
Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Neurosciences, Radiology and Muckamore Abbey Hospital
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Brona Shaw	Deputy Director of Nursing (on behalf of Miss Creaney)
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mr Wesley Emmett	Management Consultant – Observing

Apologies

Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Mrs Miriam Karp,	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mr Chris Hagan	Interim Medical Director
Mrs Caroline Leonard	Director of Surgery and Specialist Services

11/20 Minutes of Previous Meeting

Minutes of the previous meeting held on 6 February 2020 were approved subject to minor amendments.

Mr Dawson advised on plans in place in relation to Children's Hospital and the Neonatal Unit.

Mrs Heaney provided a detailed update in respect of Community Services, with the Trust facilitating two workshops for domiciliary care providers and independent care homes in order to protect hospital services.

Mrs Kennedy advised that consideration was being given to workforce as it is anticipated that there will be an impact on staff. She explained that the trade unions were fully engaged and supporting the development of workforce plans as the situation evolves. An Occupational Health staff helpline has been activated during core hours.

In response to a question from Mr McNaney, Mrs Kennedy advised that NIPSA industrial action short of strike was continuing.

Members expressed the view that given the evolving pressures NIPSA should be asked to suspend their action until COVID0-19 has been dealt with. Mr McNaney asked Mrs Kennedy, on behalf of members, to liaise with the DoH to seek a regional resolution in light of the COVID-19 situation.

Dr Loughran and Professor Jones referenced the challenging situation, which will continue to evolve and were assured the Trust was implementing appropriate action to protect services, where possible, whilst coping with the inevitable escalation in COVID-19 patients.

Mr McNaney reflected on the impact of the recent Industrial Action and the evolving COVID-19 position and commended Dr Jack and Director colleagues for their leadership and guidance

ii. Muckamore Abbey Hospital

Mrs Owens presented the Muckamore Abbey Hospital (MAH) Patient Safety report and provided assurance that patient care remained safe. There were currently 51 in-patients and 2 on trial resettlement. There were a total of 48 staff on precautionary suspension.

Members welcomed the ongoing improvement in care delivery and notably a reduction in the overall use of restrictive practices, including a reduction in the number of seclusion events.

Mrs Owens advised current nurse staffing levels, with substantive nursing staff, long-term agency staff and nurse bank, were providing a safe level of care. She noted the DoH had extended the fifteen percent salary uplift for a further three month period to 31 March 2020.

Members noted the Leadership and Governance review (LGR) team had commenced their review, the purpose of which is to critically examine the effectiveness of the Trust's leadership, management and governance

arrangements, in relation to Muckamore Abbey Hospital for the period 2012 to 2017.

Dr Jack explained, following allegations of abuse within Ennis ward in 2012, an investigation had been undertaken, however the report had not been presented to Executive Team or Trust Board. It had been agreed that this report would be included in the LGR.

Mrs Owens advised that Internal Audit had completed the fieldwork relating to the patient finances and a draft report is expected shortly. She also reported that notes from RQIA Feedback Session at MAH on 16 December 2019 had been received for factual accuracy checking. Draft reports of the inspections for 26-28 February and 15-16 April 2019 have also been received for factual accuracy checking.

Mrs Heaney provide an update in respect of the resettlement programme and the reform of the model of care for people with learning disability, all of whom have complex needs. She highlighted the need for significant investment to develop an infrastructure for the future provision of care for these patients.

Dr Loughran referred to the reducing number of patients within MAH and asked if remaining patients could be cared for in another facility.

Mrs Heaney advised that consideration was being given to forensic services transferring to Shannon Clinic on the Knockbracken site.

A discussion took place on the need to share with staff, patients and the public, a narrative reflecting the positive work being undertaken by the Trust to promote quality and safety, which would allow people to have a more accurate and complete picture of the care being provided by the Trust and reassure them that safety is the Trust's primary concern.

Dr Jack said that the additional staff were being recruited to the Communication Team and emphasised the use of social media platforms, which get a wider reach for public messages.

Mr Dawson highlighted the regional capacity issue regarding adult acute mental health beds, he had recently attended a DoH meeting and it had been agreed that a regional review is to be undertaken.

iii. Neurology Review

Mrs Owens advised that the HSCB/PHA is continuing to undertake the data analysis for the third patient Recall, to be completed for validation by the Trust in mid-March. The Case Note Review of patients (approx. 250) who have had a blood patch procedure under the care of Dr Watt will be a two-step process, i.e. An internal patient case note review, to establish if all the blood patches, performed on patients under the care of Dr Watt, were clinically indicated; and external validation of a 10% sample by the Royal College of Physicians

17,010

Minutes of the Executive Team Meeting 9th October 2013
Boardroom, A Floor, Belfast City Hospital

Attendees	Colm Donaghy	Bernie Owens
	Jennifer Welsh	Bronagh Dalzell
	Tony Stevens	June Champion
	Shane Devlin	Catherine McNicholl
	Martin Dillon	Cecil Worthington
	Brian Barry	Marie Mallon
Apologies:	Patricia Donnelly	Brenda Creaney
In Attendance:	*Pauline McCabe*	*Maura Campbell (HR)*

10. Any other Business

Catherine McNicholl reported that following an investigation last year on Ennis Ward, Muckamore the PSNI have recommended prosecution of two members of staff.

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

NOTES OF CORE GROUP MEETING

HELD ON TUESDAY 28 OCTOBER 2014

IN THE SMALL MEETING ROOM

Present: Mr John Veitch, Co-Director of Learning Disability (Chair)
Mrs Esther Rafferty, Service Manager of Hospital Services
Mrs Mairead Mitchell, Senior Manager of Service Improvement & Governance
Dr Colin Milliken, Clinical Director

ACTION

PREVIOUS MINUTES

Previous minutes were taken as read.

MATTERS ARISING

Medical Records

Mrs Mitchell informed the group that it has been agreed that Medical records will move, she has also asked the Medical Records Manager and Lorna McGrath to visit and carry out a review of processes in Medical Records.

PARIS

Mrs Mitchell informed the group that the PARIS Implementation is progressing well. Mrs Rafferty highlighted that the training is proving a challenge with the present staffing situation.

The group looked through the Wi-Fi costs for the Hospital. Mrs Mitchell will follow up with Mr Ingram about the buildings that actually need it and who will support the cost of Wi-Fi. **Mrs Mitchell**

PRN Medication Report

Mrs Scott joined the group to discuss the above which she circulated.

The group reviewed the report. Concerns were raised about P592 these were discussed at length. Mrs Scott informed the group that Dr McLorinan

ACTION

has asked for a CAHMS Practitioner to visit P592. Dr Milliken will discuss this further with Dr McLorinan. Dr Milliken will also speak to Dr McLorinan about P592 plans for when he turns 18. **Dr Milliken**

It was agreed that a title would be added to the report, date of discharge would be included and a separate name at the back with patients initials for easy reference.

Mr Veitch spoke about how we must be more robust about our discharge plans. Mrs Scott explained that patients are all given a discharge date, Mr Veitch advised if there are any issues with discharge dates to inform Senior Management and they will be escalated. **Mrs Scott**

Ennis Investigation

Ms Morrison joined the group to discuss the above investigation.

Mr Veitch spoke about the report and went through the conclusions and recommendations.

Court case has been postponed until 20 November 2014.

Ms Morrison circulated a draft of the proposed briefing for families of the patients in Ennis. The group made a number of amendments to the briefing. Ms Morrison explained that families will be telephoned and staff or Ms Morrison will go through the briefing with the families. The group agreed that this was ok. Any queries around the disciplinary action it must be stated that we are carrying out a disciplinary investigation as per Trust processes.

Ms Morrison informed the group that she is planning a final meeting to close the safeguarding processes after the relatives have been spoken to.

HIA – P593

Mrs Mitchell informed the group that she was able to obtain an address and name of GP for P593. The group discussed this at length. It was agreed that Ms Morrison would contact the GP to inform him of the concerns and to see if he is known to any other services.

ACCIDENT /INCIDENT REPORTS – IVEAGH – SEPTEMBER 2014

The above was tabled for discussion.

Mrs Scott explained that the numbers are up due to one patient.

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

NOTES OF CORE GROUP MEETING

HELD ON TUESDAY 15 SEPTEMBER 2015

AT 9.15AM IN THE SMALL MEETING ROOM

Present: Mr John Veitch, Co-Director of Learning Disability Services (Chair)
Mrs Esther Rafferty, Senior Manager of Hospital Services
Dr Colin Milliken, Clinical Director

Apologies: Mrs Mairead Mitchell, Service Manager of Service Improvement & Governance

ACTION

PREVIOUS MINUTES

Previous minutes were taken as read.

MATTERS ARISING

Bed Management

Mrs Rafferty informed the group that the Hospital is still experiencing difficulties due to people not leaving and the bed pressures remain.

Mr Veitch asked about the Bed Protocol Meetings in light of the lack of funding for Delayed Discharges. Mrs Rafferty will email Iolo Eilian to see if there is any new dates for group.

Dr Milliken spoke about admissions and a patient who was discharged on 26 August 2015 and has been readmitted from the Northern Trust four time because they are unable to financially support his community placement. Dr Milliken will email Mr Veitch with the issues.

Mrs Rafferty informed the group of the Northern Trusts request for a meeting about Consultant access for their new RAID service or Commuity cover. Mr Veitch advised that we are not commissioned to deliver this increase in Community Psychiatry.

with Mrs Mitchell on her return.

ACTION

Patient Concerns

Mrs Rafferty spoke about the above and explained that the two people who reported their concerns had filled in an evaluation sheet at the end of the shift each to say there was no issues. Mr McBride is investigating this and a member of staff has been moved to another area as an interim measure, this will be kept under review.

Ennis

Mrs Rafferty informed the group that she has met with the two staff as the investigation is now complete and there are no further actions due to the evidence from witnesses. Mrs Rafferty has wrote to both staff and has also put in place a support mechanism for them returning.

Mrs Rafferty stated that she has also arranged to meet with the Ward Sister to give her feedback.

Medical Staff

Dr Milliken informed the group of Dr Cousins success in her post. The group welcomed this. Some delays with HR and an office for Dr Cousins. Mr Veitch advised that Ms Morrison has been in liaison with Estates related to that.

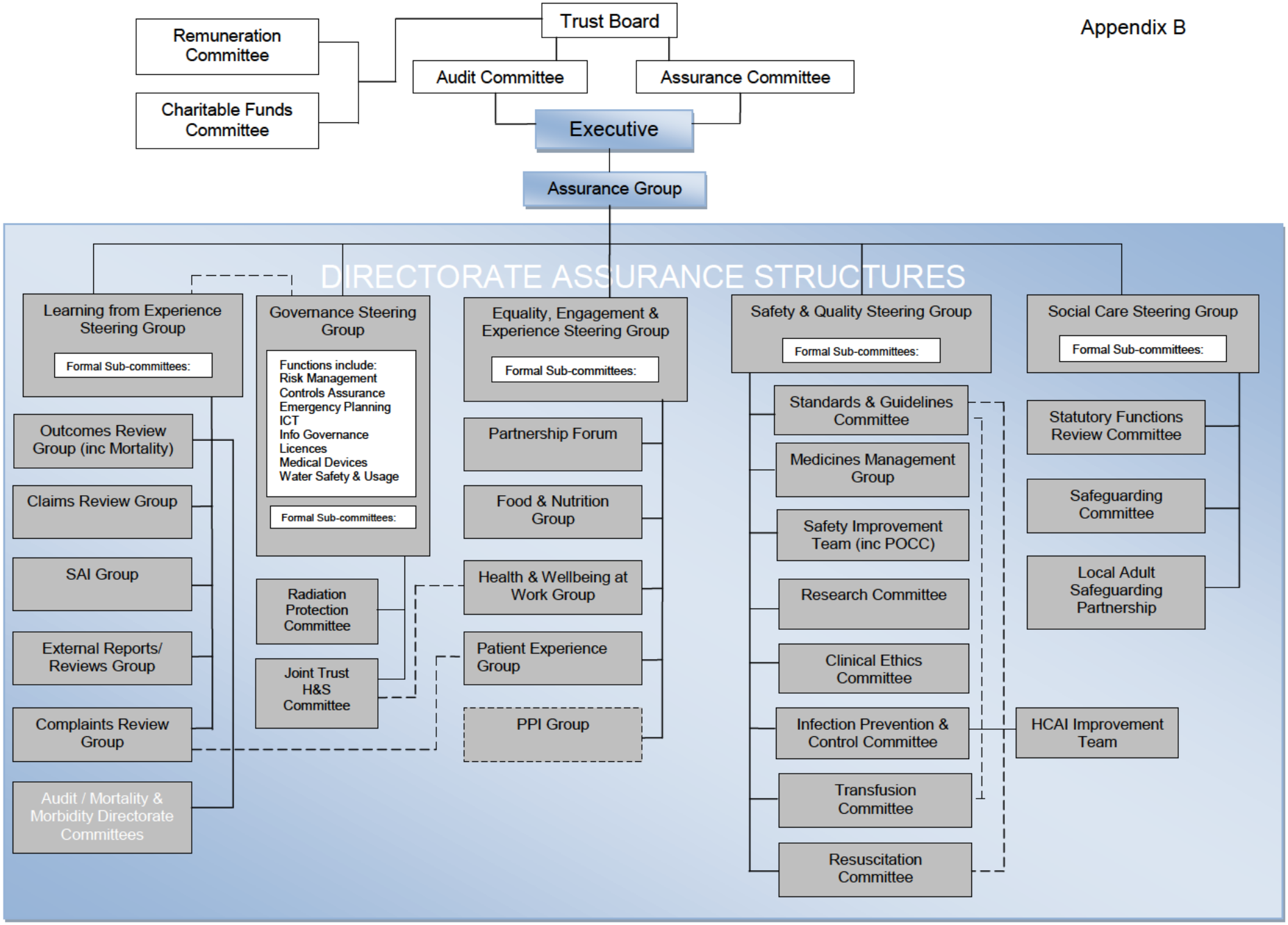
Dr Milliken raised some concern about covering Dr Corbett's post as she isn't due to return until 27 February 2016. Dr Milliken suggested that Dr NG act up until Dr Corbett's return, Dr Milliken will forward all the details to Mr Veitch.

DATE, TIME AND VENUE OF NEXT MEETING

Tuesday 29 September 2015 at 9.15am in the Small Meeting Room, Admin Building, Muckamore.

ASSURANCE SUB-COMMITTEE STRUCTURE

Appendix B



Hanna, Debbie

From: Morrison, Aine
Sent: 16 November 2012 11:47
To: Hanna, Debbie
Subject: FW: Minutes. Ennis Ward Investigation/please print

Aine Morrison
Operations Manager
North & East Belfast Community Learning Disability Teams
Everton Complex
Tel No 90566038/90566034

From: McNicholl, Catherine
Sent: 15 November 2012 15:06
To: Morrison, Aine
Subject: RE: Minutes. Ennis Ward Investigation

Aine
Thank you for this. I have just spoken to Esther and have decided that we should now move to an external (without Esther as well) investigation. I will ask John growcott to join us and will today source a senior nurse.
Is there anyone else you would want involved?
I have tried to reassure Esther that it is in everyones interest that we take this appoach, it would be good if you reinforced this.
Email me if anything arises, otherwise talk soon.
Catherine

Sent from my Windows Phone

From: Morrison, Aine
Sent: 15 November 2012 13:47
To: McNicholl, Catherine
Cc: Rafferty, Esther
Subject: FW: Minutes. Ennis Ward Investigation

Catherine,

Please find attached minutes as discussed.

Following our conversation yesterday about Board involvement, thought I should let you know that Joyce Mc Kee asked one of the Trust's Adult Safeguarding Specialists, Yvonne Mc Knight via email what was going on in Muckamore. I was making Yvonne aware that there was a major investigation underway as per normal practice when she told me this. Yvonne would intend on directing her to LD services if she makes further enquiries.

Also possibly significant is my own experience of visiting the ward yesterday. I came away distinctly uneasy about atmosphere and culture on the ward particularly in relation to the ward manager who was showing me around. This involved a lack of verbal interaction with patients and an incident where a client was ushered out of the way and a door locked in front of her.

12.106

Ennis Internal Inspection

Date completed : 12th December 2012

Updated 19th February 2013

Room / Area no.	Issue noted	Suggested resolution	Responsible person/dept	Completion date	Completed	Comments
Front Porch	Unused curtain rail above front door	Remove rail –docket	Estates	Feb 13	Complete	
	Paper sign on inside front door	**Laminate notice – Siobhan to update all notices in ward and laminate as necessary**	Nursing			
	Some notices on notice board out of date i.e. organisational chart	**As above**	Nursing			
	Varnish worn on wooden ceiling	**Re- varnish - docket**	Estates			
Front corridor (right)	Partial picture hook in wall outside room 76	Remove hook - docket	Estates	Feb 13	Complete	
	Floor dusty	Clean floor and audit for a period of 4 weeks	PCSS	21/12/12	complete	Ongoing monitoring
Room 76 (Bedroom)	Curtains partially down	Re hang curtains	PCSS	8/1/13	complete	Ongoing monitoring
	Germazap not working	Fix, remove or replace - docket	Estates			
	Rails available for screens round beds but no curtains	Replace and hang curtains	PCSS	14/1/13	complete	New curtains made. Recommend WM sources disposable type
	2 ceiling lights not working	Replace bulbs	Estates		Completed	

	(nearest the door)				16/01/13	
Room 77 (Staff room)	Very cluttered	De-clutter	Nursing			**Work in progress – well improved**
	Mirror scratched	Replace mirror - docket	Estates	Feb 13	complete	Mirror removed
	Dirt around base of toilet (at floor)	Clean toilet and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	***Door sign incorrect**	**Siobhan to send a docket to estates**				
	***Holes where mirror has been removed**	**As above**				
Room 82 (bathroom)	**Hole around copper pipe beside toilet**	**Fill hole and repaint –docket**	Estates			**Check?**
	Radiator control on top of unit	Replace control -docket	Estates		Completed 16/01/13	
	Soap dispenser empty	Fill and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	Towel dispenser empty	Fill and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	Cleaning mitt and towels sitting out on ledge	Ensure all tidied away	Nursing	Feb 13	complete	
	Colour coding and **bathroom regulations** on bench	**Put bathroom regulations on wall**	Nursing			**Colour coding on wall, bathroom regulations not available**
	Surround frame on white sheetrock behind shower broken	Fix or replace - docket	Estates	Feb 13	complete	
	Blinds dirty	Clean blinds and audit for a period of 4 weeks	PCSS	08/01/13	complete	Ongoing monitoring

Version 4

	***Blinds broken** **Window latch broken** Fan not working Cord pull for light missing Dirt on the lid of the laundry skip ***Commode dirty** ***bathroom cupboards were dirty** ***Bathroom sink was dirty**	**Siobhan speak to Andersons** **Fix latch - docket** Fix or replace - docket Fix or replace - docket Clean laundry skip and audit for a period of 4 weeks **Condemn as this isn't used**	Estates Estates Estates Nursing	Feb 13	Completed 16/01/13 Complete	Ongoing issue with fan re type of fan required for this area
Room 80 (bedroom)	**Floor scuffed** Floor stained and dusty **Redundant slide latches on doors/holes where slide latch has been**	**Capital bid? April 13** Clean floor and audit for a period of 4 weeks **Remove slide latches and cover space with blank face plate – discuss with patient**	Estates PCSS	08/01/13	complete	Brian to follow up with hotel services re the best way to clean this while awaiting capital bid in April 13 Ongoing monitoring
Room 70 (bedroom)	Extra curtain rings on pole **Patches on the walls not painted where holes have been filled in**	Remove curtain rings - Andersons **Paint walls - Docket**	Estates Estates	Feb 13	complete	Linda to discuss with Andersons 21/01/13

3

	Cup stain on windowsill	Clean windowsills and audit for a period of 4 weeks	PCSS	23/12/12	complete	
Room 75 (day area)	***Table dirty**	**Table dirty at inspection in Feb - Clean table after all meals and audit for a period of 4 weeks**	PCSS	23/12/12	Complete	Ongoing monitoring
	Blind pole on window but no blind	**Remove pole / replace blinds – decision to be made which windows require to be sandblasted - liaise with Brendan – capital bid – April 13**	Estates/nursing			
	Surface peeling off hearth	**Re paint - docket**	**Estates**			Varnish to be applied 17/01/13
	Drawer handle missing - screws exposed	Replace handles - docket	Estates	Feb 13	Complete	
	***Old table in room**	**Condemn**				
	8Screw in wall behind door	**Remove**				
Front Corridor	**Evidence of damp on ceiling outside room 83**	Fix and repaint – docket - **repainted – capital bit 2013**	Estates			
	Cobwebs on wall outside 118 and above fire door	Remove cobwebs and audit for a period of 4 weeks	PCSS	02/01/13	complete	Ongoing monitoring
	2 curtain rails on large windows, only 1 curtain hanging	Remove redundant curtain pole and re-hang curtains - Linda to decide which windows require to be sandblasted - Linda to arrange a visit from Andersons, liaise with Brendan – **capital bit April 13**	Estates/PCSS/Nursing			Linda to discuss with Andersons 21/01/13
	Fire doors scuffed	Fill holes and repaint- pending outcome **of capital bid meeting Apr 13**	Estates			Brian to assess and do what is possible pending the capital bid April 13

Room 83 (Toilet)	**Evidence of damp on walls**	Clean and re-paint toilet area- Estates will paint this toilet within next few weeks **– rub down and treat walls – repainted but walls bubbling and damp coming through again**	Estates		Completed 16/01/13	
	Faeces on toilet seat	Clean toilet seat and audit for a period of 4 weeks – random checks	Nursing		Completed 16/01/13	
	Large hole in wall – copper pipe exposed	Fill hole and repaint- pending outcome of capital bid meeting Jan 13	Estates		Completed 16/01/13	
	Nurse call button missing	Repair or replace with blank face plate - Linda to submit a docket	Estates		Completed 16/01/13	
	3 anti ligature hooks missing	Replace- Linda to submit a docket	Estates		Completed 16/01/13	
	Sock bag hanging in toilet	Remove	Nursing	21/12/12	Completed	Ongoing monitoring
	Cobwebs on walls and ceiling	Remove cobwebs and audit for a period of 4 weeks	PCSS	21/12/12	completed	Ongoing monitoring
	Floor dirty especially at join with walls	**Clean floor and audit for a period of 4 week – floor dirty – feb 13**	PCSS			
Room 118 (Linen store)	Copper pipe at room 120	Remove pipe and valve off - Linda to submit a docket – **fill hole where pipe was removed**	Estates		Completed 16/01/13	
	Store untidy	Tidy store	Nursing	Feb 13	Complete	
	Floor cluttered	Remove everything from floor onto shelves	Nursing	Feb 13	Complete	
	Floor dirty and scuffed	Clean floor and audit for a period of 4 weeks	PCSS	09/01/13	completed	Floor buffed

	***hole in wall behind door**	**Fit door stop to the wall**				
Room 85 (store)	Floor cluttered Rust on floor at front of filing cabinets, floor dirty ***Floor dirty**	Remove everything from floor to shelves Clean floor and audit for a period of 4 weeks – docket to Estates **Clean floor**	Nursing PCSS Estates	Feb 13 PCSS-Floor scrubbed 09/01/13	complete	Floor scrubbed & buffed. PCSS unable to remove rust stains requires Estates to rectify
Room 84 (store)	**Room cluttered** **Floor very dirty** Sticky labels on walls and shelves Paper notice on wall ***Holes in ceiling**	**Work in progress – continue to De-clutter room**, i.e. condemn water cooler - removed Clean floor and audit for a period of 4 weeks Remove and replace with laminated labels Laminate **Fill and repaint**	Nursing PCSS Nursing Nursing	 09/01/13 Feb 13 Feb 13 – Notices removed	 Complete Complete Complete	Floor scrubbed & buffed
Main Office	Paper notices on filing cabinets Floor scuffed and dirty Tarifold broken at back of desk ***Holes in wall where tarifold was**	Laminate Clean floor and audit for a period of 4 weeks Order replacement - Linda to submit a docket to have the bracket removed **Fill holes and repaint**	Nursing PCSS Nursing/Estates	Feb 13 Floor, moped scrubbed and buffed 16/01/13	Complete complete Completed 16/01/13	

	Sheetrock coming away from the wall in various places **Temperature in room very high** Large split between wall and ceiling **Window dirty – inside** ***Blue tack on ceiling**	**Remove and repaint - docket** **Regulate temperature and seal cover - Linda to submit a docket** Fill space and re-paint- Docket **Clean windows and audit for a period of 4 weeks** **remove**	Estates Estates Estates PCSS	09/01/13	complete	**Brian to assess feasibility of installing a thermostat** Ongoing monitoring
Room 89 (day space)	Stains on windowsill and floor **Blind pole but no blind** **Chair fabric damaged on all chairs**	Clean floor and windowsill - audit for a period of 4 weeks **Remove or replace - decide which windows require to be sandblasted - liaise with Brendan** **Re-upholster or replace**	PCSS Estates/nursing Nursing	21/12/12	complete	Ongoing monitoring Linda to discuss with Andersons 21/01/13
Kitchen store	**Needs to be painted** Floor, windowsill and skirting dirty Top of freezer sticky and dirty Large food remnants in window frame when window opened	Clean floor, windowsill and floor, audit for a period of 4 weeks Clean freezer, audit for a period of 4 weeks Clean window frame, audit for a period of 4 weeks	PCSS PCSS PCSS	21/12/12 Cleaned 21/12/12 PCSS Cleaned 21/12/12	complete complete complete	Ongoing monitoring Ongoing monitoring Ongoing monitoring

	Open bottle of water on windowsill	Dispose of bottle – keep in fridge	PCSS	Disposed of 21/12/12	Complete 21/12/12	Ongoing monitoring
	Opened biscuits on shelf	All opened food stuff should be in sealed containers	PCSS Nursing	Disposed of 21/12/12	Complete 21/12/12	Nursing should also be storing opened foods in containers
	Staff food, individual patient food and communal food all in same area – **staff food still stored in patients fridge**	Separate storage areas for staff and patient food **Remove to staff storage area**	Nursing	Ongoing		A Staff room is available - staff food should not be stored on shelving or top of fridge. The Food store is for patients food only
	lollipops		Nursing	Feb 13	Complete	These belong to pts
Dining Room	~~Old stains on surface of cupboard inside door~~	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Cleaned Daily	Complete	Ongoing monitoring
	Old stains on floor	Clean floor, audit for a period of 4 weeks	PCSS	Cleaned Daily	complete	
	Ground in (old) food debris on radiator cover	Clean area after every meal, audit for a period of 4 weeks	PCSS	Cleaned daily	complete	
	Broken window latch	Replace or fix – docket	Estates	Feb 13	Complete	
	No curtains or blinds on the windows	Replace curtains or blinds - Linda to decide which windows require to be sandblasted - Linda to arrange a visit from Andersons, liaise with Brendan	Estates	Curtains hung 11/1/13	Complete	PCSS made curtains for interim until new a re purchased. Linda to discuss with Andersons 21/01/13
	Old stains on top of bin	Clean surfaces after every meal, audit	PCSS	cleaned	complete	Ongoing monitoring

		for a period of 4 weeks		21/12/12		
	Unit at servery – top and drawers dirty	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Daily	complete	Ongoing monitoring
	Walls marked at both sides of white roll dispenser	**Clean and re-paint - Docket**	Estates			
	Old food stains on inside of door leading to the dining room	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Cleaned 21/12/12	Complete	Ongoing monitoring
	Sellotape on window frame	Remove and clean, audit for a period of 4 weeks	PCSS	removed 08/01/13	complete	
	PVC window frame cracked	**Fix or replace window frame – Capital bid – April 13**	Estates			
	Gorge out of the reveal at window	**Fill hole and repaint**	Estates			
	Wood on inside of 2nd door badly damaged	**Fix and re-paint or replace - pending outcome of capital bid meeting Apr 13**	Estates			Brian to assess damage and if not fixable – capital bit April 13
Room 98 (Dayroom)	Food stuff? / faeces? on the ceiling	Remove and clean, audit for a period of 4 weeks - Docket	PCSS Estates	PCSS removed 16/1/13	Complete	Requires estates o touch up p/work
	Germazap not working	Repair, remove or replace - docket	Estates	Feb 13	Complete	
	Fireplace not secured to wall – brackets broken	Secure safely- docket	Estates	Feb 13	Complete	
	Gouges out of door	Fill and re paint- docket	Estates	Feb 13	Complete	Brian to assess damage and if not fixable – capital bit April 13

	Faeces on chair **Damaged upholstery on all chairs**	Remove and clean, audit for a period of 4 weeks **Fix / replace**	Nursing Nursing	Feb 13	Complete	
Multi-sensory room	Paint work damaged Mirrors dirty	Re paint - Docket Clean mirrors, audit for a period of 4 weeks	Estates PCSS	Feb 13 Cleaned 2/1/13	complete complete	Ongoing monitoring
Dirty Laundry room	**Cluttered – boxes round the floor** Floor stained and dirty	**Declutter** Clean, audit for a period of 4 weeks	Nursing PCSS	Floor scrubbed 9/1/13	complete	Floor scrubbed & buffed
Clinical Room	Blue tack on walls Cobwebs in corner of room Door slow release removed – hole remains No medium gloves available Stains on doors and on floor around bottom of the doors Floor dirty Rust on floor below the O2 cylinder 2 O2 cylinders	Remove and clean Remove and clean, audit for a period of 4 weeks Fix door frame – Docket Replace gloves - is this included in nursing cleaning schedules as a task Remove and clean, audit for a period of 4 weeks Clean, audit for a period of 4 weeks Docket Are these both needed? yes	PCSS PCSS Estates Nursing PCSS PCSS Estates Nursing	21/12/12 21/12/12 Feb 13 Feb 13 21/12/12 21/12/12 Feb 13	complete complete complete complete complete complete complete Complete	Ongoing monitoring Ongoing monitoring Cage to be built to house the O2 off the floor

	2 suction machines	Send old machine to stores	Nursing	Feb 13	16/01/13 complete	Linda to send big suction machine to stores
	No hibiscrub in dispenser	**Replace**	Nursing			
	Tubes attached to suction machine	These should be sealed and readily available but not attached	Nursing	Feb 13	complete	
	Suction machine on floor	Should be on a shelf - docket	Estates	Feb 13	complete	
	Face broken on scales	Fix or replace – docket	Estates	Feb 13	complete	
	Some leaflets/notices missing	Leaflets displayed should include: • NPSA cleaning colour coding poster available for nursing and hotel services staff • Poster for dilution rates of Antichlor plus tablets • Information re the management of sharps injuries • Information leaflets re MRSA and Clostridium Difficile	Nursing	Feb 13	complete	Jenni posted 25/2/13
	Action in emergency notice out of date	**Display up to date notice**	Nursing			
	Front of drug trolley dirty	**Clean, audit for a period of 4 weeks**	Nursing			Burn bin not opening
	Drug packaging in burn bin	**Remove and dispose of appropriately – burn bin for medication only**	Nursing			
	***Burn bin not opening**	**Order new bin**	Nursing	Feb 13	complete	
	Sharps box not closed					

Version 4

	properly	Close after use				
Room 107 (Toilet)	No plug in sink		Estates		Complete 16/01/13	Decision made not to replace the plug as patients persistently remove it – this is a hand washing sink and does not require a plug
	Faeces on toilet seat	Clean, audit for a period of 4 weeks	Nursing			
	Walls damp	Treat / clean and re paint – pending outcome of capital bid meeting Jan 13	Estates		Complete 16/01/13	
	***Walls painted but pain bubbling and damp coming through**	**Treat and repaint**				
	Bare plaster on walls where something has been removed and not repainted	Re paint - pending outcome of capital bid meeting Jan 13	Estates		Complete 16/01/13	
	Sheetrock coming off outside toilet door	Fix or replace 0 Docket	Estates		Complete 16/01/13	
Back Hall	Ceiling needs to be re-varnished	Re-varnish ceiling - Docket	Estates	Feb 13	complete	
	Damage to radiator cover	**Fix or replace cover – Docket – Source new cover form closed ward**	Estates			
	Door handles dirty	Clean, audit for a period of 4 weeks	PCSS	Cleaned 21/12/12	Complete	Ongoing monitoring
	Unused shelf brackets on wall	**Remove**	Estates			
	Sellotape stain on key lock	Clean, audit for a period of 4 weeks	PCSS	cleaned	complete	

12

	***Finger guard on door damaged**	**Replace finger guard**		2/1/13		
Room 115 (bedroom)	Floor stained Partial blinds missing **Hooks in wall**	Clean, audit for a period of 4 weeks Replace or remove blinds - ?sand blast – capital bid April 13 **Remove**	PCSS Estates	Cleaned 2/1/13	complete	Linda to discuss with Andersons 21/01/13
Room 109 (bedroom)	Inside windows dirty **Missing lock keepers on chest of drawers**	Clean, audit for a period of 4 weeks **Replace**	PCSS Estates	10/1/13	complete	Ongoing monitoring
Room 114 (bedroom)	Holes on windowsills Ariel lead not covered in **Floor gouged** Key operated light switch not working ***Blinds partially missing**	Fill and re-paint - docket Cover - docket **Fix or replace – docket – capital bid April 13** Repair - Docket **Andersons/sandblasting**	Estates Estates Estates Estates	Feb 13 Feb 13 Feb 13	Complete Complete complete	
Room 110 (bedroom)	**Blinds partially missing** Wardrobes scuffed	**Replace blinds – sand blast? Capital bid April 13** Replace/repair	Estates Estates	Feb 13	Ongoing	Linda to discuss with Andersons 21/01/13 Replace with surplus as patients are discharged
Room 111 (bathroom)	Incorrect signage on door	Replace signage – docket	Estates	Feb 13	complete	Remove signage for now on this door - capital bid to replace all signage

	Lid on laundry skip dirty	Clean, audit for a period of 4 weeks	Nursing	Feb 13	complete	
	Sticky labels in hygiene cupboard	Remove and replace with wipe clean labels (laminated)	Nursing	Feb 13	complete	
	Shelves dirty	Clean, audit for a period of 4 weeks	PCSS	Daily	complete	Ongoing monitoring
	Mirror marked	Clean, audit for a period of 4 weeks	PCSS	Daily	complete	Ongoing monitoring
	Fan dirty and dusty	Clean, audit for a period of 4 weeks	PCSS/estates	Exterior cleaned		
	Shower head dirty	Clean, audit for a period of 4 weeks	PCSS	10/1/13	complete	
	Inside window dirty	Clean window	PCSS	10/1/13	complete	
	Screens dirty, rusty and dusty **Still dusty**	Replace **Clean**	Nursing			Linda to get new screens from stores
	Blind pull missing	Replace - docket	Estates	Feb 13	complete	
	Wipes container broken	Replace	Nursing	Feb 13	complete	
	Pull cord in bathroom broken	Replace pull cord - docket	Estates	Feb 13	complete	
	***bathroom rules**	**Display**				
Front office	Computer dusty	Clean computer	Nursing	Feb 13	complete	
General - relevant to all ward	Paintwork on skirting boards, windowsills, doors, door frames, windowsills, ceilings and handrails chipped	Paint all skirting boards, door frames, handrails, windowsills, ceilings and doors - pending outcome of capital bid meeting Apr 13	Estates			
	Paint flaking on the ceilings	Clean off flaking paint and paint ceilings - pending outcome of capital bid meeting	Estates			

		Apr 13				
	Plaster gouged on walls	Fill holes and repaint - pending outcome of capital bid meeting Apr13	Estates			
	Chipped paint on walls in dayrooms, bedroom and corridors	Repaint all dayrooms, bedrooms and corridors - pending outcome of capital bid meeting Apr 13	Estates			
	Redundant slide latches on doors/holes where slide latch has been	**Remove slide latches and cover space with blank face plate**	Estates			
	Surfaces, ledges, furniture, window frames, inside notice boards, behind hand rails, inside phone cupboards, top of wardrobes, top of TV cabinets and skirting boards dusty	Dust surfaces and audit for a period of 4 weeks	PCSS	Ongoing	complete	
	Notice boards unlocked/locks broken in some instances	**Order new notice boards for the ward**	Estates/Nursing			order new notice boards and submit a docket to have them put up when they arrive in ward
	Plaster work around door frames cracked	Remove plaster, re plaster and repaint - pending outcome of capital bid meeting Apr 13 - docket	Estates			
	Holes in walls due to screws etc being removed	Fill holes and repaint - Docket	Estates			Brian to assess and do what's possible pending capital bid April 13
	Screws/nails in walls Hooks in ceilings	Remove screws, nails and hooks, fill holes and paint - Docket	Estates			
	Cracks in walls	Fill cracks and repaint - pending outcome of capital bid meeting Apr 13	Estates			

	All light shades are dirty and have debris in	Clean lampshades and audit for a period of 4 weeks	PCSS/Estates			Programme of cleaning all light fittings started 2/1/13 Brian to follow up with Rosemary
	Door signage paint marks and dirty	Clean or replace - pending outcome of capital bid meeting Apr 13	Estates			
	Taps in bedroom sinks not working	Remove sinks – docket ***Replaster where sinks have been removed and repaint**	Estates			Brian to assess if an interim solution is possible pending capital bid Apr 13
	All handles on windows dirty and sticky	Clean handles and audit for a period of 4 weeks	Estates			Handles cleaned, Sticky residue left from glue being removed by Estates
	Hand washing signage missing from some hand washing sinks	**Check**	Nursing			
	Inside radiator covers dirty	Remove covers and clean - docket	Estates/PCSS	Feb 13	complete	Programme starting 23/1/13 Brian to follow up with Rosemary
	Soap dispensers missing in some toilet areas	**Check**				
	Paper towel dispensers missing in some toilet areas	**Check**	Estates			
	No bins in some toilets	**Check**	Estates			Bins should be bought out of ward budget - request WM to order – Linda to discuss with Rosemary
	Outside windows dirty	How often are these cleaned?		3x per year		Contractor not due to clean windows until
	Walls damaged from door handles	Fit door stops/fill holes in walls and repaint - docket				

	Wardrobes damaged and grubby	Clean and audit for a period of 4 weeks -			Complete 16/01/13	04/13 Brian to assess for a solution Furniture cleaned 2/1/13 Replace with surplus as patients are discharged

- Linda – to write a list of all work requiring dockets and discuss with Brian the best way to submit the work

Henry, Robert

From: Irwin, Brian on behalf of SeriousAdverseIncident-SM
Sent: 01 September 2015 16:10
To: 'seriousincidents@hscni.net'
Cc: 'Anne Kane'; McMullan, Colin; McCaul, Shane; Mooney, Geraldine; Cairns, Claire; Mitchell, Mairead
Subject: FW: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Attachments: bhsct_early alert proforma_ 09_11_12.doc.htm

Importance: High
Sensitivity: Confidential

Sent on behalf of Colin McMullan, Senior Manager Corporate Governance

Dear Colleagues,

Further to the email below the Trust wishes to clarify that this incident will not be reported by the Trust as an SAI. This is because the safeguarding investigation found the allegations were not substantiated and it therefore does not now meet SAI criteria for reporting as such.

If you have any queries or require further assistance please do not hesitate to contact Colin McMullan, Senior Manager Corporate Governance, by email: **Colin.McMullan@belfasttrust.hscni.net** or Telephone 028 950 43141.

Regards,

Brian

From: Mooney, Geraldine **On Behalf Of** SeriousAdverseIncident-SM
Sent: 05 August 2015 15:59
To: 'serious incidents'
Cc: Mitchell, Mairead; Minnis, Patricia; McCaul, Shane; McMullan, Colin
Subject: RE: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

Sent on behalf of Colin McMullan, Senior Manager Corporate Governance

Dear Colleagues,

Further to your email below regarding the queries in relation to Early Alert Notification EA/BHSCT/09/11/12 HSCB Ref: EA1658, the Directorate has confirmed that this incident was investigated through the PSNI and an extensive safeguarding process. The outcome of both investigations was that there was no evidence of any of the allegations made. The Trust would therefore request that this early alert is closed.

If you have any queries or require further assistance please do not hesitate to contact Colin McMullan, Senior Manager Corporate Governance, by email: **Colin.McMullan@belfasttrust.hscni.net** or Telephone 028 950 43141.

Regards,

Geraldine

Geraldine Mooney
Risk & Governance Officer
Belfast Health & Social Care Trust
6th Floor McKinney House
Musgrave Park Hospital
Stockmans Lane
Belfast BT9 7JB
Contact Number: 028 95048098
Email Address: geraldine.mooney@belfasttrust.hscni.net

From: serious incidents [mailto:seriousincidents@hscni.net]
Sent: 23 July 2015 11:33
To: SeriousAdverseIncident-SM

Subject: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Sensitivity: Confidential

Thank you for your email below in response to Lead Officer queries received on 13 May 2015. The Lead Officer responds as follows:

The Procedure for the reporting and follow up of Serious Adverse Incidents April 2010 under which the Trust considered this incident states "All existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate **in tandem** with this procedure" (page 7 section 3.3). The procedure also states that among its aims are to review of the circumstances and service input to "ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence; and provide a mechanism to effectively share learning in a meaningful way across the HSC" (page 5 section 2.0).

There is therefore clearly an expectation that an incident that met the SAI criteria (which in the view of the Lead Officer this one does) would be reported, irrespective of parallel processes such as criminal investigation and adult safeguarding also being initiated. Whilst information and perspectives relevant to an SAI review may well be elicited from these, there aims and objectives differ significantly. Therefore the Lead Officer would once again request that the Trust formally report this incident as an SAI, and review it as such within the terms of reference of the SAI procedure.

Can you please submit a SAI Notification, as requested, to seriousincidents@hscni.net mailbox **as soon as possible**?

Many Thanks
Roisín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064

From: Mooney, Geraldine [mailto:Geraldine.Mooney@belfasttrust.hscni.net] **On Behalf Of** SeriousAdverseIncident-SM
Sent: 13 May 2015 09:10
To: serious incidents
Cc: Mitchell, Mairead; Minnis, Patricia; McCaul, Shane; Mooney, Geraldine; McMullan, Colin
Subject: RE: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

Sent on behalf of Colin McMullan, Senior Manager Corporate Governance

Dear Colleagues,

Please find attached response regarding the queries in relation to Early Alert Notification EA/BHSCT/09/11/12 HSCB Ref: EA1658.

If you have any queries or require further assistance please do not hesitate to contact Colin McMullan, Senior Manager Corporate Governance, by email: **Colin.McMullan@belfasttrust.hscni.net** or Telephone 028 950 43141.

Regards,

Geraldine

Geraldine Mooney
Risk & Governance Officer
Belfast Health & Social Care Trust
6th Floor McKinney House

Musgrave Park Hospital
Stockmans Lane
Belfast BT9 7JB
Contact Number: 028 95048098
Email Address: **geraldine.mooney@belfasttrust.hscni.net**

From: serious incidents [mailto:seriousincidents@hscni.net]
Sent: 11 May 2015 11:16
To: SeriousAdverseIncident-SM
Subject: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

"This email is covered by the disclaimer found at the end of the message."

Please see email below, in relation to the above incident. Can you please submit a SAI for the above Early Alert?

Regards
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064

From: serious incidents
Sent: 24 April 2015 14:31
To: SeriousAdverseIncident-SM (SeriousAdverseIncident@belfasttrust.hscni.net)
Cc: geraldine.mooney@belfasttrust.hscni.net
Subject: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

Can you please confirm if the above Early Alert has been submitted as an SAI? If not, can you please submit a SAI as soon as possible as the Lead Officer has stated that this Early Alert meets the criteria for reporting a SAI?

Regards
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064

From: serious incidents
Sent: 06 March 2015 12:10
To: EarlyAlertNotificationMedDir-SM (EarlyAlertNotificationMedDir@belfasttrust.hscni.net)
Cc: geraldine.mooney@belfasttrust.hscni.net
Subject: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Sensitivity: Confidential

Please see email below, in relation to the above Early Alert, where the Lead Officer has requested that a SAI be submitted, to date we have not received a SAI. Can you please submit a SAI as soon as possible?

Regards
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064

From: serious incidents
Sent: 03 February 2015 11:54
To: 'EarlyAlertNotificationMedDir-SM'
Subject: Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Sensitivity: Confidential

The DRO would draw the Trust's attention to Section 4, Definition and Criteria, within the Procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013). This incident would appear to meet the criteria set out in 4.2.5 and 4.2.8.

Whilst it is acceptable to delay the SAI review on advice of police carrying out a criminal investigation, the DRO would draw attention to Section 7.3. of the procedure and the expectation that the SAI review will run as a parallel process. The Trust should also note the purpose of an SAI review – to identify learning and prevent where possible any future occurrence of similar incidents. The intention and the scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding investigation.

The Trust should therefore formally notify this incident as an SAI and conduct a review of this case in respect to any improvements to care planning, staff supervision, training etc.; or any other cultural or environmental features of the care setting that could be addressed to reduce the likelihood of any future occurrence.

Regards
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill

Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064

From: Irwin, Brian [mailto:Brian.Irwin@belfasttrust.hscni.net] **On Behalf Of** EarlyAlertNotificationMedDir-SM
Sent: 28 January 2015 11:21
To: serious incidents
Cc: Mitchell, Mairead; Minnis, Patricia; McCaul, Shane; Mooney, Geraldine
Subject: RE: Early Alert Notification: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

Sent on behalf of Claire Cairns, Co-Director Risk & Governance

Dear Colleagues,

Please find attached response regarding the queries in relation to Early Alert Notification BHSCT/EA/09/11/12 HSCB Ref: EA1658.

If you have any queries or require further assistance please do not hesitate to contact Claire Cairns, Co-Director Risk & Governance by email: claire.cairns@belfasttrust.hscni.net or Telephone 028 950 48098 / mob: 078 2514 7249.

Regards,

Brian

From: serious incidents [mailto:seriousincidents@hscni.net]
Sent: 16 January 2015 12:19
To: SeriousAdverseIncident-SM
Subject: Early Alert Notification: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Importance: High
Sensitivity: Confidential

"This email is covered by the disclaimer found at the end of the message."

Please see email below sent 6 March 2014, in relation to the above incident.

This Early Alert remains open. No subsequent SAI has ever been received and the DRO feels that it should be an SAI.

Can you please let me know the current status of this Early Alert, as it remains open and if an SAI is to be submitted?

Many Thanks
Roísín

Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net

T: 028 3741 4530

From: serious incidents
Sent: 06 March 2014 15:07
To: SeriousAdverseIncident-SM (SeriousAdverseIncident@belfasttrust.hscni.net)
Cc: Shane.McCaul@belfasttrust.hscni.net
Subject: Early Alert Notification: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Sensitivity: Confidential

The attached Early Alert, which was reported on **9 November 2012** remains open. No subsequent SAI has ever been received. I had contacted the DRO to see if the Early Alert could now be closed. The DRO has responded saying – '***given the serious nature of this incident and its public interest I am of the opinion that it should be an SAI***.'

Can you please let me know the status of the above Early Alert as it hasn't been reported as an SAI?

Regards.
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 3741 4530

From: McCaul, Shane [mailto:shane.mccaul@belfasttrust.hscni.net]
Sent: 09 November 2012 16:40
To: early alert; 'earlyalert@dhsspsni.gov.uk'; cx office
Cc: brenda.creaney@belfasttrust.hscni.net; Robinson, David; McNicholl, Catherine; Tony Stevens; Champion, June; Cairns, Claire; EarlyAlertNotificationMedDir
Subject: Early Alert Notification
Importance: High
Sensitivity: Confidential

Sent on behalf of Claire Cairns Corporate Governance Manager

Dear Colleagues

Please find attached Early Alert Notification for the Belfast Health & Social Care Trust.

If you have any queries or require further assistance please do not hesitate to contact Claire Cairns, Corporate Governance Manager by email: claire.cairns@belfasttrust.hscni.net or Telephone 028 950 48359 mob: 078 2514 7249.

Regards,

Shane

Shane McCaul
Risk & Governance
Belfast Health & Social Care Trust
6th Floor McKinney House
Musgrave Park Hospital
Stockmans Lane
Belfast BT9 7JB
Contact Number: 028 95048098
Email Address: earlyalertnotificationmeddir@belfasttrust.hscni.net

Henry, Robert

From: serious incidents seriousincidents@hscni.net
Sent: 09 September 2015 11:58
To: SeriousAdverseIncident-SM
Subject: Closure of Early Alert - Trust Ref: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Attachments: safeguarding and sai processes..pdf.htm

The HSCB are content to close this early alert on the basis Belfast Trust have advised the safeguarding investigation found the allegations were not substantiated. It should however be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could have been subsequently been deferred pending the outcome of the safeguarding investigation (see attached safeguarding flowchart).

Regards
Roísín

Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Roisin.Hughes2@hscni.net
T: 028 95 362064
