Muckamore Abbey Hospital Inquiry

Module 6b: Ennis Ward Adult Safeguarding Report (October 2013) Bundle for Witnesses

4a.	Note prepared by H491 regarding Ennis Ward.	96 a – m
5.	Action Plan Material: i. Proposal for Service Improvement Action Plan in Ennis Ward (undated). ii. Action plan recommended following leadership walk round with senior staff (undated). iii. Service Improvement Action Plan Ennis Ward (undated).	97 98 99 - 108
6.	Ennis Audit April 2013.	109 – 113
7.	RQIA Inspection Reports regarding Ennis: i. Quality Improvement Plan, 10 and 11 November 2010. ii. 13 November 2012. iii. 20 December 2012. iv. 29 January 2013. v. 29 May 2013.	113 a – g 114 – 144 145 – 162 163 – 182 183 – 199
8.	Correspondence between BHSCT and RQIA: i. Theresa Nixon (Director MHLD and Social Care RQIA) to Esther Rafferty (Service Manager MAH), 15 November 2012. ii. Esther Rafferty MAH to Theresa Nixon RQIA, 23 November 2012 (and enclosed Action Plan). iii. Theresa Nixon RQIA to Esther Rafferty MAH, 03 December 2012. iv. Esther Rafferty MAH to Theresa Nixon RQIA, 12 December 2012. v. Glenn Houston (Chief Executive RQIA) to Colm Donaghy (Chief Executive BHSCT), 31 January 2013. vi. Glenn Houston to Colm Donaghy, 01 February 2013. vii. Response to RQIA correspondence of 01 February 2013 (undated). viii. Theresa Nixon RQIA to John Veitch (Co-Director for Children's MHLD Services MAH), 09 May 2013. ix. John Veitch MAH to Theresa Nixon RQIA, 06 June 2013.	200 – 201 202 – 203 204 – 206 207 – 209 209 a – c 210 – 213 214 – 216 217 – 218 219 – 220
9.	Ennis Ward Adult Safeguarding Investigation, 23 October 2013 (Aine Morrison, Colette Ireland, Carmel Drysdale).	221 – 292

10.	Ennis Investigation Reports: * i. Investigation into alleged incidents on 8th November 2012 in relation to H159 (without Appendices). ii. Investigation into alleged incidents on 8th November 2012 in relation to H197 (without Appendices). iii. Investigation into alleged incidents reported on 8th November 2012 (with Appendices). * Note that the Appendices to each of these three reports are the same, therefore only one set is included.	293 – 317 318 – 339 340 – 576
11.	Timeline of Ennis Investigation (January 2010 to April 2016).	577 – 581
12.	Record of teleconference (to facilitate DAPO to communicate difficulties encountered in carrying out role), Thursday 16 January 2020.	582 – 586
13.	A Review of Leadership and Governance at Muckamore Abbey Hospital (The Muckamore Abbey Hospital Review Team, July 2020).	587 – 801
14.	Report into allegations made against Moira Mannion (David Bingham, August 2020).	802 – 804
15.	Documents contained in BHSCT – A – 00019: Synopsis of Ennis Report and Review of Ennis Investigation 2012.	805 – 812
16.	Email dated 24 January 2013; believed to be the email referred to at paragraph 8.32 of the Leadership and Governance Review Report (2020).	813 - 814

VA 7

BELFAST HEALTH & SOCIAL CARE TRUST
PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS
FROM ABUSE AND EXPLOITATION

MINUTES OF STRATEGY MEETING / CASE DISCUSSION / REVIEW

This provides a template to record who attended the meeting, reports submitted and future review arrangements. The Designated Officer will also include a minute of the essential facts, discussion and decisions taken at the meeting.

NAME: 1. [redacted] P2 2. [redacted] P3 3. [redacted] P1 4. [redacted] P4	[redacted] Ennis Ward Muckamore Abbey Hospital	[redacted] 1. [redacted] 2. [redacted] 3. [redacted] 4. 0[redacted]
COMPUTER NO: 1. EA 2117 2. NA 1720 3. EA 4065 4. SC 9490		IF NOT KNOWN, PLEASE GIVE APPROXIMATE AGE: GENDER: M ☐ F ☐

VENUE: Small Meeting Room	DATE Friday 9th November 2012
CHAIR PERSON: Ms Aine Morrison	

WAS THE USER INVITED?	YES ☐	NO ☐
WAS THE USER IN ATTENDANCE?	YES ☐	NO ☐
DID THE USER COMMUNICATE THEIR VIEWS BY OTHER MEANS EG. LETTER	YES ☐	NO ☐

IF THE USER DID NOT PATICIPATE, PLEASE SPECIFY REASON _____

12.008

OTHERS INVITED IE. ADVOCATE OR CARER

NAME _____ IN ATTENDANCE YES ☐ NO ☐

NAME _____ IN ATTENDANCE YES ☐ NO ☐

IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON _____

NAMES OF THOSE PRESENT:	TITLE
Mr H92	Senior Social Worker
Mr Patrick Ling	Specialist Doctor
Mr Richard Cherry	CT3
Mr Barry Mills	Operations Manager
Mrs Esther Rafferty	Service Manager
Ms Elaine McCormill	Sergeant, PPU, PSNI
Mrs Tracy Hawthorne	Constable, PPU, PSNI
Ms Audrey Murphy	Inspector, RQIA
Ms Marbeth McKeown	Senior Practitioner, Northern Trust

LIST OF APOLOGIES RECEIVED

1. _____ 6. _____

2. _____ 7. _____

REPORTS SUBMITTED BY:

1. _____ 3. _____

2. _____ 4. _____

INVESTIGATIVE OUTCOME/
ARE THERE ANY REASONABLE GROUNDS FOR ONGOING CONCERN: YES

Aine noted that this was a strategy meeting being held under Joint Protocol procedures to investigate allegations of verbal and physical abuse made against staff members on Ennis Ward.

On the morning of the 8/11/2012, the hospital via Esther Rafferty was informed of the following:

A care assistant working on the ward from the Priory Group, Bohill Care Home, alleged that whilst working on Ennis Ward, Muckamore Abbey Hospital on the 7/11/2012, she witnessed staff being verbally and physically abusive to four named patients. Only one patient's surname was provided but the christian names provided for the other three allowed the hospital to identify these individuals. Three of the patients are from the BHSCT and one from the NHSCT.

This care assistant stated she witnessed H159 a member of Muckamore Abbey Hospital staff pull P1 from the sofa P39 was sitting on by the hem of her trousers on to the floor and be verbally condescending. She also stated that she witnessed this same staff member speak in an inappropriate manner, such as, get out of my way/you're doing my head in. The comment from the informant was that this was shouted at patients in general.

She witnessed another patient, P2 coming from the bathroom naked screaming and shouting " I hate her/I hate her/I hate H159 she hit me." This patient was very distressed and blood was coming from her mouth. The named staff member was the same staff member who allegedly pulled P1 from the sofa. The care assistant stated that she then witnessed P3 sitting naked for a period of time and a student nurse, HSC who she named tell P2 that she wouldn't get her sweets and lemonade if she didn't put her nightdress on.

The care assistant stated she witnessed H197 push P3 so hard into her chair that she hit her head off the back of the chair. This staff member appears to have then been witnessed saying to another patient P4 when P3 had attacked her to not be "a big softie and hit her back". The initial statement from the care assistant said she witnessed patients hitting out at staff and each other with no intervention.

Finally this care assistant left without telling any Muckamore Abbey Hospital staff of what she had witnessed as she felt intimidated and that she could not say anything. She reported this information to her team leader after 10pm that evening.

The immediate protection plan was that the three members of staff alleged to have been involved in these incidents were subject to a precautionary suspension from work.

Supplementary staff including an additional Band 7 and a Band 6 staff (for evening/nights) have been moved into Ennis. These are staff who have not had any previous connection with Ennis ward. These staff have been told that there are vulnerable adult concerns and that their role is to monitor for any concerns about practice.

In addition body charts were completed for all patients during the course of their personal care. Following consultation with the police, a forensic medical examination was carried out on the four named patients.

Relatives of the four named patients were informed that allegations had been received and were being investigated.

RQIA and the Northern Trust were informed and agreed with the immediate protection plan.

All present agreed that the allegations were of significant concern, both in relation to the individual reported incidents and a potential culture on the ward which would allow staff to act openly in the manner alleged.

The PPU reported that they had not had any feedback from the FMO as yet but would seek to get this as soon as possible.

Dr Ling and Dr Cherry then reported on the body charts completed for the four named patients. These had shown a range of bruising and abrasions most of which were not immediately clearly identifiable as non accidental. It was noted that all of the four patients engaged in self injurious behaviour which could account for many of the injuries. Two of the patients did have bruising to the inner legs and arms which may indicate more concern. The hospital will make these body charts available to the police. It was subsequently agreed immediately after the meeting that the PPU would wish to have forensic photography of these bruises. As none of the four patients have capacity to consent to this, a discussion of whether this would be in their best interests was held. It was felt that the photography would not unduly distress any of them and agreed that a thorough investigation was in their interests. Senior hospital staff are to seek the assent of relatives and inform the police of family views.

The body charts of the other patients have not been analysed as yet. Hospital staff will start this process today.

It was agreed that the care records, incident and accident reports and vulnerable adult referrals for all patients for the last month should be examined and cross checked against the body charts to see if explanations could be found for any of the marks.

There was considerable discussion about the whereabouts of other staff on duty on the day and whether or not there was concern about their actions. The police phoned the witness during the meeting and ascertained that she had no specific allegations about other staff. She said that she had seen very little of the nurse in charge; that she had mostly been in the office. She said she had not seen the other staff at all. It was noted that Ennis Ward is very segregated and that it is possible for staff to be stationed in one part of the ward which is separated by a locked door and to be completely unaware of things that were happening in another part of the ward. It was agreed that there were no indicators of concern about the members of staff who had been in the other part of the ward and therefore no protective action was necessary. There was concern expressed about the role of the nurse in charge. While there were no specific allegations made against her, there was concern expressed that she did not appear to have a presence on the ward or be in charge of things. Barry also expressed his concern about the lack of clarity about staff allocation evident in the duty rota. It was agreed that there weren't sufficient grounds for concern to suspend her but that she should be moved to another ward where she would not be in charge.

It was agreed that hospital staff would examine the duty rota and staff allocation for the ward that day more closely in order to give the investigation a detailed picture of staff movements on the ward that day. Hospital staff will also review records to see what other wards the suspended members of staff may have worked in.

The police are to interview the member of Bohill staff who has made the allegations as soon as possible.

It was agreed that social work staff should interview the other members of Bohill staff who have worked in Ennis Ward to see if they have any concerns. Aine Morrison will arrange this.

There was discussion about the ability of any of the patients in the ward to give any sort of statement about what might have occurred. Hospital staff thought that this would not be possible with any of the patients. However, it was agreed that medical staff, a speech and language therapist, the police and a ABE trained social services interviewer would meet to discuss if it was possible to facilitate in any way communication with the patients. Barry Mills will coordinate this.

It was agreed that the relatives of all patients on the ward should be notified of the investigation and a form of words for this was agreed. Hospital staff are to do this.

A press statement in the event of media enquiries was also discussed to be finalised after the meeting and circulated to all concerned.

It was noted that the South Eastern Trust had patients on the ward. Aine Morrison agreed to update them on events and invite to the next strategy meeting.

It was agreed that the EHSSB should be notified. Esther Rafferty undertook to do this.

The protection plan was confirmed as follows;

Three named members of staff to remain on precautionary suspension.
The Nurse in Charge, [redacted] is to be moved to another ward where she will have no supervisory responsibility. MS4
An additional Band 7 member of nursing staff is to be on the ward during the day to monitor for any concerns.
An additional Band 6 member of staff is to be on the ward at night, again to monitor for any concerns.
Band 8a staff are to make frequent unannounced visits to the ward to again monitor for concerns..

A further meeting was arranged for Thursday 15th November 2012 at 3.30pm in the small meeting room at Muckamore Abbey Hospital.

Aine Morrison

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

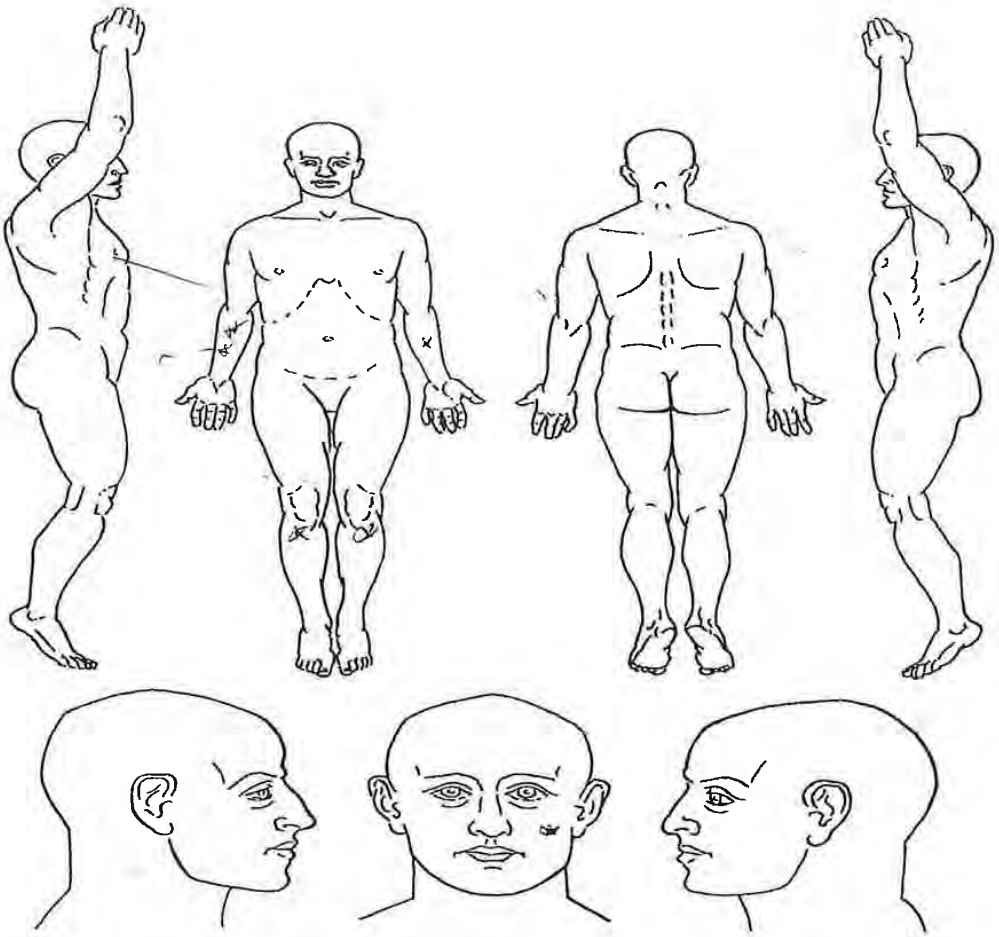
P3

Ward: ENNIS Patient: [redacted] Hospital Number: _____

Date: 9/11/12 Time: 1.00 AM

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Bdey Brown	Left arm	4x2.
Scratch above bruise	Left arm	1cx8L.
Friction Mark (Scabbed)	Left cheek.	

[redacted] MS11

Print Name: _____ Signature: [redacted] MS11 Band: 3 Date: 9/11/12

MS7 MS7

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 9/11/12

12 010

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

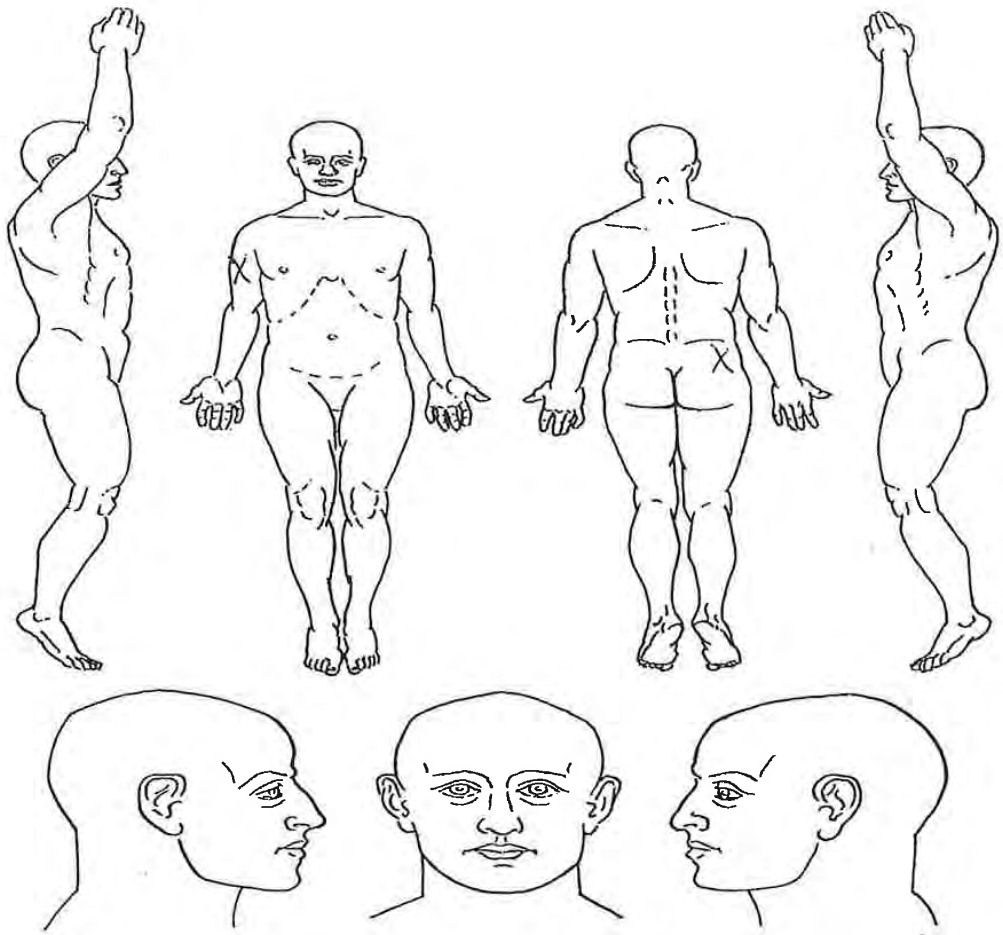
P11

Ward: Ennis **Patient:** [redacted] **Hospital Number:** _____

Date: 9/11/12 **Time:** 08:00am

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Bruise	Top of right buttocks	5 x 5cm Yellow/blue in colour.
Red marks	Top of right arm	2 x 2cm Red in colour.

Print Name: [redacted] MS10 **Signature:** [redacted] MS10 **Band:** 3 **Date:** 9/11/12

Print Name: _____ **Signature:** _____ **Band:** _____ **Date:** _____

12.011

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

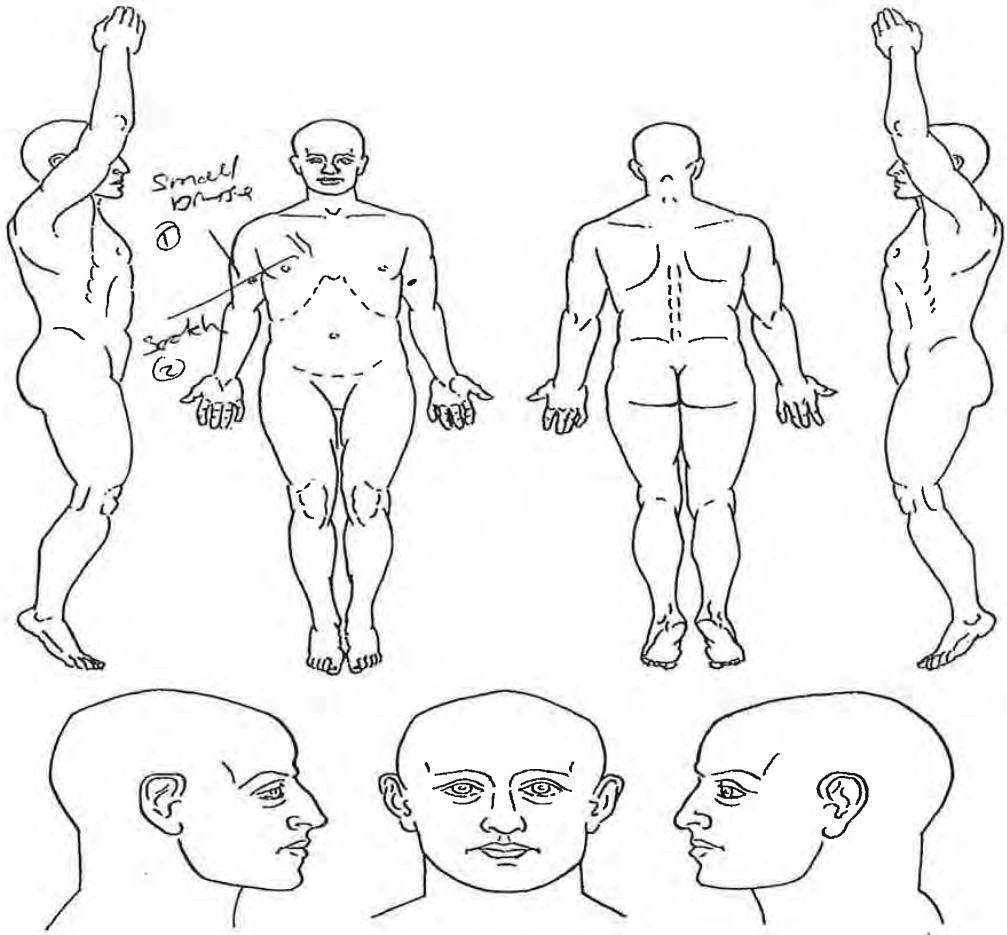
P1

Ward: Ennis Patient: [redacted] Hospital Number: EA4065

Date: 8th Nov 12 Time: 2300

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Bruise	Inner/upper Rt Arm	Dark/faded.
② Scratch	Rt chest/ region	Fresh Red.

MS12

Print Name: [redacted] Signature: [redacted] Band: 6 Date: 8th Nov 12

MS13

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/12

12 OE

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

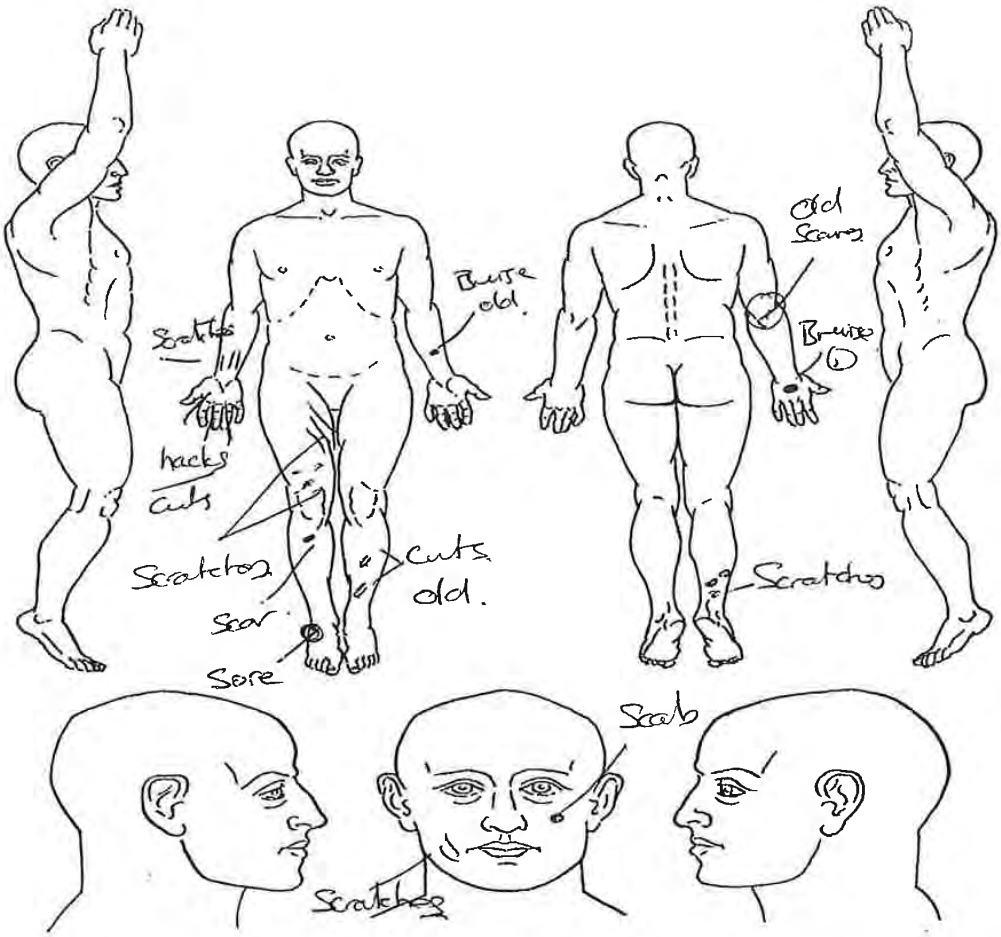
Body Chart

Ward: Ennis Patient: [redacted] P3 Hospital Number: NA 1720

Date: 8th Nov 12 Time: 2310

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Bruise	Rt/Back of hand	fresh.

MS12

Print Name: [redacted] Signature: [redacted] Band: 6 Date: 8th Nov 12

MS13

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/12

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

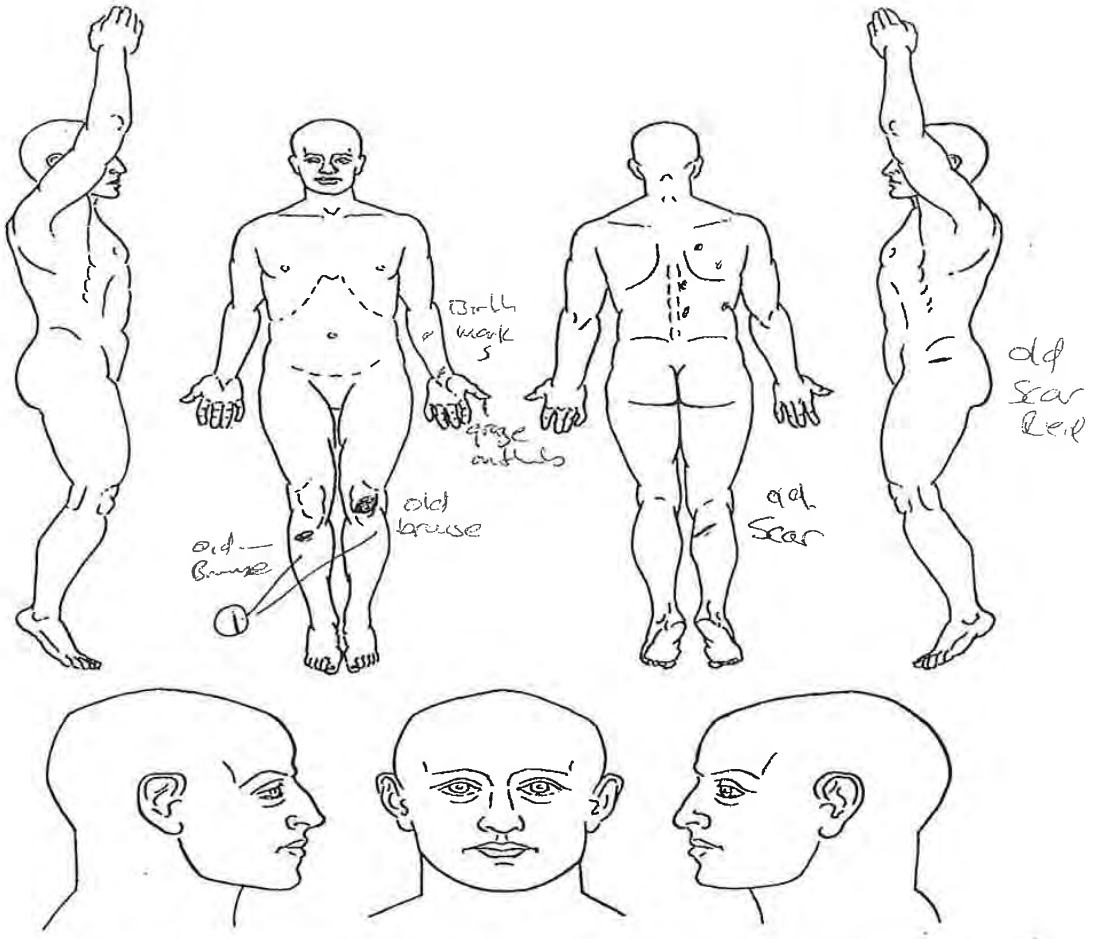
Body Chart

Ward: Ennis Patient: [redacted] P7 Hospital Number: SC 9197

Date: 8th Nov '12 Time: 9210

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Bruises	Both knees	

MS12 MS12

Print Name: [redacted] Signature: [redacted] Band: 6 Date: 8th Nov 12

MS14 MS14

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/12

12 014

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

Ward: Ennis

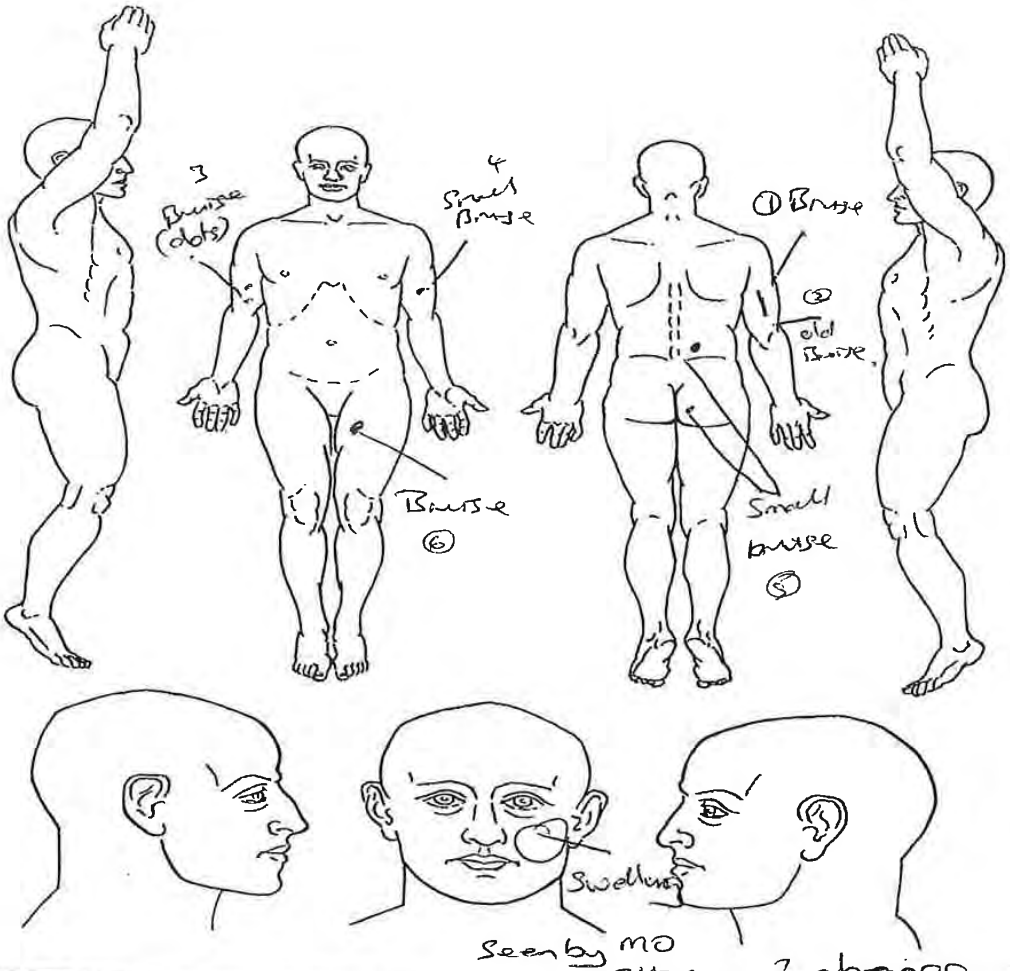
Patient: [redacted] P2

Hospital Number: EA 2117

Date: 8th Nov 12 Time: 2255

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



Seen by MO 8th Nov ? abscess

IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	Lower left leg	(1) Size (2x4 cm) (2) Yellow in colour
① Bruise	Rt upper back/arm.	Purple -2½ inches
② Bruise	Rt elbow	faded dot.
③ Bruise	upper front Lt arm	black small bruise
④ Bruise	upper front/inner Rt arm	very faded.
⑤ Bruise	Rt buttock area	small faded.
⑥ Bruise	Lt inner thigh	

MS12

Print Name: [redacted] Signature: [redacted] MS12 Band: 6 Date: 8th Nov 12

MS14

Print Name: [redacted] Signature: [redacted] MS14 Band: 3 Date: 8/11/12

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

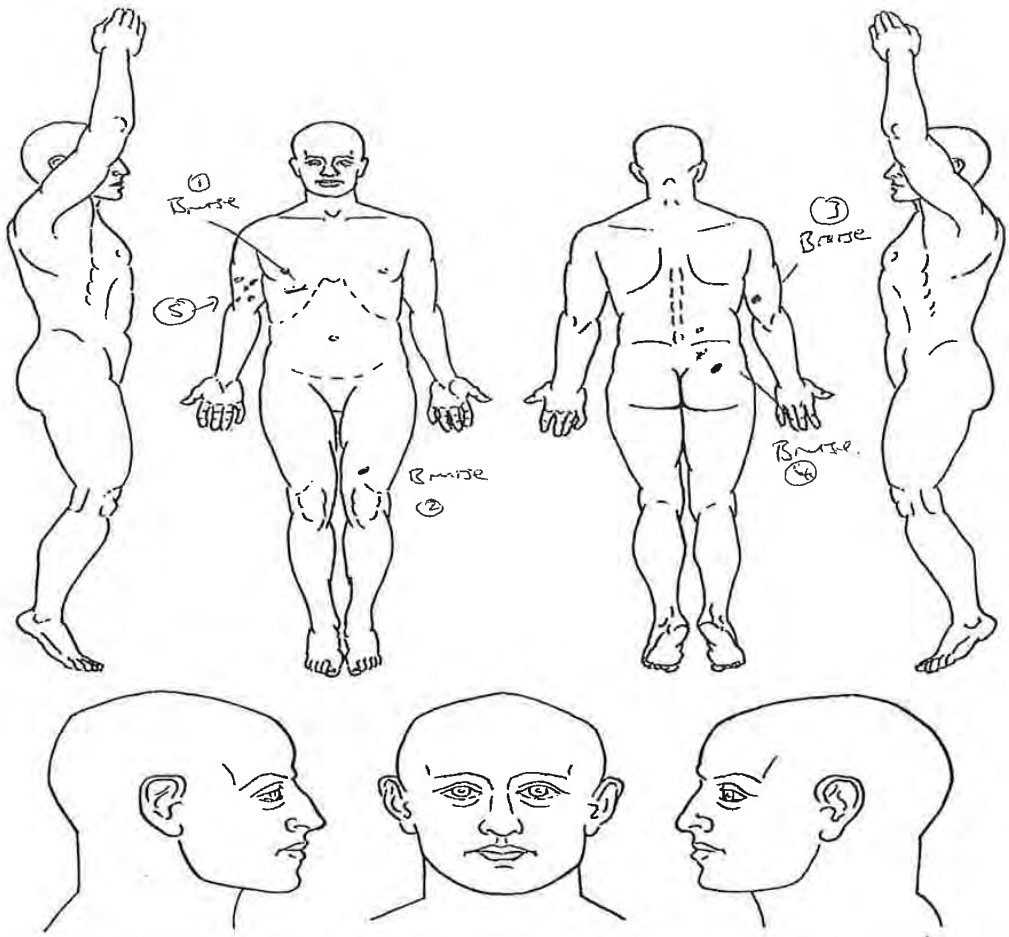
Body Chart

Ward: Ennis Patient: [redacted] P4 Hospital Number: SC9490

Date: 8th Nov Time: 2205

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
(1) Old bruise	Rt breast	faded.
(2) old bruise	Above Lt knee	faded
(3) old bruise	behind Rt arm	faded.
(4) old bruise	Rt upper buttock Region	faded.
(5) Bruising	Rt upper arm.	Small collection Red + purple

Print Name: [redacted] MS12 Signature: [redacted] MS12 Band: 6 Date: 8 Nov 12 2205

Print Name: [redacted] MS13 Signature: [redacted] MS13 Band: 3 Date: 8/11/12

12015

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

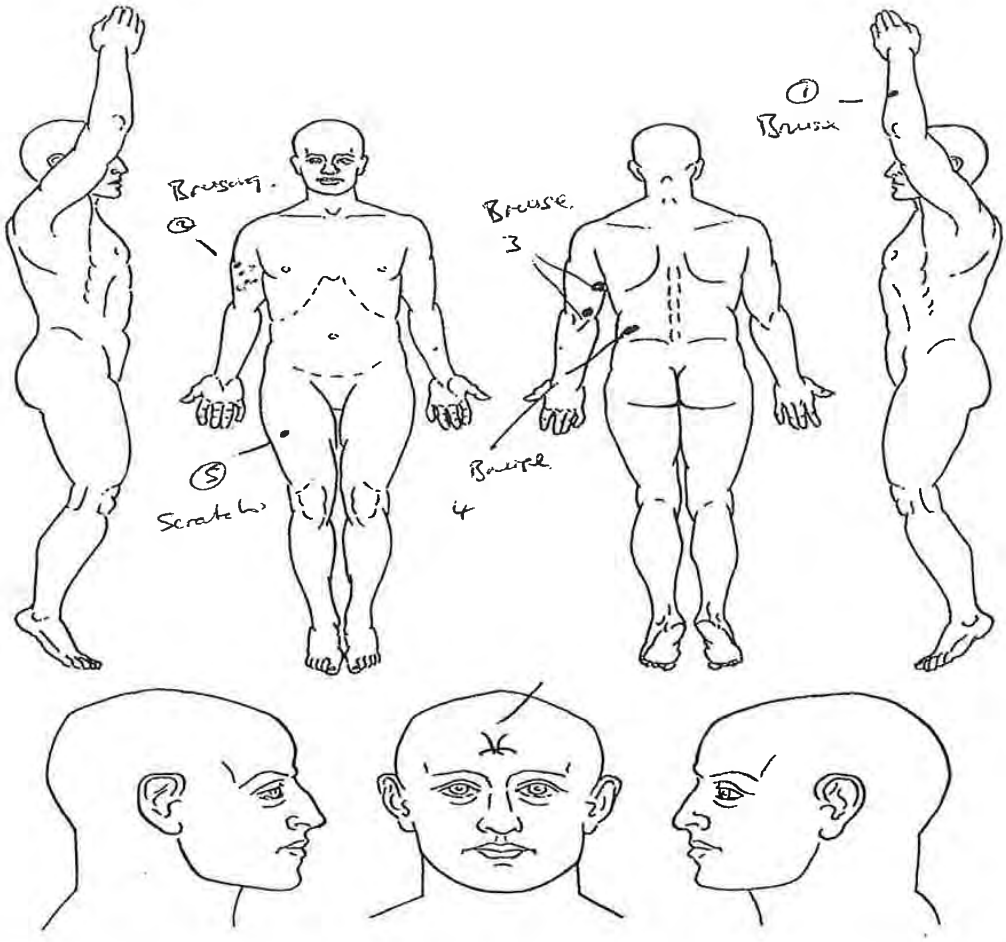
Body Chart

Ward: Ennis Patient: [redacted] P17 Hospital Number: NA 879

Date: 8th Nov 12 Time: 2215

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Bruise	~~top~~ Upper outer Rt arm	small faded.
② Bruising	Upper Rt arm.	Small collection.
③ Bruise x2	upper inner aspect Lfarm	Dark Bruising.
④ Bruise	upper lf buttock/	Purple mark long.
⑤ Scratch	Rt upper thigh	Reddish.

MS12 MS12

Print Name: [redacted] Signature: [redacted] Band: 6 Date: 8th Nov 12

MS14 MS14

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/12

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

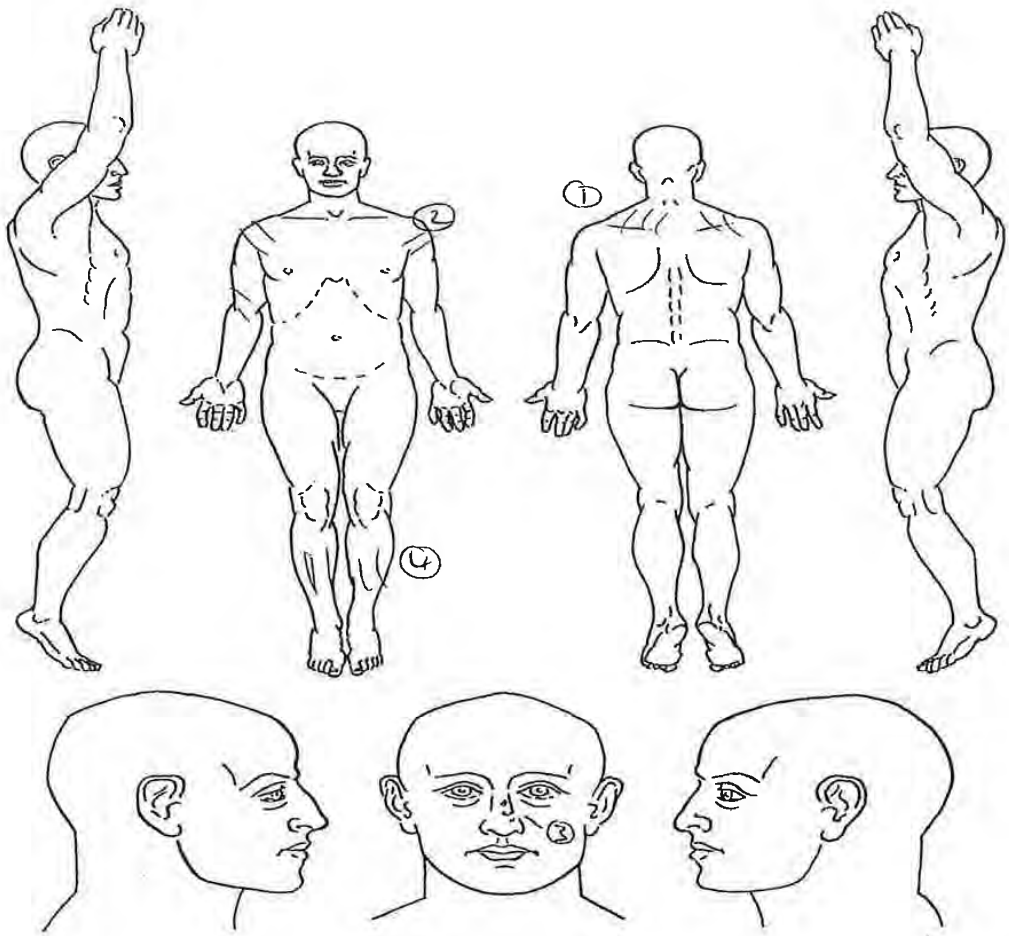
Body Chart

Ward: Ennis Patient: [redacted] P13 Hospital Number: WA 983

Date: 8th Nov 2012 Time: 2225

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
1 Old Scoring / Scratches	Upper back	Very faded 1/2 inches
2 Old Scoring / Scratches	Upper front	1/2 inch faded
3 fresh pricks	Both legs / front	lengthy with scabs
4 Scratches		

Print Name: [redacted] MS12 Signature: [redacted] MS12 Band: 6 Date: ~~29~~ 8th Nov

Print Name: [redacted] MS14 Signature: [redacted] MS14 Band: 3 Date: 8/11/12

D-018

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

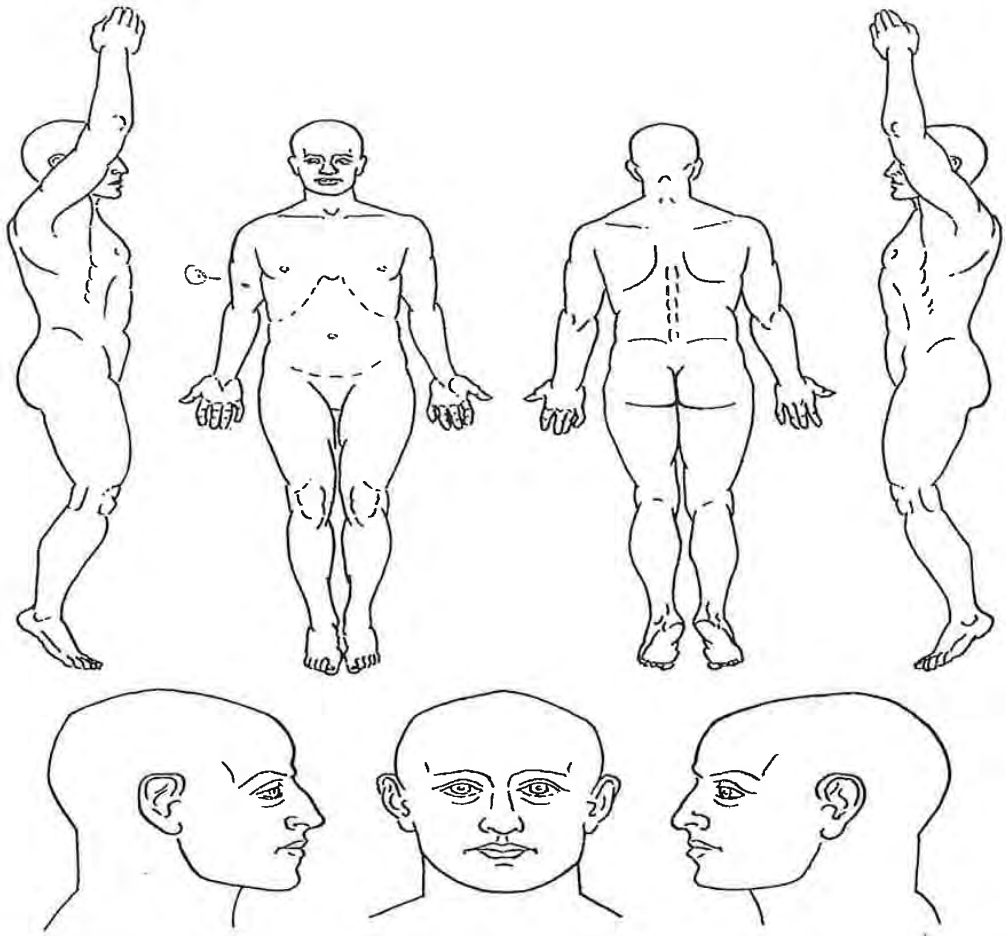
Body Chart

Ward: Ennis Patient: [redacted] P14 Hospital Number: NA 1025

Date: 8th Nov 12 Time: 22.10

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Small bruise	Upper Rt Arm	spot Very faded.

Print Name: [redacted] MS12 Signature: [redacted] MS12 Band: 6 Date: 8 Nov 12

Print Name: [redacted] MS14 Signature: [redacted] MS14 Band: 3 Date: 8/11/12

12 019

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

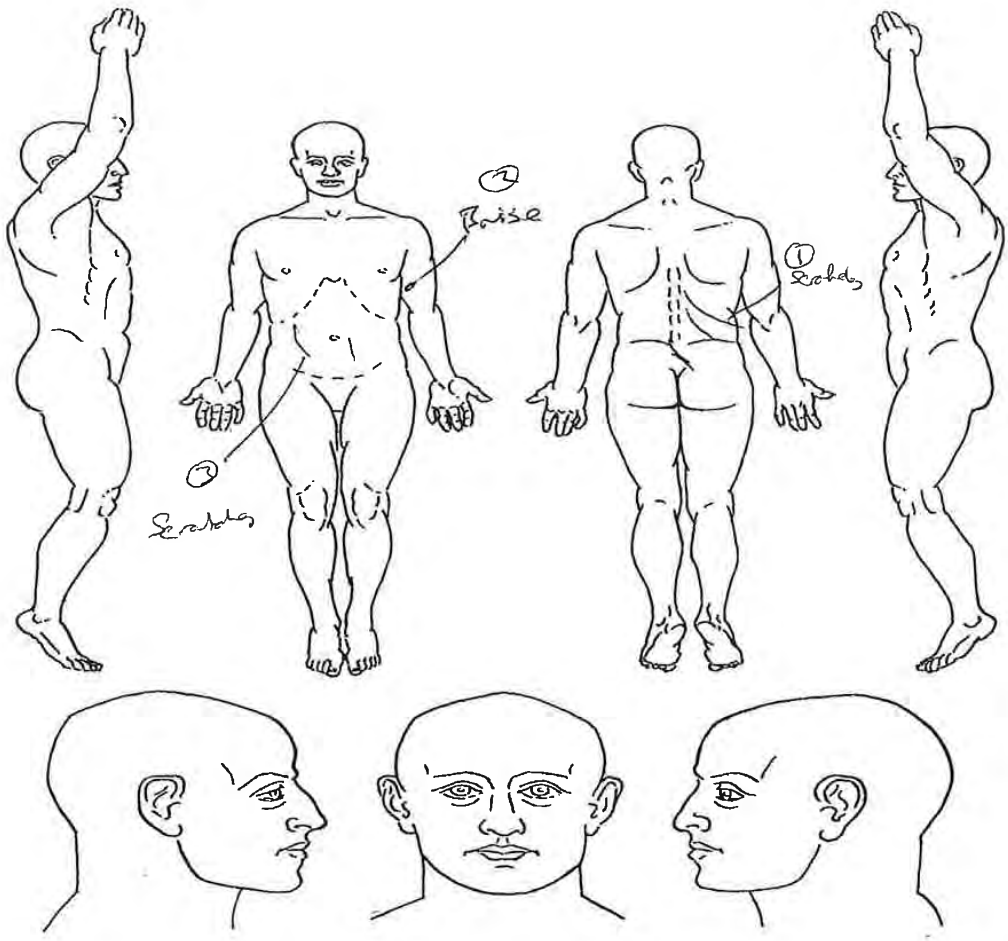
Body Chart

Ward: Ennis Patient: [redacted] PIS Hospital Number: SC 6989

Date: 8th Nov. Time: 2235

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Scratches	lower/middle Rt back	1 each 4/5 inches.
② Bruise	inner Rt arm	1 each 4cm.
③ Scratches	lower abdomen	1 each faded.

Print Name: [redacted] MS12 Signature: [redacted] MS12 Band: 6 Date: 8 Nov '12

Print Name: [redacted] MS14 Signature: [redacted] MS14 Band: 3 Date: 8/11/12

12.020

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

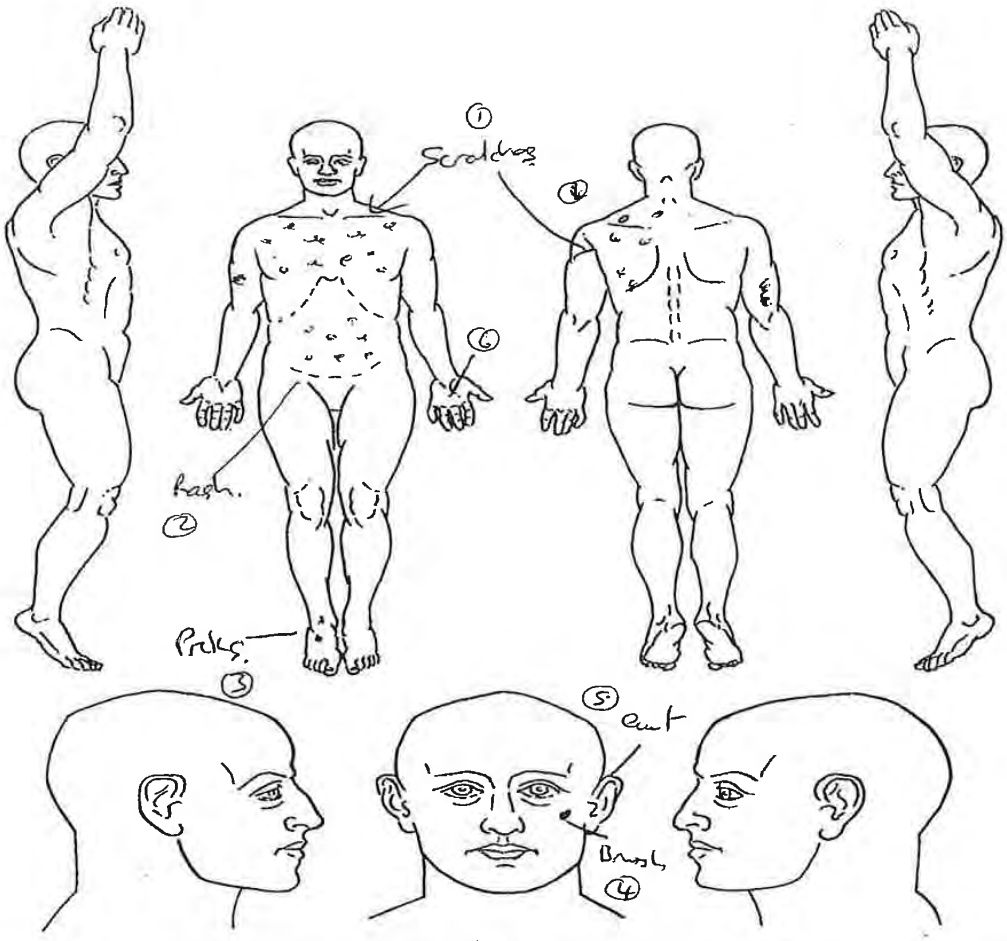
Body Chart

Ward: Ennis Patient: [redacted] PS Hospital Number: EA 4220

Date: 8th Nov '12 Time: 2240

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



Seen by MO 8th Nov 12 2100 approx

IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
① Scratches	over chest & upper back area	Reddish collection.
② Rash	lower abdomen	Reddish collection
③ Pricks	Rt lower leg	Red.
④ Bruise	lt shin bone	fresh.
⑤ Cut	lt ear lobe	½ inch fresh.
⑥ Split/ cut	lt palm	½ inch. fresh.

MS12 MS12

Print Name: [redacted] Signature: [redacted] Band: 6 Date: 8 Nov 12

MS14 MS14

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/12.

12 021

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

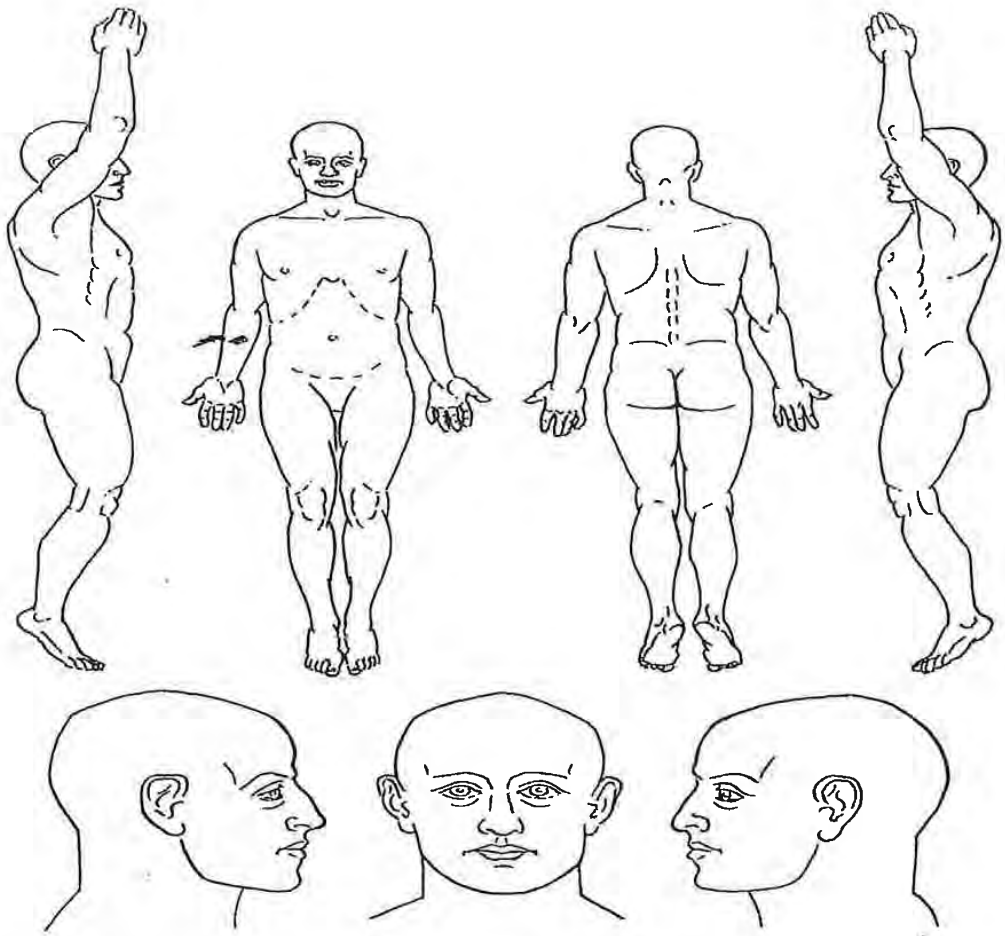
Body Chart

Ward: Ennis Patient: [redacted] PB Hospital Number: EA3561

Date: 8/11/12 Time: 10 35

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Small cut	right arm	Red

Print Name: [redacted] MSIS Signature: [redacted] MSIS Band: 3 Date: 8/11/12

Print Name: [redacted] MS16 Signature: [redacted] MS16 Band: 5 Date: 8/11/12

MAHI - ENNIS - 1 - 22

12.022

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

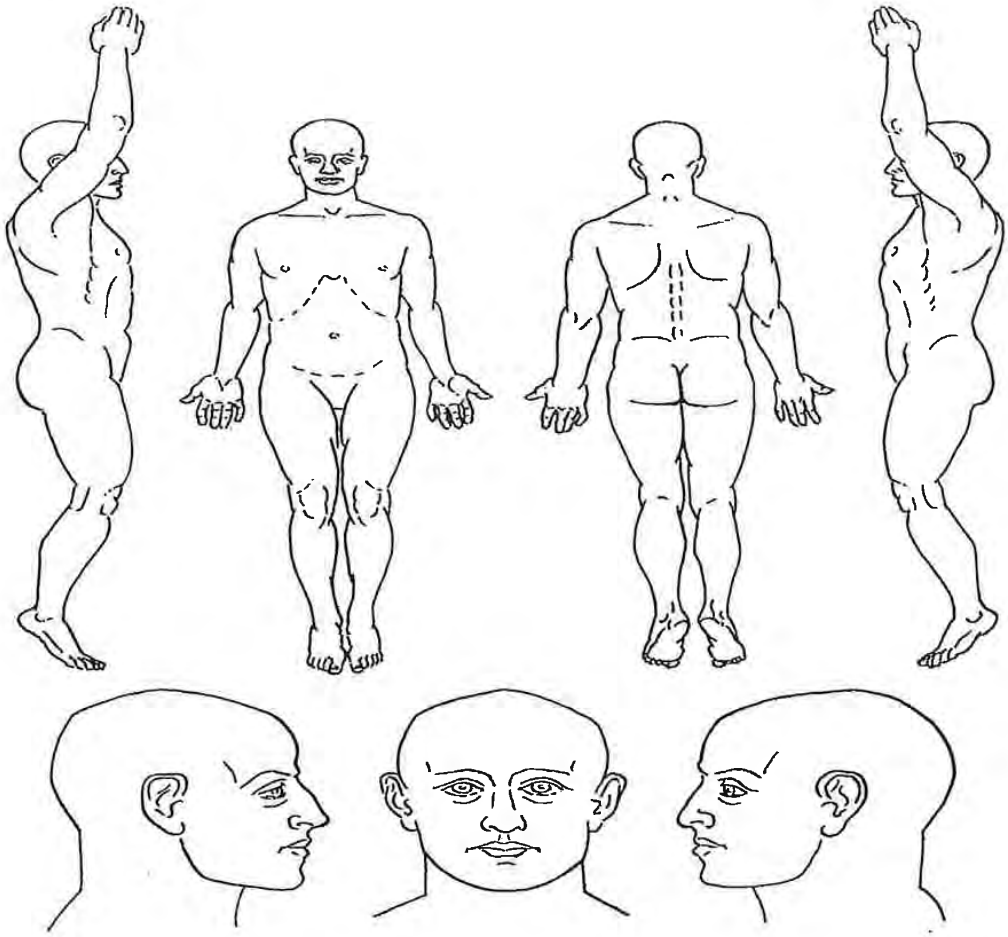
Body Chart

Ward: Ennis Patient: [redacted] P16 Hospital Number: EA999

Date: 8th Nov '12 Time: 22-55

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*

Print Name: [redacted] MS12 Signature: [redacted] MS12 Band: 6 Date: 8.11.12

Print Name: [redacted] MS15 Signature: [redacted] MS15 Band: 3 Date: 8/11/12

12 023

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

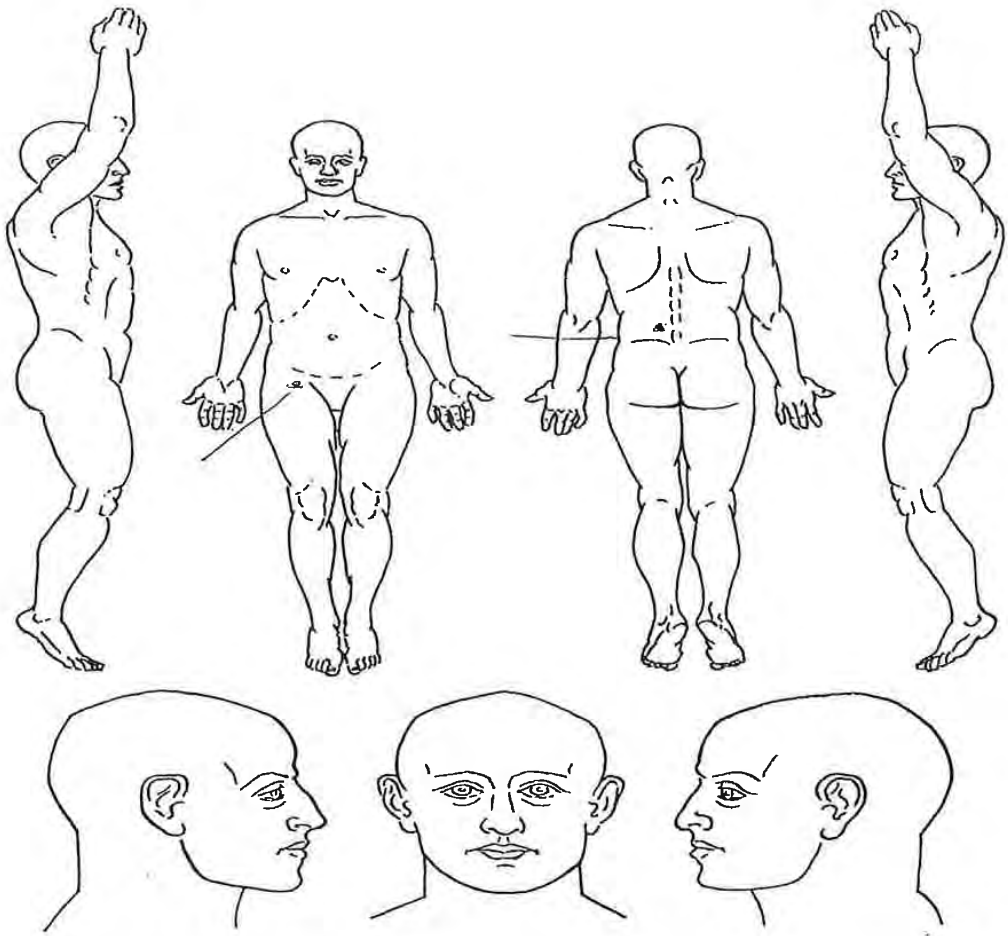
Body Chart

Ward: ENNIS Patient: [redacted] PC Hospital Number: EA 2980

Date: 8/11/12 Time: 10-10

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Two very small bruise		

Print Name: [redacted] MS16 Signature: [redacted] MS16 Band: 5 Date: 8/11/12

Print Name [redacted] MS15 Signature: [redacted] MS15 Band: 3 Date: 8/11/1

Reluctant to have body chart done, 12.024

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

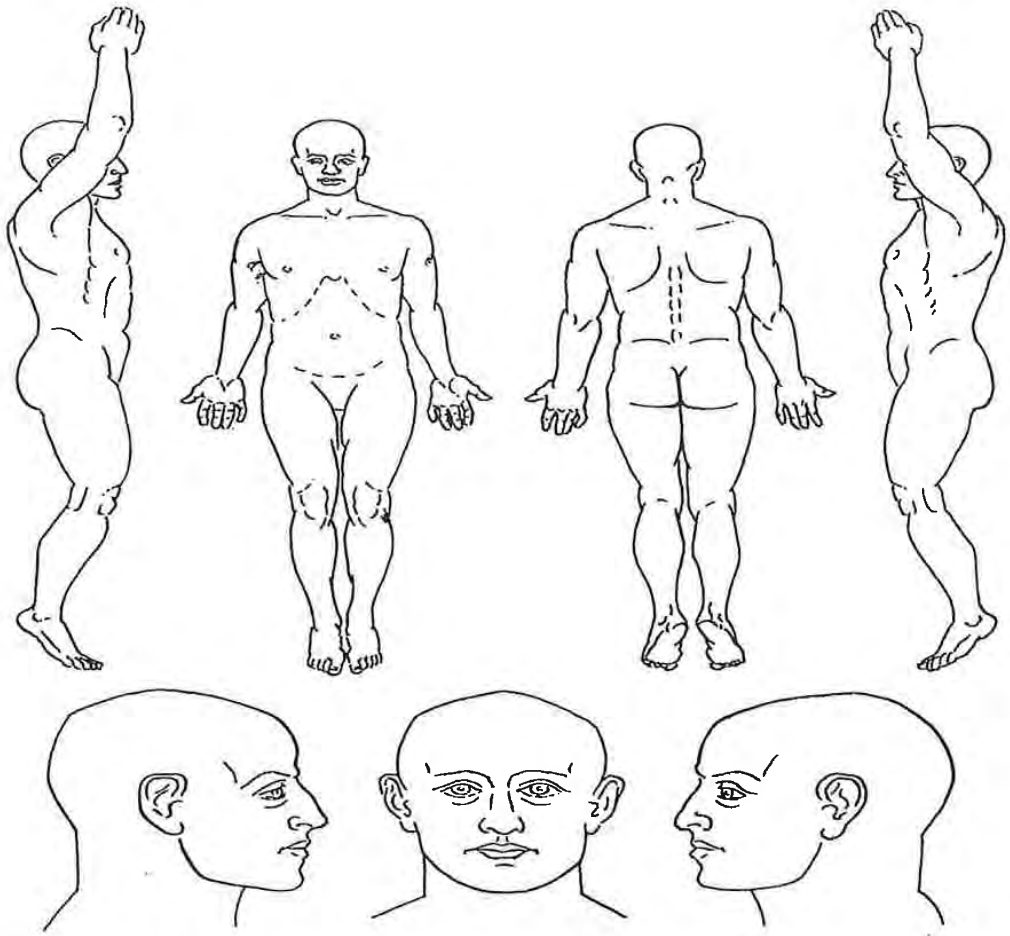
P9

Ward: ENNIS Patient: [redacted] Hospital Number: EA5066

Date: 8/11/12 Time: 10 11

REASON(S) FOR COMPLETION:

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Small bruise on arms old.		
Small bruise on left leg		

Print Name: [redacted] MS16 Signature: [redacted] MS16 Band: 5 Date: 8/11/12

Print Name: [redacted] MS15 Signature: [redacted] MS15 Band: 3 Date: 8/11/12

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

Body Chart

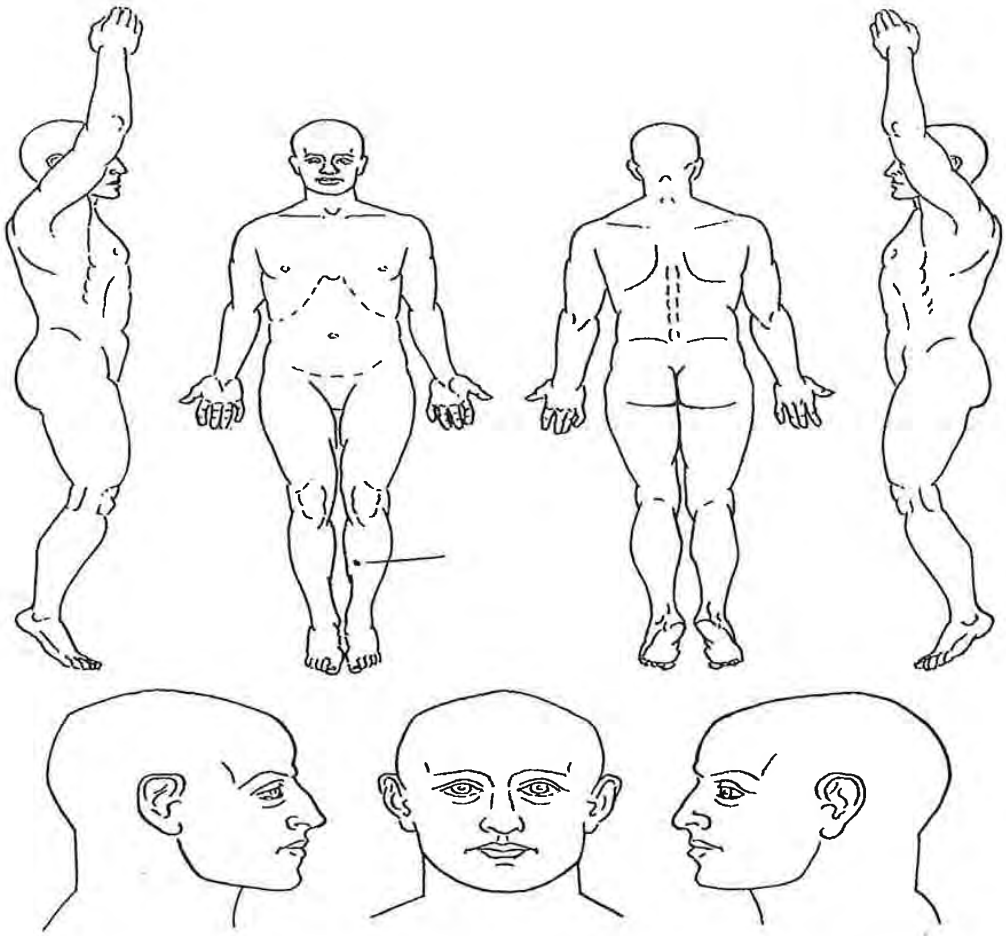
P17

Ward: ENNIS Patient: [redacted] Hospital Number: EA 208

Date: 8/11/17 Time: 10:00

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
Very small bruise a-		
left leg.		

MS16

Print Name: [redacted] Signature: [redacted] Band: 5 Date: 8/11/17

MS15

Print Name: [redacted] Signature: [redacted] Band: 3 Date: 8/11/17

Belfast Health and Social Care Trust

MUCKAMORE ABBEY HOSPITAL

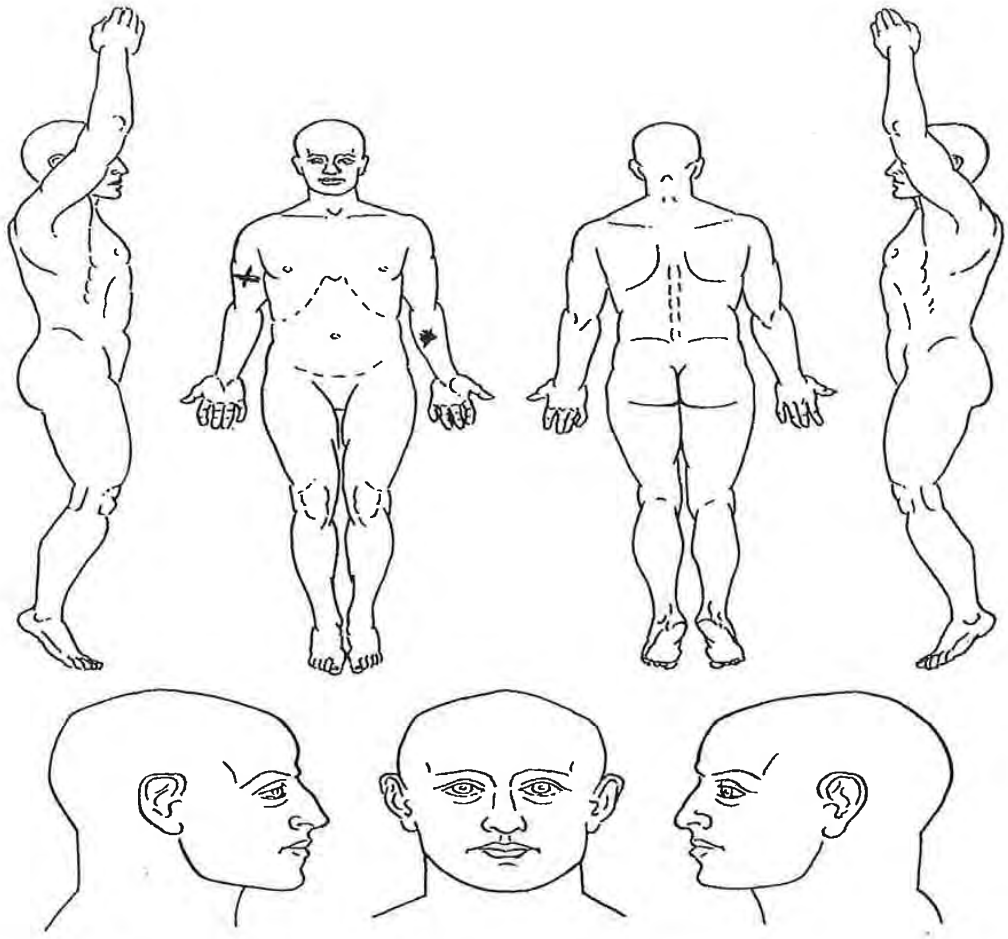
Body Chart

Ward: Ennis Patient: [redacted] PID Hospital Number: EA6839

Date: 6/11/12 Time: 10 30

REASON(S) FOR COMPLETION: _____

PLEASE MARK ON DIAGRAM AREAS AFFECTED



IDENTIFIED INJURY/BLEMISH	BODY PART AFFECTED	DETAIL
e.g Bruise	*Lower left leg*	*(1) Size (2x4 cm) (2) Yellow in colour*
bruise	right arm	black
bruise	left arm	black

Print Name: [redacted] MSIS Signature: [redacted] MSIS Band: 3 Date: 6/11/12

Print Name: [redacted] MS16 Signature: [redacted] MS16 Band: 5 Date: 6/11/12

VA

BELFAST HEALTH AND SOCIAL CARE TRUST

PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION

REVIEW OF CARE/PROTECTION PLAN

To be completed by the Designated Officer

NAME:	COMPUTER NO:	
1. P40 [redacted] 2. P41 [redacted] 3. P39 [redacted] 4. P22 [redacted]	1. EA 2117 2. NA 1720 3. EA 4065 4. SC 9390	
	DATE OF LAST REVIEW: FRIDAY 9TH NOVEMBER 2012	**DATE OF THIS REVIEW** THURSDAY 15TH NOVERMBER 2012

WHO HAS BEEN CONTACTED?

Vulnerable Adult	☐	**RQIA**	☐	**Psycho Geriatrician**			
☐ **Domiciliary Provider**	☐						
Carer	☐	**Doctor/Consultant**	☐	**District Nurse**	☐	**Care Manager**	☐
Relative	☐	**Psychologist**	☐	**Hospital Nurse**	☐	**Res. or Day Care**	☐
Police	☐	**Psychiatrist**	☐	**Community Psy. Nurse**	☐	**Rehab-Worker**	☐
Social Work Asst.	☐	**Other, please specify**	☐	_____			

IN ATTENDANCE

Ms Aine Morrison (Chair)
Ms Siobhan Rogan, RQIA
Ms Judith Agnew
Ms Margaret Cullen, RQIA
Ms Elaine McCormill, Sergeant, PPU, PSNI
Mrs Tracey Hawthorne, Constable, PPU, PSNI
Ms Edna McConville, SE Trust

APOLOGIES

REVIEW AND AMEND PREVIOUS ANALYSIS OF RISK.
COMMENTS:

Ms Morrison welcomed the group and introductions were made from those who did not attend the previous meeting. the group read the VA7 dated 09/11/12 and one amendment was requested on Mr Lings behalf:

Timeline of events to be included.

It was agreed that the investigation, planning and strategy should not include Muckamore Abbey staff. Ms Morrison to liaise with Trust staff.

ACTIONS UPDATE

Three named members of staff remain on precautionary suspension.

One named member of staff has been moved to another ward with no supervisory responsibilities.

Relatives have been notified and given contact details for both inside and outside of the hospital. As yet no concerns from relatives have been expressed.

As yet there has been no request for a press statement from BH&SC Trust.

Ms Morrison contacted the Managers of Bohill (B15 & B1) and explained the outcome of the strategy meeting. B1 conducted a further in-depth interview with the Bohill staff (B2 The staff (B2 continued to express her concerns about the abuse she witnessed and was quite distressed during the interview. She explained she was used as a member of staff with no induction, she had felt Muckamore staff did not want her there and had gave her no support. She gave further in-depth details of incidents which occurred on the evening she worked in Ennis. She also gave details to B1 on how the Nurse In Charge that evening stayed in the office and only emerged to shout abuse.

Two other members of Bohill staff expressed their concerns to B1 although they had felt they had been given an adequate induction to the ward. Three more Bohill staff have yet to be interviewed.

Ms Morrison and a Senior Social Worker visited Ennis Ward on 15th November 2012. They noted patients queuing outside the dining room at mealtimes.

RQAI made an unannounced visit on Tuesday 13th November 2012 and met with the Ward Manager. Staff allocation was scrutinised and clarification was requested. All agreed staffing levels were unacceptable.

REVIEW AND AMEND PROTECTION PLANS.
COMMENTS:

The protection plan remains in place with the following recommendations:

The matching of Incident/Accidents, care plans against body charts is ongoing. Ms Morrison to allocate someone to gather this information.

Reporting template recommended for staff to monitor vulnerable adult concerns.

Ms Morrison to allocate someone to analysis staffing allocations and responsibilities and to tie these in with Bohill staff.

Witness statements requested from Bohill staff as soon as possible.

Communication assessments on Patients. Mr Mills to arrange.

Patients from top end of Ennis Ward to be interviewed on staff. Ms Morrison to arrange.

It was agreed the Std Nurse previously suspended, be reinstated to work under supervision.

It was agreed the Nurse In Charge, H198 [redacted] be suspended.

It was agreed an independent person be appointed for monitoring and investigation.

RQAI recommends staffing levels in Ennis should rise to 7 (5+ 2 level/3obs).

Ms Morrison to discuss with Senior Hospital Management overall staffing of hospital and report findings to RQAI.

Clarification required on night duty role of Band 6.

Clarification to be addressed immediately on role of Band 7.

Date and time of next meeting:

Wednesday 28th November 2012 at 3pm in the Small Meeting Room, Muckamore Abbey Hospital.

ARE THERE ANY UNRESOLVED ISSUES? **YES** ☐ **NO** ☐
IF YES, SPECIFY HOW THESE MAY BE ADDRESSED.

INVESTIGATION OUTCOME

CONFIRMED ABUSE ☐ ALLEGATIONS ARE UNSUBSTANTIATED ☐ NO ABUSE ☐

Where allegations are confirmed place x in the box to note the main form of abuse. If there are other types of abuse please tick relevant box.

PHYSICAL ☐ FINANCIAL ☐ EMOTIONAL ☐ SEXUAL ☐ NEGLECT ☐
INSTITUTIONAL ABUSE ☐

WILL THIS CASE BE REVIEWED UNDER THE VULNERABLE ADULTS POLICY AND PROCEDURES?

☐ YES ☐ NO

VA8

IF YES,

WILL THE REVIEW BE VIA:

☐ SUPERVISION DATE: _____

☐ CASE CONFERENCE DATE: _____

WILL THE DESIGNATED AND INVESTIGATING OFFICER REMAIN THE SAME

☐ YES ☐ NO

IF NO, PLEASE SPECIFY, DESIGNATED OFFICER _____

INVESTIGATING OFFICER _____

IF NO,

☐ INVESTIGATING OFFICER WILL CONTINUE WITH A KEY WORKER ROLE

☐ TRANSFER TO OTHER KEY WORKER / SERVICE, PLEASE SPECIFY

_____

☐ CLOSE CASE

☐ OTHER, PLEASE SPECIFY _____

SIGNATURE OF DESIGNATED OFFICER	**DATE**

Minutes of strategy meeting in Muckamore Abbey following allegations of abuse on Ennis ward: 28.11.12
Third strategy meeting, in attendance 2 representatives of PSNI, one representative from NHSCT, one from SEHSCT, two inspectors RQIA, Safeguarding lead BHSCT and Aine Morrison, Chair.

- Amended minutes from the first strategy meeting were read and agreed.
- Minutes of previous meeting read and a number of points clarified and changes agreed. The minutes will now be anonymised.
- Press statement was forwarded out to all and is agreed.

Aine provided an update on the investigation and safeguarding since the last meeting on 15 November.

- There are allegations that ward staff stated "these girls are here to get rid of you" in relation to Bohill staff.
- Seven members of Bohill staff have been identified for interviews by Senior Social Workers. Set format of questions agreed. Six staff currently interviewed, one lives in Donegal and will be interviewed by telephone. Staff have been co-operative and well supported by management.
- Overall concerns have been heighted by findings thus far; of the six, four staff have made further allegations of potential criminal abuse as well as allegations of poor practice and degrading practice such as rough handling and pulling and pushing. Staff indicated that **P39** was the main recipient and most vulnerable patient. These practices were all referenced in relation to the five patients already identified. Bohill staff knew the names of the patients but did not know the names of staff involved. There are difficulties identifying the alleged staff. Work is on-going to determine staff from descriptions and rotas.
- There were repeated references from Bohill staff on the atmosphere of the ward: the same themes came through: no warmth, shouting, lack of interaction, lack of staff, lack of induction, ward under resourced.
- The PSNI are to set up interviews with the Bohill staff who have made further allegations but are not in a position to do this yet. They will be organised asap.
- Bohill staff did refer to isolated areas of good practice on the ward and indicated that the atmosphere and environment on other wards was very different.
- It was clarified that none of these issues were flagged up before. Bohill staff have been on wards for 6-8 weeks. It would seem that once one staff member has come forward it has encouraged others.
- The monitoring staff are from outside Ennis and rota has been set up for 4-6 weeks. Aine has confirmed that monitoring staff are supernumerary and provide reports of findings to her for each shift. (Guidance forwarded and in file) 24 hour monitoring is needed as staff continue to provide care on the ward who are potentially abuser who as yet have not been identified.
- The independent monitor is a senior nurse Maura Minion, from BHSCT. Her role will be to co-ordinate team of monitors, review care plans spend time on ward, announced and unannounced. A meeting is arranged or 29 November to agree processes. It was indicated that efforts had been made to get a more

independent monitor but as this individual is not linked to Muckamore hospital in any way the panel agree with this choice.

- Aine referred to the daily monitoring reports currently being sent to her. They indicate consistent concerns about the inadequate level of staffing, lack of privacy due to a patient stripping, lack of stimulation due to staffing levels. She referred to Ward Manager's emails highlighting this problem with two patients on level three observations. Privacy issue is being addressed, getting windows sandblasted as interim measure.
- The appropriate level of staffing needs was discussed at length. Telford review completed in Oct. 2012 and will be reviewed on a monthly basis. Esther has agreed a minimum of six staff, more if possible on day duty with two of them registered nurses. Night duty 6 staff till 11pm with 2 staff on nigh duty. There is a new deputy ward sister with effect from 8 November and an additional temporary ward sister who is not monitoring.
- The issue of staffing was discussed at length and the lack of clarity as to the outcome of the Telford assessment and what exactly was deemed the appropriate minimum requirement for the ward. RQIA representatives indicated that while RQIA had definitions for staffing levels for nursing homes they had no other measurement for statutory hospitals. They understood that while Telford was a tool for such an assessment considered that like any tool there was an element of discretion in its use as two senior nurses had come up with two different outcomes for the ward. They were concerned at findings from the inspection of 13 November and discussions confirmed and agreement for a compliment of six during the safeguarding process. A visit to the ward on the 15 November indicated the difficulties in maintaining this with the need to bring relief staff from other wards. This raised concerns across the site generally and the level of crisis in relation to staffing. It was agreed that Aine would check out the outcome of the Telford assessment in October 2012 to confirm what the senior nurse had felt was sufficient for the ward in view of current intelligence. All agreed that poor staffing correlated directly with poor care.
- In relation to the staffing crisis Aine stated that 30 Band 3 posts had been filled waiting for Access NI and 18 WTE registered posts advertised on 27 November. There has been a substantial improvement to the safeguarding team with a Senior SW coming for 3 months to do a lot of Designated Officer role and an additional SSW coming next month. There were 90 VA referrals this month. These additional staff will review all protection plans, initially in Ennis and then across the site.
- Aine referred to an MDT meeting with the RMO, SALT, SHO, Ward Manager, PSNI and herself to discuss the ability of the patients to give statements. They discussed the 5 patients involved and considered: could they make a statement of complaint, would it be of value to the investigation, could they tell about their treatment on the ward and give a patient experience statement. The outcome of the meeting indicated that one patient may have the capacity with help to tell of the patient experience but it may not be fit for criminal process, they will consult with her NOK on the matter. Another patient with help may also be able to provide some information on the patient experience. The others cannot provide any information, one of these being the patient identified as being targeted most.

- Of the 12 other patients 4 could not provide information of value to the investigation, 6 could give witness statements and indicate patient experience with a lot of caveats. One patient could not give witness but could indicate the patient experience. It was decided that the process of collating statements would commence with the two alleged victims in liaison with PSNI, SALT, NOK, ward staff and ABE interviewer as necessary.
- The option of attaining photos of staff to identify the newly alleged staff was considered. PSNI to check this option out. In the interim matching rotas with descriptions given will proceed. A lot of mapping is still required e.g VA referrals for last year, staff list for last year, any other wards the suspended staff may have been on duty. Mapping incident with body charts and VA1s.
- The process of analysis of training records has commenced.
- It was discussed if an advocate should be involved in the process to represent the patients. The PSNI indicated they would have concerns about the information shared. RQAI indicated that they were informed that while advocacy presence had increased it was focused mainly around resettlement and that many of the patients had family who wished to provide this role. They did not get a sense of a frequent presence on the ward and suggested that the need for a more proactive independent presence on these wards was strongly indicated by this process. It was agreed that there would be more information sought on who requires an advocate and make them aware of situation.
- The need to update the families of Ennis patients was discussed in relation to: further potential witnesses, PSNI still collating information, the investigation on going and reassurance about protection plan. The PSNI indicated they will need to contact the families of the victims , it was decided that Social services will make the initial contact and inform them that the PSNI will follow this up. They need to know how serious the matter is, the process for collating evidence.
- The PSNI indicated they will need to liaise with the PPU to clarify the offences identified, leaving a patient sitting out on the grass, is that ill treatment which can be prosecuted? They also need clarification if evidence can be used which requires therapeutic input.
- The PSNI stated they will hold off on interviewing alleged perpetrators until they have interviewed all the Bohill staff, they will hope to commence these interviews in two weeks.
- Next meeting scheduled for 20 December 2012 at 9.30 am

Ennis Ward Investigation Meeting
Held on 12th December 2012 in Muckamore Abbey Hospital

Present
Aine Morrison, Operations Manager, Belfast HSC Trust
Margaret Cullan, Regulation & Quality Improvement Authority
Siobhan Rogan, Regulation & Quality Improvement Authority
Elaine McCormill, Sergeant, PSNI, Public Protection Unit, Antrim
Tracey Hawthorne, Constable, PSNI, Public Protection Unit, Antrim
Lesley Jones, Northern HSC Trust Representative
Greer Wilson, South Eastern HSC Trust Representative
Yvonne McKnight, Adult Safeguarding Specialist, Belfast HSC Trust

Introduction
Aine advised that the meeting was a further strategy discussion being held under the Joint Protocol for Investigation 2009 arrangements. She noted that there had been two previous strategy meetings and that the purpose of this meeting was to review the protection arrangements, provide an update on the investigation and discuss and agree further actions.

Aine circulated a number of papers. These were;
i. Minutes of the two previous meetings which had been redacted.
ii. Copy of the guidance to monitoring staff and ward staff on the role of the monitors.
iii. A copy of the investigation actions.

Previous Minutes
Aine confirmed that the requested amendments to the first set of minutes have been made.

Aine asked if everyone was in agreement with the minutes for the second strategy meeting. RQIA asked for clarification on a number of points.

It was agreed that these amendments would be circulated.

Reinstatement of staff member NS2
The rationale for reinstating [redacted] the student and bank staff member was clarified.

Aine advised that this was because; following the police interview with B2 [redacted] B2 it was clear that there was no specific allegations against her. Yvonne McKnight asked if anyone present at the meeting had any concerns about her reinstatement. No concerns were raised.

Media Press
Aine advised that to date there has been no media attention. She noted that a revised media statement had been circulated. All present confirmed that they were in agreement with the content of this.

Investigation Updates

i. *Forensic Medical Examinations*
No report of these has been received as yet. Elaine and Tracey are to request these.

ii. *Bruise Charts*
Aine is awaiting confirmation from hospital medical staff that none of the bruise charts for patients other than the four who had forensic medicals showed any evidence of non-accidental injury.

iv. *Interviews with Bohill Staff by Social Services*
It was agreed at the previous meeting that the Trust would interview seven Bohill members of staff. Two others who had already come forward with concerns of a potentially criminal nature would be interviewed by the police. Aine reported that six of the seven planned interviews had taken place. The seventh interview is planned. Of the six interviewed, three had come forward with reports of further potentially criminal acts. These have been passed on to the PSNI. Some of them involve members of staff who are currently suspended, others involved unidentified staff. In addition to these concerns, the interviews showed repeated and fairly consistent concerns about:

a. Perceived low levels of staffing and pressure on staff.
b. A poor quality atmosphere on the ward, lack of warmth, lack of interaction with patients, patients not being treated with dignity and respect.
c. Lack of induction for Bohill staff. B3

Yvonne asked if Bohill staff had raised any of their concerns prior to B2 B2 coming forward. Aine stated that they had not.

v. *Police Interviews with Bohill Staff*
The police reported that no interviews with Bohill staff have taken place as yet but that they hope to organise these shortly.

Elaine noted that she intended to contact the Public Prosecution Service to have an early discussion about potential offences. At the moment the offences under consideration are common assault and ill treatment of patients with a mental disorder.

Update on Monitoring Arrangements

i. Aine noted that a Co-director of Nursing; Education and Learning had been identified to lead and co-ordinate monitoring arrangements. She had been unable to attend this meeting but would endeavour to attend future meetings. Aine and Yvonne are to meet with her tomorrow to ensure she is fully briefed and to agree her role and responsibilities. It is anticipated that she will spend both announced and unannounced time on the ward as well as supervise and support the monitors.

ii. Aine noted that at the last meeting RQIA has raised a concern that the monitoring staff were not present on the ward 24 hours a day and were not supernumerary. Aine had said that she believed this was the case. However Aine now reported that it had not been the case. This situation has now been rectified and Aine said that she had now been assured that monitoring staff were in place 24 hours a day and that they were supernumerary.

iii. Aine said that she had been receiving the monitoring reports. While considerable good practice was reported, there had also been concerns raised about low level staffing, lack of stimulation for patients and lack of privacy for the patients. Aine noted that the privacy concerns were being addressed by sandblasting the windows on the ward.

Staffing

There was considerable discussion about levels of staffing on the ward. Aine said that she had been advised by Esther Rafferty that there was currently a staffing complement of six on the ward with the number of registered nurses being increased to two on any shift. The six included the two one-to-one staff allocated to specific patients. The meeting noted the continuing concern about staffing levels noted by the monitors. It was unclear if the six staff were in place when these concerns were raised. Aine agreed to check this. RQIA raised a concern that one of the staff allocated to level 3 observations was considered to be part of the routine staff complement. They felt this contradicted the hospital's policy for level 3 observations which says that the member of staff allocated should not have any other duties. There was discussion about whether or not Barry Mills, Senior Nurse Manager had recommended a staff complement of seven following a Telford assessment.

Aine informed the meeting that Esther Rafferty had informed her that Barry had recommended a staff complement of between six and seven. Aine agreed to seek further clarification on the issues raised and inform everyone of the outcome.

Yvonne clarified with RQIA that there were no specific staffing requirements for the ward.

Interviews with Patients

Aine reported that a meeting had been set up to consider the capacity of patients to give evidence about anything that might have occurred. The meeting included the police, medical and nursing staff, speech and language therapy and an ABE trained social worker. The meeting concluded that of the five named potential victims, two might be able to provide some information.

Further consideration will be given to how this might be facilitated for these two patients. Lesley Jones will take this forward for the Northern Trust client and Belfast Trust for their client. It was noted that in the absence of patient capacity to consent to give evidence, best interests principles would be applied with next of kin being consulted. The PSNI undertook to investigate how evidence from those who would not have capacity to consent to making a statement of complaint could be used. Of the 12 other patients, it was agreed that seven of them could give witness statements if required.

Independent Advocates

The meeting discussed whether or not involving independent advocates with the patients or with the investigation would be useful. Concern was expressed about involving further people as patients are already upset by the amount of extra people who have become involved recently. There was also concern expressed, particularly by the police, about involving a non statutory service in the investigation planning. It

was also noted that many of the patients on the ward had family members who were actively involved. It was agreed that referrals for advocacy should be made for those who had limited family contact. These advocates will be given the same information as is being given to relatives.

Information for Relatives
It was agreed that relatives should be given an update on the investigation. After discussion it was agreed that this should take place by telephone by community staff and followed up by letter. Elaine advised that the PSNI would wish to contact the families of the named potential victims. Aine agreed that the Trust would ask these families if their contact details could be passed to the police.

Pre trial Therapy
It was agreed that the consultant for the ward should be briefed in relation to section 8 of the Achieving Best Evidence in Criminal Proceedings 2012. The role of intermediaries was also referenced but it was noted that this service was not operational yet.

Contact Details
It was agreed that the crimestoppers number and contact details for Aine should be displayed on the ward.

Collation and Analysis of Information
Aine noted that she had received the following information from the hospital;

- List of all staffwho had worked on the ward in the last year
- Vulnerable adult referrals for the last year
- Incidents/accidents for the last year
- Any disciplinary records for ward staff
- Any complaints received about the ward
- Photos of staff could potentially be made available if needed for identification purposes.

Analysis of this information will start.

The protection plan of 24 hour monitoring and the precautionary suspension of three members of staff was agreed as appropriate and still necessary.

A further meeting was arranged for Thursday 20th December 2012 at 9.30am in Muckamore Abbey Hospital

Aine Morrison
Operations Manager

Dated 15/11/12

REVIEW AND AMEND PREVIOUS ANALYSIS OF RISK.

COMMENTS:

Ms Morrison noted that this was a second vulnerable adult strategy meeting being held under Joint Protocol procedures to further plan the investigation into Ennis Ward staff.

RQIA requested a number of changes to the minutes of the first strategy meeting which will be circulated

Ms Morrison said that, in light of the ongoing concerns about general care practice on the ward, the Belfast Trust felt that the hospital team should no longer be involved in investigation planning. Hospital staff will continue to cooperate with other aspects of the investigation such as information gathering as requested. It was felt that this approach facilitated a more independent investigation. All present agreed with this strategy. It was agreed that Ms Morrison would be the main link to hospital staff.

ACTIONS UPDATE

Three named members of staff remain on precautionary suspension

One named member of staff has been moved to another ward where she does not have supervisory responsibilities.

Relatives have been notified and given contact details to use if they wish to discuss any concerns. As yet no relatives have come forward with any concerns.

A press statement was agreed and circulated. So far, no agency has been contacted by the media. Ms Morrison noted that RQIA had asked for some amendments to this press statement These were agreed and a revised statement will be circulated to all parties by Ms Morrison.

Ms Morrison contacted B1, Manager at Bohill and agreed that Trust staff would interview staff who had worked in Ennis to see if they had any concerns.

MS5 When B1 spoke to her staff to arrange these interviews, there were two further reports of concern. It was alleged that a bank staff, [redacted], grabbed [redacted] P1 that [redacted] P1 was thrown on the sofa and told to "get out of my f'ing face." It was also alleged by Bohill staff that it had been said to patients generally, "These girls are up here to get rid of you" The member of staff who made these allegations said that another Bohill member of staff will have witnessed these incidents. It was also alleged that [redacted] P2 was sitting outside on wet grass and that when Bohill staff asked if they could bring her in or get something for her to sit on, they were told by H159 [redacted] that they couldn't. The police are to carry out interviews with the Bohill members of staff involved.

Social work interviews with other Bohill staff had been conducted the morning of the meeting, 15.11.12. Ms Morrison had received a telephone update just prior to the meeting starting. Some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring culture in the ward. There were quite a few reports of patients being shouted at. Concerns about lack of induction for Bohill staff and lack of supervision for patients also emerged. Some staff did note positive practice by some Ennis staff. Interviews with a further 4 members of staff are to be carried out. Ms Morrison will examine the written records of these interviews and discuss them with the police to determine who might need to be interviewed by them.

H197

H159

The PSNI had interviewed [redacted], the care assistant who made the original allegations. The PSNI summarised her statement for the meeting. She confirmed allegations of physical assault against patients by two members of staff, [redacted] and [redacted]. She also confirmed that [redacted] had made an allegation that [redacted] had hit her. [redacted] also made an allegation that the nurse in charge of the shift, [redacted], had come out of the office in response to increased noise levels and shouted into the dayroom "I'm fed up with the lot of you – you're doing my head in." The meeting agreed that this added considerably to the earlier concerns about [redacted] practice. These had involved her management of the ward and potential failure to ensure appropriate supervision and care of patients. The police said that the information to date did not indicate any crime committed by her. However Trust staff and RQIA agreed that there were sufficient concerns about her care practice to recommend a precautionary suspension to hospital management.

The police noted that [redacted] did not make any specific allegations against [redacted], student nurse and bank member of staff, saying that no one else from Ennis had witnessed the alleged assaults she had. She may have been in the vicinity of the bathroom when [redacted] ran from it saying she had been hit but this is not known. [redacted] is alleged to have told [redacted] that she wouldn't get her sweets and lemonade if she didn't put her nightdress on. However it was agreed that more would need to be known about the context and background of this remark before making a judgement on it. It was agreed that this remark did not warrant suspension and as there were no other specific concerns about her, that she should be reinstated. It was agreed though that she should be transferred to another ward and work under supervision until the investigation had progressed further.

Ms Morrison noted that she had visited the ward on 13th November 2012 accompanied by H92 MAH SSW and had been shown around by the ward manager, [redacted]. Ms Morrison noted that she had been concerned about a number of things she had observed during her visit. She felt that the ward manager had spoken inappropriately about patients' care and support needs in front of them. She was also concerned about an almost total lack of interaction with any of the patients on the bottom half of the ward as she was shown around. At one stage a patient sitting behind the door was ignored with the ward manager pausing to talk to Ms Morrison and H92 directly in front of her. When Ms Morrison asked to see the bedroom corridor at the bottom end of the ward, two patients followed along. When Ms Morrison acknowledged them, the ward manager ushered them behind the corridor door, locking it in their faces. She said that this was to prevent one of the patients becoming involved in her bedtime routine. Ms Morrison did not remember the exact words used but it had been something like, get back behind the door. Ms Morrison did not see if there had been any physical intervention used but had felt uncomfortable with the lack of verbal interaction with the patients while doing this or any attempt to achieve the end result in another way. Ms Morrison did note that this had been a very brief visit and that she did not have any knowledge of the patients' needs. She also acknowledged that the ward manager might have been nervous about showing her around. She also noted that H92 had not noticed anything of concern.

Margaret Cullen noted that she had met with the ward manager yesterday and that during that visit; the ward manager had appropriately waited until they were in a private space to speak of the patients.

The RQIA had carried out an unannounced inspection on the ward on 14th November. They had noted good practice in recording and care plans. However, they were concerned about the level of staffing on the ward. It was reported to RQIA by Senior Nurse Manager, Barry Mills that in accordance with Trust policy, he felt that there should be five staff on shift in Ennis, with an additional two staff for the two patients on Level 3 Observations, bringing the total to seven. RQIA have raised this concern with the service manager for the hospital, Esther Rafferty. RQIA acknowledged that the hospital was currently experiencing severe staff shortages and were conscious of the difficulties a requirement for seven staff in Ennis might cause elsewhere. It was agreed that Ms Morrison would discuss the staffing possibilities for Ennis with Esther and then discuss further with the RQIA.

Margaret Cullen and Siobhan Rogan sought clarity about the additional staffing agreed as part of the protection plan asking if these were being provided on a 24 hr basis. They also asked for an assurance that these staff were supernumerary to the ward staff. Ms Morrison said that it was her understanding that the additional staffing was there on a 24 hour basis and that they were supernumerary. She agreed to check if this was actually the case and, if not ,ask for this to be implemented. It was agreed that these monitoring staff need to be clear about their role and have guidance about reporting arrangements. This was one of the recommendations made by the Ralph's Close review. Ms Morrison agreed to draw up this guidance.

Ms Morrison said that given the concern that the alleged incidents might reflect a wider problem with practice on the ward, she thought that it would be useful to have someone with more independence from the hospital providing the monitoring role. She noted that an outside perspective is often useful in picking up things that those more used to a situation can become accustomed to. A more independent person would be in a position to offer both protection and provide information for the investigation. All present agreed that a more independent person would be valuable. It was noted that this was also a recommendation in the Ralph's Close review. It was agreed that the person or persons would need to have considerable experience in learning disability to be able to carry out the task appropriately. Ms Morrison agreed to speak to senior Trust management about progressing this issue.

The investigative actions agreed at the previous strategy meeting have been started but require a lot more work. These include;

1. The collation of incident/accident reports and mapping these against the body charts.
2. Charting Ennis staff shifts against Bohill staff shifts.
3. Vulnerable adult referrals from the ward to be analysed and reviewed for any concerns.
4. Communication assessments for all patients on the ward to be carried out.

H197 [redacted]

H159 [redacted]

The current protection plan was confirmed as follows;

1. [redacted] and [redacted] to remain on precautionary suspension.
2. Recommendation to hospital management that [redacted] should be suspended

MS4

3. Band 6 or Band 7 supernumerary staff to be present on the ward at all times in a monitoring capacity.
4. Senior nurse managers to continue with unannounced visits to the ward again in a monitoring capacity.

Aine Morrison;
Operations Manager

12.006

Ennis Ward Investigation Meeting
Held on 20th December 2012 at 9.30am in Cranfield, Muckamore Abbey Hospital

Present
Aine Morrison, Operations Manager, Belfast HSC Trust Chair
Margaret Cullen, Regulation & Quality Improvement Authority
Elaine Mc Cormill, Sergeant, PSNI, Public Protection Unit, Antrim
Tracey Hawthorne, Constable, PSNI, Public Protection Unit, Antrim
Lesley Jones, Northern HSC Trust Representative
Yvonne McKnight, Adult Safeguarding Specialist, Belfast HSC Trust
Moira Mannion, Co-Director of Nursing: Education & Learning, Belfast HSC Trust
Geraldine Murray, Human Resources, Belfast HSC Trust
Esther Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast HSC Trust

Apologies
Siobhan Rogan, Regulation & Quality Improvement Authority
Greer Wilson, South Eastern HSC Trust Representative

Introduction
Aine welcomed all to the meeting.

Aine circulated copies of:
- amended minutes of the meeting held on 15th November 2012
- the minutes of the meeting held on 12th December 2012
- a summary of the allegations that have been made to date
- positive comments Bohill staff had made about Muckamore staff

Previous Minutes
Moira Mannion requested a copy of minutes of 9th November 2012 to be forwarded to her as she was not involved in this process at that stage.

As the minutes of 12th December 2012 were only circulated just prior to the meeting, it was agreed that they would in remain in draft form until everyone had a chance to read them fully.

It was noted in the previous minutes of 12th December 2012 under the heading 'Introduction'; that Aine had circulated copies of anonymised minutes of the two previous meetings by taking out staff and client names and replacing them with initials and had requested previous copies be destroyed. Geraldine Murray and Moira Mannion expressed some concern about the destruction of minutes..Aine explained that the Co-director for Social Work and Social Care Governance for Belfast Trust had requested that this be done saying that he would prefer that names of clients and staff were not circulated outside the Trust. Aine explained she had retained a copy of the original minutes with the full names and that the only changes were that full names had been replaced with initials. It was agreed that the wording would be changed to say that the minutes had been redacted.

Moira Mannion commented that page 2 of the minutes, Update on Monitoring Arrangements, Point 1 said that Aine and Yvonne were to meet with her to ensure she was fully briefed and to agree her role and responsibilities. She wished to point out that she had been jointly commissioned by the Director of Primary and Social Care and the Director of Nursing to carry out her role. Aine stated that she had been asked by the Director of Primary and Social Care to meet with Moira to agree her role.

Aine asked for any further amendments or wording issues on the previous minutes be forwarded to her by email.

Investigation Updates

Staff Interviews

Aine noted that the social services interviews with Bohill staff had now been completed. Three further staff had reported concerns that were potentially criminal in nature and these have been referred to police. Moira said that she had been provided with copies of these by Aine and felt that the introduction had provided too much information to Bohill staff and could be considered leading and could compromise the investigation.

Aine explained the process used within the Trust for vulnerable adult investigations. This includes exploratory interviews designed to see if staff had any further concerns to report as agreed with the PSNI. The questions were based on the issues of concern that had already been reported. Experience has shown that staff need to be told why they were being interviewed, often need to be asked direct questions and that more generalised requests for information often do not result in information being offered.

The police confirmed that they would conduct their own interviews with anyone who has made allegations of a criminal nature and would be following their own procedures in relation to this. They further confirmed that the investigation had been compromised in any way. Moira expressed herself reassured by this.

Moira said that it was important that all procedures were followed correctly as these were very serious allegations and professional reputations were at stake.

Geraldine Murray and Moira also said that if disciplinary or NMC action was to be necessary, then it was important that procedures were sound to ensure the success of any action.

Aine confirmed that all procedures were being adhered to in line with vulnerable adult policy.

Summary of Allegations
Aine asked those present to refer to the summary of allegations document she had circulated and noted which allegations had been referred to the police for investigation. These were highlighted with an asterix.

Esther noted that some of the allegations could refer to acts which could be interpreted as abusive whereas they could actually be agreed and accepted physical intervention techniques. Aine agreed that this possibility needed to be borne in mind and said that it had already been agreed that the use of physical interventions on the ward would need to form part of the investigation

Aine stressed the summary of allegations list was just that and that no judgements had been reached on any of the allegations to date. She said that the document listed the allegations as first received by the Trust and that the intention of listing them was to clarify the remit of the investigation.

Outstanding Actions

Independent Advocates
Aine noted that at the last meeting, it had been discussed whether or not independent advocacy would provide any additional safeguards for the patients in the investigation. It was felt that the patients were generally unsettled at present because of new and extra faces on the ward at present and that further new faces would not be helpful. It was also noted that many of the patients have active family involvement and that family members act as advocates. It was agreed that Aine would speak to the hospital team about which patients lacked active family involvement and might benefit from an advocate. Aine has still to do this.

Esther asked about speech and language therapists acting as advocates for patients. Aine said that while the speech and language role was vital in ensuring that the client voice was heard and that she believed that speech and language could be a useful support for an advocate, she did not feel that a speech and language therapist as an employee of the Trust could act as independent advocate.

Moira Mannion said that she objected to Aine impugning the professionalism of speech and language therapists by saying they could not be independent. Aine said that she did not believe that her words implied this in any way. Aine stated that the discussion about advocacy had been about whether or not patients needed an independent voice in the investigation and as the Trust was responsible for the investigation, she did not believe that a member of Trust staff could also act as independent advocate.

Aine noted that all staff have an advocacy role. She also noted that by separating those responsible for investigation planning from the staff involved in patient care, the Trust felt that it had introduced some independence into the investigatory process.

Section 8 - ABE

Aine noted she has still to speak to Dr Colin Milliken regarding this. Yvonne will forward her the relevant document.

Contact with Relatives
Aine noted that at the previous meeting, it had been agreed to update relatives by phoning them and then following up by letter. A letter had been agreed by all three Trusts involved.

To date, telephone contact has been made with nine relatives all of whom have spoken positively about the ward. The remaining telephone calls have not been made as yet and letters have not been sent as John Veitch, Co director, Learning Disability Services, Belfast Trust has expressed some concern that the most recent redraft may heighten the anxiety of relatives and could also lead to adverse media attention.
Aine is awaiting feedback on a redraft of the letter and agreed to share any agreed redraft with the Northern and South Eastern Trusts.

Contact has not been made as yet with all of the families of patients about whom there have been criminal allegations. When contact is made, the Trust will ask for permission to share their contact details with the police so that they can also contact them to update them on progress with the investigation.

P2

The brother of [redacted] said that his sister had repeated the allegation she made about Staff 1 hitting her. He said that he believed her and wished to make his own statement of complaint.

Moira noted that this patient had made an allegation that she had hit her. This was not the case as Moira was at no time alone with her. Moira felt it was important to note that [redacted] could make false allegations.

P2

MS4

Aine said that a new allegation had come to light during the telephone calls. A brother of [redacted] said that his sister had told him that [redacted] had grabbed her by the scruff of the neck and took her to her bedroom. [redacted] is currently suspended because of other allegations. He added he did not believe his sister told lies. Aine has been trying to contact her brother to clarify when this allegation was made but without success to date.

P6

MS4

Esther Rafferty confirmed that contact details for Aine and Police crimestoppers number had been sent by email to be posted up in the ward. Esther also noted all staff have been asked to report any concerns or allegations.

Elaine McCormill will get Crimestoppers leaflets to be placed on the ward.

Updates on Investigatory Actions

Analysis of Records
The previous minutes noted Aine had received any disciplinary records for ward staff. Geraldine Murray queried this as only records of staff who were under current sanction should have been able to be accessed. She explained disciplinary actions that have expired could not be accessed. Both Aine and Yvonne McKnight felt that it could be important in an investigation to access previous disciplinary information, not for the purposes of revisiting the disciplinary action but to see if there were any relevant factors that would contribute to a current investigation such as evidence of trends.
Yvonne agreed to take this forward as a general issue in discussions with HR.

In this case, Aine noted that she had been provided with information about one disciplinary issue. It was clarified that this issue had the status of a disciplinary investigation. This investigation is now concluded with the staff member no longer working for the Trust as they resigned. However it was noted had the staff member not left the service, the Trust would be seeking to pursue disciplinary action and has subsequently made a referral to the Independent Safeguarding Authority about concerns.

Aine expressed the view that a recent investigation into an allegation of assault by a staff member on a patient was potentially relevant to this investigation in case it provided any information on trends.

Aine said that she believed it had been daycare staff and not ward staff who reported the incident and asked Esther to clarify the circumstances.

Aine had reviewed the vulnerable adult referrals made from the ward for the last year and all appeared appropriate. Aine would like to further analyse the responses made to determine if they were appropriate and will follow this up with H92, Designated Officer for the hospital. Aine also intends to further analyse the reported incidents to see if any of them can be linked to incidents reported by Bohill staff.

Staff Rotas
Duty rotas have been collated to ascertain what Muckamore staff were on duty with each Bohill staff. As many Bohill staff were on duty for many different shifts, they worked with a wide range of Muckamore staff so it has not been further eliminate from or include in the investigation other MAH staff.

Pre-Interview Assessments (PIA)
It was agreed at the last meeting that there would be a further discussion about how to best engage [redacted] in a pre –interview assessment. This discussion was to involve the police, an ABE trained social worker, hospital staff and a speech and language therapist. The meeting is currently being arranged. Aine said she had spoken to [redacted] brother who was supportive of [redacted] being interviewed. Tracey Hawthorne said that evidence obtained from [redacted] even in the absence of her capacity to make a complaint could be used as evidence in the investigation.

At the last meeting also, it had been agreed that there would be a further assessment of whether or not [redacted] would be able to be spoken to about her experience on the ward. Lesley reported that this assessment had occurred with the conclusion being that [redacted] did not have the capacity to do be interviewed in any way.

Elaine McCormill, PPU confirmed that a PPS Prosecutor has been identified o liaise with the police about the progress of the investigation.

New Allegations

It was noted that [redacted] was likely to have the capacity to be interviewed about the allegation that she was grabbed by the scruff of her neck. It was agreed that once the timescale of this allegation is clarified, Aine will arrange for a PIA as appropriate. Moira Mannion noted that [redacted] gets agitated over Christmas and asked staff to have due regard of [redacted] needs.

An allegation was made by a Bohill staff member that when [redacted] didn't get up for tea as she said she had a sore head., an unidentified staff member said if your head is sore, you wont want your dinner and scraped it into the bin. The patient is alleged to have asked for a tablet for her headache and the staff member said she wasn't allowed one as she hadn't eaten her dinner. This staff member was described as having short, dark spikey hair and in her 40s.It was noted that [redacted] would probably be able to be interviewed in relation to this allegation. The police stated that this allegation was not criminal in nature and it was therefore agreed that social services would undertake this interview. Aine is to arrange this.

Report on Police Interviews

The PPU carried out their interviews with Bohill staff on Monday. They summarised the allegations that had been made but stressed that this was an overview and that the exact detail was contained in the police statements.

B3 (Bohill staff) gave an account of possibly criminal acts by Staff 3 and Staff 1. She also noted a very different experience working on Ennis ward as opposed to Rathmullan and Erne wards where she spoke highly of staff. Elaine McCormill noted this as a significant point that the allegations were not about care throughout the hospital but only on Ennis Ward. Aine noted that this was positive. However, it also potentially further heightened the concern about Ennis as there were clear differences being reported between it and other wards.

B3 also noted the lack of induction she received on Ennis ward.

B3 worked on Ennis on 8/10/12 where nothing untoward was noted. However on 9/10/12 when B3 also worked on Ennis she noted a marked difference in Patient A . B3 attributed this to a change in staff which made Patient A more agitated.

MS1- **H159**

B3 and **B4** (both Bohill staff) recalled that in the living room were [redacted] (MAH staff), and [redacted]. When Patient A kept taking her clothes off , staff told her 'you're doing my ******* head in'. N (Bank MAH staff) pulled [redacted] by her clothes at the chest. [redacted] then lay on the floor and tried to take her trousers off. Staff then pulled a belt tight around [redacted] and frog marched her to the fire exit and threw her out in the rain. **B3** (Bohill staff) let [redacted] back in from the fire exit.

Another incident was noted when [redacted] who likes to sit on the grass was seen sitting on the grass in the rain and her clothes were soaked. When Bohill staff queried this with MAH staff, they said we will change her if she gets any wetter.

B5 [redacted] was also interviewed. She noted [redacted] taking her trousers off and MAH staff tightening a belt around her. She also mentioned MAH staff removing [redacted] shoes and throwing them away saying it distracted her. She also said [redacted] was sitting on the arm of the chair and an older MAH staff kept pushing her away. The older MAH staff held [redacted] by the hips while a younger MAH staff tightened a belt around her. [redacted] was making crying noises. There is no confirmed identification of the MAH staff involved in this incident; the older staff is described as **description of H205** and may be called **H205** The younger staff member is described as changing her hair colouring regularly.

The PPU confirmed that this allegation is subject to further criminal investigation.

B5 [redacted] however did note that some staff were good with [redacted].

B5 didn't report sooner as she thought this was how the behaviour of patients was managed. **B5** is young and inexperienced, she has only worked in the care sector for three months. **B5** did say however the actions of the staff made her very uncomfortable.

Bohill staff all described Ennis Ward as bleak; with no stimulation and no interaction from staff.

B6 [redacted] was also interviewed. She had nothing specific to report. **B6** was given an induction to the ward. **B6** noted at break times the dining room was a hub of activity. Staff brought three patients in at a time and fed them quickly, patients were then brought out without their mouths wiped. Staff would push past patients without saying 'excuse me'.

B6 noted that staff said they changed patients for bed at 7pm. **B6** went for her break at 6.30pm and when she returned all patients were changed. She suggests that personal care could not have been carried out for all patients in that space of time.

On 5th November 12 it was noted a MAH staff described as a 'night nurse' pushed a patient into a chair.

B8 (Bohill staff) Senior Staff, has worked for many years within learning disability. She worked six shifts on Erne ward where there were no issues. B8 had induction for Ennis ward and was told of care plans but no information on individual clients. B8 noted issues in the dining room with pushing and clients being left alone. B8 didn't name staff, this was more a general comment. However she did note derogatory comments about [redacted]. B8 described Ennis as not a nice place.

MS1 H159 P1 MS3- H197

It was noted that [redacted] and [redacted] are currently suspended. In relation to the three staff who have been described but not named, it was agreed that the allegations were not clear enough to warrant suspension. It was felt that they needed further enquiry to establish context and possible explanations. Moira expressed a view that further action was not needed in relation to the member of staff who is described as having held [redacted] as she had "only held her". Aine disagreed with this, saying that she would view this with equal seriousness. The police confirmed that they did not intend to investigate these as criminal allegations. It was agreed therefore, that if staff were identified, social services would proceed to interview them in relation to the allegations.

P1

Immediate action

Esther will investigate who the staff are that have been described:

MS7

i) older staff member in description of H205 maybe called H205
ii) younger staff member, Care Assistant, who changes her hair colour regularly.
iii) staff on duty on night of 5.11.12, described as night nurse, with reddish brown spikey hair of stout build.

Aine asked Esther to check if the use of a belt was approved in a care plan or a physical intervention plan for [redacted] as a means of addressing her stripping behaviour.

P1

MS1- H159 MS3- H197

The next step for the PPU will be to interview [redacted] and [redacted] the outcome of these interviews will then guide the investigation.

Geraldine Murray asked if the Trust could proceed with disciplinary interviews before the police interviews. The police requested that this wouldn't happen. Geraldine stressed the need to move ahead with Trust processes as soon as possible and asked the police for a timescale for their investigation. The police said that they were not in a position to give a timescale.

Elaine McCormill and Tracy Hawthorne, PPU left the meeting at this point as they had other appointments.

Review of Protection Plan

It was agreed the grounds remain for the suspension of the three staff currently suspended.

Trust staff will move to identify and interview the other three staff who have been described.

Monitoring

Presently there is 24 hour monitoring on Ennis ward by staff external to the ward.

Moira Mannion has been participating in the monitoring and is also overseeing it. She presented a report summarising and analysing the monitoring reports which should be read in conjunction with these minutes.

Some of the monitoring concerns have been addressed by painting of the ward, new curtains being put up and curtains around beds being supplied. Support Services staff have attended to a deep clean of the ward. A capital bid has also been made for the ward for further improvements as it is envisaged this ward will be operational for a further year even though it is a resettlement ward.

Moira voiced her concern in relation to the impact the monitoring is having on patients. Patients are thought to be reacting badly to the presence of strange staff on the ward.

Aine noted that this factor was presumably also exacerbated by the need to use bank and agency staff at present to make up staffing numbers.

Moira said that as the monitoring had shown no signs of a culture of abuse on the ward and indeed indicated a lot of good practice, she felt that the monitoring arrangements could change and put forward a proposal in relation to this.

The plan proposed that 24 hour monitoring would cease and be replaced by the implementation of the Fifteen Steps Challenge. This would involve both further monitoring and inspection but also improvements. Moira said that she would lead a team of people charged with carrying this out. If any concerns came to light ,24 hour monitoring would be reinstated immediately.

Aine said that while she welcomed the proposal as a means of moving forward, she felt it was too early to move away from the 24 hour monitoring. She said that the allegations were extremely serious in nature and that if they had occurred as alleged, the fact that they were carried out in an open manner caused grave concern about the culture on the ward. She felt that the fact that there were a number of unidentified staff accused of poor and possible criminal practice also made her concerned about reducing the monitoring until further investigation had been carried out.

Margaret Cullen, Lesley Jones and Yvonne Mc Knight concurred with Aine's opinion. Moira was keen to agree a date when the monitoring could stop but others felt that as this was dependent on factors with unknown timescales, it was not possible to fix a date.

Moira then proposed that the monitoring could be replaced by new staff joining the core team. Esther said she would probably be in a position to do this from 7th January on. Aine said that she believed this could be a satisfactory way forward

although the role of these new staff would need clearly defined and would need to have a very clear monitoring remit.

It was agreed that arrangements would remain as they were and that the issue would be discussed again at the next strategy meeting.

Staffing Levels

Aine noted the concern and discussion at the last meeting about staffing levels. She said that she had clarified this with Esther after the last meeting and had been told that the Telford assessment had indicated 6 and that this was the current staffing level at that point. Aine noted that because of the concerns raised by RQIA and some monitoring staff, she had asked Moira to review the current assessments and carry out her own assessment.

Moira noted assessment under Telford indicated 6 staff and additional staff as extra when needed for level 3 obs. Moira said that there was only one patient on level 3 obs at present although at other times, there were two. Moira said that the current staffing level should therefore be 7, 6 core staff and one extra for the patient on level 3 obs.

Margaret Cullen asked Moira to clarify that the staff for level 3 obs were additional to the core staffing on the ward. Moira agreed that this was the case.

Margaret also asked about the skill mix on the ward. Moira and Esther said that an appropriate skill mix was part of their calculations in staffing the ward.

All agreed that 6 staff and additional staff for 1-to-1 was satisfactory.

Aine recapped on the protection plan that the three staff currently suspended will remain suspended and 24 hour monitoring will continue.

It was noted that Ennis ward staff are feeling vulnerable and anxious about the investigation. Geraldine Murray said there is a need to be careful about what is explained to ward staff as the staff currently suspended do not know full details.

Aine noted that there had been quite a bit of concern expressed about staff not being provided with information and it was an area of concern noted in Moira's report. Aine said that if Esther thought it would be helpful, she would be very happy to meet with staff to explain the process and try to allay anxieties as far as possible. Esther and Moira said that they did not feel this was necessary as staff had been briefed but it was impossible to avoid some anxiety. Moira said she thought Aine had done a good job of keeping people informed.

Interviewing Staff

There was a discussion about who should interview the three staff members who had been described in police interviews, if identified. This could be done as a vulnerable adult investigation interview only or jointly by investigation staff and

hospital management. Doing it jointly could avoid the need for reinterview under disciplinary procedures if this proved to be necessary. It was noted that the interplay between disciplinary procedures and vulnerable adult investigations is complex and still the subject of some debate. Yvonne is in ongoing discussions with HR about this but no agreement has been reached as yet. Geraldine said that until agreement is reached, it would be her preference to keep the two processes separate. This was agreed. Aine will identify staff to carry out these interviews.

Human Resources interviews will be done separately.

Care Plans

It was agreed that the investigation should move on to look at the care plans in place for patients on the ward, with a particular emphasis on behaviour support plans, restrictive practices and physical intervention plans. Moira agreed to undertake this piece of work. It was agreed that she would in the first instance look at the care plans for Patients A, B, C, D and E.

Bohill Staff Reporting

There was concern expressed that some Bohill staff had not come forward with concerns immediately or without prompting. Margaret Cullen is to raise this as an issue with Bohill management.

Actions

- In relation to the advocacy issue Aine will speak to Esther Rafferty and Clinton Stewart about this to determine which patients have limited family contact and therefore might benefit from independent advocacy.
- Aine will share the relevant Section 8 ABE document with Dr Colin Milliken.
- Aine will seek agreement to resume the telephone calls to relatives and for the revised letter to be sent to relatives.
- Aine will speak to [redacted] for further analysis of the vulnerable adult referrals reported.
- Moira Mannion will look at a selection of behaviour approaches for various patients.
- A pre-interview assessment will be carried out with Patient F when Aine clarifies the timescale for the incident that was raised.
- A pre-interview assessment will be carried out for Patient B
- A pre interview assessment will be carried out for Patient G.

- Police will interview Staff 1 and Staff 3. The Trust will await the outcome of these interviews to decide on further actions.
- Esther Rafferty will identify the three staff members mentioned in further allegations and inform Aine
- Aine will identify an Investigating Officer to carry out interviews with these staff members.
- Any further amendments to the previous minutes to be sent to Aine for action.
- Moira Mannion will review care plans for the five identified patients.
- Margaret Cullen to address reporting issue with Bohill management.

The next meeting will be held on Wednesday 9th January 2013 at 2pm in Cranfield Ward, Muckamore Abbey Hospital

Ennis Ward Investigation Meeting

Held on 9th January 2013 at 2p.m.

in the Board Room Muckamore Abbey Hospital

Present:

Aine Morrison, Operations Manager, Belfast HSC Trust: Chair

Margaret Cullen, Regulation and Quality Improvement Authority

Siobhan Rogan, Regulation and Quality Improvement Authority

Lesley Jones, Northern HSC Trust Representative

Yvonne McKnight, Adult Safeguarding Specialist, Belfast HSC Trust

Moira Mannion, Co-Director of Nursing: Education& Learning, Belfast HSC Trust

Geraldine Murray, Human Resources, Belfast HSC Trust

John Veitch, Co-Director, Learning Disability Services

Esther Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast HSC Trust

Barney McNeany, Service Manager, Community Learning Disability Services, Belfast HSC Trust

Greer Wilson, South Eastern HSC Trust Representative

Apologies:

Elaine McCormill, Sergeant, PSNI, Public Protection Unit, Antrim

Tracey Hawthorne, Constable, PSNI, Public Protection Unit, Antrim

Introduction:

Aine Morrison welcomed all to the meeting.

1. **Minutes of Meeting of 12th November.**
   It was recorded that all were happy with the amendments to these minutes as discussed at the last meeting and no further amendments suggested.

2. **Minutes of Meeting of 20th December**
   John Veitch suggested that on Page 5, under the heading Staff Rotas,the last sentence should be amended to read –"'as many Bohill staff were on duty for many different shifts, they worked with a wide range of Muckamore staff, it

has not been 'possible to' further eliminate from or include in the investigation other MAH staff''.

Margaret Cullen asked for confirmation that(on page 4 under the heading 'Contact with Relatives' 4th line from the bottom of paragraph) contact details for Aine Morrison and Police Crimestoppers have been displayed on the ward noticeboard, and Crimestoppers leaflets were also available on the ward. Esther Rafferty stated that she would check that this was the case and report at the next meeting.

On page 6 it was noted under the heading 'New Allegations' that Patient F was likely to have the capacity to be interviewed about the allegation that she was grabbed by the scruff of her neck. Aine Morrison confirmed that a Pre Interview Assessment would be carried out which would address the issue of capacity.

3. **List of Allegations**

John Veitch drew attention to the list of allegations presented by Aine Morrison at the last meeting and updated today. He noted that whilst some of the allegations were quite specific, others appeared to be negative comments i.e. not specific allegations. He emphasised the need to obtain evidence and facts when allegations are being made and noted a potential difficulty in doing so with regard to negative comments. Aine Morrison confirmed that the purpose of the list she distributed was to ensure all issues, allegations etc. that had arisen were collated to scope the investigation and to ensure all matters of concern were covered by the investigation. The list was not prepared in order to categorise or identify how progress on each issue was progressing; rather it was to act as an aide memoire. Aine Morrison stated that negative comments had come to her attention as part of the on-going investigations, may provide important information with regard to the culture on the ward and would be followed up in accordance with Trust Procedures.

RQIA raised, as a point of clarification, whether Esther Rafferty as a member of hospital staff should be involved in these meetings as the group had been previously told that a decision had been that no one involved in the management of Ennis should be part of the oversight of the investigation in order to avoid any potential conflict of interest. RQIA stressed that they did not have an objection to Esther Rafferty's attendance but were simply seeking clarification on the reasons for the change.

John Veitch confirmed that initially this had been a decision of management but that given Mrs Rafferty's role as Associate Director for Nursing and as Senior Manager in the Trust in LD, Trust Senior Management had concluded

that it was both important that she was in attendance to clarify any issues specific to nursing practice on the wards in MAH and to offer her insight and assistance to the investigation process. Given that Mrs Rafferty had no operational role in the ward, it was unlikely that she would have any conflict of interest in this process. Aine Morrison commented that it was helpful to have Mrs Rafferty as Senior Nurse at the hospital as part of the team as she would be able to bring clarification to questions and queries which came up during the investigation. John Veitch and Aine Morrison agreed to review with Esther Rafferty her attendance at these meetings. The outcome of this review will be communicated to all attendees.

4. Update on Actions

Advocacy - It was decided that due to the excellent contact with families that the advocacy service was not required for the majority of patients. Only one patient has very limited family contact and she has an advocate, - Liz Moore. Aine Morrison has made contact with her and informed her of the investigation.

Pre-trial Therapy – Aine Morrison has confirmed with Dr Milliken that no pre trial therapy is taking or likely to take place.

Contact with Relatives – Format has been agreed for letter to relatives. Once telephone contact has been completed, the letter will be sent out by Aine Morrison.

Aine Morrison had spoken to [redacted] sister to discuss interviewing [redacted] in relation to the allegation that had been made about [redacted] dinner being scraped into the bin. Her sister raised other concerns about the quality of [redacted] care. Aine Morrison detailed the concerns which her sister had voiced. After discussion, it was agreed that these concerns should be raised through the normal Trust procedures either formally or informally. Aine Morrison to check with [redacted] sister if she would like to raise these issues through the Trust Complaints Procedure. Moira Mannion reported that she had gone through [redacted] file and all the issues raised with Aine Morrison had been reported and documented on [redacted] file.

It was noted that when originally contacted, no negative comments were expressed by any of the families.

Recent allegations made concerning [redacted] and [redacted] will be shared with the families by Aine Morrison.

New Allegation [redacted] – When contacted by telephone to update on the investigation, [redacted] brother had made an allegation that she had told him she had been grabbed by the scruff of the neck. Aine Morrison clarified with the brother that this allegation had been made recently. The police, an ABE trained social worker and a speech and language therapist are to meet this week to plan an interview with [redacted]

Release of Disciplinary Records – Yvonne Mc Knight stated that the Trust HR position was that records of disciplinary actions which were spent could only be shared in exceptional circumstances. Legal advice is to be sought by Cynthia Crutchley in Human Resources on this matter.

Analysis of Ennis Vulnerable Adult Referrals - This remained outstanding and will be completed as soon as possible by H92 and Aine Morrison

Identification and Interviews of Staff Members - Two members of staff have been identified and interviewed. It was initially thought that the third member of staff referred to someone who was already on a precautionary suspension. However on reading the police report of a witness statement, Aine had rechecked the names of the staff on duty on the night in question. Rhonda Scott, Senior Nurse Manager had obtained these from the ward and they appear to differ from the original names sourced from the duty rotas. Esther Rafferty will clarify who was on duty on the nights of the 4th, 5th and 6th November.

[redacted] – use of belt in care plan or physical intervention plan – An allegation has been made that an older staff member held [redacted] whilst a younger member of staff over tightened a belt around her. Aine Morrison spoke to both staff involved who have denied any such practice. The younger member of staff expressed extreme difficulty in dealing with [redacted]'s behaviour and reported low staffing levels, lack of supervision and support. They also raised concern about a staff member supervising her mother, another member of staff, on the ward.

Moira Mannion said that there was no previous reference to problems with dynamics when family members worked together. John Veitch said that in principle if would be best to avoid relatives working as line managers of other family members, especially with regard to how this could be perceived by other staff.

Bohill Staff – concerns about failure to report.– RQIA are following up on this concern with the Priory group.

Police Update – Aine Morrison provided the update in the absence of the PSNI todayIt is anticipated that interviews with two of the suspended members of staff will be completed by the end of next week. Information will be fed back to the meeting. Aine Morrison confirmed that the PSNI were due to hold a meeting with a senior PPS prosecutor today to discuss nature of potential offences.

MS2

Aine Morrison confirmed that the PSNI had interviewed [redacted] who stated that she had neither acted inappropriately herself nor witnessed any other staff members do so.

Review of Care Plans - Moira Mannion presented her report as agreed at previous meeting and she apologised for her report only being forwarded to everyone on the morning of the meeting, due to pressure of work.

Moira Mannion confirmed that during the course of her review she has studied the notes of eight patients on the ward. She stated that all recording was of a high standard and very well documented. In relation to [redacted] removing articles of clothing, staff had supported the patient putting clothing on and had engaged appropriate de-escalation techniques e.g. turning the heating down.

Margaret Cullen stated that as far as she could ascertain there was no specific plan or guidance on this patient's particular behaviours nor were there specific Behaviour Support Plans for any of the patients. Margaret Cullen asked Moira Mannion if this was correct. Moira said that there were behaviour support plans in place.

There followed a discussion about what constituted a behaviour support plan. Moira Mannion said that the Rogan, Logan and Tierney model which was in use in the wards contained information on behaviour. Moira Mannion was asked if there was specific reference to [redacted]'s stripping behaviour and how to manage this in [redacted]'s care plan.

Moira Mannion said that she had evidenced care planning as per the Roper, Logan and Tierney model with regard to these behaviours. It was agreed that Moira Mannion would conduct a further review of [redacted]'s care plan to ascertain exactly what was there in relation to behavioural guidance and support.

It was agreed that if there was no evidence of specific behavioural advice, that [redacted] should be referred for this input.

Moira Mannion noted that advice that was given on training days may not always have been documented on the patient's notes and verbal advice from Behaviour Support services may not have been documented.

The discussion concluded that whilst Moira Mannion had presented evidence to support that Patient Care/ Nursing Records/Care planning records were good, there appeared to be a possible gap in Behaviour Support Plans.

5. Monitoring Reports

Moira Mannion outlined her review of the 108 monitoring forms received. She confirmed they all give examples of positive care. She stated that her review of the monitoring forms and her own time on the ward showed that there was no evidence of a culture of abuse within the ward. She had found clear evidence of the Roper, Logan and Tierney model of nursing care planning to be in regular use covering all fifteen activities of living. On this basis she proposed to cease monitoring in its current form.

Aine Morrison stated that that she believed the monitoring showed that staff knew what good practice was and had the skills and knowledge necessary to provide good quality care. She did not believe, however, that it was possible to extrapolate from this and state that good quality care had been the norm before the monitoring was put in place.

The meeting heard that there remained a substantial number of allegations about staff members where it had not been possible to identify the staff involved. There is the possibility that some of these unidentified staff could still be working on the ward. Further investigation needs to take place to see if identification is possible but this work has not started as yet. Aine Morrison raised concerns that with this risk remaining outstanding, withdrawing monitoring at present would continue to pose an unmanaged and unmitigated risk to Ennis patients. Those present agreed this posed an on-going risk.

Siobhan Rogan stated that there remains the possibility that an unidentified member of staff may have been involved in an assault on a patient. She stated that there must be an on-going assurance of patient safety.

Moira Mannion pointed out that in the 1519 hours covered by the monitoring reports there had been no indications of concern about any member of staff on duty and reiterated her proposal to withdraw the monitoring, as per her paper.

Esther Rafferty proposed that staff who are new to the ward could now undertake the monitoring role. The staff team in Ennis is now substantially altered with the addition of new staff and staff who have transferred from other wards.

It was agreed that the meeting would revisit the issue of monitoring when they discussed the protection plan later in the meeting.

Staffing Levels

Moira Mannion gave details of staffing levels. Moira Mannion confirmed that staffing on the ward should be at 6 with one additional staff member for each close observation (1:1) required. Moira Mannion and Esther Rafferty confirmed that there had been initial confusion with regard to the required staffing levels. This had arisen due to the original Telford model being run to automatically include at least one patient requiring close observation (1:1).

Esther Rafferty confirmed that the Telford model had been re-run and confirmed the staffing requirement at 6 plus additional staff where required for close observation. She also gave details on staff and ward management and improvements implemented since the group's first meeting. These included improved management of laundry, an increase in ward manager support together with additional support at meal times. She stated that rotas met the required standards. Night time cover was also at an appropriate level .Esther Rafferty stated that on several of occasions bank staff had to be used in Ennis but assured the meeting that those bank staff employed generally had consistent experience of working on the ward.

Aine Morrison asked Moira Mannion to look at staffing levels from monitoring reports to confirm that staffing was at or exceeded the required levels. . Moira Mannion agreed to review the last two weeks' monitoring forms and Esther Rafferty will verify staff on duty.
RQIA noted a concern raised by a member of ward staff about the competency of some bank staff who were being used. Esther agreed to look into this concern.

6. Further Investigation Proposals

Given the difficulties with staff identification, Aine Morrison proposed re - interviewing Bohill staff to see if any further information could be obtained. Aine Morrison suggested that it might be worth considering if the use of staff photographs would be acceptable in either aiding identification or eliminating staff from the enquiry. It was agreed that legal advice would need to be sought on using photographs of Ennis Ward staff for the purposes of identification. John Veitch stated that this could only be considered as a last resort. Discussion took place as to whether this threshold had been reached. John Veitch, Barney McNeany, Moira Mannion, Esther Rafferty and Aine Morrison to discuss and bring back to the meeting.

7. Review of Human Resources attendance at Strategy Meetings

The meeting was informed that the PSNI had raised concerns at the attendance of human resources staff at the VA meetings and that the police service had emphasised to Aine Morrison that they would like only core members of the vulnerable adult investigation team at meetings. John Veitch stated that this was an issue that the Belfast Trust need to address and he agreed to speak to both Cynthia Crutchley and to review guidance to reach a decision on this request.

8. Review of Protection Plan

Review of suspensions – there are three precautionary suspensions at present , Staff 1,, Staff 3 and Staff 4 in place. It was agreed that these should remain and that these should be continuously reviewed re grounds for suspension.

Review of monitoring –It was agreed that ward staff at the appropriate level (i.e. Band 5 and above) could become responsible for the monitoring with appropriate guidance and induction. Esther Rafferty agreed to review rotas to ensure that Band 5 or above staff, who have not worked on the ward during the period covered by the investigation, would be rostered in order to meet the requirements as set by this meeting. Aine Morrison, Maura Mannion and Esther Rafferty were asked by the group to induct the relevant staff, once identified, prior to commencing the monitoring role.

In the meantime the arrangements agreed at the previous meetings for on-going monitoring would continue. It was further agreed that once the requirements identified today were in place, the change to the monitoring arrangements could commence.

John Veitch further agreed to set up an arrangement for reporting any on-going staffing issues to RQIA. .

P7

Aine Morrison to give details of [redacted]'s sister's complaints to Esther Rafferty to share with the senior nurse manager who will be investigating these issues.

Actions

- **Esther Rafferty** to confirm that Aine Morrison/Crimestoppers contact details are displayed on the noticeboard of Ennis Ward and that Crimestoppers leaflets are available there.
- **John Veitch, Aine Morrison and Esther Rafferty** to review Esther Rafferty's attendance at these meetings and communicate decision to all.
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- **Aine Morrison** to send out letters to relatives when telephone contact is completed.
- **Aine Morrison** to check with [redacted] sister that she is happy to raise the issues she has through the Trust complaints' procedures
- **Aine Morrison** to share recent allegations made concerning [redacted] and [redacted] with their families.
- **Yvonne McKnight** to seek advice from Cynthia Crutchley concerning the release of spent disciplinary records.
- **Aine Morrison and** [redacted] to complete analysis of Ennis Vulnerable Adult referrals.
-
- **Esther Rafferty** to check who was on duty on the nights of 4th, 5th and 6th of November and inform Aine Morrison.
- **RQIA** to follow up with Priory Group re concerns about non reporting by their staff.
- **Moira Mannion /Esther Rafferty** to look at staffing levels from monitoring reports over last two weeks.
- **John Veitch, Barney McNeany and Aine Morrison** to meet to discuss the use of staff photographs as a means of identification and bring back to next meeting.
- **Esther Rafferty** to check on competency of agency/bank staff that have moved into staff team.
- **John Veitch to review with Cynthia Crutchley the continuing representation from Human Resources at these meetings.**
- **John Veitch** to set up arrangement for reporting any staffing issues to RQIA.
- **Esther Rafferty, Moira Mannion and Aine Morrison** to discuss and agree to changes in monitoring arrangements and give assurances to RQIA about these

John Veitch wished to record his thanks and appreciation to Aine Morrison for her ongoing contribution to this investigation, the particularly difficult role she had to undertake as both chair of this meeting and lead investigator. His thanks and appreciation was seconded by Moira Mannion.

Date of next meeting – Friday 1st February 2013 at 9.30 a.m. in Muckamore Abbey Hospital

Aine Morrison
Operations Manager

12.004

Ennis Ward Investigation Meeting held 29 March 2013

Present:

Aine Morrison,	Operations Manager, Belfast HSC Trust: Chair
John Veitch,	Co-Director, Learning Disability Services
Tracey Hawthorne,	Constable, PSNI, Public Protection Unit, Antrim
Colette Ireland,	Belfast HSC Trust
Theresita Dorman,	Discharge Co-ordinator, Northern HSC Trust
Yvonne McKnight,	Adult Safeguarding Specialist, Belfast HSC Trust

Apologies:

Esther Rafferty,	Service Manager, Muckamore Abbey Hospital, Belfast HSC Trust
Moira Mannion,	Co-Director of Nursing: Education& Learning, Belfast HSC Trust

Not Present:

Regulation & Quality Improvement Authority representative(s)
South Eastern HSC Trust representative

Setting the Context:

Aine referred to previous email sent on 20 March 2013 where she had advised that neither Esther Rafferty nor Moira Mannion were available to attend today's meeting. She noted that while consideration was given to postponing the meeting, a decision had been taken that the meeting go ahead as the Police, who had been unable to attend the last meeting, had indicated that they could attend and would be in a position to update regarding the Police investigation. Aine therefore noted that the focus of today's meeting would be largely in relation to an update from the Police and further investigation planning. Aine also advised that RQIA are reviewing their position in terms of attendance at future meetings.

Minutes of last meeting held 9th January 2013:

Aine sought feedback from the group in relation to the minutes of the last meeting. No issues or amendments were noted and the minutes were accepted as an accurate reflection of the discussion at the last meeting.

Police Report:

Tracey advised that a file had been submitted to the Public Prosecution Service (PPS) and she was hopeful that PPS would progress this to a Court Hearing. John queried how long the whole process is likely to take and Tracey advised that is impossible for her to put a timeframe on this. It was noted from past experience that such cases can take anything from 12 to 18 months. The complexities of investigating cases involving those with a severe learning disability were discussed. Tracey referenced the fact that Police had involved the PPS at an early stage in the investigative process to seek guidance.

John highlighted the fact that staff are on precautionary suspension and the importance of progressing this as quickly as possible, both for the vulnerable adults and the staff being investigated.

In terms of progressing the Trust investigation, Aine queried what would happen if during the course of Trust investigation new information of a possible criminal nature came to light. Tracey advised that Police would investigate and depending on the nature of the information it may be added to existing case or form part of a new case.

Some discussion took place regarding the issue of allegations in relation to unidentified staff. Aine noted that John, Barney and she had met to consider this issue and the decision had been taken not to use photographs of staff to assist with identification at this stage. John emphasised that the Trust have dual responsibilities and must consider the needs of the vulnerable adult but must also consider its responsibilities to its employees. He described this as a complex legal issue and stated that use of photographs for this purpose will only be considered as a last resort. John stressed the rights of staff and the importance of recognising that concerns to date focus on a small number of staff within Ennis Ward. While recognising that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse. John talked of the need to balance human rights considerations and agreed that the issue of use of photographs for identification purposes will not take place at present but will be kept under review.

Tracey noted that the two suspects are friends and suggested that their friendship may have resulted in them being more relaxed about behaving in an unacceptable manner when on duty together.

Planning of Trust Investigation

- Bohill staff to be re-interviewed to establish whether they can provide any further information in relation to unidentified staff. Twelve staff are to be interviewed and it is anticipated that this will take approximately two days
- All Trust staff working on Ennis Ward to be interviewed, including domestic staff and medical staff. Agreed Colette and Carmel to do interviews and will operate to an agreed script with a semi structured interview questionnaire. Aine noted the importance of telling staff that information from the vulnerable adult investigation would, if appropriate, be shared with Trust disciplinary investigations and PSNI. Staff rights to trade union representation if they so wished was also acknowledged. Aine advised that she would organise the timetable for interviews and it was agreed interviews would commence week beginning 15 April. John talked of the importance of careful planning and requested that Aine link with Esther to discuss this in more detail. Aine noted that Esther was aware of the plans to interview Ward staff

Update on Actions from last meeting:

- Aine confirmed that Esther had reported that Crimestoppers contact details are displayed on the ward.

- A review of Esther's attendance at the meetings had taken place. John confirmed that, as the service manager for MAH and the Associate Director of Nursing in Learning Disability, Esther needs to be present at the meetings. As the service manager, she is ideally placed to provide information and to ensure agreed actions in the context of the ward are delivered on.

- **Advocacy:** Aine noted that at the last meeting one patient was identified as not having family and requiring an advocate. It had been acknowledged that the patient

already had an advocate. Aine advised that as agreed this advocate has been briefed in the same way as other patients' families.

- **Contact with Families:** Aine advised that as agreed patients' families had been updated following the meeting on 9 January 2013 .She suggested that a further update may be appropriate. After some discussion regarding the content of the update, it was agreed that PSNI should determine the content of the update, given that to date it has been a police led investigation. Tracey decided that families of patients directly involved could be told that the police have interviewed to identified suspects and that the evidence has been forwarded to the Public Prosecution Service. Further that we await a response from the PPS and that families should be offered the PSNI details for any further queries. Families of patients not directly involved could be told that a file had gone to the PPS but that their relative was not involved.. Aine asked for and received confirmation from Tracey regarding the names of patients named in file sent to the PPS. Tracey noted that PPS often contact victims and their families with decisions regarding whether a case will proceed to Court and often do so in advance of contact with PSNI. It was agreed that Aine would provide Tracey with relevant next of kin details to be shared with PPS. Discussed how families would be updated and who would update them. It was agreed that telephone contact had worked well and should be used and that the Belfast Trust staff would undertake this. John referenced that the South Eastern Trust representative is not present and identified a need to update him re this plan.

- **Patient Interviews:** The importance of talking to patients and seeking their views was discussed. It was recognised that many of the patients would struggle to communicate and may not be able to contribute. Linking with Rosalind Kyle, Speech and Language was seen as critical in terms of maximising their potential to contribute. Use of talking maps was also identified as an aid to communication. The view taken was that possibly only 4 or 5 patients may be able to contribute. The agreed approach was a talk to patients generally about their experience on the ward in order to ensure that they had been asked for the views. Specific information about the detail of the investigation will not be given to patients.

- Yvonne advised that Alison Conroy, Adult Safeguarding PSNI Lead had suggested that a session from Crimestoppers may be helpful in terms of tuning patients into what constitutes a crime and what to do in the event of a crime. While this was not ruled out, there was some concern that the patients may not be able to comprehend this in any meaningful way.

- Aine confirmed that she had spoken to patient G's sister and she had agreed that concerns she had raised regarding patients G's care would be dealt with under the complaints procedure in the first instance. Aine emphasised that the outcome of this complaint would also be used to inform the vulnerable adults investigation.

- Aine confirmed that concerns raised in relation to patients A and B had been shared with their families.

- **Patient F:** Aine confirmed that, as agreed at the last meeting the police, an ABE trained social worker and the Speech & Language Therapist had met with patient F to plan an interview.

- **Release of disciplinary records:** Yvonne agreed to share details of legal advice with John and Aine for consideration.

- **Analysis of Ennis VA referral:** Aine advised that this work is ongoing and will report at next meeting.

- **Identification and interview of staff members:** Aine informed that at the meeting on 9 January 2013 there had been a query raised regarding who was on duty on the nights of 4th, 5th and 6th, with rotas differing from information provided in interviews. Aine noted that Esther was checking this out and that the relevant staff member will be interviewed.

- **Patient A allegation of inappropriate use of belt:** Aine reported that staff named have been interviewed and both deny that the belt was over-tightened.

- **Line management of relatives**. John confirmed his previous position that, where possible, it was best practice for the staff members not to line manage close relatives and that this situation on Ennis ward had been addressed.

- **Bohill staff failure to report:** Aine advised that RQIA are dealing with this but as they are not present, there is no update for today's meeting.

- **Police Update:** As per Tracy's report and information provided at today's meeting.

- **Review of Care Plans:** Aine confirmed that Moira and Esther are leading on this and that the work is ongoing to review and update care plans. John stressed that the ward has been subject to close scrutiny and inspection by RQIA and that a number of recommendations have been made. He advised that an action plan has been drafted and work is well underway in terms of delivering on the Quality Improvement Plan (QIP).

- **Monitoring Reports:** Aine reported that she continues to review monitoring reports and there had been no incidents reported relating to safeguarding concerns. Some environmental issues continue to be reported.

- **Staff Levels:** Aine advised that since the last meeting there have been two references to staffing levels being low. It was noted that Moira and Esther are in regular communication to address any issues arising from monitoring reports and are working together to deliver on the QIP.

- **Further investigation to identify unknown staff:** As per earlier discussion in meeting, the sharing of staff photos, without their consent, with Bohill staff in order to aid identification of unnamed staff was not sanctioned. Concerns were noted and re-interviewing of Bohill staff to assist with identification of unnamed staff was seen as an appropriate next step.

Protection Plan:

John explained that part of his role involves regular review of the Trust's position in relation to staff on precautionary suspension. He noted that, as part of this, he had in

consultation with senior staff, Human Resources and Designated Officer, taken the decision that there was not enough information to justify the ongoing precautionary suspension of one of the senior staff. He emphasised that this staff member would not be returning to Ennis Ward. He informed that the staff member would be undergoing a capacity assessment and subject to close monitoring. In relation to other named staff, it was confirmed that the precautionary suspensions remain in place.

Aine confirmed that in terms of the protection plan, the protection arrangements remain in place. She advised that as agreed at the last meeting, the internal monitors remain in place but are now part of core staff compliment on the ward. She advised that the monitors retain a clear monitoring brief and continue to link with Moira Mannion. Aine advised that she continues to review monitoring reports and while there have been a few quality issues identified there are action plans in place. John highlighted that the Ward has been subject to close scrutiny and tight surveillance since November. He noted the stress on staff and impact on patients. He emphasised that at this stage both Moira and Esther feel there is no indication of institutional abuse.

Actions:

1. Aine to provide PSNI (Tracy) with relevant patients' next of kin details to be shared with PPS.
2. Trust to provide update to all patient relatives. Details to be provided as per agreement with PSNI.
3. As South Eastern Trust representative was not present at meeting, he/she is to be briefed on plans re follow up with patients' next of kin, etc.
4. Bohill staff to be re-interviewed by Trust staff, to establish whether they can provide any further information in relation to unidentified staff or indeed any aspect of the investigation.
5. All staff working on Ennis Ward to be interviewed by Trust staff, including domestic staff and medical staff using a semi-structured interview questionnaire.
6. Patient interviews to be conducted by Trust staff. Approach will be informal and focus will be on their experience on the ward in an attempt to maximise their opportunity to share their views. Aids will include use of speech & language Therapist, Talking Mats and any other relevant aids to maximise communication.
7. Release of disciplinary records – Yvonne to update.
8. Seek update from RQIA re issue of Bohill staff failure to report concerns.
9. Aine as Designated Officer to be given access to RQIA Inspection Reports re Ennis Ward and any QIPs along with Trust action plan.
10. Issue of unidentified staff named in allegations to be kept under review.

Yvonne McKnight
Trust Adult Safeguarding Specialist
Belfast HSC Trust

Minutes of Adult Safeguarding Case Conference held on 5/7/13 Re: Ennis Ward

Present:

Aine Morrison, (Chair) Service Manager; Community LD Treatment and Support Services, Belfast H&SC Trust

John Veitch, Co-Director; Learning Disability, Belfast H&SC Trust

David Nesbitt, Care Manager; Resettlement, South Eastern H&SC Trust

Esther Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast H&SC Trust

Moira Mannion, Co-Director of Nursing: Education & Learning, Belfast H&SC Trust

Patrick Convery, RQIA; Mental Health & Learning Disability

Constable Tracey Hawthorne, PSNI, PPU Antrim

Sergeant Elaine McCormill, PSNI, PPU Antrim

Carmel Drysdale, Team Leader; North Belfast Community Learning Disability Team, Belfast H&SC Trust

Colette Ireland, Team Leader; East Belfast Community Learning Disability Team, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for Resettlement, Northern H&SC Trust

Apologies:

Carol Veitch, Operations Manager, South Eastern H&SC Trust

Siobhan Rogan, RQIA

Copies of the draft final report were circulated. As not everyone was able to read the report in advance of the meeting, it was agreed that they would take this away for further consideration.

Mr Veitch emphasised the confidential information in the report which is extremely sensitive and should be held securely.

As police officers Elaine McCormill and Tracey Hawthorne were unable to stay for the full meeting, the following issues relating to police matters were discussed.

Tracey Hawthorne advised that the outcome of their investigation remains with the PPS. They have asked that the case is prioritised but by yesterday afternoon they were advised that no prosecutor had been assigned to the case. Tracey Hawthorne has kept the patients' relatives informed and they will be notified directly by PPS regarding outcomes. Mr Veitch asked that pressure is kept on this process as public money is being spent with staff members remaining on suspension. Mr Veitch raised the question whether the disciplinary process can start pending an outcome of police proceedings. Mr Veitch asked that Mrs Rafferty would convene a meeting with the Trust's Human Resources Department to discuss proceeding with the disciplinary process. Police representatives

left the meeting. They took away a copy of the report and agreed to come back to Ms Morrison if they have any issues.

Ms Morrison advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the investigative report.

There was general agreement that there hasn't been enough time to go through the report in detail prior to the meeting. It was agreed that there would be the opportunity to do this following the meeting with the agreement that individuals would come back in two weeks with any questions or issues.

Ms Morrison advised that there is one investigative interview outstanding with P10 [redacted] a patient on Ennis Ward. One of the difficulties has been that the speech and language therapist is not available during July. This interview will be completed as soon as the speech and language therapist becomes available.

Issues arising from the report:

- Section 1- The date of the original report is wrong. Also Mr Convery queried what was meant by 'visiting staff'. This was defined by Ms Morrison as 'staff from other facilities involved in the resettlement of patients'

- Section 2-Interviews with patients and staff. One patient (referred to above) to be interviewed. Page 10 interview with H197 [redacted] was noted to be missing.

- Recommendations & Conclusions. The following issues were raised:

Mrs Rafferty asked why Bohill management had not passed on any concerns during meetings with the hospital resettlement team. Their reports to hospital management team were that the introductory process was going well. Ms Morrison advised that staff had not been feeding back their experiences on the ward to their management. Mr Convery reported that RQIA have also addressed the failure to report with Bohill management.

In relation to Point 2, last paragraph Ms Mannion advised that referrals about concerns had been made by ward staff during this time period which had been investigated. Ms Morrison noted that while monitoring staff had raised environmental concerns, she had no records of any care concerns being raised by staff prior to the allegations being made. The one report of a care concern made in May 2012 was made by daycare staff, not ward staff.

Mr Veitch raised a number of issues. This has been a comprehensive investigation which has dealt with a broad range of issues which were not part of the original allegations but arose during the interviews with Bohill staff. Mr Veitch sought clarification about the outcome of the investigation. While this is clear in relation to the two members of staff investigated by police, Mr Veitch asked about the outcome of the investigation in relation to the other allegations made. The report refers at various points to 'no conclusions drawn'. Mr Veitch queried if this meant that there was no evidence to substantiate the other allegations. Ms Morrison stated that while no new evidence had arisen during the investigation to substantiate the allegations any

further, the investigating team had felt that the Bohill staff statements had credibility. This was based on the number of accounts, the consistency of the allegations and the level of detail contained in the Bohill staff interviews. The investigating team felt that while they could not make a definitive judgement about many of the allegations, the evidence of the Bohill staff team was significant and carried weight.

In relation to the issue of ward staff stating that they were unaware of the allegations made by Bohill staff, Mrs Rafferty advised that these have been recorded on individual patient files on the ward which staff have access to. Mr Veitch advised that further consideration needs to be given to what information can be shared and what needs to remain confidential. The example given is information pertaining to the two staff members subject to police proceedings.

Mr Veitch raised a further issue in relation to the work which has been ongoing over the past eight months while the investigation has been ongoing. Hospital staff have been working closely with RQIA staff and senior nursing to implement an improvement plan. Mr Veitch felt that it was not clear from the report e.g. staff interviews what the situation was before November 2012 and since the improvement plan has been implemented. Ms Morrison said that these distinctions were made during the interviewing process and agreed to make sure any necessary distinctions were contained in the final report.

It was noted that ward staff have raised other issues which were not felt to fall into the remit of the safeguarding investigation. It was agreed that the report needs to identify these and indicate how they were dealt with.

There followed discussion about whether there was any evidence of a culture of bad practice. Ms Morrison advised that the conclusion reached by the investigation team was that there was enough to warrant a considerable level of suspicion although she did note that Bohill staff also identified good practice by ward staff which would suggest that any poor practice was not totally widespread. Ms Mannion advised that there were enough things needing to be corrected to suggest that there may have been cultural deficiencies. David Nesbitt advised that we need to acknowledge that there is a context within these wards which visiting staff need to be aware of. The example given was [redacted]ister reporting that she observed a patient in a state of undress. Some of the patients display this type of behaviour on a regular basis. Ms D concurred with the concerns raised. Ms Mannion stated that there is zero tolerance of ward conditions not being maintained. The example given is that if curtains are pulled down they should be fixed immediately. Mr Veitch advised that any concerns raised must be taken seriously and investigated.

Point 4-Environmental concerns. Ms Rafferty advised that there has been a review of the ward environment and RQIA have also carried out environmental checks.

Mr Veitch concluded the discussion. This has been an extensive and thorough investigation and the hospital team are indebted to the staff who carried out the investigation. It has been eight months since the investigation commenced and robust management action has been taken in response to any concerns.

The final report will need to take into account the improvements which have already been put in place.

It was agreed that advice would be taken from the PSNI and HR about what information arising from the investigation could be shared with staff.

Ms Mannion and Mrs Raffetry will also liaise with HR about commencing a disciplinary investigation.

RQIA inspectors have visited the ward on three occasions since November 2012, most recently at the end of May2012 and improvements were noted. Mr Convery queried a statement made on Page 16 which was a report by a staff member that RQIA had identified the ward as an example of good practice. Mr Convery did not feel that this had happened. Ms Morrison agreed to look at this issue further.

Ms Morrison advised that the investigation found no safeguarding concerns in relation to the ward manager.

Review of care and protection plan:

1. Staff suspensions will remain. Mrs Rafferty and Ms Mannion will follow up with Human Resources and Ms Morrison will check with police whether the internal investigation can proceed.
2. It was agreed that the 24 hour monitoring should be stepped down with immediate effect.
3. Ms Mannion advised that the senior nurse management team will continue with monitoring visits, a minimum of twice weekly to support staff and address ongoing improvements.
4. All parties were asked to come back within two weeks regarding any inaccuracies in the report.
5. This is the conclusion of the investigation. The investigation team will finalise the recommendations including improvements which are already in place and which need to happen.
6. A final report will be circulated with a final action plan. This will be reviewed under adult safeguarding procedures when closure of the investigation will be considered.
7. Feedback to ward staff will be given jointly by the hospital and investigation team. Ms Morrison and Mrs Rafferty will take this forward in August / September.
8. Feedback will be given to families when the report is finalised. Ms Morrison has been providing updates throughout the investigation. Police have also maintained contact with the families. Families are keen to know the conclusions.

Aine Morrison

Adult Safeguarding Case Conference held on 28th October 2013 Re: Ennis Ward

Present

Aine Morrison, (Chair) Service Manager, Community LD Treatment and Support Services, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for Resettlement, Northern H&SC Trust NHSCT

Colette Ireland , Team Leader, Team Leader, East Belfast Community Learning Disability Team, Belfast H&SC Trust

John Veitch, Co-Director, Learning Disability, Belfast H&SC Trust

Moira Mannion , Co-Director of Nursing: Education & Learning Disability, Belfast H&SC Trust

Rosaline Kelly, RQIA, Mental Health & Learning Disability

Esther Rafferty , Service Manager, Muckamore Abbey hospital, Belfast H&SC Trust

Constable Tracey Hawthorne, PSNI, PPU Antrim

David Nesbitt, Care Manager, Resettlement, South Eastern H&SC Trust

Carmel Drysdale, Team Leader, North Belfast Community Learning Disability Team, Belfast H&SC Trust

Today's meeting was convened to discuss the conclusions and recommendations following the adult safeguarding investigation in Ennis Ward.

This meeting was chaired by Ms Morrison.

Ms Morrison invited introductions from the group and outlined the agenda for today's meeting:

- Review of recommendations and conclusions made by the investigation team
- Discussion regarding updates to families/relatives of service users named in the investigation
- Update on the police investigation

A written report was provided by the investigation team which should be read in conjunction with this minute.

Ms Morrison updated that since our previous meeting held on 5/7/2013, when a draft investigation report was shared, comments were received, amendments were made and the report was emailed to the meeting participants. No feedback/issues were received in relation to the amended report.

The group reviewed the conclusions/recommendations starting on page 65 of the investigation report:

1. Disciplinary Investigation

D/C Tracy Hawthorne updated that the PPS have recommended prosecution of two staff named in the investigation – H159 and H197 – on all counts apart from one of the incidents involving P2 D/C Hawthorne noted that it could take up to several months before the case would be heard in court.

It was recommended by the investigating team that MAH pursue a disciplinary investigation in relation to the conduct of H197 and H159. Mrs Rafferty updated that a disciplinary investigation by MAH had commenced although it was at the early stages.

Mr Veitch expressed concern in relation to the commencement of a disciplinary investigation in light of the PPU decision to recommend prosecution. Mr Veitch suggested that advice be sought from Human Resources in relation to Trust actions in the first instance before MAH staff were spoken to.

2. Analysis of staff reports

Ms Morrison noted the difficulty for the investigating team in weighing up the very different evidence provided by two staff teams – the team from MAH and the team from Bohill. Mr Veitch acknowledged that whilst it is difficult for staff to come forward and raise concerns about their own practice, it is an expectation of the Trust for all staff no matter where they are working and when. Mrs Rafferty stated that MAH staff had the appropriate training to make them aware of their responsibilities in this regard(ASP/Induction Training/Child Protection/Whistle Blowing etc) Ms Kelly noted that RQIA would expect this training to be in place and that it was an important point to reinforce with staff. Mr Veitch concurred with this and advised that the Trust's view was not different from that of the regulator.

3. - Identification of Muckamore Staff

Ms Morrison noted that the investigating team had some success in identifying other un-named MAH staff from accounts provided by Bohill staff, descriptions of MAH staff from Bohill staff and cross-referencing with duty rotas at the time but it was not possible to identify all of the MAH staff whom Bohill staff alleged were involved in poor practice. Of those ~~unmanned~~ named staff who were subsequently identified, the investigating team believed that there was not enough evidence to warrant disciplinary action against these staff given the lack of other corroboration and their own differing accounts of events.

Mr Veitch raised a concern about the report's statement that there was not enough evidence in relation to these staff and sought clarification about what was meant by the term evidence. Ms Morrison said that the investigating team had considered Bohill staff reports as evidence. Mr Veitch said that he had some concerns about calling uncorroborated reports evidence. Ms Morrison said that investigations often had to consider uncorroborated reports and that in this particular instance, the investigating team had attached some credibility to the Bohill staff reports and felt they did carry

some weight as evidence. There was considerable discussion in relation to having sufficient evidence to support the allegations made.

4. - Environmental Concerns

It was noted by the investigating team that MAH management staff had made minor adjustments to ensure significant environmental improvements and that more major structural changes are planned to improve the layout of the Ennis ward. The investigating team recommended that all hospital wards are reviewed by staff external to the ward to see if any environmental changes were needed. This recommendation was accepted by hospital management.

Mr Veitch suggested that the Band 8A hospital staff could review wards other than their own. Mrs Rafferty also noted that RQIA and senior management staff regularly check wards and that this would be sustained.

5. - Staffing Concerns

The investigating team found that there were significant staffing problems on Ennis ward in the months prior to the allegations being made by Bohill staff. Whilst it was recognised that there was an action plan in relation to the overall staffing crisis throughout the hospital at that time the investigating team recommended that MAH senior management review their response to two specific incidents noted in the report. This recommendation was accepted by hospital management. Mrs Rafferty also added that there are processes in place to check staffing numbers on a daily basis throughout the hospital.

6.-Bohill Staff Induction

There were discrepancies noted in the accounts received from Bohill and MAH staff in relation to the level of induction Bohill staff received. The investigating team made a number of recommendations for the induction of visiting staff and it is understood that the hospital have reviewed their induction practice for visiting staff.

Mrs Rafferty updated that new processes for inducting visiting staff are in place and the investigation recommendations have all been included in the new process. The new induction process also includes an evaluation.

7. [redacted] PS

The investigating team recommended that clear guidance in relation to Ms [redacted] PS support needs be provided to and implemented by all staff who work with her. Mrs Rafferty agreed to check that Ms [redacted] PS care plan had been updated accordingly.

8. - [redacted] P1

The investigating team made a number of recommendations in relation to approved interventions in managing Ms [redacted] challenging behaviours and that all grades of staff are involved in discussions with behaviour support staff. Ennis ward staff have suggested that Ms [redacted] attend day-care on a fulltime basis as her behaviours are less evident in this environment. Mrs Rafferty updated that Ms [redacted] is not at day-care full-time at present but that there is currently work ongoing in relation to resettling Ms [redacted] and that it may not be wise to introduce any change to her routine at present.

The investigating team noted their concern about the support needs of staff who were managing Ms [redacted] challenging behaviours and their recommendation that these be reviewed. This recommendation was accepted by hospital management.

Hospital management accepted the recommendation that the hospital needs to review for any practice on Ennis Ward that could be deemed restrictive.

Mrs Rafferty noted that a successful bid had been made for the input of psychology services into the resettlement wards to look at the specific needs of patients.

9. - Ennis Staff Team Composition

It was noted by the group that the staff team working in Ennis has changed substantially since the investigation and that this was a potential protective factor.

10. – Impact of the investigation

The investigating team recognised the stress to staff caused by the investigation and recommended that further information could now be shared with staff subject to police and HR approval.

Mr Veitch agreed that the staff team were under a significant amount of monitoring/ scrutiny as the investigation was carried out and felt that staff should be provided with detail of the investigation process and outcomes when we had reached our conclusions in relation to the investigation. Mr Veitch also noted the need for staff to keep information shared with them confidential.

D/C Hawthorne highlighted the difficulty in sharing any information in relation to the information that the police are following up on but agreed that a more generic response could be given to the staff team. D/C Hawthorne had no objection to sharing any information that was not subject to police investigation.

Mr Veitch agreed that staff needed to know the nature of the allegations but not the detail and stressed again the need for confidentiality.

Ms Mannion suggested that the sharing of information with staff be discussed with HR in the first instance before the decision was made regarding what information to share with staff.

11. - Staff Skill and Experience

The investigating team recognised the positive comments made by the monitoring staff in relation to the care provided by ward staff since the allegations were made and concluded that the current ward staff have both the skill and experience needed to provide good quality care to service users.

No further concerns were noted

12. - Adult Safeguarding Training

Mrs Rafferty updated that all staff grades have been referred to complete this training.

13. - Management at Mealtimes

No further concerns/recommendations noted

14. - Access to a full range of services by re-settlement patients

Mrs Rafferty updated that the introduction of other professional services has commenced in Ennis Ward.

It was noted by Mr Veitch that the definition of re-settlement indicated that there was no further treatment required for patients. However time delays in finding suitable resettlement accommodation could not be overlooked and there may be times that resettlement patients require additional professional intervention.

Mr Veitch acknowledged the very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse.

Ms Mannion noted that the monitoring process had been stepped down as there was no concern about institutional abuse.

Ms Morrison stated that while the monitoring reports confirmed no evidence of institutional abuse post the allegations being made, she did not feel that this could be necessarily generalised to the period before the allegations were made. Ms Morrison re-iterated the conclusions in point two of the recommendations and conclusions section of the report and felt that this summed up the best judgement that the investigating team could form. Ms Morrison did not feel that the investigation was conclusive enough to be able to state categorically that there had not been institutional abuse. Ms Kelly concurred with Ms Morrison's views that it had not been possible to reach a conclusion on

whether or not there had been institutional abuse. She also stated that RQIA felt there was enough evidence to justify at least some concern about wider practice on the ward.

Mr Veitch said that he felt that it was important that we did not speculate but only draw conclusions on evidence. Ms Morrison said that she felt the conclusions of the report were based on evidence and on the professional judgements made by the investigating team based on that evidence.

Mr Veitch asked to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

Updates to relatives

The group agreed to discuss what information can be shared with relatives and disciplinary action when they meet with HR.

Tracy confirmed that the police will speak to the relatives of those service users where prosecution is being recommended

Outcomes

1. Meeting to be arranged with HR to discuss information sharing with staff/relatives of service users and disciplinary action by the hospital.

2. Police to provide updates to the relatives of service users where prosecution is being recommended in relation to allegations against their relatives.

3. Protection plan relating to staff suspension to continue.

4. Further meeting arranged for 20th January @ 3:00pm in MAH.

Aine Morrison

Minutes of Adult Safeguarding Case Conference held on 8/4/14 Re: Investigation into concerns arising in November 2012 regarding practice on Ennis Ward.

Present:

Aine Morrison, (chair) Service Manager Community Treatment and Support Services, Belfast H&SC Trust

John Veitch, Co-Director for Learning Disability, Belfast H&SC Trust

Ester Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast H&SC Trust

Siobhan Rogan, Senior Inspector, RQIA

Constable Tracey Hawthorne, PSNI, PPU Antrim

Carmel Drysdale, Team Leader North Belfast Community Learning Disability Team, Belfast H&SC Trust

Colette Ireland, Operations Manager Community Treatment and Support Services, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for resettlement, Northern H&SC Trust

Aine advised that the purpose of this discussion was to:

1. Obtain an update on the police investigation
2. Review the conclusions and recommendations from the investigative report
3. Discuss feedback to relatives.

Police Investigation:

Constable Hawthorne advised that the PPS were proceeding with a prosecution of two staff members. This was up in court for mention on 1/4/14 and adjourned. Aine advised that the legal representatives for the defence asked for an adjournment and are requesting a lot of information.

DLS intend inviting them in to identify what information they wanted and intend to advise them to seek a court order to obtain this.

Ester confirmed that the information requested from the hospital was being prepared and should be with Aine by Friday or Monday of next week.

Constable Hawthorne advised that there had been no date set for re-convening the hearing but it is usually a six week adjournment.

Constable Hawthorne stated that she has spoken to the relatives of patients and provided full details of the allegations made against the staff members as this information is now in the public domain and has been published in local newspapers. Constable Hawthorne will be keeping them informed of future court dates and will keep Aine informed about contact with nearest relatives.

Review the conclusions & recommendations:

Discussion followed on issues which were ongoing at the time of the last meeting

Point 1: Disciplinary Investigation:

Ester provided an update on the disciplinary investigation. Two senior managers Rhonda Scott, from Muckamore Abbey Hospital and Geraldine Hamilton from a mental health background have read all the information including staff rotas etc and will be starting to interview staff. Ester has received some communication from Trade Union representatives advising that they do not wish to participate until the court hearing is completed. It has been explained that this is a separate investigation system which is taking place under disciplinary procedures. Dates for interviews have been sent and staff are advised that they are attending to clarify issues arising from interview statements already made during the adult safeguarding investigation. Ester advised that the communication via Trade Unions has delayed the disciplinary investigation but this is proceeding and is well underway.

John asked if it was anticipated that all staff would be re-interviewed. Ester felt that only those witnesses would be interviewed where it was felt that clarification was required around what lead to particular situations. Ester advised that it has been made clear to staff that they have to participate. Some ward staff have been approached by legal representatives for the defence to attend court as witnesses.

Point 4: Environmental concerns:

Ester advised the senior management on the hospital site continue to do walks around and visit the wards. Operation Managers also do visits to other wards as well as the wards they have managerial responsibility for. Ester advised that for some wards which are due for closure the cost of a full refurbishment cannot be justified and they are prioritising these wards for closure through re-settlement.

Ester advised that the minimum standards for privacy and dignity are being met in all wards. Aine stated that there were concerns in Ennis Ward which couldn't wait. Ester advised that in all of the wards where there is a dormitory-like environment, privacy screens have been put in place. This has been a challenge but minimum standards for privacy and dignity has been achieved.

Siobhan advised that RQIA inspectors will be on all of these wards within the next two months a part of the quality improvement plan. Siobhan stated that the provision of single rooms and en suite facilities is not feasible for wards that are closing in six

months time. Patient experience interviews will be carried out by RQIA in the next two months.

John stated that environmental issues had been identified by RQIA in the Quality Improvement Plans and these have been responded to and largely completed to the acceptance of RQIA.

Point 5: Staffing concerns:

Aine stated that it had been agreed that senior management would review the response to the two untoward incident reports made in relation to staff shortages. Ester confirmed that this had been taken forward. An escalation of concern in September and October 2012 was noted and raised with Ester. Meetings took place and the action agreed was to move forward with ward closure. The closure of Finglass Ward took place.

Aine asked about the response to the two specific incidents reported by the ward manager. Ester stated that it was part of the escalation of concern about staffing levels as outlined above. There was a report made to RQIA at the time about what actions had been taken to ensure safe staffing levels.

John advised that there is a robust recording process to ensure concerns are addressed. Ester advised that she was able to highlight and identify the process used for addressing this. All incidents were taken seriously and formed part of the overall problems with staffing levels at the time. The duty system record has this information and has also recorded situations when they were unable to access additional staffing. Action: Ester can provide this information.

Point 6: Induction of external staff:

Ester advised that all recommendations have been implemented.

Point 7: P43

P43 has been resettled from the hospital to Armagh. Ester confirmed that her support needs in relation to going out and sitting outside on the grass were reviewed and clear guidance established and implemented by all staff.

Point 8: P39

P39 has been resettled from hospital to Armagh.

Ester confirmed that any practice which could be restrictive has been reviewed as part of care planning. Processes are more robust about documenting and recording restrictive practices. Ester was not able to say how many restrictive practices were in place as these are recorded on individual care plans. All care plans have been updated. All restrictive practice and deprivation of liberty are recorded on the care

plans. All staff have had training on deprivation of liberty and are advised of further training opportunities. Siobhan advised that RQIA will be reviewing these.

Point 10: Impact of the investigation:

Ester and Aine met with the staff group from Ennis. Information was shared, although in relation to particular staff members. Written information was to be provided for staff however Ester explained that this had been delayed as HR had advised not to share this until the internal investigation is complete. Staff were angry and upset during the meeting and Ester advised that they remain upset and angry.

Siobhan asked what the anger related to. Ester reported that staff felt they have not been made aware of all the allegations. Siobhan felt that it was important that staff are made aware of the allegations. There is court action and that these things happened.

Aine stated that she got the feeling that staff didn't believe. Ester felt that they disbelieved that Bohill staff couldn't identify staff when they had been working with them.

Tracy raised concern about the attitude of staff if actions reported by Bohill Staff were not deemed to be of concern.

Ester felt that this was not the case and that staff have reported concerns. Staff understand safeguarding and the requirement to report.

Aine did not agree and she stated that had concerns.

John felt this was open to debate and doesn't add to the investigation, opinions are not evidence.

Siobhan asked if there were any current concerns about practice. Ester stated no. Ennis has now officially closed and amalgamated with Erne.

John confirmed that the independent monitors were positive in their reports and had no concerns. Ester confirmed this. Aine felt that the monitoring did show that staff did know what good practice was. A protective factor was the mix up of the staff group with new staff coming on to the ward.

John advised that there has been no other evidence to inform current perceptions about the ward.

Point 12: Adult safeguarding training:

Ester confirmed that all adult safeguarding training has been updated.

Information to relatives:

There followed discussion about what further information needed to be shared with relatives at this stage. For the relatives of the four people where there were specific allegations, they are being kept informed by police and kept up to date about the court process. For the relatives of the other patients, they have been kept informed of the course of the investigation, when the police concluded and the Trust investigation commenced. It was agreed that a general update is required particularly as families will be very aware of the media coverage.

Action agreed: Aine will prepare the information and circulate for agreement. Further discussion will be required with the other Trusts involved about how this will be delivered.

Conclusions:

The adult safeguarding investigation is concluded.

There is an ongoing protection plan in place. The two staff members remain suspended.

Court proceedings are ongoing and the disciplinary investigation has commenced.

It was agreed that this meeting should be re-convened if there is any change in the protection plan.

Aine Morrison

Designated Officer

Belfast Health and Social Care Trust

BHSCT_Annex A

Initial call made to: Ms Kathy Fodey **(DHSSPS) on** 09/11/12 **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Dr David Robinson	Organisation	Belfast HSC Trust
Position	Co-Director Nursing: Governance, Standards and Performance	Phone	028 90960078

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***√
3. ***press release about harm***
4. ***regional media interest***√
5. ***police involvement in investigation***√
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***√

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

On 7 November 2012, a member of staff reported that 2 staff (one Staff Nurse, and one Health Care Support Worker) and one Student Nurse had physically abused 4 patients in Ennis Ward in Muckamore Abbey Hospital. These staff have been suspended pending outcome of investigations. The PSNI have been informed. The Trust is in the process of referring the staff to the Independent Safeguarding Authority. The Nursing and Midwifery Council has been notified of the precautionary suspension of the Registered Nurse involved in this incident.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr David Robinson on behalf of Miss Brenda Creaney

Contact details: Telephone (work or home) 02890960078

Mobile (work or home)

Email address (work or home) david.robinson@belfasttrust.hscni.net

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the **'EarlyAlertNotificationMedDir'** mailbox.

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

Henry, Robert

From: McCaul, Shane
Sent: 09 November 2012 16:40
To: 'earlyalert@hscni.net'; 'earlyalert@dhsspsni.gov.uk'; 'cx.office@hscni.net'
Cc: Creaney, Brenda; Robinson, David; McNicholl, Catherine; Stevens, Tony; Champion, June; Cairns, Claire; EarlyAlertNotificationMedDir
Subject: Early Alert Notification
Attachments: bhsct_early alert proforma_ 09_11_12.doc.htm

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

12.069

Guidance for Supervising Staff in Ennis Ward.

The additional staff members are supernumerary to the usual complement of staff on the ward.

They should not be allocated any specific duties but should assist with care tasks as appropriate.

They should not be responsible for any management tasks on the ward.

Their primary role is to observe patient care. Therefore the vast majority of their time should be spent in direct patient contact. They should aim to spend approximately 70% of their time at the bottom end of the ward and 30% at the top end.

They should observe for any indicators of concern about poor care practice. This should include any concern about;

- verbal abuse
- physical abuse
- inappropriate physical intervention
- lack of supervision of patients
- poor care

If the staff member observes something they are concerned about, they should immediately raise this with the member of staff concerned and ask them to stop.

Any concerns should also be immediately reported to the nurse in charge of the ward and to the senior nurse manager on call. These staff should follow the usual protocol for reports of concern.

The additional staff members should compile a report at the end of each shift detailing which staff were on and what their duties were, what role did they themselves play in the shift, any aspects of particularly good practice noted and any concerns noted. These reports should be submitted to the nursing office who should copy them to Aine Morrison, Designated Officer.

Guidance for Ward Managers in Ennis Ward.

The additional staff members are supernumerary to the usual complement of staff on the ward.

They should not be allocated any specific duties but should assist with care tasks as appropriate.

They should not be responsible for any management tasks on the ward.

Their primary role is to observe patient care. Therefore the vast majority of their time should be spent in direct patient contact. They should aim to spend approximately 70% of their time at the bottom end of the ward and 30% at the top end.

They should observe for any indicators of concern about poor care practice.

If the staff member observes something they are concerned about, they should immediately raise this with the member of staff concerned and ask them to stop.

Any concerns should also be immediately reported to the nurse in charge of the ward and to the senior nurse manager on call. These staff should follow the usual protocol for reports of concern.

The additional staff members should compile a report at the end of each shift detailing which staff were on and what their duties were, what role did they themselves play in the shift, any aspects of particularly good practice noted and any concerns noted. These reports should be submitted to the nursing office who should copy them to Aine Morrison, Designated Officer.

CONFIDENTIAL

Muckamore Abbey Hospital

Briefing by M Mannion – 19 December 2012

As commissioned by Catherine McNicholl, Director of the Adult, Social and Primary Care Directorate and Brenda Creaney, Executive Director of Nursing and User Experience.

Moira Mannion, Co-Director of Nursing was commissioned to complete the following:

- Commit time to engage in and complete ward observation of Staff behaviours, Patient care as professionally independent from the service,
- To complete unannounced leadership visits,
- To lead the team of monitors engaged in the monitoring activity,
- To review all the monitoring forms submitted,
- To provide an executive report of actions completed,
- To provide an improvement plan to the Director of the Adult, Social and Primary Care Directorate and the Executive Director of Nursing and User Experience and the strategy group members for discussion and agreement.

Actions completed

- Two unannounced leadership walk arounds 3hrs x 2 =6hrs,
- Monitored the ward environment for 10 hrs,
- Met with the monitors as a group for 2hrs,

  Issues identified:

  - Key concern about the impact of monitoring on patients behaviours,
  - Monitors welcomed the meeting as it was their first,
  - Not aware if there was a time frame for the monitoring plan,
  - Poor information about the investigation process.
- A draft improvement plan was submitted to the Executive Director of Nursing, the Director of the Adult, Social and Primary Care Directorate, the Co-Director of the Adult Social and Primary Care Directorate and the lead investigating officer.
- Meetings completed x 4:
  - Director of the Adult, Social and Primary Care Directorate,
  - Executive Director of Nursing,
  - Associate Director of Nursing,
  - Co-Director of the Adult Social and Primary Care Directorate, Associate Director of Nursing and the Lead Investigation Officer.

CONFIDENTIAL

Muckamore Abbey Hospital

Briefing by M Mannion – 19 December 2012

- Thematically reviewed all monitoring forms submitted using an early indicator of abuse guide and the RCN dignity standards. To date, 85 monitoring forms have been submitted over a 5 week period by 20 independent senior nursing staff, 840 hours observed practice over a 24 hour cycle.

  Results from the thematic review were are follows:

  - 24 forms out of 85 had noted a concern,
    - The 3 key themes;
    - Staff levels at key times in the day
    - Environmental issues
    - Impact of male monitor on patients who remove clothing
  - 61 did not identify any concerns,
  - All 85 forms identified many examples of best practice and positive interaction by staff with patients,
  - There was no indication of any possibility of a culture that may be accepting of behaviours or communications that could be referred to as abusive.

Moira Mannion

Co-Director of Nursing: Education and Learning

19 December 2012

Belfast Health and Social Care Trust

CONFIDENTIAL

Muckamore Abbey Hospital
2nd Briefing report by M Mannion – 9th January 2013

Actions completed

- Over the Christmas period, I undertook a further two unannounced leadership walk arounds time commitment 4hrs x 2 =8hrs,
- I have completed a review of patient's notes, medical files, and drug kardex, 4 files that were requested to be reviewed by the strategy group and a further 4 files randomly selected from the remaining population of patients on Ennis. Time commitment 18 hrs.
- I have completed analysis of the monitoring forms submitted since the 19th of December taking an inclusive approach by integrating and reviewing previous data from the first briefing completed for the 20th of Dec 2012. Time commitment 10 hours.
- I have completed a review of the learning environment using the Learning and Assessment Standards created and regulated by the Nursing and Midwifery Council NMC. This involved reviewing the student evaluations over the last 2 yrs, requesting if there were any student or external reviewers concerns about the practice environment or behaviours of staff i.e. the NMC annual reviewers, the nursing Practice Education Facilitator the clinical tutors who act as the pre-registration nursing students placement supervisors from Queens University. Time commitment 5hrs.
- Update on the draft improvement plan;
    - Environmental concerns are being addressed cleaning schedules have been improved,
    - Repair of estates issues progressing,
    - Fire safety and environmental issues have been addressed,
    - Admin support officer time increased to support the ward sister,
- Communications with:
    - Executive Director of Nursing and the Director of the Adult Social and Primary Care Directorate,
    - Associate Director of Nursing,
    - Ward Sister and Deputy Ward sister,
    - Monitors present on the ward environment when I was present,
    - Co-Director of the Adult Social and Primary Care Directorate,
    - Service manager of Ennis,
    - Behaviour support officers x 2,
    - Medical staff in the unit,
    - Relatives visiting the unit,
    - Ergonomics trainer,
    - MAPA trainer.

Preparing this briefing paper time commitment 8 hrs.

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Review of patient's notes, medical files, and drug kardex

Documents were reviewed and completed in the care environment and at all times documentation remained in the clinical environment. The information governance policy was respected in this activity.

There were 8 patients files reviewed, 4 named patients as requested by the strategy group and a random selection of files from the other 13 patients. A patient who observed me taking out her records for review asked what I was doing, when an explanation was offered she declined giving her consent for the review to take place, this request was respected. One patient is expected to be discharged within the coming week therefore not selected for review.

There is a corporate commitment for MAPA behavioural strategies to be implemented when appropriate. All of the current patients in Ennis ward are described as presenting with challenging behaviours that on occasion will require the MAPA range of interventions. Registered Nurses, unregistered Health Care Support Workers and Nursing Auxiliaries, are trained in this process. Staff requiring updates are provided with update training which has included observation by a recognised trainer of the staff member when required to use this form of intervention.

There was evidence of an audit conducted in the last year of the MAPA process reported win the patient notes. The audit outcome was positive.

Active promotion of all other prescribed personal life story work i.e. get to know me documentation recorded in each note file reviewed, personal de-escalation strategies particular to individual patients as per care plan is expected and evidence of adherence to this process is recorded within the notes.

I found within my discussion with the MAPA trainer that the moves noted as potential allegations (Allegations were not discussed with the Trainer) could have been MAPA moves designed to protect both patient and others during perceived challenging behaviour episodes.

In my discussion with the Ergonomics trainer, I was advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients therefore patients with presenting Jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients, this may appear that some one could be "hauled out of a chair" staff are encouraged to support a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step, prior to expecting them to stand or be assisted to stand. It was also noted that when moving someone who exhibits rocking movements backwards and forward or side wards rocking that staff are encouraged to move backwards and forward or sideways with them this reduces the risk of falls during dressing and moving activities.

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In my discussion with the behaviour officers it was noted that behavioural plans are regularly reviewed and that the nursing team are engaged in behavioural plans on each shift, it was noted by the 2 staff that much progress has been achieved from previous behavioural base lines in the previous ward environment prior to the transfer to Ennis this they both said was extremely positive yet constant.

In my discussion with the Ward sister regarding resettlement and community integration, she shared the following information. As a team they had been informed that the ward was due to close in March 2013 and that the Resettlement Process commenced in March 2012. All patient Annual Reviews were postponed by the Ward Consultant to facilitate weekly Resettlement meetings.

The Resettlement process began and progressed through the assessments despite working through times when there were unfortunately high levels of staff sick leave. At times the staffing suffered gross shortage ie 4 AM staff plus staff at 9.30AM.

This was highlighted with the Nurse Manager for the ward via emails, conversations and incident reporting. The manager for the ward spoke to me about my concerns.

The nursing staff's interest and morale did not appear to have lessened and every opportunity was still being provided to introduce the patients to the community. During the summer of 2012 a leaving party was held for the patients and their families. With Marquee and a musical entertainment, the patients had a great time on the day. We invited one of our ex patients, who had been successfully resettled in 2011 and she attended with a group of her friends to the dance.

Prior to this Allegation there had been a decision taken amongst patient's families, advocates and Multi disciplinary team that three patients would go to the Bohill Care Home on Trial Resettlement. Assessments have been collated and care plans drawn up. The team leader and manager had visited Ennis and had been in attendance at Resettlement meetings along with R.Scott CIP and Care Managers from the Belfast Trust.
Staff from the Bohill had begun a 6 week period of visiting the patients in Ennis and getting to know them and their needs. Unsettled behaviours of some patients were noted early on and reported to me as ward sister, this was relayed to the Resettlement team. I expressed concern that a period of 6 weeks may be too long if the patients continued to be upset.

At a meeting held in Erne ward to Review the progress of the visiting staff and patients it was requested that the "Bohill staff come to myself if they had any concerns", "I had to redirect member of Bohill staff as a disturbed patient was directing verbal aggression towards them, during their time on the ward".

The staff visits by Bohill had commenced before the ward sister in Ennis had a copy of their duty rota. Staff on duty found this confusing at the time. It was explained that there was problems with the Bohill Care Homes emailing system. The duty received did not reflect the names or numbers of all the staff who reported for duty.

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On one occasion a nurse in charge received four staff who thought they should be in Ennis that day. The staff rotated on a 3 daily basis, two and sometimes three staff together every three days. Induction for this amount of people under the conditions we were working proved to be extremely difficult. The induction process that had been agreed did take place with staff from Bohill but Bohill had sent additional staff without first communicating with the ward sister to inform her of the same. This did result in confusion.
I found evidence of adherence to Trust policy and guidance by the nursing team and active leadership by the ward sister and deputy ward sister.

Documentation review findings;

1. **Patient Nursing notes spanning last two years 2011-2012**

- Roper, Logan and Tierney model care plans in use, fifteen activities of living completed and a review process conducted each six months. This is a person centred care planning process for Nursing Care.
- Named nurse and associate named nurse identified within each set of notes, each record was signed by the nurse recording the information.
- The ward team is actively implementing the need to care for each individual patient in accord with the RCN Dignity Standards;
  - understand my health,
  - respect me,
  - get to know me,
  - having choices,
  - making decisions,
  - feeling safe and promoting my safety.
- Current Patient Protection Plans evident within the notes.
- Patient body charts were used recording bruise/marks noticed, when supporting personal hygiene care, with appropriate medical intervention when required.
- Behavioural plans with Antecedent, Behaviour and Consequences charts, known as ABC charts evident within the plans.
- Contemporary daily care reports written by registered nursing staff.
- Incident reports, Vulnerable Adult forms with associated person centred interventions recorded.
- Personal requests made by patients to be reviewed by the medical team regarding care were recorded.
- Nursing staff concerns relating to aspects of care recorded.
- Not all notes had a current Social Work report but evidence of an historical report.
- I found evidence of basic personal care, personal hygiene, Oral hygiene, fingernail and hand care, toe nail and foot care, hair care and clothing care were all appropriate and respected choice and identified personal preferences of the patients.

- For some patients there were transitional plans covering moves from the previous clinical environment to the present.
- Multi-disciplinary care reviews were recorded and more recently the integrated community plan meetings were recorded with invitation to family to be involved but not always availed off.
- All patient notes reviewed held the status of delayed discharge from 2007, with many care environments having been assessed and deemed not appropriate or the external providers deeming the patients to be complex and challenging and unsuitable for their environments.
- All files reviewed were consistent with multi professional working relationship, ie the drug kardex was in line with medical review, nursing record and other records. There was evidence of active consultation between members of the multidisciplinary team with record made in the respective notes.
- All patients reviewed had high levels of co-morbidity including learning disability, sensory impairment, communication difficulties, physical ill health, severe and enduring mental illness and challenging behaviours.

2. Drug Kardex

- Pharmacy reviews were present in the files. Current and past documentation evidenced practice adhering to the controlled drugs standards and drug trolley key , storage of drugs, administration of drugs standards by Nursing and Midwifery Council .

3. Medical file which included Allied Health Professionals interventions

- All eight files had Capably Assessment completed in 2010 for access to personal funds; Patient Financial review documentation was not reviewed.
- Regular Blood results.
- ECGs reports.
- Blood test results required for mental health drugs completed at prescribed time frames.
- Dental care, and recorded pre-intervention drug therapy to calm the individual patient were appropriate.
- Foot care.
- Speech and Language Therapist involvement.
- Behavioural plans and review.
- Day care plans and review.
- Other medical interventions and associated documentation recorded concerning physical health issues relevant to individual patients, Heart care, diabetic care, gynaecological care, assessment for dementia.

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Analysis of Monitoring Forms and Evidence of effective care process found in the review of patient files

I thematically reviewed all monitoring forms submitted and the evidence found in the patient files using The Early Indicators of Concern (University of Hull) and the RCN Dignity Standards.

A total of 118 monitoring forms covering 1519 hours of observed practice have been submitted over an eight week period by independent monitors, to observe practice over a 24 hour cycle.

Results from the monitoring form review and direct observation:

All 118 monitoring forms identified many examples of good practice and positive interaction by staff with patients and similar was directly observed.

The positive themes were;

- The monitoring forms and patient files showed that concerns about patients care and wellbeing is a high priority for all staff in Ennis. Each concern is rapidly addressed by appropriate intervention.
- I found evidence from the monitoring forms of proportionate use of supervision and observation. There was evidence that staff were aware of the need for personal privacy for patients and that intrusion must be proportionate.
- I found evidence that the nursing care and the environment encourages;
  - The care of personal processions; where there is minimal family involvement, the named nurse and associate staff promote personal belongings, as appropriate with life story work and individual preferences when possible,
  - Financial care promoting independency in appropriate manner,
  - Supporting patients to care for their personal space promoting self care appropriate to the skill and needs of each patient,
  - Essential records are being kept effectively,
  - Known personal choice/ preferences are supported e.g. country and western music, car outings, garden time, object reference such as bottle tops which supports one patient to self calm herself, time alone, etc.
- Staff anticipating behaviour escalation between patients and defusing the same when and where possible by appropriate intervention. The nursing team actively intervene to prevent challenging behaviours between patients and towards staff. When an incident occurs it is recorded and reviewed to change practice if required.
- I found evidence of a high level of critical appraisal of evidence i.e. analysis of patient behaviour, the aim of which was to understand the behaviour and therefore make an informed decision about care approaches to meet the needs of the individual. This level of attention to the caring process was complimented by

knowledgeable staff who demonstrated understanding of the diverse and complex care needs of the patients in Ennis.

- I found evidence of appropriate AHP input to personal protection plans which were also acknowledged as potential restrictive practice and recorded in patient care plans e.g;
  - Protection plan, that only three patients be present in the lower dining room to facilitate proportionate support for meal time behaviours which promote reduction of risk of choking the promotion of fluid intake and self management of dining cutlery, recommended by Speech therapist,
  - Protection plan, for some patients the requirement of doors being locked near the kitchen area to reduce the risk of self injury,
  - Protection plan, locked doors near the hall way close to the Nursing office as some patients have been assessed as requiring this intervention for self protection,
  - Care plan, promotion of personal dignity by use of bathing suit as an under garment and belt to "divert" i.e. behavioural therapy approach to reduce the behaviour of the removal of clothes.
  - Care plan recorded oral bleeding and ongoing treatment needs for one patient, this bleeding generates distress for the patient and she would be known to scream and cry out when she notices the bleeding. Staff reassures her at these times but often she appears inconsolable. She requires drug therapy prior to each dental visit and or potential intervention. It is also noted that there is minimal family involvement and desire to be involved in the community integration plan.
  - A patient was diagnosed in 2012 with an emergency condition requiring quick identification and transfer to the local general hospital along with her specific medication kept on the ward. A protection Protocol was developed and is explained to all staff in the practice environment this has facilitated staff intervening appropriately and the patient remains well.
- I found evidence of communication needs from a person centred care perspective for each patient in the care plans e.g. Pictorial support aids, Simple verbal consistent instruction, behavioural redirection, de-escalation strategies, Sensory stimulation or reduction of stimuli. This evidence was complemented by the demonstration of staff knowledge within their skills of communicating with individuals and their correct interpretation of patient's behaviours and what the behaviour may be aiming to communicate. The outcome within their approaches promoted calm and responsive care, both within the monitoring reports and my personal observation.
- I found evidence that involvement with external agencies, relatives, multi-professional staff are all openly facilitated. There is also an unrestricted visiting time freedom for visitors. The ward was an open environment with the daily contact with estate management staff, hotel services staff, administration staff, transport staff and professional staff.
- Patients are encouraged and facilitated to talk to staff and visitors, on the ward and in private. I did not find any example, during direct personal observation, of staff preventing patients speaking to staff or visitors, nor was there evidence of such

restriction on the monitoring returns. Each patient is offered an explanation of who you are and your purpose within the environment, openness is encouraged.

- I found evidence of dietary needs, choices, preferences and consistency of food requirements are individual to each patient and are meet, as far as is possible,
- I found evidence of fluid intake encouragement is promoted and supported no restrictions for patients both observed and recorded.
- I found no evidence of a culture that may be accepting of behaviours or communications that could be defined as abusive or any evidence of systemic abusive practice.
- It has been reported to me by Ester Rafferty has been given 4 induction papers that were jointly signed off as having had the opportunity and completed the induction process by Bohill staff and Ennis staff. This evidence will challenge the comments alleging that no induction took place. Ester Rafferty will report on this matter.

From the 118 monitoring forms only 67 that had identified concerns the key themes were;

- Staff levels at key times in the day impairing the ability to facilitate the needs of patients for activity based interventions,
- The challenge of keeping the curtains up with the frequency of the patients pulling them down,
- The challenge for staff maintaining dignity for some patients with the behaviour of removal of clothes,

Nursing Practice Placement Review

Prior to this practice allegation there have been no concerns with respect to this practice placement area over the last 2 years. This is inclusive of professional staff from Queens University.

Ennis currently has 3 mentors. 2 sign-off mentors and 1 mentor who are registered on the live mentor register.

The ward area was last audited in September 2012.The outcome of the audit agreed two students but reduced to one following temporary move of band 6 to Donegore. A Band 6 nursing position had not replaced by an equivalently experienced nurse at the time of the allegation. This has been resolved in November 2012. This learning environment is audited to facilitate novice to the final placement in management students, this is a commendation for the ward practice area.

The student evaluations themed were all positive about the learning and supportive experience offered them by the nursing staff in the ward some of the quotes were:
"Great support from mentor", "staff supportive", "all my learning outcomes achieved", "the induction to the ward was informative and gave me knowledge about the ward and practice".
Progressive development of an orientation pack for students is underway; also a further member of staff will be commencing the mentor training in Sept 2013.

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The ward area is still open for future student placements although the recent student was re-allocated therefore no student currently on placement.

We await the outcomes and recommendations of the investigation before advising Academic Education Institutes (AEIs) of any changes to the area prior to the next QUB allocations. Allocations will take place in January for March students.

Recommendations

- That the current protection plan of continuous monitoring activity be discontinued as there is no evidence that there is a culture tolerant of behaviours that could be defined as abusive or support systemic abuse.
- Complete investigations as rapidly as possible to allow normalisation of the care environment.
- Recommence student allocations to this practice environment for the March students in Queens University.
- That we progress with the improvement plan for staff in the Ennis environment .

Moira Mannion
Co-Director of Nursing: Education and Learning
8th of January 2013

ENNIS 2008-2012

As requested I am forwarding my thoughts surrounding Ennis ward and the Investigation into Allegations of Serious Abuse raised in November 2012.

The Changing Population 2008/09

Ennis has been a ward undergoing significant changes since November 2008. Prior to this Ennis was a relatively settled ward providing continuing care for patients with mixed needs. I was moved to Ennis at this time and I and the ward team were aware that the ward would undergo changes as the hospital continued to Retract.

At the same time a patient was moved from Killead ward into Ennis ward. She exhibited severe self injurious behaviour eg Banging her head against walls, kicking doors and screaming at staff. This was a significant change for the patient group and staff in Ennis at the time. The physical care needs in Ennis were high, one patient was mobile with long periods on oxygen etc As the existing patients did not require this level of behaviour support, most staff had not worked with this degree of Challenging Behaviour. Behaviour Services worked with the new patient and staff team during this time.

The Environment

Areas needed addressed in order to maintain safety of all at the time. I requested that all glass be assessed throughout the ward. Glass such as Mirrors above fireplace, on wardrobes and in cabinets was either removed or replaced.

The low ceilings exacerbated the noise level as the patient frequently screamed when attempting to make her needs known, the corridors and door openings were narrow and rooms were small. I was aware that for most of her time in the hosptial this patient had been nursed in more spacious environments.

After a period of time and after involvement with ABS, nursing colleagues, the Medical team and her next of kin it was decided for the safety of others this patient could not be nursed in Ennis with the current population. Another patient from the Core Hospital was transferred but again the behaviours she exhibited were too dangerous for the Vulnerable population of Ennis at the time ie. Attempted to tip patients wheelchairs.

Storage in Ennis

There was a Storage problem in Ennis. I approached the Service Manager regarding this issue suggesting that the locker room in Erne could be used partially as a store for Ennis. I was told that there were plans for Amalgamation and that this could not be facilitated at this point.

There is a large extractor fan in Ennis kitchen which was required when Ennis had been a Cooking Kitchen. I had discussions with Maintanence and requested that this be removed to allow for storage. This was declined due to costs and the fact that the ward was not to remain open.

Staff Meetings

To me are important. Through meetings staff become aware of the Expectations of the manager and roles are clarified. They provide an excellent opportunity for staff to review practice, share knowledge and to make changes. Attendance at these throughout my time in Ennis has on average been high. There have been meetings for All staff, Trained Staff and for Nurse Assisstants so that each can feel free to hightlight difficulties. There has been Group Supervision and a resource entitled WASTE to promote and share good thinking.

In Ennis from the outset I was aware staff would need a high level of support as the strategy of Retraction would affect the ward. The nursing team were already adapting to changes from the trial of the two patients from the Core Hospital. We have looked at the following areas continually over the four year period of change. Please see examples of Minutes of ward meetings.

- Routines
- Safety during mealtimes, medication rounds
- Practice
- Standards
- Activities
- Supervision
- Policies
- Behaviour Management
- Staff Development
- Responsiblities and Allocation (Different options tried as needs changed)
- Budgeting
- Changes

And so on

Standards and Activities

We began to address matters within the ward in an effort to increase patient user experience. Good quality clothing was purchased, doing away with the need for a good clothing store. Patients were expected to be dressed well every day. Patients shopped for this with staff where possible. Dining utensils and crockery were personalised at patient request and to improve standards for themselves. Patients purchased their own toiletry bags and toiletries were personalised to include quality perfume they wore to daycare and events. Activity equipment was purchased and a room was designated for patients to use daily for health and beauty activities. Books where bought for patient reading and enjoyment and health promotion. clothing, crockery, utensils, activities and opportunities for community experiences. Exercise equipment was donated to the ward following the closure of a ward.

The Ward Consultant asked if i would be prepared to lease a trust vehicle which would be a car for daily use for our ladies in Ennis. This proved to be very popular with patients although to some degree replaced the smaller ward activities as every opportunity was used, morning, afternoon and evening to create opportunities for patients to attend community events. See Activity record book.

A number of patients enjoyed overnight stays in hotels to allow them to have quality time to relax and do what they wished. Some chose shopping and theatre show's in Belfast, some chose to be pampered at the Ramada,Belfast with a variety of beauty treatments. The Ramada in Portrush allowed some to experience staying at the sea side whilst some went to the Radison in Limavady for more pampering. Overnight stays as opposed to holidays were encouraged if this was possible within resources.

All festive times were fully celebrated, families were involved in ward parties throughout the year. The ladies in Ennis mixed well at these events on all occasions and showed their enjoyment of same.

Staff were encouraged to take photographs of and for the patients of their experiences within the ward and outside the ward. Ie Birthday parties, festive times, trips out and away and in later times cookery and gardening. This was all done by the staff of the ward. Their ideas and effort and attempts to maintain this remained throughout changing times in Ennis. For some time these pictures were on display for the patients using a DVD photo frame in the hall and in the new office. The Photo frame was destroyed by one of the ladies who joined us at a later date and in more recent times the other screen was moved from the office to be used as a television until such times as a replacement could be sought. I have 8 CD's available which can be seen and are examples of some of the activities of daily Ennis life and extra activities. See file.

Welcome books and Information Booklet for the Ward

A Welcome book was introduced for patients and their families which includes information such as patient rights, advocacy, how to contact your consultant, how to make a complaint and so on. The Speech and Language department adapted this for those who preferred to use Makaton. An information book explaining the ward philosophy and aims and objectives was introduced for staff and visitors to the ward.

Changing Population 2009/10

Amalgamation New Staff and Patients

Later that year it was explained that Fairview ward was to close and Amalgamate with Ennis ward. For this to happen most Ennis patients and staff would move to Greenan ward and the majority of Fairview patients and staff transfer to Ennis.

I had experience of amalgamating a ward as an Acting Ward Manager and later as part of my permanent Sisters post in amalgamating a ward, moved a ward twice and closed a ward with little or no difficulty.

This amalgamation of Fairview patients into Ennis ward went relatively smoothly. A number of parents and staff who have known the patients a long time have consistently remarked on the positive changes and development within individuals.

During this amalgamation of Fairview with Ennis there were difficulties with regard to staff and negative attitudes towards change.

There was a resistance when there were attempts to sort morning and mealtime routines.

Later when attempts where made to improve standards and patient user experience there were similar difficulties. The SNM for the ward was made aware of these through verbal conversations and email.

Staff Development

Staff were required to be Named Nurses where they previously may not have been and a number of development issues were raised. Ennis had a higher proportion of Enrolled Nurses before and after this amalgamation than any wards I had worked in previously and staff were already engaged in providing a high level of support and assisting staff to develop.

Agenda for Change had been implemented and some staff were requiring considerable support in order that they could fullfill their role and feel comfortable doing so.

KSF and Clinical Supervision were implemented and issues were highlighted through this ie Care Planning and record keeping.

Care Planning - The resource nurse for the hospital was invited and came to the ward on three occasions at differing times during the day. She offered further individual assistance and staff were made aware that this was available to them.

I introduced Band 5 turn taking as nurse in charge to offer equal experience. This allowed staff to develop in a supported way.

I acquired CD's for sharing of good practice ie NIPEC for display on staff screen and invited staff to use and share similar resources. See in CD file.

Informal Capability was required in one instance and this remains under review.

The Senior Staff team which consisted of one full time staff nurse and two part time staff nurses reported to me that they felt frustrated that they were re addressing issues ie record keeping continuously. There were other areas of concern where they also reported to me with regard to attitude towards other staff, attitudes towards myself and staff performance in general.

All of these were discussed with my line manger and were addressed with some continuing to be monitored.

Ward Meetings 2010

I held frequent ward meetings during this time to encourage the new Ennis team team to develop with support. Ideas were encouraged from all staff, changes welcomed and made if thought beneficial to patients, staff and the ward.

These were used also to address issuses such as the importance of Staff Relations, Fairness, Staff Role, Supervision, Performance and so on. Please see copies of ward minutes at this time.

Patients Rights and Advocacy

As a team we have introduced Forums for the Patients. Independent Advocates attend these in Ennis. The patients discuss their point of view, likes/dislikes etc. All the patients in Ennis have been encouraged to attend. Those with communication and those with limited communication. A number of those with Autism choose not to attend and physically walk away. We had one lady thought to have severe Autism who sat amongst all staff and peers regularly showing an interest. She has been successfully resettled since

I would want to see more regular patient forums but have seen that necessitaties this is a process of educating and supportive staff. This has proved difficult to do within given resources.

Open Ward Policy

Although Ennis ward is open to families and visitors this was modified as a result of patient group changes. Staff were concerned that some of the newer patients behaviours on occasion would leave themselves Vulnerable ie removing top half clothing. Therefore it was discussed with families and signs were displayed at both sides of the ward to alert families and visitors indicating that they would have to report to the nurse in charge before proceeding throughout the ward.

Restrictive Practices

Staff were clearly advised that if there were Restrictive Practices then these were required to be discussed with the MDT and patients NOK. Also that proper documentation was required. ie Care planning.

The Year Ahead

There were some staffing changes at this point and the ward seemed to settle with most staff working together well and increasing standards and opportunities for the current patient group. Some of these patients enjoyed an overnight away and all got to use the ward car. This new group of patients were experiencing an enhanced daily routine and changes in ability, temperament and behaviour were noticed in some . There is one patient who does not like to leave the ward either for daycare or trips to the community, she is clearly content when sitting in the area she chooses to live in.

One of the staff who transferred asked to start a gardening group and then a cookery group whereby she and other staff sought involvement from all patients.

Staffing 2010-2011

There was some staff sick leave at the beginning, virtually none from May to September 2010. Our staffing levels were good whilst ward staff could do bank shifts. The Nurse Manger had agreed that three staff who had subsequently retired could bank in the ward regularly. There was frequent relief to other wards however and this was highlighted to the nurse manager by myself. The ward relief book and the allocation sheets evidence this. This did impact upon the level of activities we could do with our patients and our staffing budget. Both concerns were hightlighted.

Environment 2010/2011

The Environment in Ennis needs Continuous management mainly due to the narrow corridors and the population within.

The corridors are small for patients with a degree of challenging behaviour, some wheelchairs users. The paint and plaster on the walls getsconstant knocks. Curtains and their poles are pulled down continuously and chairs get ripped often.

Patients throw their shoes and jigsaws out of the windows nearly every day.

The lower end of the ward was painted less than a year ago. New flooring was fitted thoughout all halls and some living areas including the kitchen this year.

Having always had a keen interest on the impact of the environment with patients with a learning disability I was increasingly frustrated not to be able to make changes easily and at all in some cases. It was made clear to me that I could not order new furniture or fittings. I had to source equipment, pictures etc from wards that had closed and that was if I could secure these. This also became increasingly difficult to do.

I requested for sinks to be removed for Health and Safety reasons but this was declined due to cost pressure.

A "Slow traffic" sign was requested as one of our ladies used her tricycle at the time but was not provided. Replacement fire signs were requested.

Maintenance support slowed ie the speed at which jobs were attended to unless they were of an urgent nature. Most recent example is a night light first reported Middle of October this year, has been reported a few times and is still not working. I am told there are less maintenance men available than before.

The Ward Office was moved to the middle room to allow for the larger Resettlement meetings in the year to come. It was also my wish to have the nursing staff in a more central position of the ward. This allowed me to create a visitors room which also doubles up as an interview room/office. Maintenance provided sockets for this move.

Changes to Patient Group Autumn 2011

During this year i became aware that as a result of changes within the Core Hospital and Ennis was to take some patients from there. These ladies where relatively more able in many ways from the current population but had marked challenging behaviours that were to change the unit entirely in terms of safety and securtity. They were potentially more volatile and one has been extremely destructive to ward fixtures, fittings, to patient and staff property.

The potential for and actual challenging behaviour had significant effects on daily life for the patients who had moved into or were the original patients in Ennis.

The first lady to come has Prader Willi Syndrome and exhibits severe challenging behaviours which result in severe damage to property and personal possessions. She will take others belongings, hoard food, clutter her room and denies that she does so. An episode of de escalation with this lady can last up to an average of two hours involving the use of physical intervention and prn medication. She has destroyed many positive aspects of ward environment particulary in the last few months. The MDT and nurse manager were made aware of this.

The second patient to transfer has Epilepsy which the Specialists find difficult to manage, which results in result in a level of frequent threatening aggression and occasional physical aggression. She is unpredictable in how and whom she targets and came to Ennis on a Level 3 Observation for this reason. The third new patient has a history of psychosis, she is loud and likes to give others orders but has been relatively well settled during her time in Ennis.

The effects on the current patients these ladies mix with mostly has been obvious. One had to share her room with two ladies and not one. She and the other two feel that their belongings are not safe and ask for locks on their doors. Some have become visibly upset by the behaviour of others and sometimes need to move during a violent episode by another.

One of the original ennis ladies has always had a degree of Pica. This became more difficult to manage when staff had to spend long periods during physical intervention and other similar episodes, with new patients at the other part of the ward. This patient required a Level 3 observation from March for this reason.

One of our ladies who had come from Fairview was diagnosed this year with an emergency condition requiring quick identification and transfer to the local general hospital along with her specific medication kept on the ward. The Protocol needs explained to any new nurse joining the ward team.

Supervision with Manger

Prior to this I listed all the new duties the role had acquired in an effort to show the differing role and that I felt I needed time within my week to address these. We discussed the personal development issues etc. See copy of.

Staffing Autumn 2010-2012

The staff support transferred with the patients from the Core Hospital in October 2011 was one fulltime staff nurse and one part time nursing assistant. The staff nurse was on sick leave whilst the patients transferred and was replaced by a staff nurse who was pregnant. She knew these patients but was on sick leave soon after, then maternity leave.

Many of the current staff needed to become aware of the level of security required to manage these patients safely as they had not previous experience in this field. Many have not experience in

implementing and maintaining incentive plans but have all tried and made good progress during this year.

Sick leave of staff within the ward went up noticeably from October 2011 and has continued to be problematic during the past year.

The staffing of the duty nursing office by a different manager each day was unhelpful. With reference to Ennis there seemed to be confusion with regards to staffing requirement. I had concerns that senior management were not being made aware of gross shortages in Ennis and began to raise my concerns verbally and via email.ie 4staff plus relief after 9am.

The Telford review of staffing was not agreed with myself and i explained clearly that i did not feel the numbers reflected the need in Ennis Ward.

Clerical Support Staff

Unfortunately the Support Worker who had proved to be an immense resource for nursing staff and who only had been available a half day every other week was given the task of the Resettlement meetings and minutes once weekly against my wishes. This increased the clerical workload for nursing staff. I have been highlighting the lack of clerical support throughout ward EQC audits over the years.

PCCS and nurse support

I have highlighted in emails to nurse management that we do not have a housekeeper, the nurses in Ennis continue to make beds, sort out put away patients personal laundry away. Put linen into the store. With the lack of domestic support on occasion they have to do patients supper and break dishes. This takes considerable time in the morning and many afternoons.

Cleaning

The lack of permanent staff has concerned me for some time and the Supervisor has been made aware of the issues. The situation remains unchanged.

In the light of the fact that Ennis does not have domestic assistance for bed making and personal laundry support I would have thought that cleanliness would be a priority.

Environment this year.

An order for Curtains and Blinds has only partially been received. The curtains were needed in particular for the lower end of the ward and were being specifically designed to be easy to be rehung. The nurse manager had asked me to relook at the requistion due to costing. I was able to remove part of the cost by removing hall curtains where blinds were in situ and forwarded this for approval. The curtains never came and the supplies team explained they did not receive the order. I have not had time to fully investigate where the problem lay with this. But intend to contact Andersons suppliers who hopefully have copies of the agreed order.

We wanted to order new pictures and were waiting until the curtains were in place. Themes had been picked by staff and patients for each room. The lower end was the Garden room and the curtain design chosen was to reflect this. In the meantime I have asked some weeks ago for pictures we have to go up again although this has not yet happened.

The ward fixtures and fittings have suffered greatly in the last number of months during which I simply have not had the time to replace the items. In the lower dayroom a large clock and fireplace destroyed by new patient. Blinds in the front corridor destroyed. Water Cooler removed due to dangers caused when damaged by new patient. Photographic display of patient activities, lamps and pictures all of which greatly enhance the ward whilst the patients await Resettlement were damaged beyond repair.

As a team we continued to report a high level of Maintenance Faults but have noticed a lengthening in the response time for non urgent dockets. This reflects poorly upon the ward environment.

Changes to Mentorship and reducing the Student intake into Ennis October 2012

Having only one part time mentor i was required to reduce the amount of students the ward could take at any one time. The Nurse Manager was made aware of this.

Resettlement

As a team we were now aware that the ward was due to close in March 2013 and that the Resettlement Process was to commence in March 2012.

The Resettlement process began and we progressed through the assessments despite working through times when there were unfortunately high levels of staff sick leave. At times the staffing suffered gross shortage ie 4 AM staff plus staff at 9.30AM.

This was highlighted with the Nurse Manager for the ward via emails, conversations and more recently incident reporting. The manager for the ward did speak to myself about my concerns but the position remained unchanged.

The nursing staffs interest and morale did not appear to have lessened and every opportunity was still being provided to expose our ladies to the community. During the summer a leaving party was held for the patients and their families. With Marquee and a musical entertainment, the ladies had a great time on the day.We invited one of our ladies who was successfully resettled last year and she attended with a group of her friends to the dance.

Prior to this Allegation there had been a decision taken amongst patients families, advocates and Multi disciplinary team that three ladies would go to the Bohill Care Home on Trial Resettlement. Assessments have been collated and careplans drawn up. The team leader and manager had visited Ennis and had been in attendance at Resettlement meetings along with R.Scott CIP and Care Managers from the Belfast Trust.

Staff from the Bohill had begun a 6 week period of visiting the patients in Ennis and getting to know them and their needs. Unsettled behaviours of some patients were noted early on and reported to me by staff and this was relayed to the Resettlement team. I expressed concern that a period of 6 weeks may be too long if the patients continued to be upset.

At a meeting held in Erne ward to Review the progress of the visiting staff and patients it was requested that the Bohill staff come to myself if they had any concerns. I gave an example where i had to redirect member of Bohill staff as a disturbed patient was directing verbal aggression towards them.

The staff visits had already commenced before we had a copy of their duty rota. Staff on duty found this confusing at the time. It was explained that there was problems with the Bohill Care Homes emailing system. The duty received did not reflect the names or numbers of all the staff who reported for duty.

On one occasion a nurse in charge received four staff who thought they should be in Ennis that day. The staff rotated on a 3 daily basis, two and sometimes three staff together every three days. Induction for this amount of people under the conditions we were working proved to be extremely difficult. I am aware that the induction process had begun as proposed.

Communication with Management

The Senior Nurse manager and myself have spoken about staffing issues throughout and he has been informed of progress, changes etc. Please see emails including rotas emailed and incident reports.

The week before the allegation I had asked to speak with my manager re serious concerns of staffing in Ennis and of ongoing difficuilties with particular staff. The manager along with his colleague reviewed their staffing at the meeting and agreed upon some action that might help alleviate the situation.

The Allegation November 2012

I commenced Annual leave and then received notice from my nurse manger on the day the Allegation was made that three staff had been suspended from Ennis Ward. This came as a total shock to me, i attended the ward that evening to offer assistance.

On return from leave I was met by my Nursing and Medical Colleagues that day as they gave their understanding of the situation.

Within a few days the ward received an unannounced RQIA inspection. I held a ward meeting for staff and invited the Service Manager and my own manager who attended along with Mrs M.Mitchell. Staff were encouraged to avail of the Staff Care Service and Counselling Services if they were required.

The Designated officer Mrs Aine Morrison visited the ward with hospital SW H92 the evening prior to the first Strategy meeting.

Following this the lack of communication left me feeling completely powerless. This was for approximately 6 weeks. An explanation of the process for this particular investigation would have alleviated my concerns greatly.

I acknowledge the fact that there has been an improvement in this during the last week with the presence of Mrs E.Rafferty and Mrs M.Manyon who spent time with me explaining what they could. There has also been some practical changes ie pccs staff putting linen away which staff have been able to see.

A Crime-stoppers number was put up in Ennis Only this has confused and alarmed many of the staff.

I do not feel that I have had sufficient access to all the Allegations made.

Following the Allegation I felt that the staffing should have been enhanced appropriately. Taking into consideration the existing staff shortage and on top of this the hours lost from staff suspended there now were significantly less staff to provide direct care of whom the patients know. There was and remains a high level of visitors within the ward in the form of relief staff, monitors and official visitors. Many of these patients have Autism or Autistic traits. This then created further problems for the staff team trying to manage the patient's behaviours which were escalating. Staff themselves highlighted this difficulty at a Ward Meeting and asked that their concerns be relayed to management.

This was done but the situation has remained unchanged.

The monitoring remains ongoing despite the concerns that professional staff have raised about the impact of this on the patients.

In conclusion I would emphasise that I and the ward team fully accept an investigation into Allegations such as have been made was never going to be a pleasant experience and i feel that as a ward team we have co operated fully and to the best of our ability with the investigation.

I do feel however that the anxiety felt by staff with the subsequent effect on their morale and the patients daily lives could not be over emphasised.

A file is available which contains copies of all relevant communication regarding Staffing and Environmental issues and Good Practice. This can be forwarded if requested.

H491

Ward Sister

Ennis Ward

PROPOSAL FOR SERVICE IMPROVEMENT ACTION PLAN IN ENNIS WARD
Muckamore Abbey Hospital

Key Approach to commencing service improvement

It is proposed that The Productive Ward, 15 steps Challenge would be utilised and implemented. Material attached with the detail.

This would mean the engagement of a number of staff external to the ward ie the members of the monitoring team of the ward environment within a productive ward model.

Action: Moira Mannion as Project Lead

To facilitate a number of staff and identified monitors to visit an existing productive ward environment.

Action: Moira Mannion, Service Manager / Senior Nursing Team

To review the use of the SIAF indicators to assess the ward performance against recognised indicators for improvements

Action: Senior Nurse Manager / Ward Sister

Safeguarding material to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice.

Action: Nurse Development Lead

Uplift staff knowledge on current policy relevant to the environment as well as information governance / patient property.

Action: Nurse Development Lead

Commission training restating the strategic objectives of Resettlement

Action: Nurse Development Lead / CEC

Review the ward learning environment for student placements

Action: E McDougall; Practice Education coordinator

Expected completion date for the structured approach could be March 2013

Action plan recommended following leadership walk round with senior staff.

Resources

Preparation of a graph illustrating the shifts pattern, staffing numbers and patient dependency levels,
Action: Clinton Stewart; Senior Nurse Manager, 10th December
Information on high impact times e.g. meal times, getting up and bed times plus staff ratio.
Action: Clinton Stewart; Senior Nurse Manager, 10th December
Explore options to increase staff at key times; plus review roster, review shift patterns, work patterns, activity schedule for patients on the ward.
Action: Clinton Stewart; Senior Nurse Manager, 10th December

Safety

Request a ward Health and Safety Risk Assessment to be undertaken in conjunction with a fire assessment
Action: 7th December 2012
A peer hygiene inspection to be undertaken
Action: 12th December 2012
A de-clutter of the ward environment is proposed in discussion with ward staff, patients and carers.
Action: Assistance for this action via estates December 2012.
Re-designation of ward spaces in discussion with staff
Action: Senior Nursing Team, ward staff commence in December 2012
A review of the monitoring reports to date to identify trends and issues for action
Action: Esther Rafferty; Service Manager 10th December 2012.

Partnerships

Dignity and Privacy, a review of the type of curtains used in the ward on both windows and bed areas
Action: 12th September 2012
Estates department to review ward to cost sandblast of lower window
Action: 12th September 2012
A review of care planning and functional behavioural analysis of each patient on the ward
Action: Ward Sister, & staff, multidisciplinary team
RCN Dignity material to be shared with ward staff and monitoring team, with a follow up training session on dignity issues in learning disability services with the Nurse Development Lead.
Action: Nurse Development Lead

MUCKAMORE ABBEY HOSPITAL

SERVICE IMPROVEMENT ACTION PLAN

ENNIS WARD

Resources

Required

Illustration of ward shift pattern, staffing numbers and patient dependency levels.

Information on high impact times.

Options to increase staff at key times, review roster shift patterns – activity schedules for patients.

Ennis and Erne Wards had originally been one ward. They were separated in the mid to late eighties into the present units. There is still some cross over in terms of facilities. Ennis staff room is located in Erne and also the sluice room with toilet.

Ennis is a 17 bedded unit which caters for female patients. The majority of the patients have lived in the hospital for many years. All patients are on the list for resettlement other than 1 with a delayed discharge status.

Patient's ages range from 30 years to 62years

The majority of patients have a high dependency in terms of care and nursing input with approximately 6 ladies falling into the lower dependency category.

The ward is divided into two fairly independent care areas on the basis of these dependency levels.

There are four care groups and all patients have a named nurse.

Care Area 1

Group 4 comprises of the six patients who have least needs in terms of dependency (see chart). These patients reside at the front of the building or entrance to the ward. This area comprises of the following:

3 single bedrooms
1 triple bedroom
Dayroom/dining room
Wash room with shower and toilet
Single toilet
Office (old ward office)
4 store rooms

There is access to the new ward office area. The patients in this area are not restricted in the sense that they can leave the building.

Care Area 2

Groups 1, 2 and 3 reside in the bottom half of the ward. This area does have restrictions on patient's ability to leave this area due to doors being locked. This is based on the fact that patients living there have no awareness of common dangers and would be very much at risk if they managed to leave unsupervised by staff.

Groups here have a maximum of four patients (group 1 and 3), group 2 has three patients with one patient on enhanced observation, level 3.

The accommodation for groups 1, 2 and 3 comprise of =

2 single bedrooms
1 double bedroom
1 triple bedroom
1 bedroom with 4 patients
2 washrooms with showers, toilet and wash hand basins.
1 single toilet
2 day rooms
1 multi-sensory room
Clinical room

Food is prepared for patients in another ward (Sixmile) and delivered to the ward kitchen for serving. Kitchen and food store are also in area 2.

Patients are all mobile on the ward however there are some who require the use of a wheelchair if going long distances
See graphs for further information on core nursing needs appendix 1

Staff Resources

Current position – Ennis

Registered Nurses	Band	Funded	S.I.P (WTE)
	7	1	2
	6	0	1
	5	9.50	9.41

Total Registered Nurses = 12.41 WTE

Above numbers include 1 WTE Band 5 who is on long term sick leave.

Support Staff	Band	Funded	S.I.P (WTE)
	3	15.0	11.05

Numbers include Agency staff x 1 WTE. Band 3 staff on long term sick leave x 1.94 WTE.

Numbers do not include Band 3 WTE x 1 due to start 13/01/13 and 1 Band 3 on precautionary suspension.

Presently the ward is staffed in the following format:

7 staff AM (7.25am – 1pm)
6 staff 1pm – 6pm
8 staff 6pm -8.30pm

5 staff 8.20pm – 11pm
3 staff 11pm – 2.15am * (not in graph)
2 staff 2.15am – 7.25am

In order to maintain this WTE staffing the ward requires the following:

7am shifts x Mon–Sun =	7.29 WTE staff
6pm shifts x Mon–Sun =	8.12 WTE staff
2 Evening shifts (6-11pm) x Mon–Sun=	1.86 WTE staff
1 x 8.15pm – 2.15am shift x Mon–Sun=	1.12 WTE staff
Night duty shift x 2 x Mon – Sun =	4 WTE staff

Total: 22.39
+26% = 28.21

Ennis is funded for 25.50 WTE staff.

Includes additional Band 7 on temp allocation.

Present WTE staffing levels are 23.46. Registered Nurses make up just over 50% of the WTE staffing (52.89%) @ 12.41 WTE. Presently staffing allows 3 Registered Nurses per shift for day duty.

Ward Routine/Activity Schedule - Ennis

The ward routine is fairly standard being heavily influenced by wider hospital routines and service systems.

The early morning is busy. Night staff hand over to day staff 7.25am to 7.30am.

The N.I.C briefs staff on patient's conditions, planned events and allocates tasks.

All patients have a shower in the morning. In area 2 (eleven patients) four staff are allocated to assist patients to wash, dress and have breakfast. One of these staff is allocated to carry out 1:1 Level 3 observation with an individual patient.

Breakfast is a complicated process. The first group come into the dining room in pyjamas whilst the remaining 7/8 patients start to have their personal hygiene carried out and be dressed. One staff remains in the dining room after the first group and supervises the patients as they pass through in small groups of three or four.

Patients who have already washed and dressed can be waiting to dine in the day areas or the corridor at the locked dining room door.

The N.I.C administers medications from a drug trolley in the dining room, whilst patients are having breakfast.

As patients finish breakfast, there are seven each morning Mon – Fri to get ready for day care.

Both patients on level 3 observation do not attend day care am.

9.30 – 12noon

During these periods there are in total from both sides of the ward, nine patients at day care or have planned day care sessions.

During this period staff breaks are completed and staff do house keeping tasks i.e. putting away laundry, tidy toilet areas, beds etc.

12noon – 1pm approx

Patients return from day care
Toileting/hygiene
Patient's lunches are completed (routine as for breakfast). Staff breaks are started (duration of staff breaks vary depending on numbers requiring lunch).

1 – 4pm

Finish staff breaks. Six patients attend day care approximately, including one patient on level 3 observations who is escorted and supervised whilst at day care by a ward staff.

4 – 6pm

Patients return from day care.
Toilet hygiene
Teas
Staff breaks

6 – 8.30pm

Evening Activities
Preparation for bed
Bed time
Beds turned down
More dependent patients are changed into night attire.

8 30 –11pm

Medications are administered
Suppers served
Patient's toileting and hygiene needs attended to
Patients start to go to bed from 9 30pm --10pm
Patients usually in bed by 11pm

See graph appendix 2

Key Times in Ennis

Mornings to 9am
Possible adjustments/actions

- Review of day care timetable to allow a more balanced attendance between AM and PM sessions.

- Review transport pick up time for day care AM. A later pick up time should allow staff and patients more time to be prepared.

- Review level of observation for patient P22. There is two staff present during meal times in the dining area (N.I.C and 1 other). P22 could be in this area with observation

reduced during meal times to level 1/2 observation. This would free up a staff at an immensely busy time.

- Increased flexible working between day care and ward staff i.e. help from day care staff with escorting to day care, particularly in the morning. Also consideration given in future planning to allow for flexible working between wards and day care i.e. a staff could be in the ward from 7.30am – 9am and then go to day care with patients.

- Co working with other wards

There may be wards on the hospital site who would benefit from additional staff from 9am This might assist in escorting patients who have enhanced observations whilst at daycare .this would ,combined add up to a viable shift and built into the budgets

- Recognition has to be given to the additional work around resettlement.

Though this has happened to some extent with the introduction of Band 6 posts, there is a huge increase in visitors to wards seeking information, attending meetings etc. Also increase in staff visiting potential placements. Staff committed to monitoring/supporting individual patients before, during and after they are resettled. This additional work would to some extent justify the staff/patient ratio when patients are not on the ward or at day care.
Ward staff have noticed an increase in individual patients challenging behaviours when there is an increase in the numbers of new or strange people in the ward.

Ennis patient numbers are likely to be reduced by possibly up to four patients leaving in the next 4–8 weeks. If this should not happen, consideration should be given to the accommodation on the more dependent area of Ennis due to the nature of problematic behaviours patients there exhibit. Staff require more opportunities to separate individuals. This may entail the new ward office being relocated. This could then return to a patient area.

P.C.S.S. have since the commencement of the core hospital, carried out a house keeping role, i.e. laundry management, bed making etc. If this is extended to resettlement ward it would free up staff time to have increased contact/interaction with patients, increased activities for patients and more emphasis on developing patient skills.

In achieving the above staff would be able to increase attendance on training courses outside the mandatory ones.

Ennis ward is part of a wider hospital community and therefore it is difficult to review staffing on one ward without considering the positive or negative influences of the situation.

I am aware that staff in Ennis have spoken to R.Q.I.A. whilst being audited around the movement of staff from Ennis to assist other wards. This would be reflected on other wards who also have staff moved.

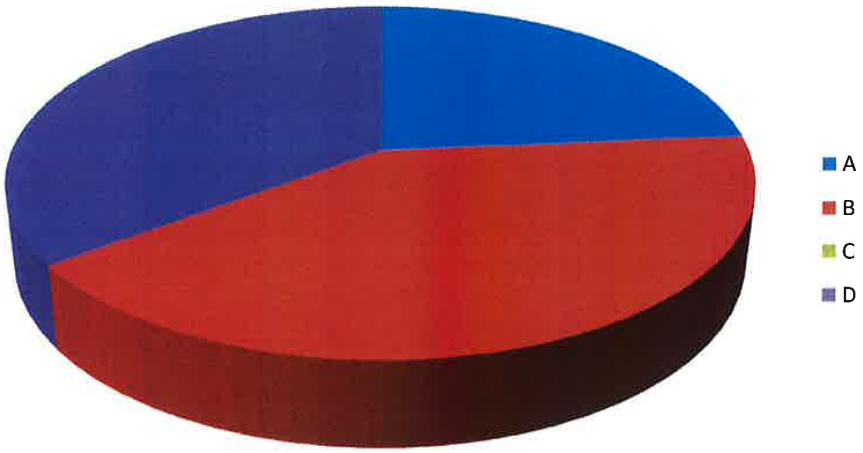
Options for future staffing in Ennis could be based on a model that required a ward or unit to be self sufficient in terms of staff. This would require the ward to have a funded staff establishment in place that accurately reflects the care requirement of the client group. Once established, staff would then not be taken off the ward to relieve other wards but would not get help from other wards (outside emergency situation i.e. fire or if there was major staff crisis i.e. flu epidemic). Benefits would be measured in terms of staff attendance, increased morale and improved continuity of patient care.

It would be acknowledged that if the clinical team increased the observation of a patient, the staffing would then be reviewed. Patients on delayed discharge status would not be transferred to resettlement wards but should a patient require treatment due to deterioration in behaviour particularly, they would have access to the core hospital facilities and full professional team services.

Assessment of Patients in Ennis

Recording of Managing Toileting Habits

A	B	C	D
4	7	0	6



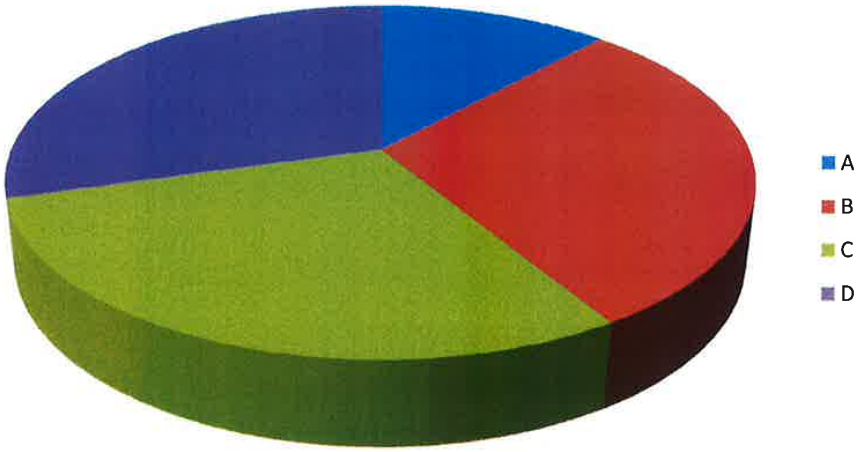
Key

A. The patient uses the toilet without any assistance
B. The patient uses the toilet with assistance
C. The patient requires to be taken to the toilet at regular intervals to maintain continence
D. The patient wears incontinence pads which need to be changed by the nurse

Assessment of Patients in Ennis

Recording Problematic Behaviours

A	B	C	D
2	5	5	5



Key

Behaviours

- Physical aggression towards others , i.e. slapping, biting, kicking, punching
- Physical aggression towards staff
- Destruction toowards property
- Inappropriate stripping of clothing

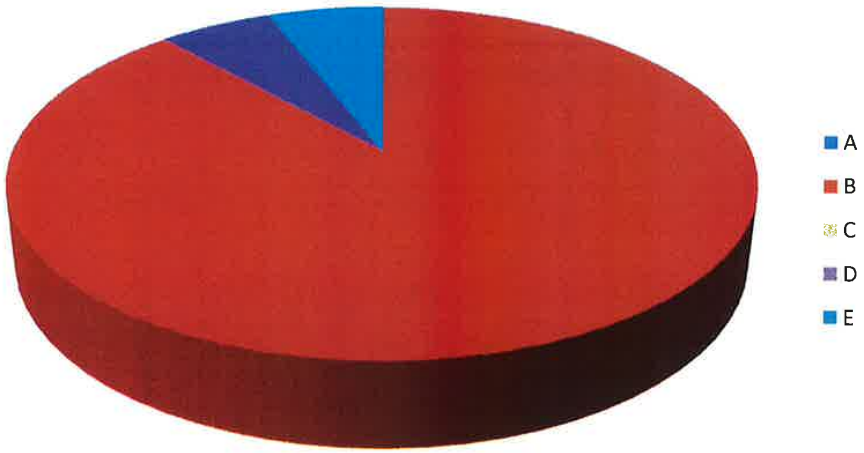
A. The patient displays 1 of the behaviours
B. The patient displays 2 of the behaviours
C. The patient displays 3of the behaviours
D. The patient displays all of the behaviours

Assessment of Patients in Ennis

Ability to Eat and Drink

A	B	C	D	E
0	15	0	1	1

* When pts mental state deteriorates



Key

A. The patient eats and drinks a meal and beverage that has been prepared without any further assistance

B. The patient eats and drinks a meal and beverage that has required further preparation, i.e. food cut into small pieces or beverage thickened without any further assistance

C. The patient requires regular physical prompting to eat the meal or drink the beverage as prepared in no.1

D. The patient requires regular physical prompting to eat the meal or drink the beverage as prepared in no.2

E. The patient requires to be fed

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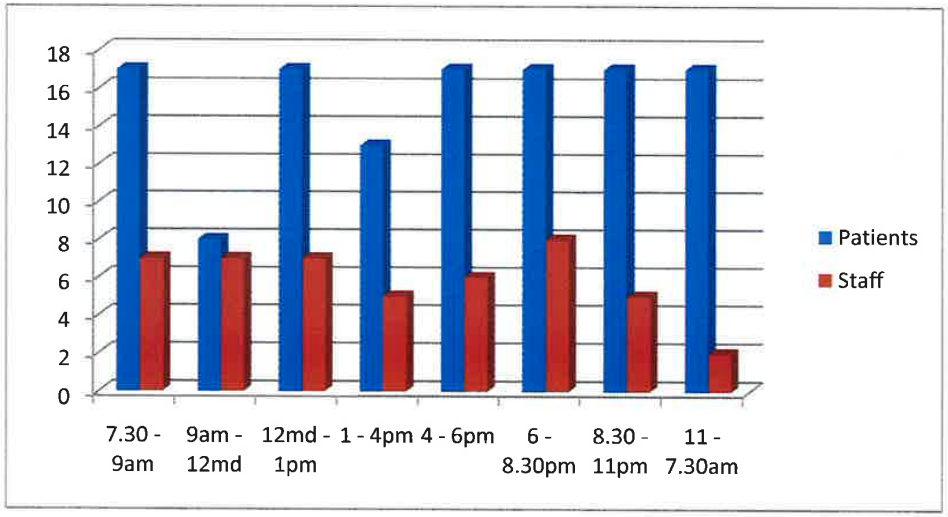
Assessment of Patients in Ennis

Staff:Patient Ratio

	Patients	Staff
7.30 - 9am	17	7
9am - 12md	8	7
12md - 1pm	17	7
1 - 4pm	13	5
4 - 6pm	17	6
6 - 8.30pm	17	8
8.30 - 11pm	17	5
11 - 7.30am	17	2



Notes

- 9am -12md - 7 staff x15 break from 9 - 10am approx
- Staff lunch breaks from 12md -2pm
- Staff tea breaks from 4.30pm

* Does not include additional 8.15pm to 2.15am shift IE 11pm 2.15am = 3 staff

Ennis Audit April 2013

The purpose of the audit was to ascertain the care plans included protection plans for the patients with regard to vulnerability to actual or potential physical harm from others

7 patients files/records were examined

4 were patients files belonging to the patients had been involved in the investigation in November 2012
3 were patients who were not involved in the investigation

The 3 files belonging to the patients not involved in the investigation were randomly selected from the patients in the ward at the time of the audit

Evidence was gathered from

- Patients care plans

The recording of restrictive practice (all 7 patients) and behavioural interventions were also examined for the 4 patients involved in the investigation

1. Is there evidence of a protection plan in relation to vulnerability in the patients care plan?

Yes	7	100%
No	0	0%
NA	0	0%

2. In relation to the 4 patients involved in the investigation, is there evidence the protection plan was reviewed daily?

Yes	4	100%
No	0	0%
NA	0	0%

The other 3 patients protection plans stated that a review would take place following the next strategy meeting.

3. Is there evidence in the patients assessment regarding the use of restrictive practice?

Yes	5	71%
No	2	29%
NA	0	0%

4. Is there evidence of behavioural intervention?

Yes	4	100%
No	0	0%
NA	0	0%

Recommendations

- Issue guidelines to staff re the recording of vulnerable adult issues and restrictive practices in the patients care plan

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

ANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

10 and 11 November 2010

The issue(s) identified during this inspection are detailed in the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with Service Manager, Senior Nurse Manager, Ward Manager Ennis ward, two staff nurses for the ward and the Ward Consultant.

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
1	Advocacy services are available to all patients.	It is recommended that the Trust is proactive in the delivery of an independent advocate service to the ward. Check minutes of Pt Team meetings & resettlement.	Great - advocate care and get to know Pt, referred or no N.O.K. Pt to be resettled and advocate took on role of independent view. 3 advocates depending on pt. green - Every family offered advocate to part of resettlement team took up. Had a Summer party with advocates present. Advocate attends Pt. Team meeting ✓	• Approach the advocacy service in order that a proactive service may be offered to the patients in Ennis ward • Awaiting outcome of advocacy referral for one patient • Mencap approached families of a further 4 patients offering this service to them and are awaiting a response	2 months 2 months 2 months
2	All patients have been advised of their rights and what they can expect in terms of care and treatment, in a manner appropriate to their understanding.	It is recommended that the outcomes of patient's' meetings are clearly recorded and monitored and that rights and routines are on a standing agenda.	✓	• The minutes will have the outcomes clearly defined and evidence of carrying out these forwarded to the next meeting	Ongoing

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
6	All patients are informed of and involved in a person centred assessment and care planning process. REGULATION & QUALITY IMPROVEMENT AUTHORITY 17 FEB 2011 MHLDT	It is recommended that patients are asked to sign their care plans to evidence consent to change. Work with 3 Trusts NT, SE & BT, taken 40 in trusts review pts for each one. BT 9–10 pts. SE 3 NT. 4 Discuss resettlement, assess etc. Dr Ling does physical exam. It is recommended that there is a record to evidence patients being asked for their views for multi-disciplinary meetings and reviews and to evidence informing them of outcomes.	No monthly MDT meeting. Views resettlement this used shelved as pts due to leave within year. Weekly meeting but all about resettlements. Dr Ling and SWS to commence Fortnightly review of pts. ✓ OMO in twice per week.	• Care plans will be discussed with the patient when reviewed and evidenced by patients signature • Review of the nursing review proforma with updated evidence of discussion and patients signature • Changes made to the monthly MDT book to reflect this ✓	Ongoing 4 months Complete
7	There will be weekly multi-disciplinary team review with patient involvement and appropriate	It is recommended that the format for recording reviews includes: • Tasks identified. • Who has responsibility for tasks.	✓	• The MDT book has been modified to include this information • Will be actioned through EQC audit tool	Complete 4 months

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
	representation from advocates and other relevant agencies involved in the patient's care.	• Who attends, including designation. • Capturing patient views prior to the meeting. • How the patient is informed.	was modified and ceased -		
9	Patients will be given the opportunity to meet and discuss in private any issues with their primary nurse or in their absence an allocated nurse on a daily basis.	It is recommended that 1:1 meaningful engagement with the named or allocated nurse is recorded as such to evidence this expectation statement.	not always documented every day -	• On a daily basis the named nurse will record in the care plan all engagement with the patient	Ongoing
11	The discharge plan should be initiated at the earlier opportunity following admission.	The method of recording must include monitoring of outcomes.	Resettlement process -	• This will be evaluated at a minimum 6 monthly (more often if actively being prepared for discharge) and signed by the patient when applicable	Ongoing

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES

ADDITIONAL RECOMMENDATIONS:

AREA OF CONCERN/ ISSUES	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
Environmental	It is recommended that all environmental recommendations in this report are resolved.	Ward closing next b	• Requests for repainting re-submitted • Requests for new flooring submitted • Referral made to Hotel Services re lack of cleaning provision • New bedroom furniture requested	a lot of abuse. other than back bed room **Ongoing**
Staffing	It is recommended that the process of taking staff from the ward to relieve other ward is reviewed and monitored as it impinges on patient care.	Initial efforts but back to using Ennis for relief.	• Senior Nurse Management to monitor and review	**Ongoing**
Patient transfers	It is recommended that there is a transfer policy for patients to and from the ward which incorporates a phased person centred approach.	Whole new ward -	• Will be referred to policy group for inclusion in the admission discharge protocol • Review transfer checklist	**4 months**

High stress for all staff - a lot of de-escalation.

Ennis not sure, staffing does not reflect this.

Resettlement -

Social activity	It is recommended that onsite social activity is monitored for all patients.	activity book care plan - improved onsite facilities provided by day care - Thocas arc - Good use of car as part of resettlement.	• Continue to record all social activities for patients including those taking place on site	**Ongoing**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

REGULATION & QUALITY IMPROVEMENT AUTHORITY
17 FEB 2011
MHLDT

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: John Donaghy

NAME: _____

DATE: 14/2/11

FOR OFFICE USE ONLY:

The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

UNANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

Belfast Health and Social Care Trust

13 November 2012

informing and improving health and social care
www.rqia.org.uk

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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover, RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. RQIA undertakes a range of responsibilities for people with mental ill health and those with a learning disability, following the transfer of duties of the former Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009.

2.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Antrim BT 41 4SH
Telephone number	02894463333
Email address	Linda.mccartney@belfasttrust.hscni.net
Person in charge on day of inspection	Linda McCartney, Ward Manager
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Resettlement/ Challenging behaviour
Number of patients and occupancy level on days of inspection	17 beds 17 patients
Number of detained patients on day of inspection	One detained patient
Date and type of last inspection	10 and 11 November 2010
Date and time of inspection	13 November 2012 09.30 – 18.00
Name of Inspectors	Margaret Cullen Siobhan Rogan Brenda Gallagher

Ennis Ward is a 17 bed resettlement female ward for adults with a learning disability who present with challenging behaviour . The ward is on the Muckamore Abbey Hospital site and is managed by the Belfast Health and Social Care Trust. The ward consists of three areas. To the right of the main entrance there are facilities for six patients; a bright and homely furnished living and dining room, a well maintained toilet and bathroom and three single bedrooms and one bedroom accommodating three patients, all of which are personalised by the patients. The patients in this part of the ward are more independent than other patients on the ward and this is reflected in the range and choice of furniture. All rooms have televisions and music equipment.

To the left of the entrance there are facilities for 11 other patients. There are two bright day rooms and each day room is appropriately furnished to reflect the needs of patients who are less able and less independent. One of the rooms has a range of furnishings and a television with DVDs and Wii for patient's use, while the other has more protective furnishings and is used by patients with more challenging behaviour.

The ward has a spacious well maintained garden with swings and a barbeque area. There is a smoking shed and chair outside the door to accommodate this. It was noted that storage facilities on the ward are limited.

3.0 Purpose of Inspection

An unannounced inspection of Ennis Ward Muckamore was undertaken on 13 November 2012 from 09.30- 18.00. The inspection team included Margaret Cullen, Siobhan Rogan and Brenda Gallagher, Mental Health and Learning Disability team Inspectors, RQIA. The inspection was in response to serious concerns reported to RQIA on 8 November, by telephone, by the Management of Bohill Nursing Home. This manager stated that a member of their staff had been on Ennis ward the previous day as part of a planned resettlement strategy. On leaving the ward on the night of the 7 Novemeber 2012 they sent a text message to their line manager to state they had concerns about observed practices on the ward. This manager contacted the member of staff early on 8 November 2012 and was informed of a number of alleged instances of abuse to patients. As they were unable to contact an appropriate manager on the Muckamore site to report the allegations they contacted RQIA as the alleged perpetrators were on duty at that time. RQIA immediately reported vulnerable adults concerns to Senior Management in Muckamore regarding allegations of physical, verbal and emotional abuse by ward staff to four patients on Ennis ward. Interim safeguarding arrangements were put in place along witha joint protocol investigation.

The purpose of this inspection was to:

Review the QIP from the last inspection on Fairness, 10 and 11 November 2010.

Review of the current safeguarding arrangements on Ennis Ward. To focus on the monitoring arrangements over the weekend and on-going arrangements to complement the current investigation rather than duplicate aspects of it.

4.0 Methods of Inspection

The inspection was unannounced and inspectors reviewed records and documentation, interviewed the Ward Manager, the Responsible Medical Officer (RMO), the Senior Social Worker and Designated Officer for Safeguarding, the Senior Nurse Manager for the ward, the Operations Manager monitoring over the weekend and Hospital Services Manager. Inspectors also spoke informally to patients who were able to communicate. These patients reside in the front section of the ward and not in the part of the ward where the alleged abuse took place. Those patients were unable to communicate with inpectors. Inspectors were informed by the Ward Manager and RMO that the increased activity on the ward as a consequence of the safeguarding arrangements and investigation was making these patients more unsettled. Inspectors were introduced to the patients but in view of this advise did not sustain a presence on this side of the ward.

During the inspection the inspectors focused on the staffing compliment and allocation, incident reporting, staff training and care plans. The summary of findings is presented on page 17 of this report.

5.0 Inspection findings

5.1 Review of the Quality Improvement Plan(QIP) from RQIA inspection of November 2010. (The returned QIP is included as Appendix 2)

Inspectors confirmed that some of the recommendations had been implemented, however, a number require to be re-stated. The Ward Manager indicated that there is enhanced and proative involvement of advocacy services. All families were offered the input of this service in relation to the resettlement programme for the ward, as yet no family have accepted this offer. Any patients on the ward who do not have family to represent their views in relation to resettlement have an advocate to provide transparency in the process. One patient who has availed of this service has since been resettled and the Advocate attended all meetings in relation to this. An advocate also attends the patient forum meetings. However, as the patients' meeting occur monthly inspectors concluded there is not a sufficiently proactive presence of advocacy on the ward. In view of the current safeguarding issues and the profile and vulnerability of the patients on the ward, the need for transparency and independent support is required. This recommendation will be re-stated.

Inspectors were informed that the minutes of patients' meetings were adapted to define outcomes of the meeting and evidence taking tasks forward and reviewed for the following meeting. Unfortunately the minutes were not reviewed due to time limitation of the inspection. These will be reviewed at a follow up inspection. .

As the ward has a resettlement focus recommendations made regarding discharge planning have been processed and incorporated into the MDT resettlement meetings on the ward. The patients on the ward orginated from three trusts (BHSCT, SEHSCT and NHSCT) There are weekly resettlement meetings on the ward which have replaced the previous monthly MDT meetings. This change was agreed as it was planned to close the ward within one year. As a consequence the recommendations made by RQIA in relation to patient involvement in their care and MDT processes have not been sustained. The Ward Manager indicated that practice was modified and then ceased once the focus on resettlement changed ward processes. Inspectors examined minutes of the resettlement meetings which confirmed that patients discharge arrangements are reviewed on a rotational basis each week so that all patients' individual cases are discussed at MDT wthin a monthly cycle. There was a typed record of all meetings which indicated attendees and

patients and issues discussed. However there was inconsistent evidence of patient/ family involvement. Furthermore it was confirmed that 1:1 named nurse contact with patients is not recorded on a daily basis.

As the annual MDT review of patients is to continue along side the resettlement processes it is recommended that the recommendations of the QIP are included in this review.

Inspectors were informed that a ward clerk is assigned to the ward one morning per week and they are used to minute the resettlement meeting discussions. The Ward Manager confirmed that the records are monitored in the EQC audit and the outcome and adherence to professional requirements and discussed with staff at staff meetings.

There were additional recommendations made in the QIP in relation to staffing, the ward environment, patient transfers and social activity.

Staffing levels are discussed in the additional section of the report. It was agreed in the QIP that the Senior Manager would monitor and review staffing in relation to the process of taking staff from Ennis to relieve other wards and the impact this had on patient care. Inspectors were not assured that this was achieved robustly or that improvements had been made regarding this.

The Ward Manager advised inspectors that the environmental issues highlighted in the previous QIP had been actioned and that new flooring had been provided except for a back bed room. Inspectors were informed that parts of the ward had been painted a few times but it remains a constant challenge to maintain the décor with the beviour and needs of the patients. As the ward is due for closure this recommendation will be kept under review.

Inspectors were advised that good use is made of the ward car as part of the resettlement programme. Inspectors were advised that the activity book for the ward, care plans and improved onsite facilities for day care have improved patient activity. This requires to be followed up robustly at the next inspection.

The recommendations which were not fully implemented will be re- stated in the QIP for this unannounced inspection.

5.2 Review of the monitoring arrangements

Inspectors interviewed the Operations Manager who had provided monitoring cover for the ward over the weekend. Inspectors also interviewed the Senior Social Worker who is the Designated Officer for the hospital site, the Senior Nurse Manager for Ennis Ward and the Responsible Medical Officer (RMO).

The Operations Manager who provided monitoring over the weekend indicated that they visited to the ward periodically. A report had been completed for the Service Manager and a copy of this report was provided to inspectors on request. They indicated that patients had been unsettled, many of them suffering from Urinary Tract Infections and the impact of additional activity from monitoring and forensic photograhers. One patient has a history of stripping and there are difficulties preserving her dignity. Staff endeavour to use screens appropriately but inspectors were advised that clear guidance is needed in relation to preserving the dignity of this patient. The Operations Manager indicated that relatives were visiting the ward and had free access to the environment. While this indicates transparency it reinforces the need to protect patients' dignity.

Inspectors were advised that all patients' relatives were informed about the current investigation and safeguarding procedure. None of the relatives have raised further issues.

The Operations Manager indicated that they understood that the role of the monitor was to look for poor practices,examine staffing levels and ensure safe and effective care. Additional staff were assigned to the ward during the safeguarding process: a night supervisor, a Band 6 nurse, another Band 7 to support the Ward Manager and the consideration of a Deputy Manager. Inspectors were advised that the allocation of staff was difficult. Patients require constant supervision and there is significant disinhibited behaviour and pushing and shoving as a consequence of poor communication. While the Operations Manager did not personally witness any assaults between patients over the weekend they were aware that one incident required the attention of two to three staff to de-escalate. The report of this manager indicated that they assessed the staffing requirements from their observation to be seven staff.

The Ward Manager provided evidence that they had raised concerns about the staffing levels and competency of staff to work with the level of challenging behaviour of the patients over the six month period prior to the safeguarding investigation. A tour of the ward indicated that the layout of the ward is such

that it represents two separate units. The six patients accommodated in the front area have better communication skills and are generally less dependent then the 11 patients to the back section of the ward. The Ward Manager advised that there is major potential for behavioural problems at both sides of the ward, such as pushing, shoving, punching and hair pulling. One of these patients requires level three observation (within eye sight at all times) due to the level of potential aggressive, unpredictable behaviour. On the back section of the ward one of the patients has Pica and requires level three observation. There are usually seven other patients in the same area as this patient so two staff are always required. However, this is not always provided in the staffing complement on duty. Another patient is very demanding to the extent that staff need to be rotated and a high level of skill is required to divert and manage the patient appropriately. Repetitive behaviours can be challenging for staff. An inspector examined staffing records and confirmed that there was a history of low staffing levels on this ward. The Ward Manager indicated that the function and profile of Ennis ward has changed as hospital retraction has continued. It no longer resembles the continuing care ward it represented and that staffing levels should reflect this.

The Ward Manager referred to the incident in relation to the patient who was allegedly hit in the bath room and came out with a bloody nose. They stated that while abusive practices would not be tolerated this patient had a condition which caused regular bleeding. Inspectors examined the patient's notes which confirmed that nose and mouth bleeds were an identified problem for this patient. The Ward Manager indicated shock and dismay at the allegations made.

The RMO confirmed that the patients on the ward are very sensitive to outsiders and environmental change. They indicated shock and surprise to hear of the allegations and reinfornced the need to support patients and staff through the investigation. The RMO referred to one other allegation of abuse in relation to the ward which was six to seven months previously. The Ward Manager provided the details explaining that the incident happened at day care and was reported by a day care staff member. The staff member subsequently resigned. This incident was notified to RQIA. The outcome of the subsequent investigation has been requested. The RMO had not been up updated on the outcome of the Forensic Medical Officer's assessment of the patients. His intial consideration from his knowledge of the patient was that of the four patients involved three would not have the capacity to be interviewed and while one patient could engage in an interview they would not have the

capacity to give a statement. However he considered that some patients could be interviewed.

He referenced the issue of patients stripping on the ward and indicated that with one patient they had tried to use a swim suit to maintain her dignity but this was unsuccessful. This behaviour was problematic in relation to their resettlement plans as three female patients were to go to a placement with three male patients from Erne. A single gender environment is now required. He highlighted the difficulty in getting appropriate placements for patients.

The RMO indicated that there is good medical cover to the ward which has increased further since these allegations. He stated that a Medical Officer was on the ward every day and he would attend the ward at least once per week for resettlement reviews. Patients' notes confirmed this statement.

Interviews with all staff indicated that they had similar interpretations of the definition of monitoring requirements for the ward though no specific explaination of monitoring role was documented. The reporting mechanism for monitors was also left to their discretion and inspectors were unclear if this was after each shift or as in the week end a report for the whole period. Inspectors referenced RQIA's review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home. It recommended clarity on the monitoring and reporting role.

6.0 Other areas reviewed:

6.1 Training records for all staff

Twelve staff training records were examined during inspection. The following training was observed to have been completed within accepted timeframes for all staff

- MAPA
- Abuse of Vulnerable Adults
- Child Protection
- Manual Handling
- Fire training
- Basic Life skills

A training file was observed with names of all staff who attended training with dates. There was no training content or hand outs retained of the training given. When the Ward Manager was questioned further regarding this she said they never retained the content or handouts of any training they completed. She said she could get copies of the training content if we needed them.

6.2 Policies

The following Policies & Procedures were observed and read by the inspector and were accessible to staff.

- Child protection policy (Operational date: 19.1.2009 Review date: 19.1.2010)
- Use of Restrictive Practice in Adults (Operational date: 2011 Review date: Jan 2014)
- Use of physical intervention by staff from Mental Health & Learning Disability Services (Operational date: June 2010 Review date: June 2013)
- Raising Awareness Exploitation (Operational date: 19.5.10 Review date: 14.12.11)
- Safeguarding Vulnerable Adults Protection Policy & Procedures (Operational: 14.12.11)
- Whistle Blowing Policy: (Operational 2008 Review Sept 2012).

All policies had a cover page with all staff names and each member of staff had signed off that they had been made aware of policy. Inspectors also noted a quick reference guide to the Safeguarding Procedures displayed in the office.

Inspectors were provided with a copy of the Levels of Supervision/Observation policy. This policy became operational in April 2007 and was reviewed in 2010 however the copy provided to inspectors by senior management was not signed by the author or Chief Exceutive.

The observation policy states clearly that level three and four observations should be provided by a designated nurse who has no other duties. (See section 4) Discussion with the Senior Nurse Manager indicated that in relation to practice they use the first level three within the staffing complement of the ward. Clarification is requested in relation to this practice and adaptation of the policy if required.

6.3 Careplans

The careplans of four patients where reviewed by inspectors. Evidence that information was being collated to support resettlement of patients was available in the careplans. This took the form of 'All About Me' booklets and included historical and current information about the patient in terms of preferences, family etc. The Ward Manager did outline actions that were being taken by nursing staff to prepare patients for their new home however the careplans reviewed did not detail activities that patients participate in as part of skills development in preparation for moving to community settings. In addition, specific details of challenging behaviours patients present with in terms of topography and function, and how best to care for meet the needs of individuals whom present with challenging behaviours where not detailed in the careplans. Careplans reviewed did not consider potential restriction to patient's liberty under the Department of Health DoL's Guidance 2010.

6.4 Incident reporting

Incident reporting over the last number of months was viewed by inspectors. A variety of incidents had been recorded to include incidents relating to physical aggression and incidents relating to patient safety due to staffing levels. The records reviewed relating to specific patients had been documented appropriately in the patients' careplan. Despite discussion with Senior Management, inspectors were unable to clarify how incidents reported by the Ward Manager relating to patient safety due to staffing levels over a six month period were addressed.

7.0 Safeguarding

Examination of patients' notes evidenced a significant numbers of vulnerable adult referrals to indicate that staff understood the process for referring patients appropriately. An Inspector interviewed the Designated Officer for Safeguarding who indicated that with enhanced training for staff the number of referrals had risen significantly. The Designated Officer on request arranged for the Inspector to have a print out of referrals for the ward in the previous six months. It was noted that one patient had been referred on eight occasions from April 2012 in relation to physical assaults from other patients. A significant number of these were from a patient who was on level three observations. Inspectors asked the Senior Nurse Manager and the Service Manager what goverance arrangements were in place to monitor protection plans and analyse vulnerable adult referrals as this level of assaults could not be deemed acceptable. Inspectors were informed that safeguarding Vulnerable Adults is a standing item on the agenda on a fortnightly core managers' meeting and the medical meeting. The Designated Officer will being forward trend data to the meeting and highlights particular cases for discussion if additional staff or a transfer of a patient is required. They weigh up the risks to reach a balanced outcome for patient safety. Inspectors did not have evidence that goverance was sufficiently robust and this matter has been escalated for clarification.

8.0 Summary of the inspection findings.

An unannounced inspection was undertaken on Ennis Ward on 13 November 2012 in response to allegations of serious abuse by staff to patients on the ward.
The focus of the unannounced inspection was to review improvements following the QIP of an inspection in November 2010 and to review the monitoring arrangements for the ward in relation to safeguarding. Patient interviews in relation to the allegations were being planned under the joint protocol investigation.

The nature of the ward has changed over recent years with hospital resettlement and the ward has changed from a continuing care ward to a resettlement ward. Inspectors were informed by the Ward Manager that the profile of patients had changed with a more volatile mix of patients and high levels of challenging behaviour. However, despite this inspectors were advised that the staffing complement for the ward is unchanged. A Telford rating assessment for the ward was completed in October 2012 but the appropriate complement of staffing for the ward remains unclear. Inpectors could not decipher the allocation of tasks and the duty list and clarity has been sought and recommendations made in all these issues. Assurances were required in relation to the maintainance of safe staffing levels on the ward.

Inspectors discussed the progress of the QIP with the Ward Manager. Some improvements were documented; such as advocacy provision on the ward, environmental issues, discharge planning, compliance with professional standards for recording. Inspectors were advised that other recommendations had been taken forward and then lapsed such as the recommendation for a format for recording MDT review and patient/carer involvement in care planning processes when the MDT meetings became more resettlement focused. These and the other recommendations will be restated in the QIP.

Inspectors spoke informally to the patients on the first part of the ward who were able to communicate. Patients indicated that they were well cared for and comfortable. Inspectors did not maintain a presence in the other section of the ward as all staff interviewed indicated that patients were unsettled with the enhanced activity on the ward as a consequence of the safeguarding investigation.

A number of concerns were raised by inspectors to include

- Staffing levels (including allocation, complement and mix of staff)
- Safeguarding
- Governace
- Guidance on dignity protection
- Deprivation of Liberty

These issues were all escalated to the Trust post inspection in relation to seeking clarity and assurance of appropriate safeguards, care and treatment for patients.

9.0 Additional concerns noted by Inspectors

9.1 Staffing

The issue of staffing on Ennis Ward was clearly highlighted as a main area of concern. The inspectors were given assurances that staffing levels would not fall below six. Inspectors indicated that they expected that consideration is given to the experience and skill mix of staff on the ward. On further discussion of our findings and from observations, review of documentation and discussions with the Ward Manager, the RMO and monitoring officer's report, the inspectors concluded that the staffing levels are currently insufficient to safeguard and protect patients and these should be increased to a minimum ratio of seven staff for the current population profile.

This view is based on the following information;

- The Operations Manager for the ward indicated to inspectors that in the review of staffing levels, the Telford Assessment was used to facilitate the inclusion of the first level three observations within the minimum staffing levels. There was only one enhanced staff for the second level three observation on the ward. This contradicts the Trust Policy on Levels of Supervision/Observation. (Operational April 2007, reviewed November 2010) which was provided. Point 4.3 of this document states:

  "Level three –Within Eyesight 1:1 The Patient should be kept within sight by a designated member of staff at all times. The staff member will not have any other duties…."

- The report from the monitoring officer for the ward over the weekend indicated that patients were unsettled and that there were high levels of challenging behaviour. He identified in this report that the total number of staff required should be seven.
- The Responsible Medical Officer and Ward Manager re-affirmed the complex needs of the patient group and that challenging behaviour displayed in the locked section of the ward requires appropriate staffing, experience and skill mix. The ward appears to have been understaffed for a significant period of time and there was clear evidence that the current investigation is having a negative impact on patients and making them more unsettled.
- The high number of Vulnerable Adult referrals referenced in relation to one patient who was allegedly assaulted eight times, from April 2012, indicated the level of potential aggression among patients.
- Inspectors noted incident reports in relation to staffing issues and requested evidence that this was highlighted by the Ward Manager to senior staff.

- Review of the QIP, following the Inspection to the ward, in November 2010, indicated that the recommendation in relation to staffing was not appropriately implemented by the Senior Nurse Manager. There was no evidence that staffing levels for the ward had been audited or of how the unmet need was escalated by senior management.

9.2 Staff allocation

Inspectors reviewed documentation relating to the allocation of staff on the ward to meet the care need of patients however it was difficult to ascertain from this information

- what staff were on the ward eg instead of a name,the allocation sheet stated 'Erne relief'
- what responsibilities were allocated to staff at each time period throughout the shift

It is recommended that this system is reviewed so that the number of staff available, the name of each staff member and their allocated responsibilities throughout their shift in Ennis is clearly documented.

9.3 Telford system

Senior management with the hospital reported to inspectors that the complement of staff for Ennis had been assessed using the 'Telford system'. However, there appeared to be a lack of clarity in relation to staff complement required for Ennis. It is recommended that ward mangers should be included in the Telford assessment process and the outcome of this assessment should be clearly communicated to all ward staff. In addition this information should be recorded on the ward and in the nursing office.

9.4. Actual Duty worked

On the day of the inspection the 'actual duty worked' recording could not be located which made the task of identifying staff allocation more difficult.

9.5 Dignity

Inspectors were informed that some patients strip on the ward and one patient strips naked on a frequent basis. The Operations Manager who was monitoring the ward indicated the level of challenge this presents for staff in relation to protecting the dignity of the patients. They indicated that no clear guidance is available and that staff use screens for this purpose.
Inspectors noted that one patient on the ward is detained under the Mental Health (Northern Ireland) Order 1986. The entrance to the ward was open but the doors to the back section of the ward which accommodates 11 patients is locked. These patietns all experience deprivation of their liberty as they are locked in and staff control access on and off the ward. Inspectors examined

patients' notes and confirmed that the need for a locked environment is written in patients' care plans. However, the documentation does not reflect the trust's adherence to the Deprivation of Liberty Safeguards- Interim Guidance 2010.

All of these issues were escalated to the Service Manager following the inspection.

Appendix 1 – Quality Improvement Plan

QUALITY IMPROVEMENT PLAN

UNANNOUNCED INSPECTION

Ennis Ward, Muckamore>

13 November 2012

The issue(s) identified during this inspection are detailed in the Quality Improvement Plan.

The findings of the inspection were discussed with the Ward Manager, Senior Nurse Manager and Service Manager.

1. RECOMMENDATIONS RESTATED FROM PREVIOUS INSPECTION

RECOMMENDATIONS RESTATED FROM PREVIOUS INSPECTIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the Trust is proactive in the delivery of an independent advocate service to the ward.	**2**	A meeting has taken place with advocates to confirm their roles and responsibilities, the outcome of this has been disemminated to all wards. Advocates are invited to and attend patient meetings. Advocates are invited to and attend patient resettlement meetings. Advocacy input is recorded in the patients care plan. Senior managment will also review availability of advocacy to this ward.	**Immediate and on going**
It is recommended that patients are asked to sign their care plans to evidence consent to change. It is recommended that there is a record to evidence patients being asked for their views for multi-disciplinary meetings and reviews and to evidence informing them of outcomes.	**2** **2**	Patients are involved in the review of their care plan, when changes are made, patients who are able to sign are asked to sign the progress evaluation , if patients refuse to or are unable to sign this is recorded	**Immediate and on going**

		When the MD meetings and reviews take place, if applicable patients are asked for their views prior to the meeting and this is recorded in the care plan with the details of the meeting, if the patient is unable to attend staff will discuss outcomes of the meeting with the patient, this is also recorded in the progress evaluation	
It is recommended that the format for recording reviews includes: • Tasks identified. • Who has responsibility for tasks. • Who attends, including designation. • Capturing patient views prior to the meeting. • How the patient is informed.	**2**	The format for recording MD meetings and reviews has been revised. This has been shared with all staff and is as detailed Who attended, including designation - Patients views prior to the meeting recorded - Relatives prior to the meeting recorded (if applicable) - Was the patient invited and attend and if not why not - How the patient was informed of outcomes, if the patient has	**Immediate and on going**

		not been informed the reason why - Patients views following the meeting recorded - Relatives views recorded - Who is responsible for tasks/outcomes identified	
It is recommended that 1:1 meaningful engagement with the named or allocated nurse is recorded as such to evidence this expectation statement	**2**	The named nurse is recording all 1:1 meaningful engagement in the care plan, each time this will be highlighted as 1:1 with named nurse and patient	**Immediate and on going**
It is recommended that the process of taking staff from the ward to relieve other ward is reviewed and monitored as it impinges on patient care.	**2**	Staffing levels will be monitored by the ward manager and senior nurse manager and appropriate staffing levels maintained. Recruitment processes are underway to fill any current vacancies	**Immediate and on gonig**
It is recommended that onsite social activity is monitored for all patients.	To be reviewed at next inspection	There is a range of activities for patients both on and off the ward. Patients are encouraged to attend. There is an activity	**Immediate and on going**

		timetable in the ward, participation is recorded in the care plan, if patients do not get the opportunity to participate, the reason for this is also recorded	
Additional Reccommendations			
It is recommended that a clear pathway for reporting safeguarding issues on a 24 hour basis is implemented and mainitained.	**1**	Staff follow all policies , procedures and guidance pertaining to safeguarding vulnerable adults. There is a 24 hour senior nurse on duty, with instruction for all staff to report all concerns through this duty system.	**Immediate and on going**
It is recommended that Patient care reflects the trust's implementation of the DHSSP Deprivation of Liberty Safeguards- Interim Guidance 2010	**1**	The patient care plans have been updated to reflect the Trust's implementation of the DHSSP Deprivation of Liberty Safeguards- Interim Guidance 2010	**January 2013**
It is recommended that the practice and policy in relation to observation levels is reviewed and clarified.	**1**	The observation policy is on the policy meeting agenda to be reviewed in January. Individual observation levels for patients will be reviewed by the ward Dr	**February 2013**

		and the nurse in charge weekly, outcomes of the review will be recorded in the care plan.	
It is recommended that staffing levels for the ward are reviewed regulary. It is recommended that there is a clear system of governance in place to audit and respond to alerts by Ward Managers. It is recommended that the outcome of assessments for staffing are clear and disseminated accurately to the Ward Manager. It is recommended that the allocation of responsibilities to staff on duty is clearly recorded	**1**	Staffing levels reviewed and shared with ward. Regular review is planned to reflect changing needs of the ward The review and any changes will be discussed with ward sister and shared with her and her team The ward manager is reviewing and revising the way in which staff allocation of responsibilities and duties are recorded	**Immediate and on going**
It is recommended that the current governance arrangements for Safeguarding are reviewed and the outcome forwarded to RQIA	**1**	Additional safeguarding officers are in post and a review of the current arrangments will be completed within the agreed timeframe	**February 2013**
It is recommended that the dignity of patients on the ward is reviewed and that guidance in relation to preserving the dignity of	**1**	Maintaining patients dignity is individually assessed, actioned	**Immediate and on going**

patients is provided to staff.		and reviewed. Where necessary patients have been referred to behaviour services for further assessment and guidance	
It is recommended that the system for work allocation is reviewed so that the number of staff available, the name of each staff member and their allocated responsibilities throughout their shift is clearly documented.	**1**	The ward manager is reviewing and revising the way in which staff allocation of responsibilities are recorded	**Immediate and on going**
It is recommended that activities as part of resettlement preparation are clearly outlined in individual patient care plans.	**1**	All patients being prepared for resettlement have an individual discharge plan in their care plan. A summary of the outcomes is recorded in the care plan following each meeting using the agreed format for MD meetings.	**Immediate and on going**
It is recommended that patient care plans should detail presenting behaviours in terms of topography and function and how best to address individual behaviours.	**1**	Presenting behaviours are individually assessed, actioned and reviewed. Where necessary patients have been referred to behaviour services for further assessment and guidance	**Immediate and on going**
It is recommended that functional communication systems are developed and implemented for all patients with communication deficits.	**1**	All patients with communication difficulties have a communication passport. These are currently being reviewed	**Immediate and on going**

		and updated with Speech & Language Therapy	
It is recommended that the Trust considers the recommendations of RQIA's review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home in undertaking this investigation.	**1**	The Trust will take cognaisance of the recommendations referred to in undertaking this investigation	**Immediate and on going**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: _____

NAME: _____ _____

MAHI - ENNIS - 1 - 143

DATE: _____
FOR OFFICE USE ONLY:

QIP viewed by inspector on:

DATE: _____

SIGNED: _____

NAME: _____

Appendix 2 – Quality Improvement Plan November 2010

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health Department:

Telephone: 028 90517530
Email: Team.mentalhealth@rqia.org.uk

Returned QIP 2012.PDF

The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

UNANNOUNCED INSPECTION

ENNIS WARD

MUCKAMORE ABBEY HOSPITAL

BELFAST HEALTH AND SOCIAL CARE TRUST

20 DECEMBER 2012

informing and improving health and social care
www.rqia.org.uk

Table of Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover, RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users, following the transfer of duties of the former Mental Health Commission to RQIA under The Health and Social Care (Reform) Act (NI) 2009.
RQIA undertakes a range of responsibilities for people with mental ill health and those with a learning disability.

2.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital, Ennis Ward
Address	1 Abbey Road, Antrim, BT41 4SH
Telephone number	028 94463333
Person in charge on day of inspection	Linda McCartney
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Resettlement / Challenging Behaviour
Number of patients and occupancy level on days of inspection	17 beds 17 patients
Number of detained patients on days of inspection	1
Date of last inspection	13 November 2012
Name of Inspectors	Margaret Cullen Siobhan Rogan Brenda Gallagher

3.0 Purpose of Visit

An unannounced inspection was undertaken by Margaret Cullen, Inspector from RQIA, on 20 December 2012. This followed a safeguarding strategy meeting, held on the 13 November 2012, in relation to allegations made on 8 November 2012, by a member of staff from Bohill House, Nursing Home. The member of Bohill staff had been placed on the ward as part of a planned resettlement programme, agreed between the Priory Care Homes, Number 2 Limited, and the Belfast Health and Social Care Trust (BHSCT). The staff member made a number of allegations concerning the physical, emotional and verbal abuse of patients by trust staff.

The purpose of the inspection was to clarify the action taken by the Belfast Trust in relation to the safeguarding investigation and review the safeguarding processes in place, in Ennis Ward, in response to the allegations of abuse of on 8 November 2012.

As part of the RQIA duties under Article 86(1) and (2) of the Mental Health (Northern Ireland) Order 1986, RQIA also attended the Belfast Trust's safeguarding strategy panel meeting, on 20 December 2012, to independently review the process of investigation and the monitoring of care and treatment provided to patients on the ward.
This report should be read in conjunction with the previous inspection report of the 13 November 2012, as RQIA had sought clarity on a number of issues from the previous inspection.
Additional assurances were sought, during the inspection, from the service manager, Muckamore Abbey Hospital, to the trust's response to RQIA, of the 12 December 2012, in respect of actions taken to address the previous concerns raised by inspectors.

The inspector investigated all of the following issues, during the course of this inspection:

- A review of the number of staff employed each day over the previous week, as the trust indicated that the staffing complement had increased to seven staff following the inspection of 13 December 2012.
- the compliment of staff available in relation to mix and status, i.e. agency, bank, relief, temporary or permanent.
- verification of the current observation levels on the ward.
- review of the most up to date policy on supervision of staff and observation of patients.
- review of the recruitment process, any advertisements and the timeline between the advertisements being approved and staff being recruited.
- evidence of the staffing problems being highlighted at trust governance forum and / or at senior management core group meetings, and with the trust's director of nursing
- evidence of the decision making process, regarding the planned closure of Finglass ward.
- copies of the community integration meetings to confirm if there was any previous negative comments received from Bohill staff.
- copies of the induction plan provided for Bohill staff by the trust.

Clarification was also sought following the strategy meeting held on 12 December 2012 of;

- the outcome of the Telford Staff Assessment which was undertaken by the trust in October 2012
- the number of level three observations.
- evidence that the contact details for the Chair of the Strategy Panel, was provided to staff, (it was agreed, at the previous strategy meeting, that this

information would be made available if staff needed support or wished to discuss any concerns).

4.0 Methodology

An unannounced inspection was undertaken following a response provided by the service manager on 12 December 2012, in relation to concerns raised at a strategy meeting held on 3 December 2012.

The inspector requested additional information from the service manager and interviewed the ward manager and deputy ward manager.

The inspector also examined two sets of patients' notes, copies of the staff rota for the previous week, the communications book and the induction programme made available to Bohill staff.
A quality improvement plan (QIP) is attached in Appendix 1, setting out the recommendations made as a result of this unannounced inspection.

5.0 Interview with Service Manager

The inspector requested, and was provided with, a copy of the trust's Policy on Supervision and Observation. Copies of additional correspondence, about actions taken by the service manager, were also requested but not immediately available on the day of the inspection. The Inspector was informed by the service manager that the rest of the material could not be collated at that time, but would be forwarded subsequently to the Director of Mental Health and Learning Disability. The correspondence was received by RQIA on 28 December 2012.
The inspector informed the service manager that, despite being told at the strategy meeting that only one patient on Ennis Ward was on level three observations the inspection of patients' records indicated that two patients remained on level three observations.
Further clarity was sought in relation the staffing complement for the ward as the safeguarding panel was informed, at the strategy meeting that the staffing complement required for the ward was seven. This was to include one staff member to facilitate the level three observations, who would have no other duties, in line with the staffing policy.
The service manager advised that she understood that there was discussion in relation to the cessation of observations for one of the patients, but if this was not the case, that the complement would remain at seven (the Telford Assessment allows for the first level three observations to be absorbed by the designated staffing complement).
The chair of the safeguarding meeting had also requested clarity, at the strategy meeting, on 12 December 2012, regarding this matter. The inspector indicated that they would advise the Director of Mental Health and Learning Disability, RQIA, the Independent safeguarding monitor and the chair of the strategy meeting, of the RQIA concerns about staffing levels.

5.1 Interview with Ward Manager

The inspector was informed by the ward manager of her concerns, in relation to the competency levels of some of the agency staff. Copies of email correspondence were sought from the ward manager highlighting evidence of these concerns being raised with senior management in the trust, and this was reviewed by the inspector, validating that such concerns were made known.

6.0 Findings from the Inspection on Ennis Ward.

6.1 Consequence of Additional Monitoring

The ward manager and deputy manager advised the inspector that staff on the ward were anxious that the on-going monitoring was taking a toll on staff in terms of persistent scrutiny of practice. She indicated that staff were hoping that the additional monitoring would cease following the strategy meeting that morning. The ward manager advised that she was supporting staff as much as possible however staff indicated they did not feel informed about what was happening. The Inspector advised that the chair of the safeguarding investigation had asked that her contact details and those of the PSNI were made available to staff. This was agreed at the second strategy meeting, held on 12 December 2012. The Inspector was advised that these contact details were not available to ward staff. The Inspector was informed that there was inconsistency in the staff used to provide duty cover, and that patients remain unsettled with the changes in staff and the additional monitoring arrangements. There could be up to five monitors per day on the ward resulting in different people coming in and out throughout the day.
RQIA staff acknowledged that this was a difficult time for staff and patients.

6.2 Observation Levels and Staff Rotas

The Inspector asked what changes had been made to the observation levels since the previous inspection. The ward manager and deputy manager advised that no changes had been made.
Two patients remain on level three observations, on separate sections of the ward. This level of observation was required consistently for significant periods. The Inspector was provided with patients' notes on request, which corroborated this information.
The Inspector examined the staff rotas and requested a copy of the rotas for the previous week. This information and feedback from staff indicated on-going problems in relation to staff being used as relief staff for other wards. The Inspector asked for the date when the staffing complement for the ward was increased to seven and this was unclear. Staff provided the Inspector with copies of the duty rotas for the previous week. This information indicated that on the day of the Unannounced Inspection (20.12.12):

- There were seven staff, including one bank and one relief in morning (07.30-13.00).

- In the afternoon (13.00- 18.00) there were six staff including two bank staff.
- From 18.00 – 20.30 there were seven staff on duty including two bank staff.
- From 20.30-23.00 there were four staff including one bank with two staff on night duty.

The rotas indicated a lack of a consistent cohort of staff available and having seven staff on duty appeared to be the exception, rather than the rule. Staff indicated that efforts were made to get seven staff, but the current demands on staffing across the hospital site prevent this. The rotas also indicated an over reliance on agency, bank and relief staff in the ward. The rotas confirm that the staffing complement daily is made up of over half agency, bank and relief staff. The Inspector was advised that other wards on site have core staff who could be transferred to support the management of patients on Ennis Ward.

6.3 Telford Assessment

The Telford assessment of October 2012 was discussed with the ward manager. The inspector was advised, by the ward manager, that the assessment was not completed with her involvement.
The Telford assessment was completed by the operations manager indicating, i.e. Day time rota; 6 staff (two registered nurse (RN) and one nursing assistant (NA)), rota 8.30 pm to 11 pm (one RM and four NA), night rota two staff (one RN and one NA). The ward manager questioned this decision at the time and asked for an explanation of how Telford worked out this staffing complement but indicated to the Inspector that she remained unclear about this. The ward manager indicated that they had stated this clearly at a meeting on the ward the previous day. The service manager had arranged a one to one meeting with the manager on the day of the inspection to explain the decision; the Inspector noted this meeting did not occur, due to other issues requiring attention on the day.
The Inspector concluded that there was a lack of clarity about the staffing requirements for the ward, as RQIA was informed, at the earlier strategy meeting, that there was only one patient requiring level three observation on the ward, on the day of the inspection. The ward manager, deputy ward manager and patients' notes indicated, however, that two patients required this level of observation. One patient has required it consistently since 22 March 2012 and one patient arrived to the ward on 6 December 2011 and was on level three observations from 19 May 2011. Both patients require this from 7.30 am to 11pm. The Inspector was concerned at the delay in allocating a consistent core group of appropriately trained and experienced staff to Ennis Ward in view of the safeguarding concerns, raised by staff from Bohill Home.

6.4 Induction of Bohill Staff

The process for the induction of Bohill staff on the ward was raised by the Inspector. The Inspector was advised that this involved use of the ward induction book for Trust staff. The inspector was also advised that there was poor communication in relation to where Bohill staff were to be placed and their specific roles on the wards. An example was given of a group of Bohill staff arriving on Ennis Ward without clear instructions about their placement, and some needed to be relocated to Erne Ward. The ward manager stated that the full ward induction programme takes five days and this was not completed with all staff.
The Inspector enquired about the Resettlement Integration Project. She was advised that the ward manager attended this project for a six week period and that while a copy of duty sheets were provided, there was no clear discussion of roles and responsibilities of the visiting staff. The ward manager stated that the responsible medical officer and senior house officer wanted to be involved but were, allegedly, informed that the induction meetings were only for nursing staff. The ward manager advised that they had two meetings with the Bohill manager after Bohill staff commenced work on the ward and she asked Bohill staff to raise any concerns they may have with her.

6.5 Case Notes

The inspector reviewed two sets of notes in relation to patients identified as requiring level three observations. The deputy manager evidenced from the other patients' notes that level three observations were provided consistently since 22 March 2012. The inspector was advised that this level of restriction was reviewed weekly. However examination of notes indicated that this practice, while not consistently evidenced weekly, was achieved more robustly by the multidisciplinary team (MDT) up until March 2012. The process of MDT meetings appeared to change, from this date and to become more focused on resettlement. There was poor evidence of reviewing observation levels after this period.

The notes examined, however, indicated good practice in relation to:

- essential life planning
- best interest documentation
- family being informed and updated
- alerts and observation needs being clearly displayed
- the need for observations being clearly outlined in the nursing care plan and reviewed by nurse.
- restrictive practices being documented in nursing care plan.
- range of assessments and care plans evidenced on patients' notes, e.g. Braden assessment, epilepsy management.
- while risk assessments were reviewed, the level of observation was not included.
- vulnerable adult (VA) referrals in file and appropriate referral.

Gaps identified included:

- no behavioural management service involvement.
- the comprehensive risk assessment was not updated.
- the protection plans in relation to VA processes lacked clarity. RQIA have asked for a review of these processes in the quality improvement plan from the inspection on 13 November 2012.

7.0 Recommendations

Staffing

The inspector recommended that;

- the staffing complement for Ennis Ward be more clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients.
- the ward manager should be centrally involved in agreeing the appropriate staffing numbers required, in order to meet the needs and safety of the patients on the ward.
- the staffing requirements in relation to special observations are clearly defined, and if the Telford and/or the Trust Observation Policy, is being adhered to. Both of these policies should be reviewed for consistency with each other.
- RQIA is informed of any deficits in staffing levels on Ennis Ward, i.e be advised if complement of seven staff is reduced to a lower number and on what basis.
- the ward manager, deputy ward manager or monitors raise, as a priority, any concerns in relation to staff competence.
- a designated person should be identified with the responsibility for reporting this information to RQIA.

It is recommended the staffing on Ennis Ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients.

Safeguarding Strategy Meetings

It is recommended that any agreed actions / recommendations from safeguarding meetings are processed accurately and in a timely manner to all relevant staff.

Care Plans

It is recommended that the MDT team review special observation levels in compliance with Trust Observation Policy and any best practice guidance, and document this in care plans. “A Medical/Nursing Review of patients on level 2,3 and 4 should occur on a daily basis and be reviewed by the full multidisciplinary team regularly”. (Trust Policy December 2012).

Process of Resettlement

It is recommended that any learning from the induction of all internal and external staff under the terms of the proposed new resettlement strategy is reviewed and any lessons learned is documented / shared with staff and forwarded to RQIA.

Conclusions

Due to the serious nature of the allegations of abuse of patients, RQIA will continue to monitor staffing levels closely, the recording of incidents, the actions taken and adherence to clear governance protocols by the trust. This will be done through the process of on-going inspections from assurances sought from the Belfast Trust as a result of RQIA's monitoring of information received from Ennis Ward.

Appendix 1 – Quality Improvement Plan

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

UNANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

20 December 2012

The issue(s) identified during this inspection are detailed in the quality improvement plan.

1. RECOMMENDATIONS

RECOMMENDATIONS FROM INSPECTION	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the total staffing complement for Ennis Ward be clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients.	**2**	**Staffing levels are based on the outcomes of the Telford Review which was carried out for this ward**	**Immediate and ongoing**
It is recommended that the Ward Manager should be centrally involved in agreeing the appropriate staffing complement required in order to meet the needs and safety of the patients on the ward.	**1**	**The ward manager was involved in the Telford review for the ward and was involved in agreeing the outcomes from this. The ward manager is currently on sick leave but another band 7 ward manager has been appointed to the ward in their absence and who has responsibility to ensure that staffing levels are maintained in accordance with the outcomes of the Telford**	**Immediate and ongoing**

		Review. The ward manager also works in conjunction with the MDT to agree enhanced observation levels when these are deemed necessary.	
It is recommended that staffing requirements in relation to special observations are clearly defined, and that RQIA is advised in writing, if the Telford and /or the Trust Observation Policy, is being adhered to and a review of both is undertaken for consistency with each other.	**2**	**Special or enhanced observations are agreed by the MDT, however in the absence of the MDT being available, the nurse in charge will make a decision on level of observation required based on the patient's presentation at the time. The Observation policy is currently subject of review and its outcomes will be communicated to all staff on site.**	**15 February 2013**
It is recommended that RQIA is informed of any deficits in staffing levels on Ennis ward, i.e. • to be advised if complement of seven staff reduced and on what basis. • Ward Manager, Deputy Ward Manager or monitors raise as a priority, any concerns and advise RQIA of action taken in relation to staff competence and that;	**2**	**Duty Nurse Manager is responsible for checking staffing levels in this ward on a daily basis and Ward manager in Ennis has been advised to work with the Duty**	**Immediate and ongoing**

• a designated person should be tasked with the responsibility for reporting this information to RQIA.		**Nurse Manager to ensure that staffing levels do not drop below those agreed within the Telford Review. Hospital Management have been raising the staffing levels in this ward and this remains on-going. Processes are in place to have any concerns noted within the ward forwarded to RQIA and there is an identified person within the hospital to do this.**	
It is recommended the staffing on Ennis ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients	**1**	**A core complement of staff have now been identified for this ward as a result of on-going recruitment.**	**Immediate and ongoing**
It is recommended that any agreed actions from safeguarding strategy meetings are processed accurately and in a timely manner, to all relevant staff.	**1**	**The ward manager will ensure that outcomes from VA Processes are incorporated into the patient's care plan – this will be audited by the Senior Nurse Managers and will be included**	**Immediate and ongoing**

		within the Evaluating Quality Care Audit.	
It is recommended that the MDT team review compliance with the special observation Trust Policy and best practice guidance. "A Medical/Nursing Review of patients on level 2,3 and 4 should occur on a daily basis and be reviewed by the full Multi-Disciplinary Team regularly" (Trust Policy December 2012).	**1**	**The Trust Special Observation Policy for Learning Disability is currently under review. This will incorporate how patients who are on levels 2, 3, and 4 are reviewed. The policy will specify that patients who are acutely unwell will be reviewed on a daily basis by medical/nursing, those who are on special observations for behavioural issues will be reviewed weekly by medical/nursing and those who are on special observations as a result of the Vulnerable Adult Process will be reviewed by the VA Team at each subsequent VA meeting relating to the patient.**	**Immediate and ongoing**
It is recommended that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and	**1**	**Induction Processes are being reviewed at present – the internal**	**Immediate and ongoing**

shared with relevant staff.		**induction process is now complete and is in operation and it is anticipated that the external induction process should be complete within the next four weeks.**	

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: _____

NAME: _____

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QIP viewed by Inspector on:

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NAME: _____

The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

UNANNOUNCED INSPECTION

ENNIS WARD, MUCKAMORE ABBEY HOSPITAL

BELFAST HEALTH AND SOCIAL CARE TRUST

29 JANUARY 2013

informing and improving health and social care
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Table of Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover, RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. RQIA undertakes a range of responsibilities for people with mental ill health and those with a learning disability, following the transfer of duties of the former Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009.

Inspectors would like to thank the patients and staff for their cooperation throughout the inspection process

2.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Antrim BT 41 4SH
Telephone number	02894463333
Email address	Linda.mccartney@belfasttrust.hscni.net
Person in charge on day of inspection	Margaret O'Boyle, Acting Ward Manager
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Resettlement/ Challenging behaviour
Number of patients and occupancy level on days of inspection	17 beds 17 patients
Number of detained patients on day of inspection	0
Date and type of last inspection	Unannounced 20 December 2012
Name of Inspectors	Patrick Convery – Lead Inspector Margaret Cullen Siobhan Rogan Rosaline Kelly Brenda Gallagher

Ennis Ward is a 17 bed resettlement female ward for adults with a learning disability who present with challenging behaviour. The ward is located on the Muckamore Abbey Hospital site and is managed by the Belfast Health and Social Care Trust. The ward consists of three areas. To the right of the main entrance there are facilities for six patients; a bright and homely furnished living and dining room, a well maintained toilet and bathroom and three single bedrooms and one bedroom accommodating three patients, all of which are personalised by the patients. The patients in this part of the ward are more independent than other patients on the ward and this is reflected in the range and choice of furniture. All rooms have televisions and music equipment.

To the left of the entrance there are facilities for 11 other patients. There are two bright day rooms and each day room is appropriately furnished to reflect the needs of patients who are less able and less independent. One of the rooms has a range of furnishings and a television with DVDs and a Wii for patient's use, while the other has more protective furnishings and is used by patients with more challenging behaviour.
Inspectors commented on the narrow corridors and the locked doors within the ward which restricted patient’s movements.

3.0 Inspection Summary

An unannounced inspection of Ennis Ward was undertaken on 29 January 2013. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults, following serious allegations made on 8 November 2012. Despite requests for information from the trust RQIA still had not received assurances that the safeguarding of vulnerable adults was adequate, at the time of the inspection.

The purpose of the Mental Health and Learning Disability (MHLD) inspection was to focus on the governance arrangements including the reporting of incidents and support for staff and patients in relation to safeguarding issues. This involved inspectors talking to individual staff and patients, meeting senior management, the review of documentation including care plans and vulnerable adults reporting mechanisms. Further observation of the ward environment including staffing levels and a review of the role of monitoring officers was also undertaken during this inspection.

The following is a summary of the inspection findings regarding the arrangements for safeguarding vulnerable adults on this ward.

Environment

There are three distinct areas of this ward, and the layout is such that this must be considered when calculating the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff, and there are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a "back hall" for some peace and quiet. This was noted by inspectors and raised at the Safeguarding Strategy meetings, in terms of the impact which the narrow corridor to the dining areas presents in relation to patient safety, i.e. the patients congregate and push each other to gain access to the dining room. Furthermore, there are a significant number of locked doors on this ward, with the entry and exit doors controlled by staff. This means that patients are very restricted in the space available to them and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.

Behavioural Support

RQIA sought assurance that these vulnerable patients had access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well- being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the Belfast Health and Social Care Trust (BHSCT) Safeguarding Strategy Panel were assured by the Independent Monitor, and verbally by the service manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before, or since, these allegations were made. This was also noted in the patients' notes examined on the unannounced inspection of 13 November 2012, and again on 20 December 2012. A recommendation was made in the quality improvement plan. While references to the management of behaviour were noted, within the care documentation reviewed, there was no evidence of care planning to adequately address patient's behavioural presentation.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2012, RQIA would expect that clear protection plans have been devised and implemented, to safeguard and protect all patients on this ward. As previously stated, five sets of patients' notes were examined.

Inspectors were concerned that no clear protection plans were evident in any of the notes examined. Inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes. The vulnerable adult referral forms included responses from the Designated Officer, often advising that patients be kept separated and advice was given that enhanced monitoring arrangements should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans

Patient Interviews

During the Inspection four patients were interviewed and asked a range of questions. The questions used were to gauge the patient's experience of their care and their understanding of their human rights. Due to the limited cognitive ability of the patients it was difficult to ascertain a definitive answer to some of the questions. However, the questions that the patients did answer highlighted that they were happy with the care they were receiving. Some of the patients were able to explain who to go to make a complaint. The patients who could communicate said the staff were kind to them and helped them a lot. One patient said they only got seven cigarettes per day and would like to look after her cigarettes herself. When the inspector spoke to the senior nurse and examined the patients notes it was very clear why this

action had been taken. Due to the complex needs of this patient it was found to be in their best interests. There was a care-plan in place and it was being reviewed regularly.
The inspector did not find any areas for concern during the patient interviews.

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4.0 Additional concerns noted by Inspectors

Following an escalation letter to the Trust Chief Executive and the most recent inspection on 29 January, RQIA requested the following information by 8 February 2013:

- Detailed chronology of the actions taken by BHSCT following the initial reporting of allegations regarding care and treatment of patients in Ennis ward, including minutes of all meetings in relation to this issue.
- A copy of individual protection plans for Ennis patients identified in relation to the allegations and clarity where these plans are stored, as these were not available to inspectors and ward staff were unaware of their location.
- Confirmation of ward manager responsibility for Ennis Ward in the absence of the substantive post holder.
- Copies of all independent monitoring reports, since the allegations of abuse emerged in November 2012, and a list of all independent monitors for Ennis Ward.
- A list of all referrals to the Adult Behaviour Services for patients from Ennis ward, from 1 January 2012 to present and the outcome of these referrals.

A meeting was arranged with senior management on Monday 11 February 2013 to follow up on the letter of escalation.

RQIA received the information requested on 14 February 2013 and this is summarised as below:

The detailed chronology of events appeared to be accurate and detailed and outlined the actions taken by BHSCT as well as evidence minutes of meetings in relation to the on-going monitoring and investigation.

RQIA received and reviewed five protection plans for patients in Ennis and although these appeared detailed, Inspectors were of the view that these should be included in the notes on the ward. There was little evidence of specific interventions being recorded for each individual to inform a specific care plan. The care plans were not available on the ward for staff reference and to facilitate development of individualised care plans to protect individuals. Staff were unaware of their existence

Confirmation of acting ward manager was confirmed as requested.

Independent monitoring reports

In total 233 independent monitoring reports were received from 17 November 2012 - 8 February 2013. However some of these were duplicates/triplicates and in total 223 were reviewed by RQIA. In one form the date/time was not specified.

The forms were reviewed and it was evident that there was significant gaps in information from specific dates. Some monitoring reports were missing from both day and night time. Areas of concerns were noted in 54 of the monitoring reports received which can be summarised as follows:

Staffing Issues

Insufficient staffing levels during the day and night-time shifts and difficulty facilitating staff breaks, due to levels of observation on the ward.

Overreliance on agency/bank staff; it was noted that on occasions there was only one substantive staff member on duty who regularly worked on the ward.

Concerns were noted regarding staff morale and pressure on staff as well as staff feeling vulnerable due to concerns and staffing levels.

Environmental Concerns

Issues regarding the environment not being suitable for the client group and that the environment is in need of upgrading. There were issues identified regarding overcrowding in some areas and challenges in observation levels particularly during tea time. Lunchtime was described as “very chaotic” in one monitoring report. There were also difficulties documented in facilitating staff teas due to levels of patient observation.

Lack of Privacy/Dignity for Patients

Privacy and dignity issues were identified particularly in relation to absence of curtains. There was issues raised regarding patients stripping off clothes and staff were unable to offer a reason for this behaviour. It was stated in one monitoring report that patient(s) were unsettled due to the presence of unfamiliar staff on the ward.

Absence of Therapeutic Activities

The lack of stimulation and absence of therapeutic activities was stated in monitoring reports and that the current staffing ratio does not facilitate therapeutic interventions.

Care Plans

During examination of one of the patient's care-plans on restrictive practices the inspector found a restrictive care-plan wrote for two restrictions on the patient. These restrictions were locked doors and covert medication. It is recommended that this should be two separate restrictive practice care-plans. These care-plans should be dated and reviewed regularly

Safety Issues

On several occasions in January it was noted that the lack of magnetic keys and alarms were giving some cause for concern and considering the environment RQIA would share these concerns and would contribute to safe and effective care.

Referrals to Adult Behavioural Service were noted in information returned which clarified that behavioural support referrals were made regarding eight patients. These were mostly in 2011 and 2012 and one assessment was noted to be on-going in January 2013. Although it was recorded on the return that advice was given to nurse regarding care planning there was no evidence of staff being aware of this and the outcome following referrals to behaviour service. This information could not be located in patients care plans on the ward and RQIA were of the view that for this to be effective it should be readily available in the patients' notes. [RK1] The expectation is that guidance by behaviour support /support plans form the basis of a care plan to manage behaviours

A returned quality improvement plan (QIP) signed by the chief executive was received on 4 March 2013. Inspectors had previously received an electronic version and concerns were expressed regarding the lack of clarity and response to the recommendations made following the unannounced inspection on 20 December 2012. These are reflected in the restated recommendations below.

Appendix 1 – Quality Improvement Plan

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

UNANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

29 January 2013

The issue(s) identified during this inspection are detailed in the quality improvement plan.

1. RECOMMENDATIONS RESTATED FROM PREVIOUS QIP

RECOMMENDATIONS FROM INSPECTION	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the total staffing complement for Ennis Ward be clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients. The monitoring reports indicate concerns regarding staffing levels and appropriately trained staff.	**3**	**Staffing levels are based on the outcomes of the Telford Reviews which were carried out for this ward. This includes the provision of suitably qualified, competent and experienced persons available in the ward. Management, ward manager and ward staff are aware of the agreed staffing levels.** **A record of staffing levels for day and night duty is maintained in the nursing administration office, all duty nursing officers have been informed of the need to notify the Senior Nurse Manager for Ennis in the event of any deficits. The**	**Immediate and ongoing**

		SNM in turn informs RQIA of any occasions when staffing levels drop below what has been agreed	
It is recommended that staffing requirements in relation to special observations are clearly defined, and that RQIA is advised in writing, if the Telford and /or the Trust Observation Policy, is being adhered to and a review of both is undertaken for consistency with each other.	**3**	**Staffing levels, are based on the outcomes of the Telford Review which was carried out for this ward. Enhanced observations are prescribed and staffing levels allocated based on the level determined. There is clear understanding that staff assigned to special observations are not included within the daily ward staff complement. The observation policy has been reviewed and signed off at governance level and is now operational hospital wide** **If for any reason agreed ward complement staffing levels cannot be met because of observation levels, RQIA are notified of this in writing.**	**Immediate and ongoing**

		In light of the reviewed observation policy issued in April 2013. The SNM for Ennis will carry out an ongoing review of the ward staff complement and observation levels for consistency with each other.	
It is recommended the staffing on Ennis ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients. The monitoring reports indicate an overreliance on input from staff from bank and other wards.	**2**	**Action complete** **A core complement of staff is now in place for this ward.** **Bank staff may still be used on occasion to cover deficits due to staff's temporary absence.** **Any on-going absence management is monitored in accordance with the Trusts Absence Management Policy**	**Immediate and ongoing**
It is recommended that any agreed actions from safeguarding strategy meetings are processed accurately and in a timely	**2**	**Outcomes from safeguarding processes**	**Immediate and ongoing**

manner, to all relevant staff. The inspectors noted the absence of individual protection plans in patient's notes.		**are incorporated in the patients care plan. All patients have an individual protection plan**	
It is recommended that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff. RQIA will continue to review the induction and training of staff and specifically in relation to monitoring within Ennis Ward.	**2**	**The internal and external induction process is now complete and is in operation. Lessons learned have been incorporated by measuring and evaluating the experience. This has been shared with all wards in the hospital.**	**Immediate and ongoing**

2. RECOMMENDATIONS

RECOMMENDATIONS FROM INSPECTION	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that individual behaviour support plans are updated regularly and information readily available within patients' notes.	**Where there has been a referral to behaviour services, the behaviour support services staff meet with the patient and the named nurse and following an initial assessment, behavioural interventions are agreed, this is written up in the patients care plan. Individual Behaviour Support Plans are devised for patients who the clinical team feel are most likely to benefit. These result from an in-depth analysis of data and observations. Where these plans are in place they are updated as indicated.**	**Immediate and ongoing**

It is recommended that patients have the opportunity to engage in therapeutic activities while on the ward.	**Activity programmes have been developed for all patients. These include beauty therapy, walks, visits to the Cosy Corner, art, table top activities such as inset boards/jigsaws, multisensory activities, such as hand massage and foot spas, Participation/non participation in activities are recorded in the patients care plan. In conjunction with this the Ward Manager and Senior Management are pursuing other options to facilitate therapeutic activity in the ward, i.e. - providing an activity room on the ward - input to the ward from art and music therapy**	**Immediate and ongoing**

It is recommended that consideration be given to upgrading the ward or alternative accommodation sought.	**A capital bid has been secured to upgrade and improve the existing environment. A meeting has been scheduled with ward staff, Senior Management and Estates to agree the extent of work required. It is anticipated to have this completed within 6 months**	**Immediate and ongoing**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: ___mairead mitchell_____

NAME: _____ _____

DATE: _____
FOR OFFICE USE ONLY:

QIP viewed by Inspector on:

DATE: _____

SIGNED: _____

NAME: _____

The Regulation and Quality Improvement Authority

RQIA

Mental Health

& Learning Disability

Unannounced Inspection

Muckamore Abbey Hospital

Ennis

Belfast Health and Social Care Trust

29 May 2013

npm national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

Table of Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

1.1 Purpose of the Inspection

The trust provided RQIA with an action plan following the areas of concern identified during the previous inspection. The purpose of this inspection was to review progress towards completion of the action plan.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the provider's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

1.2 Methods/Process

During the inspection the inspectors focused on focused on recommendations made following the last inspection in January 2013, and the progress made in their implementation. The outcomes of the inspection findings can be viewed in detail in section 6.0.

Specific methods/processes used in this inspection include the following:

- discussion with multi-disciplinary staff and managers;
- examination of records;
- file audit.

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Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

2.0 RQIA Compliance Scale Guidance

The inspector has rated the ward's Compliance Level against each recommendation made following the previous inspection.

The table below sets out the definitions that RQIA has used to categorise the ward's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

3.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Muckamore BT41 4SH
Telephone number	028 94662234
Email address	Margaret.OBoyle@belfasttrust.hscni.net
Person in charge on day of inspection	Margaret O'Boyle
Nature of service - MH/LD	Learning Disability
Name of ward	Ennis Ward
Date and type of last inspection	29 January 2013 Unannounced Inspection
Date and time of inspection	29 May 2013 2pm – 5.30pm
Name of Inspectors	Rosaline Kelly & Patrick Convery

Ennis ward is a 17 bedded ward on the Muckamore Abbey site. The ward provides long term care and accommodation for female patients with a learning disability and overlapping challenging behaviours. Patients on this ward will be moving to long term community accommodation and care as part of the regional resettlement programme.

4.0 Inspection Summary

Summary of Findings

This is a summary of the unannounced inspection findings, undertaken by Rosaline Kelly and Patrick Convery on the 29 May 2013 and reflects the position in the ward on the day of inspection.

The Health and Social Care Trust (HSCT) submitted a Quality Improvement Plan (QIP) to RQIA following the unannounced inspection on 29 January 2013. Eight recommendations were made following the last inspection. It is good to note that four recommendations had been fully met.

4.1 Recommendations 1, 2 & 3 Staffing Levels

It was good to note that staffing levels had been reviewed regularly. Minimum staffing levels had been specified and evidence was available to confirm that staffing requirements and provision in relation to special observations had been considered in the formal review of staffing levels for the ward. Increased staffing had been provided in accordance with patient requirements and policies and procedures. The skill mix of registered nurses and healthcare assistants appeared to be satisfactory at 65%/35%. This required skill mix had been specified during the formal review of staffing levels for this ward. Staff who met with the inspectors stated that they believed staffing levels had improved over recent months. It was stated by a registered nurse on the day of the inspection that bank staff working on the ward are drawn for the permanent staffing establishment for the ward. This was confirmed by reviewing the staff rota.

4.2 Recommendation 6 Individual behaviour support plans

It was good to note that since the last inspection six patients had been referred to behaviour support services. Individual assessments had been undertaken for four patients by behaviour nurse specialists who discussed care plans in detail with the inspectors. Staff had been made aware of the specialist needs of patients in relation to management of behaviours. However, the confirmation from the behaviour nurse specialist that behaviour support specialist services are not routinely involved in assessing behaviours and devising and overseeing management plans for patients who may present with behaviours that challenge on resettlement wards is concerning. A new recommendation will be made.

One recommendation had been partially met.

4.3 Recommendation 8 Upgrading the ward environment or seeking alternative accommodation

It was good to note that plans to improve both the internal and external environment had been agreed. The timescale for completion of the works was not available at the time of the inspection. This recommendation will be restated and RQIA will seek details and reassurances from the trust in relation to expected timescales for completion of agreed works to upgrade both internal and external environments.

Two recommendations had not been met.

4.4 Recommendation 4 Accurate processing of agreed actions from safeguarding strategy meetings in a timely manner to all relevant staff.

Despite assurances given by the trust it is concerning to note that this recommendation had not been fully implemented, and additional concerns noted. Review of patients' notes on the day of the inspection demonstrated that although referrals had been made to the designated officer, documentation completed and strategy meetings held, individualised protection plans had not been clearly developed. Protection plans had not been included in care plans. It was concerning to note that the acting ward sister stated that when documentation is returned to the ward by the designated officer it is not reviewed by any member of staff to ensure that an appropriate protection plan has been developed, processes are not put in place to implement any protection plan, and there is no formal mechanism in place to ensure that staff are fully aware of the detail of the protection plan and their associated role and responsibilities. A total of 95 individual monitoring forms completed between February and April were evaluated. The main theme emerging from these was that it was difficult to carry out a monitoring role and be involved in nursing duties at the same time. There were other issues in relation to the noise levels on the ward and on occasions staffing levels particularly when patients required increased supervision. A new recommendation will be made.

4.5 Recommendation 8 Therapeutic activity

The acting ward sister confirmed that a programme of therapeutic and recreational activity had not been developed.

These recommendations will be restated as recommendations of this inspection and additional new recommendations will be made..

One recommendation could not be evaluated at this inspection as processes were not in operation. This recommendation will be carried forward for evaluation at the next inspection.

5.0 Conclusion

It was good to note the significant progress made in particular areas of patient care and treatment, particularly involvement of specialist behaviour support services, and continual review of staffing levels and skill mix. However, it was concerning to note that protection plans had not been developed following referral to the safeguarding team, and the lack of review of this documentation on return to the ward by the ward manager. The lack of progress in developing therapeutic and recreational activity programmes was also noted.

Inspectors would like to thank the patients and staff, for their cooperation throughout the inspection process.

5.0 FOLLOW-UP ON PREVIOUS ISSUES

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the total staffing complement for Ennis Ward be clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients. The monitoring reports indicate concerns regarding staffing levels and appropriately trained staff.	This recommendation had been made on three previous occasions. On the day of the inspection evidence was available to confirm that staffing levels had been reviewed by senior hospital staff and the acting ward manager on 29 May 2013. Minimum required staffing levels had been specified with additional staffing included for any agreed increased levels of patient observations. Review of staff rotas for weeks beginning 20 May 2013 and 27 July 2013 demonstrated that agreed staffing levels had been consistently achieved. The skill mix of registered nurses and healthcare assistants appeared to be satisfactory at 65%/35%. This required skill mix had been specified during the formal review of staffing levels for this ward. Staff who met with the inspectors stated that they believed staffing levels had improved over recent months.	**Fully met**
2	It is recommended that staffing requirements in relation to special observations are clearly defined, and that RQIA is advised in writing, if the Telford and /or the Trust Observation Policy, is being adhered to and a review of both is undertaken for consistency with each other.	This recommendation had been made on three previous occasions. On the day of the inspection evidence was available to confirm that staffing requirements and provision in relation to special observations had been considered in the formal review of staffing levels for the ward. Increased staffing had been provided in accordance with patient requirements and policies and procedures.	**Fully met**

3	It is recommended the staffing on Ennis ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients. The monitoring reports indicate an overreliance on input from staff from bank and other wards.	This recommendation had been made on two previous occasions. It was stated by a registered nurse on the day of the inspection that bank staff working on the ward are drawn for the permanent staffing establishment for the ward. This was confirmed by reviewing the staff rota.	**Fully met**
4	It is recommended that any agreed actions from safeguarding strategy meetings are processed accurately and in a timely manner, to all relevant staff. The inspectors noted the absence of individual protection plans in patient's notes.	This recommendation had been made on two previous occasions. Five sets of patients' notes were reviewed on the day of the inspection. Referrals had been made to the designated officer and documentation completed. Reference to strategy meetings had been included. Individualised protection plans had not been clearly developed. Protection plans had not been included in care plans. It was concerning to note that the acting ward sister stated that when documentation is returned to the ward by the designated officer it is not reviewed by any member of staff to ensure that an appropriate protection plan has been developed, processes are not put in place to implement any protection plan, and there is no formal mechanism in place to ensure that staff are fully aware of the detail of the protection plan and their associated role and responsibilities. This recommendation will be restated and a new recommendation made.	**Not met**
5	It is recommended that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff. RQIA will continue to review the induction	This recommendation had been made on two previous occasions. The inspectors were informed that a new induction template and checklist had been developed. However, at the time of the inspection there were no external staff working on the ward and the new system had not been implemented. Inspectors could not fully evaluate this recommendation during this inspection.	**To be evaluated at the next inspection**

	and training of staff and specifically in relation to monitoring within Ennis Ward.		
6	It is recommended that individual behaviour support plans are updated regularly and information readily available within patients' notes.	It was good to note that since the last inspection six patients have been referred to behaviour support services. Individual assessments had been undertaken for four patients by behaviour nurse specialists who discussed care plans in detail with the inspectors. Staff had been made aware of the specialist needs of patients in relation to management of behaviours. The behaviour nurse specialist confirmed that she will continue to oversee the implementation of the behaviour support care plans. However, it was confirmed by the behaviour nurse specialist that behaviour support specialist services are not routinely involved in assessing behaviours and devising and overseeing management plans for patients who may present with behaviours that challenge on resettlement wards. A new recommendation will be made.	**Fully met**
7	It is recommended that patients have the opportunity to engage in therapeutic activities while on the ward.	The acting ward sister confirmed that a programme of therapeutic and recreational activity had not been developed. This recommendation will be restated.	**Not met**
8	It is recommended that consideration be given to upgrading the ward or alternative accommodation sought.	It was good to note that plans to improve both the internal and external environment had been agreed. The timescale for completion of the works was not available at the time of the inspection.	**Partially met**

Appendix 1 – Quality Improvement Plan

Quality Improvement Plan

Unannounced Inspection

Ennis

Muckamore Abbey Hospital

29 May 2013

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan (QIP).

The timescales for completion commence from the date of the inspection

1. RECOMMENDATIONS

RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the ward manager ensures any agreed actions from safeguarding strategy meetings are processed accurately, appropriately and in a timely manner. All staff must be made aware of the detail of the agreed actions and their role and responsibility.	**Three**	A process is being devised that will link the VA process with the care plans - this process will incorporate agreed actions from safeguarding strategy meetings being processed accurately, appropriately and in a timely manner and the sharing of the detail of the agreed actions with all staff, including their role and responsibility.	**Immediate and on-going**
It is recommended that the trust ensures that the designated officer includes details of appropriate and agreed protection plans following screening of vulnerable adult referral forms and related strategy meetings.	**One**	A process is being devised that will link the VA process with the care plans - this process will incorporate the designated officer including details of appropriate and agreed protection plans following screening of vulnerable adult referral forms and related strategy meetings. In the interim the designated officer	**Immediate and on-going**

		will include details of the protection plan on the vulnerable adult referral forms	
It is recommended that the ward manager develops and implements a system for reviewing protection plans returned to the ward by the designated officer to ensure that they are appropriate to the situation and the individual patient. All staff must be made aware of the detail of the plan and their role and responsibility.	**One**	A process has been agreed that will link the VA process with the care plans - this process includes a system for reviewing the protection plans returned to the ward to ensure that they are appropriate to the situation and the individual patient.	**Immediate and on-going**
It is recommended that the monitoring role is reviewed and dedicated staff input afforded to ensure the role is effective, and does not impact on staffs' day to day responsibilities.	**One**	The monitoring role was reviewed at a meeting on 5th July. A decision was taken to stand down 24 hour monitoring of the ward. The ward is supported by twice weekly senior Nurse visits for 1 month to support staff and continue with ad hoc monitoring.	**Immediate and on-going**
It is recommended that the trust ensures that all patients who present with a behaviour that may challenge are referred to specialist behaviour support services for assessment and implementation of formal behaviour support plans.	**One**	All Staff within Ennis are trained in challenging behaviour. The behaviour services team are providing further training for Ennis staff specifically targeted at meeting the behavioural needs of	**Immediate and on-going**

		patients. Should the multi - disciplinary team feel that any further patients in Ennis require more specialist input then the option to refer to Behaviour Support Services is available.	
It is recommended that the trust ensures that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff.	**Two**	The internal and external induction process is complete and is in operation. Lessons learned have been incorporated by measuring and evaluating the experience.	**Immediate and on-going**
It is recommended that the ward manager develops individual and group activity programmes and that patients have the opportunity to engage in therapeutic and recreational activities while on the ward.	**Two**	A template has been developed for individual and group activity programmes for patients to have the opportunity to engage in therapeutic and recreational activities while on the ward.	**29 July 2013**
It is recommended that the trust plans to upgrade the ward's internal and external environments according to a firm timetable for completion are finalised, agreed and expedited.	**Two**	Work to upgrade the ward's internal and external environments is currently underway by the contractor. All work will be completed by end September 2013	**30 November 2013**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Signed: _____

Name: _____ _____

Date: _____

FOR OFFICE USE ONLY:

QIP viewed by inspector on:

Date: _____

Signed: _____

Name: _____

Our ref: TN/CH

15 November 2012

Dear Esther,

An unannounced inspection of Ennis Ward was undertaken by the Mental Health Team on 13 November 2012, following an allegation of abuse by staff made on the morning of 8 November 2012.

The focus of this inspection was to:

- Review of the QIP from the last inspection on Fairness undertaken on 10 and 11 November 2010.
- Review of the current safeguarding arrangements.
  This focused on the monitoring arrangements put in place over the weekend and the on-going monitoring arrangements to safeguard patients in view of the current on-going investigation.

Feedback at the end of the inspection was provided to Clinton Stewart, Operation Manager, H491, Ward Manager, and to you as Service Manager by the two RQIA Inspectors as follows;

- The issue of staffing on Ennis Ward was clearly highlighted as a main area of concern. The inspectors were given assurances by you, that staffing levels would not fall below six. Inspectors indicated that they expected that consideration is given to the experience and skill mix of staff on the ward. On further discussion of our findings and from observations, review of documentation and discussions with the Ward Manager, Dr Milliken and Barry Mills, the inspectors concluded that the staffing levels are currently insufficient to safeguard and protect patients and these should be increased to a minimum ratio of seven staff for the current population profile.

This view is based on the following information;

- Clinton Stewart indicated to inspectors that in the review of staffing levels, the Telford Assessment was used to facilitate the inclusion of the first level 3 observations within the minimum staffing levels. There was only one enhanced staff for the second level 3 observation on the ward. This contradicts the Trust Policy on Levels of Supervision/Observation. (Operational April 2007, reviewed November 2010) which was provided by Clinton. Point 4.3 of this document states:

  "Level 3 –Within Eyesight 1:1

The Patient should be kept within sight by a designated member of staff at all times. The staff member will not have any other duties...."

- The report from the monitoring officer for the ward over the weekend, Barry Mills, indicated that patients were unsettled and that there were high levels of challenging behaviour. He identified in this report that the total number of staff was seven.
- The Responsible Medical Officer and Ward Manager re-affirmed the complex needs of the patient group and that challenging behaviour displayed in the locked section of the ward requires appropriate staffing, experience and skill mix. The ward appears to have been understaffed for a significant period of time and there was clear evidence that the current investigation is having a negative impact on patients and making them more unsettled.
- The high number of Vulnerable Adult referrals referenced in relation to one patient who was allegedly assaulted 8 times, from April 2012, indicated the level of potential aggression among patients. Inspectors noted incident reports in relation to staffing issues and requested evidence that this was highlighted by the Ward Manager to senior staff.
- Review of the QIP, following the Inspection to the ward, in November 2010, indicated that the recommendation in relation to staffing was not appropriately implemented by the Senior Manager. There was no evidence that staffing levels for the ward had been audited or of how the unmet need was escalated to senior management.

I would ask that you review these issues and particularly the current staffing levels on Ennis Ward and provide me with an account of your plan of action to improve and monitor the situation to enhance the safety and quality of services provided for patients on Ennis Ward, by **Friday 23 November 2012**.

Your cooperation with this matter is greatly appreciated.

Should you have any queries regarding this correspondence please do not hesitate to contact me directly to discuss.

With many thanks

Theresa Nixon
Director of Mental Health &Learning Disability and Social Care

23rd November 2012

Theresa Nixon
RQIA

Dear Theresa

Re Ennis Ward Unannounced Inspection 13th November 2012.

Thank you for your letter of 15th November. I would wish to assure you that the hospital management team is taking all appropriate steps to ensure safe and effective care for the patients in Ennis ward and for all those also inpatient in other wards in the hospital. The enclosed action plan is now in place with associated timescales.

A recent strategy meeting was held on 15th November 2012 to update the interim protection plan implemented on the 8th and 9th November 2012 upon receipt of the allegations received on the 8th November 2012. The action plan takes account of the requirements of the protection plan agreed.

It is noted that the new staff introduced as part of the protection plan did unsettle the patients who then displayed more challenging behaviours; a number were upon medical review found to have underlying health concerns which contributed to and manifested some of the behaviours observed. The ward is now becoming more settled but due to the nature of the patients residing therein at times they can pose challenges and on occasions will display challenging behaviours.

The Trust has reviewed the staffing ratios for this ward with the ward sister in October 2012 following review of concerns raised regarding staffing ratios. This will be kept under review monthly through supervision and periodic senior nurse manager visits during this time. Patients from this ward do also attend day care facility on site which has its own independent staffing compliment. There is also a duty nurse on call 24 hours per day on the hospital who is undertaking periodic visits to this ward and others. The Senior Nurse Managers will continue to monitor to ensure changes in patient dependency levels or acuity are updated and responded to. Any changes will be communicated to the duty nurse office to ensure appropriate staffing levels.

The Trust can confirm that appropriate action was taken in October following escalation of patient safety concerns by ward managers with the earlier closure of a ward to reduce the staffing vacancies on site and ameliorate the staffing situation. These vacancies arose due to an unusual number of staff resignations over a short

period of time. The Trust has already commenced recruitment processes and a number of new staff nurses have been recruited. Additional posts will be recruited with an advert planned for Tuesday 27th November.

Therefore in giving the assurance we will provide a minimum of 6 staff on duty from 7.30am until 11pm at night we can provide the necessary care and support to this group of patients whilst maintaining appropriate staffing level to afford patient safety in the other wards. Additional staff over this ratio will be provided where available.

I trust this information plus the enclosed action plan will address your concerns but should you have any further queries I am happy to discuss.

Yours Sincerely

_____.

Esther Rafferty

The Regulation and Quality Improvement Authority

Our ref: CH/TN

3 December 2012
Esther Rafferty
Hospital Services Resettlement Manager
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH

Dear Esther

Thank you for your correspondence of the November 2012 in respect of Ennis Ward (MAH). Having reviewed the action plan you provided, and in light of the strategy meeting on 28 November 2012 I am satisfied with the following monitoring and follow up arrangements including;

- The provision of 24 hour band 6/7 monitoring staff on a supernumerary basis.
- The appointment of M. Mannion to oversee the safeguarding monitoring arrangements for Ennis ward.
- The appointment of a Deputy Manager to Ennis Ward.
- The temporary provision of an additional Band 7 staff to Ennis ward.
- The submission of daily reports by independent Monitoring Officers.
- The on-going joint protocol investigation.

From the outset of the recent investigation, the level of staffing on Ennis ward has been raised and continues to be raised by a variety of informants including RQIA staff; Ennis Ward Manager; Senior Nurse Manager B. Mills; Bohill staff; and Senior Staff allocated to Ennis in a monitoring capacity as part of safeguarding arrangements. Research in relation to institutional care with patients with challenging behaviour as you are aware indicates a correlation between staffing levels and care practices on wards.

Our inspectors confirmed that staffing levels on Ennis ward had been raised by the ward manager and recorded on the incident records prior to 8 November 2012. You indicate in your correspondence that "the Trust can confirm that appropriate action was taken in October following escalation of patients' safety concerns by ward managers with the earlier closure of a ward to reduce the staffing vacancies on site to ameliorate the staffing situation. These vacancies arose due to an unusual number of staff resignations over a short period of time."

However, inspectors did not receive a satisfactory assurance from you or the senior nurse responsible for the ward that adequate steps had been taken to address the staffing shortages on Ennis ward, as identified by the Ward Manager in the six month period prior to the inspection.

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I remain unclear about the procedure you used to respond to the issues raised by the ward manager and how these concerns where discussed with your governance leads and senior management within the trust.

Having considered your response to our letter of 15 November 2012, I therefore require further clarification in following areas

- Confirmation of the compliment of staff identified following the October 2012 Telford assessment to meet the needs of the patients on Ennis ward and advise if this included cover for level three observations.
- Current BHSCT Policy on Levels of Supervision/ Observation for patients in Muckamore Abbey Hospital
- Clarification of expected governance and clinical lead responsibilities in the event of ward managers reporting patient safety concerns due to inadequate staff resources

The action plan for Ennis ward states that staffing on the ward 'will be reviewed formally on a monthly basis…or more often if independent monitoring reports indicate'. However, despite feedback from monitoring staff indicating that staffing levels are inadequate to meet the needs of patients in Ennis, it is our understanding that staffing levels have remained unchanged at 6 staff from 7.30am – 11pm. In light of the feedback from these staff I remain unclear if staffing levels were reviewed as part of your action plan?

I am aware of the difficulty adhering to the agreement of maintaining six staff on the ward and the regular use of relief staff from other wards and bank staff. This however also raises concerns regarding the potential care and safety of other patients throughout the site. As a consequence of discussing these concerns with HSCB, I understand that a review of staffing levels has now been requested by Molly Kane, Regional Lead Nurse Consultant at the PHA.

Given that the volume of vulnerable adult referrals has risen dramatically, the appointment of two additional designated officers is positive. However, the impact of the current staffing crises also raises concerns regarding the trust's ability to implement and maintain protection plans to ensure patient safety following any vulnerable adult referrals. I would be pleased if you would confirm that all protection plans for patients on the Muckamore are being fully implemented and adhered to currently.
I am concerned about the limited evidence available to inspectors in relation to the overall governance arrangements in respect of monitoring the effectiveness of safeguarding procedures. This matter was discussed with Mairead Mitchell last week by Margaret Cullen and Patrick Convery, Mairead agreed to follow up our concerns and provide feedback to RQIA on the volume and analysis of referrals sent to the Governance Leads and the timeliness of these reports.

I am also aware that Inspectors were advised by Barry Mills, Operations Manager; following his weekend of monitoring Ennis Ward that staff require clear guidance in respect of the care of a patient who repeatedly strips off her clothes in her interest of monitoring her dignity. I would be grateful if you could confirm that this guidance has now been made available to all relevant staff.

Engagement with Bohill Staff

The Social Service interviews with other Bohill staff members suggest a variation in the induction process for visiting staff and a perceived level of reluctance from some Muckamore staff to engage effectively with them and share knowledge. It would be helpful to know:

- What preparatory work was completed in relation to preparing all staff concerned in clarifying role and responsibilities?
- Was an induction process was agreed for Bohill staff and if so who was responsible for organising and implementing this?
- What level of monitoring and feedback arrangements were put in place to review any issues that might arise during the resettlement process?
- It would also be helpful to know if the current investigation had an impact on the resettlement process.

I would appreciate your response to these issues and particularly the current staffing levels on Ennis Ward and your plan of action to improve and monitor the situation to enhance the safety and quality of services provided for patients on Ennis Ward, by **Monday 10 December 2012.**

Should you have any queries regarding this correspondence please do not hesitate to contact me directly to discuss.

Your cooperation with this matter is greatly appreciated.

With many thanks

Theresa Nixon
Director of Mental Health & Learning Disability
and Social Work

Belfast Health and Social Care Trust

Muckamore Abbey Hospital
1 Abbey Road, Muckamore, Antrim BT41 4SH
Te: (028) 94463333 Fax: (028) 94467730

Our Ref:

12 December 2012

Mrs Theresa Nixon
Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Theresa

I refer to your correspondence of 3 December 2012 in relation to Ennis Ward and can provide assurance that the Senior Management Team at Muckamore Abbey Hospital continue to ensure appropriate staffing levels at Ennis taking cognisance of the complex needs of the patients and safeguarding requirements.

This process has taken account of the issues raised by those parties highlighted in your letter in response to which staffing levels were increased at critical periods and those arrangements remain the subject of continuous review by the Senior Management Team.

Of necessity this continuous review of staffing by the Senior Management Team is also ensuring that due cognisance is afforded to the clinical and safeguarding needs of all patients within hospital with particular reference to staffing requirements at all times and the deployment of agency and bank staff.

In relation to your reference to specific concerns being raised by the Ward Manager in Ennis in the in the six month period prior to the current investigation, records have been reviewed and I can confirm that this related to the need to maintain the continuous recruitment processes with the Hospital due to the increased turnover of staff and an increase of long-term sick leave associated with genuine medical conditions. Management response took full account of the governance requirements associated with concerns of this nature. Due emphasis was given to ensuring that continuous recruitment processes were maintained and approved at Director Level through the Trust's internal scrutiny processes. The issue was also highlighted and reviewed at the Service Group's Governance Forum and at the regular Hospital Senior Management Core Group Meetings.

As you should be aware this issue was also specifically added to Trust's Risk Register during March/April 2012. In addition to the action this issue was also

highlighted and reviewed through the Trusts Corporate Senior Nursing Forum and included in our earlier discussions and correspondence the Trust response included the considered decision to bring forward the planned closure of Finglass Ward.

As you have requested I can also confirm that the Telford Assessment undertaken during October 2012 identified specific requirements for staffing levels at Ennis and arrangements were immediately put in place to ensure this standard continued to be met. This included cover requirements for the first level 3 observation and took account of the possible requirement for additional observations at this level. The staff allocated on Level 3 Observations do not have any other allocated tasks whilst discharging this duty. This is consistent with the Trust Policy; a copy of which can be provided on request.

I also can clarify that any report of concern regarding patient safety due to staffing levels is immediately reported and addressed through line management and governance arrangements and as Senior Manager at Muckamore I discharge the clinical lead responsibility.

In relation to the arrangements to review staffing at Ennis I can confirm as outlined earlier that this has received attention and staffing levels have been increased to 7 during the morning period. An increase was also introduced during the late evening shift to 2.00 am.

I can also confirm that the additional designated officers to assist with Vulnerable Adult Referrals have now taken up post and I can assure you that all protection plans relating to patient safety are being fully implemented and this important issue remains the subject of continuous monitoring and review. In relation to this I understand that Mrs Mitchell has also provided all requested information.

In respect of care of the patient who repeatedly strips off her clothes, specialist behavioural support and guidance has been provided and her care plan has been reviewed in conjunction with the nursing team.

Finally in relation to Bohill staff I can confirm that a number of meetings were held prior to Bohill staff working on wards to agree shifts, span of shifts, identified patients to be worked with and for completion of person centre assessment and discharge plans. Ward sisters were aware of the agreed shifts and of induction requirements for any staff being present on their wards. Timescales were agreed directly between the ward sisters and medical team with the Bohill Manager.

A meeting was held with a Senior Nurse Manager, Ward Sisters and Bohill Home Manager to discuss progress and report any concerns, none were raised, and compliments were noted about the process.

The ongoing process was then documented weekly in the community integration meetings held on the ward and no negative comments were received by either party.

We would also wish to confirm that there has been no negative impact of the current investigation on the resettlement of any patient to Bohill Nursing Home, in fact a number of patients have moved from an adjoining ward to their new home.

I trust the above information fully addresses the issues you have raised and I wish to assure regarding the seriousness with which the Trust regards the importance of continuing to meet all requirements to ensure the complex clinical and safeguarding needs of all patients in Muckamore Abbey Hospital are met. As you are aware particular challenges have been presented by the recent unexpected high number of resignations of staff and this has reinforced the critical importance of the Trust continuing to maintain its active and focused recruitment strategy.

Regards

Esther Rafferty

MRS ESTHER RAFFERTY
Service Manager of Muckamore Abbey Hospital

31 January 2013

Our Ref: MC/PC/CH

Private and Confidential

Mr C Donaghy
Chief Executive
BHSCT
Trust Headquarters
A Floor
Belfast City Hospital
Lisburn Road
Belfast
BT9 7AB

Dear Mr Donaghy

Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

RQIA undertook an unannounced inspection of Ennis ward, Muckamore Abbey Hospital on 29 January 2013

The inspection focused on the safeguarding arrangements on the ward, following the allegations of abuse of patients made on 8 November 2012. I understand that the allegations are currently subject of a Vulnerable Adult Investigation, led by the PSNI. The inspection of the 29 January 2013, formed part of the on-going monitoring and scrutiny by RQIA of Ennis ward since 8 November 2012, including an unannounced inspection visit on 13 November 2012 and 20 December 2012.

A number of concern arose during this latest inspection, which I wish to bring to your attention, under the RQIA Escalation Policy.

Staffing

The number of staff allocated to the ward, week beginning 27 January 2013, was in accordance with the pre-assessed numbers determined by BHSCT. The Ward Manager or nurse in charge on a daily basis is included in this total, therefore cannot be fully committed to both roles (managing and nursing patients). This raises concerns about the correct number of staff to holistically meet the complex needs of 17 patients on this ward.

Additionally, for significant periods during the night only two staff are allocated to this ward, (e.g. Monday 28 January/Tuesday 29 January 2013 23.00 – 07.00 and Tuesday 29 January/Wednesday 30 January 2013 02.00- 07.00). At the time of the inspection, two patients required observation on a 15 minute basis, from 23.00 – 07.30. In considering the layout of the ward, the complex

needs of patients, the possibility that one or more patients could waken and require assistance during the night, and the required level of observations. RQIA is concerned that sufficient numbers of staff are available to holistically meet the complex needs of patients on this ward.

RQIA would request that BHSCT should undertake a risk assessment and review the staffing arrangements as a matter of urgency, to ensure that sufficient numbers of staff are available to holistically meet the needs of patients for the entire 24 hour period.

Behavioural Support

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well- being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the BHSCT Safeguarding Strategy Panel were assured in writing by the Independent Monitor, and verbally by the Service Manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, Inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before or since these allegations were made. This was also noted in the patients' notes examined on the unannounced inspection of 13 November 2012 and a recommendation made in the Quality Improvement Plan. No behavioural plans were evident within the notes.

RQIA requires assurance that these vulnerable patients, have access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

Environment

There are three distinct areas of this ward, and the layout is such that this must be considered when calculating the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff and there are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a "back hall" for some peace and quiet. It has been noted by inspectors and raised at the Safeguarding Strategy meetings the impact the narrow corridor to the dining areas has in relation to patient safety, i.e. the patients congregate and push each other to gain access to the dining room. Furthermore there are a significant number of locked doors on this ward, with entry and exit controlled by staff. This means that patients are very restricted in the space available to them and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs

and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.
RQIA concluded that the environment is not conducive to meeting the needs of the patients on this ward. RQIA would ask the trust to consider whether other suitable accommodation could be provided, within the Muckamore site as an alternative to Ennis ward.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2013, RQIA would expect that clear protection plans have been devised and implemented, to safeguard and protect all patients on this ward. As previously stated, five sets of patients' notes were examined and inspectors were concerned that no clear protection plans were evident in any of the notes examined. Inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes. The Vulnerable Adult referral forms included responses from the Designated Officer, often advising that patients be kept separated, or advice was given that enhanced monitoring should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans.

RQIA requires assurances that individual protection plans are clearly documented and reviewed to ensure their effectiveness for all patients on the ward by 8 February 2013.

In view of the concerns highlighted, RQIA wishes to arrange to meet the trusts' designated responsible managers to discuss these issues and to receive adequate assurance in relation to patient care and safeguarding. Mrs Theresa Nixon, Director of Mental Health and Learning Disability and Social Work, Mr Patrick Convery, Head of Programme, and the relevant inspector will be available on 11 February 2013 at 09.00 to meet with your designated managers in RQIA office, 5 Lanyon Place, Belfast.

I look forward to your continued co-operation in addressing these important matters.

Yours sincerely

Glenn Houston
Chief Executive, RQIA

The Regulation and Quality Improvement Authority

1 February 2013

Our Ref: MC/PC/CH

Private and Confidential

Mr Colm Donaghy
Chief Executive
BHSCT
Trust Headquarters
A Floor
Belfast City Hospital
Lisburn Road
Belfast
BT9 7AB

Dear Mr Donaghy

Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

RQIA undertook an unannounced inspection of Ennis Ward, Muckamore Abbey Hospital on 29 January 2013.

The inspection focused on the safeguarding arrangements on the ward, following the allegations of abuse of patients made by a third party to RQIA on 8 November 2012. I am advised that the allegations are currently subject of a vulnerable adult investigation, which I understand is being led by the PSNI. The inspection of 29 January 2013 is part of the ongoing monitoring and scrutiny of Ennis Ward. This also included unannounced inspections on 13 November and 20 December 2012.

A number of concerns arose during this latest inspection, which I wish to bring to your attention under the RQIA Escalation Policy.

Staffing

The number of staff allocated to the ward, week beginning 27 January 2013 was in accordance with the pre-assessed numbers determined by BHSCT. The ward manager or nurse in charge is included in this total, therefore cannot be fully committed to the roles of both managing the ward and nursing patients. This raises concerns about the correct number of staff to holistically meet the complex needs of 17 patients on this ward.

Additionally, for significant periods during the night two staff are allocated to this ward, (e.g. 28 - 29 January 2013, 23.00 – 07.00, and 29 - 30 January 2013, 02.00- 07.00).

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At the time of the inspection, two patients required observation at 15 minute intervals, between 23.00 – 07.30. In considering the layout of the ward; the complex needs of patients; the possibility that one or more patients may require assistance during the night; and the required level of observations, RQIA is concerned that insufficient numbers of staff are available to holistically meet the complex needs of patients on this ward.

RQIA would request that the trust undertakes a risk assessment, to review the staffing arrangements, to ensure that sufficient numbers of staff are available to holistically meet the needs of patients across the 24 hour period.

Behavioural Support

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well-being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the trust's Safeguarding Strategy Panel were assured by the independent monitor, and verbally by the service manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before, or since, these allegations were made. This was also noted in the patients' notes examined during the unannounced inspection of 13 November 2012, and a recommendation was made in the quality improvement plan. No behavioural plans were evident within the notes.

RQIA requires assurance that these vulnerable patients have access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

Environment

There are three distinct areas of this ward, and the layout must be considered when assessing the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff. There are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a back hall. It has been noted by inspectors, and raised at the safeguarding strategy meetings, the impact that the narrow corridor to the dining areas has in relation to patient safety. Here, the patients congregate and jostle each other to gain access to the dining room.

Furthermore, there are a significant number of locked doors on this ward, with entry and exit controlled by staff. This means that patients are very restricted

in the space available to them, and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.

RQIA concluded that the environment is not conducive to meeting the needs of the patients on this ward. RQIA would ask the trust to consider whether other more suitable accommodation could be provided within the Muckamore site, or that appropriate adaptations could be made to Ennis Ward to improve the environment for both patients and staff.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2013, RQIA would have expected that clear protection plans were devised and implemented, to safeguard and protect all patients on this ward.

As previously stated, five sets of patients' notes were examined and whilst inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes, no clear protection plans were evident in any of the notes examined.

The vulnerable adult referral forms included responses from the designated officer, often advising that patients be kept separated, or advice was given that enhanced monitoring should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans.

RQIA requires assurances that individual protection plans are clearly documented and reviewed to ensure their effectiveness for all patients on the ward with immediate effect.

In view of the concerns highlighted, I invite the trusts' designated responsible managers to meet with RQIA on 11 February 2013 at 09.00 at our offices, to discuss these issues and to receive adequate assurance in relation to patient care and safeguarding. Mrs Theresa Nixon, Director of Mental Health, Learning Disability and Social Work, Mr Patrick Convery, Head of Programme, and the relevant inspector will be present at this meeting.

I look forward to your continued cooperation in addressing these important matters.

Yours sincerely

Glenn Houston
Chief Executive

cc: Mr John Compton, Chief Executive, Health and Social Care Board
Dr Michael McBride, Chief Medical Officer, DHSSPS

RQIA Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

Report

In response to your correspondence under the RQIA Escalation Policy of 1st February 2013 following the unannounced inspection undertaken in Ennis Ward, the Trust would like to provide assurance that it continues to strive to deliver a safe and effective service to the patients in this ward whilst discharging its responsibilities in relation to the Vulnerable Adult investigation which is being led by the PSNI. The Trust continues to cooperate fully with the lead agency in this investigation and is continuing to support patients, families and staff during this period. The Trust continues to reflect on actions taken to date, information submitted daily through the reporting procedures put in place, leadership monitoring and reviews and feedback from the vulnerable adult process as well as RQIA inspections. In doing so we aim to ensure all appropriate steps continue to be taken to create the necessary impetus to achieve all the changes required to improve the service to the patients in this ward and ultimately in the hospital.

Staffing

The number of staff allocated to the ward is in accordance with the Telford Assessment undertaken by the senior nurse manager for the ward and the ward sister. This is reviewed at regular intervals and when changes in patient acuity is reported. The ward sister is included in the this total in line with Belfast Trust Policy for best and agreed practice in relation to the rostering of nursing and midwifery staff. The Telford Assessment agreed with the ward sister is in line with the policy and this has indicated an allocated 2 shifts per week to managerial, audit, appraisal tasks and supervisory time to support staff.

The allocation of night staff is in line with current level of assessed need, in the event if there is unpredictable patterns of activity during the night an additional resource is available through the on-site duty nurse co-ordinator and the on call senior nurse manager. The Trust has also reviewed the staffing assessment following a review of patients on special observation levels on this ward. Three staff are now allocated to night duty.

Patients also attend day support activities on site which provides individualised programmes of activities with a staff team which supplements the ward staffing compliment to enhance the patient experience.

The Trust acknowledges that there is ongoing active recruitment programme for the hospital. This is to fill a number of staffing vacancies on site. A number of new employees are now in post since Christmas however we still await completion of the new starts for registrant's posts. When the process is completed this will enhance the skill set and resource available to the ward to offset fluctuations in staff availability due to planned and unplanned staff absences.

Behavioural Support

The primary named nurse for the patient has care planning processes in place for the management of challenging behaviours. This is section 14 of the care plan. The multi-disciplinary team has referred those patients with the need for specialist behavioural assessment and intervention to the Specialist Behavioural Nurses on site. The assessments for the patients referred have been commenced which will result in behavioural plans formulated as required for these identified patients. It is recognised that a core skill for learning disability nursing staff is the assessment and care-planning of behaviours that challenge. Ward nursing staff have reviewed a number of care plans in consultation with behavioural team, the consultations with the specialist behavioural nurse is recorded in the daily nursing notes and the care plan updated by the primary nurse based on this advice. This peer support will continue to ensure appropriate support is available to nursing staff in Ennis as newly allocated staff become familiar with the patients' needs.

Environment

The ward environment has been reviewed by the senior nursing team in conjunction with estates department. Improvements to the environment have already been realised with some areas already refreshed. The Trust does acknowledge that these continuing care ward environments are not ideal but have been home to these patients for a number of years. As the patients are known to respond negatively to unplanned changes the multidisciplinary team are reviewing appropriate and measured responses to the concerns raised. The Trust is also aware that a recent resettlement of patient along with the planned resettlement of 4 further patients from this lower part of the ward will enhance the individual experience for patients of Ennis. The hospital management team have also as part of their considerations reviewed alternative options on the site but there is no other available ward environment that can safely meet the assessed needs of the current patient profile of Ennis ward.

The patients in the lower part of the ward have underwent previous assessments and their care-plans indicate their inability to keep themselves safe from normal day to day dangers of bathrooms, kitchens, or outdoor spaces; therefore areas are locked to prevent patients for example leaving the building unaccompanied. It is noted that whilst the patients lack capacity to choose their environment, ongoing contact with families indicate their support for continued use of Ennis as a ward. A number of relatives have voiced strong opposition to even internal transfers of their relatives to another ward on site even if available. A structured programme of activities off the ward is available to patients on site with a dedicated day support staff team. In spite of this the Trust does hold the view that we will continue to endeavour to provide betterment to this patient group through ongoing improvements where possible in the ward but ultimately appropriate community reintegration and resettlement from the hospital.

Protection plans

The Trust has an overall protection plan for Ennis ward which involves 24 hour monitoring of staff who were present during the period allegations of abuse are reported. This involves independent review of practices and nursing interventions as well as notification of areas of concern. These reports are reviewed by the service manager, designated officer for the vulnerable adult investigation and the external independent monitor and coordinator. Earlier review of these forms have highlighted areas for improvement which included environmental, privacy, staffing and patient profile and mix issues and concerns. Each of these issues have been subject to planned improvements and ongoing review and management.

The independent monitor lead and service manager have led the local team on environmental, fire safety, infection control and hygiene audits with subsequent action plans developed. The RQIA announced and unannounced inspections have also highlighted areas for improvement which the QIP's will address. The Trust is committed to delivering a safe and sustainable improvement in the ward for patients which will also support staff in the workplace.

The designated officers for vulnerable adult processes within the hospital are continuing to work with the multidisciplinary team in Ennis to monitor and review incidences of vulnerable adult concerns to minimise risks and provide external monitoring of patterns or incidents. This work remains ongoing. The Trust will ensure that all agreed actions from each report is care planned appropriately within the patient notes to ensure compliance with the protection plans.

The Regulation and Quality Improvement Authority

Our Ref: PC /CH

9 May 2013

Private and Confidential

Mr John Veitch
Co-Director for Children's Mental Health and
Learning Disability Services
Belfast Health and Social Care Trust
Adult Social and Primary Care Directorate
Fairview House
Mater Hospital
45-51 Crumlin Road
Belfast
BT14 6AB

Dear Mr Veitch

Police Investigation - Allegations of Abuse, Ennis ward, Muckamore Abbey Hospital

I refer to the recent Police Investigation Report regarding the allegations of abuse in Ennis Ward.

I note this investigation has been conducted as a Joint Protocol Investigation and poor care practices have been highlighted and incidents of a non-criminal nature identified involving some other staff members. I note through the investigation, the two suspects in this case, were repeatedly identified as being responsible for incidents of ill treatment and rough handling of the patients on the ward. The investigation report indicates that "the patients in this ward are some of the most vulnerable in the hospital, as they are not able to verbalise or communicate. Although there was only one witness to several of the incidents, the description of the actions, particularly that of H197 show consistent rough handling and aggression by a staff member who has worked at Muckamore Abbey Hospital for 32 years. The disregard for carrying out these actions in the presence of independent staff raises concern".

I wish to seek assurances that this report has been shared with key staff and that the "poor care practices highlighted and incidents of a non-criminal nature identified involving some other staff members" are being addressed by the Trust currently.

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RQIA would like to seek assurances from the trust in relation to the following

- That issues in relation to the care, treatment and culture both within Ennis and other wards have been addressed by the Trust.
- That the ongoing monitoring of Ennis ward continues in the light of this report.
- That RQIA will continue to be kept appraised of incidents involving patients and staff both in Ennis and in other wards within Muckamore Abbey hospital.

I would welcome your response to these matters by 17 May 2013.

Your co-operation is much appreciated.

Yours sincerely

Theresa Nixon
Director of Mental Health and Learning Disability
and Social Work

Emailed to TNixon on 6/6/13 @ 1607
Copy Esther/Marcel 6/6/13 @ 1607

Belfast Health and Social Care Trust

6th June 2013

Mrs T Nixon
Director of Mental Health and Learning Disability
RQIA
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Dear Theresa

Re: Police Investigation – Allegations of Abuse, Ennis Ward, Muckamore Abbey Hospital

I refer to your correspondence of 9th May 2013 and wish to sincerely apologise for our delay in providing this response which was partly due my own absence on annual leave last week.

I can now confirm that the Trust immediately initiated a thorough investigation through the joint protocol arrangements into the allegations raised by the visiting Care Worker to Ennis ward on 8th November 2012. I can also assure you that the Trust acted swiftly and diligently in immediately sharing information with all appropriate staff and in addressing the immediate and ongoing protection needs of the patients within this ward. A total of four staff were initially placed on precautionary suspension as part of the protection plan and two staff remain on suspension from the workplace; namely a Healthcare Worker Band 3 and a member of Bank staff at Band 5.

As you should be aware a number of Strategy meetings have been held to progress the ongoing investigation into the allegations. This investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse. Action included putting in place a protection plan which involved independent daily monitoring of staff interventions and the quality of care delivered on the ward. This protection plan continues to be reviewed at each Strategy meeting and currently remains in place. I can also confirm that these monitoring arrangements remain in place despite the continuing and unavoidable disruption it is recognised as having on the ward routine and initially to patients who did not respond well to unfamiliar faces within their environment.

Belfast Health & Social Care Trust, Social Services Family & Child Care, Fairview 1, Mater Hospital Site, Crumlin Road, Belfast BT14 6AB Tel 028 95046918 Fax 028 90802101 Email: john.veitch@belfasttrust.hscni.net

I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture. Support from Behavioural Services has also been provided to assist staff in their ongoing care of the patients in this ward. Environmental challenges have also been identified and are now part of the improvement plan for the ward.

Feedback from the monitoring reports has also been fully discussed at the Strategy meetings held to date at which representatives of your agency have been present. These reports have been forwarded daily to the Vulnerable Adult Designated Officer for the case, a Co-Director of Nursing, and the Hospital Service Manager who is the professional nursing lead for the service. If a concern or issue is noted these are reviewed by the hospital operational team and all actions are agreed in conjunction with the staff team in the ward.

To date key personnel within the Trust have continued to work proactively to progress improvements for patients in this ward and for all patients on site. I can also assure you that the Trust regards with the utmost seriousness any reported concern regarding any member of staff failing to provide the expected level of care, inappropriate attitude or appropriate interventions to any of those patients entrusted to our care. As the PSNI investigation is now completed, we now await a decision from the Public Prosecution Service on the next steps. The Trust is also now completing its own Vulnerable Adult processes to fully address all concerns raised including those allegations or concerns of non-criminal nature. Throughout the PSNI investigation the Trust did also act on any concerns raised regarding staff and these were addressed immediately by the Investigation team, and I understand that no actions remain outstanding.

The Trust has also over this period improved the ward environment, invested in new fixture and fittings and continued to review staffing ratios within the ward. Further quality improvements are planned over the coming weeks as outlined in recent Quality Improvement Plans submitted.

I trust the above information fully addresses the issues raised and wish to apologise again for the delay in providing this response.

Yours sincerely

J Veitch (Mr)
Co-Director of Learning Disability Services

BELFAST HEALTH & SOCIAL CARE TRUST

ENNIS WARD ADULT SAFEGUARDING INVESTIGATION

Aine Morrison/Colette Ireland/Carmel Drysdale

10/23/2013

(1) Introduction

Allegations of abuse in Ennis Ward, MAH first came to light on 08/11/12. A care assistant from the Priory Group, Bohill Care Home had been working on the ward as part of an introduction programme for patients who were moving to the Bohill. She alleged that whilst working on the ward on 07/11/12, she witnessed named staff being verbally and physically abusive to four named patients. Only one patient's surname was provided but the Christian names provided for the other three allowed the hospital to identify these individuals.

Bohill staff report some difficulty in accessing a Designated Officer at MAH to report the concerns to. They report first contacting MAH at 9.40am on the 8.10.13 and asking the receptionist for the Designated Officer. The receptionist did not know who this was but did put the call through to the service manager's office. However they were redirected a number of times before being put through to the social work office where they were told that H92, DO was on a call and would phone back. H92 did phone back but got no response. At 9.50am, Bohill staff contacted the Trust's adult safeguarding team and were referred to Colette Ireland, Team leader for Learning Disability. Colette was not available. Bohill reported the allegation to RQIA at 10.10am who reported it to MAH. Receptionist staff in MAH have now been informed about the meaning of the term "Designated Officer "and who they should contact if asked for one. The adult safeguarding team in the Trust have also been informed of the correct contact details for MAH safeguarding issues.

The details of the allegations were as follows:-

1 She witnessed H159 (staff member) pull P39 (patient) from the sofa P39 was sitting on by the hem of her trousers on to the floor and to be verbally condescending.
2 She witnessed H159 (staff member) speak in an inappropriate manner, such as, get out of my way/your doing my head in. This was shouted at patients in general.
3 She witnessed P40 (subsequently identified as P40, patient) coming from the bathroom naked, screaming and shouting "I hate her/I hate H159, she hit me." P40 was very distressed and blood was coming from her mouth.
4 She witnessed P40 sitting naked for a period of time and that H196 (student nurse) told P40 that she wouldn't get her sweets and lemonade if she didn't put her nightdress on.
5 She witnessed H197 (staff member) push P41 (subsequently identified as P41, patient) so hard into her chair that she hit her head off the back of the chair.

6 She witnessed [redacted] saying to [redacted] (subsequently identified as [redacted], patient) when [redacted] (patient) had attacked her, not to be "a big softie and hit her back".

7 She witnessed patients hitting out at staff and each other with no intervention.

An investigation started immediately during which the following actions were taken.

2a) Interviews with Bohill Staff by PSNI or Belfast Trust Staff

2a) Interviews with Bohill staff by PSNI or Belfast Trust staff.

A summary list of all the concerns emerging from both PSNI and social services' interviews is given at Appendix A.
The details of the Trust's interviews are as follows:

Initial social services interviews with Bohill staff took place on 15/11/12 and 22/11/12 using an agreed format and set of questions. A total of nine staff were interviewed. All of the staff interviewed had spent shifts working on Ennis Ward although the number of shifts staff worked varied from one shift to up to ten shifts over the period from 4/10/12 until 10/11/12.

Some Bohill staff were interviewed by PSNI and were not part of the group we interviewed by social services. The following is an account of the interviews completed by Carmel Drysdale and Colette Ireland. Both Carmel Drysdale and Colette Ireland are employed as Community Team Leaders within learning disability service and are trained Designated Officers and ABE Interviewers.

Six out of the nine staff originally interviewed were asked to attend a further interview. The aim of the second interview was to clarify issues raised in the initial interview in particular to assist staff to identify which staff members against whom the allegations were made. Only three attended for interview. One staff member did not attend due to illness, a second had left the employment of Bohill and the third declined.

A number of themes emerged from the interviews of Bohill staff (this includes information obtained from interviews carried out by social work staff and from police interviews) The full details of concerns noted can be found in Appendix A.(numbers 1-63). The numbers in the following text refer to Appendix A.

This summary of the concerns makes no comment or judgement on the validity of the issues raised.

Concerns raised about the physical treatment of patients:

There were a total of 22 incidents identified.

Two incidents related to P41 and the staff member involved was named as H197 (5&7). Bohill staff reported that the staff member had pushed P41 so hard into her chair that she hit her head of the back of her chair. The same staff member pulled P41 in to a standing position and shoved, nudged and pushed her towards her chair.

Fifteen concerns were raised in relation to P39 which were made by eight members of Bohill staff. Ward staff members were identified for some of these incidents as H197 (8, 16) and H159 1, 34, and 49) One reported

incident (48) involved another staff member named [redacted] assisted by another care assistant. In the remaining incidents (22, 25, 26, 29, 34, 52, 57, 58, and 60) Bohill staff were not able to identify the staff member. Many of these reports were similar in nature describing [redacted] being pushed, pulled backwards or grabbed by her clothing or wrists.

There was one incident when [redacted] alleged that [redacted] had hit her (3) and was observed to have blood coming from her mouth. One incident (40) involved a disclosure made by a patient [redacted] against a staff member [redacted]. In the remaining three incidents (23, 30, 32), the patients or ward staff members were not identified.

Concerns raised about the verbal treatment of patients.

There are ten reported incidents of concern about how patients were spoken to, some directed at one specific patient [redacted] (1,16,19, 38,49,62) while others were directed to the wider group (2, 11,14, 31) Staff members were identified as [redacted] (1,2,11) [redacted] (14) and [redacted] (16). One member of Bohill Staff talked about everyone shouting at [redacted] to go away or stop it in response to her stripping behaviour (19, 62). The nature of the concerns ranged from staff being described as verbally condescending (1) to incidents where the staff member was reported to have shouted in [redacted] face (16, 38).

Concerns raised about the management of behaviour of patients.

There were 16 concerns raised about the management of patients' behaviour. There was a range of issues raised. Some related to staff advising patients that they wouldn't get their meal or a treat in order to manage behaviour (4, 9) On another occasion (6) it was reported that a member of staff named as [redacted] advised a patient to hit back at another patient who had assaulted her. Other concerns related to advice given to Bohill staff about the management of behaviour for specific patients. It was reported that [redacted] (10) advised the staff member not to give [redacted] face contact, to turn her away by the band of her trousers and not to keep redressing her as this would go on all day. Another staff member was advised not to give the patients too much attention as they will want it all the time (28) and a member of Bohill staff reported that she was advised by a member of night staff not to give [redacted] attention as she was rewarding bad behaviour (58). There were two occasions when a staff member reported that ward staff pushed [redacted] away when she was holding the Bohill staff member's hand (29, 57)

There are a number of specific concerns raised about the management of [redacted] Two Bohill staff reported (20, 47, and 61) that [redacted] shoes were removed and thrown across the floor and she would go after them. Another staff member reported (24) that [redacted] was put on a chair with her legs up. The staff member sat in front of [redacted] who usually kicked staff away in order to get out of the chair. Other incidents reported (35) [redacted] tee shirt being stretched and tied between her legs. Also it was

reported that a belt was being used and tightened (36, 45, 48, 49). The staff member also reported (49) that P39 was removed from the room and placed outside in the rain.

Concerns raised regarding the lack of supervision of patients:

One Bohill staff member reported (13) being left on her own in the day room for approximately 20 minutes unable to summon assistance, (43) Also referred to a lack of adequate staffing and patients being left unsupervised. Another report relates to P43 (17, 50-may be the same incident, 53) who was reported to be sitting outside on the grass and it was raining and she was described as soaking. H159 and H197 were reported to have stated that she did not need to come into the ward and that she had a wet suit.

Concerns regarding the lack of induction for Bohill staff coming on to the ward:

This was raised by some staff (13/15, 41) However five of the Bohill staff reported that they did receive induction during their first shift. One staff member reported (12) that staff ignored her requests for help with a patient. Another, (46) that the care plan did not tell staff how to manage P39 stripping behaviour and there was no instruction from staff on how to manage this.

Other issues of concern raised:

Reports made about negative comments being made by staff (18, 37, 51, 59) about patients, two of these reports related specifically to P39

A report (21) that when the staff member would arrive at 8 am, P39 was standing naked in the hallway.

Issues raised around the management of patients waiting to get their meals and the management of meal times. (25, 30, 54, 55) There was a specific incident involving P44 (33) when it was reported that the patient didn't get up for tea as she said she had a sore head-staff member said if your head is sore you won't want your dinner and scraped it into the bin. P44 asked for a tablet for her headache, staff said she wasn't allowed one as she hadn't eaten her dinner.

A report of unnamed staff putting two pads on unidentified patients and the reason provided was that patients were wetting too much (27)

Concerns were raised about the atmosphere on the ward (44, 63) lacking stimulation and warmth. Very set routines (39, 56), also a lack of staff engagement and interaction with patients (42)

2b) Patient Interviews

2b) Patient Interviews

Patients directly involved in specific allegations were interviewed under joint protocol procedures where possible. Capacity to participate in interviews was discussed by the multi-disciplinary team including consultant psychiatry, speech and language therapy, nursing and social work staff. The PSNI were also involved. Of those named in allegations, it was deemed possible to interview P42, P44 and P40. It was not deemed possible to interview P39, P41, P22 or P43

Consideration was then given to interviewing other patients who were not specifically named to ask them generally about their experience on the ward. P45 P46 and P47 were identified as potentially having the capacity to participate in an interview. Relatives for P45 and P46 objected strenuously to these interviews going ahead on the basis of potential upset to P45 and P46 Following consultation with Dr Milliken, Consultant Psychiatrist, it was agreed that these concerns were valid and that on balance it was not in these ladies' best interest to proceed to interview.

Interview with patient P42 (held on 23/1/13)

P42 was interviewed in relation to an allegation she made to her brother that staff member H198 grabbed her by the scruff of her neck and took her to her bedroom (Appendix A No. 40)

P42 raised no concerns and said that she is very happy on the ward. She later told her brother that H198 had been joking when she made the comment.

When interviewed, H198 said that she would make such comments in a jokey manner.

Staff who know P42 well feel that she would share any concerns she would have. The investigating team feel that this comment was a likely to be a joke.

Interview with patient P40 (held on 23/1/13)

P40 was interviewed in relation to an allegation made that staff member H159 hit P40 (Appendix A No.3)

It was not possible to engage P40 in the interview. The interview did not provide any further information relating to the allegation. Following referral to the dentist, it was noted that P40 had an abscess in her mouth at the time.

Interview with P44 (held on11/1/13)

P44 was interviewed in relation to allegations made that a member of staff said to her "If your head is sore you won't want your dinner "and scraped it into the bin. P44 asked for a headache tablet, staff said she wasn't allowed one as she hadn't eaten her dinner (Appendix A – No.33)

The use of direct and closed questions was required during the interview as per the advice of Rosalind Kyle (Speech and Language Therapist) who advised on P44 communication needs.

P44 did relate an incident when her dinner was scraped into a bin by a staff member. P44 said this was because she didn't like the dinner and refused to eat it. P44 reported that she was refused a sandwich as an alternative.

It is believed that her dinner was scraped into the bin. However it is unclear what the context was or whether this was an appropriate response from staff.

At no point during interview did P44 report that she had a headache at this time. She was unable to identify any staff member.

Interview with P47 (held on 19/8/13)

This interview focused on asking P47 for her views of life on the ward. P47 was extremely positive about all aspects of ward life and reported no concerns.

2c) Contact With Relatives

2c) Contact with relatives

Family Contact

1 Contact was made with family members for P39, P40, P41 and P43 on 02/11/12 by a Senior Nurse Manager from Muckamore Abbey Hospital to inform them of the allegations. No family member raised any concerns about care on Ennis at that point.

2 At a strategy meeting on the 09/11/12, it was agreed that family members for all patients on the ward should be informed in general terms about the allegations. A Senior Nurse Manager from MAH made these calls and again no concerns were raised and many family members spoke very positively about the care on Ennis.

3 At a strategy meeting on 12/12/12, it was agreed that family members should be further updated by telephone call to be followed up by a letter, again family members were largely positive about the care on Ennis. However a number of issues were raised.

A) 17/12/12 Brother of P42 said that P42 had told him that the nurse in charge H198 (couldn't remember surname) had got her by the scruff of the neck and took her to her bedroom. Brother felt that P42 wouldn't tell lies and may not want to say anything that would get her into trouble. This was subsequently investigated (see patient interviews section). The evidence suggested that this had been a jokey comment made by H198 and there wasn't evidence of abuse.

B) 08/01/13 – Sister of P44 had previously indicated that she had no concerns, she raised some issues when contacted about an allegation concerning P44 that Bohill staff had made. The issues she raised were;

i) Felt staff levels often appeared too low, staff were rushed and she felt that staff should be in dayrooms on all occasions.

ii) Concerns about supervision – reports of P44 falling off cupboards or lifting furniture – would query where staff where.

iii) An incident where three staff were sitting at dining table in kitchen chatting. When she and her husband entered the dayroom to return P44 another patient had removed all clothing on her bottom half. She said it took quite some time to attract staff attention. She said this had happened sometime within the past year.

iv) When Dr Milliken reduced P44 sedation at Sister of P [redacted] request, named nurse called H199 said to her 'for goodness sake – I wish they wouldn't do that, it makes things harder for us'. On another occasion ward manager H491 on being told of sedation reduction by Dr Milliken in Sister of P44 presence, sighed and tutted.

v) Concerned P44 money wasn't being spent on her. P44 was wearing a cardigan full of holes on one occasion. She was told P44 has chosen this. Felt clothes were shabby although this had improved in the last year.

vi) Within the past year, P44 not allowed to go to mass for a few months, told priest had said she couldn't because of her behaviour. Sister of P44 offered to take her herself but was told this wouldn't be safe despite being allowed to take her out for the day – now attends in a wheelchair. P44 is over sedated again – that she sleeps all afternoon.

Sister of P44 also said that overall the good outweighed the bad.

It was agreed with Sister of P44 that these issues would be investigated separately as a complaint by a senior nurse manager in MAH. Sister of P44 subsequently declined to meet with Senior Nurse Manager in MAH to discuss the concerns.

Senior nurse management are to proceed with an investigation in any case.

C) 17/01/13 - Mother of P47 said she was concerned about the number of recent incidents where P47 had been assaulted by other patients. Aine Morrison agreed to check if the responses had been appropriate. This was subsequently

checked with the hospital Designated Officer (Michael Ceaney) and the actions taken were reviewed. P47 had been assaulted by other patients three times in one week. Aine Morrison felt that the protection plan put in place was appropriate.

Further updates to families during the course of the investigation did not result in any new concerns.

2d) Interviews either by PSNI or social services with staff named in allegations

2d Interviews either by PSNI or social services with staff named in allegations

H159

The allegations against **H159** are listed in Appendix A – summary of concerns raised by Bohill staff.
The PSNI interviewed **H159** on 20/02/13. She denied all the allegations stating that she was very fond of all the patients. The PSNI have referred this matter to the Public Prosecution Service with a recommendation of prosecution in relation to the following offences.

1. Common assault and ill-treatment of a patient with a mental disorder on 09/10/12: **P39**, belt fastened tightly, walked to the door and put outside the fire door.

2. Ill-treatment of a patient with mental disorder on 09/10/12; **P43** left to sit outside without appropriate protective clothing on.

3. Common assault and ill-treatment of a patient with mental disorder on 07/11/12; **P39** pulled from the sofa and onto the floor.

4. Assault occasioning actual bodily harm and ill treatment of a patient with mental disorder on 7/11/12. **P40** alleged that she had been hit by **H159** and was seen to have blood coming from her mouth.

H197

The allegations against **H197** are listed in Appendix A- summary of concerns raised by Bohill staff.

The PSNI interviewed **H197** on 28/02/13. She denied all of the allegations stating that staff would not do those things. For some of the alleged offences, she denied that she was the staff involved, despite being given the descriptions matching hers and the staff rota confirming she was on duty. The PSNI have referred this matter to the Public Prosecution Service in relation to the following offences.

1. Common assault and ill-treatment of a patient with a mental disorder on 09/10/12- **P39** - belt fastened tightly, walked to the door and put outside the fire door.

2. Common assault and ill-treatment of a patient with a mental disorder on 09/10/12- P39 - grabbed by the jumper at the chest and told " get the fuck out of my face" and / or either " this is doing my head in" or "she's fucking doing my head in". P39 then pulled across the room and pushed onto a sofa.

3. Ill-treatment of a patient with mental disorder on 09/10/12 P43 left to sit outside without appropriate protective clothing on.

4. Common assault and ill-treatment of a patient with a mental disorder on 05/11/12- unknown patient pushed onto a chair.

5. Common assault and Ill-treatment of a patient with a mental disorder on 07/11/12- P40 - blood wiped roughly from her mouth using a personal hygiene mitt.

6. Ill-treatment of a patient with a mental disorder on 07/11/12- P22 - failed to intervene when P22 was being assaulted by fellow patient P41 P41 and encouraged her to hit back.

7. Common assault and Ill-treatment of a patient with a mental disorder on 07/11/12- P41 - pushed into a chair, causing her to hit her head off the back of the chair.

H203

B5 , Bohill staff alleged that a MAH member of staff described as being a care assistant description of H203 description of H203 was involved in an incident with P39 she described the incident as follows.

P39 was making crying noises and the care assistant stood up from her chair and put her hands on P39 mid back and pushed her away. P39 came back, happened quite a few times, and then P39 started to take her trousers down. Care assistant was getting agitated - could tell by the tone of her voice. She said "that's enough" went towards P39 and was trying to get her belt tightened but P39 was moving about. Another member of staff (H205 came over and held P39 P39 had her hands on the arm of the chair and was bent over. H205 held P39 by her hips or top half of her body while the care assistant yanked at her belt forcefully pulling it and fastening it. Her belly was all pushed up and hanging over the belt, she looked really uncomfortable.

MAH management staff subsequently identified the care assistant as likely to be H203 .

On 21/12/12 Aine Morrison, Operations Manager and Orla McCreary, Social Worker interviewed H203 in relation to this allegation. Leonard Johnston, a UNISON rep was also present.

H203 agreed that she matched the description given of the care assistant.

She denied the allegation. She said that everyone tightens the belt but that she had never seen it too tight or higher than her waist. She said that P39 never takes the belt off - she wriggles out of her trousers. She said that she sometimes put P39 belt on with her buckle at the back as she found this easier due to P39 weight.

Other more general comments are included in the general staff interviews section of this report.

B5 's report is convincing in its detail and the concerns about belt tightening are echoed in other Bohill staff interviews. However, H203 denies the allegations. There are no other witnesses and MAH staff deny any practice of belt-tightening.

The investigating team concluded that the allegations about H203 could not be confirmed.

H205) Care Assistant

B5 , Bohill staff alleged that a MAH member of staff, H205 described as being in her description of H205 and a 2nd staff member were involved in an incident with P39 . She described the incident as follows;
P39 was making crying noises and a care assistant stood up from her chair and put both her hands on P39 mid back and pushed her away. P39 came back, happened quite a few times, then P39 started to take her trousers down. Care assistant was getting agitated – could tell by the tone of her voice. She said 'that's enough' – went towards P39 and was trying to get her belt tightened but P39 was moving about. H205 came over and held P39 P39 had her hands on the arm of the chair and was bent over. H205 held P39 by her hips or top half of the body while the care assistant yanked at her belt forcefully pulling it and fastening it. Her belly was all pushed up and hanging over the belt. She looked really uncomfortable.
MAH management staff subsequently identified this person as likely to be H205 .

Aine Morrison, Operations Manager and Orla McCreary, SW interviewed H205 H205 in relation to this allegation on 21/12/12. Daughter of H205 was also present.

H205 denied the allegation. She said that it only takes one member of staff to put P39 belt on, that it was put on the loops of her trousers and that P39 can take the belt off herself.
Other more general comments are included in the general staff interviews section of this report.

B5 's report is convincing in its detail and the concern about belt-tightening is echoed in other Bohill staff interviews. However H205 denies the allegation. There are no other witnesses and MAH staff deny any practice of belt tightening. The investigating team concluded that the allegations about H205 could not be confirmed.

H206

B6, Bohill staff member identified someone called H206 as witnessing another MAH staff member pushing a patient into a chair without much care, causing her to flop on the couch. She said 'sit back down'.
H206 was identified by MAH staff as likely to be H206. The other member of staff was identified as likely to be H197.

H206 was interviewed by Aine Morrison on 8/4/13. Joe McCambridge, RCN rep was also present. H206 said she had no recollection of any such incident and said that if this had occurred, she would have reported it. When asked if she recognised the description of the other staff member, H206 said that because she knew H197 was suspended, she knew that it was likely to be her. She said that H197 was a brilliant nurse and that she had no concerns about her practice.

H198

H198 was interviewed by Carmel Drysdale and Colette Ireland. Joe McCambridge was also present. The allegations made against her during the course of the investigation were put to her.

Allegation made by Brother of P42, that P42 had told him that staff member H198 had said to her that she would grab her by the scruff of the neck and bring her to her room. (Appendix A No 40)

H198 denied the allegation but did say that P42 enjoyed banter and she thought that it was possible that she would have said something like this in a jokey fashion.

Allegation made by B2, a staff member from Bohill, that she was left on her own with patients while H198 was in charge of the ward and was assaulted. (Appendix 20 No13)

H198 denied any knowledge of such an incident saying it had never been reported to her. However she did comment on staffing on the day.

Extract from interview:

H198 We were working short staffed on that day (7/11/12). It was a stressful day because of staffing. In the a.m. there should have been seven staff instead there were four. Many of the staff were not in on their normal shift but were covering extra. I was in on extra time. From 7.30 to 9 am two of the staff were bankers, one trained and one new from another ward. At 9 am another assistant came who did not know the ward. In the afternoon there was five staff instead of six. One staff in the upper room, one on enhanced supervision, leaving two staff in the day room. I was left very vulnerable. I had to manage it in the best interests for the care and safety of the girls.

Carmel: What did you do when you were concerned about staffing?

H198 On that day I did ring through and spoke to the girl on the switch board to highlight that I wouldn't be able to attend vulnerable adult training that day due to staff shortages. I did speak to the duty manager but I don't remember who that was. They said that they were aware that we were short staffed and only had five on duty but there was no further staff available. That day I had to spend a lot of time in the office recording and speaking to families about the behaviour of patients.

Allegation made by B2, Bohill staff that H198 had come out of the office in response to increased noise levels and shouted into the day room 'I'm fed up with the lot of you, you're doing my head in' (Appendix A No 14)

H198 said she couldn't recall this and said that she wouldn't use language like this.

In relation to the allegation of grabbing P42 by the scruff of the neck, P42 disclosed nothing of concern in a pre-interview assessment conducted on 23/1/13. Brother of P42 who had made the allegation subsequently told Aine Morrison that P42 had later said it was only a joke. Given H198 report of frequent banter between the two of them, it seems likely that this was a jokey comment.

In relation to the allegation made by B2, Bohill staff member, that she was left on her own with patients and assaulted, the staffing situation on the day as reported by H198 could suggest that there was an increased likelihood of her being left on her own. B2 acknowledged that she did not report the assault during her shift.

In relation to the allegation made by [redacted] of [redacted] shouting, we have two differing accounts and no other witnesses, and are therefore unable to draw any further conclusions. The investigating team concluded that the allegation about shouting could not be confirmed.

2e) Interviews with Ward Staff

2e) Interviews with ward staff

These summaries report what staff said but make no comment on the validity of the statements made. Individual records of each interview are available. Conclusions are drawn in the Conclusions and Recommendations section of this report.

Staff were interviewed by Carmel Drysdale and Colette Ireland DOs
Summaries of emerging themes were as follows organised under the question headings.

Interviews with registered nursing staff

1) Profile of staff interviewed:

Band 8A, has responsibility for four resettlement wards including Ennis (as well as other duties) works eighteen and half hours. Has not always had responsibility for Ennis Ward but current period has been for the last 4 to 5 years. Would have a presence on Ennis Ward approximately twice per month but this could vary from month to month.

Band 8A, job shares with the above Band 8A, has responsibility for a resettlement ward (as well as other duties) works eighteen and three quarter hours. Covers Ennis Ward as and when required. Also is copied into e mails, correspondence with regard to the ward. Within the last year may have been on the ward a handful of times for planned meetings or in response to something which may have happened on the ward

Band 7; ward manager, four years working on Ennis ward, longer working in the hospital. Works full time. On sick leave since January 13.

Band 6 (temp), five years until September 12. Returned to work on the ward in December 12. Works full time.

Band 5, 3.5 years working on the ward, full time, nights only.

Band 5, 8-9 years on the ward, full time.

Band 5, did bank shifts on Ennis prior to nurse training about four years ago. Has worked two shifts post November 12 as relief from another ward as qualified staff nurse.

Band 5, part time worker, working on Ennis for the past four years.

Band 5, full time working on Ennis for the past four years.

Band 5, has worked in hospital 33 years. Moved to Ennis at the same time as the patients from F4, full time.

Band 5, part time bank staff, has worked in hospital since 1974, does two evenings per week in Ennis.

Band 5 has worked on Ennis for 16 years, now banks and works a mixture of shifts.

Band 5, has worked in the hospital for 40+ years, 5-6 years in Ennis works day time shift three days a week.

Band 5, works full time and has been working in Ennis since July 12.

Question asked and summary of responses

Have you ever had any concerns about the physical treatment of patients on the ward?

No concerns.

Have you ever had any concerns about staff attitudes towards patients?

No concerns. One staff member commented that she had concerns in the past about an incident some years ago, she raised it with the line manager and it was investigated. While the situation was described as stressful, the staff member stated that she would do this again if she had concerns.

A Band 8A reported that last year she was asked to investigate a concern raised about a staff member from Ennis Ward who had accompanied a patient to day care who was on an increased supervision level. The concerns related to how she spoke to the patient and managed her behaviour. The staff member resigned and did not engage in the investigation. Despite the fact that the investigation was incomplete because of the staff member's lack of engagement, the outcome was that there were grounds for concern.

One of the 8A's interviewed said that RQIA inspections of Ennis ward have been very positive and on one occasion Ennis ward was used as an example of good practice by inspectors from RQIA when discussing another ward within the hospital.

Have you ever had any concerns about the level of supervision on the ward?

No incidents of concern were raised. However the majority of staff raised the issue of staff shortages which made it difficult at times. An example given by some staff was that the 1:1 staffing would sometimes also have to supervise 2 or 3 other patients in the day room. This is addressed under the next heading.

The Band 8A advised that the Telford formula is used for calculating staffing (recently introduced prior to November 2012) A key part of this is the requirement for the first enhanced observation i.e. levels 3 and 4 to be carried out by the existing staff team. If there was a requirement for a second enhanced observation then a request would be made for an additional staff member. All decisions to increase the level of observation are clinical decisions either made by the nurse in charge in response to an emergency situation and subsequently agreed by the multi-disciplinary team or as planned intervention agreed at a multi-disciplinary meetings. Since November 2012 there has been a change and any requirement for enhanced observation requires an additional staff member.

Have you ever had any concerns about the levels of staffing on the ward prior to 8/11/12 or since?

All of the registered nursing staff raised issues about the levels of staffing prior to the 8/11/12

A range of issues were raised:

- The change of patients on the ward e.g. patients moving from Fairview with more complex needs, more challenging behaviour requiring de-escalation and physical intervention at times.
- The ward split in half which one staff member described as Ennis being really two wards.
- Some of the patients who were not on 1:1 supervision still required a high level of individual attention, for example, a patient involved in stripping behaviour. It was also difficult to cover appointments for patients. Other tasks such as laundry duties took staff off the floor.
- Staff were managing a period of major change as a result of the new patients.
- Increasing demands placed on staff such as the introduction of e procurement, electronic recording in addition to training meant there was less time available for working with patients. Considerable time also spent trying to find staff to cover shortages. Re-settlement process took up time in preparing information and attending meetings. Number of staff on sick leave and a lot of part time staff. Staff being moved to other wards and not replaced.
- Often only one qualified staff member on duty.
- Sometimes when there was a full compliment of staff, some staff were sent out to relieve other wards.

Night staff did not experience the same level of difficulty as the shift usually was covered. Since November '12, the number of night staff has increased from two to three staff on duty.

Staff reported that they were aware that the ward manager was raising these issues with her line manager. They also reported that they were aware that staff shortages were being experienced in other wards throughout the hospital.

The ward manager provided a file of evidence of measures she had taken to highlight to management the staff shortages.

The Band 8As reported that tough decisions were having to be made by them and the duty officers to try to prioritise providing cover to wards as there was insufficient staff available. There is a proforma kept documenting staffing levels per ward and how or if a deficiency was covered. Discussion would take place with the nurse in charge about how best to cover situations when there was no staff available to cover. Examples given were re-arranging outings or hospitals review appointments (these discussions are not recorded)

After 8/11/12 all staff reported that there was an increase in staffing which presented its own difficulties in terms of new staff not knowing the patients' needs and patients becoming unsettled as they do not cope well with change.

The Band 8As reported that concerns about staff shortages within the hospital go back at least two or three years and had been raised with senior management and had gone as far as the Department. One example given related to the closure of Finglass Ward which it was felt was closed prematurely and staff relocated to other wards. It was felt that this had limited impact in resolving the staff shortages.

A number of factors were identified which contributed to staff shortages:

- Not allowed to use over time, some agency staff used (in a few wards) or banking staff(it was explained that banking staff were often staff with a good knowledge of the patients and ward)
- Enhanced supervision requirements are not budgeted for and currently it is calculated that 109 Whole Time Equivalent (WTE) staff are needed each week to cover enhanced supervision requirements throughout the hospital.
- Level of sick leave as a result of the number of physical assaults, verbal assaults, pressures on staff covering additional shifts, levels of stress which is impacting on staff's mental health. Staff are also concerned about the stability of their jobs; aware of the resettlement time scale.
- Difficulties with recruitment of staff e.g. delays going through scrutiny because of re-banding, the length of time it takes for the recruitment process, attracting applicants because of the posts being temporary and the low numbers of learning disability nurses being trained.

Workforce planning papers have been prepared and were sent to the Board.

What preparation was there for Bohill staff coming to work on the ward?

Advised by ward manager that trained staff were asked to give Bohill staff an induction on to the ward. (This was confirmed by a number of staff members) Also pen pictures and care plans were shared. Ward staff had visited Bohill and Bohill

management staff attended resettlement meetings and were given information about the individual patients. The MAH induction booklet was used for the induction of Bohill staff. One staff member commented that as Bohill staff changed every few days, this had to be repeated.

Not all qualified staff had experience of carrying out this induction e.g. night staff and a staff member who had completed only a few shifts on the ward as relief and some others who would not have been on duty when Bohill staff arrived on the ward for the first time or were not working with the specific patients identified to move. Another hadn't worked on the ward during the period Bohill staff were present.

Some difficulties were identified. A duty list of Bohill staff was forwarded to the ward but it didn't reflect the number of staff attending e.g. one name on the rota but four turned up on one occasion. This was unsettling for patients. One staff member commented that it may have been better if key worker staff had come from Bohill . Staff reported that Bohill staff were not working with the patients transitioning choosing to spend time with other patients. One staff member commented that Bohill staff were 'sitting around' and not taking an interest in the patients.

The Band 8As reported the following measures:

- Ward managers were advised that staff were to have induction and a 'buddy' system to be put in operation
- Bohill staff were to come at different times and not all together
- Ward managers were given rotas for Bohill staff coming to the ward
- The Band 8A responsible for this resettlement process met with the manager of Bohill during this period and the feedback was all positive.

Informed that induction has been revised since November 2012 with regard to anyone coming into the ward to work with patients.

Have you ever had any concerns about the level and quality of how staff engage/listen/interact with patients?

No concerns were raised. One staff member felt that post November 12 with the arrival of new staff it took time for them to get to know the patients and the ward routines. Generally it was felt that the interaction was good. While there is a key pad on the front door of the ward, relatives visit the ward regularly and would go through the ward.

Have you ever had any concerns about the quality and level of care provided for the patients?

No concerns identified. One staff member commented that with staff shortages it limited the opportunities for 1:1 time with individual patients.

A few staff mentioned the benefits to patients getting out in the car when there was one available to the ward. Many felt the patients really missed this opportunity. Staff were unsure why the car was no longer available and one staff member felt it was associated with the allegations made in November 12.

A number of staff commented that they felt the quality of life and standard of care improved for the patients since they moved from F4 to Ennis Ward.

Have you ever had any concerns about the atmosphere on the ward?

No concerns identified. Described as pleasant, warm and homely. It could be noisy and the staff member attributed this to the low ceilings and some patients being loud. However a number of factors identified which had an impact on the atmosphere in the ward:

- Post November 12, a lot of new staff coming on to the ward plus monitors. This was stressful for staff who felt demoralised and upset. They said that they did not having any idea about the nature of the allegations yet nursing care needed to continue in an atmosphere of uncertainty.
- With new staff a lot of time was spent on induction.
- Patients moving in from F4 and the core hospital
- Lay out of the ward, lack of space. Decoration needs upgrading (this has started)
- Staff feeling rushed at times to cover all the tasks.
- Differing needs and abilities of patients on the ward will determine how much interaction

Staff felt that they did the best they could and used the space available. Patients were placed in the most appropriate areas for them to minimise vulnerable adult incidents. One staff member commented that the team worked well together and the care of patients was good.

One member of staff felt that the limits placed on having Christmas decorations on ward was the result of the allegations.

The Band 8A advised that just prior to the allegations being made, the ward manager had raised a concern about difficulties with the staff group gelling. There were no

concerns raised about the care of patients and they had talked about possibly moving a staff member.

It was also raised that the backlog of delayed discharges for example the delay in the move to Bohill resulted in no reduction in patient numbers within the ward. The introduction of new patients affects the dynamics of the ward but it was felt that this was not uncommon. Difficulties with the merging of two staff groups was not felt to be uncommon. Resettlement patients have completed their treatment and compared to the acute side of the hospital do not have access to the range of professional staff e.g. social work, psychology.

Tell us about the activities available to patients?

All staff who worked shifts during the day were able to identify a range of activities including attendance at day care in the mornings. One staff member mentioned that over a period these were modified to meet the needs of patients. The loss of the ward car was raised by a number of staff as it curtailed opportunities for community based outings. The Band 8A reported that the ward would still have access to the hospital car.

Tell us about P39 . We understand that she presents with challenging behaviours. Were any restrictive interventions used by staff, if so were they risk assessed and written up as a restrictive practice? Was this information accessible/subject to review?

All staff reported on P39 frequent stripping behaviour and described their approach to managing this which they felt was recorded in the care plan and not viewed or written up as a restrictive practice. There were differing views on the frequency of care plan reviews e.g. 3 monthly, six monthly and updated as situations changed.

All staff described the belt which was used on P39 jeans but did not feel this was a restrictive practice. Doesn't wear a belt at night so night staff had no comments on this matter. P39 came to the ward with the belt and swimsuit in use written up as part of her care plan. Some of the reasons given for using the swim suit was to prevent P39 accessing her pad, protecting her dignity and delaying her stripping which allowed staff a bit more time to respond.

Not felt to be restrictive practice as she is able to remove both.

Staff reported that when P39 stripped, you just put her clothes back on.

To distract P39 from stripping, staff described how they would give her attention and take her out for walks. She doesn't present the same difficulties in day care.

P39 likes to be with staff and enjoys throwing the ball. The belt was worn to keep her trousers up. You had to be careful how tight to put the belt, the staff member described putting her two hands down the back of P39 trousers to ensure the belt was not too tight.

P39 came from F4 wearing the swim suit to protect her dignity when she stripped. P39 also wore a belt which was placed through the loops on her jeans. She is able to get out of her trousers but the belt was felt to slow up her stripping so that staff could intervene.

P39 will stand at the dining room door a lot and this can be the cause of her being hit by other patients who want her to move.

Any current issues about the management of behaviour are discussed at the handovers during the day at 7.30, 1pm and 8.30pm. Staff are encouraged to record any changes / concerns on the care plan.

Tell us about P43. We understand that she likes to be outside/sit on the grass. Does she require assistance on to /off the grass? How does she get outside/back inside?

Staff reported that P43 is autistic, she likes her own space, her own company and if she can't get out to the garden, she will tend to choose to sit in an area in the hall way or in the multi-sensory room. P43 will bang or rattle the door if she wants out to the garden. She has a particular area on the garden where she likes to sit and pick at the grass. If there is enough staff and weather permitting, she will be able to go out (protective clothing used). In the summertime this is more likely and the door would be left open. Two staff members mentioned that P43 has epilepsy and one staff stated that she needs to be supervised at all times as P43 has drop attacks.

Accounts varied in relation to the level of supervision available to P43 when she is in the garden. A staff member reported that P43 needed staff to supervise her in the garden as she would pick things up from the grass. Others stated that P43 is on general observation when she is outside. (P43 is not on 1:1 supervision)If more patients than P43 are outside then staff are able to be outside also.

There were different experiences about how P43 would get back into the building ranging from the door has to be open if patients are in the garden and the door is left open particularly in the summertime to if the door was closed, P43 would rattle the door indicating she wanted in or the door can be opened from the outside.

Staff reported that P43 is able to get off the grass independently.

Staff reported that P43 is only out for a time limited period. She is in day care in the morning, goes out around 2 pm, comes in for personal care and break at 3/3.30 and can go out again until 4 pm when it is tea time. It was said that P43 would sit outside all day if you let her. She doesn't tend to be out after 6 pm when the doors are locked. Some exceptions mentioned when there was recent good weather and patients were out in the garden in the evening.

P43 is not out if it is raining, frosty or cold.

Some staff had no experience of this as they worked mornings when P43 was at day care or covered the night shift.

What is your experience of mealtimes on the ward? Do you have any comments about how individual patient's needs are met during mealtimes?

Staff described how the system has developed in response to the needs of individual patients. In the earlier days larger groups of 5 -7 patients were tried in the dining room together but this didn't work. No more than three patients are in the dining room at any time which reduced the risks and could be supervised better by staff. A range of individual needs were described by staff. Some patients are on specialised diets, thickened drinks and require close supervision and / or assistance to eat. There is also a risk of choking for some patients. Others may grab food and cram it into their mouth so management is important for safety.

Some patients (P39 and P43 named) wait at the door wanting to get into the dining room. This was described as not difficult to manage as staff know the patients who like to eat first and will prioritise them. Patients also know the routine. Staff know which patients like to eat together and where they like to sit. There is always staff in the day room to supervise the rest of the patients. Patients can become impatient but staff try to get their meals prepared so that they can get in next. Sometimes patients don't want to leave or don't want to come in for their meals and this can lead to delays.

Patients' needs are well met and alternatives provided if the patient does not want their meal.

Staff described two staff, sometimes three being present in the dining room during meal times. One staff is doing medication.

Staff felt that mealtimes are well organised and needs are well met. Arrangements were discussed at staff meetings re: which patients eat first and reasons why.

Tell us about where you get your support regarding managing any challenging behaviours /concerns on the ward:

- Referrals to behaviour support
- In house discussions, staff described as approachable for informal discussion, opportunities to discuss concerns at the handover. Good support within the team. Informal discussion with ward sister and / or the senior on the ward that shift.
- Group supervision for trained staff
- Training-MAPA, also can consult with trainers.
- Discussion with ward doctor
- Supervision with line manager, clinical supervision annually
- Informal approach with senior management, access to staff in nursing office
- PCP-staff appraisal annually
- KSF-annual review, a chance for all levels of staff to identify their training needs.
- Alarm system –responded to by staff from the next ward Erne
- Awareness of external supports e.g. Staff Care, Occupational Health
- For newly qualified nurses, 4 weekly meetings with preceptor

Comment made by staff member that they felt unsupported in relation to the allegations. However the general feedback was that staff felt supported. This was also raised by one of the Band 8A's who felt unable to provide as much support as she wanted because of the lack of information about the allegations.

Have you any worries / concerns about other work related issues on the ward?

- Previously staff shortages but this has improved.
- New staff are gaining experience and are settling in.
- Qualified staff have an increasing amount of paperwork
- Lack of clerical support

- Lack of house keeping and laundry support services.

Have you any suggestions that might possibly improve practice and/ or improve the quality of care for patients?

- Ward sister should be supernumerary
- Environmental changes, a larger environment –more space for patients especially quiet areas and more storage space. Decorate the ward.
- Clear decision whether the ward is closing or not.
- Experienced staff who have a good working knowledge of the patients.
- More day care opportunities for patients.
- Ensure that the ward is fully staffed at all times.
- Full time day care place for P39 as she doesn't strip in this environment.
- Split attendance at day care rather than all the patients being out at the same time.
- Bring back the ward transport.
- Staff should not be using their mobile phones while on duty.
- The need to move ahead with resettlement.
- Patients still under treatment in the core hospital should not be moved to the ward due to bed shortage.
- A change to the assumption that patients in the resettlement wards are more settled and do not present the same level of complexity as the core hospital.
- Recognition that the work involved in resettlement is substantial. A proposal has been made to introduce a band 6 staff (deputy ward manager).
- Compatibility of patient's needs further consideration. The number and mix of patients
- Staffing levels and skill mix.

Tell us about what training you have had.

All staff had completed induction training, the mandatory training requirements, MAPA training, protection of vulnerable adults and child protection. Some also had life saving training.

Staff felt they had opportunities for training. Suggested training on dementia as there is a patient on the ward with a diagnosis.

There is a list of training opportunities on the wall and staff can ask to go on courses. One of the qualified nurses takes the lead for booking all training for ward staff. One staff member commented that she didn't feel there were enough training opportunities for unqualified staff.

Do you have any questions?

- Can we see the allegations at some point?
- No questions but hopeful that the investigation would soon be concluded
- Some staff requested a copy of minute of their interview
- One comment-I have found this process strange as we are not aware or have any indication about the allegations made
- Are you investigating a culture of behaviour on the ward, staff member had heard this said.
- I have concerns about patients moving out to the community. It's sad, Muckamore has been their home for years. Could you not build accommodation on site? I don't feel that patients have a say. Example given was P39 .
- Concern raised by the Band 8A s that the processes in place did not work on the day when Bohill staff first contacted the hospital to raise concerns.

Band 3 Staff Interviews

Band 3 Staff Interviewed

Profile of staff interviewed

A total of twelve Band 3 staff and a student nurse (management placement) were interviewed by Colette Ireland and Carmel Drysdale. A further two Band 3 staff were interviewed by Aine Morrison. Their experience of working in M.A.H ranged from two – thirty five years and length of time working on Ennis Ward from 2 months to six years. Two staff members worked night shifts only with the remaining nine staff working a range of shifts. Only three staff worked fulltime hours (i.e. 37.5hrs p/w).

Have you ever had any concerns about the physical treatment of patients on the ward?

No staff reported any concern about the physical treatment of patients on the ward. One staff member noted that they found staff on the ward to be very good to patients.

Have you ever had any concerns about staff attitudes towards patients?

No staff reported any concerns about staff attitudes towards patients.

Have you ever had any concerns about the level of supervision on the ward?

Eight staff reported concerns about the level of supervision of patients on the ward. All eight staff attributed this to staff shortages on the ward due to Ennis staff being taken from the ward to work elsewhere in the hospital. This was reported as a frequent occurrence with one staff member noting that it happened more frequently on Ennis ward than any other ward they had worked on. Staff said that this impacted in a number of ways including:-

- Increased stress levels for staff.
- Difficulties for staff to meet the demands of level three observation especially at night.
- Opportunities for staff to have their full break entitlement.

Some staff were aware of attempts by the nurse in charge/nurse manager's attempts to improve staffing levels on the ward but this was not always available

Have you ever had any concerns about the levels of staffing on the ward prior to 8/11/12 or since?

All staff noted an improvement in staffing levels post November 2012.

Prior to Nov 2012, staff noted that the staffing quota on the ward was not what it should have been due to staff being taken off the ward to cover elsewhere in the hospital.
(similar to question 3)

What preparation was there for Bohill staff coming to work on the ward?

All staff interviewed said that they were aware that Bohill staff were coming to work on the ward and knew which Ennis patients were moving to live in Bohill but due to shift patterns for some M.A.H staff, they had no contact with Bohill staff and were not aware of what preparation there was for Bohill staff coming to work on Ennis ward. One M.A.H staff said they had some informal contact with Bohill staff asking if they wanted to accompany/shadow her on her shift.

Have you ever had any concerns about the level and quality of how staff engage/listen/interact with patients?

No staff noted concerns about the level and quality of how staff engage/listen/interact with patients on the ward.
One staff highlighted that she found staff to be very good at listening to patients but some staff felt vulnerable if they were working on their own with a patient who could make an allegation against them. On staff member highlights that not all patients want interaction although staff still try to do this.

Have you ever had any concerns about the quality and level of care provided for the patients?

There was a general agreement that the level or quality of care provided to patients on the ward was good with two staff describing it as

- "first class"
- "A1"

even during periods when the ward was short staffed. One staff member noted that patients' care needs always came first which could impact on the ability of staff to offer other activities to patients.

One staff member felt that F4 was a better environment for the patients because it had more space and disagreed with patients moving from F4 to the back ward in Ennis.

Have you ever had any concerns about the atmosphere on the ward?

In general, staff considered the atmosphere on the ward to be good. One staff member felt that the day-room was too small for the number of patients on the ward and on occasions day-time staff appeared stressed due to staff shortages.

One staff member commented that the presence of close relatives working together on the ward with one being in a supervisory role led to perceived favouritism.

Tell us about the activities available to patients?

All staff were able to identify a wide range of activities available to patients on the ward including attendance at day-care. There was disappointment noted by staff in the ward no longer having access to their own transport (car) with staff not knowing why this resource was no longer available to them. Losing the car limited options offered to patients who would have previously availed of drives/weekends away/outings for meals off site. Some staff also mentioned having an activities room on the ward but this space was later used for office space. It was also noted that staff shortages impacted on activities offered to patients.

Tell us about P39 [redacted]. We understand that she presents with challenging behaviours. Were any restrictive interventions used by staff, if so were they risk assessed and written up as a restrictive practice? Was this information accessible/subject to review?

All staff were aware that patient P39 wore a swim suit under her clothing and a belt on her trousers due to her regularly stripping off all her clothing. None of the staff interviewed considered these as a 'restrictive practice' but could identify them being used to preserve P39 dignity due to her stripping behaviours. Some staff were unaware of the term 'restrictive practice' but were aware that any necessary information pertaining to patients would be written up in care plans and/or shared verbally at staff handovers.

Tell us about P43. We understand that she likes to be outside/sit on the grass. Does she require assistance on to /off the grass? How does she get outside/back inside?

Ten staff were able to respond to this question however two staff who only worked night shifts were unable to comment on P43 going outside to sit on the grass.
There was a general consensus that P43 liked to be outside and would indicate that she wanted to go outside by standing at the door. Three staff noted that P43 wore waterproofs to go outside and two staff said that she only went outside if the weather was good. There was a difference of opinion regarding the level of supervision P43 received when she was outside. Four staff said that staff observe P43 when she is outside and go in/out to check on her, three staff said that P43 required supervision when she was outside with one adding that this was difficult to provide if the ward was short staffed and two staff said if P43 goes outside with other patients, staff go outside too. Most staff said that P43 could get up off the grass independently, two staff were clear that P43 needed assistance. One staff thought P43 may have epilepsy with another noting that P43 took drop attacks. All staff said that P43 could get back in independently as the door was left open.

What is your experience of mealtimes on the ward? Do you have any comments about how individual patient's needs are met during mealtimes?

All staff noted a maximum of three patients ate in the dining room at any one time supervised by two staff with one staff member supervising the remaining patients in the day room. Staff were aware of which patients required assistance with their meals with two patients requiring a minced diet. It was clear that choices were offered to patients however the food menu was planned one week in advance and on most occasions when a patient changed their mind it would only be possible to provide a sandwich or cold alternative at short notice. Mealtimes were described as busy and could take up to 50 mins. The dining room can accommodate a maximum of nine patients however the staff were clear why a maximum of three patients are in at one time – to reduce patients taking food from each other. Some staff noted that other patients may try and get into the dining room if they knew people were in there eating.

Tell us about where you get your support regarding managing any challenging behaviours /concerns on the ward:

The majority of staff identified the nurse in charge as providing support regarding the management of any challenging behaviours or concerns on the ward. Eight staff members noted that they also had an annual PCP review. Some staff said that they got information on patients' care plans and from colleagues. One staff member said that she felt very unsupported and that the band 3s were left to manage challenging behaviour by themselves without any support. She said that she would often do long periods of time up to five hours without a break in the lower day room and find herself exhausted due to the intensity of the challenging behaviour she was managing. She acknowledged that a break should have been given but staffing levels at the time didn't always allow for this.

Have you any worries / concerns about other work related issues on the ward?

There were no worries or concerns noted by staff in relation to other work related issues.
Seven staff were able to identify a range of suggestions that might possibly improve practice/quality of care on the ward. These include:-

- Maintaining current staffing levels
- Better rotation of staff around all wards
- Use of the car
- More space for patients
- 1:1 support for all patients on the ward
- Activity room
- Better planning before wards are amalgamated
-

Tell us about what training you have had.

Staff were able to identify their mandatory training requirements but some were unsure if they had ever completed any Adult Safeguarding training. Staff did advise that there were opportunities to complete training and that there was an identified staff member on the ward with responsibility for arranging training.

Do you have any questions?

- One staff member asked why the decision was taken to move so many patients into such a small space with nothing in it given their needs.
- Staff should be getting a 30min break during their shift but staff shortages do not allow this to happen.
- Can I hear the outcome of the investigation?
- One staff member asked if a previous interview she gave in relation to Ennis would be recorded and shared with her?
- What happens next? The student nurse expressed how she felt stressed having been interviewed by the police, university and Trust staff without any feedback

Band 2 staff interviews

Band 2 staff interviews
Profile of staff interviewed:

A total of five Band 2 staff (Domiciliary Support) were interviewed.

Their experience of working on Ennis Ward ranged from 1 -8 years.

All staff worked part-time hours ranging from 12hrs per week – 32.5hrs per week.

Two staff worked in the kitchen area of the ward only.

Have you ever had any concerns about the physical treatment of patients on the ward?

None of the staff interviewed had any concerns about the physical treatment of patients on the ward.

Have you ever had any concerns about staff attitudes towards patients?

None of the staff interviewed had any concerns about staff attitudes towards patients on the ward. One staff member described the staff on the ward as very good, friendly, helpful, quick to help patients and very hard working.

Have you ever had any concerns about the level of supervision on the ward?

None of the staff interviewed had any concerns about the levels of supervision on the ward. One staff member noted that staff were good, very helpful, another said that there were usually a lot of nurses around.

Have you ever had any concerns about the levels of staffing on the ward prior to 8/11/12 or since?

None of the staff interviewed noted any concerns about staffing levels on the ward. Two staff interviewed said that they would not be aware of what the staffing levels on the ward should be because they either worked in the kitchen or at the front of the ward.

One staff member said that she was on holiday from 27/10/12 and returned to the ward after events in November and has not noted any concern since her return.

Two staff said that whilst they had no concerns they would have over heard staff say :

"We could do with more staff" or "the ward is short staffed"

Have you ever had any concerns about the level and quality of how staff engage/listen/interact with patients?

None of the staff interviewed noted any concern regarding the level and quality of how staff engage/listen/interact with patients on the ward.

Two staff commented that they thought this was good/very good.

Have you ever had any concerns about the quality and level of care provided for the patients?

None of the staff interviewed had concerns about the quality or level of care provided to the patients on the ward. One staff member described the patients as "well looked after"

Have you ever had any concerns about the atmosphere on the ward?

None of the staff interviewed had any concerns about the atmosphere on the ward. One staff member described the ward as very homely, a pleasure to work on. Another staff member said " the atmosphere was good, everyone is friendly on the ward"

Have you any worries / concerns about other work related issues on the ward?

None of the staff interviewed had any concerns about other work related issues.

Do you have any suggestions that might possibly improve practice and/or the quality of care for patients?

Only one staff member suggested better staffing levels. No other suggestions were noted.

Do you have any questions?

There were no specific questions however two staff made the following comments:

"I have no idea what happened on the ward, only know there is an ongoing investigation"

H200 was a very good nurse. I was shocked when I came back from holiday and H200 was gone"

Interview with Speciality Doctor for Ennis Ward

4) Interview with Speciality Doctor for Ennis Ward

The speciality doctor for Ennis ward was interviewed. The doctor has been working in Muckamore Abbey Hospital for a total of 2.5 years with 1.5 years experience on Ennis Ward.

The doctor works full-time hours (Monday – Friday 9am-5pm) and spends one hour in Ennis every day as well as responding to emergencies, attending meetings or ward rounds.

Have you ever had any concerns about the physical treatment of patients on the ward?

No concerns regarding the physical treatment of patients on the ward were reported.

Have you ever had any concerns about staff attitudes towards patients?

No concerns regarding staff attitudes toward patients were reported.

Have you ever had any concerns about the level of supervision on the ward?

No concerns regarding the levels of supervision on the ward were reported.

Have you ever had any concerns about the levels of staffing on the ward prior to 8/11/12 or since?

Since November 2012 there have been occasions where staffing levels were low due to staff suspensions or sick leave.

New staff were assigned to the ward who didn't know the patients.

Patients became more challenging as a result (Nov/Dec – Jan'13)

Prior to November 2012 there wasn't a concern for safety; it would have been nice to have additional staff.

What preparation was there for Bohill staff coming to work on the ward?

I knew they were coming to meet the patients regarding learning their routines as the patients were unable to have a phased discharge to Bohill.

Care-plans were shared with Bohill staff – Bohill manager- who agreed to develop their own.

Manager from Bohill regularly attended the resettlement meetings.

Have you ever had any concerns about the level and quality of how staff engage/listen/interact with patients?

No concerns were noted regarding how staff engage/listen/interact with patients.

Have you ever had any concerns about the quality and level of care provided for the patients?

No concerns were noted about the level or quality of care provided.

Have you ever had any concerns about the atmosphere on the ward?

The atmosphere was tense after the investigation commenced.

Staff were tense and afraid to say something that may be mis-interpreted

The ward became less relaxed/homely.

Tell us about the activities available to patients?

A range of activities were identified including: - day-care, puzzles, T/V, art/craft, relaxation room, and lying about – patients do what they like and staff help facilitate this.

Tell us about P39. We understand that she presents with challenging behaviours. Were any restrictive interventions used by staff, if so were they risk assessed and written up as a restrictive practice? Was this information accessible/subject to review?

Staff would redress her – is this restrictive? – she doesn't want to wear clothes.

She wears a bodysuit – used to preserve her dignity

She is not physically restricted from removing her clothes; she is dressed in clothing that would slow-down her stripping that allows staff to intervene.

Information is recorded in the doctor's diary. Behaviour Support Service has been involved – not new behaviours, behaviour is unlikely to improve.

Information is discussed with medical staff. If it is agreed that an intervention is required it would be written up in the medical file. Nursing staff record/keep their own records.

Ward rounds are only attended by the doctor and ward staff. Other professionals attend as/when required.

P39 did have an annual review that included family but this has been replaced by the resettlement meetings that are held on the ward.

Tell us about P43. We understand that she likes to be outside/sit on the grass. Does she require assistance on to /off the grass? How does she get outside/back inside?

The doctor was not aware that this patient liked to be outside/sit on the grass and was therefore unable to comment.

What is your experience of mealtimes on the ward? Do you have any comments about how individual patient's needs are met during mealtimes?

I know it is phased x 3 at a time.

The dining room is quite small.

Patients want to be in the dining room when they know it is mealtime or want to eat – patients are not distressed by waiting outside, but may be upset that they are not first.

Some patients need fed/closely supervised as they retch, drink too much and have swallowing difficulties.

Some patients hit out and require space.

Some patients steal each other's food.

It is not possible to have everyone in together – safety concerns e.g. patient P22 [redacted] who has PICA.

Tell us about where you get your support regarding managing any challenging behaviours /concerns on the ward:

The speciality doctor identified that they received support via their line manager ([redacted] H50 who was easily available

Formal supervision is received on a weekly basis.

Have you any worries / concerns about other work related issues on the ward?

There were no other work related issues identified.

It was noted that the ward is small and noisy.

Tell us about what training you have had.

Apart from medical training, Child Protection Level 2 has also been completed.

No Adult Safeguarding training has been done.

Do you have any questions?

No questions were asked.

Interview with Consultant Psychiatrist for Ennis Ward

5) Interview with the Consultant Psychiatrist for Ennis Ward

The Consultant Psychiatrist has been the responsible medical consultant for Ennis Ward for five years and works full-time hours (Mon-Fri 9am-5pm) and the "on-call" system.

The consultant has weekly ward rounds (Thursdays) and the focus of this has been on resettlement work.

The assigned doctor for the ward (Speciality Doctor) has daily contact with the ward and with the consultant psychiatrist.

Issues/concerns are discussed on a daily basis.

Have you ever had any concerns about the physical treatment of patients on the ward?

Patients' physical health care is good – There is room for improvement and we continue to make the case for enhanced input from G.P's.

I would not tolerate any physical mistreatment of patients, would report immediately.

Have you ever had any concerns about staff attitudes towards patients?

No concerns were noted.

The needs of patients on the ward and the range of disabilities on the ward, may be difficult for outside (new staff) to understand.

It was a ward that I considered to be homely/warm and would not have thought there would be any abuse on the ward.

Have you ever had any concerns about the level of supervision on the ward?

No concerns were noted but it was added that the ladies on Ennis Ward were sensitive to change.

Have you ever had any concerns about the levels of staffing on the ward prior to 8/11/12 or since?

Post November 2012, there was deterioration for 2-3 months in patients' behaviour after the allegations.

There were lots of unfamiliar people on the ward – RQIA, monitors, and new staff.

Pre November 2012, across the site, there were a number of patients with specific supervision requirements that were a drain on resources throughout the hospital which impacted on staffing levels.

There are not too many patients with high supervision levels – one patient on Ennis ward on Level 1 supervision due to her PICA.

I would be surprised if there wasn't an impact on staffing levels because it was well known that there were staff shortages across the hospital.

Ennis ward is currently settled. Families are concerned regarding the impact of resettlement.

What preparation was there for Bohill staff coming to work on the ward?

The Bohill managers attended resettlement meetings at Muckamore.

Patient information was shared (assessments etc.) to allow Bohill staff to draw-up their care plans.

I didn't meet the staff from Bohill who worked on the ward.

Perhaps there was a need for better planning for less experienced staff coming on to the ward to work with patients with challenging behaviours and provide explanation for why things are done in a certain way – rationale

Have you ever had any concerns about the level and quality of how staff engage/listen/interact with patients?

No concerns were noted. The consultant added that a fair proportion of patients cannot engage at a particular level however they do have relationships with staff.

The ward sister worked hard to develop the quality of life experiences for patients.

Some patients are very intense, constantly looking for staff attention – trying.

I have never seen anything of concern.

Staff work hard with a range of ability levels e.g. autism, P22 screams and doesn't like to be outside.

Have you ever had any concerns about the quality and level of care provided for the patients?

No concerns were noted however any concerns would have been around staffing levels, resource levels, quality of life opportunities and environmental restrictions.

Have you ever had any concerns about the atmosphere on the ward?

I thought Ennis a pleasant ward to work on with a caring group of staff.

Atmosphere was more notable after the allegations were made. Staff were afraid of suspension and fear of allegations being made against them by patients.

The length of time the investigation has taken has impacted.

Monitoring also impacted on staff.

Tell us about the activities available to patients?

The following activities were identified as available to patients:

A lot of outings, community based.

Car use.

Over nights away.

A lot of effort by staff to create a homely environment.

Limited amount of real integration can be achieved due to the ability levels of patients/limitations.

Staff did the best with what they had.

RQIA regulations regarding infection control impacted on art work or decorations being put up.

Tell us about P39. We understand that she presents with challenging behaviours. Were any restrictive interventions used by staff, if so were they risk assessed and written up as a restrictive practice? Was this information accessible/subject to review?

Recording of restrictive practice has improved. P39 needs restrictive practice to manage her behaviour – she strips, all sorts of efforts were made to preserve her dignity. Advice from Behaviour Support Service has been sought.

I am not aware of any treatment that will stop her stripping.

Information recorded in her care plan – behaviours are not new.

The use of the belt and bodysuit were necessary rather than restrictive.

The ward manager would report concern in patient behaviour quickly to the Speciality Doctor/Consultant Psychiatrist.

Would try medication changes and referrals to Adult Behaviour Support may also have been required.

Restrictive practices maybe not written up as well as it should be as per Philip Moore's audit.

Tell us about P43. We understand that she likes to be outside/sit on the grass. Does she require assistance on to /off the grass? How does she get outside/back inside?

I know a fair bit about P43 epilepsy – drop epilepsy- and her physical health which is the main focus of my work.

She is autistic and likes to be on her own.

There was no knowledge of how P43 got on/off the grass or back inside the ward if she was outside.

What is your experience of mealtimes on the ward? Do you have any comments about how individual patient's needs are met during mealtimes?

I have been on the ward at mealtimes.

The physical environment isn't good.

Meals are staggered – a lot of effort has been put into compatibility of who eats together - patient groups are carefully thought out.

Early morning is a pressure time – tablets to give out, preparing patients for day-care

Some patients need more time/help than others at mealtimes.

Some patients are hungry and eat first.

Some patients require specific crockery.

Tell us about where you get your support regarding managing any challenging behaviours /concerns on the ward:

I have spoken to H209, Grainne Healey, and Colette Caldwell.

Second opinions from colleagues regarding medication/treatments.

All staff are MAPA trained – medical staff are "Breakaway" trained in managing challenging behaviours.

Have you any worries / concerns about other work related issues on the ward?

No additional concerns to those previously noted were identified.

The Consultant added that the bulk of work falls to nursing staff and that the job is hard – he also noted the lack of community placements for patients as a concern

Suggestions to improve practice were noted and included:

- Documentation of restrictive practices
- Improve resources of Behaviour Support Teams
- Stable/settled staff team
- Staff not being pulled out to other wards
- Induction of community staff on to the ward
- Reduction of social work input into the ward has impacted
- Staff morale has been affected by the investigation

Any external scrutiny is welcomed but needs to be realistic to the needs of patients.

Tell us about what training you have had.

I have responsibility for medical staff/staff appraisals – training needs are specific.

I have completed Adult Safeguarding, Child Protection, Autism, Epilepsy, CR144 (Challenging behaviour a Unified Approach) and Mental Illness.

We have had staff team training/discussion on patient management (akin to Social

Do you have any questions?

No questions were asked.

2f) Review of Previous Adult Safeguarding Referrals from Ennis Ward

Aine Morrison reviewed a sample of the adult safeguarding referrals received between 01/06/12 and 07/11/12 and found these referrals were appropriately made as were responses.

2g) Review of Incidents/Accidents over the previous six months

Aine Morrison reviewed the incidents and accidents reported from Ennis from 01/06/12 to 07/11/12. The only incidents of potential relevance to this investigation were:
18/09/12 – low staffing levels reported.
23/10/12 – low staffing levels reported.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports bear this out.

2h) Review of previous disciplinary records for ward staff.

Sen. Management provided records for the period Nov.'11 – '12. This was to see if there was any evidence of trends or patterns of concern about staff behaviour.

There was just one incident reported in May 2012 when a MAH day-care staff member reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. The incident was investigated by the police who did not take any further action. MAH undertook a full investigation. This concluded that there was a case to answer and some recommendations were sent to H.R. – the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA.

It is potentially significant that this was another occasion when poor care practice by Ennis staff was reported by non-Ennis staff. However the investigating team do not feel they can draw any further conclusions about this.

2i) Review of care plans

Aine Morrison reviewed the nursing care-plans for P39 , P41 , P43 and P22 . She found that while there were descriptions of the types of behaviour displayed by patients, details in relation to the management of these behaviours was sparse. Moira Mannion (Co-Director of Nursing, Education and Learning) also reviewed care plans and found these to be satisfactory. (see report of 8/3/13) RQIA found the guidance in P39 care plan was not specific enough and that the support plan was not detailed to her specific requirements.

2j) Information from monitoring

Twenty-four hour monitoring was put in place following the allegations and regular reports from these monitors have been received. No concerns about care practice were raised in these reports. Some staffing issues were raised when the monitoring was first introduced but these were resolved reasonably quickly. Environmental issues have also been raised (see point 4 in conclusions section). Recent monitoring reports continue to report concerns about overcrowding and lack of space. They also continue to report the difficulties caused by the level of challenging behaviour on the ward.

Other Issues Raised:- Staff Interviews

There were a number of issues raised in staff interviews that were not thought to be relevant to the adult safeguarding investigation but were passed on to hospital senior management or RQIA for comment/clarification or action as required;

1. The use of the car – It was confirmed by hospital management that changes to the arrangements for the car were not linked to the adult safeguarding investigation.

2. Staff not knowing about the allegations/investigation. The hospital management team have met staff on a number of occasions to share as much information as possible.

3. Relatives in a supervisory role – the hospital senior management team have changed the arrangements in Ennis Ward to ensure this is not happening and have reviewed the policy in relation to this.

4. Changes in arrangements about artwork and ward decorations followed a directive from the Director of Nursing regarding management of infection control and cleaning standards/hygiene.

5. A Band 8 A member of staff said at interview that Ennis had been noted by RQIA as an example of good practice. RQIA have commented that while previous inspection of Ennis highlighted no concerns there was no evidence to suggest that it was cited as an example of good practice.

6. The comments made by Sister of P44 have been passed to the hospital senior management team for internal investigation.

7. Staffing issues – MAH did experience a significant staffing crisis in the months before the allegations were raised. Hospital senior management report escalating this crisis to the appropriate authorities and agreeing an action plan.

3) Conclusions and Recommendations:

3) Conclusions and Recommendations:

1) Disciplinary Investigation:
The Trust awaits the outcome of the P.P.S considerations and recommendations. When these are concluded, the investigating team believes that there is enough evidence of concern about the behaviour of H159 and H197 to warrant a disciplinary investigation.

Recommendation: ***MAH should pursue a disciplinary investigation in relation to the conduct of*** H197 ***and*** H159 ***.***

2) Analysis of staff reports:
The investigating team had the difficult task of weighing up the very different evidence provided by two staff teams, the team from Bohill and the team from MAH. The Bohill team had significant concerns about care practice while the MAH team had none. The concerns of the MAH team focused on environmental and staffing issues.

The investigating team gave weight to the amount of concerns raised by twelve members of Bohill staff, the consistency between accounts and the level of detail contained in the Bohill staff interviews. The team noted as potentially particularly concerning the reports that the alleged behaviours happened openly in front of visiting staff.

The investigating team thought it unlikely that Bohill staff would have any motivation to falsely report.

However the team would acknowledge that the Bohill staff were working in a new environment where the context of some actions may not have been clear to them. It is also acknowledged that staff from Bohill were coming from a newly built, bright, spacious, physical environment in contrast to an older style hospital ward.

The investigating team recognises that it can be difficult for a staff team such as the Ennis team to come forward with concerns about their own practice. However the investigating team's experience is that this has happened in

other investigations and therefore gives some weight to the fact that no MAH staff reported any care concerns. The investigating team also noted the apparent genuineness and caring attitude shown by MAH staff in their interviews.

3) Identification of Muckamore Staff

A further difficulty in the investigation lay in the identification of MAH staff by Bohill staff. Many of the Bohill staff had only spent short periods on the ward and did not know staff names. Descriptions were used to try and identify staff where possible and Bohill staff were re-interviewed to try and establish further identification details but this had no success. Staff rotas were also used to try and help with identifications.

The majority of the incidents relating to identified staff involved H159 and H197. However there are a number of Bohill reports from staff who were able to identify H159 and H197 but also alleged that other members of staff had been involved in poor practice.

Some allegations refer to a bigger group of staff being involved; in particular it is alleged that many members of staff behaved in an inappropriate fashion towards P39.

The investigating team believe that of the named staff apart from H197 and H159, there is not enough evidence to warrant disciplinary action against any of them. there in some? / Evid evidence to establish of allegat. + not substantiate the 'most'

The team also believe that there is no way of knowing who, if any, of the other staff were involved.

4) Environmental Concerns:

There is general agreement between all groups of staff including monitoring staff that the Ennis Ward environment was unsatisfactory. Concerns ranged from

i) Maintenance issues such as minor repairs, decorating

ii). Lack of privacy for patients as there were no curtains

iii). Lack of space and overcrowding

Hospital management staff have subsequently ensured significant environmental improvement by making minor adjustments. More major structural works are also planned in order to improve the layout of the ward and maximise the use of the available space.

The investigating team recognises the physical limitations of some of the wards on the hospital site. However, it is clear that some positive changes were relatively easily achievable. The team feels that it is possible for people who are accustomed to a particular environment not to notice flaws.

Recommendation: ***The team would recommend that all wards in the hospital are reviewed by staff external to the ward to see if any environmental changes are needed.***

5) Staffing Concerns

It is clear that there were significant staffing problems on the ward in the months prior to the allegations being made. Apart from the general problems this created in terms of time and attention for patients, there were times when it was not possible to maintain agreed observation levels. The ward manager appropriately reported her concerns about staffing to senior management. This is most obvious in the incident reports completed on 18/9/12 and 23/10/12. When Band 8A were asked about their general responses to reports of inadequate staffing, they said that this was always reported to more senior management and advice given to the ward manager about how best to manage the situation. This was typically not recorded.

Recommendation: ***the investigating team recognise that there was an action plan in relation to the overall staffing crisis in MAH at the time which would have included Ennis but recommend that hospital senior management review their response to these two specific incident reports to see if this was appropriate***.

The Telford Formula was used on the ward prior to the allegations to determine staffing levels however further review of appropriate staffing levels following the allegation confirmed that additional staffing was necessary. The team would therefore question the appropriateness of the Telford Model. The team recognises that MAH now have adapted their use of this model.

The investigating team did have concerns about the appropriateness of a daughter being in a position of having to supervise her mother. When this came to light, the investigating team recommended that the management team review this practice. This has now been done and the practice discontinued.

6) Bohill Staff Induction

There is a discrepancy between Bohill staff and MAH staff accounts about the level of induction that was provided to Bohill staff. Band 8A staff report that they were in contact with Bohill management over this period and the feedback was very positive.

Recommendation: ***The investigation team would recommend that in any future instances where staff from other facilities are spending time in MAH as part of an introductory process, the following should happen.***

- ***i) An induction checklist of necessary information should be agreed between both facilities before visiting staff start in the ward.***
- ***ii) A formal induction going through the agreed necessary information should be completed before visiting staff start to work with patient.***
- ***iii) A clear agreement should be made before each shift about the duties and responsibilities of visiting staff and MAH staff respectively and this must be shared with all staff concerned including health care and nursing assistant staff. The agreement must stipulate what supervision the visiting staff should receive.***
- ***iv) Visiting staff must be informed of who they should report any issues experienced on shift to.***
- ***v) Visiting staff should have the opportunity to discuss their experience with a nominated member of MAH staff at the end of each shift.***

The team is aware that practices for inducting visiting staff have been revised but would wish to ensure that the revised practice covers all the above areas.

7) P43

The MAH staff interviews reveal a lack of clarity and differing views about P43 support needs when sitting outside on the grass. This related to the levels of supervision required, the level of physical assistance needed, the clothing required and the means of access in and out of the garden.

Recommendations: ***The investigating team recommends that P43 support needs in relation to going out and sitting outside on the grass are reviewed. Clear guidance should be established and implemented by all staff.***

8) P39

The investigating team had very substantial concerns about the frequency with which P39 featured in the allegations. The consistency in Bohill staff reports in relation to belt tightening and a practice of throwing away her shoes caries considerable weight. The team believes that it is significant that P39 clearly presented and continues to present major behavioural challenges particularly in relation to her stripping behaviours. The team believes that it is likely that staff were at times stressed by P39 behaviour. The monitoring reports indicate that staff continue to experience considerable challenge in managing patients' stripping behaviours. The team believes that the guidance contained in P39 care plan was not sufficient and not specific enough. RQIA also found in an inspection following

the allegations that the guidance.....? The team believes that given the level of challenge P39 presents with, it would have been advisable to involve specialist behaviour support services for detailed assessment, care planning and review.

The investigating team understand that specialist behaviour support services are now involved with P39

Recommendation: ***The team would recommend that band 3 staff are fully involved in discussions with the behaviour support services about P39 The team would also recommend that specialist behaviour support services review the support needs of staff working with P39 and make any necessary recommendations to hospital management about how such support could be provided.***

The investigating team would recommend that the hospital review for appropriateness what criteria ward staff use for considering referral to specialist behaviour support services.

There was some debate about whether or not the use of a swimsuit and a belt with P39 should be considered a restrictive practice. The investigating team feels that as some MAH staff described the use of the swimsuit as a delaying tactic to allow staff time to intervene, this should be considered as a restrictive practice. The belt is largely described by MAH staff as a means of keeping her trousers up which should not be considered restrictive. The team recommends therefore that hospital policy in relation to the approval and recording of restrictive practices should be followed in relation to this issue.

The team further recommends that the hospital review for any other practices on the ward that could be deemed restrictive and that hospital policy should be applied to them also.

The investigating team notes the suggestion made by staff that P39 should be considered for a full time day care placement as she does not strip in this environment. The team would recommend that the hospital considered if this would indeed be helpful and if so, consider if it can be provided.

9) Ennis Staff Team Composition

The investigating team is aware that the staff team working in Ennis has changed substantially since the investigation began with approximately half of the staff being new to the ward. While the investigating team is unable to draw definitive conclusions on many of the allegations, if there had been wider issues about practice on the ward, the team believe that this would now be an important protective factor.

10)Impact of the Investigation

The investigating team recognise the stress to staff caused by the investigation. The inability to share significant details of the allegations and the length of time the investigation has taken have been particular factors.

Recommendation :***The team feels that further information could be shared at this point and that this would help staff morale. The team would recommend that advice is taken from both the P.S.N.I. and H.R. about what information could be shared and that based on that advice, as much information as possible is shared about the allegations, the investigation process, the outcomes and the conclusions and recommendations. Again, if there had been wider issues about practice on the ward, the team believes that sharing the concerns would now serve as an important protective factor.***

The investigating team would recommend that they be involved in facilitating such discussion with staff.

11) Staff Skill and Experience

The investigating team have noted the universally positive comments made by monitoring staff about the care provided by ward staff since the allegations were made. The team have concluded from this that current ward staff have the skills and abilities necessary to provide good quality care.

12) Adult Safeguarding Training

The investigating team noted that not all staff were sure if they had had safeguarding training.

Recommendation: ***The team recommends that hospital management ensure that all bands of staff working on the ward have received the appropriate level of safeguarding training. This includes medical staff.***

13) Management of mealtimes:

There are varying accounts about the management of mealtimes. It was clear from Muckamore Abbey staff accounts that considerable thought had been given to mealtime routines. However the reports of staffing difficulties may have meant that it was difficult to manage the patients waiting outside the dining room for their meal. One Muckamore Abbey member of staff did report a patient running up and down outside the room and there was an acknowledgement that patients found it hard to wait on meals. The investigating team felt it was possible that visiting staff may not have known the rationale behind this routine.

20.1.14

14) Access to a full range of services by re-settlement patients.

The investigating team notes that re-settlement patients do not always have access to a full range of professionals.

Recommendation: *The investigating team* ***recommend that this position is reviewed.***

Signed:

Aine Morrison

Carmel Drysdale

Colette Ireland

Date:

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012 In Relation to H159

CONTENTS

List of Appendices

1. INTRODUCTION

In July 2013 Esther Rafferty, Service Manager, Learning Disability commissioned Rhonda Scott, Senior Nurse Manager, Learning Disability Manager and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability to undertake an investigation into incidents alleged to have taken place within Ennis Ward involving Belfast Trust employee H159. These allegations were reported to RQIA on 8th November 2012 by the manager of the Priory Group, Bohill Care Home who had staff working on the ward as part of the resettlement programme for patients who were moving to the Bohill.

A joint Adult Safeguarding Investigation started immediately between the PSNI and the Belfast Health and Social Care Trust. This report details an internal investigation which followed the Adult Safeguarding Investigation and draws on information from the subsequent report which was completed in October 2013.

2. TERMS OF REFERENCE

1. To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H159 Band 3 Health Care Worker whilst working in Ennis ward in October and November 2012.

In addition the investigation team must:

2. Consider any other issues of concern relevant to the investigation.
3. Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.
4. To make recommendations including referral for disciplinary action.

To support the investigation process the investigators were provided with:

- Witness statements
- Adverse Incident/ Accident Reports
- Minutes of Ward Meetings and Resettlement Meetings
- Adult Safeguarding Report with related interviews and minutes of meetings
- Briefing Reports post allegations by Moira Mannion, Co-Director, Education & Learning
- Duty Rotas (including rosters for Bohill Staff (Appendix 21) who worked on Ennis Ward)
- Shift Planner
- Daily Ward Reports
- Vulnerable Adult Referrals

- Patients notes/Care Plans
- Medical Files
- Day Care Attendances
- Access to interview Ennis staff and Bohill staff who were still available

NB: B2 (Bohill) not available during entirety of investigation and declined to be interviewed when contacted via PSNI on 1st August 2014
B3 (Bohill) not available during entirety of investigation
B8 (Bohill) unable to contact
B9 e (Bohill) unable to contact
B10 (Bohill) unable to contact
B1 (Bohill) did not attend for interview in spite of pro-active attempts to accommodate
H198 (Ennis) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 2)
H870 (staff on relief to Ennis on the 7th November 2012) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 3)

The following Bohill staff also worked on Ennis during this period. These staff made no allegations or raised any concerns during their time on Ennis but have since left the service and no contact details were available:

B11
B12
B13
B14

- Access to interview Ward Manager (Appendix 4) on Ennis during this period and Senior Nurse Manager responsible for Ennis Ward, Muckamore Abbey Hospital (Appendix 5)
- Access to interview Bohill staff, B4 (Appendix 6), B7 (Appendix 7), B5 B5 (Appendix 8) and B6 (Appendix 9) who worked in Ennis at the time of the allegations.
- Access to interview H197 (Appendix 10), Bank Nurse and H159 (Appendix 11) Health Care Support Worker who were named in the allegations.
- Access to interview H205 (Appendix 12), H869 (Appendix 13), H203 (Appendix 14) and H206 (Appendix 15) Health Care Support Workers who worked in Ennis at the time of the allegations
- Access to interview H196 (Appendix 16) Student Nurse on placement in Ennis at the time of the allegations.
- Access to interview Moira Mannion, Co-Director, Education & Learning

- Access to interview Aine Morrison, Senior Officer, Adult Safeguarding Investigation Team and lead author of Adult Safeguarding Report

SCOPE OF INTERVIEWS

The interviews covered the themes below – with specific adaptation for those involved in the allegations:

- Induction processes
- Training
- Staffing (numbers, attitudes, team working, morale)
- Supervision
- The Environment (Physical and General Atmosphere)
- Resources
- Summary of allegations from Adult Safeguarding Investigation (Appendix 1)
- Reporting processes

1. ADDITIONAL EVIDENCES

- Duty Rota – confirmed all involved in investigation worked in Ennis (allegations as per Adult Safeguarding Report state the alleged incidences occurred between **9th October and 7th November 2012** – same information elicited and confirmed from interview with [redacted] (Bohill) 19th May 2014.

- Allocation Book – Inadequate skill mix on ward at time of allegations. Skill mix 60% unregistered: 40% registered staff; this was further reduced by registered nurse sick leave. No clear allocation of duties – this was corroborated in subsequent staff interviews. Clear evidence in Duty Allocation Book that the responsibility for the patients at the lower end of Ennis (where incidents were alleged to have taken place) was mostly with unregistered staff.

- Adverse Incidents/ Accident Reports – no evidence of under reporting; all correlated with entries documented in patient notes, daily ward reports and care plans. An increase in incidents was also noted from November 2012 until February 2013 – this correlates with a monitoring rota which was implemented post allegations (Appendix 17). Staff noted in interviews that the monitoring in itself was disruptive to the patients and this may have had a bearing on these statistics.

- Day Care Attendances from Ennis (Appendix 18). This information highlighted a significant number of cancelled Day Care places during the period the alleged incidents took place. These cancellations added additional pressure to a ward that was already short staffed. The attached attendance report also highlights staff shortages in Day Care Services around this time

- Minutes of Resettlement Meetings (Appendix 19)

FINDINGS

This was a complex and lengthy investigation. The Terms of Reference as noted above required the investigating team to look at the whole system i.e. the context of Ennis Ward within the wider Muckamore Abbey Hospital site, the managerial processes on the ward, staffing, practices and individual patient needs. All interviews are attached and conclusions/ findings are summarised under each term of reference as follows:

2. **To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H159 Band 3 Health Care Worker whilst working in Ennis ward in October and November 2012.**

The allegations listed below are from the Adult Safeguarding Report. For ease and consistency of reference the allegation numbers correspond to their chronological order in the Adult Safeguarding Report.

1. **H159 – MAH Staff – pulled P39 (patient) from the sofa P39 was sitting on, by the hem of her trousers, onto the floor and was verbally condescending (Source: B2, Bohill Staff)**

H159 interviewed re allegation. H159 stated that at no time did she or did she ever witness staff push or pull P39 by any item of clothing, she has denied this allegation. She confirmed that staff needed to be assertive and due to the noise levels in the environment you had to raise your voice to be heard, she said that at no time did she ever shout at patients.

H197 interviewed re the allegation. She confirmed that staff did not shout but would have used a firm tone with her (P39) when she was about to hit another patient to prevent her continuing with this behaviour, P39 responded to this firmer tone and it would have prevented her from hitting another patient. H197 stated that she had not witnessed staff push or pull P39 by any item of clothing. Staff would have turned P39 away from an area by putting their hands on her shoulders and turning her away.

B7 , B5 and B6 (Bohill) all interviewed and stated that they had not witnessed staff pull P39 by items of clothing or use abusive language to the patients.

H206 , H205 , H869 , H203 Band 3 Support Workers within Ennis, H491 Ward Sister of Ennis and H196 Student Nurse on placement in Ennis at this time all interviewed. All staff stated that they had not raised any issues regarding any staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with.

Investigating team unable to interview B2 (Bohill staff), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

2. **H159, MAH Staff, spoke in an inappropriate manner such as, 'get out of my way'/you're doing my head in', to patients in general. (Source: B2, Bohill Staff)**

H159 interviewed re allegation. She confirmed that staff needed to be assertive and firm to be heard in the noisy and challenging environment but she denied shouting or speaking to any patients in an inappropriate manner.

Other relevant staff interviewed re: this allegation and responses as follows:

H869 interviewed, Question 6, response: *"I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202, P43 and P41 could be very vocal and it could be hard to be heard."*

H206 interviewed, Question 6, response: *No*

H203 interviewed, Question 6, response: *"Not shouting at her, staff may have used a firmer tone if P39 was displaying Challenging Behaviour."*

H196 interviewed, Question 10, response: *No*

H205 interviewed, Question 6, response: *"Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way."*

B7, B5 and B6 staff from the Bohill interviewed and all stated that they had not witnessed staff speak to patients inappropriately or use abusive language.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) H198 (Ennis) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

3. **H159, MAH Staff, hit P40 (patient). P40 observed coming from the bathroom naked screaming and shouting "I hate her. I hate her, I hate H159 H159, she hit me". P40 very distressed and blood was coming from her mouth. (Source: B2, Bohill Staff)**

H159 interviewed. Question 8, response: *"the ward was short staffed; I was there on my own. I decided to start self-care earlier than usual straight after tea. I did not change P40 she was in the toilet having a bowel movement and was screaming and yelling. I heard her I did not see her. Student Nurse H196 came to help after 10 mins with the patients self care. I started changing the girls between 6.15pm and 6.30pm and bringing them to the dayroom. At 7pm I finished, locked the bathroom door and commenced the patient's suppers. Patient P43 was soiled so I took her to the bathroom. Student Nurse H196 brought patient P40 to the bathroom, she was naked. B2 came down to the bathroom when I was changing P43, I asked her to get fresh pyjamas for P40 and then take her back to the dayroom. I did not see blood and I did not complete P40 's oral hygiene that night. No staff had made me aware of anything P40 had said that evening."*

Other relevant staff interviewed re: this allegation and responses as follows:

H196 interviewed. Questions 4, 5 6, 7, and 8:

Question 4, response: *"I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans. I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else."*

Question 5, response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was* B2 *'s first day.* B2 *had stated that she had applied for nursing but did not get in. Cannot remember* B2 *asking for assistance."*

Question 6, response: "*No*"

Question 7 response: "*No I cannot remember*"

Question 8 response: "*No I cannot remember*"

H197 interviewed re: allegation. Question 8, response: *"I was in the day room and then went with the Student Nurse to administer an enema on patient* P41 *.* P40 *was in the day room Student Nurse went to get pyjamas for her. I did not change any patients that evening.* P40 *alleges these things all the time. I do not recall as she says these things all the time."*

H196 called to attend a second interview 2nd June 2014.

Question 1, response: *"I took laundry down to the back area of the ward. I put slippers on a patient."*

Question 2, response: *"I cannot remember the patients' names"*

Question 3, response: *"Yes I did help with bedtime changes but do not remember who"*

Question 4, response: *"Cannot remember"*

H869 interviewed, Question 6, response: *"No never."*

H206 interviewed. Question 5, response: *"Yes* P40 *would say this about other patients never heard her say this about a member of staff."*

How was this addressed? Response: *"If we had not witnessed anything we would have reported this to the Nurse in Charge."*

H203 interviewed. Question 5, response: *"Frequently alleged that other patients had hit her e.g.* P44 *or* P43 *. If she said that* P43 *had hit her then this would be true".* H203 did not think that P40 ever alleged that staff had hit her. When asked how her behaviours were addressed she responded: *"*P40 *would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the Nurse in Charge or another trained staff member that day."*

H205 interviewed. Question 5, response: *"Yes, but about patients only not staff. Heard her say patient* P43 *had hit her but this patient was not in the area at the time she was in the garden area. Patient* P40 *was coming from the bathroom on that occasion.* P40 *would have alleged this a lot." When asked how this behaviour was addressed she responded: "I asked patient were she had been hit and I identified that the patient was not on the ward at the time."*

Sr H491 interviewed. Question 10, response: *"Patients P197 and P40 make allegations, this should be in their care plan. Patients who strip should have this in their Care plans"*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis). However, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis

H196, Student Nurse on Ennis ward at this time was unable to provide any further information regarding this allegation. Staff in Ennis gave varying perceptions as to whether P40 would make allegations regarding staff; H205, H203, H206 and H869 stated they had not heard her say this about staff. Sr H491 stated that P40 would make allegations and that this should have been documented in her care plan. The investigation team examined P40's care plan and there is reference that she does make allegations but does not state if this is against patients and/or staff.

P40 was referred to the Dentist immediately following this incident and it was noted that she had an abscess in her mouth at the time. It is probable that the alleged bleeding coming from P40's mouth was caused by the abscess.

H159 has denied that she carried out personal hygiene with P40 on this evening and has stated that Student Nurse H196 worked with P40. H197 during interview stated that Student Nurse H196 went and got pyjama's for P40. Student Nurse H196 stated during second interview that she did assist with getting the patients ready for bed that evening but cannot state who she worked with.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

11. H159, MAH staff, entered the day room where there were two patients, shouting something like 'would you behave, that's enough'. (Source: B2, Bohill Staff)

Refer to allegation 2.

The investigating team concluded that the allegation made by B2 could not be substantiated.

17. H159, MAH Staff, told Bohill Staff they could not bring P43 (patient) in from where she was sitting outside on the wet grass or get her something to sit on. (Source: B3 or B4, Bohill Staff)

B4's confirmed in her interview that this incident had occurred. When asked who the staff was she responded: *"H159 I think was her name."*

When asked who the patient was she stated: *"P39."*

She was asked to describe the clothing the patients had on and responded: *"P39 was wearing a hoodie and Jeans."*

When asked if she made any attempt to bring the patient back in she responded: *"No B3 B3 brough her back in immediately I did not say anything."*

B7 , B5 ; and B6 (Bohill) interviewed. Responses: No issues/ concerns raised by any of these staff.

H159 interviewed re: allegation. Question 13, Response: *"No,* P43 *likes to be on her own and loves the garden she sits in the same area all the time.* P43 *was able to get back into the ward by the door but generally staff had to go and get her to bring her back in.* P43 *would have become agitated or self-injurious if she wanted out to the garden.* P43 *was only out in the garden if the weather permitted this and was observed by staff.* P39 *did not go out unless staff were with her she was never put out."*

H197 interviewed re: allegation. Question 18, Response: "P43 *loved out in the garden. All the patients liked this area and used it in the summer.* P39 *was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there."*

H205 and H869 from Ennis were asked if there was scope for patient engagement in activities apart from day-care. Both staff stated that the garden was used.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 , Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. records show that it did not rain on these two days and the moisture content was low.

3. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

32. Unnamed Staff (described as usually long standing staff) pulling/ dragging unnamed patients off sofa. Example given – female patient had just laid down on sofa when a staff member reached for her feet, swung her legs around and reached for her wrist and elbow and pulled her out of the chair with force. (Source: B10 ; Bohill Staff)

The interviews conducted questioned staff generally on moving interventions employed and observed.

Refer allegation 1.

H197 (Ennis) interviewed. Question 23, Response: "P39 *- we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with* P41 *."*

H159 (Ennis) interviewed. Question 22, Response: *"Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients* P39 *and* P41 *."*

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step prior to expecting them to stand or be assisted to stand."

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

34. Unnamed staff (but including H159) – would reach for P39 (patient) by the shoulders from behind and pull her backwards into a chair, then staff would sit in front of her to stop her moving. (Source: B10 , Bohill Staff)

Refer to allegation 1 & 32

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

35. Unnamed staff (but described as H159 usually) – would stretch P39 P39 's (patient) T-shirt between her legs and tie it in place. (Source: B10 , Bohill Staff)

H159 (Ennis) interviewed. Question 17, Response: Never

H197 (Ennis) interviewed: Question 17, Response: No

H206 , H205 and H203 (Ennis) interviewed. Question 9, Response: No

H869 (Ennis) interviewed. Question 9, Response: *"No some of the patients wore vests with poppers at the bottom."*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

36. Unnamed Staff (but again described as usually H159) would put P39 P39 's belt on over her clothes, just under her breasts and tie it tight to stop her stripping. B10 , Bohill Staff, said to MAH staff that it looked tight but staff said that P39 would be fine. When B10 took P39 to be changed, she would loosen the belt but again when she came back from her tea break, the belt would be tightened again. (Source: B10 Bohill Staff)

H159 (Ennis) interviewed. Question 10, Response: "P39 *can display very challenging behaviours. She is obsessed with food, strips off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains.* P39 *knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times."*

How were these behaviours managed at ward level? Response: *"Staff tried to amuse* P39 *with soft balls, toys that sang or played music, this helped her to behave. Staff constantly redressed her.* P39 *'s behaviours usually got worse between lunch and tea time. New or strange staff was informed not to let* P39 *grab your hand as she would nip you or pull you around you had to set boundaries with* P39 *.* P39 *wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity."*

H197 (Ennis) interviewed. Question 19, Response: *"Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity."*

Were these written in the patients care plans? Response: *"Do not know. The nurse in charge was aware of all of these."*

H206 (Ennis) interviewed. Question 11, Response: *"Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged open. A swimsuit was used on* P39 *for dignity as she kept this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and* P39 *liked to take this off and play with it.* P39 *could take the belt off and was not considered as restrictive practise as other people wear a belt."*

H205 (Ennis) interviewed. Question 10, Response: *"No staff did not need assistance to put the belt on Tracey she always let you put the belt on her.* P39 *liked her belt and if she did not have one on she would take staff to her room to get one for her.* P39 *'s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on."*

H869 (Ennis) interviewed. Question 11, Response: *"Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations. Patient* P43 *has drop attacks and these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair. Patient* P39 *wore a swimsuit and or a vest."*

H203 (Ennis) interviewed. Question 10, Response: *"No you did not need assistance to put a belt on* P39 *as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her."*

B6 (Bohill) interviewed. Question 10, Response: No

B5 (Bohill) interviewed. Question 10, Response: *"I was commencing night duty and* P39 *was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's."*

When asked if she was made aware of how and why this was done she responded: *"I did not say anything as I was not sure if two staff were needed this was the only occasion."*

B7 (Bohill) interviewed. Question 10, Response: *"Cannot remember"*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager)

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

37. H159, MAH Staff – said 'thank God you are taking her, she's a pain/ pest/ hard work', referring to P39 (patient). Not known if this was said within earshot of patients. (Source: B10, Bohill Staff)

B6, B7 and B4 (Bohill) interviewed re: this and no issues/ concerns raised by any of these staff.

B5 (Bohill) interviewed. Question 13, Response: *"Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore."*

No reference was made during any of the interviews that comments between staff were derogatory about patients.

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated.

39. H159 – very set in routines – e.g. P39 gets changes at these times only – no need to take her now. (Source: B10, Bohill Staff)

Bohill staff interviewed B7, B5, B4 and B6 did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team identified that the ward had routines in place to ensure the safe and effective operation of the ward.

The investigating team were unable to substantiate the allegation

49. 9th October 2012 B3, Bohill Staff also there) H197 MAH Staff (a Bank nurse) and H159, MAH Staff (care assistant). P39 taking her clothes off – H197 got up and grabbed P39, who was wearing a hoodie, at the chest area, said 'get the f* out of my face', and pulled P39 over to the sofa and pushes her onto it. P39 got up again and tried taking her clothes off. She lay on the floor and took her trousers down past her hips. H159 and H197 got out of their chairs and lifted her up, pulled her trousers up, pulled her belt quite forcefully and pulled the belt tightly. H159 and H197 took an arm each and pulled other out of the living room.**

They walked her to the fire doors, opened them, put P39 outside where it was raining and closed the door (no handle on outside). Then they walked away. (source: B4, Bohill Staff)

B4 (Bohill) interviewed. Question 7, Response: "No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the f*** out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and description of H159 the other staff was blond and called H197 who was banking that day."

When asked how she addressed what she witnessed she said that she did not raise this with any staff in Ennis. When questioned why she didn't speak to other staff in Ennis about this incident she responded: "I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me."

When asked she confirmed that she had attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September.

She was asked to confirm when she raised this as a concern and how it was addressed and she responded: "I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me."

B4 (Bohill) Question 9, Response; "Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden." If so who was this staff member, Response; "Cannot be 100% sure may have been H159. This was the same day I seen staff pull P39 up from the floor."

Both H159 (Ennis) and H197 (Ennis) denied this allegation.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 50 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview with the internal investigation team stated that she thought it was H159 who had pulled P39 by the clothing and placed her outside however in the allegations reported in the Adult Safeguarding it states that B4 had identified H197 and H159 as the staff members who allegedly did this.

4. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The Investigating team unable to interview B3 or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

50. 9th October 2012 – P43 (patient) sitting outside on the grass and was soaking. B4 (Bohill Staff) asked H197 (MAH Staff) and H159 (MAH Staff) would she bring her in. H197 said she was alright where she was and that she had a wet suit if it got any heavier. (source B4, Bohill Staff)

Refer to Allegation 49

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 49 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 (Appendix 20) and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview identified one member of staff, H159 placing P39 outside in the rain and in the allegation it states that B4 identified two staff doing this, H159 and H197.

4. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

52. 9th October 2012 8am -8pm. P39 was removing her clothing frequently and needing dressed. A bank nurse got up from her chair and said either "this is doing my head in "or "she is ****ing doing my head in". She grabbed P39 by the clothing at the chest and forcibly pulled her over to a sofa where she pushed her into the sofa. Later on P39 couldn't get her top off so she lay on the floor and was trying to get her trousers off. She had got them down a bit when the bank nurse and a care assistant got up and went over to her. They tied her belt very tightly and lifted her up and marched her to the back door beside the living room, opened it, pushed her out and locked it, leaving her outside by herself. The care assistant described as being in her 50s, really thin. The two staff left and went into the dining room. B3 let P39 back in. Bank nurse described as heavy set, brown or dirty blonde hair styled in a bob, wore glasses, said she was retired and was banking, would say she was in her 60s. (source B3 Bohill staff, worked 8am-8pm on 8/10/12)

Refer to allegation 49 and 50

The Investigating team unable to interview B3 or B1 (Bohill Manager).

In relation to the allegation made by B3 the investigating team concluded that the allegation could not be substantiated and as per allegation 7 there is some evidence to discredit it.

B4 during interviewed stated to the investigation team that she was not happy that B3 had taken off to Australia and that she was left to deal with all of this. She stated that she did not want to be involved and that she had been to her doctor as this was affecting her mental health. B4 stated that she would not be attending the pending court case if she got support from her GP. The investigation team feel that if allegations involving B4 proceed to disciplinary hearing that she will not attend.

Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The investigation team found the anomaly relating to the time of the alleged incident and the confirmed reporting of the incident 4 weeks later to be of significance and passed this information to the PSNI.

4. Limitations of Investigation Process

The investigation team would acknowledge that this investigation has had its limitations. The allegations were reported on the 8th November 2012 and immediately following this there was an Adult Safeguarding Investigation in joint protocol with the PSNI investigation. The Internal Investigation Team used the Adult Safeguarding Report as a frame of reference and with the exception of the recommendations to discipline 2 named staff, the general outcomes, conclusions and recommendations where similar. The Internal Investigation Team met with the Senior Officer leading the Adult Safeguarding Investigation in June 2015 to discuss these differing conclusions and acknowledged that some evidence given to the Adult Safeguarding Team from Bohill staff in December 2012 differed from evidence given to the Internal Investigation Team when they were re-interviewed in June 2014. The Adult Safeguarding Team also had access to interview 2 key witnesses one of whom declined to be interviewed by the Internal Investigation Team and the other was not contactable. The Internal Investigation Team also was able to interview staff directly involved in the allegations that weren't accessible to the Adult Safeguarding Team. The Senior Officer acknowledged this but re-stated that the recommendations to discipline 2 named staff remain valid.

This internal investigation commenced in September 2013 and was concluded in February 2015. The duration of the internal investigation was delayed due to a number of factors:

Reviewing patients notes, staff duties, accident and incident forms

Gaining access to the allegations

Gaining access to all parties' statements - the investigation team were unable to view the statements taken by the PSNI from Ennis and Bohill staff

Engaging staff in the investigation process

Some relevant staff who worked in Ennis in November 2012 have since left the service and the investigation team had to make proactive attempts to engage them in interviews

Interviews being cancelled and rescheduled at short notice

Staff who worked in the Bohill in November 2012 having left the service and the investigation team making proactive attempts to engage them in interviews – the Team Leader B1 cancelling appointment for interview on day they were scheduled to take place on three occasions.

To consider any other issues of concern relevant to the investigation .Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.

1. **Induction**

The ward staff on Ennis all gave good accounts of what their expectations were of the Bohill staff and this had been communicated to them, however, Sr H491 had instructed the staff in Ennis to induct Bohill staff using the Hospital Induction book which requires to be completed over a period of 5 days. This proved difficult for staff to complete as Bohill staff only worked 3 days maximum and were not always there as per rota i.e. different staff names/sickness/changed.

The ward communication book was used to communicate induction requirements to staff and staff were familiar with this process, this was then recorded using the ward diary for each day of induction. Pen pictures and care plans were shared with the Bohill staff. Ennis staff had visited Bohill and the Bohill Team Leader, B1 ; attended resettlement meetings and was given information about the individual patients.

Band 8A staff report that they were in contact with the Bohill Team Leader over this period and the feedback was very positive, no issues/concerns were raised or identified. Ennis staff reported that some Bohill staff were not working with the patients transitioning choosing to spend time with other patients.

On examining staff records it is clearly recorded that staff on Ennis have received an Induction when they commenced work on the ward using the hospital induction booklet. The information elicited during interview highlighted that the quality of the induction received by Bohill staff was dependent on the member of registered staff completing this.

2. **Training**

The investigation team reviewed staff training records within Ennis. H159 had completed her mandatory training to include Management of Actual or Potential Aggression however she had not attended Adult Safeguarding training as was the same for other staff on Ennis ward. There is evidence of continuing development and training for registered staff to provide a skilled and highly motivated workforce, the ward sister highlighted that additional training had been sought for registered staff on care planning.

Health Care Support Workers had no formal training on how to support people with behaviours that challenge and little or no other training outside of the required Trust Mandatory Training. The ward sister had completed the Trust Leadership programme which addresses the needs of good clinical and managerial leadership.

All staff on Ennis interviewed had a good understanding of their personal accountability. The Health Care Support Workers had limited understanding of the legislation as most viewed the use of the belt on one patient as not being a restrictive practice.

The investigation team noted that prior to the allegation Ennis was a nursing practice placement for student nurses. No students have raised any concerns within this placement and the ward is audited at regular intervals by Queens University as a suitable learning environment; last audit was in September 2012.

3. Staffing (numbers, attitudes, team working, morale)

It is evident from this investigation that there were significant staffing deficits on Ennis ward prior to the allegations. Sr H491 had reported her concerns about staffing to Senior Nurse Manager C Stewart and B Mills and had completed incident forms on the 18/9/12 and 23/10/12 regarding staffing deficits on the ward.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports correlate with this.

The Senior Nurse Manager with responsibility for Ennis, Mr C Stewart, was interviewed by the investigation team. During interview Mr Stewart stated he was responsible for Erne, Ennis, Moylena, Iveagh and Night Staff plus he had input to Forrest Lodge during this period. He works eighteen and half hours per week. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on the Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. He reported to the investigation team that Iveagh at this time was his main concern and priority as it also had staffing shortages and given the location of this service, i.e. being geographically isolated from the main MAH site, it was difficult to staff as resources within the hospital were already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch, Dr Milliken, Dr O'Kane, Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital. A meeting with Sr H491 Mrs McLarnon and Mr Stewart was held the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. The majority of bank shifts used to cover the shortfalls within Ennis were booked directly by staff within Ennis and this resulted in staff time being taken up to cover these shifts.

Ward reports prior to the allegations were fairly static. When unfamiliar staff came onto the ward to work towards resettlement of patients, it was highlighted to Mr Stewart by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings etc.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced observations was included in the staffing ratio. Ennis had two enhanced level of observations so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and Mr Stewart.

Staff from Ennis who were interviewed stated that the staff team worked short staffed but they all worked together to help each other. Some staff stated that there they were stressed due to the shortage of staff. No staff raised any concerns or issues regarding attitudes, or morale, all staff stated they worked as a team.

Staff from the Bohill who were interviewed clearly stated the ward was shorted staff. Some said the staff were friendly and made them fell welcome; one said there was a clique on the ward and one said she was not made feel welcome, however, later in interview at a different question said staff spoke away and got on well together. One said staff in Ennis were 'lovely'. She stated the following in interview: "*The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff.*" Another staff said 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

The investigation team concluded that the staffing levels impacted on the ward regarding the safety and quality of the care to the patients. The investigation team did not feel that there was a culture of poor attitude within the ward environment, however, the reduced staffing levels, challenging behaviours described and restricted ward environment would most probably have impacted on morale without the staff within the team realising this.

4. Supervision

Staff within Ennis all stated they had their Personal Contribution Plan and Appraisal completed. They all stated that they had no concerns/issues on the ward and the investigation team felt confident that the staff felt safe and comfortable to raise anything they thought was wrong. While some staff in Ennis had not completed their Safeguarding training staff were clear in their roles and responsibilities as they stated they reported behaviours etc. to the nurse in charge.

Sr H491 stated during interview that when Fairview staff came to the ward in 2010 KSF supervision was a new process for them and attempting to implement this within a busy, short-staffed ward was difficult.

Mr Stewart, Senior Nurse Manager, stated during interview that copies of team meetings were forwarded to him on a two to three monthly basis and that he was satisfied that Supervision and Appraisal processes were in place and occurred on a regular basis.

Families and other visitors were allowed access to the ward or individual patients' bedrooms. This meant there was opportunity for outsiders to observe daily living in the ward and limited the opportunity for a closed culture to develop on the ward, the ward was open and transparent.

The investigation team concluded from the evidence provided that staff had supervision and annual appraisals completed.

5. The Environment (Physical and General Atmosphere)

The ward as described by all staff interviewed was divided into two parts; the upper end of the ward where the patients who were more independent lived and the lower end of the ward were the patients (11) who were more dependant lived; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed (2010). These patients'

behaviours were challenging in that they stripped, pushed/shoved etc. It was in the lower end of the ward where all the incidents were alleged to have taken place.

The upper end of the ward was described by all staff as brighter with lighter paint work. It had artwork and the windows were draped. Each patient had their own individual personal items on display. One patient had a double room that had been converted into her own personal space with a settee and TV and this patient refers to this as her apartment. The lower end of the ward was darker in paint work, had no personal items on display, windows are not draped and many of the patients are in one room.

Physical changes had been made to the ward over the previous few years by Sr H491 these included:

Feb 09 – activity room created for beauty activity

Aug 09 – storage for kitchen. Re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – New blinds

Jan 10 – Additional medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office, this was good for observation – other office doubled up as a visitors' room and office.

Staff on Ennis who were interviewed stated that they were informed of the changes but were not consulted. The investigation team were informed by all staff interviewed that the activity room being converted into an office had impact as it was missed by the patients and staff who previously could utilise this room to separate patients and do activities that helped to manage behaviours e.g. hair, nails etc.

A Bathroom was converted to a staff toilet and locker room and this also had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them and staff additional distress.

The investigation team concluded that the wards physical environment did not meet the needs of the patients; the lower end of the ward was over-crowded; there was limited room available for the patients and the behaviours they displayed. The conversion of the activity room resulted in patients being confined to one room in the lower end of the ward further impacting on behaviours.

The investigation team note that the ward was due to close in 2012 with the resettlement agenda therefore no major work was being commissioned for this ward.

6. Resources

The investigation team noted from interview with Mr Stewart that the resettlement wards, Ennis being one of them, do not have the same service delivered by Patient and Client Support Services (PCSS) as wards within the CORE Hospital do. Nursing staff on the resettlement wards still maintain the responsibility of bed making and laundry whereas in the CORE wards this is completed by PCSS staff. There were also limited resources from psychology Adult Behaviour Services (ABS) as these services were concentrated on the Core Hospital.

The investigation team spoke to ABS and their manager Mr Mills they stated that all referrals are forward to Mr Mills and that these are allocated to a member of the Behaviour Team, each behaviour nurse will then prioritise each case. In most case prioritising is based on the intensity of the behaviour presented i.e. high level of restrictive practice used i.e. Seclusion, Physical intervention and PRN medication. ABS confirmed that they had not received any referrals for P39 P40 or P43 pre the allegations.

Sr H491 stated during interview that patients from the Core Hospital who came to Ennis had Support Plans but that the other patients on Ennis did not have these and that they wouldn't be requested unless there was a significant change in a patient's behaviour. She stated that LD nurses are trained in behaviour and how to manage this and that generally challenging behaviours are managed by activities, however, she acknowledged that scope for activity was reduced due to low staffing levels.

The investigation team concluded that referrals for the behaviours described by the staff in Ennis should have been referred to Adult Behaviour Services.

7. Reporting processes

P39 , P43 , P40 and P41 's care plans were reviewed; Roper, Logan and Tierney was the model used. The named nurse and associate nurse were identified and evidence of person-centred care including personal care needs, protection plans recorded, body charts completed, daily entries by registered nurses, multidisciplinary meetings/Community Integration meetings and entries in relation to accident and incident forms, Adult Safeguarding and Physical Intervention. There was evidence of multidisciplinary team working. The investigation team found that there was a description of the types of behaviour that patients displayed recorded in the care plans there was little detail in strategies for staff to manage or de-escalate these behaviours.

A record of physical interventions employed within the ward was reviewed, September 2012, October 2012 and November 2012, however, none of these was with any of the patients identified in the allegations.

The number of safeguarding incidents was reviewed by the investigation team from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of referrals from an average of 3.57 for the period April 2012 to October 2012 to an average of 22.4 for November 2012 to March 2013 (Appendix 23). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

Review of Incidents/Accidents in Ennis was reviewed from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of incidents from

an average of 7.57 for the period April 2012 to October 2012 to an average of 30.6 for November 2012 to March 2013 (Appendix 17). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

There was evidence on the ward of information sharing via the ward communication book and care plans in relation to visitors/carers/advocates, patient's requests and staffing levels.

Monitoring of the ward took place post the allegations; this was over a 24 hour period and was carried out by registered staff both employed at Muckamore Abbey Hospital and from staff within the Trust. This allowed for observation of staff interacting with the patients and practices on the ward. This supportive process gave a clear picture of what was happening on the ward and formed part of the reporting of risk management up through its governance. The investigation team noted on reviewing these monitoring forms that supervision and observations for patients were maintained. An area highlighted for concern was the ward environment i.e. overcrowding, décor.

Prior to the allegations there was an incident reported in May 2012 when a day-care staff reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. This incident was investigated by the police who did not take any further action. Senior management undertook a full investigation and concluded that there was a case to answer, recommendations were sent to Human Resources but the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA. This demonstrates that Ennis had accountability and governance in place.

In summary the investigation team noted a number of themes that, not individually, but collectively created a situation on Ennis Ward that created vulnerability for both the patients and the staff:

1. Reduced staffing levels across the entire service
2. Ennis' status as a Resettlement Ward – reduced support from PCSS as opposed to the wards in the CORE Hospital.
3. A cramped and dark environment in the lower end of the ward
4. Environmental changes being agreed that had a negative effect on patients and the staff managing the patients
5. Poor skill mix on the ward – i.e. staff working in the lower end of the ward were mostly unregistered staff
6. Poorly documented evidence based practice for managing/ de-escalating identified challenging behaviours
7. Lack of communication to and training of unregistered staff in understanding and being able to articulate the strategies that they were using to manage challenging behaviours
8. Lack of knowledge generally within the ward staff re: legislation around restrictive practices and their implications

The allegations as noted in this report were thoroughly investigated but in the majority of cases the investigating team were unable to substantiate these. During this internal investigation however, a number of statements given by Bohill staff and interpreted as 'incidences' were subsequently refuted by the staff. One allegation was re-iterated by B4 B4 (Bohill) during interview however, during interview B4 informed the investigation team that she was not happy that B3 had *"taken off to Australia"* and that she was *"left to deal with all of this."* She stated that she did not want to be involved in this case and that she had been to her GP as this was affecting her mental health. B4 B4 stated that she had hoped to be exempt from attending the pending court case with support from her GP but she was informed that this was not permissible and could result in legal action being taken against her. The investigation team do not anticipate the attendance or co-operation of B4 if the allegation she has made were to proceed to disciplinary hearing as she has refused to engage with the investigation team since her interview with them and has refused to take phone calls from the investigation team. Of note, the investigation team found evidence to discredit other allegations made by B4. The Senior Officer who led the Adult Safeguarding Report states that the recommendations made by the PSNI to proceed with a court hearing both H197 and H159 remain valid.

8. Recommendations

In view of the findings elicited through this process the investigation team recommend the following:

- An overview of this Report should be shared with all the staff involved. During interviews staff reported that they found the process of investigation immediately post allegations to be covert and unsupportive and for some this has had a lasting and negative impact.
- Immediate training for all staff on the legislation and use of restrictive practice
- Refresher training for all staff on manual handling techniques
- All care plans to be updated to include strategies for managing behaviours
- Mechanisms within the ward to be introduced to ensure all staff – registered and unregistered - understand and can articulate practices/ techniques employed to respond to patients needs e.g. MAPA, Manual Handling techniques, restrictive practices, diversionary techniques, de-escalating techniques
- A review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present
- Increased supervision for H491 and support re: roistering to ensure good skill mix and support for all staff
- Future stringent review and justification of any environmental changes on wards
- All staff to be made aware of Here4U and Staffcare services available to them for extra emotional support if needed.

- Adult Safeguarding Team to consider NMC referral for [B1], Manager of Bohill at time of allegations to investigate non-reporting of incidents alleged to have taken place on Ennis on 9th October 2012.

- The internal investigation team are unable to support the recommendation to progress to formal disciplinary action in relation to the allegations made re: [H159] due to the following:

  1. The internal investigation were unable to substantiate the allegations based on the available evidence
  2. Four witnesses from the Bohill were unavailable for interview ([B1], [B2], [B3] and [B10]).

9. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

Mental Health and Learning Disability

Date_____

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012 In relation to H197

3 002

CONTENTS

List of Appendices

1. INTRODUCTION

In July 2013 Esther Rafferty, Service Manager, Learning Disability commissioned Rhonda Scott, Senior Nurse Manager, Learning Disability Manager and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability to undertake an investigation into incidents alleged to have taken place within Ennis Ward involving Belfast Trust employees. These allegations were reported to RQIA on 8th November 2012 by a care assistant from the Priory Group, Bohill Care Home who had been working on the ward as part of the resettlement programme for patients who were moving to the Bohill.

A joint Adult Safeguarding Investigation started immediately between the PSNI and the Belfast Health and Social Care Trust. This report details an internal investigation which followed the Adult Safeguarding Investigation and draws on information from the subsequent report which was completed in October 2013.

2. TERMS OF REFERENCE

1. To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to [redacted] Band 5 Staff Nurse Bank whilst working in Ennis ward in October and November 2012

In addition the investigation team must:

2. Consider any other issues of concern relevant to the investigation.
3. Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.
4. To make recommendations including referral for disciplinary action.

To support the investigation process the investigators were provided with:

- Witness statements
- Adverse Incident/ Accident Reports
- Minutes of Ward Meetings and Resettlement Meetings
- Adult Safeguarding Report with related interviews and minutes of meetings
- Briefing Reports post allegations by Moira Mannion, Co-Director, Education & Learning
- Duty Rotas (including rosters for Bohill Staff (Appendix 21)who worked on Ennis Ward)
- Shift Planner
- Daily Ward Reports
- Vulnerable Adult Referrals

- Patients notes/ Care Plans
- Medical Files
- Day Care Attendances
- Access to interview Ennis staff and Bohill staff who were still available

NB: B2 (Bohill) not available during entirety of investigation and declined to be interviewed when contacted via PSNI on 1st August 2014
B3 (Bohill) not available during entirety of investigation
B8 (Bohill) unable to contact
B9 (Bohill) unable to contact
B10 (Bohill) unable to contact
B1 (Bohill) did not attend for interview in spite of pro-active attempts to accommodate
H198 (Ennis) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 2)
H870 (staff on relief to Ennis on the 7th November 2012) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 3)

The following Bohill staff also worked on Ennis during this period. These staff made no allegations or raised any concerns during their time on Ennis but have since left the service and no contact details were available:

B11
B12
B13
B14

- Access to interview Ward Manager (Appendix 4) on Ennis during this period and Senior Nurse Manager responsible for Ennis Ward, Muckamore Abbey Hospital (Appendix 5)
- Access to interview Bohill staff, B4 (Appendix 6), B7 (Appendix 7), B5 B5 (Appendix 8) and B6 (Appendix 9) who worked in Ennis at the time of the allegations.
- Access to interview H197 (Appendix 10), Bank Nurse and H159 (Appendix 11) Health Care Support Worker who were named in the allegations.
- Access to interview H205 (Appendix 12), H869 (Appendix 13), H203 (Appendix 14) and H206 (Appendix 15) Health Care Support Workers who worked in Ennis at the time of the allegations
- Access to interview H196 (Appendix 16) Student Nurse on placement in Ennis at the time of the allegations.
- Access to interview Moira Mannion, Co-Director, Education & Learning

- Access to interview Aine Morrison, Senior Officer, Adult Safeguarding Investigation Team and lead author of Adult Safeguarding Report

SCOPE OF INTERVIEWS

The interviews covered the themes below – with specific adaptation for those involved in the allegations:

- Induction processes
- Training
- Staffing (numbers, attitudes, team working, morale)
- Supervision
- The Environment (Physical and General Atmosphere)
- Resources
- Summary of allegations from Adult Safeguarding Investigation (Appendix 1)
- Reporting processes

3. ADDITIONAL EVIDENCES

- Duty Rota – confirmed all involved in investigation worked in Ennis (allegations as per Adult Safeguarding Report state the alleged incidences occurred between **9th October and 7th November 2012** – same information elicited and confirmed from interview with [redacted] B4 (Bohill) 19th May 2014.

- Allocation Book – Inadequate skill mix on ward at time of allegations. Skill mix 60% unregistered: 40% registered staff; this was further reduced by registered nurse sick leave. No clear allocation of duties – this was corroborated in subsequent staff interviews. Clear evidence in Duty Allocation Book that the responsibility for the patients at the lower end of Ennis (where incidents were alleged to have taken place) was mostly with unregistered staff.

- Adverse Incidents/ Accident Reports – no evidence of under reporting; all correlated with entries documented in patient notes, daily ward reports and care plans. An increase in incidents was also noted from November 2012 until February 2013 – this correlates with a monitoring rota which was implemented post allegations (Appendix 17). Staff noted in interviews that the monitoring in itself was disruptive to the patients and this may have had a bearing on these statistics.

- Day Care Attendances from Ennis (Appendix 18). This information highlighted a significant number of cancelled Day Care places during the period the alleged incidents took place. These cancellations added additional pressure to a ward that was already short staffed. The attached attendance report also highlights staff shortages in Day Care Services around this time

- Minutes of Resettlement Meetings (Appendix 19)

FINDINGS

This was a complex and lengthy investigation. The Terms of Reference as noted above required the investigating team to look at the whole system i.e. the context of Ennis Ward within the wider Muckamore Abbey Hospital site, the managerial processes on the ward, staffing, practices and individual patient needs. All interviews are attached and conclusions/ findings are summarised under each term of reference as follows:

1. **To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H197 Band 5 Staff Nurse Bank whilst working in Ennis ward in October and November 2012**

The allegations listed below are from the Adult Safeguarding Report. For ease and consistency of reference the allegation numbers correspond to their chronological order in the Adult Safeguarding Report.

5. H197, MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair (Source: B2, Bohill Staff)

H197 interviewed re allegation. Question 15, Response: *"She P41) has involuntary constant jerking and hits her head off the chair frequently. She becomes agitated at times and this is an indication that she needs an enema. She has Bi-Polar Affective Disorder with associated mood fluctuation and self-injurious behaviours."*

H197 was asked how these behaviours managed at ward level. Response: *"We used the same chair for P41 and administered an enema once a week as was prescribed."* Question 16, Response: *"P41 has a very unsteady gait and walks on her tip toes, when outside she would use a wheelchair. She positions herself into her chair but her upper and lower body movements would have caused her head to hit the back of the chair."*

H159 interviewed re allegation. Question 15, Response: *"Constant jerking movements and throws her head back when agitated. Has a problem with bowel movements which can cause agitation and needs enema to manage this. She can be aggressive can kick out and hit."*

H159 was asked how these behaviours were managed at ward level? Response: *"She loves music. You always worked to the side of her and she needs constant supervision."* Question 16, Response: *"In a wheelchair at times when off the ward. On ward when walking if needed used an elbow block and guided her with your hand on her back. She always settled herself into her chair."*

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients, therefore patients with presenting jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients."

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 that H197, MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair the investigating team concluded that the allegation could not be substantiated

6. H197, MAH staff, said to P22 (patient) when P41 (patient) had attacked her "not to be a big softie and hit her back," (Source B2 B2 Bohill staff)

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H197's statement from interview re: this allegation as follows: *"On the day of this allegation P41 went over to P22 who was lying on the couch P41 jumped up and down on P22. I went over and took P41 by her arm and elbow. P41 put her legs down on the ground and I walked her to another chair. B2 was at the window in the day room and her view of this was restricted as I was between her and P41. I put P41 into her chair and she settled herself as described earlier."*

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 (Appendix 3) stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

In relation to the allegation made by B2 that H197, MAH Staff, said to P22 when P41 had attached her not to be a big softie and hit her back the investigating team concluded that the allegation could not be substantiated

7. H197, MAH Staff, pulled P41 (patient) into a standing position and shoved, nudged and pushed P41 towards her chair. (Source: B2 B2, Bohill Staff)

Refer to allegation 5

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation could not be substantiated

8. H197, MAH staff, was being rough with P39 (patient); grabbing the band of her trousers, turning her and pushing her away, pulling her back by the band of her trousers on a few occasions when P39 stumbled. (Source: B2 B2, Bohill Staff)

H197 interviewed re allegation. Question 12, Response: *"No. You would have turned P39 away by placing your hands on her shoulders and moving her that way. You would have moved her to de-escalate her behaviours."*

H159 interviewed re allegation. Question 12, Response: No never

B7, B5, B4 and B6 (Bohill) all interviewed re: this and no issues/ concerns raised by any of these staff.

The following staff; H196, H206 H205, H203 and H869 from Ennis were asked:

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing? Response from all staff was No

Investigating team unable to interview B2 (Bohill) B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

9. H197, MAH staff, told P39 (patient) that if she did not stop stripping, she would not be allowed any lunch.

Source: B2, Bohill staff.

The investigation team were unable to interview B2 or B1 Bohill Manager)

B7, B5, B4 and B6 (Bohill) all interviewed re: this and no issues/ concerns raised by any of these staff.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

10. H197, MAH staff told B2, Bohill Staff that if she continued trying to put P39 's (patient) clothes back on, she would do it all day and advised B2 not to be face on to P39 and to turn her away by the band of her trousers. (Source: B2, Bohill Staff)

Refer to allegation 8

The investigating team concluded that the allegation made by B2 could not be substantiated

12. H197 and H196, MAH Staff, ignored B2 's requests for help with P40 (patient). H196 did then respond. (source: B2 B2, Bohill Staff)

H197 interviewed re: allegation. Question 9, Response: *"I cannot remember I was administering an enema to P41."*

H159 interviewed re: allegation, Question 9, Response: *"No"*

H196 interviewed. Question 5, Response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2's first day. B2 had stated that she had applied for nursing but did not get in. Cannot remember B2 asking for assistance. "*

H197 and H159 gave the investigation team a thorough account of their activities the evening this was alleged to have taken place. If B2 requested staff's assistance H197 and H159 it appears that they did not intentionally ignore this request. H197 cannot remember if she was asked but has stated that she was not in a position to leave the patient she was working with and H159 has stated that she did not hear this request. H196 stated she does not remember if B2 asked for assistance and cannot give any further information regarding this.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

13. H197, MAH Staff – told B2, Bohill Staff who had just arrived on ward for the first time that she was going to the toilet and would be back soon. B2 left with patient for approximately 20 minutes, patients became agitated. B2 was assaulted and had no means of obtaining assistance. P39 (patient) had got faeces on her hand and B2 had no means of cleaning this or gaining access to the bathroom and had to sit holding P39 's wrist to prevent her from putting her hand near her mouth. When H197 returned, B2 asked if she could change P39. She was given a key. She asked where the pads were kept and was informed they were in a cupboard. P39 's clothes had also got soiled. B2 did not know where P39 's bedroom was and stood at the door of the bathroom shouting for assistance before help arrived. (Source: B2, Bohill Staff)

H197 interviewed re allegation. Question 9, Response: *"I did not leave B2 for 20 minutes in the day room alone, H870 t, relief staff, was in the day room with B2 when I left. When I returned P39 has faeces on her hand B2 took P39 to the toilet and H870 got P39 a change of clothes."*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

In relation to the allegation made by B2 the investigating team have a statement from H870 to substantiate H197's account.

16. H197, MAH Staff, grabbed P39 (patient), threw her on sofa and told her to get out of my f*ing face' (Source: B3 or B4, Bohill Staff)**

Refer to allegations 49 & 52.

Interview with B4 Question 7, Response: "*I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to 'get the fuck out of my face' and heavily pushed her onto the sofa. One of these staff was called* H159 *and* description of H159 *the other staff was blond and called* H197 *who was banking that day.*"

If yes how were these issues addressed? Response: "*No did not raise these issues with Ennis staff*"

If not why not? Response: "*I did not know these people I was in a new environment. I reported these to my manager* B1 *at the Bohill the next day; this was then reported to* B15 *The next thing the CID came to the Bohill to interview me.*"

When questioned B4 confirmed that she has attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September 2012.

H197 interviewed and denied the allegation.

H159 interviewed re: allegation, Question 18, Response: *"Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients."*

B7, B5, B4 and B6 (Bohill) interviewed and no issues/concerns raised d by any of these staff.

H206, H205, H203 and H869 from Ennis were asked:

Have you ever heard staff shout at P39 with a raised voice? Response from all staff was No.

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

In relation to the allegation above, made by B3 or B4 the investigating team concluded that during interview B4 re-stated that this incident had occurred. The investigation team contacted Bohill on the 20th February 2015 @ 4pm to speak to B4 to seek her cooperation to proceed with this allegation. B7 informed the investigation team that B4 had a "*panic attack*" when informed that they wished to speak to her. B7 spoke to B4 and she reported on B4 's behalf that B4 B4 would not take part in any further discussion in relation to the allegations. She refused to speak to the investigation team herself.

The investigation noted that B4 and B3 worked in Ennis during the 7th 8th and 9th October 2012. B4 stated during interview that she had reported this to her manager B1 the following day. The allegations were reported to the hospital on the 8th November 2012. The investigation team contacted the manager of the Bohill, B15 ; she has confirmed via e mail that these allegations were reported on the 8th November 2012 (Appendix 20)

49. 9th October 2012 (B3 , Bohill Staff also there) H197 , MAH Staff (a Bank nurse) and H159 , MAH Staff (care assistant). P39 taking her clothes off – H197 got up and grabbed P39 , who was wearing a hoodie, at the chest area, said 'get the f* out of my face', and pulled P39 over to the sofa and pushes her onto it. P39 got up again and tried taking her clothes off. She lay on the floor and**

took her trousers down past her hips. H159 and H197 got out of their chairs and lifted her up, pulled her trousers up, pulled her belt quite forcefully and pulled the belt tightly. H159 and H197 took an arm each and pulled other out of the living room. They walked her to the fire doors, opened them, put P39 outside where it was raining and closed the door (no handle on outside). Then they walked away. (source: B4, Bohill Staff)

B4 (Bohill) interviewed. Question 7, Response: "No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and description of H159 the other staff was blond and called H197 who was banking that day."

When asked how she addressed what she witnessed she said that she did not raise this with any staff in Ennis. When questioned why she didn't speak to other staff in Ennis about this incident she responded: "I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me."

When asked she confirmed that she had attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September.

She was asked to confirm when she raised this as a concern and how it was addressed Question 8 and she responded: "I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me."

B4 (Bohill) Question 9, Response; "Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden." If so who was this staff member, Response; "Cannot be 100% sure may have been H159. This was the same day I seen staff pull P39 up from the floor."

Both H159 (Ennis) and H197 (Ennis) denied this allegation.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 52 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview with the internal investigation team stated that she thought it was H159 who had pulled P39 by the clothing and placed her outside however in the allegations reported in the Adult Safeguarding it states that B4 had identified H197 and H159 as the staff members who allegedly did this.

4. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The Investigating team unable to interview B3 or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

50. 9th October 2012 – P43 (patient) sitting outside on the grass and was soaking. B4 (Bohill Staff) asked H197 (MAH Staff) and H159 (MAH Staff) would she bring her in. H197 said she was alright where she was and that she had a wet suit if it got any heavier. (source B4, Bohill Staff)

Refer to Allegation 49

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 (Appendix 20) and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview identified one member of staff, H159, placing P39 outside in the rain and in the allegation it states that B4 identified two staff doing this, H159 and H197.

4. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

52. 9th October 2012 8am -8pm. P39 was removing her clothing frequently and needing dressed. A bank nurse got up from her chair and said either "this is doing my head in "or "she is ****ing doing my head in". She grabbed P39 by the clothing at the chest and forcibly pulled her over to a sofa where she pushed her into the sofa. Later on P39 couldn't get her top off so she lay on the floor and was trying to get her trousers off. She had got them down a bit when the bank nurse and a care assistant got up and went over to her. They tied her belt very tightly and lifted her up and marched her to the back door beside the living room, opened it, pushed her out and locked it, leaving her outside by herself. The care assistant described as being in her 50s, really thin. The two staff left and went into the dining room. B3 let P39 back in. Bank nurse described as heavy set, brown or dirty blonde hair styled in a bob, wore glasses, said she was retired and was banking, would say she was in her 60s. (source B3 Bohill staff, worked 8am-8pm on 8/10/12)

Refer to allegation 49.

B4 (Bohill) interviewed. Question 10, Response: Yes I heard a staff say to a patient get the f*** out of my face. This occurred around lunchtime or the afternoon. This was the only time I heard abusive language.

B4 was asked If so who was this staff member. Response; H197 the Bank Nurse I had been talking to these staff so I knew their names. Stated she was in her 60's and her husband had passed away."

B4 during interviewed stated to the investigation team that she was not happy that B3 had taken off to Australia and that she was left to deal with all of this. She stated that she did not want to be involved and that she had been to her doctor as this was affecting her mental health. B4 stated that she would not be attending the pending court case if she got support from her GP. The investigation team are confident that if allegations involving B4 proceed to disciplinary hearing that she will not attend.

Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

B4 stated in interview that H197 said get the f*** out of my face. B3 as per allegations from Safeguarding Report stated this is doing my head in "or "she is ****ing doing my head in.

The investigation team found the anomaly relating to the time of the alleged incident and the confirmed reporting of the incident 4 weeks later to be of significance and passed this information to the PSNI.

The Investigating team unable to interview B3 or B1 (Bohill Manager).

In relation to the allegation made by B3 the investigating team concluded that the allegation could not be substantiated and as per allegation 49 there is some evidence to discredit it.

1. Limitations of Investigation Process

The investigation team would acknowledge that this investigation has had its limitations. The allegations were reported on the 8th November 2012 and immediately following this there was an Adult Safeguarding Investigation in joint protocol with the PSNI investigation. The Internal Investigation Team used the Adult Safeguarding Report as a frame of reference and with the exception of the recommendations to discipline 2 named staff, the general outcomes, conclusions and recommendations where similar. The Internal Investigation Team met with the Senior Officer leading the Adult Safeguarding Investigation in June 2015 to discuss these differing conclusions and acknowledged that some evidence given to the Adult Safeguarding Team from Bohill staff in December 2012 differed from evidence given to the Internal Investigation Team when they were re-interviewed in June 2014. The Adult Safeguarding Team also had access to interview 2 key witnesses one of whom declined to be interviewed by the Internal Investigation Team and the other was not contactable. The Internal Investigation Team also was able to interview staff directly involved in the allegations that weren't accessible to the Adult Safeguarding Team. The Senior Officer acknowledged this but re-stated that the recommendations to discipline 2 named staff remain valid.

This internal investigation commenced in September 2013 and was concluded in February 2015. The duration of the internal investigation was delayed due to a number of factors:

Reviewing patients notes, staff duties, accident and incident forms

Gaining access to the allegations

Gaining access to all parties' statements - the investigation team were unable to view the statements taken by the PSNI from Ennis and Bohill staff

Engaging staff in the investigation process

Some relevant staff who worked in Ennis in November 2012 have since left the service and the investigation team had to make proactive attempts to engage them in interviews

Interviews being cancelled and rescheduled at short notice

Staff who worked in the Bohill in November 2012 having left the service and the investigation team making proactive attempts to engage them in interviews – the Team Leader B1 cancelling appointment for interview on day they were scheduled to take place on three occasions.

To consider any other issues of concern relevant to the investigation .Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.

1. **Induction**

The ward staff on Ennis all gave good accounts of what their expectations were of the Bohill staff and this had been communicated to them, however, Sr H491 had instructed the staff in Ennis to induct Bohill staff using the Hospital Induction book which requires to be completed over a period of 5 days. This proved difficult for staff to complete as Bohill staff only worked 3 days maximum and were not always there as per rota i.e. different staff names/sickness/changed.

The ward communication book was used to communicate induction requirements to staff and staff were familiar with this process, this was then recorded using the ward diary for each day of induction. Pen pictures and care plans were shared with the Bohill staff. Ennis staff had visited Bohill and the Bohill Team Leader, B1 ; attended resettlement meetings and was given information about the individual patients.

Band 8A staff report that they were in contact with the Bohill Team Leader over this period and the feedback was very positive, no issues/concerns were raised or identified. Ennis staff reported that some Bohill staff were not working with the patients transitioning choosing to spend time with other patients.

On examining staff records it is clearly recorded that staff on Ennis have received an Induction when they commenced work on the ward using the hospital induction booklet. The information elicited during interview highlighted that the quality of the induction received by Bohill staff was dependent on the member of registered staff completing this.

2. **Training**

The investigation team reviewed staff training records within Ennis. H197 had completed her mandatory training to include Management of Actual or Potential Aggression however she had not attended Adult Safeguarding training as was the same for other staff

on Ennis ward. There is evidence of continuing development and training for registered staff to provide a skilled and highly motivated workforce, the ward sister highlighted that additional training had been sought for registered staff on care planning.

H197 had no formal training outside of her nurse training on how to support people with behaviours that challenge and little or no other training outside of the required Trust Mandatory Training. The ward sister had completed the Trust Leadership programme which addresses the needs of good clinical and managerial leadership.

All staff on Ennis interviewed had a good understanding of their personal accountability. The Health Care Support Workers had limited understanding of the legislation as most viewed the use of the belt on one patient as not being a restrictive practice.

The investigation team noted that prior to the allegation Ennis was a nursing practice placement for student nurses. No students have raised any concerns within this placement and the ward is audited at regular intervals by Queens University as a suitable learning environment; last audit was in September 2012.

3. Staffing (numbers, attitudes, team working, morale)

It is evident from this investigation that there were significant staffing deficits on Ennis ward prior to the allegations. Sr H491 had reported her concerns about staffing to Senior Nurse Manager C Stewart and B Mills and had completed incident forms on the 18/9/12 and 23/10/12 regarding staffing deficits on the ward.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports correlate with this.

The Senior Nurse Manager with responsibility for Ennis, Mr C Stewart, was interviewed by the investigation team. During interview Mr Stewart stated he was responsible for Erne, Ennis, Moylena, Iveagh and Night Staff plus he had input to Forrest Lodge during this period. He works eighteen and half hours per week. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on the Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. He reported to the investigation team that Iveagh at this time was his main concern and priority as it also had staffing shortages and given the location of this service, i.e. being geographically isolated from the main MAH site, it was difficult to staff as resources within the hospital were already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch, Dr Milliken, Dr O'Kane, Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital. A meeting with Sr H491 Mrs McLarnon and Mr Stewart was held the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. The majority of bank shifts used to cover the shortfalls within Ennis were booked directly by staff within Ennis and this resulted in staff time being taken up to cover these shifts.

Ward reports prior to the allegations were fairly static. When unfamiliar staff came onto the ward to work towards resettlement of patients, it was highlighted to Mr Stewart by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings etc.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced observations was included in the staffing ratio. Ennis had two enhanced level of observations so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and Mr Stewart.

Staff from Ennis who were interviewed stated that the staff team worked short staffed but they all worked together to help each other. Some staff stated that there they were stressed due to the shortage of staff. No staff raised any concerns or issues regarding attitudes, or morale, all staff stated they worked as a team.

Staff from the Bohill who were interviewed clearly stated the ward was shorted staff. Some said the staff were friendly and made them fell welcome; one said there was a clique on the ward and one said she was not made feel welcome, however, later in interview at a different question said staff spoke away and got on well together. One said staff in Ennis were 'lovely'. She stated the following in interview: "*The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff.*" Another staff said 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

The investigation team concluded that the staffing levels impacted on the ward regarding the safety and quality of the care to the patients. The investigation team did not feel that there was a culture of poor attitude within the ward environment, however, the reduced staffing levels, challenging behaviours described and restricted ward environment would most probably have impacted on morale without the staff within the team realising this.

4. **Supervision**

Staff within Ennis all stated they had their Personal Contribution Plan and Appraisal completed. They all stated that they had no concerns/issues on the ward and the investigation team felt confident that the staff felt safe and comfortable to raise anything they thought was wrong. While some staff in Ennis had not completed their Safeguarding training staff were clear in their roles and responsibilities as they stated they reported behaviours etc. to the nurse in charge.

Sr H491 stated during interview that when Fairview staff came to the ward in 2010 KSF supervision was a new process for them and attempting to implement this within a busy, short-staffed ward was difficult.

Mr Stewart, Senior Nurse Manager, stated during interview that copies of team meetings were forwarded to him on a two to three monthly basis and that he was satisfied that Supervision and Appraisal processes were in place and occurred on a regular basis.

Families and other visitors were allowed access to the ward or individual patients' bedrooms. This meant there was opportunity for outsiders to observe daily living in the ward and limited the opportunity for a closed culture to develop on the ward, the ward was open and transparent.

The investigation team concluded from the evidence provided that staff had supervision and annual appraisals completed.

5. The Environment (Physical and General Atmosphere)

The ward as described by all staff interviewed was divided into two parts; the upper end of the ward where the patients who were more independent lived and the lower end of the ward were the patients (11) who were more dependant lived; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed (2010). These patients' behaviours were challenging in that they stripped, pushed/shoved etc. It was in the lower end of the ward where all the incidents were alleged to have taken place.

The upper end of the ward was described by all staff as brighter with lighter paint work. It had artwork and the windows were draped. Each patient had their own individual personal items on display. One patient had a double room that had been converted into her own personal space with a settee and TV and this patient refers to this as her apartment. The lower end of the ward was darker in paint work, had no personal items on display, windows are not draped and many of the patients are in one room.

Physical changes had been made to the ward over the previous few years by Sr H491 these included:

Feb 09 – activity room created for beauty activity

Aug 09 – storage for kitchen. Re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – New blinds

Jan 10 – Additional medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office, this was good for observation – other office doubled up as a visitors' room and office.

Staff on Ennis who were interviewed stated that they were informed of the changes but were not consulted. The investigation team were informed by all staff interviewed that the activity room being converted into an office had impact as it was missed by the patients and staff who previously could utilise this room to separate patients and do activities that helped to manage behaviours e.g. hair, nails etc.

A Bathroom was converted to a staff toilet and locker room and this also had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them and staff additional distress.

The investigation team concluded that the wards physical environment did not meet the needs of the patients; the lower end of the ward was over-crowded; there was limited room

available for the patients and the behaviours they displayed. The conversion of the activity room resulted in patients being confined to one room in the lower end of the ward further impacting on behaviours.

The investigation team note that the ward was due to close in 2012 with the resettlement agenda therefore no major work was being commissioned for this ward.

6. Resources

The investigation team noted from interview with Mr Stewart that the resettlement wards, Ennis being one of them, do not have the same service delivered by Patient and Client Support Services (PCSS) as wards within the CORE Hospital do. Nursing staff on the resettlement wards still maintain the responsibility of bed making and laundry whereas in the CORE wards this is completed by PCSS staff. There were also limited resources from psychology Adult Behaviour Services (ABS) as these services were concentrated on the Core Hospital.

The investigation team spoke to ABS and their manager Mr Mills they stated that all referrals are forward to Mr Mills and that these are allocated to a member of the Behaviour Team, each behaviour nurse will then prioritise each case. In most case prioritising is based on the intensity of the behaviour presented i.e. high level of restrictive practice used i.e. Seclusion, Physical intervention and PRN medication. ABS confirmed that they had not received any referrals for P39 P40 or P43 pre the allegations.

Sr H491 stated during interview that patients from the Core Hospital who came to Ennis had Support Plans but that the other patients on Ennis did not have these and that they wouldn't be requested unless there was a significant change in a patient's behaviour. She stated that LD nurses are trained in behaviour and how to manage this and that generally challenging behaviours are managed by activities, however, she acknowledged that scope for activity was reduced due to low staffing levels.

The investigation team concluded that referrals for the behaviours described by the staff in Ennis should have been referred to Adult Behaviour Services.

7. Reporting processes

P39, P43, P40 and P41's care plans were reviewed; Roper, Logan and Tierney was the model used. The named nurse and associate nurse were identified and evidence of person-centred care including personal care needs, protection plans recorded, body charts completed, daily entries by registered nurses, multidisciplinary meetings/Community Integration meetings and entries in relation to accident and incident forms, Adult Safeguarding and Physical Intervention. There was evidence of multidisciplinary team working. The investigation team found that there was a description of the types of behaviour that patients displayed recorded in the care plans there was little detail in strategies for staff to manage or de-escalate these behaviours.

A record of physical interventions employed within the ward was reviewed, September 2012, October 2012 and November 2012, however, none of these was with any of the patients identified in the allegations.

The number of safeguarding incidents was reviewed by the investigation team from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of referrals from an average of 3.57 for the period April 2012 to October 2012 to

an average of 22.4 for November 2012 to March 2013 (Appendix 23). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

Review of Incidents/Accidents in Ennis was reviewed from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of incidents from an average of 7.57 for the period April 2012 to October 2012 to an average of 30.6 for November 2012 to March 2013 (Appendix 17). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

There was evidence on the ward of information sharing via the ward communication book and care plans in relation to visitors/carers/advocates, patient's requests and staffing levels.

Monitoring of the ward took place post the allegations; this was over a 24 hour period. This allowed for observation of staff interacting with the patients and practices on the ward. This supportive process gave a clear picture of what was happening on the ward and formed part of the reporting of risk management up through its governance. The investigation team noted on reviewing these monitoring forms that supervision and observations for patients were maintained. An area highlighted for concern was the ward environment i.e. overcrowding, décor.

Prior to the allegations there was an incident reported in May 2012 when a day-care staff reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. This incident was investigated by the police who did not take any further action. Senior management undertook a full investigation and concluded that there was a case to answer, recommendations were sent to Human Resources but the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA. This demonstrates that Ennis had accountability and governance in place.

In summary the investigation team noted a number of themes that, not individually, but collectively created a situation on Ennis Ward that created vulnerability for both the patients and the staff:

1. Reduced staffing levels across the entire service
2. Ennis' status as a Resettlement Ward – reduced support from PCSS as opposed to the wards in the CORE Hospital.
3. A cramped and dark environment in the lower end of the ward
4. Environmental changes being agreed that had a negative effect on patients and the staff managing the patients
5. Poor skill mix on the ward – i.e. staff working in the lower end of the ward were mostly unregistered staff
6. Poorly documented evidence based practice for managing/ de-escalating identified challenging behaviours

7. Lack of communication to and training of unregistered staff in understanding and being able to articulate the strategies that they were using to manage challenging behaviours

8. Lack of knowledge generally within the ward staff re: legislation around restrictive practices and their implications

The allegations as noted in this report were thoroughly investigated but in the majority of cases the investigating team were unable to substantiate these. During this internal investigation however, a number of statements given by Bohill staff and interpreted as 'incidences' were subsequently refuted by the staff. One allegation was re-iterated by B4 B4 (Bohill) during interview however, during interview B4 informed the investigation team that she was not happy that B3 had *"taken off to Australia"* and that she was *"left to deal with all of this."* She stated that she did not want to be involved in this case and that she had been to her GP as this was affecting her mental health. B4 B4 stated that she had hoped to be exempt from attending the pending court case with support from her GP but she was informed that this was not permissible and could result in legal action being taken against her. The investigation team do not anticipate the attendance or co-operation of B4 if the allegation she has made were to proceed to disciplinary hearing as she has refused to engage with the investigation team since her interview with them and has refused to take phone calls from the investigation team. Of note, the investigation team found evidence to discredit other allegations made by B4. The Senior Officer who led the Adult Safeguarding Report states that the recommendations made by the PSNI to proceed with a court hearing both H197 and H159 remain valid.

8. Recommendations

In view of the findings elicited through this process the investigation team recommend the following:

- An overview of this Report should be shared with all the staff involved. During interviews staff reported that they found the process of investigation immediately post allegations to be covert and unsupportive and for some this has had a lasting and negative impact.
- Immediate training for all staff on the legislation and use of restrictive practice
- Refresher training for all staff on manual handling techniques
- All care plans to be updated to include strategies for managing behaviours
- Mechanisms within the ward to be introduced to ensure all staff – registered and unregistered - understand and can articulate practices/ techniques employed to respond to patients needs e.g. MAPA, Manual Handling techniques, restrictive practices, diversionary techniques, de-escalating techniques
- A review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present
- Increased supervision for H491 and support re: roistering to ensure good skill mix and support for all staff

- Future stringent review and justification of any environmental changes on wards
- All staff to be made aware of Here4U and Staffcare services available to them for extra emotional support if needed.
- Adult Safeguarding Team to consider NMC referral for B1, Manager of Bohill at time of allegations to investigate non-reporting of incidents alleged to have taken place on Ennis on 9th October 2012.
- The internal investigation team are unable to support the recommendation to progress to formal disciplinary action in relation to the allegations made re: H197 due to the following:

  1. The internal investigation were unable to substantiate the allegations based on the available evidence
  2. Three witnesses from the Bohill were unavailable for interview (B1, B2 and B3).

9. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

Mental Health and Learning Disability

Date_____

1.001

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012

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1. INTRODUCTION

In July 2013 Esther Rafferty, Service Manager, Learning Disability commissioned Rhonda Scott, Senior Nurse Manager, Learning Disability Manager and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability to undertake an investigation into incidents alleged to have taken place within Ennis Ward involving Belfast Trust employees. These allegations were reported to RQIA on 8th November 2012 by a care assistant from the Priory Group, Bohill Care Home who had been working on the ward as part of the resettlement programme for patients who were moving to the Bohill.

A joint Adult Safeguarding Investigation started immediately between the PSNI and the Belfast Health and Social Care Trust. This report details an internal investigation which followed the Adult Safeguarding Investigation and draws on information from the subsequent report which was completed in October 2013.

2. TERMS OF REFERENCE

•To investigate matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse of patients by staff received from a visiting staff member from Priory Group, Bohill Care Home. (Bohill)

•To investigate managerial processes i.e. that the ward had been managed in a safe and effective manner particularly in relation to the day to day running of staff rosters, the daily activities of the ward and the environment requirements, prior to the Adult Safeguarding Investigation.

•To immediately report to the Trust any matter which may undermine the objectivity or robustness of the investigation. Referring any issue of concern, not directly relevant to the terms of reference, to the appropriate senior manager for action as appropriate.

•To make recommendations on what action if any should be taken in relation to the matters investigated. This should include a recommendation on whether the case should be referred to a disciplinary hearing.

To support the investigation process the investigators were provided with:

- Witness statements
- Adverse Incident/ Accident Reports
- Minutes of Ward Meetings and Resettlement Meetings
- Adult Safeguarding Report with related interviews and minutes of meetings
- Briefing Reports post allegations by Moira Mannion, Co-Director, Education & Learning
- Duty Rotas (including rosters for Bohill Staff (Appendix 21)who worked on Ennis Ward)
- Shift Planner
- Daily Ward Reports
- Vulnerable Adult Referrals

- Patients notes/ Care Plans
- Medical Files
- Day Care Attendances
- Access to interview Ennis staff and Bohill staff who were still available

NB: B2 (Bohill) not available during entirety of investigation and declined to be interviewed when contacted via PSNI on 1st August 2014
B3 (Bohill) not available during entirety of investigation
B8 (Bohill) unable to contact
B9 (Bohill) unable to contact
B10 (Bohill) unable to contact
B1 (Bohill) did not attend for interview in spite of pro-active attempts to accommodate
H198 (Ennis) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 2)
H870 (staff on relief to Ennis on the 7th November 2012) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 3)

The following Bohill staff also worked on Ennis during this period. These staff made no allegations or raised any concerns during their time on Ennis but have since left the service and no contact details were available:

B11
B12
B13
B14

- Access to interview Ward Manager (Appendix 4) on Ennis during this period and Senior Nurse Manager responsible for Ennis Ward, Muckamore Abbey Hospital (Appendix 5)
- Access to interview Bohill staff, B4 (Appendix 6), B7 (Appendix 7), B5 B5 (Appendix 8) and B6 (Appendix 9) who worked in Ennis at the time of the allegations.
- Access to interview H197 (Appendix 10), Bank Nurse and H159 (Appendix 11) Health Care Support Worker who were named in the allegations.
- Access to interview H205 (Appendix 12), H869 (Appendix 13), H203 (Appendix 14) and H206 (Appendix 15) Health Care Support Workers who worked in Ennis at the time of the allegations
- Access to interview H196 (Appendix 16) Student Nurse on placement in Ennis at the time of the allegations.
- Access to interview Moira Mannion, Co-Director, Education & Learning

- Access to interview Aine Morrison, Senior Officer, Adult Safeguarding Investigation Team and lead author of Adult Safeguarding Report

SCOPE OF INTERVIEWS

The interviews covered the themes below – with specific adaptation for those involved in the allegations:

- Induction processes
- Training
- Staffing (numbers, attitudes, team working, morale)
- Supervision
- The Environment (Physical and General Atmosphere)
- Resources
- Summary of allegations from Adult Safeguarding Investigation (Appendix 1)
- Reporting processes

3. ADDITIONAL EVIDENCES

- Duty Rota – confirmed all involved in investigation worked in Ennis (allegations as per Adult Safeguarding Report state the alleged incidences occurred between **9th October and 7th November 2012** – same information elicited and confirmed from interview with B4 (Bohill) 19th May 2014.

- Allocation Book – Inadequate skill mix on ward at time of allegations. Skill mix 60% unregistered: 40% registered staff; this was further reduced by registered nurse sick leave. No clear allocation of duties – this was corroborated in subsequent staff interviews. Clear evidence in Duty Allocation Book that the responsibility for the patients at the lower end of Ennis (where incidents were alleged to have taken place) was mostly with unregistered staff.

- Adverse Incidents/ Accident Reports – no evidence of under reporting; all correlated with entries documented in patient notes, daily ward reports and care plans. An increase in incidents was also noted from November 2012 until February 2013 – this correlates with a monitoring rota which was implemented post allegations (Appendix 17). Staff noted in interviews that the monitoring in itself was disruptive to the patients and this may have had a bearing on these statistics.

- Day Care Attendances from Ennis (Appendix 18). This information highlighted a significant number of cancelled Day Care places during the period the alleged incidents took place. These cancellations added additional pressure to a ward that was already short staffed. The attached attendance report also highlights staff shortages in Day Care Services around this time

- Minutes of Resettlement Meetings (Appendix 19)

FINDINGS

This was a complex and lengthy investigation. The Terms of Reference as noted above required the investigating team to look at the whole system i.e. the context of Ennis Ward within the wider Muckamore Abbey Hospital site, the managerial processes on the ward, staffing, practices and individual patient needs. All interviews are attached and conclusions/ findings are summarised under each term of reference as follows:

4. **To investigate the following matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse of patients by staff received from a visiting staff member from Priory Group.**

The allegations listed below are from the Adult Safeguarding Report. For ease and consistency of reference the allegation numbers correspond to their chronological order in the Adult Safeguarding Report. The investigation team noted themes in the allegations and have grouped these in this report.

36. Unnamed Staff (but again described as usually H159) would put P39 P39 's belt on over her clothes, just under her breasts and tie it tight to stop her stripping. B10 , Bohill Staff, said to MAH staff that it looked tight but staff said that P39 would be fine. When B10 took P39 to be changed, she would loosen the belt but again when she came back from her tea break, the belt would be tightened again. (Source: B10 , Bohill Staff)

H159 (Ennis) interviewed. Question 10, Response: "P39 *can display very challenging behaviours. She is obsessed with food, strips off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains.* P39 *knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times."*

How were these behaviours managed at ward level? Response: *"Staff tried to amuse* P39 *with soft balls, toys that sang or played music, this helped her to behave. Staff constantly redressed her.* P39 *'s behaviours usually got worse between lunch and tea time. New or strange staff was informed not to let* P39 *grab your hand as she would nip you or pull you around you had to set boundaries with* P39 *.* P39 *wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity."*

H197 (Ennis) interviewed. Question 19, Response: *"Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity."*

Were these written in the patients care plans? Response: *"Do not know. The nurse in charge was aware of all of these."*

H206 (Ennis) interviewed. Question 11, Response: *"Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged open. A swimsuit was used on* P39 *for dignity as she kept this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and*

P39 *liked to take this off and play with it.* P39 *could take the belt off and was not considered as restrictive practise as other people wear a belt."*

H205 (Ennis) interviewed. Question 10, Response: *"No staff did not need assistance to put the belt on* P39 *she always let you put the belt on her.* P39 *liked her belt and if she did not have one on she would take staff to her room to get one for her.* P39 *s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on."*

H869 (Ennis) interviewed. Question 11, Response: *"Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations. Patient* P43 *has drop attacks and these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair. Patient* P39 *wore a swimsuit and or a vest."*

H203 (Ennis) interviewed. Question 10, Response: *"No you did not need assistance to put a belt on* P39 *as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her."*

B6 (Bohill) interviewed. Question 10, Response: No

B5 (Bohill) interviewed. Question 10, Response: *"I was commencing night duty and* P39 *was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's."*

When asked if she was made aware of how and why this was done she responded: *"I did not say anything as I was not sure if two staff were needed this was the only occasion."*

B7 (Bohill) interviewed. Question 10, Response: *"Cannot remember"*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager)

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

45. Staff would fasten P39 **' (patient) belt as tight as possible to stop her removing her clothes. (Source:** B5 **, Bohill Staff)**

Refer to Allegation Number 36 above.

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

48. H205 early 50's – description of H205 (MAH Staff) and a 2nd staff member (care assistant) in her 20's, small, thin, dark hair down past her shoulders and was different colours all the time (MAH Staff). Think her name began with S. P39 (patient) was making crying noises and care assistant stood up from her chair and put both her hands on P39 's mid back and pushed her away. P39 came back, happened quite a few times, then P39 started taking her trousers down. Care assistant was getting agitated – could tell by the tone of her voice. She said – that's enough – went towards P39 and was trying to get her belt tightened but P39 was moving about. An older care assistant came over and held P39 . P39 had her hands on the arm of the chair and was bent over. Older care assistant held P39 by her hips of top half of the body while the younger care assistant yanked at her belt forcefully pulling it and fastening it. Her belly was all pushed up and hanging over her belt. She looked really uncomfortable. (Source: B5 , Bohill Staff) another belt allegation

Refer to allegation 36

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. It is noteworthy that B5 stated during interview that her query was in relation to why two staff had been required to put on P39 's belt and that nothing untoward had occurred in relation to the tightness of the belt.

The investigating team were unable to substantiate this allegation.

1. H159 – MAH Staff – pulled P39 (patient) from the sofa P39 was sitting on, by the hem of her trousers, onto the floor and was verbally condescending (Source: B2 , Bohill Staff)

H159 interviewed re allegation. H159 stated that at no time did she or did she ever witness staff push or pull P39 by any item of clothing, she has denied this allegation. She confirmed that staff needed to be assertive and due to the noise levels in the environment you had to raise your voice to be heard, she said that at no time did she ever shout at patients.

H197 interviewed re the allegation. She confirmed that staff did not shout but would have used a firm tone with her (P39) when she was about to hit another patient to prevent her continuing with this behaviour, P39 responded to this firmer tone and it would have prevented her from hitting another patient. H197 stated that she had not witnessed staff push or pull P39 by any item of clothing. Staff would have turned P39 away from an area by putting their hands on her shoulders and turning her away.

B7 , B5 and B6 (Bohill) all interviewed and stated that they had not witnessed staff pull P39 by items of clothing or use abusive language to the patients.

H20 H205 , H869 , H203 Band 3 Support Workers within Ennis, H4 H491 Ward Sister of Ennis and H196 Student Nurse on placement in Ennis at this time all interviewed. All staff stated that they had not raised any issues regarding any staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with.

Investigating team unable to interview B2 (Bohill staff), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

8. H197, MAH staff, was being rough with P39 (patient); grabbing the band of her trousers, turning her and pushing her away, pulling her back by the band of her trousers on a few occasions when P39 stumbled. (Source: B2 B2, Bohill Staff)

H197 interviewed re allegation. Question 12, Response: *"No. You would have turned P39 away by placing your hands on her shoulders and moving her that way. You would have moved her to de-escalate her behaviours."*

H159 interviewed re allegation. Question 12, Response: No never

B7, B5, B4 and B6 (Bohill) all interviewed re: this and no issues/ concerns raised by any of these staff.

The following staff; H196, H206, H205, H203 and H869 from Ennis were asked:

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing? Response from all staff was No

Investigating team unable to interview B2 (Bohill) B1 r (Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

10. H197, MAH staff told B2, Bohill Staff that if she continued trying to put P39 's (patient) clothes back on, she would do it all day and advised B2 not to be face on to P39 and to turn her away by the band of her trousers. (Source: B2, Bohill Staff)

Refer to allegation 8

The investigating team concluded that the allegation made by B2 could not be substantiated.

26. Unnamed Staff – rough handling of P39, staff grabbing/ pulling at her when redressing. Mostly just 2 staff (care assistants) doing this. (Source: B5 B5 Bohill Staff)

Refer to allegations 45 and 48

The investigating team concluded that there is no allegation.

2. H159, MAH Staff, spoke in an inappropriate manner such as, 'get out of my way'/you're doing my head in', to patients in general. (Source: B2, Bohill Staff)

H159 interviewed re allegation. She confirmed that staff needed to be assertive and firm to be heard in the noisy and challenging environment but she denied shouting or speaking to any patients in an inappropriate manner.

Other relevant staff interviewed re: this allegation and responses as follows:

H869 interviewed, Question 6, response: *"I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202, P43 and P41 could be very vocal and it could be hard to be heard."*

H206 interviewed, Question 6, response: *No*

H203 interviewed, Question 6, response: *"Not shouting at her, staff may have used a firmer tone if P39 was displaying Challenging Behaviour."*

H196 interviewed, Question 10, response: *No*

H205 interviewed, Question 6, response: *"Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way."*

B7, B5 and B6 staff from the Bohill interviewed and all stated that they had not witnessed staff speak to patients inappropriately or use abusive language.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) H198 (Ennis) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

11. H159, MAH staff, entered the day room where there were two patients, shouting something like 'would you behave, that's enough'. (Source: B2, Bohill Staff)

Refer to allegation 2.

The investigating team concluded that the allegation made by B2 could not be substantiated.

16. H197, MAH Staff, grabbed P39 (patient), threw her on sofa and told her to get out of my f*ing face' (Source: B3 or B4, Bohill Staff)**

Refer to allegations 49 & 52.

Interview with B4 Question 7, Response: *"I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to 'get the fuck out of my face' and heavily pushed her onto the sofa. One of these staff was called H159 and*

description of H159 *the other staff was blond and called* H197 *who was banking that day."*

If yes how were these issues addressed? Response: "*No did not raise these issues with Ennis staff"*

If not why not? Response: "*I did not know these people I was in a new environment. I reported these to my manager* B1 *at the Bohill the next day; this was then reported to* B15 *The next thing the CID came to the Bohill to interview me."*

When questioned B4 confirmed that she has attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September 2012.

H197 interviewed and denied the allegation.

H159 interviewed re: allegation, Question 18, Response: *"Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients."*

B7 B5, B4 and B6 (Bohill) interviewed and no issues/concerns raised d by any of these staff.

H206, H205, H203 and H869 from Ennis were asked:

Have you ever heard staff shout at P39 with a raised voice? Response from all staff was No.

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

In relation to the allegation above, made by B3 or B4 the investigating team concluded that during interview B4 re-stated that this incident had occurred. The investigation team contacted Bohill on the 20th February 2015 @ 4pm to speak to B4 to seek her cooperation to proceed with this allegation. B7 informed the investigation team that B4 had a "*panic attack*" when informed that they wished to speak to her. B7 spoke to B4 and she reported on B4 's behalf that B4 would not take part in any further discussion in relation to the allegations. She refused to speak to the investigation team herself.

The investigation noted that B4 and B3 worked in Ennis during the 7th 8th and 9th October 2012. B4 stated during interview that she had reported this to her manager B1 the following day. The allegations were reported to the hospital on the 8th November 2012. The investigation team contacted the manager of the Bohill, B15; she has confirmed via e mail that these allegations were reported on the 8th November 2012 (Appendix 20)

18. Unnamed MAH Staff said to patients generally 'these girls are here to get rid of you', referring to Bohill Staff. (Source: B3 or B4, Bohill Staff)

B4, B7, B5, and B6 (Bohill) interviewed and raised no issues/ concerns re: this allegation.

H205, H869 H206 H203 (Ennis) interviewed and all staff stated that this type of communication did not happen.

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

19. Unnamed MAH Staff – everyone shouting at P39 (patient) with raised voices usually after day care when she stripped off. (Source: B8, Bohill Staff)

Refer to allegations 1, 2, 11, 16 & 38.

An allegation, taken from the Adult Safeguarding Investigation Report, was made by B2 B2 Bohill staff that H198, Nurse in Charge, had come out of the office in response to increased noise levels and shouted into the day room 'I'm fed up with the lot of you, you're doing my head in'

Investigating team unable to interview B8 (Bohill), B2 (Bohill), B1 B1 (Bohill Manager) or H198 (Ennis), however, H491 (Ennis Ward Sister) interviewed re any concerns raised. Question 3, Response: *"Pre the allegations one staff raised her voice and this was reported by a Band 3 to me. I witnessed this and spoke to the staff member – this was documented and monitored."* H491 reported that this person was a Band 5 Nurse and following reporting, addressing this with the staff member and monitoring, no further incidents of this nature appeared.

The investigating team concluded that the allegation could not be substantiated.

37. H159, MAH Staff – said 'thank God you are taking her, she's a pain/ pest/ hard work', referring to P39 (patient). Not known if this was said within earshot of patients. (Source: B10, Bohill Staff)

B6, B7 and B4 (Bohill) interviewed re: this and no issues/ concerns raised by any of these staff.

B5 (Bohill) interviewed. Question 13, Response: *"Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore."*

No reference was made during any of the interviews that comments between staff were derogatory about patients.

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated.

38. Unnamed staff (described as most staff) – responded to P39 (patient) when she would try to get keys by shouting at her 'don't be…', 'don't push…' no attempt to distract. (Source: B10, Bohill Staff) put with other shouting allegations

Refer to allegations 1, 2, 11, 16 & 38.

Ennis staff H206, H203, H869 and H205 all stated that they never heard staff shout at P39 but a firm tone would be used to distract her from her behaviours.

Bohill staff interviewed B7, B5, B4 and B6 and they did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

51. Comments between staff often derogatory about patients. (Source B4 B4, Bohill staff)

Refer to allegation 16

B4 interviewed re this allegation she stated during interview she had heard one staff use abusive language to a patient however did not raise any concerns about staff often being derogatory about patients.

The investigating team concluded that the allegation could not be substantiated

59. Anyone who spoke to me about P39 was very negative. Source: B8, Bohill Staff, PSNI Interview

Refer to allegation 16 & 51

The Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

61. Some staff raised their voices at P39 asking her to 'stop it' or 'go away'. Source: B8, Bohill Staff

Refer to allegation 16 & 51

The Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

5. H197, MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair (Source: B2, Bohill Staff)

H197 interviewed re allegation. Question 15, Response: *"She P41 has involuntary constant jerking and hits her head off the chair frequently. She becomes agitated at times and this is an indication that she needs an enema. She has Bi-Polar Affective Disorder with associated mood fluctuation and self-injurious behaviours."*

H197 was asked how these behaviours managed at ward level. Response: *"We used the same chair for* P41 *and administered an enema once a week as was prescribed."* Question 16, Response: *"*P41 *has a very unsteady gait and walks on her tip toes, when outside she would use a wheelchair. She positions herself into her chair but her upper and lower body movements would have caused her head to hit the back of the chair."*

H159 [redacted] interviewed re allegation. Question 15, Response: *"Constant jerking movements and throws her head back when agitated. Has a problem with bowel movements which can cause agitation and needs enema to manage this. She can be aggressive can kick out and hit."*

H159 was asked how these behaviours were managed at ward level? Response: *"She loves music. You always worked to the side of her and she needs constant supervision."* Question 16, Response: *"In a wheelchair at times when off the ward. On ward when walking if needed used an elbow block and guided her with your hand on her back. She always settled herself into her chair."*

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients, therefore patients with presenting jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients."

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 that H197, MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair the investigating team concluded that the allegation could not be substantiated

7. H197, MAH Staff, pulled P41 (patient) into a standing position and shoved, nudged and pushed P41 towards her chair. (Source: B2 B2, Bohill Staff)

Refer to allegation 5

H197's statement from interview re: this allegation as follows: *"On the day of this allegation* P41 *went over to* P22 *who was lying on the couch* P41 *jumped up and down on* P22 *. I went over and took* P41 *by her arm and elbow.* P41 *put her legs down on the ground and I walked her to another chair.* B2 *was at the window in the day room and her view of this was restricted as I was between her and* P41 *. I put* P41 *into her chair and she settled herself as described earlier."*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation could not be substantiated

8. H197, MAH staff, was being rough with P39 (patient) grabbing the band of her trousers, turning her and pushing her away, pulling her back by the band of her trousers on a few occasions when P39 stumbled. (Source; B2, Bohill staff, police report)

This was investigated by the PSNI.

During interview H197 denied this allegation

Bohill staff interviewed B7, B5 and B6 and they did not raise any issues regarding this.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, MrsH870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation could not be substantiated

22. Unnamed staff – staff would push P39 (patient) back by putting two hands on her shoulders. This occurred during the process of letting patients in and out of the dining room when P39 would try to push in. (Source, B8, Bohill Staff)

B7 (Bohill) interviewed. Question 7, Response: *"I didn't have concerns when I was there the only thing was the pads which was more of a query than a concern."*

B7 (Bohill) Question 8, Response: *"No I didn't raise anything I had no concerns. I was approached by line manager afterwards post the allegations. I was interviewed regarding the VA process I did not see any abusive practices."*

B5 (Bohill) interviewed re: this and no issues/ concerns raised.

B6 (Bohill) stated that she saw staff push patients away from dining room door although she reported that she wasn't sure if this was right or wrong. She felt that it wasn't abusive although stated that staff did not explain what they were doing and why when they were working with the patients. She stated that she discussed this with her Line Manager the next time they met but was informed that concerns had already been raised about Ennis at this stage. When asked if she would have raised this as a concern had other issues not been raised and she replied *"No I did not think it was abusive practice."*

B4 (Bohill) was asked about her understanding of how the Meal Time routine was managed. Response: *"The patients were taken in small groups, three I think at a time, this was organised.* P39 *was to go in for her meals as she would have over loaded her mouth and it took longer than the others to feed her as she needed help with feeding and drinking."*

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however it is noteworthy that the description of how P39 may have been moved is in keeping with Manual Handling.

23. Unnamed Staff – an unnamed patient was 'more than guided', grasped around the wrist, some force used, wasn't resisting. (Source, B8, Bohill Staff)

B7, B5, B4 and B6 (Bohill) were interviewed re: this and no issues/concerns were raised.

H869 (Ennis) interviewed re: this and described how she would have put her hand on a patients elbow and her other hand on their wrist to move them safely with guidance.

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

24. Unnamed Staff – P39 (patient) put into a chair. P39 sat with legs up. Staff sat with back to her on the same chair. P39 usually kicked staff away to get out of chair. (Source: B9, Bohill Staff)

B7, B5, B4 and B6 (Bohill) all interviewed re: this allegation and reported no issues/ concerns.

Investigating team unable to interview B9 (Bohill) or B1 (Bohill Manager).

The investigating team was unable to identify any staff member or members in relation to this allegation and were therefore unable to substantiate the allegation.

25. Unnamed staff (short, spikey dark hair) – P39 (patient) trying to get into the kitchen – staff firmly put hands on shoulders from behind and moved her away. (Source: B9, Bohill Staff)

Refer to allegation 30

Investigating team unable to interview B9 (Bohill) or B1 (Bohill Manager). Unable to identify who the staff was.

The investigation team were unable to substantiate the allegation however it is noteworthy that the description of how P39 may have been moved is in keeping with Manual Handling.

30. Unnamed Staff – pushing patients away from dining room door rather than say excuse me. (Source: B6, Bohill Staff)

Refer to allegation 22 & 25

B6 (Bohill) stated that she saw staff push patients away from dining room door although she reported that she wasn't sure if this was right or wrong. She felt that it wasn't abusive although stated that staff did not explain what they were doing and why when they were working with the patients. She stated that she discussed this with her Line Manager the next time they met but that concerns had already been raised about Ennis at this stage. When asked if she would have raised this as a concern had other issues not been raised and she replied *"No I did not think it was abusive practice."*

The investigation team concluded that there is no allegation.

54. Clients fed as quickly as possible, brought out again without wiping their faces. Source: B6, Bohill Staff. (worked 11am-11pm on 5/11/17)

Refer to allegation 22, 25, & 30

B6 during interview did not raise this as a concern

The investigation team concluded that there is no allegation

55. Patients crowding at the door – pushed out of the way without speaking to them or saying excuse me.
Source: B6, Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 22, 25, 54 & 30

The investigation team concluded that there is no allegation

32. Unnamed Staff (described as usually long standing staff) pulling/ dragging unnamed patients off sofa. Example given – female patient had just laid down on sofa when a staff member reached for her feet, swung her legs around and reached for her wrist and elbow and pulled her out of the chair with force. (Source: B10, Bohill Staff)

The interviews conducted questioned staff generally on moving interventions employed and observed.

Refer allegation 1.

H197 (Ennis) interviewed. Question 23, Response: "P39 - *we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with* P41 ."

H159 (Ennis) interviewed. Question 22, Response: *"Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients* P39 *and* P41 ."

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step prior to expecting them to stand or be assisted to stand."

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

34. Unnamed staff (but including H159) – would reach for P39 (patient) by the shoulders from behind and pull her backwards into a chair, then staff would sit in front of her to stop her moving. (Source: B10 , Bohill Staff)

Refer to allegation 1 & 32

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

60. Staff would place 2 hands on P39 's shoulders and push her away from trying to get into the drinking room – not forcefully Source: B8 , Bohill Staff.

Refer to allegation 1, 32 & 34

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

3. H159 , MAH Staff, hit P40 (patient). P40 observed coming from the bathroom naked screaming and shouting "I hate her. I hate her, I hate H159 H159 , she hit me". P40 very distressed and blood was coming from her mouth. (Source: B2 , Bohill Staff)

H159 interviewed. Question 8, response: *"the ward was short staffed; I was there on my own. I decided to start self-care earlier than usual straight after tea. I did not change P40 she was in the toilet having a bowel movement and was screaming and yelling. I heard her I did not see her. Student Nurse H196 came to help after 10 mins with the patients self care. I started changing the girls between 6.15pm and 6.30pm and bringing them to the dayroom. At 7pm I finished, locked the bathroom door and commenced the patient's suppers. Patient P43 was soiled so I took her to the bathroom. Student Nurse H1 brought patient P40 to the bathroom, she was naked. B2 came down to the bathroom when I was changing P43 , I asked her to get fresh pyjamas for P40 P40 and then take her back to the dayroom. I did not see blood and I did not complete P40 P40 's oral hygiene that night. No staff had made me aware of anything P40 P40 had said that evening."*

Other relevant staff interviewed re: this allegation and responses as follows:

H196 interviewed. Questions 4, 5 6, 7, and 8:

Question 4, response: *"I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans. I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else."*

Question 5, response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2 's first day. B2 had stated that she had applied for nursing but did not get in. Cannot remember B2 asking for assistance."*

Question 6, response: *"No"*

Question 7 response: "*No I cannot remember*"

Question 8 response: "*No I cannot remember*"

H197 interviewed re: allegation. Question 8, response: *"I was in the day room and then went with the Student Nurse to administer an enema on patient* P41 *.* P40 *was in the day room Student Nurse went to get pyjamas for her. I did not change any patients that evening.* P40 *alleges these things all the time. I do not recall as she says these things all the time."*

H196 called to attend a second interview 2nd June 2014.

Question 1, response: *"I took laundry down to the back area of the ward. I put slippers on a patient."*

Question 2, response: *"I cannot remember the patients' names"*

Question 3, response: *"Yes I did help with bedtime changes but do not remember who"*

Question 4, response: *"Cannot remember"*

H869 interviewed, Question 6, response: *"No never."*

H206 interviewed. Question 5, response: *"Yes* P40 *would say this about other patients never heard her say this about a member of staff."*

How was this addressed? Response: *"If we had not witnessed anything we would have reported this to the Nurse in Charge."*

H203 interviewed. Question 5, response: *"Frequently alleged that other patients had hit her e.g.* P44 *or* P43*!. If she said that* P43 *had hit her then this would be true".* H203 did not think that P40 ever alleged that staff had hit her. When asked how her behaviours were addressed she responded: *"*P40 *would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the Nurse in Charge or another trained staff member that day."*

H205 interviewed. Question 5, response: *"Yes, but about patients only not staff. Heard her say patient* P43 *had hit her but this patient was not in the area at the time she was in the garden area. Patient* P40 *was coming from the bathroom on that occasion.* P40 *would have alleged this a lot." When asked how this behaviour was addressed she responded: "I asked patient were she had been hit and I identified that the patient was not on the ward at the time."*

Sr H491 interviewed. Question 10, response: *"Patients* P197 *and* P40 *make allegations, this should be in their care plan. Patients who strip should have this in their Care plans"*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis). However, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis

H196 ', Student Nurse on Ennis ward at this time was unable to provide any further information regarding this allegation. Staff in Ennis gave varying perceptions as to whether P40 would make allegations regarding staff; H205 , H203 ', H206 and H869 stated they had not heard her say this about staff. Sr H491 stated that P40 would make allegations and that this should have been documented in her care plan. The investigation team examined P40 's care plan and there is reference that she does make allegations but does not state if this is against patients and/or staff.

P40 was referred to the Dentist immediately following this incident and it was noted that she had an abscess in her mouth at the time.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

4. H196, MAH Staff, told P40 (Patient) that she wouldn't get her sweets and lemonade if she didn't put her nightdress on. P40 sitting naked for a period of time. (source: B2, Bohill Staff)

H196 interviewed re allegation and she denied that this had occurred.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

9. H197, MAH staff, told P39 (patient) that if she did not stop stripping, she would not be allowed any lunch.

Source: B2, Bohill staff.

The investigation team were unable to interview B2 or B1 (Bohill Manager)

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

12. H197 and H196, MAH Staff, ignored B2's requests for help with P40 (patient). H196 did then respond. (source: B2 B2 Bohill Staff)

H197 interviewed re: allegation. Question 9, Response: *"I cannot remember I was administering an enema to P41."*

H159 interviewed re: allegation, Question 9, Response: "*No*"

H196 interviewed. Question 5, Response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2's first day. B2 had stated that she had applied for nursing but did not get in. Cannot remember B2 asking for assistance. "*

H197 and H159 gave the investigation team a thorough account of their activities the evening this was alleged to have taken place. If B2 requested staff's assistance H197 and H159 it appears that did not intentionally ignore this request. H197 cannot remember if she was asked but has stated that she was not in a position to leave the patient she was working with and H159 has stated that she did not hear this request. H196 stated she does not remember if B2 asked for assistance and cannot give any further information regarding this.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

13. H197, MAH Staff – told B2, Bohill Staff who had just arrived on ward for the first time that she was going to the toilet and would be back soon. B2 left with patient for approximately 20 minutes, patients became agitated. B2 was assaulted and had no means of obtaining assistance. P39 (patient) had got faeces on her hand and B2 had no means of cleaning this or gaining access to the bathroom and had to sit holding P39's wrist to prevent her from putting her hand near her mouth. When H197 returned, B2 asked if she could change P39. She was given a key. She asked where the pads were kept and was informed they were in a cupboard. P39's clothes had also got soiled. B2 did not know where P39's bedroom was and stood at the door of the bathroom shouting for assistance before help arrived. (Source: B2, Bohill Staff)

H197 interviewed re allegation. Question 9, Response: *"I did not leave B2 for 20 minutes in the day room alone, H870t, relief staff, was in the day room with B2 when I left. When I returned P39 has faeces on her hand B2 took P39 to the toilet and H870 got P39 a change of clothes."*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

In relation to the allegation made by B2 the investigating team have a statement from H870 to substantiate H197 account.

17. H159, MAH Staff, told Bohill Staff they could not bring P43 (patient) in from where she was sitting outside on the wet grass or get her something to sit on. (Source: B3 or B4, Bohill Staff)

B4 confirmed in her interview that this incident had occurred. When asked who the staff was she responded: '*H159 I think was her name."*

When asked who the patient was she stated: '*P39."*

She was asked to describe the clothing the patients had on and responded: '*P39 was wearing a hoodie and Jeans."*

When asked if she made any attempt to bring the patient back in she responded: *"No B3 B3 brough her back in immediately I did not say anything."*

B7, B5, and B6 (Bohill) interviewed. Responses: No issues/ concerns raised by any of these staff.

H159 interviewed re: allegation. Question 13, Response: *"No, P43 likes to be on her own and loves the garden she sits in the same area all the time. P43 was able to get back into the ward by the door but generally staff had to go and get her to bring her back in. P43 would have become agitated or self-injurious if she wanted out to the garden. P43 was only out in the garden if the weather permitted this and was observed by staff. P39 did not go out unless staff were with her she was never put out."*

H197 interviewed re: allegation. Question 18, Response: *"P43 loved out in the garden. All the patients liked this area and used it in the summer. P39 was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there."*

H205 and H869 from Ennis were asked if there was scope for patient engagement in activities apart from day-care. Both staff stated that the garden was used.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. records show that it did not rain on these two days and the moisture content was low.

3. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

49. 9th October 2012 (B3, Bohill Staff also there) H197, MAH Staff (a Bank nurse) and H159, MAH Staff (care assistant). P39 taking her clothes off – H197 got up and grabbed P39, who was wearing a hoodie, at the chest area, said 'get the f* out of my face', and pulled P39 over to the sofa and pushes her onto it. P39 got up again and tried taking her clothes off. She lay on the floor and took her trousers down past her hips. H159 and H197 got out of their chairs and lifted her up, pulled her trousers up, pulled her belt quite forcefully and pulled the belt tightly. H159 and H197 took an arm each and pulled other out of the living room. They walked her to the fire doors, opened them, put P39 outside where it was raining and closed the door (no handle on outside). Then they walked away. (source: B4, Bohill Staff)**

Refer to allegation 13

B4 (Bohill) interviewed. Question 7, Response: "No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called

H159 and description of H159 the other staff was blond and called H197 who was banking that day."

When asked how she addressed what she witnessed she said that she did not raise this with any staff in Ennis. When questioned why she didn't speak to other staff in Ennis about this incident she responded: "I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me."

When asked she confirmed that she had attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September.

She was asked to confirm when she raised this as a concern and how it was addressed and she responded: "I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me."

Both H159 (Ennis) and H197 (Ennis) denied this allegation.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 52 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 , Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The Investigating team unable to interview B3 or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

50. 9th October 2012 – P43 (patient) sitting outside on the grass and was soaking. B4 (Bohill Staff) asked H197 (MAH Staff) and H159 (MAH Staff) would she bring her in. H197 said she was alright where she was and that she had a wet suit if it got any heavier. (source B4 , Bohill Staff)

Refer to Allegation 13

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 , Bohill Manager has clearly stated that she

was made aware of concerns/issues on the 8th November 2012 (Appendix 20) and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview identified one member of staff, H159, placing P39 outside in the rain and in the allegation it states that B4 identified two staff doing this, H159 and H197.

4. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

52. 9th October 2012 8am -8pm. P39 was removing her clothing frequently and needing dressed. A bank nurse got up from her chair and said either "this is doing my head in "or "she is ****ing doing my head in". She grabbed P39 by the clothing at the chest and forcibly pulled her over to a sofa where she pushed her into the sofa. Later on P39 couldn't get her top off so she lay on the floor and was trying to get her trousers off. She had got them down a bit when the bank nurse and a care assistant got up and went over to her. They tied her belt very tightly and lifted her up and marched her to the back door beside the living room, opened it, pushed her out and locked it, leaving her outside by herself. The care assistant described as being in her 50s, really thin. The two staff left and went into the dining room. B3 let P39 back in. Bank nurse described as heavy set, brown or dirty blonde hair styled in a bob, wore glasses, said she was retired and was banking, would say she was in her 60s. (source B3 Bohill staff, worked 8am-8pm on 8/10/12)

Refer to allegation 49.

The Investigating team unable to interview B3 or B1 (Bohill Manager).

In relation to the allegation made by B3 the investigating team concluded that the allegation could not be substantiated and as per allegation 7 there is some evidence to discredit it.

B4 during interviewed stated to the investigation team that she was not happy that B3 had taken off to Australia and that she was left to deal with all of this. She stated that she did not want to be involved and that she had been to her doctor as this was affecting her mental health. B4 stated that she would not be attending the pending court case if she got support from her GP. The investigation team feel that if allegations involving B4 proceed to disciplinary hearing that she will not attend.

Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr Ling no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The investigation team found the anomaly relating to the time of the alleged incident and the confirmed reporting of the incident 4 weeks later to be of significance and passed this information to the PSNI.

53. P43 (patient) would have sat outside by herself without any staff going out with her or checking her. B3 told staff the grass was damp but they told her this was normal. (Source B3, Bohill Staff, worked 8am -8pm on 8/10/12).Refer allegation 14 and 23

Refer to allegation 50

The investigating team is unable to substantiate the allegation

15. H198 MAH Staff, failed to provide induction for B2. Failed to ensure appropriate supervision and care of patients. (source: B2, Bohill Staff)

H198 has retired from MAH since this allegation was made. She declined the opportunity of an interview however she sent a letter to the investigation team on 8th April 2014 - H198 stated in her letter that the person from the Priory (Bohill) commenced duty at approx. 10am on the day of the allegation. H198 stated that she did not give this person an Induction but introduced her to the staff she would be working with and asked them to keep her informed. H198 stated that the ward was extremely busy and that they worked short of staff for the day. This was further compounded by day care sessions being cancelled. H198 has stated in her letter that when she did her hand over to the night staff at the end of the day there was no concerns, issues reported (Appendix 2).

H491 (Ward Sister Ennis) interviewed: Question 5, Response: *"Staff knew through the communication book that they needed induction. Communication book relayed to staff that they had to go through the Hospital Induction Booklet with Bohill staff – Nurse in Charge or the 'back-up' nurse had responsibility to make sure this was allocated and done. This was not identified on an allocation sheet as staff knew to do this. When Bohill staff arrived on the ward I got the impression that these staff were not experienced and that these patients needed a high level of trained staff and the Bohill staff were not trained and had limited experience."* She also stated that the Bohill staff asked to work with patients who weren't identified for their service and that the patients' behaviour changed when the new 'faces' arrived on the ward.

H203 (Ennis) interviewed. Question 11, Response: *"I was informed that the Bohill staff were coming to see certain patients. I was told they could come with us to learn for the first few days and then the Bohill staff were to work with the patients directly. It was felt by the staff in Ennis that the Bohill staff did not want to be there and they did not want the patients that had been identified to go to the Bohill when they seen their behaviours, especially P39. They spent most of their time with patient P202 in the garden area. Some of the Bohill staff came in and sat most of the shift in the day room and did not interact with the patients. Some of the staff from the Bohill did interact with patients and staff."*

H205 (Ennis) interviewed. Question 11, Response: *"When they came onto the ward they were introduced to the staff they were to shadow who worked with the patients identified for the Bohill, these were the only patients they were to shadow us for. Many times they did not work with the identified patients and would be with other patients e.g. P202. The manager of the Bohill arrived on the ward to talk to the staff and they were outside with patient P202, the three of them stayed outside during this time. I worked quite a bit with the Bohill staff and never saw them work with patient P199, who was identified to go there. The Bohill staff did not arrive on the ward until late morning, we would have put back the personal hygiene on the patients going to the Bohill for as long as we could to allow them to work with them but generally the patients would have been at day care by the time they*

arrived. The Bohill staff would then have gone to day care to see the patients there. I cannot remember the Bohill staff being there in the evenings I recall that they usually left about 5.30pm or before this."

H869 (Ennis) interviewed. Question 10, Response: *"The Bohill staff were there to get to know the patients. I saw some of the Bohill staff getting their Induction by the Nurse in Charge. They were shown around the ward, introduced to staff and patients and it appeared to be well done. A few of the Bohill staff worked with me. I would have given them information on the patients. Sometimes it was hard to get them to concentrate on the patients going to the Bohill as* P202 *would have taken up some of their attention. Some of the staff were young and had said they had not worked in an environment like Ennis before. I worked a 1230 to 2300 on the 7.11.12. I worked in the lower end of the ward until 1800 that day and the remainder of my shift I worked with the girls at the upper end of the ward I think I may have been carry out* P198 *'s level 3 observations."*

H206 (Ennis) interviewed. Question 10, Response: *"I was just told Bohill were coming to the ward, no other communication was given to me regarding this. There was no clear guidance given on how to work with the Bohill staff. Bohill staff did not come at the times they were planned to be on the ward. They would have arrived late in the mornings, could have been 10am, by this time the patients identified for the Bohill were already up and dressed and on occasions would have been at day care. Sometimes the staff from the Bohill would have gone to day care at other times they stayed on the ward and interacted with others. They rarely saw patients getting up in the morning getting washed dressed etc. Bohill staff also left early, could have left at 6pm, therefore they did not see the patients getting ready for bed. One staff did a night duty on Ennis she arrived after the patients had received their suppers and medication, approx after 10pm, then left at approx 430am, patients would still have been in bed at this time."*

B1 (Bohill Manager) attended resettlement meetings on ward pre the Bohill staff coming to work on Ennis – it was expected that she would give her staff information on working on Ennis and the patients they would be working with.

B7 (Bohill) interviewed. Question 2, Response: *"We were to work with the patients prior to them coming to the Bohill to find out their daily routine, personal care, care plans etc to add to our own care planning. The first week was information gathering and for the patients to get used to us and us to them, this was to happen over several weeks. There was not much of an Induction we arrived about 7.30am on the Saturday and staff were having a cup of tea in the dining room. We sat at one table and the Ennis staff sat at another table. We were told they were not expecting us until 8am. Me,* B8 *and* B10 *were in Ennis that day. The Nurse in Charge was a big lady I cannot remember her name. We were not given any keys, there was not much chat with the staff and we did not feel very welcome. Erne was a different ward very welcoming"*

B5 (Bohill) interviewed. Question 2, Response: *"We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them. I got a very good induction by Mary she was great."*

B4 (Bohill) interviewed. Question 2, Response: *"I was given limited information from Bohill management on the ladies in Ennis prior to going there. Given limited information on patient* P39 *and the wee lady who likes to carry the cigarette paper. We were told we were going to observe staff managing the patients and to ask questions and then after a few days we were to work with the patients. On the ward the Ward Sister spoke to me and* B3 B3 *re: the patients and introduced us to the patients and staff. We were given a set of keys for the ward. We shadowed staff who were working with the patients. We were given a good Induction and made feel welcome.*

B6 (Bohill) interviewed. Question, Response: "*A young nurse with long blonde hair did my induction. She was very nice and friendly. She showed me around the ward, informed of ward routines, informed me I was there to observe initially, introduced me to the staff and patients and answered any questions I had, she made me feel welcome.*"

Investigating team unable to interview B2 (Bohill) or H198 (Band 5 Staff Nurse Ennis).

The investigation team from reviewing duty rotas for Ennis and Bohill staff can confirm that H198 was the nurse in charge of Ennis on this day, 7th November 2012. H198 has stated in her letter that due to staff shortages that day and day care sessions being cancelled that she did not complete an Induction for the Bohill staff. The investigation team confirmed that the ward was short staffed that day and that day care sessions had been cancelled.

The investigation team is unable to confirm who the nurse in charge was was the day that B7 B7 stated she did not have much of an Induction. On reviewing the duty rotas for the Bohill staff there is no Saturday that the three staff B7 named worked in Ennis together.

In relation to the allegation made above by B2 that H198, MAH Staff, failed to provide induction for B2, the investigating team found enough evidence to uphold this allegation.

20. Unnamed MAH Staff – all staff – when P39 (patient) would take her shoes off, staff threw them away and said they did this to occupy her as she went after them. (Source, B8, Bohill Staff)

B5 (Bohill) interviewed re: any concerns. Question 11, Response: *"I saw this twice in one day by the same staff member.* P39 *was on the floor and was stripping her clothes off. The staff member removed her shoes and set them to the side to divert* P39 *from stripping. This was acceptable for the staff to do this as it was used as a diversion for* P39 *to stop her stripping."*

B6 and B7 (Bohill) interviewed re: concerns in relation to this and none raised.

B4 (Bohill) interviewed and she did not during interview raise any issues regarding staff taking P39's shoes off and throwing them away to occupy her.

H206 (Ennis) interviewed. Question 7, Response: *"No.* P39 *will throw her shoes out the window or throw them across room herself especially if they are new shoes."*

H205 (Ennis) interviewed. Question 7, Response: *"No,* P39 *would take her shoes off herself and bring them to you this was her way of gaining attention. If the shoes were off* P39 *would bring them to staff to put them on. If she had new shoes she frequently took them off and threw them away until she got used to them."*

H869 (Ennis) interviewed. Question 7, Response: *"No,* P39 *liked her shoes, she could take these off. She would have thrown her own clothing and shoes out the window on occasions."*

H203 (Ennis) interviewed. Question 7, Response: No

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that P39 's (patient) shoes were removed by both herself and staff but were unable to find evidence of any abusive practice in relation to this.

47. A care assistant, really thin, short brown hair about 50 – said if P39 (patient) was on the ground, they would throw them across the floor to distract her. (Source: B5 , Bohill Staff)

Refer to Allegation 20

B5 (Bohill) interviewed. Question 11, Response: "I saw this twice in one day by the same staff member. P39 was on the floor and was stripping her clothes off. The staff member removed her shoes and set them to the side to divert P39 from stripping. This *was acceptable for the staff to do this as it was used as a diversion for* P39 *to stop her stripping."*

The Investigating team unable to interview B1 (Bohill Manager).

The investigating team concluded that there is no allegation

61. Staff would sometimes LIFT P39 's shoes and throw them away from her; (Source B8 , Bohill Staff)

Refer to allegation 20 & 47

The investigation team unable to interview B8 or B1 (Bohill)

The investigating team concluded that there is no allegation

29. Unnamed Staff – staff would push P39 (patient) away when she came up and held B6 (Bohill Staff) hand, saying to P39 'leave her alone'. (Source: B6 , Bohill Staff)

B6 (Bohill) interviewed. Question 12, Response: *"Staff said if you take her hand* P39 *will pull you around all the time. Staff knew the patients."*

How did they remove P39 's hand from yours? Response: *"This did not happen. No one took* P39 *'s hand away I allowed her to hold my hand."*

B6 during interview did not raise this as a concern.

The investigating team concluded that this allegation is void.

57. Standing in the day room talking to the younger nurse H206 when P39 approached me and wanted to take my hand. Another patient whose name I don't know was walking up behind P39 . P39 was turned away by H206 but not roughly. Then the night nurse (different staff member) pushed the other patient into the chair without much care causing her to flop on the couch. She said 'sit back down'.
Source: B6 , Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 29

The investigating team concluded that this allegation is void

58. P39 approached me again and took me by the hand and brought me around the ward. The night nurse said that I was rewarding P39 for bad behaviour by letting her bring me round the ward.
P39 was redirected away from me a lot, by the nurse and H206. H206 wasn't rough but the night nurse was pushing at her. She was very abrupt. She is quite a stocky lady so I don't know if she meant to be so rough but she would push them at arm's length abruptly. She was quite tall with reddish brown short hair, in her mid 50's – talked about retiring.
Source: B6, Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 29 & 57

The investigating team concluded that this allegation is void

21. Unnamed MAH Staff- P39 (patient) standing naked in the hallway every morning at 8am when B8, Bohill Staff, arrived on shift. (Source, B8 B8 Bohill Staff)

B7, B5 B4 and B6 (Bohill) interviewed re: this and no issues/concerns raised by any of these staff.

H197, H159 H206 H869 H203 (Ennis) interviewed and all stated that P39 stripped off her clothing frequently and that this was one of her behaviours that needed to be managed.

H491 (Ward Sister Ennis) interviewed in relation to management of behaviours on the ward and she stated that behaviour such as stripping should be documented in the patient's care plan. When asked if strategies to manage behaviours were documented in the care plans she replied: *"Yes it was expected to be. The Ward Manager monitored care plans. If new behaviours occurred I would check the care plan to see if this was documented – if this was not documented I would either add this myself or leave a message for Named Nurse to do this."* She also informed the investigation team that the evaluation sheets were read every day and that care plans were audited by the EQC Resource Nurse who recently offered additional training and support for care plans.

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team reviewed duty rotas for B8 working in Ennis. Records show that she worked on the 1st 2nd 6th and 7th October 2012 from 8am to 8pm.

Due to the reported and documented frequency of stripping behaviour by P39 the investigation team can conclude that this allegation is possible.

56. Took a break from 6.30 – came back at 7pm, all patients in their pyjamas – don't think possible to wash and change all patients in half an hour told bedtime routine started at 7.30pm.
Source: B6, Bohill Staff (worked 11am-11pm on 5/11/17)

B6 (Bohill) interviewed re: this and no issues/concerns raised.

The investigating team concluded that this allegation is void

27. Unnamed Staff – staff were putting 2 pads on at a time on unnamed patients. When B7 , Bohill Staff queried this she was told patients were wetting too much. (Source: B7 , Bohill Staff)

B7 (Bohill) interviewed re: this allegation. Question 16, Response: *"This was not said by a member of staff in Ennis, it was said by a member of staff in Erne I believe when I was talking about it in that ward."* Ms B7 went on to report that when she asked staff about patients wearing 2 pads she was informed that some patients are incontinent and pass large volumes of urine. She informed the investigation team that she had no concerns re: this explanation.

B7 stated clearly during interview that this conversation did not take place in Ennis.

The investigating team concluded that this allegation is void.

28. Unnamed Staff told B7 , Bohill Staff, if you offer too much attention, they will want it all the time. (Source: B7 , Bohill Staff)

B7 (Bohill) interviewed; Question 15, Response: *"This was pertaining to one patient who was not moving to the Bohill. She was singing in the day room one staff said do not give too much attention to this. This was not a concern."*

B7 during interview did not raise this as a concern.

The investigating team concluded that this allegation is void.

31. Unnamed Staff – 2/3 staff were putting a delivery away and patients were in the day room unsupervised – 2 patients emptied out all the laundry bags. Staff came in and shouted aggressively 'who did this?' staff then made an assumption as to who it was and told other staff angrily '..... did this'. (Source: B6 , Bohill Staff)

B6 (Bohill) interviewed. Question 14, Response: *"I was coming out of the office walking towards the bottom of the ward. I was not in the room I did not see the patient I only heard."*

Who were the two patients? Response: *"Don't know"*

Who were the members of staff? Response: *"Don't know, I didn't see."*

What did the other staff in Ennis do when a staff member made the assumption that a patient had done this? Response: *"I was walking towards bottom of ward when I heard this I couldn't see."*

What did you do when you heard staff shout aggressively at patients? Response: *"I walked on past."*

B6 informed the investigation team that she did not report this alleged incident to anyone at the time. Her statement to the investigation team that she did not see either staff or patients involved is contradictory to the detail in the original allegation.

The investigating team is unable to substantiate the allegation.

33. Unnamed staff member (described as a care assistant, having short, dark, spikey hair, aged in her 40's, average weight) – P44 (patient) didn't get up for tea as she said she had a sore head – staff member said if your head is sore you won't want your dinner and scraped it into the bin. P44 asked for a tablet for her headache, staff said she wasn't allowed one as she hadn't eaten her dinner. (Source: B10, Bohill Staff)

Below information taken from the Adult Safeguarding Investigation

Interview with P44 (held on11/1/13)
P44 was interviewed in relation to allegations made that a member of staff said to her "If your head is sore you won't want your dinner "and scraped it into the bin. P44 asked for a headache tablet, staff said she wasn't allowed one as she hadn't eaten her dinner.

The use of direct and closed questions was required during the interview as per the advice of Rosalind Kyle (Speech and Language Therapist) who advised on P44's communication needs.

P44 did relate an incident when her dinner was scraped into a bin by a staff member. P44 said this was because she didn't like the dinner and refused to eat it. P44 reported that she was refused a sandwich as an alternative.

It is believed that her dinner was scraped into the bin. However it is unclear what the context was or whether this was an appropriate response from staff.

At no point during interview did P44 report that she had a headache at this time.
She was unable to identify any staff member.

Investigating team unable to identify who the staff member was. Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team is unable to substantiate the allegation

35. Unnamed staff (but described as H159 usually) – would stretch P39 P39's (patient) T-shirt between her legs and tie it in place. (Source: B10, Bohill Staff)

H159 (Ennis) interviewed. Question 17, Response: Never

H197 (Ennis) interviewed: Question 17, Response: No

H206 H [redacted] and H203 (Ennis) interviewed. Question 9, Response: No

H869 (Ennis) interviewed. Question 9, Response: *"No some of the patients wore vests with poppers at the bottom."*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

39. H159 – very set in routines – e.g. P39 gets changes at these times only – no need to take her now. (Source: B10, Bohill Staff)

Bohill staff interviewed B7, B5, B4 and B6 did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

41. Unnamed Staff – lack of induction, orientation and information sharing for Bohill Staff. (Source: 6 Bohill Staff)

Refer to Allegation Number 15

The investigation team is able to uphold the allegation in relation to H198 as it has been identified that she did not give B2 an Induction and it would indicate that B7 received a poor induction also.

42. Unnamed Staff – lack of staff engagement/ interaction with patients. (Source: 5 Bohill Staff)

B7 (Bohill) interviewed: Question 17, Response: *"Ennis staff spoke to each other there was not much interaction between patients and staff. The music channel was on the staff were busy there was a lot going on there were patterns of routine there may have been more time in the afternoon for staff to interact with patients."* B7 also reported that the Ward was very un-stimulating.

B5 (Bohill) interviewed. Question 15, Response: *"Staff were good. Patients were not left sitting staff interacted with them. Staff were very calm and made an effort."*

B4 (Bohill) interviewed. Question 14, Response: *"Staff spoke to the patients but there was not a lot of interaction as the staff were very busy on the ward. I did not witness any ward activities. I mainly shadowed staff working with P39. She was hard to work with re: her stripping, grabbing and attention seeking behaviours."*

B6 (Bohill) interviewed. Question 17, Response: *"Staff were a bit abrupt but not all of them. Got the impression that they did not have much time for them. Staff on this day may have been having a bad day. Lunch time was stressful for staff on this day patients meals appeared rushed. I helped with feeding patients, changing patients. I got a couple of patients changed and helped staff out when I could. The ward was busy."*

H159, H197, H206, H205 and H869 (Ennis) all stated that the ward was short of staff and they worked as a team to meet the needs of the patients. Some have said that there was stress on the ward due to the workload especially in the mornings but everyone worked together.

H203 (Ennis) interviewed. Response: *"The atmosphere on the ward was awful due to staff shortages; ward was always working short staffed, staff were stressed due to this. In the lower end of the ward it was the same routine day after day. The atmosphere between*

staff was good we worked really well together and everyone got on with the work. Staff helped each other out and pulled together as a team."

The Investigating team unable to interview B1 (Bohill Manager).

The investigation team concluded that Ennis was short staffed and the team were under pressure to complete care tasks. This would appear to be more evident in the morning shift when staff demands were at their highest.

The investigation team concluded that due to demanding care needs, low staffing levels, cancelled day care and reported staff stress that a lack of staff engagement/ interaction with patients was very likely. The allegation is therefore upheld.

43. Unnamed Staff – lack of adequate staffing, patients left unsupervised. (Source: 4 Bohill Staff)

It is evident from all the interviews completed and from looking at staffing resources that the ward was short staffed.

The Investigating team unable to interview B1 (Bohill Manager).

The investigation team concluded that this allegation can be upheld.

44. Unnamed Staff – atmosphere/ culture on ward described as dull, unstimulating, institutionalised, dark, gloomy, lacking in warmth etc. (Source: 6 Bohill Staff)

B7 (Bohill) interviewed. Question 19, Response: *"The ward was segregated; the dining room was the focus of the ward. There was two sides to Ennis the doors between each side was locked. The lower end of the ward was quite dark but this was the design of the building and the décor was very plain it was an institutional building. The staff spoke away and got on well together."*

B5 (Bohill) interviewed. Question 17, Response: *"The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff."*

B4 (Bohill) interviewed. Question 14, Response: *"The ward was very busy. Atmosphere was quite dull the ward décor was outdated with not much colour. Atmosphere between staff was quite good; they got on with their work. The ward staff were stretched, staff were busy and the patients had many needs which was tough on the staff. 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat."*

B6 (Bohill) interviewed. Question 19, Response: *"Décor and age of the place did not help and it was not homely. Staff did not speak to each other very much. Seemed to be a clique of staff on the ward. Did not feel that I could join them at breaks etc or join in on the conversations. Felt staff were a bit stressed out for no reason. This was on both my shifts."*

H197 (Ennis) interviewed. Question 24, Response: *"The ward was good to work in. The staff all worked as part of a team and were helpful to each other. There was no stress on the ward; all staff helped each other to address the staff shortages on the ward. Everyone*

helped each other. The patients were in a small area and they all had Challenging Behaviour."

When asked about the environment H197 responded: *"The environment on the ward was too small for the number of patients and their challenging behaviours. Day care was cancelled regularly for the patients in Ennis as the day care staff were used to cover the shortfalls of staff on the wards within Muckamore Abbey Hospital."*

H159 (Ennis) interviewed. Question 24, Response: *"The ward was very busy but we all worked well as a team and helped each other out, you looked out for each other. There was stress on the ward especially in the mornings as the workload was greater at this time and there were staff shortages."*

H196 (Ennis) interviewed. Question 14, Response: *"Cannot comment as duration on ward was short. Cannot remember."*

H205 (Ennis) interviewed. Question 17, Response: *"Stressful due to staffing levels and the additional work with the Bohill staff. This put pressure on staff as the patients behaviours increased as they were not familiar with these staff. Some of the Bohill staff appeared very inexperienced. The staff team in Ennis all worked together. We were under pressure and stress due to staffing levels on the ward and we did the best we could. Our main priority was the care of the patients."*

When H869 (Ennis) was asked if she would like to highlight anything during interview that may be beneficial to the investigation she responded: *"I always found it a good team we were short staffed but we got on with our work. I was not stressed re this. I have worked with these girls (patients) so long and I am really attached to them that if I thought anyone hurt them I would speak up immediately I would not hide anything."*

H203 (Ennis) interviewed. Question 17, Response: *"The atmosphere on the ward was awful due to staff shortages; ward was always working short staffed, staff were stressed due to this. In the lower end of the ward it was the same routine day after day. The atmosphere between staff was good we worked really well together and everyone got on with the work. Staff helped each other out and pulled together as a team."*

H206 (Ennis) interviewed. Question 16, Response: *"Ennis is a good ward with good staff team. The ward worked short staffed but that became the normal and we got on with it. The staff shortages did annoy some staff."*

H491 interviewed re: the ward environment and any changes made to the ward environment and responded as follows:

Feb 09 – created activity room for beauty activity
Aug 09 – requested storage for kitchen – did not do this initially but then did. Requested re-decoration and 3 new shower rooms. **Bathroom on ward was changed to create staff toilet and locker room**
Aug 09 – ordered new blinds
Jan 10 – there was an extra medication cupboard put up Jan 10 – Snozelum Room created and swing
Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get
Jan 11 - New flooring requested – same replaced June 11 – re-painting of ward June 11 – **activity room turned into a second office** – this was good for observation – other office doubled up as a visitors' room and office – one staff did not like this but I felt this was improvement for patients and staff Ward was over-crowded

The Investigating team unable to interview B1 (Bohill Manager).

The investigation team acknowledge that the Bohill staff were coming from a newly built, bright, spacious, physical environment in contrast to an older style hospital ward.

The investigation team concluded that at the time of the allegation that the ward environment was un-stimulating and not conducive to easily managing challenging behaviours. Generally a good atmosphere was reported between staff in spite of this.

46. Nothing in P39 's care plan to tell anyone how to manage stripping behaviour and no instruction from staff on how to manage it. (Source: B5 B5 Bohill Staff)

B5 (Bohill) interviewed. Question 5, Response: *"Yes I was on night duty one night and read the care plans. They gave good detail and insight into the patients. Staff were really informative. Staff kept me updated as we went along and worked with the patients."*

The Investigating team unable to interview B1 (Bohill Manager).

The investigating team concluded that there is no allegation.

63. Ennis Ward a horrible place-based on 20 years care experience. (source B8 B8 Bohill Staff)

Refer allegation 22

The Investigating team unable to interview B8 or B1 (Bohill Manager)

The investigation team acknowledge that the Bohill staff were coming from a newly built, bright, spacious, physical environment in contrast to an older style hospital ward.

The investigation team concluded that at the time of the allegation that the ward environment was un-stimulating and not conducive to easily managing challenging behaviours. Generally a good atmosphere was reported between staff in spite of this.

6. H197 , MAH staff, said to P22 (patient) when P41 (patient) had attacked her "not to be a big softie and hit her back," (Source B2 B2 Bohill staff)

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 (Appendix 3) stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

This was investigated separately and a conclusion was reached, it was therefore not re-investigated.

14. H198, MAH staff, came out of the office in response to increased noise levels and shouted into the dayroom, "I'm fed up with the lot of you, you're doing my head in."

This was investigated separately and a conclusion was reached from this investigation

40. H198 – grabbed P42 by the scruff of her neck and took her to her bedroom

This was investigated separately and a conclusion was reached, it was therefore not re-investigated.

5. Limitations of Investigation Process

The investigation team would acknowledge that this investigation has had its limitations. The allegations were reported on the 8th November 2012 and immediately following this there was an Adult Safeguarding Investigation in joint protocol with the PSNI investigation. The Internal Investigation Team used the Adult Safeguarding Report as a frame of reference and with the exception of the recommendations to discipline 2 named staff, the general outcomes, conclusions and recommendations where similar. The Internal Investigation Team met with the Senior Officer leading the Adult Safeguarding Investigation in June 2015 to discuss these differing conclusions and acknowledged that some evidence given to the Adult Safeguarding Team from Bohill staff in December 2012 differed from evidence given to the Internal Investigation Team when they were re-interviewed in June 2014. The Adult Safeguarding Team also had access to interview 2 key witnesses one of whom declined to be interviewed by the Internal Investigation Team and the other was not contactable. The Internal Investigation Team also was able to interview staff directly involved in the allegations that weren't accessible to the Adult Safeguarding Team. The Senior Officer acknowledged this but re-stated that the recommendations to discipline 2 named staff remain valid.

This internal investigation commenced in September 2013 and was concluded in February 2015. The duration of the internal investigation was delayed due to a number of factors:

Reviewing patients notes, staff duties, accident and incident forms

Gaining access to the allegations

Gaining access to all parties' statements - the investigation team were unable to view the statements taken by the PSNI from Ennis and Bohill staff

Engaging staff in the investigation process

Some relevant staff who worked in Ennis in November 2012 have since left the service and the investigation team had to make proactive attempts to engage them in interviews

Interviews being cancelled and rescheduled at short notice

Staff who worked in the Bohill in November 2012 having left the service and the investigation team making proactive attempts to engage them in interviews – the Team Leader B1

cancelling appointment for interview on day they were scheduled to take place on three occasions.

To investigate that managerial process, had been adequately managed in a safe manner concerning the day to day running of staff rosters, the daily activities of the ward and the environment requirements, prior to the Vulnerable Adults Investigation.

6. Induction processes

There is disparity between Bohill staff and MAH staff about the level of induction that was provided to Bohill staff. Allegation number 12 was upheld by the investigation team and it is thought that the same Band 5 Nurse (H198) was responsible for B7 's statement of a poor induction.

The ward staff on Ennis all gave good accounts of what their expectations were of the Bohill staff and this had been communicated to them, however, Sr H491 had instructed the staff in Ennis to induct Bohill staff using the Hospital Induction book which requires to be completed over a period of 5 days. This proved difficult for staff to complete as Bohill staff only worked 3 days maximum and were not always there as per rota i.e. different staff names/sickness/changed.

The ward communication book was used to communicate induction requirements to staff and staff were familiar with this process, this was then recorded using the ward diary for each day of induction. Pen pictures and care plans were shared with the Bohill staff. Ennis staff had visited Bohill and the Bohill Team Leader, B1 , attended resettlement meetings and was given information about the individual patients.

Band 8A staff report that they were in contact with the Bohill Team Leader over this period and the feedback was very positive, no issues/concerns were raised or identified. Ennis staff reported that some Bohill staff were not working with the patients transitioning choosing to spend time with other patients.

On examining staff records it is clearly recorded that staff on Ennis have received an Induction when they commenced work on the ward using the hospital induction booklet. The information elicited during interview highlighted that the quality of the induction received by Bohill staff was dependent on the member of registered staff completing this.

7. Training

The investigation team reviewed staff training records within Ennis. The majority of staff in Ennis have completed their mandatory training to include Management of Actual or Potential Aggression. Not all staff had attended their Adult Safeguarding training on the ward. There is evidence of continuing development and training for registered staff to provide a skilled and highly motivated workforce, the ward sister highlighted that additional training had been sought for registered staff on care planning.

Health Care Support Workers had no formal training on how to support people with behaviours that challenge and little or no other training outside of the required Trust Mandatory Training. The ward sister had completed the Trust Leadership programme which addresses the needs of good clinical and managerial leadership.

All staff on Ennis interviewed had a good understanding of their personal accountability. The Health Care Support Workers had limited understanding of the legislation as most viewed the use of the belt on one patient as not being a restrictive practice.

The investigation team noted that prior to the allegation Ennis was a nursing practice placement for student nurses. No students have raised any concerns within this placement and the ward is audited at regular intervals by Queens University as a suitable learning environment; last audit was in September 2012.

8. Staffing (numbers, attitudes, team working, morale)

It is evident from this investigation that there were significant staffing deficits on Ennis ward prior to the allegations. Sr H491 had reported her concerns about staffing to Senior Nurse Manager C Stewart and B Mills and had completed incident forms on the 18/9/12 and 23/10/12 regarding staffing deficits on the ward.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports correlate with this.

The Senior Nurse Manager with responsibility for Ennis, Mr C Stewart, was interviewed by the investigation team. During interview Mr Stewart stated he was responsible for Erne, Ennis, Moylena, Iveagh and Night Staff plus he had input to Forrest Lodge during this period. He works eighteen and half hours per week. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on the Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. He reported to the investigation team that Iveagh at this time was his main concern and priority as it also had staffing shortages and given the location of this service, i.e. being geographically isolated from the main MAH site, it was difficult to staff as resources within the hospital were already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch, Dr Milliken, Dr O'Kane, Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital. A meeting with Sr H491 Mrs McLarnon and Mr Stewart was held the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. The majority of bank shifts used to cover the shortfalls within Ennis were booked directly by staff within Ennis and this resulted in staff time being taken up to cover these shifts.

Ward reports prior to the allegations were fairly static. When unfamiliar staff came onto the ward to work towards resettlement of patients, it was highlighted to Mr Stewart by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings etc.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced observations was included in the staffing ratio. Ennis had two enhanced level of observations so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and Mr Stewart.

Staff from Ennis who were interviewed stated that the staff team worked short staffed but they all worked together to help each other. Some staff stated that there they were stressed due to the shortage of staff. No staff raised any concerns or issues regarding attitudes, or morale, all staff stated they worked as a team.

Staff from the Bohill who were interviewed clearly stated the ward was shorted staff. Some said the staff were friendly and made them fell welcome; one said there was a clique on the ward and one said she was not made feel welcome, however, later in interview at a different question said staff spoke away and got on well together. One said staff in Ennis were 'lovely'. She stated the following in interview: "*The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff.*" Another staff said 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

The investigation team concluded that the staffing levels impacted on the ward regarding the safety and quality of the care to the patients. The investigation team did not feel that there was a culture of poor attitude within the ward environment, however, the reduced staffing levels, challenging behaviours described and restricted ward environment would most probably have impacted on morale without the staff within the team realising this.

9. Supervision

Staff within Ennis all stated they had their Personal Contribution Plan and Appraisal completed. They all stated that they had no concerns/issues on the ward and the investigation team felt confident that the staff felt safe and comfortable to raise anything they thought was wrong. While some staff in Ennis had not completed their Safeguarding training staff were clear in their roles and responsibilities as they stated they reported behaviours etc. to the nurse in charge.

Sr H491 stated during interview that when Fairview staff came to the ward in 2010 KSF supervision was a new process for them and attempting to implement this within a busy, short-staffed ward was difficult.

Mr H377 Senior Nurse Manager, stated during interview that copies of team meetings were forwarded to him on a two to three monthly basis and that he was satisfied that Supervision and Appraisal processes were in place and occurred on a regular basis.

Families and other visitors were allowed access to the ward or individual patients' bedrooms. This meant there was opportunity for outsiders to observe daily living in the ward and limited the opportunity for a closed culture to develop on the ward, the ward was open and transparent.

The investigation team concluded from the evidence provided that staff had supervision and annual appraisals completed.

10. The Environment (Physical and General Atmosphere)

The ward as described by all staff interviewed was divided into two parts; the upper end of the ward where the patients who were more independent lived and the lower end of the ward were the patients (11) who were more dependant lived; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed (2010). These patients'

behaviours were challenging in that they stripped, pushed/shoved etc. It was in the lower end of the ward where all the incidents were alleged to have taken place.

The upper end of the ward was described by all staff as brighter with lighter paint work. It had artwork and the windows were draped. Each patient had their own individual personal items on display. One patient had a double room that had been converted into her own personal space with a settee and TV and this patient refers to this as her apartment. The lower end of the ward was darker in paint work, had no personal items on display, windows are not draped and many of the patients are in one room.

Physical changes had been made to the ward over the previous few years by Sr H491 these included:

Feb 09 – activity room created for beauty activity

Aug 09 – storage for kitchen. Re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – New blinds

Jan 10 – Additional medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office, this was good for observation – other office doubled up as a visitors' room and office.

Staff on Ennis who were interviewed stated that they were informed of the changes but were not consulted. The investigation team were informed by all staff interviewed that the activity room being converted into an office had impact as it was missed by the patients and staff who previously could utilise this room to separate patients and do activities that helped to manage behaviours e.g. hair, nails etc.

A Bathroom was converted to a staff toilet and locker room and this also had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them and staff additional distress.

The investigation team concluded that the wards physical environment did not meet the needs of the patients; the lower end of the ward was over-crowded; there was limited room available for the patients and the behaviours they displayed. The conversion of the activity room resulted in patients being confined to one room in the lower end of the ward further impacting on behaviours.

The investigation team note that the ward was due to close in 2012 with the resettlement agenda therefore no major work was being commissioned for this ward.

11. Resources

The investigation team noted from interview with Mr Stewart that the resettlement wards, Ennis being one of them, do not have the same service delivered by Patient and Client Support Services (PCSS) as wards within the CORE Hospital do. Nursing staff on the resettlement wards still maintain the responsibility of bed making and laundry whereas in the CORE wards this is completed by PCSS staff. There were also limited resources from psychology Adult Behaviour Services (ABS) as these services were concentrated on the Core Hospital.

The investigation team spoke to ABS and their manager Mr Mills they stated that all referrals are forward to Mr Mills and that these are allocated to a member of the Behaviour Team, each behaviour nurse will then prioritise each case. In most case prioritising is based on the intensity of the behaviour presented i.e. high level of restrictive practice used i.e. Seclusion, Physical intervention and PRN medication. ABS confirmed that they had not received any referrals for P39 P40 or P43 pre the allegations.

Sr H491 stated during interview that patients from the Core Hospital who came to Ennis had Support Plans but that the other patients on Ennis did not have these and that they wouldn't be requested unless there was a significant change in a patient's behaviour. She stated that LD nurses are trained in behaviour and how to manage this and that generally challenging behaviours are managed by activities, however, she acknowledged that scope for activity was reduced due to low staffing levels.

The investigation team concluded that referrals for the behaviours described by the staff in Ennis should have been referred to Adult Behaviour Services.

12. Reporting processes

P39 , P43 P40 and P41 's care plans were reviewed; Roper, Logan and Tierney was the model used. The named nurse and associate nurse were identified and evidence of person-centred care including personal care needs, protection plans recorded, body charts completed, daily entries by registered nurses, multidisciplinary meetings/Community Integration meetings and entries in relation to accident and incident forms, Adult Safeguarding and Physical Intervention. There was evidence of multidisciplinary team working. The investigation team found that there was a description of the types of behaviour that patients displayed recorded in the care plans there was little detail in strategies for staff to manage or de-escalate these behaviours.

A record of physical interventions employed within the ward was reviewed, September 2012, October 2012 and November 2012, however, none of these was with any of the patients identified in the allegations.

The number of safeguarding incidents was reviewed by the investigation team from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of referrals from an average of 3.57 for the period April 2012 to October 2012 to an average of 22.4 for November 2012 to March 2013 (Appendix 23). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

Review of Incidents/Accidents in Ennis was reviewed from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of incidents from

an average of 7.57 for the period April 2012 to October 2012 to an average of 30.6 for November 2012 to March 2013 (Appendix 17). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

There was evidence on the ward of information sharing via the ward communication book and care plans in relation to visitors/carers/advocates, patient's requests and staffing levels.

Monitoring of the ward took place post the allegations; this was over a 24 hour period. This allowed for observation of staff interacting with the patients and practices on the ward. This supportive process gave a clear picture of what was happening on the ward and formed part of the reporting of risk management up through its governance. The investigation team noted on reviewing these monitoring forms that supervision and observations for patients were maintained. An area highlighted for concern was the ward environment i.e. overcrowding, décor.

Prior to the allegations there was an incident reported in May 2012 when a day-care staff reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. This incident was investigated by the police who did not take any further action. Senior management undertook a full investigation and concluded that there was a case to answer, recommendations were sent to Human Resources but the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA. This demonstrates that Ennis had accountability and governance in place.

In summary the investigation team noted a number of themes that, not individually, but collectively created a situation on Ennis Ward that created vulnerability for both the patients and the staff:

1. Reduced staffing levels across the entire service
2. Ennis' status as a Resettlement Ward – reduced support from PCSS as opposed to the wards in the CORE Hospital.
3. A cramped and dark environment in the lower end of the ward
4. Environmental changes being agreed that had a negative effect on patients and the staff managing the patients
5. Poor skill mix on the ward – i.e. staff working in the lower end of the ward were mostly unregistered staff
6. Poorly documented evidence based practice for managing/ de-escalating identified challenging behaviours
7. Lack of communication to and training of unregistered staff in understanding and being able to articulate the strategies that they were using to manage challenging behaviours
8. Lack of knowledge generally within the ward staff re: legislation around restrictive practices and their implications

The allegations as noted in this report were thoroughly investigated but in the majority of cases the investigating team were unable to substantiate these. During this internal

investigation however, a number of statements given by Bohill staff and interpreted as 'incidences' were subsequently refuted by the staff; these are the allegations classed as 'void'. One allegation was strongly re-iterated by B4 (Bohill) during interview in relation to H197 (Allegation 16) however, during interview B4 informed the investigation team that she was not happy that B3 had *"taken off to Australia"* and that she was *"left to deal with all of this."* She stated that she did not want to be involved in this case and that she had been to her GP as this was affecting her mental health. B4 B4 stated that she had hoped to be exempt from attending the pending court case with support from her GP but she was informed that this was not permissible and could result in legal action being taken against her. The investigation team do not anticipate the attendance or co-operation of B4 if the allegation she has made were to proceed to disciplinary hearing. Of note, the investigation team found evidence to discredit other allegations made by B4 . The Senior Officer who led the Adult Safeguarding Report states that the recommendations made to discipline both H197 and H159 remain valid.

13. Recommendations

In view of the findings elicited through this process the investigation team recommend the following:

- An overview of this Report should be shared with all the staff involved. During interviews staff reported that they found the process of investigation immediately post allegations to be covert and unsupportive and for some this has had a lasting and negative impact.
- Immediate training for all staff on the legislation and use of restrictive practice
- Refresher training for all staff on manual handling techniques
- All care plans to be updated to include strategies for managing behaviours
- Mechanisms within the ward to be introduced to ensure all staff – registered and unregistered - understand and can articulate practices/ techniques employed to respond to patients needs e.g. MAPA, Manual Handling techniques, restrictive practices, diversionary techniques, de-escalating techniques
- A review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present
- Increased supervision for LMcC and support re: roistering to ensure good skill mix and support for all staff
- Future stringent review and justification of any environmental changes on wards
- All staff to be made aware of Here4U and Staffcare services available to them for extra emotional support if needed.
- Adult Safeguarding Team to consider NMC referral for B1 , Manager of Bohill at time of allegations to investigate non-reporting of incidents alleged to have taken place on Ennis on 9th October 2012.

14. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

Mental Health and Learning Disability

Date_____

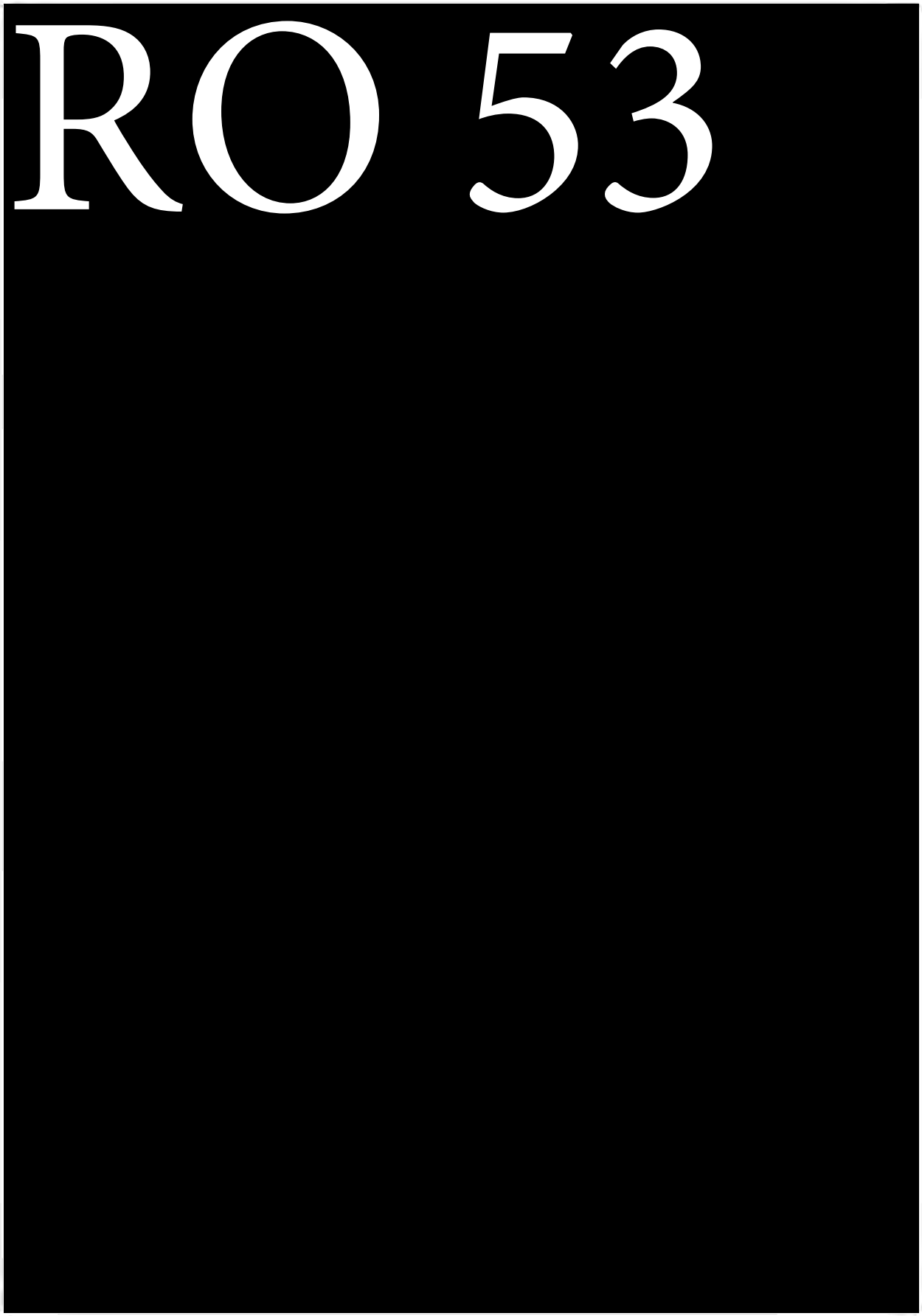
1.COURTS

Appendix 1

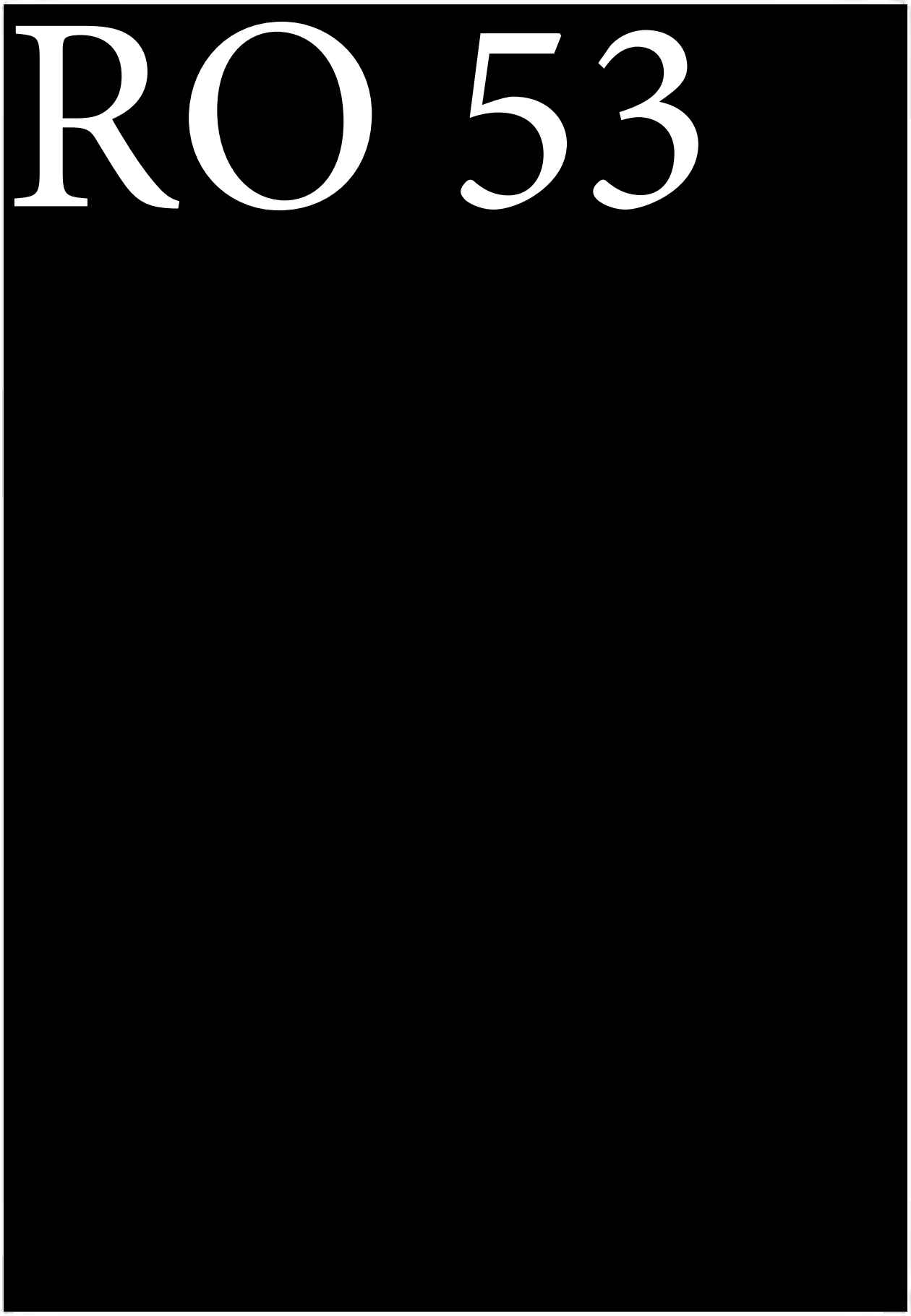
Summary of Allegations under Investigation

[redacted]

RO 53


RO 53


RO 53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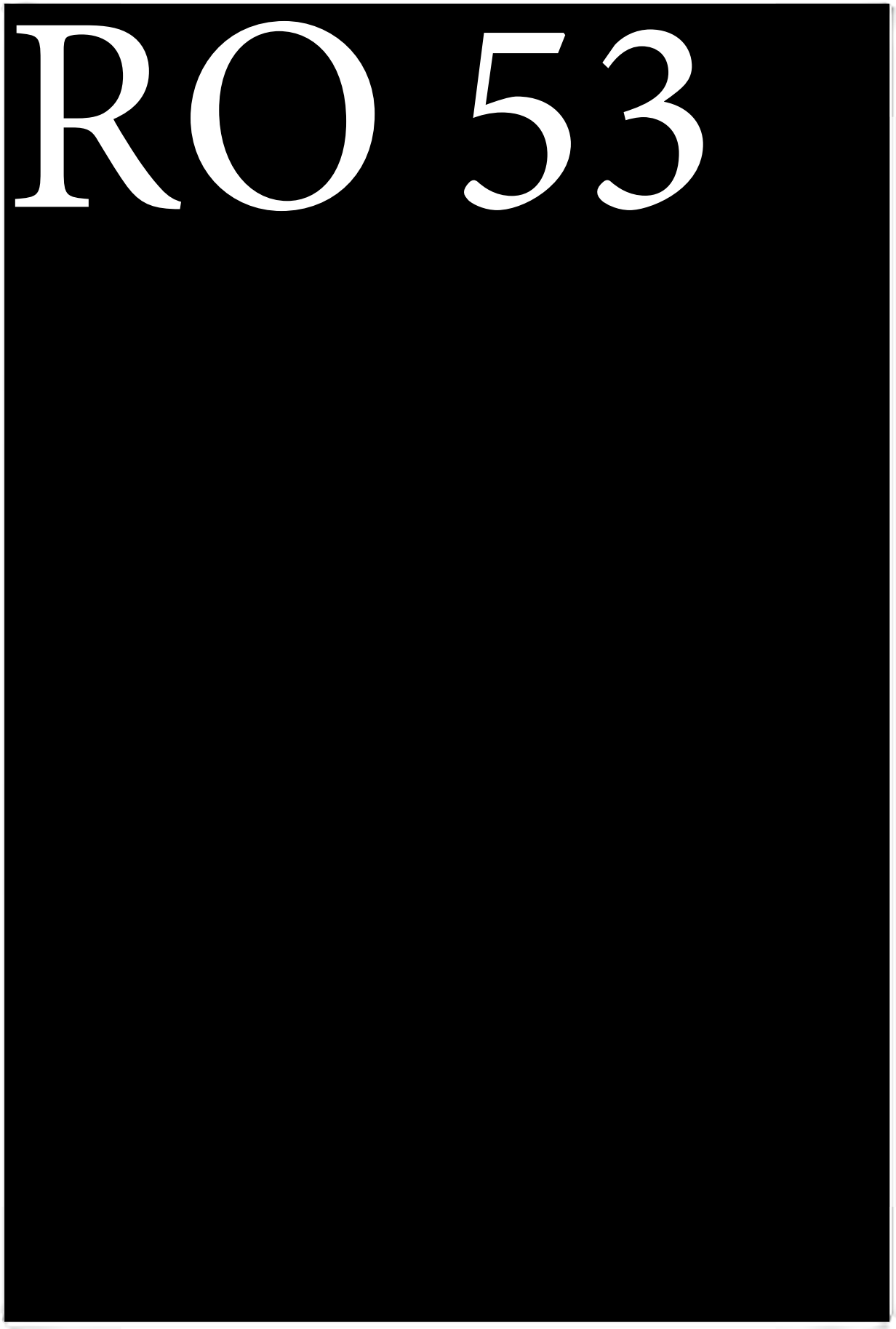
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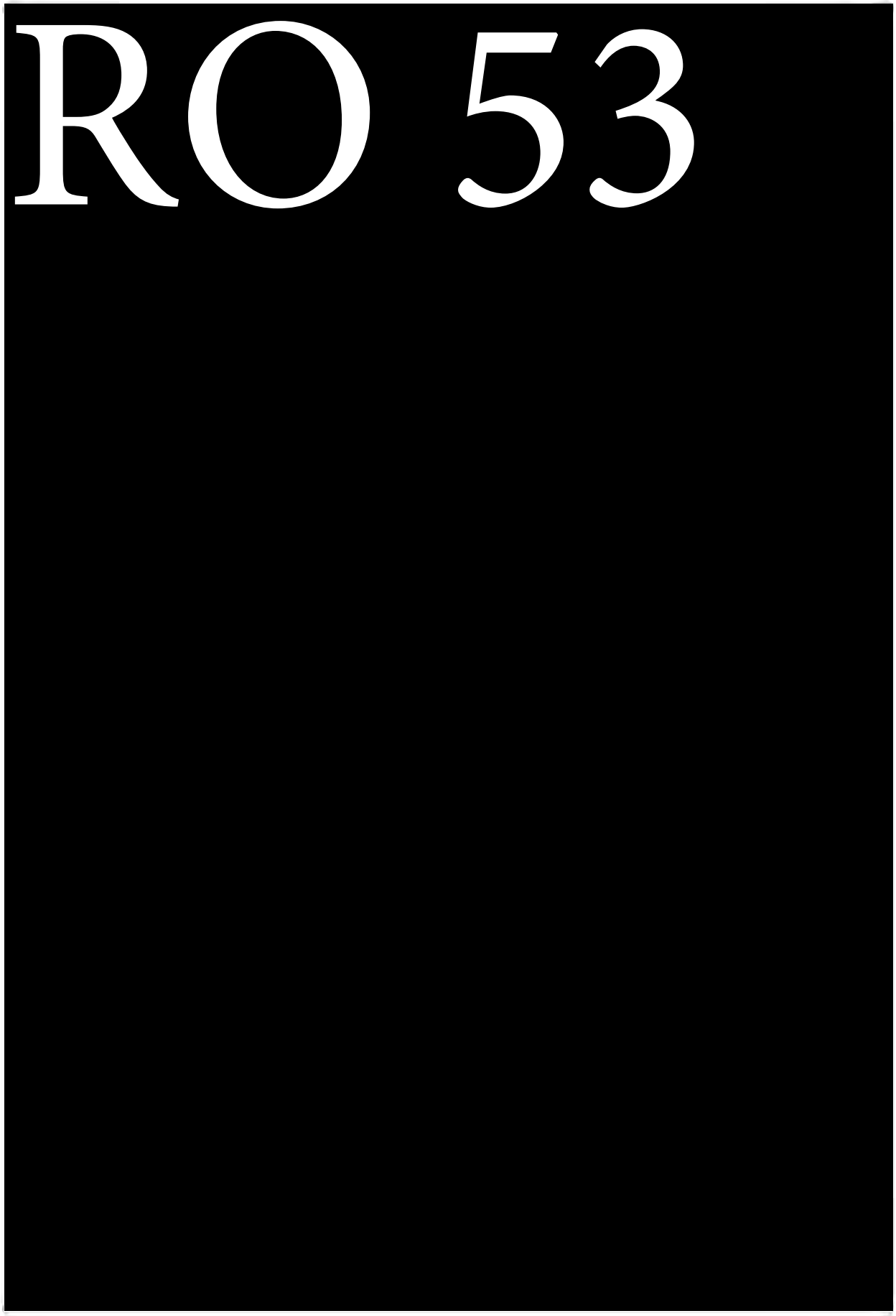
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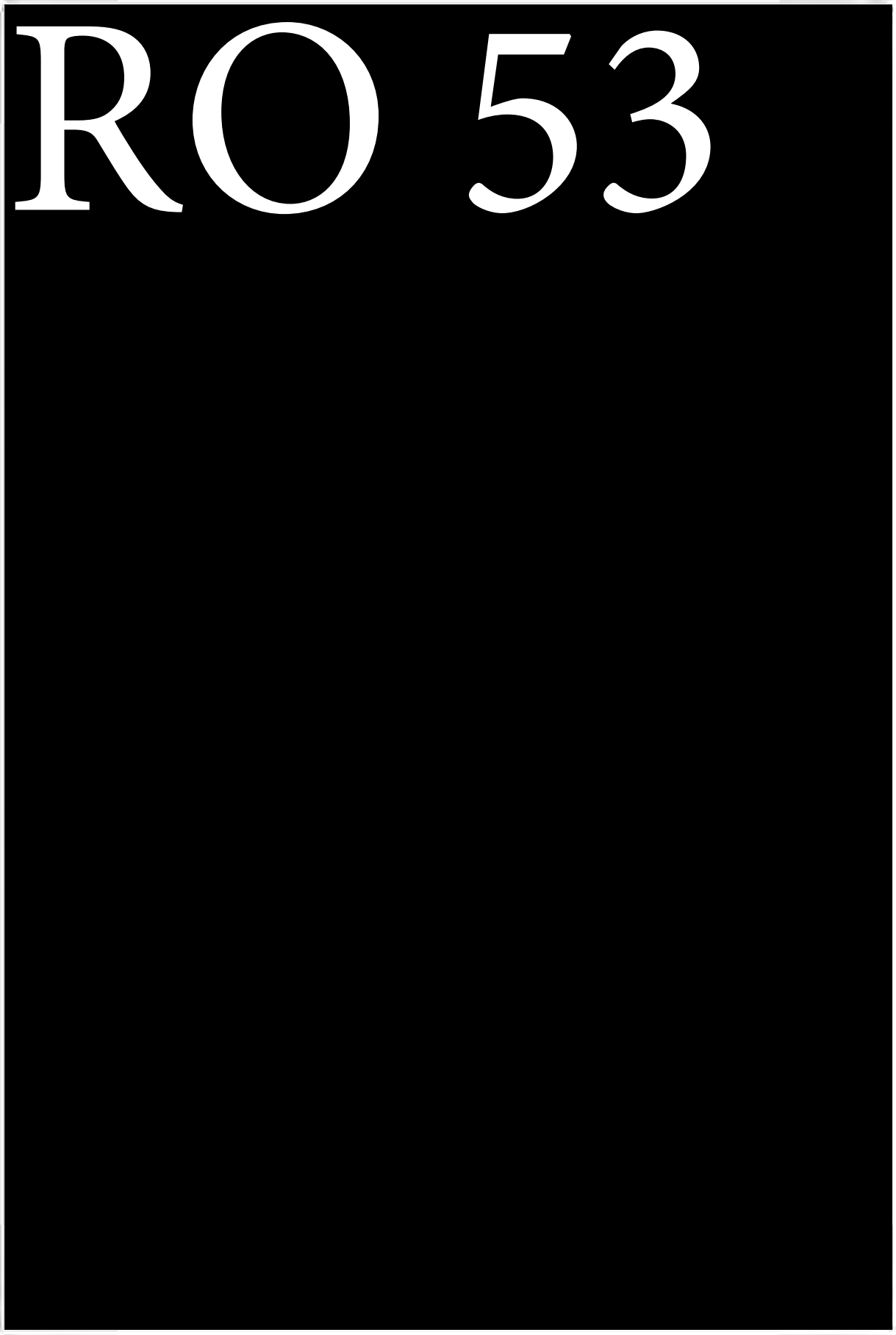
RO 53

RO 53

RO 53

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Appendix 2

1.006

[redacted]

Rhonda,

I will not be attending the disciplinary meeting on 16/4/14 as I no longer work for the Belfast trust at Muchamore Abbey Hospital.
My nursing Career was terminated on the gounds of my failing Ill Health which was exacerbated by events over the last 16mths.

I am forewarding to yourself a Statement of events for 7/11/12.

Kinds Regards.

[redacted]

(1) 8/4/14.

I have been nursing in Muchamore Abbey Hosp. Since 80's and I have always maintained my professionalism throughout my career.

On the morning of the 7th Nov '12 I commenced working E/H at 7.25 Am in Ennis to learn I had only one permanent ward staff one Barber and a relief staff from Ennis. Altogether 4 staff when in fact I should have had 7 staff. There was then another relief staff from Oldstone at 9.30 Am

The student and the Privy Nurse commenced duty @ approx 10 Am. The Privy nurse was in to shadow some of our ladies who were part of the resettlement process to the Privy in Coleraine.

The Student commenced her own studies working in the front office. I introduced the Privy nurse to the staff down at the back end of the ward and asked them to keep the Privy nurse informed on what to do as I was extremely busy. I didnt get time to give her an introduction as I was dealing with many ward issues on that particular morning. i.e. Incident of Agression, Family coming on ward to take their sister to an APP in A.A.H. and dealing with a Patients relative Per Phone. Altogether I had an extremely busy Stressfull morning. I continued to carry out the remainder of my office duties for the morning.

Staffing levels dropped back down to 4 over lunchtime when the 2 relief staff left at 12. mid.

We commenced giving out lunch and doing medications Another one occured over lunch time which was dealt with by myself. The Ward was very noisy at this Period in time as workmen were in all morning Carrying out repair work to many of the doors.

The afternoon was much quieter. I worked on some

peices for the resettlement programme. The primary nurse took the opportunity to go through some care plans in the afternoon.

I again was busy after tea time typing up my report for the nursing office, completing progress and evalution sheets, checking patients money drawers and entering Bath slights on the computer.

The staff were busy putting away laundry and getting patients ready for bed and giving out Suppers. The student and primary staff were supernumary but did help after tea time at my request.

Another inc occured @ 8.pm which I dealt with accordingly and to the best of my ability.

Altogether I feel the day was stressfull but I had an excellent ward team on duty who kept along with myself the ward running smoothly and so therefore I had no concerns and was happy and content all was well considering the staffing levels were low.

our staffing levels were $\frac{4}{17}$ 7.30 - 9.30 $\frac{5}{17}$ to 12 md. $\frac{4}{17}$ over lunch time and $\frac{5}{17}$ remainder of Pm. our staffing levels should have been 7-6-7.

There was also daycare consultations morn & afternoon and as a result the ward was unsettled at different intervals.

I handed over to the night staff with no worries, reports, or concerns from any member of staff on duty that day. I went off duty at 8.30pm.

H198

1.006d3

Appendix 3

H870's address
[redacted]

Dear Rhonda Scott,

From what I can recall on the day of question I was working in Ennis ward, on relief from oldstone. I think the hours I spent in Ennis wee 9am - 12pm.

During the hours I spent in Ennis Ward I seen nothing untoward or unproffessional during that time. For the 3 hours I was in Ennis I was allocated to supervise the backdayroom alongside Ennis staff and then for a short while alongside a community staff member who was working with particular patients.

As I am no longer an employee of muckamore Abbey I would prefer to have no more contact regarding this issue. The information I have given is true to my knowledge and what I recall.

Yours Sincerely

H870

Appendix 4

Notes of Interview with

Sr H491

29th April 2014

Question 1

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you as the ward manager ensure the following;

Patient Safety

Highlighted staffing via e mails to line manager from May 2012 ie about incidences, safety, danger and the changing needs of the patients from 2008 to present.

Poor staffing Staff banking on top of their contracted hours in substantive post.

Could not do activities these are very important to decrease incidences. Used experienced staff to engage patients in activities to reduce incidences

Incidences increased when Bohill staff came to ward. Communicated with Duty Nurse Manager re staff shortages, Duty Nurse Managers changing every day which made this difficult

Wards working on safety levels. Telford was completed but this incorrect - Ennis worked below safety numbers. Highlighted this on the 12.10.12 to Barry Mills via email as own Line Manager on leave

Current levels insufficient to run resettlement programme on ward

Incidences increased once monitoring commenced

Issues highlighted at resettlement meetings

2010 patients from Fairview moved over

7-8 referrals made to Behaviour Support Services

Changes in behaviours of patients highlighted in Care Plans

Patient P43 was allocated additional space on ward

We believed Ennis was closing Dec 2012 but still had a Bar B Que and Picnic in the summer of 2012

Staff Safety

Supervision was completed as and when it could be given – I try to be as approachable as possible to staff

In 2010 when Fairview closed the two staff teams amalgamated in Ennis which was difficult

Locked doors on ward – and patient P43 had extra area

Snozelum room

Meetings held on ward to bring team together every 2-3 months – topic covered were; waste, KSF, supervision, restrictive practices

Routines were reviewed constantly to look at safety, staff practices, allocation, standards, activities, policies, staff development – e.g.number of patients in dining room

ABS had no remit on Ennis but referrals were made re: P39 & P44??

Staff team were not used to working with behaviours

There was difficulty with staff sickness on ward

Specific management of patients was discussed one patient at a time and how to manage the behaviours

Staff handovers

The Resource Nurse was used to improve Care Plans from 2010 to 2011

Patients from Core Hospital caused anxiety amongst staff (P201 & P198)

Safety alarms were installed

Security on ward re-looked at as ward not for challenging behaviours

Telford assessment completed – this resulted in working one staff down due to level of observations on the ward – worked on 7 staff pre- the Telford assessment but 6 was deemed safe. Telford showed 6 in the morning and 5 in the afternoon staffing levels. This was not completed by me but by Clinton and Esther

There were no hotel services on Ennis which had significant impact

Skill mix allocation

Talked to Line Manager in Supervision regularly – I felt skill mix on ward was inadequate e.g. in August 2012 the only full time band 5 was on capability. There was always 2 qualified staff on duty then the rest were nursing assistants

It was agreed that night duty was to be covered in the first instance -the communication book was used for daily communication

Gave all band 5s turns at taking on new roles and responsibilities

There was a lot of staff sickness on ward this was highlighted in supervision and informal discussion

Duties were allocated by ward allocation sheet of which several versions had been tried

The rota was heavily subsidised by banking staff but they were predominantly ward staff which lead to tiredness and sickness

There was more enrolled nurses in Ennis than in any other ward and therefore there were learning issues such computers

Staff Rotation

Band 5 turn taking – i.e. band 5s all got opportunity to be nurse in charge

Staff rotated between front and back of ward

Duty rota shortages were covered by ward staff

One staff was re-allocated to anther ward as she got promotion

Ward Manager felt she was doing a Band 5 role

Small senior staff team taught other staff on ward

Patient engagement in activities

Activities ongoing on ward – gardening and cookery

Valentine's Day – Build a Bear

Easter Hunt every year

December 12 Ennis was to close and in Summer 2012 there was a Summer Fair on the Ward

Patients re: allegations lived in a more protective environment

Ward environment was not being maintained as ward was due to close however new floors were laid

Visits to Ramada Hotel

Visits to Nail Bars

The workload of staff in resettlement wards .i.e laundry, bed making

Engagement was ongoing but reduced due to staffing levels

There was an activity rota on the ward but not in individual care plans

There was a record on the ward of patient activities that H491 monitored

The ward vehicle was removed

Question 2

Was staff's annual appraisal, supervision and team meetings all carried out consistently within Ennis.

As much as possible I was not supernumerary

New to KSF supervision - Fairview ward came in 2010 – this was a new process for staff which they had to learn, this was hard to meet due to staffing levels

Question 3

Have any staff raised any issues with yourself regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with pre the allegations.

One staff raised her voice and this was reported by a Band 3 to me. I witnessed this and spoke to the staff member – this was documented and monitored

Band 5 nurse – this was addressed

If yes how did you address these issues

Re: Band 5 - Spoke to staff, recorded and documented, monitored the behaviour and no further issues appeared

Question 4

Please tell us how you monitored staff's practices, attitudes and professional conduct.

That is my role

I monitor everything – my job is a problem solver. I monitor everything from patient happiness, safety, families and staff interaction

I identify problems and act upon these

Induction of staff, induction booklets

Clear expectations from Ward Manager outlined at meetings to all staff and followed up with email e.g. April 2011

Regular meetings

Monitored and addressed issues with staff such as motivation

Supervision – identified issues staff would have and talked about how to change things

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to your staff team?

Staff knew through the communication book that they needed induction

Communication book relayed to staff that they had to go through the Hospital Induction Booklet with Bohill staff – Nurse in Charge or the 'back-up' nurse had responsibility to make sure this was allocated and done. This was not identified on an allocation sheet as staff knew to do this

[redacted] (Bohill Manager) attended resettlement meetings on ward pre the Bohill staff coming to work on Ennis – it was expected that she would give her staff information on working on Ennis and the patients they would be working with

When Bohill staff arrived on ward I got the impression that these staff were not experienced and that these patients needed a high level of trained staff and the Bohill staff were not trained and had limited experience

Bohill staff asked could they work with patients not identified for their service

Patients' behaviour changed when new faces arrived on ward

Question 6

Was there restrictive practice employed in Ennis

Yes – 2 doors locked most times – dining room and door near office were locked

At times the door at the back of the ward was locked to allow for personal hygiene

All in one suits were not allowed to be used on the ward – P39 wore a swimsuit – this was not deemed to be restrictive as it was not always worn and was used to maintain her dignity

A belt was used to hold up another patient's trousers but was not used to stop her stripping

If Yes how were these monitored and audited

Documented in Careplan re locked doors

Were these written in the patients care plans

Yes documented in care plans – not sure if P39 's swimsuit was in care plan

Question 7

How were Behavioural Support Plans developed and how often where they reviewed?

Patients from Core Hospital who came to Ennis had Support Plans – other patients on Ennis did not have these

There was 4 handovers a day on the ward

Support Plans were not required until the patients' behaviour changed. LD nurses are trained in behaviour and how to manage this. Behaviours are managed by activities but these reduced due to staffing levels.

Question 8

Was there any CRA's completed for the patients in Ennis

No – except for the patients from the core Hospital- the CRAs came with them

The Consultant would not sign the CRAs as he felt they were for Forensic patients only – Ward Manager had brought 16 completed CRAs to be signed – these were not signed and he refused to look at them. Discussed this with Senior Management and Resource Nurse

I was unaware if CRAs were kept updated and reviewed by the Consultant

No MDT Meeting and Social Worker withdrawn in 2008 however we could call on them if required

When resettlement commenced in May 2012 annual reviews were discontinued – there was a high level of work with resettlement i.e. All About Me

Question 9

Was there any Risk Screening Tools completed for the patients in Ennis

They were competed for all patients but not agreed by an MDT as there was none and the Consultant refused to sign

Question 10

Did patients have it identified in there care plans their behaviours such as stripping, allegations

P197 and P40 – making allegations should be in their care plan

Stripping should be in their Care plans

If yes was it documented how staff where to manage these behaviours.

Yes it was expected to be

Ward Manager monitored care plans

If new behaviours occurred I would check Care plan to see if this was documented – if this was not documented I would either add this myself or leave message for Named Nurse to do this

Evaluation sheets read every day

Care plans audited by EQC

Resource Nurse offered additional training and support for Care plans

Question 11

Did Support Workers have access to the care plans and how often did they read them

They were encouraged to read them and to write in them. The nurse in Charge would be the one responsible to review this. Mostly NAs would not write in the care plans – it was generally left to trained staff

Question 12

There were environmental changes to the ward. Can you please tell us how you consulted with staff on these changes and what were the outcome of these changes for patients and staff?

Feb 09 – created activity room for beauty activity

Aug 09 – requested storage for kitchen – did not do this initially but then did. Requested re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – ordered new blinds

Jan 10 – there was an extra medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring requested – same replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office – this was good for observation – other office doubled up as a visitors' room and office – staff did not like this but I felt this was improvement for patients and staff

Ward was over-crowded

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The 11/10/12 highlighted at resettlement meeting that patients' behaviour had deteriorated – Bohill staff arrived in 3s and 4s and did not adhere to rota issued to them re: their shifts. Also swapped shifts amongst themselves. If on sick leave they would report sick to the ward but not to Bohill. Male staff came onto ward who should have been in Erne

12/10/12 email to Barry Mills re: staffing levels on ward saying resettlement could not conitune due to staffing levels

25/10/12 B1 expressed no concerns at meeting with H491

2/11/12 identified unsafe staffing levels to Clinton Stewart. Staffing was poor. Highlighted risks re: own health and well-being and how situation unmanageable – H491 on leave following this

3.036

ADDITIONAL NOTES

Interview with WD/SR H491

29th April 2014

Patient Safety

- Incident forms were completed with reference to 5 separate days reporting issues of patient and staff safety caused by staffing shortage. These were completed during my own time.
- Telford. Actual form devised Duty Nurse Office had incorrect information, no plus on ennis form indicating that no extra staff were to be provided for levels of supervision led to confusion amongst duty nurse managers
- SNM Mills informed Service Manager Mrs Rafferty of this who asked SNM Stewart to discuss this with me following his leave
- Outside Garden party was attended by almost all patient's families and ex patients with community staff and other patients. SNM x 2 attended. Monies were provided by the trust for the hire of a marquee as this was also a Closing Party.

Staff Safety

Patient P43 had extra garden area fenced off, also built due to fact P39 and P30 would leave ward on occasion

Staff team were not used to working with SEVERLY CHALLENGING behaviours

Staff Sickness was discussed with SNM. Noticable rise from Oct 11 and explained that this was when patients from Core Hospital were transferred to Ennis

Specific Management of patients was discussed at ward meetings and opportunity given at daily handovers

Daily handovers – 3 minimum per day and introduced another for 6/11 worker when they came on duty.

Behaviour of patient P201 deteriorated only when Monitoring began. Patient begun to block doorways, removed her clothing and agitated others causing major disturbance to running of the ward re routines and reactions of peers. Ward staff and visiting could not walk through the ward feely, patients were more disturnbed. Staff were dealing with this whilst being monitored. What was being witnessed was not usual behaviour of patients in Ennis and there was less staff to who knew patients to deal with this.

Hotel Services in Ennis was minimal since core hospital opened. No improvement despite requests for extra staff. No bedmaking, assistance with breaks/suppers, laundry and putting away of linen. Required significant time. Service manager secured extra time for putting away of linen during this time.

Skill Mix Allocation

Sickness was not casual and was noted to have risen when patients came from Core Hospital

Ward Allocation – changed as patient need changed therefore a number of templates were tried

Enrolled Nurses – Had not been Named Nurses before, this required considerable and consistent direction from small senior team

Staff Rotation

One staff re-allocated was loss of senior staff who was one of two full time staff and was not replaced

No band 6 on ward

Patient Engagement in Activities

Had explained there was a Full Rota from Morning until nightime for all patients displayed which was followed.

Protective Enviroment provided at one end of the ward was described and photos evidenced provided of soft furnishings and high back chairs

Question 5

Staff were instructed to induct staff using the Hospital Induction book. A request was made in the ward Communication book. Staff were familiar with this process using the ward diary for each day of induction. As this induction is completed over a period of 5 days it became difficult for staff to complete as community staff only worked an of 3 days maximum and were not always there as per rota ie diff staff names/sickness/changed shifts.

Review meeting held, I explained the volatile nature of some of the patients in Ennis to [redacted] B1 giving examples also requested that she would ask her staff to come to myself or other nic.

Visiting Community Staff read care-plans almost all day everyday, was told they declined to do activities with patients on occasions

Question 6

Explained that patients came to Ennis wearing all in one vests/suits and that It required significant work to change staff attitudes/behaviour and to encourage patients into other clothing. Also that there was significant amount of shopping for clothing/shoes and perfume in an effort to improve standards.

Re wearing of a swimsuit P39 – explained this was being discussed fully through MDT with B1 B1 present, the reason for this was explained to B1 current MDT considered this was necessary on occasions to maintain P39 dignity.

Question 7

Behavioural Support plans explanation was given that P42 P45 had one, P46 and P44 in process of.

Was explained that prior to investigation/presence of monitoring the behaviours of patients in ennis were not thought to have been severe.

By giving examples explained how the behaviours of the patients changed dramatically when monitoring begun explained clearly this was an artificial situation both what staff were trying to manage and what others may have perceived.

Also that ABS did not have a remit to work in Resettlement wards but we could make a referral if we deemed it necessary

Question 8

Risk Screening tools had been completed for all. CRA's for 7/8

Consultant declined to sign explaining he felt they were for forensic patients

Question 10

Phrase removing of clothes was used as opposed to stripping (staff had been asked to use this terminology also)

When reviewing incident forms I would then add newly denoted behaviours to cplan or leave message for staff to do this

Question 11

Nurse in charge responsible to ensure entries in care plans by nurse assistants were appropriate and to guide staff

Question 12

States staff did not like this - I had explained that I learned that one particular staff member did not like the change of office but she had not come to discuss this with myself at any point

Helpful to investigation

12/10/12 As before explained that SNM Mills shared my concerns with Service Manager who requested that SNM Stewart would discuss them with me on return from his leave. Explained that this was done just before I went on leave and that some action was agreed at this point.

25/10/12 B1 expressed that she had no concerns at a Resettlement meeting with full MDT. I explained there are minutes available which evidence this. Also that this meeting was weeks after a date reported in local paper as to when alleged assaults had taken place.

I explained following no response from anyone regarding Incident forms I had submitted of a serious nature I had lost faith in the Incident Reporting System within the trust. I gave examples of how the system in the hospital prior to this flagged up issues immediately and action was taken as a result.

I explained on three occasions that I felt I was not being given enough time to answer the questions I was being asked in full.

RCN Michael McQuillan was present during this interview.

H491

August 2014

1.00885

Appendix 5.

Notes of Interview with C Stewart

16th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

It is acknowledged that the ward worked with limited resources. How did you address the staff shortages?

I was responsible for Erne Ennis Moylena Iveagh and Night Staff plus I had input to Forrest Lodge during this period. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. Iveagh at this time was a main concern as it also had staffing shortages and given the location of this service it was difficult to staff as resources within the hospital was already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch Dr Milliken Dr O'Kane Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital.

A meeting with Sr H491 Mrs McLarnon and myself was held I believe the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

The staff shortages was continually raised at meetings with Senior Managers. The staff shortages within the hospital was placed on the Risk Registar.

Question 2

As the Senior Nurse Manager was there annual appraisal, supervision and team meetings all carried out consistently with Ennis staff and did you get copies of team meetings.

Yes copies of team meetings were forwarded to me on a two to three monthly basis. I am satisfied that the above processes, Supervision and Appraisal were in place and occurred on a regular basis.

Question 3

Did the Ward Sister keep you fully appraised of patient activities, nursing staff levels and was there any risks highlighted to you.

Ward Sister kept me fully appraised of staffing levels within the ward on a regular basis. No risks were raised with me. There were a few issues with a few of the patients such as P198 and her epilepsy and Restrictive Practices these should be well documented within her care plan. Issues re patient P201 and her behaviours were raised by the ward sister. Prior to her moving to Ennis I did voice my objection to her suitability for the ward at our Senior Nurse Mangers meeting as this was a resettlement ward and P201 was a Delayed Discharge patient however regardless of this the patient did move to Ennis.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. Ward reports prior to the allegations was fairly static. When unfamiliar staff came onto the ward to work for the resettlement it was highlighted to me by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced obs was included in the staffing ratio. Ennis had two enhanced level of obs so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and me.

Question 4

Within Ennis there was a proportion of shifts that was covered with banking did you monitor this and was any issues raised by the ward sister regarding this

Ward Sister raised issues re the banking within the ward on a regular basis and unfamiliar staff. A large % of the deficits were covered by experience staff who worked in Ennis, internal staff within the hospital or staff who had retired from the hospital and banked. Ennis was short staffed as was all wards within the hospital at that time. The majority of bank shifts used to cover the shortfalls within Ennis was booked directly by staff within Ennis this resulted in staff's time being taken up to cover these shifts.

The resettlement wards within the hospital do not have the same support as the Core Hospital wards i.e. PCSS Services put away laundry, bed making again staff time in Ennis was spent on these chores instead of with the patients. There were also limited resources from psychology ABS as these services were concentrated on the Core Hospital.

Question 5

Did you raise the shortage of resources with your line manager

On a regular basis. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital.

Staffing shortages within the hospital was requested to be placed on the Risk Register.

Question 6

Have you ever had any issues raised with you regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices pre the allegations in Ennis.

There was one incident of an allegation from a patient about a staff member regarding the patient's cup. The patient later withdrew this allegation.

RQIA reports on Ennis were positive and Ennis was expressed as an area of good practice at Moylena's inspection feedback one year prior to the allegations.

The resettlement wards are environmentally not up to 21st Century standards.

No issues have been raised re staff attitudes, treatment of patients etc in Ennis.

If yes how were these issues addressed

The process regarding allegations was followed

Question 7

Will you explain the patient group that was in Ennis at the time of the allegation and any difficulties that this posed to the staff team?

The ward at the time of the allegations accommodated 17 patients. Patients P198 and P201 were two Delayed Discharge patients that moved from the Core Hospital into Ennis a resettlement ward; this changed the dynamics of the ward due to the challenging behaviour of these two patients.

The ward was divided into two; the more independent patients (approx 6) were accommodated at the front/upper end of the ward. These patients' behaviours would have been more physically aggressive. These patients would have had a better environment in that they had more individual rooms. The patients who were more dependant (11 patients) were accommodated at the back/lower end of the ward; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed. These patients' behaviours were challenging in that they stripped, pushed/shoved etc. Patient P201 was accommodated in the back/lower end of the ward and some of her behaviours included stripping and blocking doors with her body. This patient's presence on the ward made a big change to the ward dynamics and may have impacted on the behaviours of the other patients in this area. P201 was a large lady and intimidating person. She would have stood at the door blocking entry and exit to the area particularly at meal times when there was additional traffic in the area. When the door was opened she would pushed through as she was very focused on food and the kitchen. Staff would have to use persuasion techniques to move her or navigated her to move.

Environmentally the ward was not good.

Is there anything that you would like to tell us that you feel would be helpful to the investigation

Mr Stewart demonstrated how to move a patient blocking a doorway by placing two hands on each shoulder and using a push/pull technique to move a patient left or right. This is a technique taught in MAPA on how to move patients. Staff in Ennis would have been trained in this technique when attending MAPA training. All staff would be up to date with MAPA training.

Any previous issues/concerns of this nature would have been addressed within the hospital in line with procedures.

1.009d6

Appendix 6

Notes of Interview with B4

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked from 8am to 6pm on Ennis ward I was only there for a short space of time I think I worked on the ward on the 6th to the 8th ?November cannot remember exactly the dates.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

I was given limited information from Bohill management on the ladies in Ennis prior to going there. Given limited information on patient P39 and the wee lady who like to carry the cigarette paper. We were told we were going to observe staff managing the patients and to ask questions and then after a few days we were to work with the patients.

On the ward the Ward Sister spoke to me and B3 re the patients and introduced us to the patients and staff. We were given a set of keys for the ward. We shadowed staff who were working with the patients. We were given a good Induction and made feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

I thought that the staff was very good they gave us information on the patients. Staff took me with them when working with the patients; the staff knew the patients very well and gave me good information about them, it was amazing what they were able to tell me about the patients.

I felt supported by my line manager and was looking forward to going to work in Muckamore.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

B1 the manager, at one meeting, informed us that the patient's from Ennis Muckamore Abbey Hospital was to come to the Bohill. We were going to Muckamore to work with these patients and staff. Pen pictures of the patients were given to us. Initially we were informed that we were to shadow the staff at Muckamore.

Question 5

Did you read the identified patients care plans?

No. Did read care plans in Erne but not in Ennis I did not think I asked to read the care plans in Ennis did not think about this.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked about the likes and dislikes of the patients. Asked about had they ever tried P39 without the use of the swimsuit. Staff was very knowledgeable about the patients and gave me good information on them. I asked about other patients on the ward as well.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and description of H159 the other staff was blond and called H197 who was banking that day.

If yes how were these issues addressed

No did not raise these issues with Ennis staff

If no why not

I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me. I have attended my Vulnerable Adults training prior to working in Muckamore this was around the second week in September.

Question 8

Did you raise any concerns with your line manager at the Bohill?

I reported these to my manager B1 at the Bohill

If yes when you did raise these concerns and how were they addressed?

I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me.

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden

If so who was this staff member

Cannot be 100% sure may have been H159. This was the same day I seen staff pull P39 up from the floor.

B3 went over and opened the door and let P39 back in.

This was reported to B1 my manger at the Bohill the day I reported the other incident Both of these happened on the one day.

Question 10

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

Yes I heard a staff say to a patient "get the fuck out of my face". This occurred around lunchtime or the afternoon This was the only time I heard abusive language.

If so who was this staff member

H197 the Bank Nurse I had been talking to these staff so I knew their names. Stated she was in her 60's and her husband had passed away.

Question 11

Did you witness staff put a patient outside in the rain.

Yes

If so who was this member of staff

H159 I think was her name

If yes who was the patient

P39

If yes please describe the clothing the patients had on

P39 was wearing a hoodie and Jeans

If yes did you make any attempt to bring the patient back in

No B3 brough her back in immediately I did not say anything

Question 12

Did you hear staff say to patients what you were doing on the ward and if so what was said?

H491 (Ward Sister) introduced me the first day Explained I was there to see the patients.

Question 13

How did you observe staff to transfer patients from one area to another?

Staff would have taken P39 's hand to move her other patients walked on their own Staff did not have to help them.

Question 14

How did staff on Ennis interact with the patients?

Staff spoke to the patients there was not a lot of interaction as the staff were very busy on the ward.

Question 15

What activities were the patients on Ennis engaged in and did you participate in these activities

Staff on the ward were busy I did not witness any ward activities. I mainly shadowed staff working with P39. She was hard to work with re her stripping, grabbing and attention seeking behaviours.

Asked what was the routine like at Meal Times

The patients were taken in small groups three I think at a time this was organised. P39 was to go in for her meals as she would have over loaded her mouth and it took longer than the others to feed her as she needed help with feeding and drinking.

Question 16

Please describe how you found the atmosphere on the ward

The ward was very busy. Atmosphere was quite dull the ward décor was outdated with not much colour.

Atmosphere between staff was quite they got on with their work. The ward staff were stretched, staff were busy and the patients had many needs which was tough on the staff.

1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

Question 17

Have you attended any training in Physical Restraint such as MAPA?

Not MAPA prior to working in Ennis but did attend some form of PI training prior to working in Ennis cannot remember the name of it.

If yes please tell us when and what training.

Attended MAPA training a few weeks ago

Is there anything that you would like to tell us that you feel would be helpful to the investigation

No

1.010d7

Appendix 7

Notes of Interview with B7

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward

I was only there for a day and a half this was only if someone had to go to Ennis and did not want to be there on their own, I was there to work with the boys in Erne. I worked with B8, I think, on Saturday 6th in Ennis and I think the 1st

Question 2

Can you please tell us the Induction you had to Ennis Ward

We were to work with the patients prior to them coming to the Bohill to find out their daily routine, personal care, care plans etc to add to our own care planning. The first week was information gathering and for the patients to get used to us and us to them, this was to happen over several weeks.

There was not much of an Induction we arrived about 7.30am on the Saturday and staff were having a cup of tea in the dining room. We sat at one table and the Ennis staff sat at another table. We were told they were not expecting us until 8am. Me B8 and B10 were in Ennis that day. The Nurse in Charge was a big lady I cannot remember her name. We were not given any keys, there was not much chat with the staff and we did not feel very welcome. Erne was a different ward very welcoming

Question 3

Did you feel supported while working on the ward and did you get support from your line manager

I didn't feel supported on Ennis ward I felt a bit abandoned. We took a lady to the shower room she had on two pads from the night duty. We were shown were the pads etc were dept. There was not much information given to what was happening, staff what they were doing and went about this.

B1 line manager called at the ward to see how we were doing I reported to her that everything was fine.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you.

Our manager informed us that the patients were coming to the Bohill we were to go to Muckamnore to get to know the ladies, get the ladies familiar with us, read their care plans, learn how to work with them and commence our own care plans for the ladies.

Question 5

Did you read the identified patients care plans

Yes I did read the care plans the medical files were better but I was looking specifically at physical health.

Question 6

Did you ask staff on Ennis was for information pertaining to these patients and if so how useful did you find this

We would have asked the staff in Ennis about the ladies and they gave us advise. Regarding the other patients on the ward there was no explanation given to us on these patients on how to manage the behaviours and reasons for staff practices.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with.

I didn't have concerns when I was there the only thing was the pads which was more of a query than a concern.

If yes how were these issues addressed

If no why not

Question 8

Did you raise any concerns with your line manager at the Bohill

No I didn't raise anything I had no concerns. I was approached by line manager afterwards post the allegations. I was interviewed regarding the VA process I did not see any abusive practices.

If yes when you did raise these concerns

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

No

If so who was this staff member

Question 10

Did you witness staff put a belt around P39 ?

Cannot remember

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

No

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

No

If so who was this staff member

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said

We did not really get introduced staff in Ennis showed us their rooms and we introduced ourselves

Question 14

How did you observe staff to transfer patients from one area to another?

Patients moved themselves

Question 15

You have stated that you were informed if you offer the patients too much attention they will want it all the time. Can you please tell us who said this when it was said and under what context it was said?

This was pertaining to one patient who was not moving to the Bohill. She was singing in the day room one staff said do not give too much attention to this. This was not a concern.

Question 16

You have stated that staff was putting on 2 pads at a time on a patient. When you queried this staff said to you patients were wetting too much. Can you please tell us

Who said this to you

This was not said by a member of staff in Ennis it was said by a member of staff Erne I believe when I was talking about it in this ward.

What context was this said in

It was said in the context that when a patient was incontinent they passed a large volume of urine. They was no concerns re this.

Question 17

How did staff on Ennis interact with the patients?

Ennis staff spoke to each other there was not much interaction between patients and staff. The music channel was on the staff were busy there was a lot going on there were patterns of routine there may have been more time in the afternoon for staff to interact with patients.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities

None it was very un-stimulating

Question 19

Please describe how you found the atmosphere on the ward

The ward was segregated the dining room was the focus of the ward. There was two sides to Ennis the doors between each side was locked. The lower end of the ward was quite dark but this was the design of the building and the décor was very plain it was an institutional building. The staff spoke away and got on well together.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

Yes

If yes please tell us when and what training.

Prior to working in the Priory worked in Muckamore and did my MAPA training there

Is there anything that you would like to tell us that you feel would be helpful to the investigation

I never seen abuse I think the building contributed to the allegations. Staff would have done what was right for the patients but may not have explained this to the staff from the Bohill. What the others witnessed sounds more like older practices. Our staff had little experience of Learning Disability especially Challenging Behaviour. They probably did not know what to expect and this may have been a shock to them.

1.011d8

Appendix 8

Notes of Interview with [redacted] **B5**

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked a lot of shifts at Muckamore. Not sure of the dates I worked but will have them in my old diary. It was agreed that these would be e-mailed to R Scott.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

I got a very good induction by Mary she was great.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

Yes got good support from Ennis staff and my line manager at the Bohill Staff in Ennis were lovely

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

Question 5

Did you read the identified patients care plans?

Yes I was on night duty one night and read the care plans They gave good detail and insight into the patients.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Staff were really informative Staff kept me updated as we went along and worked with the patients.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

No issues

Question 8

Did you raise any concerns with your line manager at the Bohill?

On one occasion there was rough handling of P39 I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. I did not say anything as I was not sure if two staff were needed this was the only occasion.

If yes when you did raise these concerns?

How were they addressed?

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed?

No

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's.

If yes, can you explain how and why this was done?

I did not say anything as I was not sure if two staff were needed this was the only occasion.

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

I saw this twice in one day by the same staff member. P39 was on the floor and was stripping her clothes off. The staff member removed her shoes and set them to the side to divert P39 from stripping. This was acceptable for the staff to do this as it was used as a diversion for P39 to stop her stripping.

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

Not to patients sometimes amongst staff

If so who was this staff member?

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore

Question 14

How did you observe staff to transfer patients from one area to another?

Staff would have held patients hands to transfer them.

Question 15

How did staff on Ennis interact with the patients?

Staff were good Patients were not left sitting staff interacted with them Staff were very calm and made an effort

Question 16

What activities were the patients on Ennis engaged in and did you participate in these activities?

None that I saw

Question 17

Please describe how you found the atmosphere on the ward?

The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff

Question 18

Have you attended any training in Physical Restraint such as MAPA?

Not sure will check diary

If yes please tell us when and what training?

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

1,012df

Appendix 9

Interview Questions [redacted]

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked in Erne for ½ a day I worked in Ennis 2 to 3 days as far as I can remember but I am not sure what month this was. I drove in one day with [redacted] and worked with her and one day with [redacted] and one day on my own.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

A young nurse with long blonde hair did my induction. She was very nice and friendly. She showed me around the ward, informed of ward routines, informed me I was there to observe initially, introduced me to the staff and patients and answered any questions I had, She made me feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

We were told that we were going to Muckamore and that was it. There was limited communication given to us. Line manager was not really involved and I did not feel supported.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were told just to go up to get to know the routines, read the care plans and get to know as much as possible about the patients. Not really discussed with line manager, this was discussed among staff, it was identified on the duty sheet who was to go and that was it.

Question 5

Did you read the identified patients care plans?

Yes they contained good information and were useful. Care plans were given to us by staff in Ennis.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked questions staff were very helpful they seemed to know the patients well this was very helpful.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

Staff pushed patients away from dining room door. Not sure that this was right or wrong.

Question 8

Did you raise any concerns with your line manager at the Bohill?

Yes re patients at window of dining room door how they were moved and them staring into the dining room. Did not think it was abusive how staff worked with the patients. Staff did not give an explanation on what they were doing when working with the patients.

If yes when you did raise these concerns?

I reported these the next time I seen my line manager but at his stage issues of concerns had already been raised about Ennis.

Would you have reported this if concerns had not already been raised?

No did not think it was abusive practices.

How were they addressed?

I was told not to worry about it, other things had come to light about Ennis and that this was being taken further.

Question 9

Did you witness staff push and/or pull [redacted] **items of clothing? If yes please describe what you witnessed?**

No.

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

No

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

No

Question 12

You have stated that staff in Ennis would push P39 away when she came up and held your hand. Can you please tell us:

What exactly did staff say?

Staff said if you take her hand P39 will pull you around all the time. Staff knew the patients.

How did they remove P39 's hand from yours?

This did not happen No one took P39 's hand away I allowed her to hold my hand.

Was there any reason given to you by staff on why they did this?

As stated above

Did you ask staff in Ennis why they did this?

Question 13

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

No

If so who was this staff member?

Question 14

You have stated that when 2 patients emptied out all the laundry bags staff came in and shouted aggressively "who did this"? Can you please tell us:

Where you were at this time, what were you doing and where was the staff?

I was coming out of the office walking towards the bottom of the ward. I was not in the room I did not see the patient I only heard

Who were the two patients?

Do not know

Who were the members of staff?

Do not know did not see

What did the staff in Ennis do when a staff member made the assumption that a patient had done this?

Was walking towards bottom of ward when I heard this I could not see.

What did you do when staff allegedly shouted aggressively?

Walked on past

Who did you report this to at the time?

No

Question 15

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Staff told me about the patients but I was not introduced to them I did this myself

Question 16

How did you observe staff to transfer patients from one area to another?

No did not see this

Question 17

How did staff on Ennis interact with the patients?

Staff were a bit abrupt but not all of them. Got the impression that they did not have much time for them. Staff on this day may have been having a bad day. Lunch time was stressful for staff on this day patients meals appeared rushed.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities?

I helped with feeding patients, changing patients. I got a couple of patients changed and helped staff out when I could. The ward was busy.

Question 19

Please describe how you found the atmosphere on the ward?

Décor and age of the place did not help and it was not homely. Staff did not speak to each other very much Seemed to be a click of staff on the ward Did not feel that I could join them at breaks etc or join in on the conversations. Felt staff were a bit stressed out for no reason. This was on both my shifts.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

Not while employed at the Bohill Have not done any training whilst at the Bohill

If yes please tell us when and what training?

Did this training while completing my degree training as nurse

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

1.013d10

Appendix 10.

Notes of Interview H197

12.5.14

Question 1

As a Bank Nurse in Ennis did you feel supported while working on the ward?

All the time

What supports were available to you?

The ward sister was a good support had previously worked with her in 2010. All the staff on the ward were a great bunch.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Your duty of care was to the patients. You had to work faster made sure you prioritised your care of patients. One staff that morning was on a relief staff from another ward this was a good help her name was H870 and she came from Oldstone. Group one patients were left in bed to allow the other patients to get their personal hygiene attended to. Then I and the relief staff worked together. Staff was usually taken from Ennis to go on relief to Greenan or one of the Core Wards.

Staff Safety

There were two patients on the ward who required level 3 observations. I usually worked on groups 2, 3 or 4 all these patients had challenging behaviour. We had to contain the patients by locking doors so that we could supervise them and observe them. I have nursed for 42 years and knew these patients. I never felt unsafe on the ward. The ward manager had risen issues regarding staffing on the ward and she was aware of the locked doors as this was at her direction. A lot of the trained staff time was wasted looking for additional staff to come into the ward to work to cover the shortfalls of staff. The nurse in charge would have prioritised the workload of staff to meet the staffing levels.

Was there Staff Rotation within the ward?

Yes there was staff rotation this helped staff to know all the patients; I worked in all areas of the ward although staff who knew the patients generally worked with these patients. The behaviours of the patients increased when there were strange people on the ward.

Was there clear allocation of duties for each shift?

There was not clear allocation of duties on the 7.11.12 due to limited staff on the ward. There was only three staff on the day of the allegation, one staff to each area. I had changed duty to accommodate the staff shortages. Two staff was required for group 2, 3 and 4. Group 1 can dress themselves and need help with personal hygiene. At the start of each shift you were given a hand over. The nurse in charge on the day of the allegation did the breakfasts that morning she was on her own until 10am.

Was there scope for patient engagement in activities apart from day care?

The patients on the ward have severe Learning Disability and have Challenging Behaviour. Few of the patients would engage in activities, one patient was blind. [redacted] P39 threw items out the window, P201 stripped of her clothes lay on the floor and defecated, other patients had ADSD. There was no time to engage patients in activities as there were staff shortages. Group 2 patients had their own TV, music colouring in books, spools etc. One patient in the bottom areas had PICA. Main role was to supervise the patients and maintain their safety due to staffing levels. Ward did have a bus but could not be used due to staffing levels.

Question 3

As a Bank Nurse did you have annual appraisal, supervision and team meetings all carried out consistently with Ennis.

Did b=not attend meetings minutes of these were available. I attended all my in service training. I have no PCP or supervision in any ward.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

There was never anything to report. Is a good ward to work in and staff are good.

If yes how were these issues addressed

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

Bohill staff said they were there to familiarise themselves and to observe the patients. Nurses on the ward said they were to work with the patients. Nurse in charge said they were there to work with the patients. Bohill staff did not start until 8am at the earliest, I did not work with a lot of staff from the Bohill if they were asked they helped some of them were more helpful than others. I was informed of what Bohill staff were on duty that day by the nurse in charge. The staff from the Bohill arrived and came into the ward and sat down they had the opportunity to read care plans. The nurse in charge was doing the medication round which took two hours when they arrived so an Induction was not done then but this was done later in the shift I think. The strange people on the ward were unsettling for the patients.

Question 6

Can you please describe the behaviours that would be exhibited by patient [redacted] P40 ?

P40 displayed different behaviours from day to day and from hour to hour. She liked to interact with staff and referred to me as Nurse H197. Was very vocal, striped clothing at will and would say get me my buttons; I want chocolate I want lemonade, loved sweets and chocolate. She moved furniture around with her shoulder on the floor. When having a bowel motion sat on toilet and screamed. Was very vocal especially during hygiene and would shout leave me alone. She would also laugh a lot.

How were these behaviours managed at ward level?

She was nursed in group 2 with two other patients; she got on well with P44 and P199. She was in day room with group 3 and4.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Quite a few times this was one of her behaviours. Would have said this and laughed. Sometimes no one was in the area. Was vocal during hygiene shouting leave me alone or would have squealed.

If yes how was this addressed?

You would have said no one was there or you would have diverted her attention.

Question 8

Can you please explain what you recall the evening that it was alleged that a staff member assaulted patient P40 ?

P40 was in the day room. I apparently cleaned her mouth I cannot remember this I and the student nurse H196 were administering an enema the student nurse went to get pyjamas for the patient. The only patient I changed that night was P41 after her enema I was supervising the day room. I cannot recall P40 saying a staff had hit her if so I would not have paid much attention to this as this was normal behaviour for P40 she alleges these things all the time.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

I cannot remember as I was so involved with P41. If I had been called I would not have been in a position to help as I could not leave P41.

Question 10

Can you please describe the behaviours that would be exhibited by patient P39 ?

P39 is hard work as she had very challenging behaviours. Openly masturbates in public, wilful incontinence to command attention, smearing faeces over people or the ward or will attempt to eat this, striping clothing, pulling her hair out. She is very destructive on the ward will throw clothing out the window, steal food, stuff her mouth with food, regurgitate food and then eat same is obsessed with food, throw items out the window such as clothes and shoes.

How were these behaviours managed at ward level?

She was nursed in the bottom day room so she could be observed. Staff had to maintain her dignity so was continually redressed. Would walk along the ward corridor. Parts of her day she could display no challenging behaviours, Bohill staff where informed that she demanded attention and not to let her stand in front of you as she would nip you. Staff kept boundaries with the patients to manage their behaviours. They prevented her from striping by distracting her. All new and strange staff were informed of her behaviours.

Question 11

Did you or did you ever witness staff throwing P39 's shoes away to occupy her?

No staff ever did this. P39 would have removed her own socks and shoes and would throw them away this was one of her behaviours.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No, staff would have turned P39 away by the shoulders to de-escalate her behaviours.

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

No not shouting. If she was about to hit another patient staff would have used a firmer tone to stop her, she responded to this.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

P43 loved out in the garden. All the patients liked this area and used it in the summer.

P39 was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41?

Some days there are no issues/concerns with P41, she likes music and would sit and listen to this in her chair would sit with her legs underneath her. Have involuntary movements so jerks all the time due to this would hit her head of her chair frequently. Would become agitated at times and this may indicate that an enema is required as she suffers from constipation. She has Bi-polar so moods can fluctuate can display self-injurious behaviour.

How were these behaviours managed at ward level?

P41 loves music so this was used to settle her. She likes to sit in the same chair and staff would sit her in this. Enema's when required were administer this is usually mid-week to alleviate constipation.

Question 16

Can you describe how P41 is assisted to mobilise?

P41 has a very unsteady gait; she walks on her tip toes. When out of the ward uses a wheelchair. When walking with P41 you would take her arm to guide her where you wanted to go. When you put her in her chair you placed her arms on the arms of the chair, P41 then put her legs below her when sitting and moved in the chair to position herself. She has upper and lower body involuntary movements and her head would have hit off the back of the chair due to this.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 18

Have you ever raised your voice or used foul language to any patient or staff

No

Question 19

Was there restrictive practice employed in Ennis?

Not at all. Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity.

Were these written in the patients care plans?

Do not know. The nurse in charge was aware of all of these.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Do not know, not aware of this.

If yes how was this information disseminated to you

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Risk assessment was completed for P40 re making allegations.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes. P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41 .

P41 on the day of the allegation went over to P22 who was lying on the couch P41 jumped up and down on P22 . I went over and took P41 P41 by her arm and elbow. P41 put her legs down on the ground and I walked her to another chair. B2 was at the window in the day room and her view of this was restricted as I was between her and P41 . I put P41 into her chair and she settled herself as described earlier.

If yes can you please give a description of the MAPA techniques employed?

P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was good to work in. The staff all worked as part of a team and were helpful to each other. There was no stress on the ward; all staff helped each other to address the staff shortages on the ward. Everyone helped each other. The patients were in a small area and they all had Challenging Behaviour.

Question 25

Is there anything that you would like to tell us that you feel would be helpful to the investigation

Some of the staff from the Bohill did not want to be there. B2 told me that she had been told horrendous stories about Ennis. The Bohill staff were watching and looking at the staff in Ennis they did not want to be there. The patient's behaviour deteriorated when the Bohill staff were there as they were strange to the patients. Bohill staff had made comments about Ennis said it was a horrible place.

The environment on the ward was too small for the number of patients and their challenging behaviours. Day care was cancelled regularly for the patients in Ennis as the day care staff were used to cover the shortfalls of staff on the wards within Muckamore Abbey Hospital.

I did not leave B2 for 20 minutes in the day room alone as she stated. I did go to the toilet but H870 was in the day room with B2. When I returned to the day room P39 had faeces on her hands. B2 had no keys for the ward; she had taken P39 to the toilet. H870 went down to the toilet to assist B2 B2 and she was the staff who got P39 her change of clothes' I thought I had heard someone shout but I am not sure.

I left B2 with 2 patients while I gave out the lunches to the other patients; I gave B2 a full explanation the reason for this. I then brough B2 into the dining room and asked her to give P39 her lunch; I gave B2 a full explanation of P39 's behaviours during mealtime and explained how to feed her.

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Appendix 11

Interview Questions H159

12.5.14

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward.

Yes

What supports were available to you?

Staff were great The ward sister was approachable There was a good staff team in Ennis and we all worked and got on well together

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following;

Patient Safety

On occasions had to lock a door to keep patients safe and in one area for supervision and observations this was at the direction of the nurse in charge. Staff assisted each other and the work was prioritised to keep self and patients safe.

Staff Safety

There was usually a second staff present, staff had alarms. Felt safe on ward as we knew the patients really well and their behaviours.

Was there Staff Rotation within the ward

Generally worked on the same group usually at the bottom of the ward were the patients had challenging behaviour. It was better as this allowed the patients to get used to the staff and the staff to know the behaviours of the patients. Patients at the

top end of the ward had Challenging behaviour as well but these were not as challenging and they knew the staff that worked with them. Strange staff on the ward could escalate these behaviours.

Was there clear allocation of duties for each shift?

The nurse in charge gave the handover this was three times a day and was always completed regardless of staffing levels. There were allocation sheets on ward for staff, communication book and the ward diary. Changes were discussed with staff.

Was there scope for patient engagement in activities apart from daycare

Not really. Doors were open for the patients to go outside weather permitting. The Snoozelem Room off the dayroom was well used. Walks etc were not possible due to staffing levels on the ward. Music was on for the patients. Daycare would have been the main activity for the patients.

Question 3

As a Support Worker did you have annual appraisal and team meetings all carried out consistently with Ennis.

I had my KSF and PCP completed annually I did not have supervision like the trained staff. Team meetings were held monthly approx. I attended these and there were helpful. There was also the ward handovers.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

No never. The ward had a lot of students families members of the MDT on ward nothing was ever reported. Patient care was a priority to the staff. I was never asked to do anything I did not feel comfortable with.

If yes how were these issues address

Question 5

What was your understanding of the communication that was given to yourself re the Bohill staff coming to work in Ennis and how was this information disseminated to you.

They were coming to Ennis to familiarise themselves, get to know and work with the 3 patients who were to resettle to the Bohill. They were to ask staff in Ennis questions about these three patients. We knew when staff were coming and at what time. The staff did not come onto the ward until after all the patients were up washed and away to daycare, some staff from the Bohill would have followed them to daycare when they arrived. Some staff from the Bohill stayed on the ward and sat around in the day room. B2 spent three and half hours in the office reading care plans on the 7.11.12. Bohill said that the ward was not what they had expected though it may have been more like a nursing home said it was dismal, thought they were coming to the ward to paint patients nails etc. The staff from the Bohill was made to feel welcome by the staff in Ennis.

Question 6

Can you please describe the behaviours that would be exhibited by patient P40 ?

She had an unsteady gait walked with her chin in her chest. Would squeal and yell say I hate you I don't like you epically at toileting times or she won't give me that. Accused peers and staff of hitting her and hating her. Also striped of her clothing, pulled trousers down did not wear pyjamas. Liked to play with tops or buttons and would crawl about the floor moving furniture to retrieve her tops. Did not like strangers on the ward none of the patients did. Was known for bleeding gums and generally had bad breath. I had a good rapport with her.

How were these behaviours managed at ward level?

Was nursed in the middle day room of the ward on occasions would have come into the lower of the day rooms. Was settled when she had a top or button to play with, this made her content.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Oh yes frequently

If yes how was this addressed?

You would have cajoled P40, distracted her of offered her a drink and biscuit. Never made an allegation against me until the 7th November when later on I was informed of this.

Question 8

Can you please explain of what you recall the evening that it was alleged that a staff member assaulted patient P40

I was there on my own H196 came down to help about ten minutes later as we were short staffed. I decided that I would start the self-care after tea, I cannot remember the order I carried this out on the patients. I did not change P40 that evening. She was in the toilet and I was in the bathroom. I could hear P40 squealing and yelling as she was on the toilet having a bowel motion, she more than likely had taken her clothes off as that is what she normally does but I do not know as I did not see her; I heard her but did not see her.

Between 6.15 and 6.30pm I was changing the girls and bringing them to the day room. I finished this about 7pm locked the bathroom door and began to help with the suppers for the patients. I was in the day room for about ten minutes when P43 was very badly soiled and I took her to the bathroom to change her. H196 brought P40 to the bathroom to change her she was naked. B2 came down to bathroom to help when I was changing P43 she stood and watched me but did not help. I asked B2 to get fresh pyjamas for her which she did and then went back to the day room. I did not do P40 oral hygiene that evening nor did I see any blood. No staff was made aware of anything P40 had said that night that I am aware of. P40 immediately stripped going to bed each night and again first thing in the morning when she went into the bathroom.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

No

Question 10

Can you please describe the behaviours that would be exhibited by patient P39 ?

P39 can display very challenging behaviours. She is obsessed with food, stripes off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains. P39 knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times.

How were these behaviours managed at ward level?

Staff tried to amuse P39 with soft balls, toys that sang or played music, this help her to behave. Staff constantly redressed her. P39 's behaviours usually got worse between lunch and tea time. New or strange staff were informed not to let P39 grab your hand as she would nip you or pull you around you had to set boundaries with P39 .

P39 wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity.

Question 11

Did you or did you ever witness staff throwing P39 's shoes away to occupy her?

No P39 threw her shoes away in the day room or put them out the window. She did not like new shoes.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

The day room is very noisy there is eleven patients with Challenging Behaviour Staff would have been more assertive to be heard and changed tone when Challenging Behaviour was evident. Staff did not shout.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

No P43 likes to be on her own and loves the garden she sits in the same area all the time. P43 was able to get back into the ward by the door but generally staff had to go and get her to bring her back in. P43 would have become agitated or self-injurious if she wanted out to the garden. P43 was only out in the garden if the weather permitted this and was observed by staff.

P39 did not go out unless staff were with her she was never put out.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41?

P41 constantly has jerking movements, throws her head back this usually gets worse when she becomes agitated or annoyed. Has problems with her bowels and needs an enema to manage this, when she becomes agitated this is usually a sign that she is constipated. P41 could be aggressive in that she could kick out or hit. She also had pre menstruation pain. She could have thrown cutlery/crockery across the room.

How were these behaviours managed at ward level?

You always stayed to the side when walking or working with her due to her jerking movements P41 loved music. Needed supervised at all times. I had a very good way with P41 on occasions you had to wait until her agitation decreased to work with her. When she was constipated she had an enema.

Question 16

Can you describe how P41 is assisted to mobilise?

At times needed her wheelchair such as when she was outside the ward would have walked her to the bus for day care. You always placed her away from other patients to prevent them getting injured. P41 jerked while sitting. You walked to the side of P41 and if you needed would have placed you hand on her elbow to prevent her jerking her elbow into and to protect you. Staff also placed their hand on her back to guide her in the right direction. When she sat in a chair she always jerked and moved around to get comfortable.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 18

Have you ever raised your voice or used foul language to any patient or staff

Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients.

Question 19

Was there restrictive practice employed in Ennis?

No restrictive practices. When questioned further stated the doors would have been locked into middle day rooms. Doors in the bottom area of the ward locked for the patient's safety. Swim suit was not used as a restrictive practice as the patient could remove this it was for her dignity and for the environment for the other patients.

Were these written in the patients care plans?

I would have thought so but I did not read these everyday as I would not have had time to do this. Read care plans when patients first come to the ward.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Not with the patients at the bottom of the ward.

If yes how was this information disseminated to you?

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Not sure. Nursing staff that came from the ward that the patients had come from worked with us on the floor and informed us on how to work with these patients.

If yes was it documented how staff where to manage these behaviours?

Staff from the other ward worked with you on the floor and told you how to work with the patients.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes.

If yes can you please give a description of the MAPA techniques employed?

Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients P39 and P41 .

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was very busy but we all worked well as a team and helped each other out, you looked out for each other. There was stress on the ward especially in the mornings as the workload was greater at this time and there was staff shortages.

Question 25

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The ward was very short staffed. Nothing untoward happened on the ward. The staff from the Bohill did not want these three patients said there was other patients on the ward that they could take that had not been identified.

When B2 and I went out for a smoke she did not raise any concerns with me she talked to me about hair, nails etc.

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Appendix 12

Notes of Interview with H205

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I was supported by own staff on the ward. We all mucked in as we were under stress due to staff shortages but we managed. I got support directly by my Ward Manager H491. The workload on the ward was adjusted to meet the staffing levels we prioritised our work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

This was our main priority and I always ensured this. I always made sure someone was with them or within eyesight and not away doing other things. We prioritised our work.

Staff Safety

We completed our main duties things that needed to be done. We helped each other out and looked out for each other.

Was there Staff Rotation within the ward?

Most of the time you stayed with the same group the patients were dependant on staff who knew them well, You generally worked on the group you were key worker for. I mainly worked on Group 4 the girls at the front of the ward and I worked well with patient P198.

Was there clear allocation of duties for each shift?

There was an allocation sheet on the ward showing who was to work were this was adjusted when there was staff shortages. The allocation sheet identified what groups you were working with and who was doing the escorts.

Was there scope for patient engagement in activities apart from day-care?

The ward car would have been used even just to take the girls out for a drive. The activity room was used for beauty treatments. There was DVD's Games Cold Cookery in the evenings and the garden was used depending on the weather.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I think I may have had my KSF completed once. There was ward meeting regularly and if you did not attend you received minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

Never had to

If yes how were these issues addressed

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes but about patients only not staff. Heard her say patient P43 had hit her but this patient was not in the area at the time she was in the garden area. Patient P40 was coming from the bathroom on that occasion. P40 would have alleged this a lot.

If yes how was this addressed?

Asked patient were she had been hit and I identified that the patient was not on the ward at the time.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 would take her shoes off herself and bring them to you this was her way of gaining attention. If the shoes were off P39 would bring them to staff to put them on. If she had new shoes she frequently took them off and threw them away until she got used to them.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 10

Did you ever assist staff to put a belt around P39 ?

No staff did not need assistance to put the belt on P39 she always let you put the belt on her. P39 liked her belt and if she did not have one on she would take staff to her room to get one for her. P39 s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on.

If yes, can you explain how and why this was done?

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

When they came onto the ward they were introduced to the staff they were to shadow the staff who worked with the patients identified for the Bohill, these were the only patients they were to shadow us for. Many times they did not work with the identified patients and would be with other patients eg P202 . The manager of the Bohill arrived on the ward to talk to the staff and they were outside with patient P202 , the three of them stayed outside during this time. I worked quite a bit with the Bohill staff and never seen them work with patient P199 who was identified to go there.

The Bohill staff did not arrive on the ward until late morning we would have put back the personal hygiene on the patients going to the Bohill for as long as we could to allow them to work with them but generally the patients would have been at daycare by the time they arrived. The Bohill staff would then have went to daycare to see the patients there. I cannot remember the Bohill staff being there in the evenings I recall that they usually left about 5.30pm or before this.

Question 12

Was there restrictive practice employed in Ennis?

No

Were these written in the patients care plans?

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

No We worked with the patients and their behaviours by trying different things to see what worked and what did not and knowing our patients. This was communicated within the staff team at handovers and through each other.

If yes how was this information disseminated to you?

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes I think it was as we reported these behaviours to the trained staff.

If yes was it documented how staff where to manage these behaviours?

I am not sure We would have looked at any new patients care plan but we did not have time to read the care plans on a daily basis Infomration regarding patients was communicated between staff.

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Level 1 and 2 holds were used with the patients at the front of the ward. I think it may have been used on patient P30 for Self Injurious behaviour but this would have been a level 1 hold to prevent her injuring herself as she was banging her head.

Patient P39 would have stood at the door of dining room There was no reason to move P39 from the this door as she would move herself when asked by staff to do so.

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

Stressful due to staffing levels and the additional work with the Bohill staff. This put pressure on staff as the patients behaviours increased as they were not familiar with these staff. Some of the Bohill staff appeared very inexperienced. The staff team in Ennis all worked together.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

We were informed of the changes but were not consulted. The bathroom on the front corridor was changed to make this a staff cloakroom. This had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them distress.

The activity room was converted to an office. This was used for patients activities pre this such as beauty, spas and cold cookery this only left the big dayroom for this. This impacted on the patients if one patient was watching the TV and another activity was taking place in this room which could cause challenging behaviour.

Snoozlen room was of no benefit as all the patients could open the door if someone was using it.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

We were under pressure and stress due to staffing levels on the ward and we did the best we could. Our main priority was the care of the patients.

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Appendix 13

Notes of Interview with H869

16th May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I enjoy my work in Muckamore Abbey Hospital the only thing was the staff shortages. My colleagues and the nurses in charge gave me support. Everyone helped each other out we got on well as a team and you only had to ask for help if you needed it.

Ward Sister had e-mailed Senior Nurse Manger regarding the staff shortages on the ward. Staff on the ward did cope with the staff shortages.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We had a level 3 observation in the lower end of the ward her staff was always with her. There were 2 groups in the lower end of the ward on occasions one staff had to do the two groups.

Staff's knowledge and experience of the patients helped to keep them safe. [redacted] P39 loved to walk and I would have taken her with me when doing laundry etc.

Staff Safety

Staff had a good knowledge of the girls and because I knew the girls I felt safe. The area was never left without staff supervision if I had to leave the area I would have asked the Nurse in Charge to come to the area to let me leave. I would never had left the area and left one member of staff on their own.

Was there Staff Rotation within the ward?

There was rotation but I was generally down the lower end of the ward. I was allocated to these girls as I was their associate nurse. I preferred to work in this area of the ward as I knew these girls, I loved working with these girls and being down the back.

Was there clear allocation of duties for each shift?

Yes there was a communication book allocation sheet on the ward. I knew what I had to do. Allocation sheet identified groups. Escorts and laundry etc was work that everyone knew had to be completed

Was there scope for patient engagement in activities apart from day-care?

There was the Snoozlem Room, music was always on as the girls liked this, TV which was generally the music channel. The garden area was used which summer seats and swings, one patient in particular had liked outside. Foot spa's was carried out in the dayroom in the afternoons and evenings.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

Yes I had my KSF/PCP completed 2 to 3 times in Ennis.

Team Meetings I did not get to a lot of them as I do voluntary work. I cannot remember how often they occurred but I did get minutes of these meetings. These meetings contained information on resettlement, use of ward vehicle updates on patients and any items staff raised.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No. When the patients moved from Fairview to Ennis it was a smaller ward but the patients adapted well to this environment change. The two staff teams when combined as one worked well together and gelled.

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

No never

If yes how was this addressed?

Question 6

Have you ever heard staff shout at P39 with a raised voice?

I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202, P43 and P41 could be very vocal and it could be hard to be heard.

Question 7

Did you witness staff throwing P39 s shoes away to occupy her?

No P39 liked her shoes, she could take these off. She would have thrown her won clothing and shoes out the window on occasions.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No. P39 wore a belt to help keep her trousers up as she wore incontinence products which resulted in her hips being wider than her waist. Her trousers were usually too big for her on the waist as a result of this so a belt was used to keep her trousers up. On occasions she wore tracksuit bottoms so she did not need a belt.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No some of the patients wore vests with poppers at the bottom.

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

The Bohill staff were there to get to know the patients. I saw some of the Bohill staff getting their Induction by the nurse in charge. They were shown around the ward, introduced to staff and patients and it appeared to be well done. A few of the Bohill staff worked with me I would have given them information on the patients. Sometimes it was hard to get them to concentrate on the patients going to the Bohill as P202 would have taken up some of their attention. Some of the staff were young and had said they had not worked in an environment like Ennis before.

I worked a 1230 to 2300 on the 7.11.12. I worked in the lower end of the ward until 1800 that day and the remainder of my shift I worked with the girls at the upper end of the ward I think I may have been carry out P198 's level 3 observations.

Question 11

Was there restrictive practice employed in Ennis?

Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations.

Patient P43 would have drop attacks and would these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair.

Patient P39 wore a swimsuit and or a vest.

Were these written in the patients care plans?

Yes P22 level of observations.

Not sure about the others

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Would have completed sheets on patients behaviours in the lower end of the ward this would then have went to ABS not sure if this was pre or post the allegations.

If yes how was this information disseminated to you?

Asked to complete these sheets

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Yes

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes blocking to prevent patients being self-injurious

If yes can you please give a description of the MAPA techniques employed?

Hand over their hand to prevent patient nipping themselves

To move patients would have put hand on their elbow and the other hand on their waist.

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

I always found it a good team we were short staffed but we got on with our work. I was not stressed re this.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

I was not consulted I am not sure about other staff being consulted. I probably would have kept the activity room if I had been asked

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

I have worked with these girls (patients) so long and I am really attached to them that if I though anyone hurt them I would speak up immediately I would not hide anything. ([redacted] is very passionate about these patients it is clearly evident)

1.017d14

Appendix 14

Notes of Interview [redacted]

12TH May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Response

Not all of the time we were short staffed. There was a lot of bus outings still going on but it was always the girls/patients at the top end of the ward who went out on these. This left us with all the other girls/patients down at the bottom end of the ward, one of which was on level 3 observations, the girls from the bottom end of the ward all had challenging behaviours such as stripping. Sometimes staff from the upper ward would give the staff help in the lower end of the ward if they were not out on the bus. Support dependant on what staff were on duty.

There was a click on the ward and these staff usually worked with the patients at the upper end of the ward. When they were finished they would be in the office.

There was support from the staff who worked in the bottom end of the ward they helped each other out.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We did our best most of the time we were running around like headless chickens. We tried our best to supervise the patients at all times. In the good weather we opened the doors to allow patients outside, P43 and P202 liked outside. The middle dayroom was utilised. The AM shifts were easier to manage as a lot of the patients were out at day care. The majority of the work such as laundry was done in the mornings to allow staff to supervise the patients in the afternoon as not as many patients were at day care then. The staff team worked together.

Staff Safety

Staff were hit or slapped by patients. There was only enough seating in the dayroom for the patients, staff had to sit on the arms of chairs this was when we got hit or slapped. I have had a jumper ripped off and items threw at me, I never really felt safe. I tried to know my patients and the triggers for their behaviours.

When patients from the upper end of the ward became challenging they were placed in the lower end of the ward. This was as the top end of the ward had ornaments etc sitting about and this was to prevent them getting broke. When the patients came down to the lower end of the ward due to challenging behaviour they would have broken items in that end of the ward. This resulted in the lower end of the ward being baron and dismal.

Was there Staff Rotation within the ward?

Some people worked in the same groups I would have liked a change as the lower end was constant. The staff in the lower end of the ward always did the laundry for the whole ward as staff from the upper end of the ward was working with patients.

Was there clear allocation of duties for each shift?

Not really only groups, activities and outings were allocated. Laundry escorts etc were not allocated.

Was there scope for patient engagement in activities apart from day care?

No the activity room had been turned into an office. There was not a lot of activity for the patients in the lower end of the ward. Jigsaws etc well not well maintained with pieces missing. The upper end of the ward had more activities such as bingo for the patients. The Snoozelem room at the bottom end of the ward was taken over by patient P202. Music was always on at the lower end of the ward as patient P41 liked music.

The activity room had been used for the patients in the lower end of the ward to do hairdressing, make-up painting, games etc this was a great wee room for these patients.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

KSF/PCP completed once by the Ward Sister a couple of years ago.

There were team meetings one or two a year for all staff; minutes were available for these meetings. There were more frequent meetings for trained staff; I was not given minutes of these meetings.

Meetings contained the Ward Sisters agenda. Any issues brough up by staff was given lip service such as staffing levels on ward.

Ward Sister delegated al lot of tasks to staff, I was asked on occasions to phone staff to see if they would work to cover shortfalls. The Ward Sister never came to the lower end of the ward except to get the drug trolley. She did not know the patients and would not have understood how hard it was.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No never

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Frequently alleged that other patients had hit her eg P44 or P43. If she said that P43 had hit her then this would be true. Does not think that she has said that staff have hit her.

If yes how was this addressed?

P40 would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the NIC or another trained staff member that day.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not shouting at her staff may have used a firmer tone if P39 was displaying Challenging Behaviour.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Did you ever assist staff to put a belt around P39 ?

No you did not need assistance to put a belt on P39 as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her.

If yes, can you explain how and why this was done?

She liked a belt

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was informed that the Bohill staff were coming to see certain patients. I was told they could come with us to learn for the first few days and then the Bohill staff were to work with the patients directly.

It was felt by the staff in Ennis that the Bohill staff did not want to be there and they did not want the patients that had been identified to go to the Bohill when they seen their behaviours especially P39 . They spend most of their time with patient P202 P202 in the garden area. Some of the Bohill staff came in and sat most of the shift in the day room and did not interact with the patients. Some of the staff from the Bohill did interact with patients and staff.

Question 12

Was there restrictive practice employed in Ennis?

Patients in the lower end of the ward were moved from the dayroom when a patient from the upper end of the ward was there due to aggression.

There were locked doors on the ward at the lower end of the ward

Were these written in the patients care plans?

I don't think so I am not sure

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

Some of the patients from the upper end of the ward had Incentive Plans the patients in the lower end of the ward did not

If yes how was this information disseminated to you?

This is written up in their Incentive Plan which is kept in the office and that can be easily read by staff. Patients were able to inform you of their Incentive Plans.

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I do not know as I never got the chance to read the care plans as I was never in the office. Due to my shift pattern I was always covering ward duties during handovers and did not get a handover when I came on duty. Other staff kept me up to date on what was happening within the ward.

If yes was it documented how staff where to manage these behaviours?

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

P198 full PI

P46 full PI

Both of the above either sitting or standing

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

The atmosphere on the ward was awful due to staff shortages; ward was always working short staffed, staff were stressed due to this. In the lower end of the ward it was the same routine day after day.

The atmosphere between staff was good we worked really well together and everyone got on with the work. Staff helped each other out and pulled together as a team.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Activity room was made into an office we were not consulted on this it was just done. The patients enjoyed the activity room it was an area to allow the patients in the lower day room to be spaced out and separated.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

Since the allegations there was a new Ward Sister on the ward which made a big difference she was;

- Approachable
- She knew the patients, had a relationship with the patients and they all liked her
- She help out on the ward and was hands on
- She was a breath of fresh air
- She made a big difference

1.018d15

Appendix 15

Notes of Interview with H206

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes felt supported by the staff team. Staff shortages were a big issue but we got used to this and adopted to it. Trained staff would be allocated to work on groups, usually they were allocated to work on the group they were named nurses for, in the morning and evenings and would then be in the office. The trained staff came to help/assist when asked but we mainly worked with Support Workers without direct supervision of trained staff. The Nurse in Charge would do the tablets and office work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Patients were supervised by staff. Observations of patients and patients on Constant Supervision was completed.

Staff Safety

The staff in Ennis worked as a team helping each other out.

Was there Staff Rotation within the ward?

No generally you worked on the group you were Key Worker for. I was on night duty so would have floated between groups but mainly worked with the patients at the back of the ward. Only change was if you were on a Level 3 Observation.

Was there clear allocation of duties for each shift?

You looked to see what group you were on there was no allocation of other duties. Staff worked a team to complete other duties.

Was there scope for patient engagement in activities apart from daycare?

We used the car pre the allegations this was taken away just after the allegations. There was an activity room on the ward but this was turned into an office, not sure when this occurred. The patients from the top end of the ward went to the cinema every Sunday. All the patients went on holidays in small groups about two years ago there has been no holidays since this.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I had my appraisal completed annually by H325 on the ward. Staff meetings were once every six months I attended these on a couple of occasions those I did not attend I got minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No Nobody ever raised any issues with me

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes P40 would say this about other patients never heard her say this about a member of staff.

If yes how was this addressed?

If we had not witnessed anything we would have reported this to the Nurse in Charge.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

No

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 will throw her shoes out the window or throw them across room especially if they are new shoes.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No P39 stripes her won clothing off and throws away clothing and shoes.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was just told Bohill said were coming to the ward, no other communication was given to me regarding this. There was no clear guidance given on how to work with the Bohill staff.

Bohill staff did not come at the times they were planned to be on the ward. They would have arrived late in the mornings, could have been 10am, by this time the patients identified for the Bohill were already up and dressed and on occasions would have been at day care. Sometimes the staff from the Bohill would have gone to day care at other times they stayed on the ward and interacted with others. They rarely saw patients getting up in the morning getting washed dressed etc.

Bohill staff also left early, could have left at 6pm, therefore they did not see the patients getting ready for bed. One staff did a night duty on Ennis she arrived after the patients had received their suppers and medication, approx after 10pm, then left at approx 430am, patients would still have been in bed at this time.

Question 11

Was there restrictive practice employed in Ennis?

Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged opened.

A swimsuit was used on P39 for dignity as she keep this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and P39 liked to take this off and play with it. P39 could take the belt off and was not considered as restrictive practise as other people wear a belt.

Were these written in the patients care plans?

I do not know

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Not that I know off not aware of any.

If yes how was this information disseminated to you?

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I reported these behaviours to the Nurse in Charge but I do not know if it was in the Care Plan

If yes was it documented how staff where to manage these behaviours?

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Arms holds on patients P198 and P46 No moves used to move patients at doors

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

Ennis is a good ward with good staff team. The ward worked short staffed but that became the normal and we got on with it. The staff shortages did annoy some staff.

Question 17

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Bathroom was converted to a staff toilet and locker room. Clinical room was changed to a a staff room about 4 to 5 years ago.

The Activity room was converted to a second office this was for the Nurse in Charge and staff. The first office was the Ward Sisters Office the only other time I seen it used was for the ward report to be completed at 7am in the morning by the Nurse in Charge.

The Snozelem Room was created when Fairview patients came.

The Activity Room was missed by me. I felt that the patients missed this room as it was used every day for art and craft, footspa, etc. Staff were not consulted re the changes to the ward environment.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

1.019d16

Appendix 16

Notes of Interview H196

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Student Nurse in Ennis did you feel supported while working on the ward?

Response

I only worked 8 shifts on Ennis pre allegation

Yes felt supported by

- Opportunity to ask questions
- Given an induction
- Supported by staff team
- Used a buddy system on ward
- Shadowed staff and the Nurse in Charge

Question 2

Did you have a Comprehensive Induction to the ward and where you given pen pictures of the patients on the ward?

Response

Had a good Induction

Cannot remember is she was given pen pictures

Question 3

Did you ever raise any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

Response

No

If yes how were these issues addressed

Question 4

Can you please describe what you recall the evening that it was alleged that a staff member assaulted patient P40 ?

Response

I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans.

I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else.

Question 5

Did B2 request assistance to try and settle patient P40 and if so how did you respond?

Response

Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2's first day. B2 had stated that she had applied for nursing but did not get in.

Cannot remember B2 asking for assistance.

Question 6

Did you witness a member of staff wipe patient P40 's mouth roughly with a mitt?

Response

No

Question 7

Did you hear patient P40 say anything on that evening regarding staff?

Response

No I cannot remember

Question 8

Have you ever heard P40 allege that a member of staff or patient had hit her?

Response

No I cannot remember

If yes how was this addressed?

Question 9

Did you inform patient P40 that she would not get her sweets and lemonade if she did not put her clothes on?

Response

No

Question 10

Have you ever heard staff shout at P39 with a raised voice?

Response

No

Question 11

Did you witness staff throwing P39 's shoes away to occupy her?

Response

No

Question 12

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

Response

No

Question 13

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Response

No

Question 14

How would you describe the atmosphere on the ward within the staff team during this time?

Response

Cannot comment as duration on ward was short. Cannot remember

Question 15

What was communicated to you about the Bohill staff being on Ennis?

Response

I had attended a resettlement meeting so I knew what Bohill staff were doing on ward. Did not have much involvement with Bohill staff.

Meet a few of the staff but cannot recall their names. Would not have worked with Bohill staff as I was shadowing other staff.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

Response

No

3.919

Notes of Second Interview H196

2nd June 2014

Administration Building

Muckamore Abbey Hospital

Question 1

A number of staff have described the night that P40 alleged that a member of staff had hit her. Staff have stated that you were in this area at this time. Can you please clarify for us what you recall from that evening?

I took laundry down to the back area of the ward. I put slippers on a patient

Question 2

Did you take patient P40 to the bathroom area that evening?

I cannot remember the patients names

Question 3

Did you help staff with patients routines that evening?

Yes I did help with bedtime changes but do not remember who

Question 4

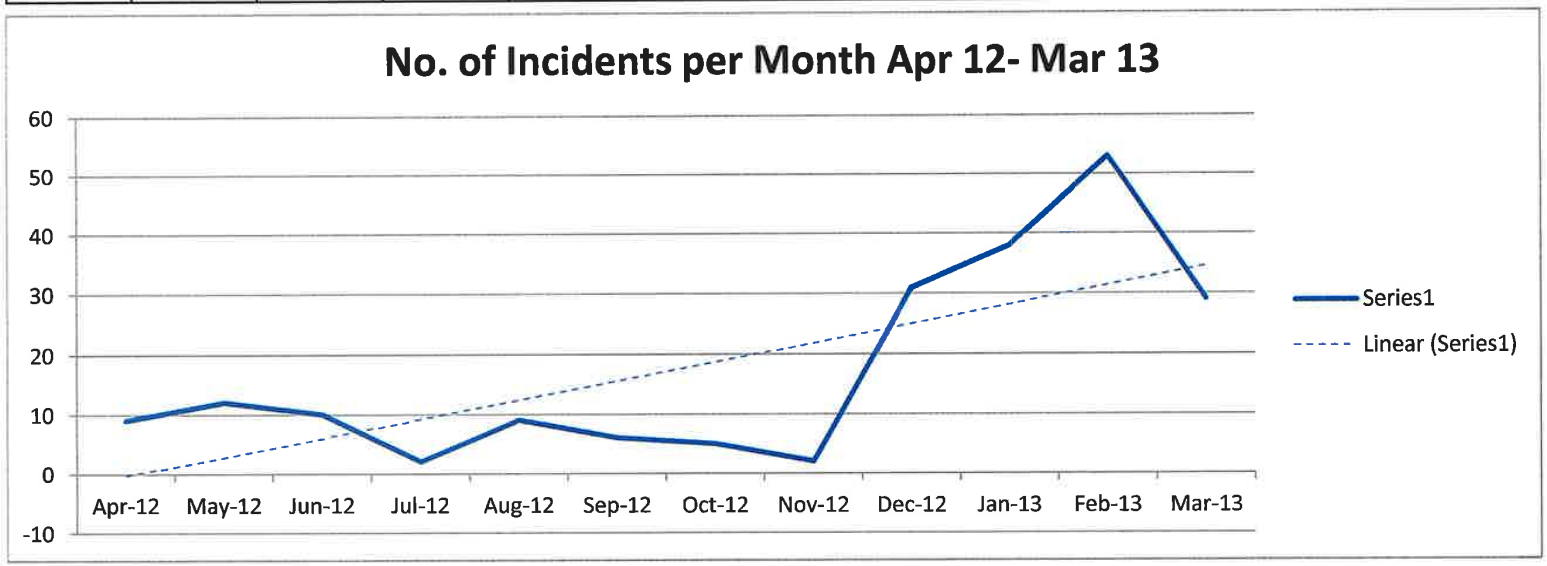
Do you recall the staff on duty that evening?

Cannot remember

1.020d17

Appendix 17

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
9	12	10	2	9	6	5	2	31	38	53	29



1.021d18

Appendix 18

Appendix 3

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

From: Mrs K Murray
Day Care Services Manager

To: Mrs R Scott
Senior Nurse Manager

Ref: **KM/**os

Date 8th May 2014

Re: **Requested Information**

Please see attached information requested regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012.

Please do not hesitate to contact me if you need further information or clarification.

K. Murray

Kim Murray
Day Care Services Manager

In response to your request for information regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012, information was gathered from the following sources:-

- Epex
- Duties
- Situation Sheets
- Diary
- Care Plans
- Staff files

In relation to 7th November 2012 the following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P200
- P197

The reason for this cancellation was due to the fact that Moyola had four members of staff on sick leave and one on Jury Service. This, therefore, necessitated the closure of Room 7 and Room 3 affecting the aforementioned patients.

In relation to the other days in November 2012 please see the following:-

Thursday 1st November 2012

No patient Day Care was cancelled, however, both P198 and P40 P40 refused to attend.

Friday 2nd November 2012

All Ennis patients attended.

Monday 5th November 2012

Room 7 in Moyola was closed and the following patients were cancelled:-

- P30
- P39
- P41

The reason for the closure of Room 7 lies with the fact that four staff were on sick leave and one staff was on Jury Service. P198 did not attend on this day and records indicate she was sick.

Tuesday 6th November 2012

P30 , P39 and P41 did not attend Day Care on this date. The records indicate that the reason for this was that a ward escort was not available. The following patients were cancelled by Day Care:-

- P42
- P46

The reason for this cancellation was due to four members of Moyola staff being on sick leave and one on Jury Service. P40 did not attend on this day and the records indicate that she refused.

Wednesday 7th November 2012 – as previously outlined.

Thursday 8th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P46
- P42
- P40

The reasons for this cancellation was due to four staff being on sick leave but also records indicated that four Nursing Assistants were sent to the ward on relief. This would have impacted and resulted in closure of Room 4 in the afternoon affecting P46 and P42 .

Friday 9th November 2012

The following patients' Day Care was cancelled:-

- P46
- P42
- P45

The reason for this cancellation was due to two Nursing Assistants being sent to the ward on relief due to ward shortages. P40 did not attend due to an appointment.

Monday 12th November 2012 – Friday 16th November 2012

The following patients' Day Care was cancelled for the week:-

- P198
- P197
- P40
- P45
- P41
- P30
- P39

The reason for this cancellation was due to having three members of staff on sick leave for the week.

P44 did not attend on Monday 12th November '12 and records indicate she had an appointment.

Monday 19th November 2012

Day Care was cancelled for the following patients:-

- P43
- P47

The reason for this cancellation was due to three members of staff being on sick leave, one member of staff being on compassionate leave and one member of staff being on Carers' Leave.

Tuesday 20th November 2012

All Ennis patients were in attendance.

Wednesday 21st November 2012

All Ennis patients were in attendance.

Thursday 22nd November 2012/Friday 23rd November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41

The reason for this sick leave was due to three members of staff being on sick leave.

Monday 26th November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P198
- P197
- P40
- P45

The reason for this appears to be three staff members on sick leave as well as one staff getting an emergency annual leave day.

Tuesday 27th November 2012

All Ennis patients attended on this day.

Wednesday 28th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P40
- P45
- P40

The reason for this was due to three staff being on sick leave and one member of staff being on Compassionate Leave.

Thursday 29th November 2012/Friday 30th November 2012

All Ennis patients attended, there were no cancellations.

See attached table with shows an overview of Ennis patients' attendance for November'12

Kim Murray
Day Care Services Manager

Ennis Attendance Numbers for November 2012

Name	T 1	F 2	M 5	T 6	W 7	T 8	F 9	M 12	T 13	W 14	T 15	F 16	M 19	T 20	W 21	T 22	F 23	M 26	T 27	W 28	T 29	F 30
P30			RC	WENA	RC			RC								RC	RC	RC				
P39			RC	WENA	RC			RC								RC	RC	RC				
P41				WENA	RC			RC								RC	RC	RC				
P202					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
P44								APPT										APPT				
P43													RC									
[redacted]	R		S		RC	RC		RC	RC	RC	RC	RC						RC		RC		
P197					RC	RC		RC	RC	RC	RC	RC						RC		RC		
P46				RC		RC	RC															
P42				RC		RC	RC															
P199					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
P204					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
P40	R			R		RC	APPT	RC	RC	RC	RC	RC						RC		RC		
P45							RC	RC	RC	RC	RC	RC						RC		RC		
P47													RC									

R-Refused **S-Sick** **WENA-Ward Escort Not Available** **RC- Room Closed** **Appt-Appointment**

1.022019

Appendix 19

Ennis Resettlement Meeting **21/10/2012**

Belfast Trust

Present

Dr Milliken

Dr Ling

Rhonda Scott

Mary Mc veigh

B1 (Bohill)

H196 STD N

Catherine O'Callaghan

Liz Moore

Catriona Mulvenna

Bohill Update

The 3 ladies from Erne for Bohill are P199, P43 and P39.

Care plans will be discussed with a hope of signing off when amendments have been made.

Timescales will also be discussed.

No concerns from Bohill staff that have been working in Ennis with the 3 ladies.

Timescale discussed for ladies to move W/C 12th November 2012, it is thought that it would be best for all 3 to move together. Staff from Ennis will visit Bohill on a daily basis for the first 2 weeks initially (an Ennis staff member there 24 hrs) but this can be reviewed, Clinton Stewart has agreed to same.

It was discussed after discussion surrounding behaviours of some female patients that single gender units would be the best way forward.

Restrictive Practices will be discussed further with H92 for his opinion.

Issue with registering with G.P still on-going, B1 is dealing with this at present.

B1 had enquired as to wither a month supply of medications could be prescribed from M.A.H, Dr Ling will enquire with Pharmacy regarding same.

Risk Assessments will be completed for all and monitored 3 monthly.

Advocacy is happy with arrangements.

P199

Care plan was discussed and amendments noted, B1 will make amendments with signing off at a further date.

It was discussed that P199 will need encouragement in the mornings.

Funeral plan, H491 will update when completed and hope that the plan will be finished before the move to Bohill.

P43

Care plan discussed and amendments noted, B1 will update. Discharge summary from Ennis.

Family have visited Bohill, they are still nervous regarding resettlement but were impressed with staff, they are aware that there will be male staff on duty but they will not administer personal care.

Wheel chair is used for P43 's own safety when she has a seizure, this will need to be noted as a restrictive practice and on Bohill's risk register.

P39

Care plan discussed and amendments noted, B1 to update.

Even though seizures are historical the procedure in the community when a seizure occurs is to call 999.

Staff from Bohill had stated they were concerned re P39 removing her clothing as there would be male peers in the same unit it was discussed that P39 wears a swimsuit under her clothing and the possibility of a body suit will be explored, she could also be withdrawn to her bedroom and that every way of managing her behaviour has been explored, for this reason it was discussed that there would be issues surrounding vulnerable adults and restrictive practices, Catherine will refer to B.S.S for further clarification.

At this stage the possibility of single gender units was discussed, B1 will speak to RQIA regarding this issue as B1 felt that RQIA would seem more favourable towards mixed units in the community.

Rhonda will discuss further with H92 issues surrounding vulnerable adults and get his views on the issue.

All updates will be discussed at the next meeting.

1.023d/20

Appendix 20

Scott, Rhonda

From: B15 B15's email address
Sent: 22 October 2014 16:39
To: Scott, Rhonda
Cc: Gavin OHare-Connolly; Rosemary Dilworth
Subject: RE: Ennis Investigation

Hello Rhonda

The actual date that I was made aware was the 8th November 2012 by the Team Leader at the time.

Kind regards

B15

Home Manager
ore Care

Tel: 028 70 325180
Fax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 14:22
To: B15
Subject: RE: Ennis Investigation

B15
I am keeping well how are you everything good at your end
Thank you for this B15 can you just clarify for us I know the report states the 8th Nov 2012 but what I need you to
firm for me is when you where first alerted to concerns in Ennis
Thank you
Rhonda

From: B15 B15's email address
Sent: 22/10/2014 13:59
To: Scott, Rhonda
Cc: Gavin OHare-Connolly
Subject: RE: Ennis Investigation

Hello Rhonda

Hope you are keeping well.

The initial report date of allegations are the 8th November 2012.

Kind regards

B15

Home Manager
Amore Care

Tel: 028 70 325180
Fax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 13:23
To: B15
Subject: Ennis Investigation

B15
Can you confirm for me the date that staff at the Bohill raised concerns around the practices in Ennis As you know I am npleting the internal investigation and just need clarity on this issue
Rhonda

1.024d21

Appendix 21

MAHI - ENNIS - 1 - 561

Week commencing 15th October 2012

	Monday 1st	Tuesday 2nd	Wednesday 3rd	Thursday 4th	Friday 5th	Saturday 6th	Sunday 7th
B7	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B14			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B16	ERNE 8-8	ERNE 8-8					ERNE 8-8
B10	ENNIS 8-8	SICK 8-8				SICK 8-8	SICK 8-8
B5			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B13			ERNE 8-8	ERNE 8-8	ERNE 8-8		
B9						ENNIS 8-8	
B17			ERNE 8-8	SICK 8-8	SICK 8-8		
B8	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8

Week commencing 8th October 2012

	Monday 8th	Tuesday 9th	Wednesday 10th	Thursday 11th	Friday 12th	Saturday 13th	Sunday 14th
B3	ENNIS 8-8	ENNIS 8-8	ENNIS 8-8				
B4		ENNIS 8-8	ENNIS 8-8	ENNIS 8-8			
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B5	ENNIS 8-8				ENNIS 8-8		
B9			ERNE 8-8	ERNE 8-8			ENNIS 8-8
B17					ERNE 8-8	ERNE 8-8	ERNE 8-8
B12			ERNE 8-8	ERNE 8-8		ENNIS 8-8	

MAHI - ENNIS - 1 - 562

Week commencing 15th October 2012

	Monday 15th	Tuesday 16th	Wednesday 17th	Thursday 18th	Friday 19th	Saturday 20th	Sunday 21st
B11				ENNIS 8-8		ERNE 8-8	
B12	8-8	8-8			8-8		
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B13			ENNIS 8-8	ERNE 8-8			ERNE 8-8
B9	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8
B17			ERNE 8-8		ERNE 8-8	ERNE 8-8	ERNE 8-8
B8	ERNE 8-8	ERNE 8-8	ENNIS 8-8	ENNIS 8-8			

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B18							8-8 Ennis
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis				
B13	8-8 N/D Erne	8-8 N/D Erne				8-8 N/D Erne	8-8 N/D Erne
B17				8-8 N/D Erne	8-8 N/D Erne		ERNE 8-8
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B16	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 RATHMULAN						
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis				
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13		8-8 Erne				8-8 Erne	
B6	11-11 Ennis						
B5		ENNIS/N/D 8-8	ENNIS N/D 8-8			SICK	

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B14		8-8 Erne					
B18							~~8-8 Ennis~~ Patrick
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis				
B13	8-8 N/D Erne	8-8 N/D Erne				8-8 N/D Erne	8-8 N/D Erne
B17				8-8 N/D Erne	8-8 N/D Erne		
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B11							
B4			8-8 Rathmullan	8-8 Rathmullan	8-8 Rathmullan		
B8	8-8 Rathmullan	8-8 Rathmullan				8-8 Rathmullan	8-8 Rathmullan
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 Erne	8-8 Erne				~~8-8 Erne~~	8-8 Erne
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

B16

B18

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis	11-11 Ennis	11-11 Ennis		
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13	8-8 Erne	8-8 Erne				8-8 Erne	8-8 Erne
B6	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis

1.025 of 22

Appendix 22

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CONFIDENTIAL

Muckamore Abbey Hospital
2nd Briefing report by M Mannion – 9th January 2013

Actions completed

- Over the Christmas period, I undertook a further two unannounced leadership walk arounds time commitment 4hrs x 2 =8hrs,
- I have completed a review of patient's notes, medical files, and drug kardex, 4 files that were requested to be reviewed by the strategy group and a further 4 files randomly selected from the remaining population of patients on Ennis. Time commitment 18 hrs.
- I have completed analysis of the monitoring forms submitted since the 19th of December taking an inclusive approach by integrating and reviewing previous data from the first briefing completed for the 20th of Dec 2012. Time commitment 10 hours.
- I have completed a review of the learning environment using the Learning and Assessment Standards created and regulated by the Nursing and Midwifery Council NMC. This involved reviewing the student evaluations over the last 2 yrs, requesting if there were any student or external reviewers concerns about the practice environment or behaviours of staff i.e. the NMC annual reviewers, the nursing Practice Education Facilitator the clinical tutors who act as the pre-registration nursing students placement supervisors from Queens University. Time commitment 5hrs.
- Update on the draft improvement plan;
    - Environmental concerns are being addressed cleaning schedules have been improved,
    - Repair of estates issues progressing,
    - Fire safety and environmental issues have been addressed,
    - Admin support officer time increased to support the ward sister,
- Communications with:
    - Executive Director of Nursing and the Director of the Adult Social and Primary Care Directorate,
    - Associate Director of Nursing,
    - Ward Sister and Deputy Ward sister,
    - Monitors present on the ward environment when I was present,
    - Co-Director of the Adult Social and Primary Care Directorate,
    - Service manager of Ennis,
    - Behaviour support officers x 2,
    - Medical staff in the unit,
    - Relatives visiting the unit,
    - Ergonomics trainer,
    - MAPA trainer.

Preparing this briefing paper time commitment 8 hrs.

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Review of patient's notes, medical files, and drug kardex

Documents were reviewed and completed in the care environment and at all times documentation remained in the clinical environment. The information governance policy was respected in this activity.

There were 8 patients files reviewed, 4 named patients as requested by the strategy group and a random selection of files from the other 13 patients. A patient who observed me taking out her records for review asked what I was doing, when an explanation was offered she declined giving her consent for the review to take place, this request was respected. One patient is expected to be discharged within the coming week therefore not selected for review.

There is a corporate commitment for MAPA behavioural strategies to be implemented when appropriate. All of the current patients in Ennis ward are described as presenting with challenging behaviours that on occasion will require the MAPA range of interventions. Registered Nurses, unregistered Health Care Support Workers and Nursing Auxiliaries, are trained in this process. Staff requiring updates are provided with update training which has included observation by a recognised trainer of the staff member when required to use this form of intervention.

There was evidence of an audit conducted in the last year of the MAPA process reported win the patient notes. The audit outcome was positive.

Active promotion of all other prescribed personal life story work i.e. get to know me documentation recorded in each note file reviewed, personal de-escalation strategies particular to individual patients as per care plan is expected and evidence of adherence to this process is recorded within the notes.

I found within my discussion with the MAPA trainer that the moves noted as potential allegations (Allegations were not discussed with the Trainer) could have been MAPA moves designed to protect both patient and others during perceived challenging behaviour episodes.

In my discussion with the Ergonomics trainer, I was advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients therefore patients with presenting Jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients, this may appear that some one could be "hauled out of a chair" staff are encouraged to support a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step, prior to expecting them to stand or be assisted to stand. It was also noted that when moving someone who exhibits rocking movements backwards and forward or side wards rocking that staff are encouraged to move backwards and forward or sideways with them this reduces the risk of falls during dressing and moving activities.

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In my discussion with the behaviour officers it was noted that behavioural plans are regularly reviewed and that the nursing team are engaged in behavioural plans on each shift, it was noted by the 2 staff that much progress has been achieved from previous behavioural base lines in the previous ward environment prior to the transfer to Ennis this they both said was extremely positive yet constant.

In my discussion with the Ward sister regarding resettlement and community integration, she shared the following information. As a team they had been informed that the ward was due to close in March 2013 and that the Resettlement Process commenced in March 2012. All patient Annual Reviews were postponed by the Ward Consultant to facilitate weekly Resettlement meetings.

The Resettlement process began and progressed through the assessments despite working through times when there were unfortunately high levels of staff sick leave. At times the staffing suffered gross shortage ie 4 AM staff plus staff at 9.30AM.

This was highlighted with the Nurse Manager for the ward via emails, conversations and incident reporting. The manager for the ward spoke to me about my concerns.

The nursing staff's interest and morale did not appear to have lessened and every opportunity was still being provided to introduce the patients to the community. During the summer of 2012 a leaving party was held for the patients and their families. With Marquee and a musical entertainment, the patients had a great time on the day. We invited one of our ex patients, who had been successfully resettled in 2011 and she attended with a group of her friends to the dance.

Prior to this Allegation there had been a decision taken amongst patient's families, advocates and Multi disciplinary team that three patients would go to the Bohill Care Home on Trial Resettlement. Assessments have been collated and care plans drawn up. The team leader and manager had visited Ennis and had been in attendance at Resettlement meetings along with R.Scott CIP and Care Managers from the Belfast Trust.
Staff from the Bohill had begun a 6 week period of visiting the patients in Ennis and getting to know them and their needs. Unsettled behaviours of some patients were noted early on and reported to me as ward sister, this was relayed to the Resettlement team. I expressed concern that a period of 6 weeks may be too long if the patients continued to be upset.

At a meeting held in Erne ward to Review the progress of the visiting staff and patients it was requested that the "Bohill staff come to myself if they had any concerns", "I had to redirect member of Bohill staff as a disturbed patient was directing verbal aggression towards them, during their time on the ward".

The staff visits by Bohill had commenced before the ward sister in Ennis had a copy of their duty rota. Staff on duty found this confusing at the time. It was explained that there was problems with the Bohill Care Homes emailing system. The duty received did not reflect the names or numbers of all the staff who reported for duty.

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On one occasion a nurse in charge received four staff who thought they should be in Ennis that day. The staff rotated on a 3 daily basis, two and sometimes three staff together every three days. Induction for this amount of people under the conditions we were working proved to be extremely difficult. The induction process that had been agreed did take place with staff from Bohill but Bohill had sent additional staff without first communicating with the ward sister to inform her of the same. This did result in confusion.
I found evidence of adherence to Trust policy and guidance by the nursing team and active leadership by the ward sister and deputy ward sister.

Documentation review findings;

1. **Patient Nursing notes spanning last two years 2011-2012**

- Roper, Logan and Tierney model care plans in use, fifteen activities of living completed and a review process conducted each six months. This is a person centred care planning process for Nursing Care.
- Named nurse and associate named nurse identified within each set of notes, each record was signed by the nurse recording the information.
- The ward team is actively implementing the need to care for each individual patient in accord with the RCN Dignity Standards;
  - understand my health,
  - respect me,
  - get to know me,
  - having choices,
  - making decisions,
  - feeling safe and promoting my safety.
- Current Patient Protection Plans evident within the notes.
- Patient body charts were used recording bruise/marks noticed, when supporting personal hygiene care, with appropriate medical intervention when required.
- Behavioural plans with Antecedent, Behaviour and Consequences charts, known as ABC charts evident within the plans.
- Contemporary daily care reports written by registered nursing staff.
- Incident reports, Vulnerable Adult forms with associated person centred interventions recorded.
- Personal requests made by patients to be reviewed by the medical team regarding care were recorded.
- Nursing staff concerns relating to aspects of care recorded.
- Not all notes had a current Social Work report but evidence of an historical report.
- I found evidence of basic personal care, personal hygiene, Oral hygiene, fingernail and hand care, toe nail and foot care, hair care and clothing care were all appropriate and respected choice and identified personal preferences of the patients.

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- For some patients there were transitional plans covering moves from the previous clinical environment to the present.
- Multi-disciplinary care reviews were recorded and more recently the integrated community plan meetings were recorded with invitation to family to be involved but not always availed off.
- All patient notes reviewed held the status of delayed discharge from 2007, with many care environments having been assessed and deemed not appropriate or the external providers deeming the patients to be complex and challenging and unsuitable for their environments.
- All files reviewed were consistent with multi professional working relationship, ie the drug kardex was in line with medical review, nursing record and other records. There was evidence of active consultation between members of the multidisciplinary team with record made in the respective notes.
- All patients reviewed had high levels of co-morbidity including learning disability, sensory impairment, communication difficulties, physical ill health, severe and enduring mental illness and challenging behaviours.

2. Drug Kardex

- Pharmacy reviews were present in the files. Current and past documentation evidenced practice adhering to the controlled drugs standards and drug trolley key , storage of drugs, administration of drugs standards by Nursing and Midwifery Council .

3. Medical file which included Allied Health Professionals interventions

- All eight files had Capably Assessment completed in 2010 for access to personal funds; Patient Financial review documentation was not reviewed.
- Regular Blood results.
- ECGs reports.
- Blood test results required for mental health drugs completed at prescribed time frames.
- Dental care, and recorded pre-intervention drug therapy to calm the individual patient were appropriate.
- Foot care.
- Speech and Language Therapist involvement.
- Behavioural plans and review.
- Day care plans and review.
- Other medical interventions and associated documentation recorded concerning physical health issues relevant to individual patients, Heart care, diabetic care, gynaecological care, assessment for dementia.

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Analysis of Monitoring Forms and Evidence of effective care process found in the review of patient files

I thematically reviewed all monitoring forms submitted and the evidence found in the patient files using The Early Indicators of Concern (University of Hull) and the RCN Dignity Standards.

A total of 118 monitoring forms covering 1519 hours of observed practice have been submitted over an eight week period by independent monitors, to observe practice over a 24 hour cycle.

Results from the monitoring form review and direct observation:

All 118 monitoring forms identified many examples of good practice and positive interaction by staff with patients and similar was directly observed.

The positive themes were;

- The monitoring forms and patient files showed that concerns about patients care and wellbeing is a high priority for all staff in Ennis. Each concern is rapidly addressed by appropriate intervention.
- I found evidence from the monitoring forms of proportionate use of supervision and observation. There was evidence that staff were aware of the need for personal privacy for patients and that intrusion must be proportionate.
- I found evidence that the nursing care and the environment encourages;
  - The care of personal processions; where there is minimal family involvement, the named nurse and associate staff promote personal belongings, as appropriate with life story work and individual preferences when possible,
  - Financial care promoting independency in appropriate manner,
  - Supporting patients to care for their personal space promoting self care appropriate to the skill and needs of each patient,
  - Essential records are being kept effectively,
  - Known personal choice/ preferences are supported e.g. country and western music, car outings, garden time, object reference such as bottle tops which supports one patient to self calm herself, time alone, etc.
- Staff anticipating behaviour escalation between patients and defusing the same when and where possible by appropriate intervention. The nursing team actively intervene to prevent challenging behaviours between patients and towards staff. When an incident occurs it is recorded and reviewed to change practice if required.
- I found evidence of a high level of critical appraisal of evidence i.e. analysis of patient behaviour, the aim of which was to understand the behaviour and therefore make an informed decision about care approaches to meet the needs of the individual. This level of attention to the caring process was complimented by

knowledgeable staff who demonstrated understanding of the diverse and complex care needs of the patients in Ennis.

- I found evidence of appropriate AHP input to personal protection plans which were also acknowledged as potential restrictive practice and recorded in patient care plans e.g;
  - Protection plan, that only three patients be present in the lower dining room to facilitate proportionate support for meal time behaviours which promote reduction of risk of choking the promotion of fluid intake and self management of dining cutlery, recommended by Speech therapist,
  - Protection plan, for some patients the requirement of doors being locked near the kitchen area to reduce the risk of self injury,
  - Protection plan, locked doors near the hall way close to the Nursing office as some patients have been assessed as requiring this intervention for self protection,
  - Care plan, promotion of personal dignity by use of bathing suit as an under garment and belt to "divert" i.e. behavioural therapy approach to reduce the behaviour of the removal of clothes.
  - Care plan recorded oral bleeding and ongoing treatment needs for one patient, this bleeding generates distress for the patient and she would be known to scream and cry out when she notices the bleeding. Staff reassures her at these times but often she appears inconsolable. She requires drug there prior to each dental visit and or potential intervention. It is also noted that there is minimal family involvement and desire to be involved in the community integration plan.
  - A patient was diagnosed in 2012 with an emergency condition requiring quick identification and transfer to the local general hospital along with her specific medication kept on the ward. A protection Protocol was developed and is explained to all staff in the practice environment this has facilitated staff intervening appropriately and the patient remains well.
- I found evidence of communication needs from a person centred care perspective for each patient in the care plans e.g. Pictorial support aids, Simple verbal consistent instruction, behavioural redirection, de-escalation strategies, Sensory stimulation or reduction of stimuli. This evidence was complemented by the demonstration of staff knowledge within their skills of communicating with individuals and their correct interpretation of patient's behaviours and what the behaviour may be aiming to communicate. The outcome within their approaches promoted calm and responsive care, both within the monitoring reports and my personal observation.
- I found evidence that involvement with external agencies, relatives, multi-professional staff are all openly facilitated. There is also an unrestricted visiting time freedom for visitors. The ward was an open environment with the daily contact with estate management staff, hotel services staff, administration staff, transport staff and professional staff.
- Patients are encouraged and facilitated to talk to staff and visitors, on the ward and in private. I did not find any example, during direct personal observation, of staff preventing patients speaking to staff or visitors, nor was there evidence of such

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restriction on the monitoring returns. Each patient is offered an explanation of who you are and your purpose within the environment, openness is encouraged.

- I found evidence of dietary needs, choices, preferences and consistency of food requirements are individual to each patient and are meet, as far as is possible,
- I found evidence of fluid intake encouragement is promoted and supported no restrictions for patients both observed and recorded.
- I found no evidence of a culture that may be accepting of behaviours or communications that could be defined as abusive or any evidence of systemic abusive practice.
- It has been reported to me by Ester Rafferty has been given 4 induction papers that were jointly signed off as having had the opportunity and completed the induction process by Bohill staff and Ennis staff. This evidence will challenge the comments alleging that no induction took place. Ester Rafferty will report on this matter.

From the 118 monitoring forms only 67 that had identified concerns the key themes were;

- Staff levels at key times in the day impairing the ability to facilitate the needs of patients for activity based interventions,
- The challenge of keeping the curtains up with the frequency of the patients pulling them down,
- The challenge for staff maintaining dignity for some patients with the behaviour of removal of clothes,

Nursing Practice Placement Review

Prior to this practice allegation there have been no concerns with respect to this practice placement area over the last 2 years. This is inclusive of professional staff from Queens University.

Ennis currently has 3 mentors. 2 sign-off mentors and 1 mentor who are registered on the live mentor register.

The ward area was last audited in September 2012.The outcome of the audit agreed two students but reduced to one following temporary move of band 6 to Donegore. A Band 6 nursing position had not replaced by an equivalently experienced nurse at the time of the allegation. This has been resolved in November 2012. This learning environment is audited to facilitate novice to the final placement in management students, this is a commendation for the ward practice area.

The student evaluations themed were all positive about the learning and supportive experience offered them by the nursing staff in the ward some of the quotes were:
"Great support from mentor", "staff supportive", "all my learning outcomes achieved", "the induction to the ward was informative and gave me knowledge about the ward and practice". Progressive development of an orientation pack for students is underway; also a further member of staff will be commencing the mentor training in Sept 2013.

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The ward area is still open for future student placements although the recent student was re-allocated therefore no student currently on placement.

We await the outcomes and recommendations of the investigation before advising Academic Education Institutes (AEIs) of any changes to the area prior to the next QUB allocations. Allocations will take place in January for March students.

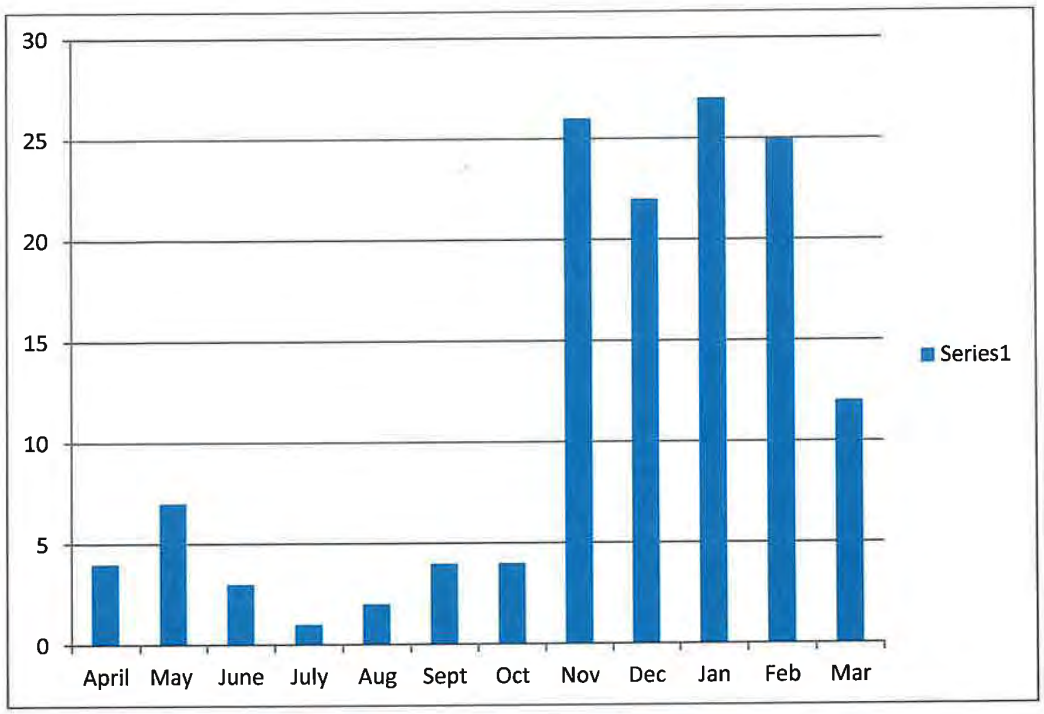
Recommendations

- That the current protection plan of continuous monitoring activity be discontinued as there is no evidence that there is a culture tolerant of behaviours that could be defined as abusive or support systemic abuse.
- Complete investigations as rapidly as possible to allow normalisation of the care environment.
- Recommence student allocations to this practice environment for the March students in Queens University.
- That we progress with the improvement plan for staff in the Ennis environment .

Moira Mannion
Co-Director of Nursing: Education and Learning
8th of January 2013

1.026d23

Appendix 23



Vulnerable Adult Referral 20012 to 2013

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
4	7	3	1	2	4	4	26	22	27	25	12

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Date	Activity	Notes	Day
Jan-10	Ward F4 closed and all patients transitioned to Ennis ward	Consultation took place with families	
18/09/2012	Datix Incident recorded staffing shortages	No prior incidents regarding staffing levels recorded back to 01/01/2011. Manager asked that staff record incidents and make him aware of periods of staff shortages	
12/10/2012	Email to B Mills from H491 highlighting staffing shortages		
23/10/2012	Datix Incident recorded staffing shortages	Bank staff used. ASM requesting Access NI to be fast tracked. New band 6 deputy roles being created.	
26/10/2012	Datix Incident recorded staffing shortages	Agency staff recruited. Staffing establishment reviewed.	
01/11/2012	Email from ER to CS asking to meet to discuss staffing shortages		
02/11/2012	H491 Met with CS to dicuss staffing shortages	CS agreed to review staffing levels and make changes	
07/11/2012	Concerns raised by Bohill staff member	A Bohill staff member finishes her shift in Ennis ward and contact her line manager at 22:30 to raise concerns about her experience in Ennis ward.	
08/11/2012	Internal monitoring report highlights issues	Issues with atmosphere, culture and lack of stimulation	
08/11/2012	Bohill management attempt to contact BHSCT to report concerns	Bohill staff try to contact the DO at MAH at 09:40, they are put through to the Duty SW but don't get an answer. 09:50 Bohill attempt to contact MAH safeguarding officer but do not get to speak to anyone.	1
08/11/2012	10:10 Bohill report concerns to RQIA		1
08/11/2012	RQIA make ER aware that a complaint has been received.	Priory email MAH a breakdown of allegations. ER emails D-O-C informing her of RQIA report	1
08/11/2012	MAH medical staff commence body charts for all patients on Ennis ward.		1
08/11/2012	4 VA1 forms are completed by MAH staff		1
08/11/2012	Families contacted by telphone regarding allegations		1
09/11/2012	AM drafts a press relase regarding incidents	Sent out for review and comment	2
09/11/2012	AM sends press realrease to RQIA (AM)	Back with comments	2
09/11/2012	MAH strategy meeting held	Decision that NOK should be contacted for all patients on Ennis ward.	2
09/11/2012	Senior Nurse manager contacts all family members	No concerns raised.	2
09/11/2012	Early alert notification submitted?		2
09/11/2012	Email from NMcG at the department enquiring about early alert to JV	Received a verbal overview… ER said that a more detailed written version is to follow next week. Can I just confirm an EA is in the pipeline? LF emails ER on the 13 Nov asking her to respond to NMcG and forward a copy of EA to JV	2
12/11/2012	Email from PSNI to AM, ER & JK outlining allegations	B2 made statemnt 09/11/12	5
14/11/2012	Email from PSNI to AM confirming staff can be advised of concerns being raised		7
14/11/2012	RQIA unnanounced inspection		7
15/11/2012	Letter form RQIA to ER outlining concerns from unanounced inspection		8
15/11/2012	24hr monitoring commences on Ennis ward		8
15/11/2012	BHSCT staff met Bohill staff to carry out interviews	9 Bohill staff interviewed who had provided shifts from 04/10/12 - 10/11/12 on Ennis Ward Total of **76 incidents involving 6 patients 63 concerns**	8
15/11/2012	Email from AM to CMcN re baord member queries	JMcK board member asked the safeguarding specialist what was going on in MAH, was directed to LD services. AM highlights concerns about recent visit to ward. ' 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'	8
15/11/2012	Risk analysis update Strategy meeting	Update provided on PSNI investigation. Update on allegations. AM visited Ennis ward with H92, concerned about a number of things she had observed during her visit. She felt the ward manager had spoken inappropriately about patient care and support needs in front of them. Lack of interaction with patients.	8
21/11/2012	Email from RS to HR requesting lists of all staff who worked in Ennis		14
22/11/2012	6/9 Bohill staff reinterviewed by BHSCT staff	This was to seek further information to try to identify MAH staff	15
23/11/2012	Internal monitoring report	Lack of stimulation, lack of privacy and no activities	16
29/11/2012	Draft letter to follow up telephone contact with familes.	This does not appear to have been sent - see emails from AM & JV 14/12/12 & 18/12/2012	22
30/11/2012	Email from AM to ER & JV attaching draft letter to families	For Info letter that will go out to relatives following a phonecall to them. JV forwards letter to M Mitchell, she repsonds weith ' John I have issues re this letter, can we discuss tomorrow>'	23
30/11/2012	M mMitchell sends copies of past monitoring reports for Ennis ward.		23
03/12/2012	Letter from RQIA outlining the actions they want taken forward and requesting a response by 10 Dec 2012		26
04/12/2012	Email from JV to AM, ER & PMcF - discussion with families to be deferred.	Aine, I have only picked up on this this week and would like to be fully briefed on progress to date on the vulnerable adults investigation as quickly as possible on your return from leave. At our meeting I would like to review communication with families to date and agree how best to keep patients and families informed. Pending our meeting I should be grateful if you could postpone further communication or correspondence to families. In your absence I tried unsuccessfully to contact Debbie with the request that further discussion with families is deferred and letters are not issued in your absence and have asked Pat, in Barneys absence, if he could follow this up on my behalf. We can discuss further next week on your return. John'	27
05/12/2012	Email from P McF in respons to JV email	John, Sorry little success. Letter was typed in carlisle and then forwarded to Everton to Aine for circulation. No records are kept in Everton of outgoing mail, therefore unable to determine if letters have gone out. Tried to contact Aine on her personal mobile no luck left message if she gets back I will update you.	28
12/12/2012	Response to RQIA letter sent by ER providng update and response to queries		35
12/12/2012	MAH strategy meeting held	Further update to given to familes and then followed up with letter, feedback 'largely positive'	35
12/12/2012	Ennis ward investigation meeting	Trust interviews with Bohill staff have taken place. PSNI interviews have not happened yet. MM to be appointed as lead to coordinate monitoring. Monitoring reports so far show good practice but concerns raised about low staffing levels, lack of stimulation for patients and lack of privacy for patients. All relatives to be updated and a letter to sent to follow up. Calls to be made by community staff.	35
12/12/2012	Email from AM to JV highlighting admin resource difficulties delaying the investigation	John, I know we discussed asking M to be a minute taker for the Ennis meetings. However I have discovered that the temporary admin member of staff that I was relying on to do other Ennis admin work left suddenly last week. This has left me with a large amount of work undone, thus delaying the investigation. There is a lot of admin work associated with this investigation particularly the collation of lots of information. As you know, I can't use D as she is related to two Ennis staff members. This investigation has meant a dramatic increase in my current work load and I am struggling to find the time to do all that is needed. I feel that I have a urgent need for some admin support with it.	35
14/12/2012	Email from AM to ER chasing up body charts		37
14/12/2012	Email to JV from AM informing him some of the family contact had already taken place, AM felt that a follow up letter to families needed to go asap. Draft letter attached.		37
17/12/2012	Email from Colette Ireland listing family contact	10 family members contacted by phone (names redacted) . CI contacted ER to confirm a telephone number for P39, ER asked her not proceed with the letter being sent.	40
17/12/2012	Contact by patients brother highlighting concerns raised by sister	Call from P4 [redacted] that sister said a staff member had grabbed her by the scruff of the neck. Told this would be taken forward in the investigation.	40
18/12/2012	Email from JV to AM in response to her draft letter to families.	As you know I have considerable reservations about formalising communication with families at this stage of a Vulnerable Adults Investigation and understand that this is not routine practice. Such an approach from my experience tends to unnecessarily raise anxieties of next of kin who are immediately more likely to involve third parties such as the press or legal representatives which I do not believe would be helpful or appropriate at this early stage. I would like to discuss this further if a letter is essential at this stage as a consequence of our recent telephone contact I think this should be confined to confirming that a Vulnerable Adult Investigation has commenced and Collette (or whoever made telephone contact, can address any queries if necessary. Dependent on nature of any such queries decision can be taken to refer to police, Esther or yourself)'	41

20/12/2012	Ennis strategey meeting	9 families have been telephoned, the rest have not been contacted yet and letter has not been sent as Mr V expressed concerns that the most recent draft may heighten anxiety of relatives and could lead to adverse media attention. MM noted that one of the patients involved had made an allegation that she hit her. This was not the case as she has at no time been alone with her. MM felt it was important to note that this patient could make false allegations. Bohill staff referenced positive experience on other wards in MAH compared to Ennis. Elaine McCormill noted this is a significant point that the allegations were not about care throughout the hospital but only on Ennis Ward. AM noted that this was positive however, it also potentially further heightened the concern about Ennis as there were clear difference being reported between it and other wards. MM expressed a view that further actions was not needed in relation to the staff who is described as having held patient A as she had 'only held her'. AM disagreed with this saying that she would view this with equal seriousness. HR asking if the Trust could proceed with disciplinary interviews, the PSNI said no. GM stressed the need to move ahead with Trust processes as soon as possible, the police could not provide a timescale. MM expressed concerns about the impact of monitoring on staff and proposed monitoring should be stopped and move to the 15 step model. AM said this could be a proposal for moving forward, she felt it was too early to move away from 24hr monitoring as the allegations are extremely serious in nature and that they had occurred as alleged the fact that they were carried out in an open manner caused grave concern about the culture on the ward. AM offered to brief staff about their concerns but ER & MM said this wouldn't be necessary. Confirmation that social service interviews with Bohill staff are now complete. MM felt the introduction had provided too much information to Bohill staff and could compromise the investigation. She said it was important all procedures were followed correctly as these were very serious allegations and professional reputations were at risk. ER suggested the use of SALT to advocate for patients, AM said that SALT had a role to support advocates but she did not feel SALT as Trust employees could act independent. MM said she objected to AM impugning the professionalism of SALT by saying they could not be independent. AM noted by separations those responsible for investigating planning should be separate from staff delivering care, the Trust felt it had introduced some independence into the investigation.	43
28/12/2012	Email from JV to AM, responding to emails to ask for sign off on letters to family	Aine, Sorry for the delay in getting back to you but think formal correspondence regarding this matter can now wait until early new year. On look at revised minimalist draft I still think it is likely to cause undue concern (and possible external interest) at this early stage of the investigation. Has any part come back to us in the meantime to request letter? I think we should review position on Wednesday on Barney's return.	51
08/01/2013	Patient [P44] sister raised 7 concerns	These do not appear to have been investigated.	62
08/01/2013	Meeting with PSNI	Interviews with 2 staff planned, hopefully next week. Concerns expressed about HR sitting on the strategy team. PSNI advised not to start staff interviews until after the 2 accused are interviewed.	62
09/01/2013	Ennis ward investigation meeting	Mr V drew attention to the list of allegations presented by AM at last meeting. He noted whilst some of the allegations were quite specific, others appeared to be negative comments i.e. not specific allegations. He emphasised the need to obtain evidence and facts when allegations are being made and noted a potential difficulty in doing so with regard to negative comments. AM confirmed the purpose of the list was to ensure all issues, allegations etc. that had arisen were covered. AM stated that the negative comments had come to her attention as part of the ongoing investigation, may provide important information with regard to culture on the ward. RQIA representative questioned ER being part of the working group due to her role within MAH. Mr V explained he thought she should because of her operational knowledge. Excelled contact with families, AM to contact advocate for 1 patient. Format agreed for letter to relatives to be sent once telephone contact has been completed, letter to be sent by AM. AM discussed the allegation of belt tightening, she had spoken to both staff involved. The younger staff member reported low staffing levels, lack of support and supervision. Both members raised concern about a daughter managing her mother within the ward. MC fed back that there was no specific plan or guidance on this patients behaviours nor were there specific behaviour support plans for any patients. She requested that patients are refereed for behaviour support input as there were gaps in behaviour support plans. MM requested that monitoring in Ennis ward stop. AM stated that she believed monitoring showed that staff knew what good practice was and had the skills and knowledge necessary to provide good quality care but she did not believe however that it was possible to extrapolate from this and state good quality care had been the norm before monitoring was put in place. AM raised concerns that with this risk remaining (unidentified staff) withdrawing monitoring at present would continue to pose an unmanaged & unmitigated risk to Ennis patients. RQIA rep agreed monitoring should continue. MM stated 1519 hours of monitoring reports showed no indications of concern about any members of staff on duty & reiterated her proposal to withdraw monitoring.	63
09/01/2013	Briefing report provided by MM regarding monitoring of Ennis Ward	1. MAPA trainer said allegations could be just use of MAPA moves. 2. MM recommends that current protection plans of continuous monitoring activity be discontinued as there is no evidence that there is a culture tolerant of behaviours that could defined as abusive or support systemic abuse.	63
09/01/2013	PSNI to meet with PPS		63
09/01/2013	Patient interview[P44]		63
11/01/2013	Interview with patient[P44] regarding allegation that her dinner had been scraped into the bin and she was refused pain relief.	Patient gave repetitive answers, could not remember the occasion and kept referring to not liking her dinner.	65
17/01/2013	Contact with mother of patinet [P47] concerned about the number of assaults by another patient.	Checked by staff meber and happy appropriate action was taken, there had been 3 attacks in one week and appropriate protection plans in place	71
21/01/2013	Email ER to JV re Ward sister	J, In consultation with HR this morning following the ward sister in Ennis reporting unfit for duty this morning. We agreed that as she is unfit for duty a precautionary suspension is not issued at this time. I met with ward sister and her union rep unison with Clinton. She has been advised that as she is unfit for duty she is to report directly to senior management and not to her ward in the first instance. If the investigation is still not completed a decision will be taken as appropriate at that time depending on circumstance.	75
23/01/2013	Patient interview held[P46] with PSNI	Patient was not able to contribute	77
25/01/2013	Patient interview[P46]		79
25/01/2013	Patient interview interupted by staff member	Email from Carmel Drysdale NHSCT -'I forgot to mention that when Margaret (SN) came into the room during PIA, Tracey asked her if there was something she needed / wanted - M replied that she was just checking that we were all ok. M then stood for a while holding the room door open the proceeded to whisper to Tracey that the patient, whom she nodded towards had said on the ward the night before that another patient had hit her but that the alleged perpetrator wasn't there last night and added that the patient makes things up. As M was leaving the room she left backwards pulling the door with her but still looking into the room - I could see her trying to make eye contact with the patient and pulling a face to her. When she left Tracy and I looked at each other and said what was that about?'	79
25/01/2013	RQIA unannounced inspection of Ennis Ward		79
28/01/2013	Reminder from PSNI requesting patient careplans so they could progress interviews		82
29/01/2013	RQIA Inspection	3 recommendations - individual behaviour support plans are updated regularly and information readily available with patient notes. Patients have the opportunity to engage in therapeutic activities on the ward. Consideration be given to upgrading the ward or alternative accommodation sought	83
31/01/2013	Letter from RQIA to ER following up on discussion 29 Jan 13 . Request for agreed list of information to be provided by 8th Feb 13		85
01/02/2013	RQIA letter regarding unannounced inspection of Ennis ward - concerns	1. Staffing levels, ward manager or NIC are included in the numbers and shouldn't be, risk assessment required. 2. Behavioural support - 5 sets of patient's notes checked and found no evidence of input from BSS. No behavioural plans were noted. 3.3 Environment - concerns about layout, lack of privacy, locked doors, patient movements continuously monitored & controlled by staff. Patients do not have access to bedrooms and personal belongings. 4. Protection plans - 5 sets of patient notes examined no clear protection plans were evident	86

	ER forwards RQIA letter to CM	M response to ER, M Mitchell, JV, VS ' Thank you for copying RQIAs letter of escalation to me. I note the Trust is to meet with RQIA on 11/02/13 to discuss. The letter raises a number of areas of concern which I would value clarity about as RMO as the Ennis team and I continue to develop the best possible practice in the care of the patients in Ennis. In this context I welcome RQIAs input and advice. I would ask that consideration continues to be given by us all to the need for stability, familiarity and confidence in staffing in Ennis. The patients are, as you know, extremely sensitive to change and I would like RQIA to recognise this, in addition to important considerations about staffing numbers. The letter refers to behaviour support input and correctly refers to high levels of unpredictable behaviours. The letter states that RQIA found no evidence of input from behavioural support services before, or since, these allegations were made. I'm not clear whether RQIA expected referrals to ABS, this is done for P46 & P198 for example. Many of the patients have been previously referred to ABS and past advice is reflected in care plans and management. I think that, for most, the possibilities for detailed therapeutic assessment and resultant plans and management. I think that, for most, the possibilities for detailed therapeutic assessment and resultant changes are limited. I can assure you that, where the team feel this is appropriate clinically, that individuals will be referred. I would appreciate guidance / clarity about protection plans. I assume the ongoing monitoring represents a significant protective intervention. In some cases, we have had VA referrals, with specific protection plans. Is it felt by RQIA that specific individual protection plans are in place for each individual?, and if so how can this be designed, given that the team and I aren't aware of the specific allegations and what sort of protection is required? I am very anxious, as everyone involved is, to resolve concerns and to maintain optimum care. I would welcome discussion and clarity to help with this.'	
05/02/2013			90
	Repsonse from JV to CM	Colin, ER is currently preparing a briefing for Catherine and myself on issues raised by RQIA and I note will also be meeting with you to discuss. Once we are clearer on issues we need to agree our strategy for meeting on Mon and who should attend to best effect in deescalating this if we can. We will discuss further in next couple of days but would you be available if necessary on am?	
06/02/2013			91
08/02/2013	Email from ER to JV & cm forwarding RQIA report and prepared report regarding points raised		93
11/02/2013	Email from AM to JV, BMcN & ER informing PSNI interviews with 2 satff members did not go ahead, one was ill and the other hadn't organised a solicitor		96
11/02/2013	Meeting with RQIA to discuss concerns from recent inspection - JV & ER		96
13/02/2013	Further follow up from RQIA for information requested	Further to our meeting on Monday 8th February, you indicated that the information I sought on 31 January 13 was posted to me on Friday. I note that at close of play today we have no record of having received this information. I would appreciate if you could forward your response to me by 12pm tomorrow at the latest.'	98
12/02/2013	Follow up email from AM to ER requesting update to monitoring template	AM is chasing up ER for the agreed updated monitoring template, ER responds to say it hasn't been changed and she will continue to discuss with Dr HS	97
14/02/2013	Email from JV to ER asking her to ammend response letter to RQIA	Just to confirm Catherine has requested we formally respond to RQIA following meeting on Monday. I know Moira is very willing to assist with this'	99
19/02/2013	Email from BI to Mmitchell attaching complete QIP for approval - needs to go back urgently to RQIA		104
20/02/2013	M Mitchell forwards QIP to ER -	Ensure that its as you discussed with RQIA'	105
20/02/2013	Police interview H159	Referral to PPS for prosecution (09/10/12 P39 09/10/12 P43 07/11/12 P39 07/11/12 P40	105
22/02/2013	AM concerns to ER about monitoring passed to RS		107
25/02/2013	Email from JV to MM saying as this is a draft respinse to RQIA he does not need to be involved.		110
28/02/2013	PSNI interview H197 referred to PPS for prosecution	Referral to PPS for prosecution (09/10/12 P39 09/10/12 P39 09/10/12 P43 05/11/12 UNKNOWN, 07/11/12 P40 07/11/12 P22 07/11/12 P41	113
05/03/2013	Email from AM to management team raisng concerns about recent monitoring reports	I'm becoming a bit concerned about the general flavour of recent monitoring reports for Ennis. Since the withdrawal of the supernumerary monitors, there seems to be a greater number of quality concerns reported. I'm also picking up on some reports of staff stress in dealing with challenging behaviour on the ward. I haven't had time to analyse these in detail and many of the reports continue to be very positive... I am also conscious that we have now interviewed H198 who denies any wrongdoing. I feel that there is more investigation required into her alleged actions but would suggest that it would be appropriate to review the necessity of her ongoing suspension as part of a protection plan.'	118
05/03/2013	PSNI interview H159	accused claims 'statements are a vendetta against staff because Bohill staff didn't want to be there'	118
06/03/2013	Reply from ER to AM's email 05 Mar raisng monitoring concerns.	In continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing with information on the quality of the nursing care provided to the patients on the ward of which there are positive reports, whilst including challenges which are present. The monitors are expressing that the monitoring role itself is stressful. A weekly support meeting is in place to discuss concerns. We have a number of action plans that are in place to address environmental issues, furnishings issues, staffing complement, additional staff supports. Further resolution to some issues will occur when the planned resettlements are completed. In relation to the staff nurse I am happy to discuss the staff member if you contact me to provide an update.'	119
06/03/2013	Reply from AM to ER email	My preference would be to meet as I don't have the details of the action plans you refer to. However as an alternative, perhaps you could provide me with these? The details of the discussions at the weekly support meetings would also help keep me in touch with the issues. I remain concerned that I can't identify from the monitoring reports whether or not staffing levels are appropriate because of the changing staff observation levels. I know that I had enquired about this before and you said that it was difficult to do but wondering if we could simply ask staff to identify if the staffing dropped below the required level at any stage during their shift as monitor and if so by how many and for how long. Would that work?'	119
08/03/2013	Email from JV to B McN asking if internal meeting has been set up yet		121
11/03/2013	Email from ER to JV proposing lifting of suspension of H198	I had a conversation with AM this morning regarding H198 who is on precautionary suspension. A has confirmed that there is no evidence to substantiate the allegation of manhandling a patient. She expressed concern regarding the allegation of shouting into a dayroom but agrees that this issue does not warrant a precautionary suspension but wishes this to remain part of the VA investigation. The other issues raised are management issues of shift supervision and co-ordination which I will propose to manage under the capability process. In light of this I would propose to lift the precautionary suspension'	124
26/03/2013	Email from JV HR should not attend strategey meetings - relevant updates will be provided.		139
29/03/2013	Ennis ward Investigation meeting	File has went to the PPS recommending prosecution, this could take 12-18 months. Mr V stated ' while recognising that the investigation is incomplete, he emphasised we are 5-6 months into this investigation and there is no evidence of institutionalised abuse' Staff interviews will commence 15/04/13. Mr V confirmed ER should continue to attend meetings. AM confirmed families were updated after 09/01/13 meeting but should be updated again, it was agreed the PSNI would provide the update. There is reference to discussion with patients generally about the ward (I can only see one interview) AM referred to P205 s sister complaint and stated it would not form part of the safeguarding investigation. Team asked to feedback on Safeguarding report (Doesn't occur to July 13 see 17/07/13)	142
29/03/2013	PSNI shared copy of police investigation report emailed to ER, BMCN and M Mitchell		142
05/04/2013	Report on Ennis Ward provided by ER	Outlining action taken to date and next steps	149
10/04/2013	ER emails list of all staff who should be interviewed to AM		154
11/04/2013	AM emails lists of questions for staff interviews to ER, BmCn, JV,DH, CD & CI		155
22/04/2013	Email from HR to JV & BMcN requeting update on investigation and suspensions	GM in HR emailing asking if PSNI have said the internal investigation can go ahead. Asking if we are in a position to review suspensions. BmN replies that he has moved from LD services so cannot help with this query.	166
23/04/2013	Email response from JV to HR	Police have forwarded file to PPS for 2 staff. ER is currently following up with police to establish if we can commence our own disciplinary process	167
09/05/2013	Letter form Theresa Nixon RQIA requesting update	Letter dated 09/05/13, received by JV 15 May 13, emailed TN to say he could not meet the deadline but would respind bt 27 May 13	183
16/05/2013	Email from M Mitchell to JV attaching audit of protection plans and care planning	MM had asked JA to carry out an audit of protection plans and care planning - 7 patient records examined. Restrictive practice 5/ 7 yes recommendation to issue guidelines to staff re the recording of vulnerable adult issues and restrictive practices in the patients care plans	190
22/05/2013	Ennis strategey meeting scheduled but cancelled by AM		196
22/05/2013	Email from JV to ER asking her to ammend response letter to RQIA	I do think letter needs some redrafting as it is ambiguous in places e.g. it suggests Band 3 and Band 5 who retired did so because they were abusing patients which would feed into an assumption of institutional abuse…. Also I was not aware that the Trusts internal investigation in relation to these staff has commenced and assume we received written agreement from the police that they were content for us to do so. What are the ToR and who is investigating?....It is also important to emphasise that this investigation has not only focused on specific allegations but has equally explored any concerns regarding institutional abuse'...It is also important in addressing this specific concern to refer to the continuing daily monitoring arrangements which have been maintained despite the disruption to the ward routine and which have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture'	196

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24/05/2013	Email from JV to AM asking when she will be interviewing the last of the staff and aksing for report to be ready by the end of June. AM responds that this is achievable.		198	
30/05/2013	Email from HR to JV asking for further update	Review of suspensions, can internal investigation commence.	204	
06/06/2013	JV provides a written update to RQIA as requested on 9 May 2013	I can assure you the Trust acted swiftly and diligently in immediately sharing information with all appropriate staff and in addressing the immediate and ongoing protection needs of the patients within this ward..' ' This investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse.... I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture'	211	
28/06/2013	RQIA response to update from JV (written by ER)	Requesting copy of the investigation report. Reference to an announced inspection 29 May 2013, inspector noted the internal actions taken following the recommendations made following 25 January 13 inspection. You refer in your letter to the fact that information was shared with all staff but the inspector interviewed staff on ward and it appeared that they were not aware of the nature of these allegations so you may wish to review.	233	
01/07/2013		ER commissioned RS & GH to undertake an investigation into incidents alleged to have taken place within Ennis Ward. ToR agreed and provided to the investigating staff	236	
05/07/2013	Ennis ward investigation meeting	Update from PSNI no decision from PPS yet. MR V asked that pressure be put on to move this forward as public money is being used to pay suspended staff. Mr V asked ER to meet with HR and see if the investigation could start. AM advised that the conclusion reached by the investigation team was that there was enough evidence to warrant a considerable level of suspicion (culture of bad practice) Mr V stated there had been an extensive and thorough investigation & the hospital team are indebted to the staff who carried this our. It has been 8 months since the investigation commenced and robust management action has been taken in response to any concern. The final report will need to take into account the improvements which have already been put into place.	240	
17/07/2013	Email feedback on Safeguarding report from MM	General feedback on typos etc. Clarity of some information required. Sections need to be set in context.	252	
02/08/2013	Email from RQIA - comments and feedback in relation to Ennis investigation report.	Requst that interviewwith [redacted] takes place urgently as it is now 8 month after event. RQIA inspections in Dec12, Feb 13 and May 13 show no eveidence of protection plans - hwi is the report saying protection plans were appropraite? Concerned that the report says no evidence of belt tightening, they felt there was sufficent evidence as it seemed to be a regular occurrence. **33 Queries**	268	
19/08/2013	Patient [redacted] interviewed	Postive about time living on the ward	285	
19/09/2013	Email from RS to AM explaining she and GH are starting the internal investigation	You may be aware GH 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 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 possible.	316	
19/09/2013	Email response from AM to ER cc JV	Esther I wasn't aware 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.	316	
19/09/2013	Email ER responding to AM	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. AM responds asking if this is a disciplinary investigation and ER responds yes.	316	
04/10/2013	Email from PSNI to AM PPS are reccomending prosecution of two staff.		331	
25/10/2013	Email to strategey team attaching updated Safeguarding report, from Am	Hi All, Thanks for comments on the draft report. These have all been considered and the report amended accordingly. I apologise for the delay in sending this out. A lot of discussion at the last meeting focused on the validity of some of the statements made by staff in interviews. The investigation team felt that the summaries of what staff had said should remain in the report. However, it is made very clear that in reporting what was said, no comment is being made on the validity of these statements. The conclusions based on all the evidence including what staff said are to be found in the conclusions and recommendations section. There was also concern at the last meeting that the report contained statements about issues that did not constitute adult safeguarding issues but that the reader may nevertheless be concerned about. The investigation team has therefor added a section on page 62 detailing comments and clarifications that were provided to the team on these matters. It should also be noted that this investigative report does not constitute the full record of the adult safeguarding process. It should be read alongside all other documentation, minutes and reports that were presented during this process. I would propose that the meeting on Monday concentrates on the recommendations and any necessary actions in relation to these.	352	Safeguarding Report Complete and circulated
28/10/2013	Ennis ward investigation meeting	Mr V expressed concerns re investigation whilst PPS are taking charges, request to seek HR advice. Mr V concerned about calling Bohill statements evidence. Mr V acknowledged the very thorough investigation and that it showed no concerns about institutionalised abuse. AM did not feel that the investigation was conclusive enough to be able to state categorically that there had not been institutionalised abuse. Mr V said it was important not to speculate but only draw conclusions on evidence.	355	
11/11/2013	Email from HR to ER asking for an update on investigation	Request for update on PSNI - can investigation commence? Update on staff suspensions and update on VA investigation	369	
12/11/2013	Email from ER responding to HR queries	PSNI investigation complete, VA investigation is complete AM will have report signed off Jan 14. PPS going ahead with investiagtion, Trust content that staff remain suspended. Investigators have been appointed (RS & GH), ToR enclosed which were agreed with MM. JV asked ER to liaise with MM to agree ToR	370	VA investigation comeplete ToR agreed for internal investigation
22/11/2013	Email from PSNI to SM about report from family member	Allegation that [redacted] had been hit in the face by a door, staff said it was accidental but sister worried due to current allegations. PSNI visited ward, met patient and checked notes. Concerned notes did not fully record what happened but were satisfied no criminal act. NOK were updated.	380	
26/11/2013	Media enquirey form Chris Kilpatrick	ER agreed media response 'We are not in a position to comment on ongoing legal proceedings, however all allegations of ill treatment to the people in our care are taken very seriously'	384	
20/01/2014	Adult Safeguarding meeting scheduled but cancelled.		439	
07/02/2014	Communication from solicitors representing 2 staff members	Court case due to take place 11/2/14, seeking adjournment and requested an extensive list of documentation within 7 days	457	
25/02/2014	Email from AM to JV, ER, MM CD, CI & DH requesting to approve last two sets of Ennis meetings urgently (Jul 13 & Oct 13)	The minutes need to go to the defence team 'I need the minutes finalised before any rearranged meeting. Given the amount of debate in the two meeting which mostly involved Trust staff, I would prefer it if we could agree any amendments internally before sending out to RQIA, the PSNI & other Trusts'	475	
05/03/2014	Email from AM to ER asking for information to be gathered for defence request (Court)		483	
06/03/2014	Email from The Board RE early alert submitted in Nov 12	Stating it remains open and no SAI has been received . Contact was made with the DRO to ask if it could be closed. DRO ' given the seriousness of this incident and its public interest I am of the opinion that it should be an SAI'	484	
06/03/2014	Email to AM from JV	JV asking if AM could advise whether this is the most recent version of the safeguarding report or if there have been subsequent amendments. AM replies on the 10 March to say there are a few final tweaks to be made **Report is dated 23 Oct 13**	484	Was Safeguarding Report still being altered at this stage? Report dated 23/10/2013
12/03/2014	Email from AM to litigation providing list of information gathered.		490	
08/04/2014	Email from AM to litigation listing the information for the defence which is still outstanding		517	
08/04/2014	Adult Safeguarding Conference Ennis Nov 12	Aim of meeting to obtain update on police investigation, review the conclusions & recommendations from the investigative report and discuss feedback to relatives. PPS continuing with prosecution, AM explained solicitors have requested a lot of information. ER confirmed that the information requested was being prepared and should be with AM by Friday. PSNI spoke to families and told them the charges as this is now in the public domain, they will continue to update them with court dates. Update on investigation, 2 staff selected to carry out RS & GH. Letters sent to all staff inviting to interview but Trade union discussion are causing delays. AM expressed still having concerns about staff attitude ER & Mr V said this was perception and no evidence. Discussed that staff on ward did not believe Bohill allegations. PSNI rep concerned that these allegations did not concern staff. Mr V felt this was open to debate and doesn't add to the investigation, opinions are not evidence. Mr V confirmed that the independent monitors were positive in their reports and had no concerns. ER confirmed this. AM felt that the monitoring did show that staff did know what good practice was. A protective factor was the mix up of staff group with new staff coming on to the ward. Mr V advised that there was no other evidence to inform current perceptions about the ward	517	
01/06/2014	Bohill staff interviewed for disciplinary investigation		571	Bohill staff internal investigation interviews
26/09/2014	AM email to Mr V & ER update on court proceedings	PSNI contacted to advise that the contest had been delayed waiting on the return of the main witness from Australia, she has made contact to say she will not be returning. PPS keen to communicate with families and ask if they would be satisfied with disciplinary action. ER confirms investigation on going and AM communicated that the Trust disciplinary procedure is separate and not for use by the PPS.	688	
26/09/2014	ER email response to AM RE Investigations	Aine The Trust investigation has not concluded as yet. A decision of further action can only be taken once the investigation report has been reviewed. The PPS need to make their own decision regarding their own processes.	688	
06/10/2014	Email from PSNI informing PPS have set contestr date for 23 October 2014		698	
21/11/2014	[redacted] convicted of 1 crime, [redacted] aquitted of all charges			
16/12/2014	[redacted] given a suspended sentence in court			

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16/01/2015	Further email from Board governace team - EA remains open, no subsequent SAI has ever been received and the DRO feels that it should be an SAI. Update required.		800	
28/01/2015	Email TO Board Governace team -responding (not available)		812	
03/02/2015	Board governace team response	DRO highlighting SAI reporting criteria, this incident meets 4.2.5 and 4.2.8. Acceptable to delay Sai until after criminal proceedings, the SAI should run parallel. SAI should identify learning. Trust should formally notify this as an SAI.	818	
06/03/2015	Email from Board Governace team again requesting SAI		849	
24/04/2015	Email from corp gov asking if SAI has been submitted yet.		898	
13/05/2015	Email from corp gov to Board gov team	Repsonse to queries regarding EA - happy to shre investigation report but not re-opening investigation	917	
01/06/2015	Investigation team meet AM as part of their investigation		936	
02/09/2015	Letter to H159 stopping suspension	Letter from ER ' Dear H159 , I am writing to confirm that the allegation of abuse of a vulnerable adult has been fully investigated under the protection from abuse of a vulnerable adult process and there is no evidence to substantiate the event. The management team have therefore reviewed your precautionary suspension recommending you are eligible to return to your workplace as a Healthcare worker Band 3 in MAH and as a bank healthcare worker Band 3. This is effective from 14 September 2015, please report to CN Lewis in Cranfield Men at 9.00 on this date. The precautionary suspension was a means of facilitating a proper and fair investigation of this matter. I would like to thank you for your co-operation during this time. The Trust recognises that this may have been a difficult time and should like to make you aware that the Trust can offer a confidential counselling service provided by the occupational health dept	1029	Did H159 appeal her prosecution? No evidence of this in emails or news atricles online
23/07/2015	Email from Lead officer at Board gov team	Clear expectation that an SAI should be reported and completed	988	
23/07/2015	Email from CMcM to MM asking for a service repsonse to Boards request for SAI		988	
27/07/2015	Email from MM to JV making him aware board want an SAI	John, This is re ennis, dro wants an sai report done. Ludicrous or what? I have asked for the name of the dro so I can speak to them about this'	992	
14/09/2015	Letter to H197 Stopping suspension	Letter from ER ' Dear H197 I am writing to confirm that the allegation of abuse of a vulnerable adult has been fully investigated under the protection from abuse of a vulnerable adult process and there is no evidence to substantiate the allegations as stated. The management team have therefore reviewed your precautionary suspension recommending you are eligible to return to your workplace as a Bank staff nurse Band 5 this is effective from 4 September 2015. The precautionary suspension was a means of facilitating a proper and fair investigation of this matter. I would like to thank you for your co-operation during this time. The Trust recognises that this may have been a difficult time and should like to make you aware that the Trust can offer a confidential counselling service provided by the occupational health dept	1041	
09/10/2015	Email from JV to ER, GMCk	Esther / Gladys, Yesterday Aine drew my attention to recommendations from the earlier vulnerable adults investigation which she recalls recommended that the above named should not work with vulnerable adults in the future. I have to acknowledge that I had not recalled this in considering the outcome of the recent disciplinary investigation reports and while I am aware the investigation team interviewed Aine as part of their process I do not think this issue was highlighted in the final report although we do need to double check this. I am also aware of the separate but very much related processes pertaining to vulnerable adult and disciplinary procedures. Within this context can you please forward copies ASAP of formal correspondence issued in relation to both staff members return to work from formal suspension together with details of their current deployments at Muckamore. I am aware we have a further meeting scheduled at Muckamore for 26 October and propose that we use the opportunity to meet also with Aine on that date to discuss this issue further.	1066	
13/10/2015	Email from JV to GMcK	Gladys, we would not have received the Vulnerable adults investigation - in receipt of the investigation carried out by RS & Gh under disciplinary procedure. ER had met with both individuals on 2 Sep to share the outcome of this investigation. Correspondence from ER was forwarded to H159 & H197 I am aware that H159 has returned to work in MAH wef 14 Sep. H197 was a bank only member of staff to date I am have not been advised of her working any shifts.	1070	
14/10/2015	Email to GMcK & ER	I have received Vulnerable Adults investigation report and note relevant recommendation relates to Disciplinary action not as outline in my email of 9 October. I therefore suggest 3 of us review the outcome of Disciplinary process either before or after our 2pm meeting on 26 October	1071	
07/03/2016	Email from AM to MrV requesting a meteing	John, As per our most recent discussion about this issue, please find attached last set of minutes about Ennis which detail the ongoing protection plan of suspension of the two staff and the need to reconvene if there was to be a change.	1216	
24/03/2016	Response email Mr V TO ER	Esther as mentioned yesterday we can discuss after Easter with a view to meeting with AM and a senior HR rep to discuss.	1233	
19/04/2016	Email from Mr V to ER & AM	Apologies for the delay with this but I have now spoke to Gladys who has kindly agreed to join us for this discussion. This will require a review of the Trusts investigation and report completed by Rhonda Scott & Geraldine Hamilton in relation to the actions of H159 & H197 I am now asking Lesley to try to arrange for 4 of us to meet for probably an hour in the next few weeks.	1259	

Teleconference by Marie Heaney and Carol Diffin with Aine Morrison & Jackie McIlroy – Thursday 16th January

Purpose of the teleconference was to facilitate Aine Morrison communicate the difficulties she encountered in carrying out her DAPO role in the Ennis Investigation. Below is a summary of the key points that AM raised during this discussion:

- AM realised in September 2019 that aspects of the Muckamore Leadership & Governance review may touch on her role in the Ennis Investigation. She advised that she experienced considerable difficulty in carrying out the investigative processes which may be relevant to the L & G review. Also AM did not feel she could talk to the families openly and honestly when she couldn't discuss the issue

- At the time she was a Service Manager for LD Community Services. ER was SM for hospital – B McN was her line manager (off sick at the time the AS referral came in). JV Co Director was on leave when the AS referral came in. AM was the designated officer (DAPO) (AM was initially 8A ASM, later on that year she was promoted to Service Manager and Associate Director of SW(LD)). As there was no one else around it was assumed AM would be the DO leading it.

- Bohill staff had made a number of allegations and statements claiming that abuse was happening very openly on Ennis Ward. AM described that her "antennae were up" in relation to the nature of these allegations. Bohill staff very clear that concerns were confined to Ennis – steered those involved to see it as an Ennis problem.

- Investigation was conducted under the Joint Protocol Procedures and there was a Strategy meeting with PSNI. Dr Milliken was the consultant for the Ward and AM advised she did not think it was appropriate for him or anyone from the ward to attend strategy meeting. ER objected strongly to this and there was a major row between AM and ER about this as ER had wanted him there. ER phoned CMN (Director) who agreed that no one from the hospital would be part of this and she advised ER of this. AM believed she was supportive of her rationale for this decision. This was problematic as it meant that no one from the hospital was present at the meeting.

- AM advised that this row had led to problems with her relationship with ER

- When JV and B McN returned to work ER did re-join the meetings which was helpful

- AM described that she had experienced hostility from a number of people and opposition to things she was saying and doing/was it necessary. There was a very high degree of scrutiny which she thought was unnecessary. AM Behaviours were quite aggressive towards her. AM described that MM, inappropriate challenges were made (MM)

- AM advised that ER and herself did not work well together although the direct opposition did not necessarily come from her but rather came from MM.

- AM described that she experienced direct and open opposition from MM who was part of the nursing oversight arrangements, and she was extremely hostile. AM came under verbal attack – "how dare she suggest that nurses were involved in abuse, they were professionally regulated and accountable, they worked to a code of conduct, how could she suggest this?"

- MM was very critical of the Bohill staff and queried the type of training they had received.

- AM advised that the level of hostility was such that after meetings RQIA/PSNI staff would have phoned her to see if she was ok as she had been subject to verbal attacks.

- AM advised that the protection plan for Ennis consisted of external nursing staff providing a monitoring presence on the Ward. AD described that MM was opposed to the protection plan, and fought her every step of the way. The Protection plan involved external nursing staff 24/7 to oversee practice. As the investigation went on opposition to protection plan increased. It was extremely hard to know if the Protection Planning was operational. AM added that the PP was continually opposed and that this was unnecessary – doubling the ward of registered nursing; causing disruption to patients – constant challenge (MM)

- The band 8A from the hospital and MM did some shifts and adhoc visiting in Ennis

- AM advised that they came to very different judgements on the care plans and that their views differed from hers in terms of what was adequate.

- AM described that the hostility did not let up.

- AM advised that she then became the service manager for LD and that she came under very sustained pressure from JV on 2 aspects- he challenged her privately and in meetings
    - What counted as evidence? This challenge was pretty sustained. AM's response was that there were 6 Bohill staff all saying the same thing but JV challenged her on how can she prove it? AM described this as very inappropriate senior manager pressure. There was a keenness by these individuals to provide a better picture. There was significant pressure in the form of questioning.
    - Continuous questioning and pressure not to use the term institutional abuse. AM described that JV would question- was she sayng there was no evidence of institutional abuse. AM responded that she was not saying that there was no evidence. She wrote her report and it said what it needed to say. JV had wanted her to say the allegations were unsubstantiated. JV did not object to the final report.

- AM described JV as hugely difficult and held the view that the Bohill staff hadn't been on the ward that long. Identification of the staff was difficulty – could we ask Bohill staff to look at photographs to identify the staff? JV was extremely opposed to this and AM described a lack of willingness to even consider this.

- Senior management was not as invested in fully exploring issues as she was. AM was very convinced about H159 – very much lacking proof

- There was a suspicion about the abuse going on without the knowledge of others. AM described a meeting that she attended with the staff in Ennis I relation to what had been alleged, what had been found as a result of the investigation and what the concerns were. This meeting was held with 2 x IOs and ER but ER did not speak throughout the meeting. The Ennis team attacked AM verbally and ER did not provide any support for her during this. She described feeling very isolated.

- AM had recommended disciplinary action against the two staff. She became aware of information regarding the staff identified for PPS that disciplinary action was not taken despite the recommendation – however no-one spoke to her about this. She had to try to persuade JV of the relevance of her report and following this they did come to talk to her.

- AM advised that the investigating team went off looking for fresh evidence and they did not speak to her. They had tried to contact the Bohill staff who refused to engage as they were fed up with investigation

- AM believed that there was a disconnect between the two investigations, and that she subsequently had heard that the two staff hadn't been sacked following the disciplinary investigation.

- AM spoke to JV and advised him that she believed these two staff were dangerous to vulnerable adults. Her protection plan involved that they should not be near vulnerable adults.

- JV was more supportive on that occasion – he set up a meeting with HR (possibly Maura Campbell) however it was not to state that the service had major concerns rather to facilitate HR view was that these were separate processes. She was concerned that two different parts of the Trust had two different conclusions. She had stressed her concerns to JV. AM stressed that she was not saying there was a cover up, however resistance/unwillingness of these staff to hear outside their view.

- Overall AM felt that Social Work was pretty unwelcome on the hospital site.

- AM advised that the PSNI at one time had had a plan to put covert CCTV in situ – the Director was aware of this but AM did not think it was implemented. Catherine McNicholl did involve JV in conversation re covert CCTV

- AM advised she had had several conversations with John Growcott and found him to be very supportive raised concerns about independence of internal investigation . The PSNI had also contacted her at this stage and told her that she could not tell anyone. AM argued that she needed to be able to talk to someone and eventually was able to tell C McN. C McN involved JG- the purpose of this was to have a degree of independence in these complex investigations.

- AM advised that in total there were 57 allegations/matters of concern but not all were allegations of abuse. ON clarification she referred to 57 reports of concerns some of which contained allegations of abuse.

- AM again advised she did not believe that this was a cover up but rather was an unwillingness to hear that there was an opposition to outside voices and resistance to outside scrutiny and opinions.

- AM advised she felt she had very clear evidence of H197 and H159 behaviour- one patient was clearly targeted but she could not tell which other staff were doing this but could stand over her concerns regarding H197 and H159

- Disciplinary process really different it is its own process – nothing we can do about it.

- At the final strategy meeting she followed up to see if all issues she had raised had been actioned.

- AM confirmed that she had delivered an investigation outcome that she could stand over and that despite the hostility etc there was no overall impact on the final recommendations that she made.

A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Executive Summary

1. The confidence of families and carers in the health and social care system's ability to provide safe and compassionate care was significantly undermined by the abuse of patients at Muckamore Abbey Hospital (MAH) which came to light in 2017. An Independent Review Team was commissioned by the Health and Social Care (HSC) Board and Public Health Agency at the request of the Department of Health to review leadership and governance arrangements within the Belfast HSC Trust between 2012 and 2017 to ascertain to what degree, if any, said leadership and governance arrangements contributed to the abuse of vulnerable patients going undetected. An Independent Team was appointed in January 2018 to conduct a level three Serious Adverse Incident (SAI) investigation of patient safeguarding at MAH. The outcome of that review, the *A Way to Go* report, was published in November 2018. The Department of Health (DoH) considered that that report had not explored leadership and governance arrangements at MAH or the Belfast HSC Trust sufficiently. The current review commenced in January 2020.

2. MAH opened in 1949 as a regional hospital for children and adults with learning disabilities. Initially, the hospital principally provided long-term inpatient care. In 1984 the Hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients. During the 1980s the policy direction was to provide care for people with learning disabilities within the community. From that time the intention was to reduce the number of patients and to develop resettlement options. The 1992/97 Regional Strategy established three targets: 'develop a comprehensive range of support services by 2002; have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and reduce the number of adults admitted to specialist hospitals.' Progress was slow but following the Bamford Reviews and the 2011 publication of Transforming Your Care, targets were established to close long-stay institutions and complete resettlement by

2015. The rate of ward closures and the numbers resettled progressed significantly with targets monitored for compliance. The current review took place within the context of retraction and resettlement which had significant implications for staffing, patients, and their relatives and carers. By July 2020 there were fewer than 60 patients at MAH.

3. The Review Team conducted the review by examining a range of Trust documents and by interviewing key staff at Muckamore Abbey Hospital, Belfast Health and Social Care Trust, the Health and Social Care Board and Public Health Agency, and the Department of Health. It also visited MAH during February 2020 and met staff and patients during visits to the wards. The Review Team met with a number of parents, advocates, a Member of Parliament, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Patient and Client Council (PCC), the Permanent Secretary of the Department of Health, and the Health Minister. Representatives of the Review Team also had the opportunity to attend a meeting of the Muckamore Abbey Departmental Advisory Group. The Review Team acknowledges the cooperation afforded to them by all those they met. It regrets that due to the Covid-19 lockdown it was not able to meet with more patients, relatives, and carers. Only three retired members of staff did not meet with the Review Team for a number of reasons.

4. The Belfast HSC Trust is one of the largest integrated health and social care organisations in the UK. It has appropriate governance structures in place with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care. The Trust Board and Executive Team rarely had MAH on their agendas. Issues which were discussed at that level generally focused on the resettlement targets. The annual Discharge of Statutory Functions Reports did not provide assurance on the degree to which statutory duties under the Mental Health Order 1986 were discharged. The Review Team saw no evidence of challenge at Trust, HSC Board, or Department of Health level regarding the adequacy of these reports. The Review Team was informed that matters came to the Trust Board on an issue or exceptionality basis and that the acute hospital agenda dominated. In

addition, the Review Team was advised that the emphasis was on services rather than facilities, such as MAH. The comprehensive governance arrangements were not a substitute for staff at both MAH level and Director level in the Trust exercising judgment and discernment about matters requiring escalation. The Review Team was informed that there was a high degree of autonomy afforded to Directors and senior managers given the scale of the Trust's operation. The Review Team concluded that there was a culture within MAH of trying to resolve matters on-site. The location of MAH at some distance from the Trust and the lack of curiosity about it at Trust level caused the Review Team to view it as a place apart. Clearly, it operated outside the sightlines and under the radar of the Trust.

5. The leadership team at MAH was dysfunctional with obvious tensions between its senior members. There was also tension around the intended future of the hospital with some managers viewing its future as a specialist assessment and treatment facility while others perceived it as a home for patients; many of whom had lived in the hospital for decades. There was a lack of continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level. Visits of Trust Board members and other Directors to MAH were infrequent. Leadership was not visible. The Review Team was told that staff at MAH were not always clear which Trust Director had responsibility for services on-site. As the *A Way to Go* report noted, staff felt a loyalty to one another rather than to the Trust. Leadership was also found wanting at Director level as issues relating to the staffing crisis at MAH and its impact on safe and compassionate care were not escalated to the Executive Team or Trust Board as a means of finding solutions. One Director told the Review Team of his efforts to undertake regular walkabouts at MAH as a means of understanding the issues confronting staff and patients. Other Directors referred to occasional visits to the site but not on a structured or regular basis. The value base of the Belfast Trust is well articulated in its strategies and leadership frameworks. Unfortunately, there were no effective mechanisms in place to ensure that these values were cascaded to staff at MAH. The value base of some staff was antithetical to that espoused by the Trust as an organisation.

6. The Review Team considered three events at MAH to structure its review of leadership and governance. The first was the Ennis investigation which commenced in November 2012 following complaints from a private provider's staff about physical and verbal abuse of patients in the Ennis Ward. The investigation was carried out jointly with the police under the Trust's adult safeguarding and the Joint Protocol processes. It resulted in two staff members being charged with assault. One staff member was not convicted while the other's charge was overturned on appeal. The investigation took eleven months to produce a final report. The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board levels for wider learning and training purposes. It was not addressed in the Discharge of Statutory Functions Reports nor was there evidence in the documentation examined that its findings were disseminated to staff and relatives/carers. The Review Team considered that the Ennis Investigation merited being addressed as an SAI, as a complaint, and as an adult safeguarding matter. Each of these additional processes would have provided a mechanism to bring matters at Ennis to the Trust Board. The HSC Board for some considerable time pressed the Trust to submit an SAI in respect of Ennis. When the Trust accepted that it was in breach of requirements by not conducting an SAI, the Board let the matter rest. The Review Team considered the situation at Ennis to be an example of institutional abuse. Learning from Ennis therefore had the potential to identify any other institutional malpractice at an earlier stage.

7. The second issue considered by the Review Team was the installation of CCTV initially at Cranfield in the male and female wards and in the Psychiatric Intensive Care Unit (PICU), as well as in the Sixmile wards. The concept of installing CCTV for the protection of patients and staff was first raised around August 2012. A business case was developed and approved in 2014. In 2015 CCTV cameras were installed in Cranfield and Sixmile wards. From an extensive examination of all documentation, the Review Team concluded that the CCTV system was operational and recording from July 2015. There was no policy nor procedure to inform the use of CCTV. The

Review Team identified extensive delay in finalising a CCTV policy; some 25 months after the cameras were installed. During July/August 2017 notices were displayed in Cranfield and Sixmile wards advising that the CCTV cameras would become operational from the 11th September 2017.

8. The Trust paid for regular maintenance of the cameras following their installation. The system on which the CCTV cameras operate is one where the cameras are triggered by motion. Recordings are due to overwrite after 120 days. Due to the motion activation of the cameras it is likely that recordings were of longer duration than the 120 days. The Review Team concluded that the footage now available had overwritten previous footage.

9. CCTV footage in late August/early September 2017 revealed abuse and poor practice in several of the wards. The CCTV cameras had been recording for a considerable amount of time, apparently without the knowledge of staff or management. The discovery of historical CCTV recordings prompted by the intervention of a concerned parent, revealed behaviours which were described as very troubling, professionally and ethically, which were morally unacceptable and indefensible. It is apparent from extensive discussion with staff at all levels that there was no awareness that the cameras were operational. The MAH staff member (retired) most likely to be in a position to clarify matters regrettably did not respond to the request to meet with the Review Team.

10. The existence of CCTV recordings was reported to senior staff at the Trust's HQ on 20th September 2017. This was at least two to three weeks after the situation was identified at MAH. Immediate steps were taken at Trust Executive Team level to inform the police about the existence of CCTV footage in relation to an alleged assault which occurred on 12th August 2017 as well as other incidents. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions; at least 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. Despite

the scale of the abuse it is important to note that carers and families have frequently attested to the care and professionalism of many staff working at MAH.

11. The third incident considered was a complaint about an assault on a patient at PICU which occurred on 12th August 2017. This assault was not reported to the patient's father until 21st August 2017. The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father.

12. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable.

13. The Review Team intended to visit centres of excellence to provide comment on best practice. Due to lockdown this was not possible. The Review Team has however, provided comment which it considered appropriate to the development of a person-centred rights based model of care for patients in learning disability hospitals.

14. The Review Team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation. This failure resulted in harm to patients. The Review Team concluded that while senior managers at MAH may not have been aware of the culture of abuse, that their responsibility for providing safe and compassionate care remained. The Review Team made twelve recommendations to the Department, HSC Board, and the Trust in order to improve future practice. These recommendations took account of the improvements already implemented by the Trust.

15. The Review Team acknowledges the recent efforts made by the Belfast HSC Trust to promote and monitor a safe person-centred environment at MAH.

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Appendices

1. Introduction

1.1 At the request of the Department of Health (DoH), the Health and Social Care Board (HSCB) and Public Health Agency (PHA) commissioned a review to examine critically the effectiveness of the Belfast Health and Social Care Trust's (Belfast Trust) leadership and governance arrangements in relation to Muckamore Abbey Hospital (MAH).[1] The review's remit spans the period from 2012 to 2017.[2] This five year period preceded serious adult safeguarding allegations that came to light in August 2017. Under its Serious Adverse Incident policy the Belfast Trust commissioned a review into these allegations by appointing a team of independent experts in January 2018.

1.2 The expert team in November 2018 published its report, *A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital.* The HSCB/PHA and the DoH concluded that leadership and governance issues in MAH and within the Belfast Trust merited further examination. It was therefore decided that a further review focusing on leadership and governance be conducted in order to 'establish if good leadership and governance arrangements were in place and failed, and, if so, how/why; or were effective systems not in place.'[3]

1.3 A complaint and allegations made in 2017 that vulnerable patients were physically and mentally abused by staff at Muckamore Abbey Hospital resulted in the police and the Belfast Trust initiating investigations under the Trust's Safeguarding of Vulnerable Adults policy, Complaints policy, and its Serious Adverse Incident policy. A considerable volume of video evidence exists in relation to the alleged abuse; the PSNI has a lead role in these investigations given their criminal nature.

[1] Terms of Reference, Appendix A(i)
[2] During that period there were three key events around which the Review Team focused its attention: November 2012 allegations made regarding the care and treatment of patients in the Ennis Ward; August 2017 complaints by a parent regarding his son's care; and August 2017 the identification of video recording regarding the care and management of patients.
[3] Purpose of Review, Terms of Reference, January 2020

A number of MAH staff and ex-staff have subsequently been arrested, some of whom have been referred to the Public Prosecution Service (PPS), while others have been suspended from their jobs. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions, 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. The PSNI has confirmed that the scale of the evidence has required the establishment of a dedicated investigation team.

1.4 During 2018/19 the Belfast Trust and DoH set up a series of measures to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH. This included the establishment of: the *Way to Go* Review Team by the Belfast Trust; as well as the Muckamore Abbey Hospital Departmental Assurance Group (MDAG) jointly chaired by the DoH's Chief Social Services Officer and the Chief Nursing Officer.

1.5 From the outset the leadership and governance Review Team decided to accept the safeguarding concerns raised in the following reports, rather than re-examine these events:

- November 2012 in the Ennis Ward;
- the incidents evident in CCTV footage available from March to August 2017; and
- the complaint made by a patient's father in August 2017 regarding his son's alleged abuse by staff.

The Review Team has accepted these events as key events in its review of governance and leadership and will consider them within that context in Section 8 of the report.

2. Terms of Reference

2.1 The Terms of Reference (ToR) were agreed between the HSCB/PHA and the Department in consultation with the MDAG. The full Terms of Reference are available at Appendix 1. The ToR can be summarised as follows:

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience. Drawing upon families, carers and staff's experience; conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

- *Strategic leadership across the Belfast Trust.*
- *Operational management*
- *Professional / Clinical leadership*
- *Governance*
- *Accountability*
- *Hospital culture and informal leadership*
- *Support to families and carers*

2.2 The ToR also requires that the Review Team:

- interview key individuals and scrutinise relevant documentation;
- establish lines of communications with all the organisations impacted by the review; and
- act fairly and transparently and with courtesy in the conduct of its work.

3. The Review Team

3.1 The HSCB and PHA established a three-person review team with organisational, clinical, and professional expertise from their previous work experiences within health and social services in Northern Ireland. Review Team members comprised:

David Bingham

Maura Devlin

Marion Reynolds

Katrina McMahon – Project Manager

Appendix 2 sets out brief curriculum vitae in respect of each of the Review Team members.

4. Methodology

4.1 The methodology provided by the HSCB/PHA was based on the establishment of a team of independent members with extensive experience of leadership and management within the health and social care sector (See Para 3.2).

4.2 The Review Team's first task was to establish lines of communication with all those likely to be impacted by the review. The Belfast Trust was the main focus of the review. Others contacted included: the DoH; HSCB; PHA; RQIA; families and carers as well as their representatives; advocacy services; the Patient and Client Council (PCC); other HSC Trusts with patients in MAH; and the PSNI.

4.3 The Review Team met with senior staff from each of these organisations and a number of family members. On 21st February 2020 the Review Team visited MAH to meet with patients and staff. The Review Team determined the type and range of documentation required to establish the policies and operational protocols extant during the period under review. The Belfast Trust was asked to provide extensive documentation to enable the Review Team to assess its governance and leadership arrangements. This included Trust policies on controls assurance, management of risk, complaints, and serious adverse incidents. Details of organisation charts, minutes of management, Directorate, and Board meetings were also sought. The Review Team experienced some difficulty in acquiring documentation due to Lockdown. Other organisations were also asked to provide relevant documentation. The list of documentation examined by the team is set out in Appendix 3

4.4 Having examined documentation furnished by the Belfast Trust the Review Team met with key individuals in the Trust and other organisations. It also identified further documentation it required. The purpose of these interviews was to establish how leadership and governance were exercised between 2012 and 2017 and to

ascertain the degree of adherence with extant policies and protocols. A list of those interviewed is provided in Appendix 4. Three retired senior managers of the Belfast Trust did not engage with the review process:

- a retired Service Improvement and Governance manager and Co-Director of Learning Disability Services at MAH[4] replied to a request to meet with the Review Team stating she was not willing to participate;

- a retired co-Director for Learning Disability Services who retired from the service in September 2016 would not meet with the Review Team as his request to the Trust for an extensive range of documents to examine prior to interview was not met. He requested that the Review be extended in order to facilitate his review of documents. This request could not be met by the Review Team due to the time frame set for completion of this Review and the view that his request for an extension was unreasonable;

- a retired Business and Service Improvement Manager at MAH made no response to repeated requests, made through the Trust, for an interview with the Review Team.

In each of these cases the Review Team informed the individual that it would reach its conclusions on the basis of the documentary evidence available to it and comments made by other interviewees. A former Chief Executive of the Trust was also not available for interview within the time scale set for the Review. The Review Team regrets that its conclusions were not informed by input from these individuals.

[4] Service Improvement and Governance until October 2016 when then promoted to Co-Director for Learning Disability Services

4.5 A timeline for the Review was established by the HSCB and PHA. The Review Team commenced its work in January 2020 with an agreed target date of 30th April for an interim report with the full report being produced by 30th June 2020. It was recognised that there was a particular urgency to this work given the need to reassure family members, carers, staff, and the public that the serious safeguarding issues that had arisen in MAH had been identified and addressed, and that lessons had been learned and acted upon.

4.6 The lockdown and social distancing measures that followed the start of the Coronavirus pandemic in March 2020 meant that the Review Team had to suspend its work for a period of six weeks. The Review Team resumed its examination of documents and interviews in mid-April 2020 using online conferencing technology, namely Zoom. The HSCB/PHA set a new date for a final report of 31st July 2020. It was also agreed that the interim report stage would be omitted to minimise the delay in delivering the Review Team's report. Plans to visit centres of excellence to inform Best Practice had to be shelved and replaced by a literature review.

4.7 During lockdown the Review Team was unable to meet with as many patients, relatives, and friends as it would have wished. It deeply regrets that it was unable to meet with more service users. It did, however, benefit from interviews with:

- three parents/relatives;
- The Chair of Friends of Muckamore Abbey;
- representatives of Bryson House and Mencap which provide advocacy services to patients at MAH; and
- a representative of the Patient and Client Council which the Department had engaged to provide independent support for Families and Carers who became involved with the review process.

Representatives of the Review Team attended one meeting of the Muckamore Abbey Departmental Advisory Group in March 2020. The Review Team also issued a general invitation through a representative of the Action for Muckamore group, to meet with any relatives/carers who wished to meet either in person or via Zoom. No further requests for interview were received.

4.8 The Review Team would appreciate an opportunity to meet with patients, relatives and carers at the conclusion of the Review to provide feedback to them about its conclusions and recommendations.

5. Background to Muckamore Abbey Hospital

5.1 This section provides a brief historical overview of Muckamore Abbey Hospital and the plan to resettle patients in community settings.

A. Muckamore Abbey Hospital – A Brief Historical Overview

5.2 Muckamore Abbey Hospital opened in 1949 as a regional service for children and adults with learning disabilities. It is located in a rural setting outside of Antrim town. The opening of the hospital enabled children and adults to be admitted over time from six mental health hospitals; some 743 patients of whom 120 were children.

5.3 Initially, the hospital principally provided long-term permanent inpatient care for its patients. Services provided have undergone significant changes over the years, reflecting evolving policy imperatives for people with a learning disability. The function of the hospital has therefore expanded over time to include: supervised activity for a minority of patients; return to the community; and a centre for medical research. 'Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patient living there long term.'[5]

5.4 The *A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go* report sets out a timeline for the hospital, from 1946 to 2016 which notes that nurse training began at the hospital in 1955; followed by the opening of a special needs teacher training college in 1963.[6]

[5] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 46
[6] Op. Cit., Pages 46 - 51

5.5 In 1966 Muckamore Abbey Hospital had 880 patients. By the late 1960s and early 1970s there was a growing realisation that treatment and training should take place outside of a hospital setting. There was also a problem with overcrowding at the hospital.[7] By 1980 the hospital had more than 20 units on its site. During 1984 the hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients.

5.6 From the 1980s attempts were made to provide care in the community for patients. The delivery of this objective was described as 'a very slow process'. 'We had targets and dates before [2015/16], and there was a lot of criticism that those were not met. We are talking about a long period; certainly, in my experience of work, from the 1980s to today.'[8] In 1986 a Rehabilitation Unit was established at the Hospital to promote a return of patients to community settings.

5.7 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy, Health and Wellbeing into the New Millennium, required that Boards and Trusts:

- develop a comprehensive range of support services by 2002, and
- have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and
- reduce the number of adults admitted to specialist hospitals.

The target established by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.[9]

[7] Ibid, Page 48
[8] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Mr. Aidan Murray, Page 6
[9] By that time, half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

5.8 In 1993 the number of patients in the Hospital had reduced to 596. Despite the Regional Strategy the hospital argued for the retention of a specialist Assessment and Treatment service on the site. In 1994 a Forensic Unit was also established. The *A Way to Go* Report noted that, 'by the mid-1990s the presence of adolescents on adult wards had become a significant problem.'[10] The removal of children from the Hospital was achieved with the establishment of the Iveagh Centre an inpatient service for children.

5.9 In 1998 Pauline Morris' study of long stay hospitals for patients with a learning disability was published.[11] The study criticised the medical model of care and recommended a socio-therapeutic model in which training was deemed as important as nursing and medical functions. There was however, a lack of community resources in Northern Ireland to support the discharge of long-stay patients from the hospital. It was therefore acknowledged that patients who had been resident for 30 to 40 years would remain in hospital.

5.10 Due to inappropriate living conditions seven of the hospital's wards were closed in 2001. Around this time a survey of admissions to the hospital found, 'that most admissions … were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.'[12] In 2003 a business case for a new core hospital was submitted to the Department. This resulted in the building of a 35 bed Admission and Treatment Unit and a 23 place Forensic Unit. Both facilities were completed in 2006/07 at a cost of £8.4m. The hospital at that time had three distinct patient treatment groups:

- Admissions and Treatment;
- Resettlement; and

[10] Ibid, Page 49
[11] Morris, Pauline Put Away: A Sociological Study of Institutions for the Mentally Retarded Taylor & Francis, 2003 First Published in 1998
[12] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 49

- Delayed discharges.

5.11 In 2002 the Department of Health, Social Services and Public Safety (DHSSPS) established the Bamford Review to inquire into the law, policy, and services affecting people with a mental illness or a learning disability. A key message emerging from the Bamford Review was an emphasis on a shift from hospital to community-based services. The second report from the Bamford Review, *'Equal Lives',* published in 2005, set out the Review's vision for services for people with a learning disability which envisaged that hospital should not be considered as a home for learning disabled people. *Equal Lives* included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay learning disability hospital for more than a year as of 1st April 2007 were defined as Priority Target List patients. There have been two Action Plans (2009-2011 and 2012-2015) created to take forward the Bamford Review's recommendations.

5.12 In 2005 the Hospital had 318 patients and a target was set that this would reduce to 87 by 2011. By December 2011 however, 225 patients remained.[13]

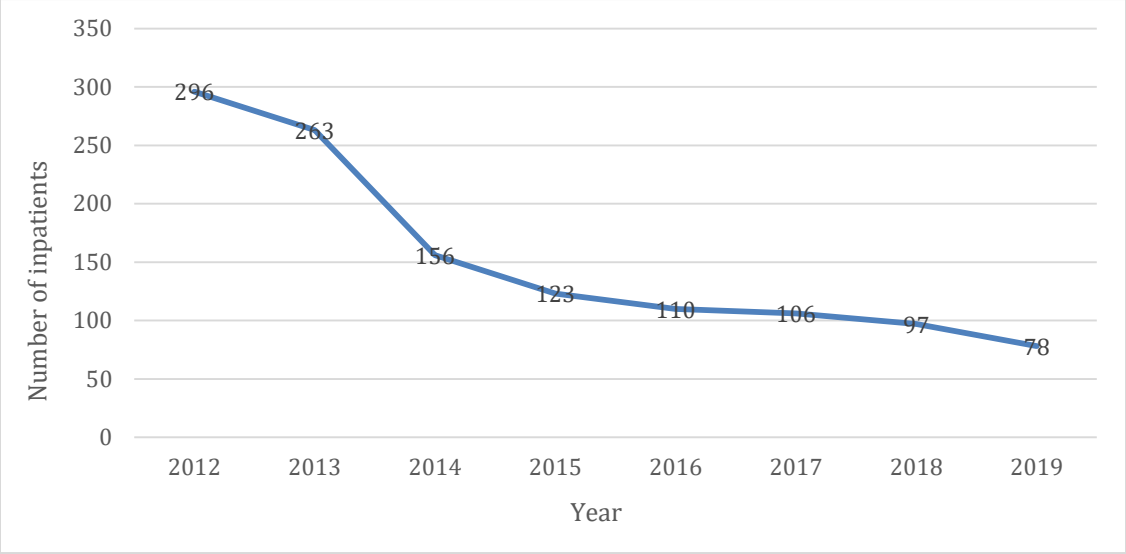
5.13 In 2011 The Minister for Health published *Transforming Your Care: A Review of Health and Social Care (TYC)*[14]. TYC sets out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. It restated the Bamford Review commitment to closing long-stay institutions and completing the resettlement programme by 2015.

[13] Ibid, Page 50

[14] http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

5.14 As part of the TYC agenda a central feature of the Department's plans for the reform of the health and social care system in Northern Ireland was the move from hospital-based care towards an integrated model of care delivered in local communities, closer to people's homes. In addition to the TYC document, a draft Strategic Implementation Plan (SIP) was developed.[15] In terms of learning disabilities, the SIP focused efforts on resettlement, delayed discharge from hospital, access to respite for carers, individualised budgets, day opportunities, Directly Enhanced Services (DES), and advocacy services.[16]

5.15 As of April 2020 the Hospital has under 60 patients and operates from six wards[17] providing inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs, or challenging behaviour. From a regional hospital with more than 20 units and at one time over 1,400 patients, the hospital is now greatly reduced in both the number of wards and the number of patients. The following table[18] demonstrates the reduction in number of patients between 2012 and 2019:



[15] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40
[16] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40.
[17] Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which deal mainly with forensic patients, and Erne wards for male and female patients with complex needs.
[18] The figures in the Table include Iveagh Unit which is a 6 bed unit caring for children aged under 12 years of age.

5.16 Although originally a regional service, the hospital now largely serves the Belfast HSC Trust which manages it, and the Northern HSC Trust in whose area it is located, as well as the South-Eastern Trust. Remaining Trusts have arrangements in place to meet the needs of their learning disabled residents without recourse to the hospital.

B. Resettlement

5.17 Various plans and targets aimed at resettling patients from the hospital to community settings have been in place since the 1980s (see Paras 5.6 – 5.13). Since 1992 however, the Department's overarching policy direction has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities. In 1995 a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

5.18 Efforts to secure this strategic objective in relation to the hospital are evident in the 1992/97 Regional Strategy, the Bamford Review (2002 and 2005), and TYC (2011) as well as associated action plans. The reasons for delay are complex and include:

- the difficulty in moving patients from a facility which they have regarded as their home. As noted in Para. 5.9 there was an acknowledgement that patients who had been resident for 30 to 40 years could remain in hospital;

- the lack of community resources to support the discharge of long-stay patients from the hospital;

- the fact that many people living with a learning disability have associated co-morbidities, such as physical and mental health conditions, including epilepsy and autism. Mental health conditions and certain specific syndromes may also be associated with other physical conditions and challenging behaviour. Patients currently remaining in the hospital have, therefore, very complex needs which makes their resettlement particularly challenging.

5.19 A senior Medical Adviser in her evidence to an Assembly Committee in 2013 set out the broad policy thrust of the Department of Health in relation to mental health and learning disability services. She stated that, 'in the January 2013 Bamford action plan that scopes 2012-15 - the emphasis across mental health and learning disability was on early intervention and health promotion; a shift to community care; promotion of a recovery ethos, largely in respect of mental health; personalisation of care; resettlement; service user and carer involvement; advocacy; provision of clearer information; and short break and respite care.'[19]

5.20 The evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017. It found that the resettlement programme was nearing completion. Of the 347 long-stay patients in learning disability hospitals in 2007, only 25 remained in long-stay institutions in 2016. Since then further progress has been made. By early 2020 there were ten inpatients from the original Priority Target List remaining in the hospital, with a further individual undergoing a trial resettlement in the community.

5.21 The increased focus on the resettlement of patients driven forward by the Bamford Review and TYC resulted in the closure of wards and the bringing together of staff and patients into new living arrangements. The Review Team

[19] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Page 2

concluded that the focus on resettlement had a negative impact on the culture of the hospital with insufficient attention being afforded to the functioning of the inpatient wards.

5.22 The criticism that the 1980s resettlement objective was progressed slowly, was due in the Review Team's opinion, to the arrangements which were established to monitor delayed discharges and patient discharges post the Bamford Review. The scale of the resettlement achieved was significant with a decrease from 347 long-stay patients in learning disability hospitals in 2007, to 25 by 2016 and 10 by 2020. From the information available to the Review Team they concluded that the Belfast HSC Trust's focus was on its resettlement objectives rather than on the hospital in its totality.

5.23 The resettlement plan caused anxiety among the staff team. During its orientation visit to the hospital in February 2020 and afterwards in written comments made in 2012 by hospital staff, the Review Team found that in addition to anxiety around job security and staff recruitment, there were a number of concerns including:

- the adequacy of staffing levels and skill mix on wards;
- the staffing rota which was heavily supplemented by bank staff which led to tiredness and increased sickness levels;
- insufficient staffing to run the resettlement programme. An email sent in October 2012, to an Operations Manager (part-time) by a Sister in one of the Wards, stated that resettlement could not continue due to staffing levels;
- the resettlement process which increased workload in respect of assessments;
- patient activities which were curtailed due to staff shortages;
- the mix of patients' needs in wards which were at time incompatible and competing;

- the impact of some patients' behaviour on the dynamics of a ward and reservations expressed regarding the decision to place specific patients within a given ward;

There was also a view that the 'resettlement wards are not up to 21st Century standards'.

5.24 The drift associated with earlier resettlement plans from the 1980s was possibly also associated with the resistance of some staff and families to the plan to close the hospital. In the opinion of the Review Team this may explain why the post Bamford resettlement plans were advanced without the benefits of feedback systems capable of monitoring how the roll-out impacted upon matters such as: the operation of wards; staff sickness and absences; untoward incidents; and patient safety. Such a process would have ensured that core hospital functions could have been maintained safely while the resettlement model was progressed.

5.25 At the hospital there were two competing service models: a medical model which informed the core hospital services and a social care model focused on resettling patients into the community. The *A Way to Go* report noted the 'hospital requires focus regarding its role and place in the future of learning disability services in NI'.[20] The Welsh government's review of learning disability services stated that 'hospital is not a home'. It found: 'Patients were remaining in hospital units for a long time and were transferred between hospitals when alternatives in the community could have been considered. The average length of time was found to be five years, with one patient staying for 49 years. People should only stay in hospitals if there are no other ways to treat them safely.'[21]

[20] *Way to Go, November 2018, Page 5, par. 5*
[21] Warmer, K. Hospitals should never be anyone's home, Published February 2020, Welsh Government https://www.ldw.org.uk/hospital-should-never-be-anyones-home/

5.26 Resettlement needs a cultural shift in thinking about the resourcing of learning disability services. It also requires an approach which provides adequate financial resources and community infrastructure to support resettlement objectives and to successfully maintain discharged patients in the community. Section 9 on Best Practice considers this cultural shift in greater depth.

5.27 In conclusion, in undertaking its review the Review Team wants to place the key events listed in Para. 1.5 and in Appendix 5 in the context of a comprehensive understanding of the hospital, its culture, and the resettlement programme which it actively pursued after the two Bamford Reviews.

6. Review of Governance

6.1 The following section considers:

i. what governance is

ii. corporate and clinical/professional governance

iii. the Effectiveness of Corporate and Clinical/Professional Governance

i. What governance is

6.2 In undertaking its review of governance the Review Team considered a range of definitions and guidance which was available at all levels within the Health and Social Care system in Northern Ireland in order to decide on which definition to use to inform its examination of the Trust's governance structures and arrangements.

6.3 The Social Care Institute for Excellence (SCIE) notes that the quality of services provided are the responsibility of individual staff members and their employers: 'Every staff member has, responsibility for providing good quality social care. Social care governance is the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[22]

6.4 More organisationally focused definitions conceive of governance as 'a framework within which health and personal social services organisations are accountable for continuously improving the quality of their services and taking

[22] Social care governance: A practice workbook (NI) 2nd edition, SCIE, 2013, Page 1 http://www.belfasttrust.hscni.net/pdf/Social-Care-Institute-for-Excellence-Social-care-governance.pdf

corporate responsibility for performance and providing the highest possible standard of clinical and social care' (Best Practice, Best Care, DHSSPS, 2002[23]).

6.5 The Department of Health (DoH) cites in its Introduction to Governance[24] Her Majesty's Treasury (HMT): 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' DoH noted that this influenced the way in which organisations:

- manage their business;
- determine strategy and objectives; and
- go about achieving these objectives.'[25]

6.6 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland.[26] To facilitate the achievement of service improvements the Quality Standards for Health and Social Care were published in 2006. These standards require governance arrangements which 'must ensure that there are visible and rigorous structures, processes, roles, and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.'[27]

6.7 The Quality Standards also require the RQIA to commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five quality themes

[23] https://www.scie-socialcareonline.org.uk/best-practice-best-care-the-quality-standards-for-health-and-social-care/r/a11G000000182tdIAA
[24] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[25] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[26] Article **34.**—(1) Each Health and Social Services Board and each **[**F1HSC trust**]** shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—
(a)the health and **[**F2social care**]** which it provides to individuals; and
(b) the environment in which it provides them. http://www.legislation.gov.uk/nisi/2003/431/article/34
[27] The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, Page 1, par. 1.3, March 2006 https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

contained within them.[28] This enhanced the RQIA's general duty of encouraging improvements in the quality of services commissioned and provided by the HSC by promoting a culture of continuous improvement and best practice through the inspection and review of clinical and social care governance arrangements.[29]

6.8 The Quality Standards comprise three key themes, one of which is clinical and social care governance. The Quality Standards note that to promote service improvements 'clinical and social care governance … must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments.'[30]

6.9 Standard 1 of the Quality Standards, Corporate Leadership and Accountability of Organisation, has as its Standard Statement: 'The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.'[31]

6.10 The criteria by which compliance can be assessed are:

a) 'has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

[28] Ibid, Page 5 par. 1.7 and 1.9 Quality themes: 1. Corporate Leadership and Accountability of Organisations; 2. Safe and Effective Care; 3. Accessible, Flexible and Responsive Services; 4. Promoting, Protecting and Improving Health and Social Well-being; and 5. Effective Communication and Information.
[29] Ibid, Page 4, par. 1.8
[30] Ibid, Page 6, par. 2.1
[31] Ibid, Page 10, par. 4.2

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation

k) undertakes robust pre-employment checks including: qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body:

- police and Protection of Children and Vulnerable Adults checks, as necessary;
- health assessment, as necessary; and references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.'[32]

6.11 The Review Team considered the Quality Standards approach appropriate to its task, particularly as these were the basis upon which the RQIA served four Improvement Notices in respect of failures to comply on the Belfast HSC Trust in

[32] Ibid, Pages 10 -11, par. 4.3

November 2019. The Quality Standards require governance arrangements which: 'must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care' (see Para 6.6). By doing so the Review Team will be facilitated by having access to a number of the criteria established (see Para 6.10) to determine the robustness of the Trust's governance arrangements objectively.

ii. Corporate and Clinical/Professional Governance

6.12 The Review Team considered corporate and clinical/professional governance arrangements within the Trust as it related to MAH.

Corporate Governance

6.13 The Trust was formed under the Belfast Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It came into existence on 1st April 2007 with the merging of six Trusts, namely:

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

6.14 The Belfast HSC Trust is a complex organisation with an annual budget of over £1.3bn and a workforce of over 20,000 full time and part time staff. It is one of

the largest integrated health and social care Trusts in the United Kingdom delivering integrated health and social care to approximately 340,000 citizens in Belfast. In order to ensure the best possible delivery of these services they have been grouped into ten Directorates. The Trust also provides the majority of regional specialist services in Northern Ireland and comprises the major teaching and training hospitals in Northern Ireland. The following section considers governance under two headings:

A. Organisational Structures; and
B. Information Systems.

(A) Organisational Structure

6.15 The Belfast Trust provides a range of disability services in the community, at home, and in hospitals. The Review Team examined the systems and information systems established by the Belfast HSC Trust to enable it to assure 'the quality of services that it commissions and provides to both the public and its staff' in respect of the services provided at MAH (see Para 6.9). The Trust's organisational structure in 2012/13 encompassed the following:

- a Trust Board of five Executive Officers and seven non-Executive Directors, including the Chairman. Accountable directly to the Board were four committees (Remuneration, Charitable Trust Funds, Audit, and Assurance) which met on a bi-monthly basis. The Executive consists of the Chief Executive and the Executive Directors of Finance, Medicine, Social Work, and Nursing. The Board is responsible for the strategic direction and management of the Trust's activities. It is accountable, through its Chairman, to the Permanent Secretary at the Department of Health and ultimately to the Minister for Health;

- the Executive Team which is accountable to the Trust Board in regards to the day to day operational management and development of the Trust. It meets on a weekly basis. It receives reports from Executive and Operational Directors based on information received from Co-Directors who have operational responsibility for service areas such as: Learning and Disability Services; Mental Health; and Health Estates. Information was also provided from the Assurance Group;

- an Assurance Group. The Trust's Assurance Framework sets out the committee structures for Clinical and Social Care Governance and risk management. The Framework describes the mechanisms to address weaknesses and ensure continuous improvement, including the delivery of the delegated statutory functions and corporate parenting responsibilities. Five groups report to The Assurance Group:

  - the Governance Steering Group, which covers 15 areas including: risk management; policies; control assurance; and information governance. The steering group was served by two sub-committees;

  - a Safety and Quality Steering Group which was served by five sub-committees;

  - a Serious Adverse Incident (SAI) Board which reviewed each SAI;

  - a Social Care Steering Group which was served by three sub-committees; and

  - an Equality, Engagement and Experience Steering Group which was served by three sub-committees.

6.16 The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board.

6.17 Structurally therefore the Belfast HSC Trust had arrangements in place capable of assuring the quality of the services which it provided. The structure is complex with a significant number of Committees, Steering Groups, and Sub-Committees. This structure placed significant demands and challenges on senior and middle management staff. The range of services provided by the Trust and their complexity inevitably requires systems which are complex.

6.18 The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. 6.15 may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them. Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation.

6.19 From email correspondence between the HSC Board's Deputy Director and the Trust dated between the 6th February 2013 and the 3rd September 2015 it is apparent that repeated requests from the Board for the Ennis allegations to be dealt with as an SAI were not met. In September 2015 the HSC Board wrote

asking that the Trust accept that this was a breach of requirements. On 7th September 2015 the Trust responded accepting that it was in breach of the SAI procedures [both the 2010 and 2013 procedures] but 'as the allegations were not substantiated by the safeguarding investigation it was content to live with the procedural breaches.'

6.20 At MAH level governance arrangements were also in place during the period under review. On site was a Service Improvement and Governance member of staff. On a weekly basis the Trust's Co-Director for Learning Disability Services convened a multidisciplinary meeting at MAH comprising the Service Improvement and Governance manager and hospital and community staff.

6.21 The minutes of these meetings show that they were well attended by all staff and comprehensive minutes were taken of the proceedings. A community-based social worker regularly attended these meetings as one of her duties was to complete the Statutory Functions Report for the learning disability programme of care.[33] None of the minutes examined provided information on the following:

- the information which would be provided to the HSC Board in respect of the Discharge of Statutory Functions; or
- issues arising from the Ennis investigation and follow-up actions.

6.22 Information was available on the receipt of RQIA inspection reports; there was, however, no indication from the MAH records examined that findings from these inspections were viewed as negative or requiring remedial action. This finding is confirmed by an examination of governance meetings chaired by the Service

[33] The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994. The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs. CIRCULAR (OSS) 4/2015: STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf

Improvement and Governance manager. The minutes regularly reference an RQIA announced or unannounced inspection at wards within the hospital. From these minutes information was not available to indicate any serious concerns being raised by the Regulator. As noted in Para. 6.11 it was not until November 2019 that RQIA served four Improvement Notices in respect of failures to comply on the HSC Trust, in respect of the MAH site. Improvement Notices had previously been served on Iveagh which was the children's disability service. The Review Team was advised by RQIA that there was significant learning emerging from its inspection of Iveagh which, had it been applied, could have improved practice at MAH. The Review Team found that issues arising from complaints and incidents or RQIA reports were not discussed. Therefore they did not inform the education plans for staff in MAH.

(B) Information Systems

6.23 The only way in which any organisation can know how it is performing is to have access to all the relevant data describing its performance in meeting the relevant legislation and regulatory and professional standards. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted: 'it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.'[34]

6.24 The Review Team therefore considered the range of data collated by the Trust, how it was analysed, and how it was used by the Trust to monitor and review performance with particular reference to MAH.

[34] The report of the Independent Inquiry into the issues raised by Paterson, Page 2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

6.25 The Trust had a number of systems in place to record and monitor adverse incidents, serious adverse incidents, and complaints as part of its risk management strategy. Risk management involves the establishment of systems to understand, monitor, and minimise risks to patients and staff. It involves learning from mistakes/incidents in order to improve the quality of patient care and to inform staffing numbers and qualifications to ensure that patients' needs are met. It is apparent that Governance and Core Group meetings at MAH regularly had access to a wide range of data (see Para 6.83).

6.26 MAH was also monitored by its regulator, the RQIA, which over the course of its inspections, collated significant information on practice within wards and also acquired verbal feedback from patients and staff. The scale of the significant concerns revealed by the CCTV footage (2017) or the Ennis investigation (2012/13) was not identified through inspections. Regulators, such as senior managers, rely on the information provided to them as well as what they can reasonably be expected to identify in the course of inspection activities.

6.27 A relevant backdrop to how information was divulged is provided by the *A Way to Go* report. It noted that it, 'was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations. Also, since some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file.'[35]

6.28 Learning from mistakes or near-misses requires staff to be open to a review of their practice and to be willing to challenge when they observe concerning

[35] Op. Cit Para. 32, Page 13

professional practices. From the Ennis Report (2013) and the CCTV footage it is apparent that the challenge function was generally not evident among the staff team. In respect of the Ennis complaints, the verbal and physical abuse of patients was not raised by ward staff but rather staff from a private provider who were working on the ward to prepare a number of patients for discharge to their facility. Similarly, the very significant number of alleged assaults on patients captured on CCTV footage which, to date, has resulted in seven members of staff being charged by the PSNI, 59 have been placed on temporary suspension, with a further 47 staff working under supervision. The nature and scale of events were not brought to the Trust's attention by MAH staff.

6.29 The Trust had corporate and clinical/professional arrangements in place. The Review Team concluded however, that the nature of the hospital as somewhat of a place apart from the mainstream of the Trust's hospital services, together with ongoing issues around its future, meant that staff loyalties were with their colleagues rather than the patients or their employer. There is also no indication from the records examined that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents, serious adverse incidents, complaints, or the issues likely to be associated with staffing deficits and limited behavioural supports for patients.

6.30 In conclusion, governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH. The next section considers governance specific issues.

Clinical and Professional Governance

6.31 Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish.'[36] It covers activities which help sustain and improve high standards of patient care. Clinical governance is a means of reassuring the public that the care they receive within the health and social care system is of the highest standard.

6.32 Clinical governance is often thought of in terms of the following seven constructs:

6.33 The British Medical Journal definition of clinical governance: 'In short, it's doing the right thing, at the right time, by the right person - the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all - that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.'[37]

[36] Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-65
[37] BMJ 2005;330:s254 https://www.bmj.com/content/330/7506/s254.3

6.34 As noted in Para. 6.6 the Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland. Clinical governance is a means by which the duty of quality can be achieved for service users of health and social care services in Northern Ireland. Clinical governance 'aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided (in terms of outcomes, access and appropriateness.'[38]

6.35 In 2012, The King's Fund set out three lines of defence 'in the battle against serious quality failures in healthcare:'[39]

- frontline professionals, both clinical and managerial, who deal directly with patients, carers, and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide;
- the Boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations who are ultimately accountable when things go wrong; and

- the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

6.36 The legislative framework within which the health and social care structures operates is the Health and Social Care (Reform) Act (Northern Ireland) 2009. The roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department, alongside the

[38] Clinical Governance in the UK NHS. DFID Health System Resource Centre https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf
[39] The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed September 2019. https://1vju531mjrgz2givvt3vgvrr-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/MPAF_WEB.pdf

roles and responsibilities devolved from the Department, which are taken forward on behalf of the Department by the PHA/HSCB are set out in the Health and Social Care Assurance Framework (2011).

6.37 Service Frameworks set out the standards of care that individuals, their carers, and wider family can expect to receive from the HSC system. The standards set out in a service framework reflect the agreed way of providing care by providing a common understanding of what HSC providers and users can expect to provide and receive.

6.38 The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the:

- **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

- **Director of Social Work** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce;

- **Medical Director** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

6.39 There is also a service framework pertinent to the services provided at MAH which applies to all those working with patients namely, the Service Framework for Learning Disability published in 2013 and revised in 2015. 'This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.'[40]

6.40 Professional Governance Frameworks are underpinned by legislation and a range of standards and policies set by the Department of Health alongside standards set by professional regulators. A robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across the professions.

6.41 Since its formation in 2007 the Belfast Trust has had in place a structure to support the Executive Directors of Nursing, Social Work, and Medicine to provide assurance to the Chief Executive, Executive Management Team, and the Trust Board. Muckamore Abbey Hospital is medically led by a Clinical Director. The largest workforce on site is drawn from the nursing profession and healthcare assistants. There was a small social work team and a number of Allied Health

[40] Ministerial Foreword, Service Framework for Learning Disability, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

Professionals based at the hospital. Although MAH is a hospital and is led as such by medical personnel, the day-to-day operation of MAH was in practice left to nurse managers and their staff. The following section therefore focuses strongly on the governance arrangements within nursing, which also encompasses healthcare assistants (see Para 6.38).

6.42 The Review Team examined the systems and information established by the Belfast Trust to enable it to ensure that patients in MAH were receiving high quality, safe, and effective care. The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to their Directorate role and 30% to their professional role as Associate Directors of Nursing.

6.43 This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing.

6.44 The Executive Director of Nursing met formally on a monthly basis with Co-Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely:

- patient, quality and safety;
- patient experience; and
- professional nursing.

Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing. These meetings were attended by Divisional Nurses and provided an opportunity for the Executive Director of Nursing to discuss, advise, and seek assurance that all follow-up actions to ensure onward referral to the regulator or internal capability processes had been taken forward.

6.45 Directors of Nursing, according to A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery (2010-2015), were required to be proactive in identifying future nursing workforce requirements. The Executive Director of Nursing in a Trust is also responsible for advising the Trust Board and its Chief Executive on all issues relating to nursing workforce requirements. On a bi-monthly basis the Executive Director of Nursing held a Nursing and Midwifery Workforce Steering Group. This group comprised senior nurse leaders, the Co-Director for Workforce and Education, and a representative from HR, Finance, and staff-side organisations. This meeting addressed all workforce issues relating to nursing and produced a workforce trends analysis.

6.46 In addition to the Workforce Steering Group meetings, the Trust had processes in place to provide assurance to the Executive Director of Nursing on all issues relating to the nursing workforce requirements in MAH. Learning Disability Nursing workforce issues were discussed regularly at the senior nurse meetings which were held on a monthly basis in MAH and at the Core Group meetings chaired by the Co-Director for Learning Disability services. Discussion also took place at Divisional Nurse meetings chaired by the Executive Director of Nursing.

6.47 During the period under review, professional nursing governance arrangements existed within MAH, as indicated by the previously noted senior nurse meetings, which took place on a monthly basis. Those in attendance included senior nurse managers, ward managers, and the nurse development lead. Additionally, there was a Professional Senior Nurse Forum. These meetings were chaired by the Service Manager for Hospital Services and included senior managers from MAH and the Directorate along with the Nurse Development Lead. The agenda for these meetings focused on nurse-sensitive indicators including supervision, appraisal, and mentorship along with training, education, and staff development.

6.48 The Nursing and Midwifery Council (NMC) sets the standards of practice and behaviour applicable to all registered nurses. These standards are outlined in the Code (2015).[41] They are a means to promote safe and effective practice.

6.49 The commitment to professional standards is fundamental to nursing and reinforces professionalism. As such all nurses and healthcare assistants in MAH are required to:

- prioritise people;
- practice effectively;
- preserve safety; and
- promote professionalism and trust.

6.50 The NMC Code established a common standard of practice for all those on its register. Guidance to nurses was also provided by the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) as professionally they continued to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a

[41] The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associated, NMC, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

satisfactory standard.[42] The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

6.51 Standards for Nursing Assistants employed by HSC Trusts published by the Department In February 2018 apply to all healthcare assistants. This document recognised that nursing assistants 'are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.'[43] In MAH it was apparent that at times healthcare assistants made up a greater proportion of staff on wards due to the difficulties experienced in recruiting and maintaining an adequate number of nursing staff. This matter is discussed further in paragraph 6.96.

6.52 The Trust collated and analysed a range of information as a means to identify nursing concerns. The Review Team considered the Trust's wide range of information, along with the minutes of professional and operational management meetings. The key sources of information were:

- Professional Governance Frameworks;
- RQIA Inspection findings;
- Nurses in Difficulty reports;
- Risk Registers;
- Vulnerable Adult reporting;
- Use of Physical Intervention;
- Quality Improvement Plans;
- Key Performance Indicators;

[42] Support Resources for Record Keeping Practice Framework for Nursing Assistants. NIPEC https://nipec.hscni.net/download/projects/previous_work/highstandards_practice/record_keeping_practice_framework_for_nursing-Assistants/SUPPORT-RESOURCE-NA-Framework-Final.pdf

[43] Standards for Nursing Assistants employed by HSC Trusts. Foreword, https://nipec.hscni.net/download/professional_information/resource_section/nursing_assistants/standards-for-nursing-assistants.pdf

- Commissioned Education;
- Staff absence management and recruitment;
- Professional Nursing Reports; and
- Alerts or issues for escalation.

6.53 Since its formation in 2007 the Trust's Model of Governance has been an integrated approach where clinical and wider organisational risks are managed within a single integrated Assurance Framework. Key elements of clinical governance include:

- clinical audit and research;
- incident reporting;
- education and training;
- supervision and appraisal; and
- the adoption of evidence-based practice to ensure safe and effective care.

Arrangements are also in place within the Trust for the management of professional concerns about nurses and midwives. Issues relating to healthcare assistants were dealt with through line management arrangements.

6.54 Capacity for the integration of professional governance into the Directorate's governance arrangements was evidenced in the regular multidisciplinary meetings convened by the Trust's Co-Director who had a social work background and comprised the Clinical Medical Director, the Nursing Service Manager, and the Service Improvement and Governance manager at MAH. Attendance by other professionals or Operational Managers was dictated by the agenda for each meeting.

6.55 The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information

detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH.

6.56 Professional Accountability for medicine arrangements were outlined as follows:

‘All substantive doctors including consultants are accountable via the line management structure. That is to the Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director and are managed using Maintaining High Professional Standards Guidance, a framework set out by the Department of Health in 2003. Where appropriate the Trust will also invoke the services of the National Clinical Assessment Service.’

6.57 The Review Team had no access to medical workforce data. A review of senior staff meetings referenced however, a range of the workforce issues faced by the medical team on site. Between 2012 and 2016, minutes of the Core Group meetings highlight issues regarding the medical team’s ability and capacity to provide 24-hour cover at the hospital. There were efforts over an extended period of time to commission GP services and a GP out-of-hours service. Concerns were also noted about the ability of on-call doctors to complete the admission criteria assessment. A GP out-of-hour service was commissioned in November 2013.

6.58 Consultant medical staff shortages were also evident and were raised frequently by the Clinical Director at Core Group meetings. The management of sickness absence among medical staff was also difficult. Records indicate that locum cover was hard to secure.

6.59 In July 2103 the Clinical Director wrote to the HSC Board to secure additional consultant sessions. The resettlement assessment process placed additional demands on medical staff and the Review Team noted ongoing concerns expressed by the Clinical Director about patient safety resulting from the mix of patients on some wards and the consequent demands placed upon medical staff.

6.60 Nursing staff advised of some difficulties in securing timely access to medical review once an episode of seclusion was activated. There were also difficulties in securing Multidisciplinary Team (MDT) input into comprehensive risk assessments.

6.61 In respect of social work since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards[44]. Arrangements for professional oversight are designed to ensure that statutory functions are discharged[45] in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions in respect of:

- child care;
- mental health services;
- disability services,
- community care; and
- the social work and social care workforce.

[44] Health and Personal Social Services (Northern Ireland) Order, 1994

[45] Para. 1.2 CIRCULAR (OSS) 3/2015: 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986.

6.62 Executive Directors of Social Work have a number of specific areas of professional responsibility including:

- professional governance;
- standards and practice across all services for children, families and adults;
- development of the social work workforce;
- management and/or development of social work and social care services generally; and
- oversight of statutory functions discharged by the HSC Trust.

6.63 In addition to the aforementioned areas of professional responsibility, social workers also have a role in the general management of the HSC Trust, including sharing in corporate responsibility for policy making, decision making, and the development of the HSC Trust's aims and objectives.

6.64 HSC Trusts are accountable to the DoH through the HSC Board for their performance which includes accountability for the discharge of delegated statutory functions. Schemes of Delegation of Statutory Functions[46], which are documents sealed by the Department, the HSC Board, and each HSC Trust, provide a specific legal mechanism to monitor and report on the discharge of statutory functions on an annual basis. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the HSC Board to the Chief Social Services Officer (CSSO) and ultimately to the Health Minister.

6.65 Paragraph 3.1 of Circular (OSS) 4.15 clarifies that: 'Accountability is a key element in the discharge of Delegated Statutory Functions (DSF). The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the

[46] CIRCULAR (OSS) 4/2015: Statutory Functions – Professional Oversight

performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.' Paragraph 3.2 also notes that, 'responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs [Arms Length Bodies].'

6.66 All social care workers and professional social workers receive supervision within the organisation. A Supervision Policy exists to inform practice. In unidisciplinary teams, professional social work supervision must be provided by professionally qualified senior social workers, ensuring opportunity to review an individual's professional practice and accountability for the standard of his/her practice. Within integrated teams social workers received monthly supervision from their line managers. Where the manager was not a social worker, professional supervision was required from a social work manager on a three-monthly basis. Both managers were required to meet with the social worker to discuss operational and professional practice on a bi-annual basis. The Review Team was advised that audits relating to social work supervision were conducted. The audits did not confirm compliance with all aspects of the supervision policy, particularly in relation to the bi-annual meetings with managers.

6.67 Audits were also conducted at MAH which were independently commissioned by the Trust.[47] In respect of the deprivation of patients' liberty this report found: 'It is a major concern that aspects of the 'key evidence base' used to underpin these policies were out of date when the policy was written; e.g. NMC and NICE Guidelines.' The audit found that the Seclusion policy 'should have been reviewed in November 2016 and this was not completed.' The Review Team noted that the draft DHSSPS guidance on Restraint and Seclusion had not been used to inform

[47] Cannon F. & Barr O, Report of Independent Assurance Team Muckamore Abbey Hospital, June 2018

Trust policies in these areas.[48] The Review Team noted that the Southern HSC Trust had used the draft guidance to inform its policy. The DHSSPS draft guidance contained helpful advice on: patients' rights; training; and monitoring. It is unfortunate that final guidance was not provided by the Department.

6.68 Arrangements were in place to promote social work practice across client groups. The Executive Director of Social Work chaired the Trust's Adult Safeguarding committee which was established in 2015, although managerially he did not have responsibility for this client group until June 2016 when the Trust as a cost improvement measure removed a number of senior management posts at headquarters and MAH levels.

6.69 The Adult Safeguarding committee was modelled on child protection arrangements which were well established within the Trust and provided a model for improving safeguarding arrangements for vulnerable adults. A Professional Social Work Forum was also in place within the Trust prior to 2012. Managers at Grade 8B and above, attended by the Trust's social work governance lead, chaired the forum which addressed professional development and performance across the Trust. The 8B staff member with responsibility for social work services at MAH also attended the Professional Forum. The Trust's Safeguarding Specialist attended this Forum, at times, to provide updates on adult safeguarding issues.

6.70 There was an unbroken professional line from the frontline social worker to the Trust's Executive Director of Social Work as required legislatively. There were however, insufficient numbers of social workers at MAH to provide a service to all wards or to have the time to visit the wards regularly thereby acquiring an overview of patient care and treatment.

[48] Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005

6.71 The Review Team was informed that there was a picture of the safeguarding social worker and contact details on ward notice boards so that patients and family members would have had details of a contact point should they have concerns. The Executive Director of Social Worker also outlined a number of walk-around visits he made to MAH during his period in post (from June 2016 to August 2017), during which he met with staff and patients. He acknowledged that from these visits he was conscious of tensions in managerial relationships within the hospital, unease about its future, and low staff morale. He stated that he had no indication of the patient care issues which subsequently emerged once CCTV footage came to light.

iii. The Effectiveness of Corporate and Clinical/Professional Governance

6.72 The Trust identified delivering safe, high quality care as a key priority. It measured and collected a wide range of data as a means of learning from and improving outcomes and experience for service users. To consider effectiveness of professional governance the following section considers:

a. audit;
b. KPIs;
c. discharge of statutory functions;
d. workforce planning;
e. education training and continuing professional development; and
f. overview.

a. Audit

6.73 During the period covered by the Review, 2012 - 2017, the Trust held bi-monthly Mental Health and Learning Disability Audit meetings. It was intended that the agenda for these meetings would be informed by two audit forums, one representing Learning Disability, the other Mental Health. From 2012 to 2015 a total of 14 audits were completed:

- six audits - led by medical staff;
- five audits - led by an Occupational Therapists;
- one audit - led by a forensic Psychologist;
- one audit - led by a safeguarding officer who was a social worker; and
- one audit - led by a resource nurse.

6.74 Audit activity undertaken by nursing staff outside the formal clinical audit cycle was not noted in minutes of professional nursing meetings but referenced in RQIA reports. These audits are inclusive of Nursing Care Plans, risk assessments, and behaviour support plans.

6.75 Minutes from the Audit meetings show that they were poorly attended, and that Mental Health dominated audit topics. Staff representing Learning Disability services frequently acknowledged difficulty in engaging staff to gather data. Completed audits often failed to produce Action Plans capable of providing future measurements to demonstrate improvement and impact over time. During 2014 the Audit Forum for Learning Disability was stood down due to poor attendance and engagement. It subsequently merged into a single forum with Mental Health.

6.76 At a subsequent Governance meeting chaired by the Co-Director for Learning Disability, it was acknowledged that the lack of engagement and the failure to

contribute to the prioritisation of audit topics was a missed opportunity to address areas of concern within learning disability services.

b. KPIs

6.77 Key Performance Indicators (KPIs) are measurable indicators that demonstrate progress towards a specific target. They are essential in order to drive improvements in safety, efficiency, quality, and effectiveness as well as evaluating performance. During the period under review there were a number of KPIs against which nursing care at MAH was monitored. These were corporate KPIs used across all care settings. There were no person-centred or care specific KPIs for inpatient learning disability services. Additional performance indicators were identified by learning disability staff. These included nursing supervision, appraisal, mandatory training, and workforce.

6.78 The Trust also used NICE Guideline (NG11)[49] which were published and endorsed by the Department of Health in 2015. NICE guidelines are accepted as best practice. These guidelines cover interventions and support for adults with a learning disability and behaviour that challenges.

6.79 Workforce Steering Group minutes indicate that in 2015, MAH was progressing through The Quality Network National Peer Review. This is a standards-based quality network that facilitates the sharing of good practice. At the same time efforts were being made to introduce ward-based outcome measurement tools.

6.80 In January 2016 there was an agreement between senior nursing staff that the hospital should sign up to the Restraint Reduction Network[50]. The Network exists to support organisations to reduce reliance on restrictive practices.

[49] https://www.nice.org.uk/guidance/ng11
[50] Restraint Reduction Network @THERRNETWORK

6.81 During the period under review the Trust achieved a high rate of compliance with the Corporate Nursing KPIs. This is reported in the annual report of the Director of Nursing on the Key Challenges and Achievements which are reported to the Trust Board on an annual basis.

6.82 The Standards for supervision in nursing were met with exceptions recorded for some Bank and Agency staff. These reports were presented annually to the Trust Board and sent to the Chief Nursing Officer.

6.83 Data pertaining to vulnerable adults, physical intervention, restraint, and seclusion was collected and discussed generally on a fortnightly basis at Governance and Core Group meetings. There was no evidence of an analysis of the data or the production of trend data. At times it was noted that staffing levels, the admission of a new patient, or ward changes impacted upon the number of incidents recorded. There was no evidence that the information collated was used in a proactive manner to address factors known to relate to challenging behaviours on wards. There was also no reference to measurement of compliance with the NICE Guidelines in the documentation provided to the Review Team. The failure to use information to affect changes in practice led, in the opinion of the Review Team, to the over-use and misuse of physical intervention, restraint, and seclusion as found in the *A Way to Go* report (November 2018).

6.84 Regular audits of Nursing Care Plans, Risk Assessments, and Behaviour Support were not discussed at professional or operational meetings. Those topics were however, subsequently introduced into these meetings as part of findings emerging from RQIA inspections. Routine audit findings were not evident in any of the documentation examined by the Review Team.

6.85 The *A Way to Go* Report considered 61 RQIA reports and found that, ‘the RQIA inspection reports and Patient experience interviews do not provide a single

overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients.' It further noted that, 'it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm.'[51] RQIA reports, audit reports, and an ongoing analysis of the range of data collected by the Trust provided professional leads with the opportunities to work preventatively rather than reactively to events at MAH. One manager described to the Review Team 'a sensation of always fire fighting' at MAH.

6.86 Senior nursing staff advised the Review Team that Care Plans were often incomplete and activity records at various times were poor. From the documentation available to the Review Team it was unclear whether the Quality Network National Peer Review initiative was pursued to completion (see Para 6.75).

6.87 Membership of the Restraint Reduction Network was to be discussed at the Core Meeting in Feb 2016. The Review Team found no reference to this discussion or that membership was ever taken up. It is clear however, from the *A Way to Go* report that in 2018 restraint, physical interventions, and seclusions were still being used extensively. It commented: 'Three other [RQIA] reports noted the marked absence of an agreed, consistent, proactive behavioural management strategy…physical environment not conducive to the patients' needs, particularly concerning noise levels…the importance of developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.' [52] References to boredom, the environment, and/or the absence of proactive

[51] A Way to Go, December 2018, par. 7 - 8, Pages 7 - 8
[52] Ibid, Para. 95, Page 29

behavioural support strategies were regularly noted when incident data were reviewed. Yet the information did not inform revised ways of working with patients with complex and/or challenging needs.

c. Statutory Functions Reporting

6.88 The Review Team reviewed the Trust's Discharge of Statutory Functions (DSF) Reports from 2012 to 2017. The legal significance of these reports has been set out in paragraphs 6.58 and 6.59. The reports were largely repetitive and gave little sense of the extent of compliance with statutory functions. A Safeguarding Report was provided separately from the Discharge of Statutory Functions Reports. Despite repeated requests the Review Team did not receive copies of these associated reports.

6.89 The DSF Reports gave no specific details about how statutory duties under the Mental Health Order 1986 were discharged. Article 121 of the Order addresses the ill-treatment of patients.[53] The Review Team considered the absence of information on DSF Reports providing assurances on the treatment of patients to be an omission. The DSF Reports did not report to the HSC Board on the Ennis Report, on its conclusions, or how recommendations were being taken forward. The 2014 DSF report did not report on approval for the installation of CCTV at three wards in MAH to improve safeguarding arrangements. Neither was the subsequent installation of CCTV during July 2015 reported.

[53] Mental Health Order 1986, *Ill-treatment of patients*

121.—(1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the **[**F1 Board or a director of the **[**F2HSC trust**]** managing**]** a hospital, or a person carrying on a private hospital or nursing home —

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b)ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient,

shall be guilty of an offence.

6.90 The Review Team was informed that during the period of its review there had been discussion about altering the structure of the DSF Reports due to their repetitiveness. The view then was that the DSF Reports needed in the future to be a more outcome-focused reporting system. In the absence of a new DSF structure, reporting continued to lack specificity.

6.91 The HSC Board met annually with Belfast HSC Trust to review its DSF report. The Review Team had access to extracts of reports from the HSC Board to the Trust. Comments regarding MAH related to missing resettlement targets. The emphasis on resettlement is a recurrent theme in the management of MAH, at times to the detriment of the core hospital and the quality of patient care (see Para 5.21). There was no information in DSF Reports regarding the uncertainty about the hospital's future which was causing problems in staff recruitment and retention. The associated issues surrounding the use of bank and agency staff and the implications for the quality and continuity of care for patients was not evident in DSF reports.

6.92 As currently structured and reported upon, the DSF Reports examined by the Review Team did not provide sufficient assurances about the discharge of statutory functions as they related to learning disabled patients.

d. Workforce Planning

6.93 From the Review Team's examination of minutes and discussions with senior nursing staff it is evident that nursing staff shortages were directly impacting on the hospital's ability to provide safe and effective care. In March 2012 this was deemed to be a red risk and was added to the hospitals risk register. Minutes of the monthly Senior Nurse meetings held in 2012 - 2017 make frequent reference to:

- staffing at crisis level;
- staff working excessive hours;
- high reliance on bank and agency staff;
- qualified staff not being in place;
- high levels of sickness absences;
- poor staff morale;
- high levels of staff turnover;
- early ward closures designed to relieve staffing pressures;
- staffing deficits recorded on the Datix information system;
- day care activities restricted for patients to maintain safe staffing levels on wards; and
- the increase of adult safeguarding incidents which was attributed to staff shortages.

6.94 RQIA inspection reports also reported on staff shortages and resulted in a number of whistle-blowing concerns being raised with RQIA during the period under review. The Review Team did not have access to workforce plans or documentation identifying safe or minimum staffing levels and associated skill mix ratios for years 2012 - 2017. Senior nursing staff did report the use of the Telford assessment tool but recognised that this did not take into account the complexity and acuity of patient needs. Nonetheless there is no evidence in any of the documentation reviewed of any systematically applied objective assessment of staffing needs across the hospital. The *A Way to Go* Report also noted that 'the appropriate complement of staff for the wards remains unclear.'

6.95 Short term workforce planning resulted in the recruitment of staff on temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community

infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors.

6.96 Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time. The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster.

6.97 The Review Team was advised by the Director of Nursing that she was not assured that the staffing ratios were sufficient to provide safe and effective care. She issued a directive stating the need for a minimum of at least two registrants per shift. When interviewed she advised the Review Team that she believed current ratios and the skill mix were not an accurate reflection of the acuity of the remaining patients. This will undoubtedly result in poorer outcomes for patients and inhibit nursing innovation and improvement. The Review Team noted that the Director of Nursing was not the financial budget holder for the nursing workforce.

6.98 Throughout the period under review there was clear evidence of recurrent recruitment drives for staff at MAH. The regional challenges associated with recruiting Registered Learning Disability Nurses was noted by the Review Team. The Trust's investment in supporting staff to undertake the Specialist Practitioner programme was also noted. The staffing crisis meant that those specialist staff were needed to meet the core staffing needs of the wards. Their skills and expertise were not therefore available to use in developing and supporting person-centred nurse developments.

6.99 The uptake of training was also adversely affected by staffing shortages. During a 2017 Listening Exercise the Trust found ‘cancelled training sessions resulting in poor compliance with mandatory training updates.’ The Review Team considered that the high vacancy and turnover rates also impacted upon the Trust’s ability to develop staff to meet new and emerging best practice developments.

6.100 An examination of correspondence between the ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and their skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services’ Risk Register during the Spring/Summer of 2012 as a high risk. Yet this risk was not placed on the Trust’s Corporate Risk Register as per the Trust’s policy.

6.101 Immediately after the Ennis complaint (November 2012) came to light the Executive Director of Nursing asked a Co- Director of Nursing with a Trust-wide remit for nursing workforce and education to work in support of the Service Manager and to provide assurance to its Executive Team on the Ennis Investigation. This staff member had regular supervision with the Director of Nursing throughout this deployment. An assessment of nursing within the Ennis Ward was undertaken. This assessment identified a number of shortcomings around matters which included:

- staff induction;
- the student learning environment;
- staffing;
- care planning; and
- monitoring.

A number of improvements were put in place which included enhanced staffing, staff appraisal, and training while remedial action was taken to improve the ward environment.

6.102 While there was an agreed formula (The Telford Formula) to determine staffing levels in learning disability hospitals, it is evident from documentation considered by the MAH Review Team that there were ongoing issues relating to the adequacy of staffing numbers and qualifications. CCTV footage showed patients being harmed by staff in the Psychiatric Intensive Care Unit (PICU), which had the highest staffing levels and ratios of qualified staff. Yet no safeguarding referrals were made and no members of staff spoke out.[54] There is therefore no straightforward linkage between staffing levels and abuse. That being said, over-stretched and tired staff are more likely to be less resilient when dealing with patients with complex and/or challenging needs.

6.103 Inspection reports from RQIA and minutes of senior staff meetings confirmed that the hospital was operating without the full range or availability of a multidisciplinary team (MDT). In 2012 it was reported that the hospital had:

- no Occupational Therapists;
- only 1.5 whole time equivalent (WTE) Speech and Language Therapists based in Day Care;
- 0.5 WTE Dietician,
- one psychologist;
- two WTE Physiotherapists, which was subsequently reduced to 1.5 WTE to meet cost improvement targets.

In addition there were three social workers and a small number of behaviour support nurses or assistants.

[54] Op. Cit. par. 4, Page 4

6.104 Senior staff advised the Review Team that much of the focus of the MDT was directed to the resettlement wards. Psychology input was evident in PICU but efforts to secure funding to extend psychology services across the hospital were unsuccessful. The Review Team found that restricted access to psychology had a detrimental effect on the ability to develop, educate, and support nursing staff to deliver therapeutic interventions. The Review Team acknowledged the role of the Behaviour Support Service but noted that staff and RQIA both reported inconsistent availability of these staff, evidenced by patients' behaviour management plans which were poorly documented.

6.105 Minutes of senior nurse managers meetings recorded difficulties in accessing MDT input into comprehensive risk assessment.

e. Education Training and Continuing Professional Development

6.106 The Trust has committed to building the capacity of its workforce through education, learning, and development with a range of clinical and leadership opportunities.[55] An integral part of good governance is education, training, and continuing professional development activities for staff. These are also essential in enabling the Belfast HSC Trust to achieve its objective to deliver safe and effective care. Access to continuing professional development and leadership opportunities support the Trust's ambition to become a leader in providing high quality care through a relentless focus on quality improvement.

6.107 The Trust has in place structures and processes to support education training and induction for all staff including Health Care Assistants (HCAs). These are translated into functions within the HR Directorate and embedded in professional

[55] https://belfasttrust.hscni.net/working-for-us/staff-development/

assurance structures. These structures include a Co-Director of Nursing for Education and Learning who is a member of the Central Nursing and Midwifery Team along with a senior nurse for Nursing Research and Development. Similar arrangements are in place for the medical profession where a Deputy Medical Director is employed with responsibility for education and workforce issues.

6.108 For social work the Trust employed a governance specialist at Director level with responsibility for the professional development of social workers and for wider governance assurances and policy developments in respect of social work and social care issues. By chairing a Professional Forum of social work managers at Level 8B and above, the Executive Director of Social Work was able to promote consistency of professional social work practice across all Directorates. This also provided an opportunity for updates on professional practice by, for example, input from the Trust's safeguarding specialist.

6.109 Professional regulators, such as the NMC, the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC) also require Continuous Professional Development of their registrants. Professional development in the Trust must be offered to comply with such requirements. A wide range of Education Programmes and learning opportunities are available to staff which are accessed through Queen's University Belfast, the Ulster University, the Open University, and a range of other providers such as the Royal Colleges, the Clinical Education Centre, and the Leadership Centre.

6.110 Service led education commissioning for nurses in the Trust is translated into a learning needs analysis. This needs analysis is informed by:

- individual review/appraisal;
- incidents and accidents;
- service developments; and

- professional developments and complaints.

6.111 Additionally, education delivered by the Clinical Education Centre was also available to staff under a Service Level Agreement with the Trust. This education was provided under the auspices of full or half-day programmes, short courses, or bespoke education at the request of the Trust.

6.112 The Belfast Trust has a long history of promoting and supporting Practice Development as a means of changing and improving practice. Much of this work is undertaken in partnership with the Ulster University. It is widely published and is recognised on an international level. Practice Development is seen as a complex intervention and one that embraces attitudinal and behavioural change. The ultimate purpose of practice development is the development of person-centred culture delivering safe and effective person-centred care.[56]

6.113 Post-Registration Education Commissioning for nursing was a robust process undertaken on an annual basis. It is difficult from the information provided to discern what education was commissioned specific to staff at MAH as records refer only to Learning Disability. Trust records of commissioning requests between 2012 and 2017 include a range of requested programmes:

- the Management of Actual and Potential Physical Aggression (MAPPA) Training;
- Developing Practice in Health Care;
- Principles of Assessing People with Learning Disability and Mental Health problems;
- Contemporary issues in Learning Disability;
- Fundamentals in Forensic Healthcare;
- Specialist Practitioner Learning Disability (2015 and 2016); and

[56] McCance T. & McCormack B. Person Centred Nursing: Theory and Practice, Wiley, 2010

- A range of RCN programmes to support the development of ward managers.

6.114 The number of places requested was small with the exception of MAPPA Training which had approximately 50 places and the Specialist Practitioner Programme which had 12 places and required staff to be released from practice to study full time during the academic year.

6.115 The Review Team commend the commissioning of the Specialist Practitioner programme and MAPPA training. The Review Team noted, however, that little priority was given to therapeutic, evidence-based learning. This is against the backdrop of the 2015 NICE Guidelines and a growing body of evidence to support therapeutic intervention.

6.116 At the beginning of 2016 minutes of a senior nurse managers meeting at MAH reflected discussions and a desire to strengthen positive behaviour support. Reinforce Appropriate, Implode Disruption (RAID) training was discussed and training offered to Band 6, Band 7, and Band 8A staff. The Review Team noted that further training was planned but staffing on the wards remained challenging and psychology support was insufficient because of limited resource. The Review Team noted that the RAID approach like MAPPA is reactive in nature to short term management of violence and aggression and is less relevant to NICE Guideline 11 (NG11) (see Para 6.78) which promotes preventative approaches leading to a reduction in restrictive interventions. Approval of the policy to support the roll-out of the Positive Behaviour Strategy in MAH was not received until October 2017.

6.113 The Review Team further noted that whilst Practice Development was encouraged and supported across other programmes of care, the opportunities for staff in MAH were very limited. The Review Team found no evidence of Practice Development Initiatives other than the Productive Ward/Releasing Time to Care series in 2012.

6.114 Induction Training was predetermined for all staff working in MAH and was essential for the preparation of Health Care Assistants. The review team did not access training records for these staff but noted in 2012 that the Co-Director of Nursing for Education and Workforce reported there was little evidence of adequate induction and staff lacked knowledge of the safeguarding framework. The Service Manager was asked to put in place an appropriate induction plan, which was monitored and reported upon, in subsequent RQIA Inspections. The findings of these inspections confirmed that induction training was available but often compromised because of staffing shortages.

6.115 Mandatory training was also specified for all staff working in MAH. Compliance was monitored by the ward managers and formed part of the appraisal process. It was also reviewed by RQIA during its inspections which found that the uptake of mandatory training was inconsistent across the hospital site. The *A Way to Go* Report supports these findings, as does the Listening Exercise with staff conducted in 2017.

f. Overview

6.116 At corporate and clinical levels the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems, risk monitoring, educational and professional development processes, and information systems capable of ensuring good governance at MAH. RQIA in its 2016 Report (Review of Quality Improvement Systems and Processes),[57] noted that the main areas of activity for the Belfast Trust were acute hospital care, community care, and social care. The limited focus on a learning disability hospital was also evident on the Trust's website which was only updated in July 2020 to include MAH as one of the Trust's hospitals.

[57] https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf

6.117 The Review Team in its meetings with senior Trust personnel and MAH staff formed the view that MAH was not only geographically distant from the Trust but was largely 'outside its sightline' as one staff member stated. The review of minutes from Trust Board meetings and Executive Team meetings up until until August 2017 showed that the hospital operated with minimal attention at Trust level.

6.118 The values of the Belfast Trust are:

- working together;
- excellence;
- compassion; and
- openness and honesty.[58]

These values did not pervade the care provided by some staff at MAH to vulnerable adults as evidenced by the Ennis investigation and the events captured on CCTV during 2017. The reasons for such lapses are complex and the Review Team considers it too simplistic to attribute it solely to staffing difficulties when one considers that the events in PICU in 2017 occurred on the ward with the highest staff to patient ratio and a greater number of registrants to healthcare assistants. Similarly, governance arrangements do not adequately answer why problems occurred and went undetected and un-remedied.

6.119 RQIA listed a number of specific drivers to embed a Quality Improvement (QI) culture in MAH which included:

· learning from Serious Adverse Incidents (SAI)

[58] **Working Together - We work together to achieve the best outcome for people we care for and support.**
Excellence - We deliver safe, high quality, compassionate care and support to everyone including you.
Openness and Honesty - We are open and honest with each other and act with integrity and sincerity.
Compassion - We are sensitive, caring, respectful and understanding towards people we care for.
https://belfasttrust.hscni.net/working-for-us/hsc-values/

- the ability to meet Key Performance Indicators
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence.[59]

6.120 The Review Team saw limited evidence of a learning culture from the minutes it reviewed or of a willingness to interrogate the significant amount of information which was collated regularly and brought to Governance and Core Group meetings at MAH. An Executive Director noted a 'lack of curiosity' amongst senior clinicians at MAH. The fact that MAH information, staffing, or performance were rarely on the agenda for Trust Board or Executive Team meetings showed that a lack of curiosity. Any focus at Trust and HSC Board levels on MAH appeared restricted to resettlement matters and failure to meet these targets.

6.121 In commenting on the closed nature of relationships at MAH the *A Way to Go* Report states that 'some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients.' (see Paras 6.27 and 6.29) This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust.

[59] Op Cit. Review of Quality Improvement Systems and Processes, RQIA, Page 13

Summary Comments and Findings

- **The Trust is one of the largest integrated health and social care organisations in the UK. Its governance structures were complex and appropriate.**

- **The organisational governance structures remained largely consistent between 2012 and 2017. Had they been used appropriately, they had the capacity to alert the Executive Team and Trust Board to matters of concern at MAH.**

- **Complaints about professional practice in Ennis ward in November 2012 were not raised as an SAI or a complaint.**

- **Inspection findings from RQIA were Ward specific. A single overview of the hospital was not provided. RQIA reports resulted in multiple recommendations which were frequently repeated. There was no indication of wider learning or action plans to implement the recommendations from inspection reports. RQIA did not serve Improvement Notices on the Trust in respect of MAH until November 2019.**

- **Clinical audit was dominated by mental health services. Learning disability services were reluctant to engage with audit. This was a missed opportunity to address issues of concern with this directorate.**

- **KPIs were generic rather than specific to inpatient learning disability services and lacked a person-centred focus.**

- **Discharge of Statutory Functions (DSF) Reports were largely repetitive**

narrative documents which provided limited information regarding the discharge of functions under the Mental Health Order 1986. Generally, comments on these reports from the HSC Board related to resettlement targets. There was insufficient challenge at Trust Board, HSC Board, and Departmental levels to ensure DSF Reports were outcome focused.

- **Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care.**

- **Wards closed earlier than planned without due regard to the impact on patients or the required skill mix within the staff team. A low ratio of nurses to healthcare assistants was reported. The dominance of healthcare assistants compromised the quality and scope of professional nursing oversight.**

- **Patient activities were curtailed due to staffing shortages which resulted in increased levels of boredom and behavioural challenges with an over reliance on restrictive practices.**

- **Consistent recruitment drives resulted in temporary appointments due to the moratorium on recruitment which was driven by the plan to close large portions of MAH under the resettlement agenda.**

- **The lack of a career development pathway resulted in staff leaving to take up positions in Health Visiting.**

- **The hospital operated without the full range or availability of a multidisciplinary team which reduced the behavioural support available to patients.**

- **The focus on education and training was on mandatory training rather than therapeutic evidenced based learning. The lack of investment in staff training and development meant that challenging behaviours were poorly understood. Staff attendance at mandatory training was also poor because of staff shortages.**

- **A comprehensive range of data was collected on a monthly basis and presented at Governance and Core Group meetings. There was no evidence of analysis or triangulation of this data or its use to inform patient care or staff training.**

- **There was a clash of values between MAH and the Trust.**

7. Review of Leadership

7.1 This section considers leadership in the Belfast Trust at the following levels:

i. leadership requirements for a HSC Trust;
ii. leadership and management arrangements within the Belfast HSC Trust; and
iii. leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels.

i. Leadership Requirements for a HSC Trust

7.2 The Belfast HSC Trust was established in April 2007 as part of the Review of Public Administration (RPA): a major reorganisation of public sector bodies in Northern Ireland. Prior to this reorganisation there were 19 HSC Trusts, with four commissioning HSC Boards providing integrated health and social care services to the population of Northern Ireland on behalf of the Department of Health under the provisions of the Health and Personal and Social Services (Northern Ireland) Order 1972. The RPA resulted in the reconfiguration of the 19 Trusts into six Trusts. The four HSC Boards were replaced by a regional HSC Board.

7.3 When established the Belfast HSC Trust was the largest of the new Trusts with a budget of £1.1billion, employing more than 20,000 staff. Four of the six Trusts which merged to create the Belfast HSC Trust were acute hospital Trusts: the Royal Group of Hospitals, the Belfast City Hospital, the Mater Infirmorum Hospital, and Greenpark Trust. The remaining two Trusts were community health and social care Trusts serving the North and West Belfast and the South and East Belfast

populations of Belfast. Prior to the RPA Muckamore Abbey Hospital had been managed by the North and West Belfast Community Trust.

7.4 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 established the Regulation and Quality Improvement Authority (RQIA) (Article 3). Article 35 of the Order defines the role of RQIA. The legislation also conferred a statutory duty of quality on each health and social care organisation in Northern Ireland (Article 34(1)[60].

7.5 In 2006 the Department published standards[61] (Quality Standards) to support good governance and best practice within the HSC. The five key quality themes within these Standards are:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information.

7.6 In publishing the Standards the Department stated that, 'RQIA in conjunction with HSC organisations, services users and carers, will agree how the standards will be interpreted to assess service quality. Specific tools will be designed to allow the RQIA to measure that quality and assist HSC organisations to assess themselves. RQIA will provide a report on its assessment of governance from 2006-2007 onwards.'

[60] **34.**—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of —
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them.

[61] Quality standards for health and social care https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

7.7 The Review Team's remit relates to governance and leadership within the Belfast HSC Trust. In this regard the first quality standard, Corporate Leadership and Accountability, is most relevant to the Review. This standard establishes a number of criteria by which RQIA and HSC organisations can determine the degree to which each organisation complies with it. Relevant criteria when reviewing leadership and determining compliance levels include:

- 'Has a coherent and integrated organisational and governance strategy appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.

- Has structures and processes to review and action its governance arrangements.

- Ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory function and in relation to interagency working.

- Undertakes systematic risk and risk management of all areas of its work.

- Has a workforce strategy in place that that ensures clarity about structure, function and roles and ensures workforce development to meet current and future service needs in line with Department policy and the availability of resources.'

7.8 Section 6 of this report examined the range of governance issues within Belfast HSC Trust relevant to Standard 1 of the Quality Standards, namely: the governance structures; risk management arrangements; assurance in respect of the discharge of statutory functions; and workforce strategy.

ii. Leadership and Management Arrangements in the Belfast HSC Trust

7.9 *The Belfast Way* was published by the Belfast Trust in 2008. It set out a strategic direction for the Trust. Its objective was to offer guidance and motivation to all those involved in serving its resident population. It stated that the Trust would work within government policy to secure the purpose of the Trust which was to improve the health and wellbeing of its population and to reduce health inequalities. *The Belfast Way* had five strategic objectives:

i) Safety and Quality - continuous improvement in the quality of our services and a focus on safety is a priority for all our people, from the Board of Directors to the teams providing care and services.

ii) Modernisation - We believe it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so that we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens.

iii) Partnerships - working in partnership with individuals and communities leads to more appropriate care and treatment, improved outcomes, better experience by our service users, improved health outcomes and wellbeing for communities and greater social inclusion.

iv) Our People - Our vision is to be seen as an excellent employer within the health and social services family and beyond. Our people will feel valued, recognised and rewarded for their endeavours. They will be supported in their development and their worth as individuals will be respected in the application of their skills in delivering our vision and purpose.

v) Resources - Our financial strategy will ensure that the income we receive from Government provides services which add value, are affordable and set within the organisations overall risk and assurance framework. The organisations duty of care to the public is paramount in all expenditure decisions.'

7.10 These strategic objectives were underpinned by a set of values which include:

- respect;
- dignity;
- accountability;
- openness;
- trust; and
- learning and development.

7.11 In 2009 the Trust set out its approach to leadership in a document titled 'Leadership and Management Strategy 2009-2012'. The Review Team was advised that this strategy document was replaced in 2016 by a Leadership and Management Framework known as 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels.' (see Para 7.25)

7.12 The Leadership and Management Strategy sets out how it supported the Trust's five corporate objectives contained in *The Belfast Way*. It also considered the distinction between leadership and management. It stated that: 'The key purpose of leadership and management is to provide direction, gain commitment, facilitate change, and achieve results through the efficient, creative, and responsible deployment of people and other resources.' It provided definitions of each:

- 'Leadership is an interpersonal relationship and process of influencing, by employing specific behaviours and strategies, the activities of an individual

or organised group towards goal setting and goal achievement in specific situations.

- Management, in contrast refers to the co-ordination and integration of resources through planning, organising, directing and controlling to accomplish specific work related goals and objectives.'

7.13 The strategy included a management and leadership charter. The charter set out the principal actions, knowledge, and guiding behaviours required of leaders and managers in the Belfast Trust and reiterated the values that were set out in *The Belfast Way*, (see Para 7.10). During the period under review (2012 - 2017) the Trust had three different Chief Executives, one of whom served on a part time basis. There was also a six month period during which an Interim Chief Executive was in place pending the appointment of the new Chief Executive. During the review period responsibility for learning disability services also rested with three different Directors.

7.14 In 2007 the Trust Board approved the management structure to provide leadership within the new organisation. Responsibility for MAH was included in the Directorate of Social Work, Children's Community Services, and Adult and Primary Care Services. This was a huge Directorate which accounted for approximately a quarter of the total spend of the Trust. When the Director retired in 2012 the post was split into two with the creation of a Director of Social Care and a Director of Adult and Primary Care. Under each Director were a number of Co-Directors, each of whom had responsibility for a discrete service area. MAH came under the remit of the Co-Director for Mental Health and Learning Disability Services. In addition to the Director with operational responsibility for MAH, the Executive Director of Nursing was responsible for professional matters in respect of nursing.

7.15 The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included:

- The structure had been tried before, prior to 2012, and senior staff in both Directorates felt the portfolio was unworkable;
- It diluted the community voice within the organisation and specifically at Trust Board level;
- It unbalanced the make-up of the Executive Team;
- The job was huge in volume and complexity (comprising a third of the Trust's business area) resulting in the post-holder considering that at times he was 'skimming over issues and information';
- The span of control with 11 direct reports was too great;
- Other Trusts had three persons in post discharging the functions required of the post-holder.

7.16 The Director recommended a return to two Directorates which occurred in the latter part of 2017. In addition to merging the two Directorates in June 2016, the Co-Director Learning and Disability Services post was surrendered when that post-holder retired circa September 2016 as a cash releasing exercise. A Band 8B post at MAH was also surrendered in 2016 on the retirement of the incumbent. The Review Team was advised on the effort taken by the Director of Social Work, Children's Community Services, and Adult and Primary Care Services to secure the re-instatement of both these posts.

7.17 There was no evidence available to the Review Team that having one Director specifically with an Adult and Primary Care remit resulted in MAH being afforded a greater level of attention. The Director did hold a number of meetings on site but according to interviewees, staff at MAH were not aware of who was responsible for the hospital at Executive Team and/or Trust Board levels. The Review Team was told that the decision to surrender the Co-Director Learning Disability Service and the Band 8B posts for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made. The incoming Director stated that he spent much of the next year working to have these posts reinstated; an objective which he secured. The Co-Director post was filled during October/November 2016 by MAH's Service Improvement and Governance manager.

7.18 There is no information from Executive or Trust Board minutes of a greater focus being afforded to MAH when the Director Adult and Primary Care was in post from 2012 to 2016. The Review Team had the benefit of interviewing this retired staff member. Although the Ennis investigation took place during 2012/13, the Director of Adult and Primary Care could not recall any engagement she had with the investigation process. She did, however, state that she had read the report. The Report had not been tabled at Executive Team or Trust Board meetings as the Director of Adult and Primary Care considered the matters to have been appropriately addressed. Much of the focus of the Director of Adult and Primary Care related to the resettlement agenda at MAH and the cash releasing targets set by the Department at that time.

7.19 The Executive Director of Nursing was aware of the Ennis investigation. She was aware that approximately £500,000 was provided to fund the 24/7 monitoring on

that ward as a consequence of the investigation. Like the Director of Adult and Primary Care, the Director of Nursing did not bring the Ennis investigation or the subsequent report to the attention of Executive Team colleagues or the Trust Board. The Review Team was concerned that multiple alleged abuses of patients by more than one perpetrator was not considered of significant enough priority to bring it to the attention of the Executive Team or the Trust Board.

7.20 Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern.

7.21 The Review Team found a 'culture clash' at MAH (see Para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This led to a period of supervised practice with support provided by the Co-Director of Nursing for Workforce and Education and the Leadership Centre.

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

7.23 At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates.

7.24 In 2016 the Trust introduced collective leadership under its 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels' strategy.[62] The purpose was to 'grow a culture of collective leadership where everyone at every level has the capability to deliver improvements for the Trust as a whole, not just in their own roles or work areas.' The Trust stated that its ambition was 'to make Belfast Trust a world leader in the provision of health and social care' and that the Trust be recognised as a high performing organisation. Our focus is on continual learning and the improvement of care that is safe, effective, high quality, and compassionate.' The Collective Leadership strategy also was designed to align with the Trust's learning and development strategy, 'Growing Our People today for tomorrow – living our value of maximising learning and development.'

[62] Leadership & Management Framework

7.25 The Collective Leadership strategy aimed to embed leaders at all levels in the organisation working towards high performance and improvement: ‘the ethos is not dependent on position, grade or role and has the potential to more effectively transform the organisation and our Trust Ambition. All staff can be leaders and can demonstrate leadership qualities and behaviours.’ The strategy sought to place responsibility for the success of the Trust as a whole while being successful in their work roles. The strategy acknowledged that it would take time to ‘review our current culture, look at what works well and identify what needs to be improved. This will inform our new collective leadership strategy.’

7.26 The characteristics of culture set out in the strategy were:

- an inspiring vision;
- clear objectives and priorities at every level;
- supportive people management and leadership;
- high levels of staff engagement;
- learning and innovation the responsibility of all; and
- high levels of genuine team working and cooperation across boundaries.

7.27 The values expected of staff set out in the strategy were:

- ‘being respectful to others;
- showing compassion for those who need our care;
- acting fairly;
- acknowledging the good work of others;
- supporting others to achieve positive results;
- communicating openly and consistently;
- listening to the opinions of others and acting sensitively;
- being trustworthy and genuine;
- ensuring that appropriate information is shared honestly;

- actively seeking out innovative practice;
- participating in new approaches and service development opportunities;
- sharing best practice with others;
- promoting the Trust as a centre of excellence;
- acting as a role model for the development of others;
- continuing to challenge my own practice;
- fulfilling my own statutory and mandatory training requirements;
- actively support the development of others;
- taking responsibility for my own decisions and actions;
- openly admitting my mistakes and sharing learning from others;
- using all available resources appropriately; and
- challenging failures and poor practice courageously.'

7.28 The Review Team was informed that the community sector of the Trust did not respond well to the collective leadership strategy. The reaction was described by a former Director as the community sector being 'up in arms.' The view was that the strategy was more appropriate to the acute sector. Interestingly, in reference to medical engagement the Leadership Framework stated that, 'there is clear and growing evidence that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins the argument that medical engagement is an integral element of the culture of any healthcare organisation and the system and therefore one of the highest priorities within an organisation.' The Review Team found little evidence of proactive engagement between managers and medical staff on the MAH when it came to the quality and safety of patients.

7.29 The Review Team saw no evidence of work being undertaken at MAH on a review of culture or of a learning and staff development programme to support the implementation of the Collective Leadership strategy. The practices which were captured by the CCTV footage from August 2017 also were not informed by

the value statements set out in the strategy. Training and staff development have been addressed at Section 6 (Paras 6.106 - 6.115).

iii. Leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels

7.30 There were at various times four Executive Directors with professional and managerial responsibilities for staff based at MAH namely: the Director of Adult and Primary Care; Director of Social Work; Director of Nursing; and clinical leadership which was provided by the Clinical Director. There was limited information on the documentation examined of the extent of the role at MAH. A copy of the Clinical Director's Job Description references the role in clinical leadership. The post-holder was accountable to the Co-Director of Learning Disability Services and professionally accountable to the Trust's Medical Director and from 2016 to the Associate Medical Director.[63]

7.31 The Clinical Director regularly attended a range of senior management meetings, including Governance and Core Group meetings. In his evidence to the Ennis investigation he stated that he completed a weekly ward round whereas the specialist doctor for the ward would have had a daily presence on the ward. Overall, he concluded that the ward was effectively managed by nursing personnel. There is evidence that at times the Clinical Director was not supportive of approaches recommended by ward staff and the Service Manager in relation to developing care and protection plans for patients. His view was that the suggested

[63] Extract from Job Description: 'The appointee will provide clinical leadership and contribute to the strategic development of the Service Group across the Trust and participate as a member of the clinical service senior management team. He/ she will provide professional advice to the Co-Director and Associate Medical Director on professional medical issues of the service. He/she will have a key role in developing clinical leadership and ensuring ownership of new strategies and policies within the clinical service area and of ensuring excellent communications between clinicians and the management team of the Clinical Service area as well as Service Group. The appointee will be professionally accountable to the Associate Medical Director for medical professional regulation within the service.

approach was required for forensic patients only. The follow-up action required of medical staff as part of policy when patients were subject to restraint, seclusion, or physical intervention was not always evident. The staffing pressures on the medical side and the difficulty in recruiting medical staff, which was regularly documented, likely contributed to a number of these omissions.

7.32 There is limited evidence of the Clinical Director promoting positive behavioural support approaches to patient care or of challenge to the high levels of restraint and seclusion which were used regularly especially in respect of a small cohort of patients. It is evident from minutes of meetings attended by the Clinical Director that he was aware of these matters and was very familiar with specific patients and their needs. The Clinical Director regularly attended Core Group meetings at the hospital where data regarding these practices were routinely shared. There is no evidence of a challenge function being exercised in an effort to change practice as a means of reducing incidents. The *A Way to Go* Report found that:

- 'There was a culture of tolerating harmful and disproportionately restrictive interventions.
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic.'
- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training.'[64]

These findings confirm for the Review Team that clinicians at MAH did not contribute to ensuring that safe and effective treatment was available at all times on site.

[64] Op. Cit. par. 4, Pages 4 - 5

7.33 The Review Team also found the absence of either medical or nursing staff at MAH competent to address the physical health needs of patients to be concerning. The Review Team identified a number of instances where patient's physical health needs remained undiagnosed and untreated for unacceptable lengths of time. The health inequalities which exist between learning disabled and the general population are well recognised.[65] There is evidence in the documentation examined of efforts made to procure GP and out-of-hours medical cover from services local to MAH. There was significant delay in procuring such services. As a hospital service the Review Team are of the view that greater pressure should have been applied to ensure the Trust took corrective action in respect of this shortcoming.

7.34 The Clinical Director briefed the Trust's Medical Director on 20th September 2017 immediately after viewing the CCTV footage at the PICU of the assault on a patient on 12th August 2017. He also informed the Medical Director that the footage also showed ill-treatment of another patient and the inaction of other staff. The Medical Director's notes of the meeting draw a conclusion that 'the whole staff team [at PICU was] complicit.' On learning of events on PICU the Medical Director requested that an independent SAI be established to review events at MAH; she extended this review to other wards.

7.35 When the Review Team met with Clinical Director he stated that in addition to his role at MAH, he also held the regional lead for forensic services and provided outpatient clinics. He was managerially responsible for medical personnel at MAH until after 2017 when his role changed. He advised that he had submitted requests to the commissioning Board for additional medical input. He was unsuccessful in securing additional staffing in either case. He noted the significant delay in

[65] People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017). Mencap https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

discharging patients due to the absence of a sufficient range of community resources. At the time of interview he noted that there were fewer than 60 patients in the hospital of whom around five required treatment or assessment. In discussing the use made of data provided at meetings which he attended regarding incidents involving vulnerable adults; physical intervention, seclusion, and restraint, the Clinical Director agreed that prior to 2017 information was viewed on a meeting by meeting basis rather than trend data analysed to inform alternative strategies or training. He noted that recent presentation of data was more trend focused. The Review Team found little evidence that the Clinical Director played a proactive leadership role in the management team.

7.36 The Review Team considered leadership at a range of levels across the Belfast HSC Trust in respect of MAH. An examination of Trust Board and Executive Teams' minutes showed that MAH rarely featured on the agenda. There was no reference to it in the Trust's Annual Quality Reports or within the Discharge of Statutory Functions Reports (DSF). The Review Team considered the repetitiveness of the DSF reports and the general absence of assurance regarding the degree to which statutory functions were discharged should have resulted in challenges at Trust Board and HSC Board levels.

7.37 Neither the vulnerability of the patients cared for at MAH nor an awareness of the likely risks associated with institutional living brought MAH into focus at any level at Trust Board or Executive Team levels. The Review Team concluded that for a number of reasons MAH was perceived, as one Co-Director noted, as a self-contained community with its own culture and identity. Its geographic distance from the Trust and the resettlement plan for the hospital led in the Review Team's opinion, to it being viewed as a place apart. MAH had no champions at either the Executive Team or at Trust Board levels with a curiosity about it and those for whom it cared. The Review Team concluded that the Trust's values (see Para 7.10) and the objectives established in *The Belfast Way* (see Para 7.9) were not

guiding principles at MAH. The Review Team identified a cultural divide between the Trust and MAH.

7.38 Organisational culture is a set of shared assumptions that guide what happens in organisations by defining appropriate behaviour for various situations.[66] Organisational culture affects the way in which people and groups interact with each other, with clients, and with stakeholders. Additionally, organisational culture may influence how much employees identify with their organisation.[67] A deeply embedded and established culture illustrates how people should behave, which can help employees achieve their goals. This behavioural framework in turn ensures higher job satisfaction when an employee feels a leader is helping him or her complete a goal.[68] Organisational culture, leadership, and job satisfaction are all inextricably linked.

7.39 The Review Team found low levels of staff morale reported by a range of interviewees and by staff whom they met during the visit to MAH in February 2020. It also found significant leadership issues in that events which occurred at MAH were seldom brought to the attention of the Executive Team, the Trust Board, the HSC Board, or the Department of Health. The culture at MAH appeared not to be influenced by the Trust's modernisation agenda or its value base. It also found expression in the reluctance of a number of managers to embrace the resettlement agenda by accepting the implication for the hospital's future and to learn from good practice to ensure a higher proportion of patients made a successful transition to community living. Such an approach may also have served to allay the fears and

[66] Ravasi, D. & Schultz, M. Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal,* 2006, 49 (3): 433–458

[67] Schrodt, P. The relationship between organizational identification and organizational culture: Employee perceptions of culture and identification in a retail sales organization". *Communication Studies* 2002, 53: 189–202

[68] Tsai, Y. "Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction." *BMC Health Services Research BMC Health Serv Res,,* 2011 (11)1, 98

apprehensions of family and carers of patients who were understandably concerned about changes to the living environment of their loved ones.

7.40 The lack of Trust Board and Directors engagement with MAH is understandable given the scale and complexity of the Belfast Trusts and the degree to which the acute agenda dominated Executive and Trust Board meetings. It is not however, an excuse for having MAH operate under the radar with little effective challenge at the failure of its leaders to bring issues relating to the service to the attention of the Trust Board. A closed institution carries associated risks regarding the wellbeing of residents. This has been well established in institutions such as prisons, children's homes, and other learning disability services.[69] Visible leadership with regular engagement with a service and its staff is an important means not only of being alert to possible problems in a service but also of communicating the organisation's values and objectives for the service.

7.41 In the Review Team's opinion, how the physical environment was maintained conveyed a message to staff about how the hospital was valued by the Trust. Much of the hospital had been allowed to deteriorate over time and problems which emerged were addressed in-house in reactive fashions. For example, to solve issues relating to staff shortages wards were closed earlier than planned with insufficient attention afforded to the mix of patients in the amalgamated wards. Similarly, staff shortages resulted in fewer activities for patients which had negative consequences in relation to their management and behavioural challenges.

7.42 In the opinion of the Review Team the role of leaders is to interrogate and analyse information to develop approaches to proactively address root causes. Yet the absence of behavioural support staff meant there was no strategy in place capable of reducing incidents of physical intervention, restraint and/or seclusion. From a

[69] The Winterbourne Review, 2012 https://www.nhs.uk/news/medical-practice/winterbourne-view-failures-lead-to-care-system-review/#:~:text=The%20report%20into%20the%20events,reports%20of%20abuse%20were%

number of correspondences between one Ward Sister and her line manager it is apparent that she stopped raising issues of concerns because it made no difference and her concerns remained unanswered. Addressing one's own difficulties without support obviously caused this Ward Sister to feel ignored and frustrated. The degree to which her views were representative of opinions across MAH is not known.

7.43 The Review Team concluded that a number of MAH senior managers attempted to deal with issues in-house, rather than escalate them to Director level. The Review Team considered that this was one possible explanation for why an SAI was not competed in November 2012 in respect of the Ennis Investigation by MAH staff (see Para 8.30)

7.44 A culture which separated MAH from its parent Trust is evident. The Review Team noted MAH staff's desire to train on-site rather than at Trust locations. When patients became ill or needed hospital treatment staff also elected to attend at a Northern HSC Trust facility rather than one of Belfast Trust's hospitals. There was no sense that MAH staff felt a loyalty to the Belfast Trust.

7.45 In 2012 the Trust Board agreed to meet at each of its facilities to increase its visibility with staff groups and to apprise itself on the range of services it provided. The first Trust Board meeting at MAH was held in 2016. The priority afforded to MAH is possibly reflected on the Trust's website which until July 2020 did not list MAH as one of its hospitals.

7.46 When events of August 2017 were brought to the attention of the Trust Broad on 20th September 2017 it decided to appoint an External Assurance/Support Team. The purpose of the Team was to provide independent assurance to the Trust Director lead Governance and Improvement Board in relation to the response to the serious safeguarding concerns in Muckamore Abbey Hospital. The Team

consisted of the Trust's Adult Safeguarding Specialist, a Professor of nursing and learning disability (Ulster University), and a senior professional officer at the Northern Ireland Practice and Education Council (NIPEC). Proposed priority areas for the Team to review were:

- model of service delivery;
- advocacy arrangements;
- nursing staffing levels, skill mix, training and education;
- enhanced monitoring;
- Adult Safeguarding processes; and
- the viewing of CCTV footage.

7.47 A Director's Oversight Group was also established. The group met on a weekly basis to review the Action Plan for Protection of Patients with the service management team, provide support, and offer an 'open door' to any staff member who wished to speak to the Directors. Directors have also visited clinical areas. The current action plan considered actions under the following headings:

- enhanced monitoring;
- improving staffing;
- communication;
- reflection and learning;
- adult safeguarding; and
- disciplinary investigations.

7.49 The Trust Board also established in January 2018 an independent Review Team under the leadership of Margaret Flynn to investigate adult safeguarding at MAH as a Level 3 SAI. The resulting report was published in November 2018.

7.50 An examination of the Executive Team and Trust Board's minutes since CCTV footage came to light demonstrated the higher priority afforded to MAH. The senior

leadership team, which has since been deployed at MAH, represents personnel with significant expertise. The Review Team considered that this level of attention will be required in the future to ensure that safe, effective, and compassionate care is available to patients who are some of the most vulnerable citizens in Northern Ireland.

Summary Comments and Findings

- **The Belfast Trust made significant efforts after the RPA to develop clear strategic direction and sought to communicate this to its staff and citizen.**

- **The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust. The scale and complexity of the Trust and its focus on acute services meant that there was a lack of engagement with or curiosity about MAH. There is no evidence of senior people championing the hospital.**

- **There was a lack of evidence that the Trust Board or Executive Team displayed interest or curiosity about MAH. The site was rarely visited.**

- **The frequent changes in Trust management structures did not provide stability for those trying to provide learning disability services. Staff at MAH were at times unclear about who the Directors were with responsibility for the service.**

- **The Trust's focus was on resettlement of patients in MAH. This came at the cost of scrutiny of the safety and quality of care of those in the hospital.**

- **Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the**

Corporate or Principle Risk Registers.

- **The appointment of the Service Manager in 2012 from outside Learning Disability Services was met with hostility by some managers in MAH. There was a lack of support for her at times from her superiors and evidence of a dysfunctional senior team at MAH.**

- **There was reluctance within Learning Disability to let other parts of the Trust know what was going on in the hospital. The reluctance to use appropriately the SAI procedures was an example of this.**

- **Leadership on the MAH site was ineffective and did not prevent or challenge a culture of institutional abuse towards patients.**

- **There was limited evidence of effective medical leadership on the MAH site.**

- **The Trust's values and corporate objectives did not inform practice at MAH.**

- **There was a culture divide between the parent Trust and MAH which developed over many years.**

- **Trust Board members were not well served by those Directors who did not escalate matters such as the Ennis investigation to it.**

- **The absence of adequate medical cover to address the physical health needs of patients and behavioural support services to manage their behaviours resulted in harm being caused to some patients.**

- **Neither Directors nor Board members grasped the scale of the historic**

CCTV footage or its implications in the latter part of 2017 until 2019.

- **Steps taken since August 2017 have contributed positively to improvements to patients' care and wellbeing.**

8. Key milestones of the Review

8.1 The Review Team's approach to the three key events which occurred within the timeframe covered by its Terms of Reference is set out at paragraph 1.5. These events inform the structure of this section under the following headings:

i. the Ennis Report;
ii. CCTV; and
iii. the complaint made by a patient's father in August 2017.

8.2 The Review Team acknowledges that the three key stages may not fully represent standards of leadership and governance from 2012 to 2017. They do, however, provide the Team with robust information upon which to base its conclusions and recommendations.

i. The Ennis Report

8.3 The Review Team focused on the substance of the Ennis report and its subsequent influence on practice, culture, leadership, and governance at MAH rather than on any events subsequent to media involvement in October 2019. The following sub-sections reflects this approach:

a. a summary of the events which led to the Ennis Report;

b. the Ennis ward context - November 2012;

c. The Safeguarding Investigation

d. the processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same;

e. outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care;

f. governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations; and

g. observations and conclusion.

a. A Summary of the events which led to the Ennis Report

8.4 On the 8th November 2012 the Trust received allegations that four patients at Ennis Ward were the subject of verbal and physical abuse. The allegations were initially made by a staff member employed by a private provider. Other staff from this provider made similar allegations following the initial allegations. The external staff were working in Ennis to familiarise themselves with a number of patients who were scheduled to be resettled in a facility owned by the private provider.

8.5 The nature of the allegations made included:

- rough handling of some patients;
- alleged assaults;
- staff speaking inappropriately to patients;
- a patient being encouraged to hit back when she was attacked by another patient;
- patients hitting out at staff and each other without appropriate intervention; and

- issues relating to the management of patients around meal times which appeared distressing to some of them.

8.6 On receipt of the allegation three staff members (two nurses and a healthcare assistant) and a student nurse were immediately placed on precautionary suspension pending further investigations. The nurses were referred to the Nursing and Midwifery Council. The healthcare assistant was referred to the Disclosure and Barring Service.

8.7 A Vulnerable Adult Safeguarding Review was established immediately. The review was led by a Designated Officer (DO) not based at MAH, who was assisted by two social workers from the Trust's community learning disability team who acted as Investigating Officers (IOs). The investigation was conducted under the Trust's Safeguarding of Vulnerable Adults policy. Given the alleged criminal nature of a number of the allegations the investigation was conducted jointly by the Trust and the PSNI. The Trust's DO ensured that interviews took place with staff from:

- the Private Provider;
- Ennis ward;
- several patients who were potentially injured parties along with their relatives/carers;
- the Clinical Director; and
- the Specialist doctor for the ward.

Records indicate that interviews took place between 19th November 2012 and 15th May 2013.[70] The Review Team had access to witness statements which were taken as part of the Trust's investigation, excluding statements taken by the PSNI.

[70] There were 6 interviews with MAH staff which were undated and they are excluded.

8.8 The report into the Ennis investigation was completed in October 2013. Appendix 1 of the Ennis Report lists 63 incidents. In its examination of the incidents the Review Team was unable to determine the exact number of incidents. From its review of the records the Review Team identified a significant degree of duplication (see Appendix 6). Dates when the incidents allegedly occurred were not available. This made it difficult to deduce whether the same incident was referenced more than once using different terminology or whether there was more than one occurrence.

8.9 The Review Team found it difficult at times to determine the precise nature of the allegation being made. This difficulty was compounded by the statements provided by four staff from the Private Provider made to the Trust's Human Resources personnel in 2014. Information available from the IOs and the Human Resource department meant that the Ennis Review Team identified conflicting information on a number of matters. These included the level of induction available to the private provider's staff, the nature of interaction with patients, and the assistance provided by Ennis staff. A significant number of alleged incidents were deemed by the Review Team to be of a practice nature and related to the care of patients by both nurses and healthcare assistants. They indicated the likelihood of a culture prevalent in the ward at that time.

8.10 As a result of its investigation the PSNI charged a nurse and a healthcare assistant with a number of common assaults and ill-treatment of patient. At trial the nurse was acquitted while the healthcare assistant was found guilty on one count of common assault which was subsequently overturned on appeal.

8.11 The healthcare assistant retired and resigned from the MAH bank pool of staff at the conclusion of the police investigation. A disciplinary investigation was commissioned in respect of the nurse. The Review Team was advised that only one of the allegations made against this staff member was capable of being taken

to a disciplinary hearing. The nurse returned to work for a short time, although not in Ennis ward, and retired shortly afterwards.

b. The Ennis Ward Context - November 2012

8.12 Ennis was a resettlement ward caring for 15 patients. The Review Team considers the circumstances under which patients lived and staff worked at the time of the allegations as significant. This is because they provide a context to assist an analysis of the day to day running of the ward. The *A Way to Go* report commented that, 'the ward environments impact on patients, their families and staff.'[71] Similarly, Prof Ian Kennedy, who chaired the Kennedy Review into the practice of the breast surgeon Ian Paterson, noted that: 'at times of stress in an institution, the first people who are overlooked are patients.'[72]

8.13 Documentation examined by the Review Team noted that Ennis staff had expected the ward to close in December 2012 and had already held some events to mark the planned closure. Similarly, the ward environment had not been maintained due to its imminent closure. The ward was described as overcrowded and lacking in space. Challenging behaviours were at a level which caused difficulties on the ward.[73]

8.14 The Review Team was advised that MAH was exempt from cash releasing measures in 2012/13 as it was envisaged that the £1m it was required to release would be achieved by ward closures. The Review Team was further advised that MAH on an annual basis had an operating surplus which was used to offset overspends in the community learning disability services.

[71] A Way to Go, Page 43, par. 2
[72] Seven Organisational Weaknesses – Prof Ian Kennedy on the Ian Patterson Report
[73] Ennis Investigation File Page 62

8.15 The nurse to patient ratio was also reported to be low in Ennis with a high ratio of healthcare assistants. The Review Team was advised that a staff ratio of 20:80 nurses to healthcare assistants pertained at times in Ennis. RQIA in its response to the draft Ennis Report stated that, 'staffing shortages appear to be a significant contributory factor to the allegations. There are issues of redeployment and concerns expressed regarding bank and agency staff.' More concerning was an RQIA comment in the same document that, 'the issue of staffing levels is a recurrent theme and particularly as staff move more frequently from Ennis to other wards.'

8.16 The uncertainty around the hospital's future caused recruitment difficulties. Coupled with staff shortages this resulted in a high reliance on bank and agency staff for cover. The Review Team was told that some staff worked bank hours resulting in a working week of 70 - 80 hours. At times, the ratio of registrants on duty was as low as 20% of those on duty. Staffing concerns were not unique to Ennis. By March 2012 hospital managers had escalated the staffing situation by placing it on the MAH Risk Register at red, which the Service Manager told the Review Team meant it had been brought to the attention of the Trust Board. The examination of the Trust's Corporate and Principle Risk Registers[74] found, however, no reference to the staffing crisis at MAH.

8.17 Staff shortage resulted in the curtailment of patient activities in Ennis. RQIA stated that it 'was not aware of activities happening at Ennis during previous inspections.'[75] In the documentation examined by the Review Team, the lack of activities correlated with behavioural issues. It also meant that at times it was impossible to maintain agreed observation levels. The ward manager reported these concerns to her line manager.[76] The Telford Formula was employed in MAH

[74] Corporate Risk Register – Trust Executive Team. Principle Risk Register – Trust Board.

[75] RQIA response to draft Ennis Report 2nd August 2013

[76] Op. Cit., Page 67

to agree staffing levels. The Ennis Report voiced concerns about its appropriateness, as did RQIA, especially given the mix of patients requiring care on the ward.

8.18 The Ennis ward was structured in two halves; upper and lower. The upper half having six patients who were deemed to be more able than the nine patients cared for in the lower half. Patients in the lower half of the ward had complex needs and challenging behaviours; this area was locked as a means of protecting them. The Review Team had access to internal correspondence from the Ward Sister to her line manager expressing concerns about the mix of patients and the skill mix of the staff team, which she deemed to be inappropriate to meet the patients' needs. Other correspondence stated that there was insufficient staff to enable the ward to progress its remit as a resettlement ward.

8.19 The Review Team was advised that in November 2012 Ennis Ward had four patients to a bedroom. Although the ward was overcrowded, therapeutic space for patients had nevertheless been reassigned by the Ward Sister to provide additional accommodation for staff. The furniture in the ward was described as very old. There were few chairs and sofas and furniture reportedly did not meet the mobility needs of a number of patients. An Internal Audit of the Ward undertaken on 12th December 2012 and updated on 19th February 2013 comprehensively reviewed the ward. Its subsequent 17-page report lists a range of environmental shortcomings. The ward was described as dull, dismal, and un-stimulating by staff from the private provider's service.

8.20 MAH was registered as a hospital. Efforts to bring the Ennis ward up to hygiene and infection control standards meant changes were made, for example, to the display of patients' artwork and arrangement of ward decorations. This caused a culture clash between those who viewed the ward as the patients' home and those seeking to apply the standards required of a hospital. There is no information on

the records examined of discussion with RQIA to inquire in what ways patients' living space could be maintained.

8.21 The service manager when appointed in 2012 had an objective to resettle where appropriate patients into community settings. This would allow the hospital to have a core focus on treatment and assessment. Her agenda, which was in keeping with that of the Bamford Reviews, the Department of Health, the commissioning HSC Board, and the Trust was met with resistance from a number of staff as well as from patients' carers and relatives who had come to view MAH as a home setting. As many patients had lived there for decades, concerns expressed about resettlement are understandable. The idea of a hospital as a home is not a sustainable way forward for those with learning disabilities.

8.22 Ennis was not viewed as an environment fit for its purpose as a resettlement ward according to information provided to the Review Team; this conclusion was not unique to Ennis. In respect of the other resettlement wards examples provided were of wards with dormitory sleeping arrangements of up to 10 patients with no potential for individualisation.

8.23 As activities in the ward were limited a number of sources referred to resulting boredom and lack of stimulation among patients. The removal of the ward's car also denied the opportunity for patient outings. The *A Way to Go* report reported the views of a patient advocate who observed that: 'there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards.'[77] Often staffing difficulties, which was a common feature across MAH, limited patients' ability to attend the onsite day care centre as there were insufficient staff to take them there.

[77] Op. Cit. Page 25, par. 87

8.24 The physical environment on the ward as described to the Review Team was considered to be un-conducive to the promotion of a patient centred approach to care. It is apparent from witness statements accessed by the Review Team that staff who worked in the lower part of the ward felt less favourably treated. It is likely, in the opinion of the Review Team, that patients may also have experienced similar sentiments.

8.25 In addition to a dated and un-stimulating physical environment, Ennis also largely functioned on a uni-disciplinary basis. The Review Team was told that a multi-disciplinary approach was absent within the ward, that there were no occupational, behavioural, speech and music therapies, nor social worker attached to the ward. The Review Team was informed that in contrast, MAH in November 2012 had:

- 1.5 speech and language therapists;
- 0.5 dieticians;
- a psychologist;
- two physiotherapists;
- a technical assistant responsible for aids and appliances; and
- three social workers.

There was no pharmacy cover at the hospital. GP services were contracted from an Antrim practice to meet patients' physical health care needs. On site input from psychiatric services was also limited as the psychiatrists also had duties in respect of outpatient clinics across the region. The absence of an agreed medical model reportedly resulted in tension between psychology and psychiatry services within the hospital according to information provided to the Review Team. It is noteworthy that at this time (2012) there were some 250 inpatients in MAH.

8.26 The Ennis ward's staff and patients faced significant challenges across a range of measures. The private provider's staff who complained about patient care in Ennis,

had come to work in an environment very different from the modern facility to which they were accustomed.

c. The processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same

8.27 The allegations received by the Trust on the 8th November 2012 could have been dealt with potentially as:

- a complaint;
- a Serious Adverse Incident (SAI); and/or
- an adult safeguarding investigation.

8.28 On receipt of the allegations the decision was made to process them as a safeguarding matter under the Trust's safeguarding vulnerable adults' policy. This decision in the opinion of the Review Team had a number of consequences. It meant that the allegations were then all classified as being of a safeguarding nature, although this was not the case. It also meant that there was no formal arrangement to bring the safeguarding investigation to the attention of the Executive Team of the Trust's Board. In the case of complaints and Serious Adverse Incidents, arrangements exist to apprise the Trust Board of such complaints and incidents through relevant reporting arrangements.

8.29 A review of Appendix 1 of the Ennis Report shows that a number of the complaints related to poor practice and issues of care. Concern was expressed about the level of induction for staff from the private provider and the degree to which patient information was shared with them, as well as the level of support provided to them by MAH staff. In the opinion of the Review Team, allegations should have been disaggregated in such a way as to ensure the safeguarding investigation's focus

was maintained which would have enabled practice issues to have been addressed more expeditiously.

8.30 In its wider consideration of structural issues in Ennis and across MAH, the Review Team concluded that in addition to the safeguarding investigation, the allegations should also have triggered an SAI. An SAI is defined as 'any event or circumstance that led or could have led to serious unintended or unexpected harm, loss, or damage to patients. This may be because:

- It involves a large number of patients;
- There is a question of poor clinical or management judgment; …
- It is of public concern;
- It requires an independent review.

The Health and Social Care Board, with input as appropriate from the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA), reviews each incident and decides whether any immediate action is required over and above that which has already been taken by the reporting organisation. The reporting organisation is required to carry out an investigation into the incident and forward a report within 12 weeks to the Health and Social Care Board.'[78]

8.31 The Review Team had access to correspondence between the HSC Board and the Belfast HSC Trust where the former asked on multiple occasions from the 6th February 2013 until the 3rd September 2015 for an SAI to be submitted in respect

[78] NI healthcare: What is a serious adverse incident? 6th October 2016 https://www.bbc.co.uk/news/uk-northern-ireland-37563833#:~:text=A%20serious%20adverse%20incident%20is,loss%20or%20damage%20to%20patients.

of the Ennis allegations. [79] On the 7th September the Trust accepted that it was in breach of both the 2010 and 2013 SAI procedures but was content to live with the procedural breaches as the allegations were not substantiated by the safeguarding investigation. The Review Team was concerned that acceptance of such a breach would have occurred without the approval of the Trust Board. In its discussion with Trust Board members it is apparent that they were not aware of this admission. Similarly, the Review Team considers that the HSC Board should seek to assure itself that any such admission has been endorsed by the Trust.

[79] Request 6th February 2013 asking if the Early Alert is closed as no SAI has been received. 4th March 2014 email noting no SAI has been received and asking if the Early Alert is closed. 6th March 2014 email requesting to Trust notify the Trust given the serious nature of the allegations and in the public interest the Board views this as an SAI, apologies for not picking up earlier that an SAI had not been received; notes the Early Alert remains open. The Trust replied on 28th January 2015 stating the Early Alert remains open and the matter has been investigated under safeguarding arrangements not as an SAI. Advises the Early Alert should be closed. HSC Board replies stating the incident appears to meet Criteria 4.2.5 and 4.2.8 of the SAI Procedures for Reporting and Following up of SAI (October 2013). It notes while appropriate to delay SAI on the request of the police that Section 7.3 of the procedures expects that the SAI will run as a parallel process. 'The intention and scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding Investigation.' The Trust is requested to formally notify the HSC Board of the incident as an SAI and conduct a review of this case in respect to care planning, staff supervision, training etc or any cultural or environmental features in the care setting that could be addressed to reduce the likelihood of future reoccurrence. The Trust responded on the 13th May 2015 stating that the y had made the decision on the basis of the 2010 procedures which were extant at the time of the incident. The HSC Board responded on the 23rd July 2015 noting that under Section 3.3 of the 2010 procedure an SAI should have been completed. The Trust was again asked to submit an SAI in respect of the incident. The Trust responded on the 5th August 2015 stating the matter had been investigated by the PSNI and an 'extensive safeguarding process' and that 'there was no evidence of any of the allegations made.' The Trusts requested that the Early Alert be closed. 28th August 2015 HSC Board responded it would prefer to keep the Early Alert open until an SAI was received from the Trust. 1st September 2015 the Trust's explanation for its decision not to submit an SAI as requested 'the safeguarding investigation found the allegations were not substantiated and as such does not meet the SAI criteria.' The Trust acknowledged that it should have been dealt with as an SAI at the time but would have been deferred pending the conclusion of the safeguarding investigation. If it had been reported as an SAI it would then have been de-escalated given the unfounded allegations. If the Trust did now submit it would also be asking for it to be de-escalated due to the unfounded allegations. Trust felt referral now would be a paper exercise. The Board agreed to close on the following wording from the Trust: 'HSCB are content to close this early alert on the basis BHSCT have advised the safeguarding investigation found the allegations were not substantiated. It should be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could subsequently have been deferred pending the outcome of the safeguarding investigation.' The Board replied on the 3rd September noting if the Trust could live with the breach in respect of SAI reporting the HSCB could. The Trust replied on the 7th September 2015 stating it could live with this breach.

8.32 As a result of the criminal investigation led by the PSNI, two members of staff faced criminal charges. One staff member was acquitted at initial hearing while the other's conviction was overturned on appeal. The standard of proof in criminal trials is defined as being beyond reasonable doubt. On the other hand, the balance of probability test means that a matter is more likely to have happened than not. This lower standard of proof is usually used by social services in determining the likelihood of harm/risk in safeguarding cases. The Trust repeatedly advised the HSC Board that the safeguarding investigation was unable to substantiate the allegations even though the Public Prosecution Service determined that charges should be brought. The Review Team was concerned about the Trust's approach due to the threshold applied in this matter. The definition of evidence and a decision on whether the Ennis allegations constituted institutional abuse were still unresolved at the time of the last Adult Safeguarding Case Conference held on the 28th October 2013. An internal email dated 24th January 2013 which was copied to the DO leading the safeguarding investigation, stated that, 'there is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis is relevant.' These matters are analysed in paragraphs 8.36 to 8.62 as part of its wider consideration of the adult safeguarding investigation.

8.33 The Review Team considers that the Ennis allegations merited the submission of an SAI either to operate in parallel with the safeguarding investigation or to have taken place at its conclusion. The SAI policies for 2010 and 2013 would have facilitated either approach. The Review Team concluded that:

- the Trust failed adequately to interpret the SAI reporting criteria;
- the potential existed for a fuller investigation of events at Ennis, which could have identified many of the issues described in the *A Way to Go* report (2018); and that
- factors contributing to the situation subsequently captured on CCTV during 2017 included: the staffing crisis, the focus on resettlement, ward closures,

patient mix, the lack of a multidisciplinary approach, and excessive levels of seclusion, restraint and staff overtime.

8.34 The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed off-site. In discussions with Trust Board members the Review Team was told that MAH was 'not in their line of sight' of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and wellbeing of patients. While the 2018 - 2020 period falls outside of the Review Team's Terms of Reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions.

8.35 Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements, and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies which in turn could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017.

d. The Safeguarding Investigation

8.36 The following section considers the conduct of the safeguarding investigation. The initial safeguarding referral resulted from disclosures from a care assistant employed by a private provider who had been working on the ward on 7th

November 2012. She then 'witnessed patients [sic staff] being verbally and physically abusive to four named patients.' Three of these patients were from the BHSC Trust and one from the NHSC Trust's areas.[80] The Care Assistant identified three staff and one student nurse in her allegations. Her concerns were reported to her employer's team leader at ten o'clock that evening. Steps were taken the following day to ensure the Trust was alerted to the care assistant's allegations.

8.37 The decision to conduct an adult safeguarding investigation was taken upon receipt of the allegations on the 8th November 2012 by the Operations Manager for the Trust's Community Learning Disability Treatment and Support Services. In the absence of her line manager, the Operations Manager decided to lead the investigation. She took appropriate action to ensure the immediate safeguarding of patients and notified the PSNI as per the Trust's protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults. Staff members implicated in the alleged abuses were immediately subjected to precautionary suspension.

8.38 On 29th November 2012 the Operations Manager drafted a letter to family members/ carers of Ennis patients seeking to furnish them with an update on the safeguarding investigation. The Co-Director for Learning Disability when provided with a draft of this letter determined that further discussion was required before an update could be produced. On 18th and 19th January 2013 a shorter, less informative letter was issued.

8.39 The Investigation Officers (IOs) contacted relatives/carers of patients in Ennis to ascertain if they had any concerns about the care provided. This resulted in

[80] In an email dated 29th November 2012 the NHSC Trust confirmed that it would be represented at adult safeguarding case conferences but 'responsibility for updating families by phone and letter should remain with BHSCT ensuring a consistent approach.'

minimal supporting evidence for the investigation. Family members and carers were advised that they would be kept up to date with the investigation's progress.

8.40 In an email dated 17th December an IO wrote to the DO stating that of the eight families contacted, one had expressed concern about patient care. In that instance a relative noted that his sister had claimed to have been taken by 'the scruff of the neck … to her bedroom'. He felt it was unlikely that his sister would tell lies but 'may not want to say anything that would get her into trouble.' None of the others expressed concerns about care on Ennis ward although two raised concerns about the future of the ward and their worries over its closure. One man noted the potential of any resettlement to disrupt his sister who had lived at the hospital for 30 years. Another interviewee related in a telephone interview on 8th January 2013 a number of concerns she had relating to low staffing number. She felt there was a need for staff in dayrooms at all times and was anxious about the level of supervision available for her sister. She was also concerned that her sister's money was not being spent on her. She felt her sister's clothing was shabby and that her sister was being over-medicated as she slept all afternoon. The overall assessment of the ward from this interviewee was, however, that 'the good outweighs the bad.'

8.41 Another telephone interview on 15th January 2013 took place with a patient's mother in which she reported that in her opinion the staff 'are very good'. She did however, express concerns about the number of incidents of peer assaults on her daughter. Another relative telephoned on the same day noting that there was in her opinion a lack of communication amongst the staff. The engagement with patients, relatives and carers made by the investigation staff in an effort to keep them informed and to seek their views was viewed positively by the Review Team.

8.42 Interviews with 17 MAH staff were subsequently undertaken and recorded. Six of the records are undated and most were unsigned. From the dates available it is

apparent that the majority of interviews (seven (64%)), took place between 8th and 15th May 2013: some seven months after receipt of the allegations. Two earlier interviews with MAH staff took place on 21st December 2012 with the remaining two taking place on 21st February and 8th April 2013.

8.43 The Review Team was concerned at the length of time taken to complete interviews with MAH staff. It was also perturbed at the timescale for the completion of clarification interviews with a patient who was an injured party who was deemed probably capable of giving evidence. This interview finally took place on 23rd January 2013. At that time the patient had no recollection of events of 7th November 2012 and did not want to engage in conversation about them. The Review Team was advised of a lengthy process involved in determining if patients have capacity and then acquiring necessary consent to be interviewed. Accepting that there are inevitable delays in completing such tasks, the Review Team concluded that a three-month delay with a learning disabled patient was not likely to result in good recall of past events.

8.44 An undated discussion between medical personnel, the PSNI, the Speech and Language Therapist, and the DO to determine capacity of Ennis patients identified 12 who could possibly give evidence. On 19th April 2013 an email from the DO to the Clinical Director sought his views on interviewing Ennis patients. The response was that one of the five patients had moved and that one patient's mental functioning had deteriorated. Given that Ennis patients have significant intellectual impairment, the Review Team considered the delay in interviewing them as likely to have further impaired their ability to contribute meaningfully to the safeguarding investigation.

8.45 Similarly, there was significant delay in police interviews with the two suspects. These interviews took place on 20th and 28th February 2013. An undated PSNI

report on interviews, which must postdate the 28th February, provided a summary of the evidence furnished by:

- the four private provider's staff;
- two relatives;
- the Forensic Medical Officer;
- the absence of evidence from the injured party; and
- the two suspects.

The report concludes with the PSNI's recommendation to the Public Prosecution Service to prosecute. The initial police interview with the complainant took place on 9th November 2012 with interviews of suspects not completed until 28th February.

8.46 There were eight case conferences or strategy discussions convened between 9th November 2012 and 28th October 2013. Appendix 7 sets out the information base for the Review Team's analysis of these meetings.

8.47 The second strategy discussion on 15th November 2012 did not commence with consideration of how aspects of the initial Protection Plan had operated. A revised Protection Plan was agreed. The staffing component of this was to be addressed by the DO with senior Trust managers. Professional practice at Ennis was the focus of much of discussion at this meeting. The Review Team considered that preliminary discussion with MAH managers and delegation of the staffing issue to them would have been a more inclusive working arrangement.

8.48 The third strategy discussion on 12th December 2012 addressed the issue of pending interviews. Considerable discussion took place around staffing on the Ward and the 24/7 monitoring arrangements. The Review Team considered that

greater focus was required on the handling of alleged incidents so that the safeguarding investigation could be brought to an early conclusion.

8.49 The fourth strategy meeting was held on 20th December 2012. Discussion at this meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run parallel. Additionally, in the view of the Review Team, it underlined the fact that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considered it essential that at the outset each allegation should have been assessed on the basis of the existing information. They should have been categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

8.50 In the fifth strategy meeting convened on 9th January 2013 initial focus was given to a consideration of progress against the actions established at the previous meeting. The Review Team considered such an approach commendable as it served to focus attention on any outstanding matters. The Co-Director of Learning and Disability Services, raised his concern about the list of allegations presented by the DO, some of which were specific while others were imprecise, negative comments. He stressed the need to obtain clear evidence and facts. The Review Team considered that had the initial allegation been disaggregated (see Para 8.29), the safeguarding investigation would have been able to focus its energies on abusive issues.

8.51 The sixth strategy meeting was held on 29th March 2013. This was almost two months later than initially scheduled. The focus of this meeting was the provision of an update from the PSNI and to plan further for the investigation. The first references to the potential for institutional abuse is recorded in these minutes. At the meeting it was agreed that all staff in the Ennis were to be interviewed by the two IOs. At this stage, five months after receipt of the allegations, neither patients

nor all of the staff working at Ennis had been interviewed by Trust staff. The Review Team considered this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

8.52 The seventh strategy meeting was held on 5th July 2013 during which copies of the draft final report were circulated. The Public Prosecution Service at this point still had to assign a public prosecutor to the case. One of the patient's interviews remained outstanding due to the absence of a Speech and Language therapist during July. The issue of initiating disciplinary proceedings was raised given the cost to the public purse. It was noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with private provider staff.' The DO noted that 'no evidence had been found to substantiate the allegations' but that 'the investigating team felt the [private provider staff] were credible.' Having read the minutes of the Case Conference of 28th October 2013, the Review Team concludes that there were sufficient concerns found to suggest a culture of bad practice. It is also evident that the private provider's staff identified good practice which the Case Conference considered 'would suggest that any poor practice was not totally widespread.'

8.53 The Review Team noted that:

- the report was not provided in a sufficiently timely manner to facilitate an informed discussion of it during this meeting;
- six months after the initially allegations were received patients had not been interviewed;
- the issue of staff disciplinary action and when it could be progressed had not been dealt with in a more timely fashion;
- the additional allegations made may have added considerably to the length of time for the investigation team to report without adding anything further to the body of available information;

- after such a lengthy review a more definitive conclusion about the culture of practice on Ennis ward had not been reached.

8.54 The final case conference meeting (for which minutes are available on case records) was held on 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation on Ennis ward. The DO noted the difficulty experienced by the investigation team in weighing the 'very different evidence provided by the two staff teams' [MAH and Private Provider staff]. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the private provider's staff's reports as evidence.

8.55 The Co-Director, Learning and Disability Services, noted at that Case Conference that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' The RQIA representative supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked to review minutes of previous meetings for any discussion of institutional abuse before the case conference would conclude on this issue. A further meeting was arranged for 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

8.56 The Review Team was of the view that there was significant delay in bringing the Ennis Report to a conclusion given that the draft report had been tabled for discussion at the strategy discussion convened on 5th July 2013. Action in relation to staff disciplinary proceedings was also delayed, and on the basis of this meeting was likely to remain so pending court hearings. In the Review Team's opinion, consideration of disciplinary action should, where possible, be pursued at the commencement of any investigation. Reasons for a decision on any deferment

should be provided in writing and be subject to monthly review. Such an approach would demonstrate greater regard and accountability for the public purse.

8.57 The Review Team was particularly concerned that at this late stage in the investigation process consideration was being afforded to the issue of whether or not the abuse was of an institutional nature. In the opinion of the Review Team this discussion should have occurred early in the investigation process to assist with informing the subsequent nature of the investigation. Such an approach would also have assisted the Trust to comply with the SAI procedures which it acknowledged it had breached (see Paras 6.19 and 8.31). In discussions with Trust specialists working with vulnerable adults the Review Team were advised by one individual that the allegations were unambiguously of an institutional nature while the other felt a decision centred on the way institutional abuse was conceived. The DO felt she was being pressurised by the Co-Director to state the investigation had not identified institutional abuse. In the DO's opinion she did not have enough evidence to reach a definitive conclusion.

8.58 From the case records examined the Review Team considered that:

- the Strategy Meeting extended its remit through its detailed consideration of the operation of Ennis ward rather than in establishing a broad framework to inform the safeguarding of patients. In the Review Team's opinion, concerns noted by the regulator (RQIA) in respect of staffing would have been better progressed through its usual regulatory functions rather than via the strategy discussion process;

- the DO appeared to have adopted an oversight function in respect of the operation of the Ennis ward by, for example, emailing the Service Manager at MAH on 5th March 2013 noting that from the nursing monitoring reports she could not identify whether or not staffing levels were appropriate. It is the

opinion of the Review Team that the action of the DO in this respect was not appropriate. It carried the potential to undermine the managerial system at MAH. The Review Team's view was that to report on the implementation of recommendations was the proper way to seek to monitor levels of compliance or non-compliance; and that

- the safeguarding investigation took from 8th November 2012 until 23rd October 2013. This is much longer timescale than one would have expected, especially given the nature of the complaints. Allowing for the significant amount of work carried by the DO, the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation. The time delay had significant implications for Ennis staff and the costs associated with precautionary suspensions.

8.59 The safeguarding investigation took some 11 months to complete. There is evidence of initial feedback on the investigation being furnished to relatives and carers. An extensive number of interviews took place with MAH nursing and clinical staff, staff employed by the private provider, patients deemed to have capacity, and the relatives/carers of Ennis patients. Many of these interviews were held some five and six months after the start of the investigation. The delay in interviewing patients was of particular concern to the Review Team as it reduced the likelihood of evidence being forthcoming. Given the general level of social functioning among patients, any delay reduced the likelihood of evidence being forthcoming. In the opinion of the Review Team the absence of dates and signatures from six of the interviews with MAH staff is a significant omission. There can be no certainty as to when these interviews took place. Five or six months into the investigation appear a likely timescale as the majority of MAH staff interviews were held in that period.

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8.60 It is apparent from an examination of the records of those interviewed that no clear consistent picture emerged from any of the groups interviewed. The Review Team considered that the allegations made in November 2012 should have been disaggregated to allow for safeguarding issues to be the sole focus of the investigation. Other matters should have been dealt with under the Trust's complaints procedure or its disciplinary processes which are in place to deal with poor practice concerns.

8.61 The Review Team views the failure to identify the failings reported at Ennis as an SAI as a missed opportunity to identify wider problems within MAH. Subsequent events confirm that a number of wider structural and cultural issues arising in the Ennis safeguarding investigation were not confined to that ward.

8.62 The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions.[81] In the opinion of the Review Team the history of previous inquiries at MAH provided a context supportive of an early consideration of the potential for institutional abuse.

[81] Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, par. 3.3, Page 11, 2006 and the Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, par. 13, Page 7, NIO / DHSSPS, March 2010

e. Outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care

8.63 During the course of the Ennis investigation a requirement was established for 24-hour monitoring of staff working on the ward as a protective measure for patients. The monitoring staff were employed at Band 6A levels at a minimum. They were in place for a period of some 9 months. The cost to the Trust was estimated to be in the region of £500,000. The Review Team was informed by the Trust's Director of Nursing that these monies were available from the in-year MAH budget. Approval of the Trust Board for this level of expenditure was not required. A weekly support meeting was established to discuss any concerns arising from the monitoring arrangements. The monitoring reports were also provided to the Operations Manager who was leading the safeguarding investigation as DO. There is evidence in the case records of discussion between the Operation Manager and MAH Service Manager to agree on action required as a consequence of the monitoring reports.

8.64 The establishment of 24/7 monitoring role meant that information on wider patient care issues were identified. These included:

- patient privacy;
- lack of stimulus/ lack of visual stimuli;
- no attempts to engage in therapeutic activities;
- overcrowding in the bottom dayroom; and
- lack of quiet space for patients;

8.65 As a result of the allegations a number of remedial actions were taken to improve the care and the quality of the environment on Ennis Ward. The Review Team noted that this included:

- an additional Ward Sister who was redeployed to Ennis for an initial period of two months from 8th November 2012 with a Deputy Ward Sister appointed from 25th November 2012;
- a review of the Telford staffing formula for Ennis ward which resulted in a subsequent increase in staffing levels;
- assurance to provide a minimum of six staff on duty during day shifts with additional resources deployed where possible. Night duty, up until 11pm, would also comprise six staff reduced to two for overnight duty; and
- a monthly monitoring of staffing ratios to ensure an appropriate skill mix in the staff team.

8.66 Service Improvement Action Plans were created for Ennis. Key steps included:

- leadership walk-arounds and viewing the environment with fresh eyes;
- safeguarding materials to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice;
- to uplift staff knowledge on current policy relevant to the environment as well as information governance/patient property;
- commissioning training restating the strategic objective of resettlement;
- reviewing the ward's learning environment for student placements.

8.67 A multidisciplinary team was introduced to Ennis to improve patient care with the appointment of a psychologist and improved access to behavioural support services. Greater focus was also afforded to stimulating patients through increased levels of activities. The enhanced staffing numbers further improved the 1:1 contact between patients and staff. A review of each patient's care plan and a functional behavioural analysis was also undertaken.

8.68 Despite the plan to close Ennis Ward, environmental improvements were made to enhance the living and sleeping arrangements in the ward. This was not only at a cosmetic level but a capital bid was approved to facilitate structural improvements.

8.69 Safety and hygiene checks were also undertaken on the ward with Estates Department to assist with improving the dignity and privacy of patients.

8.70 Considerable improvements occurred as an appropriate response to the allegations made in November 2012 and the staffing and environmental factors which in the opinion of the Review Team contributed to the events then noted.

f. Governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations

8.71 To deliver on improvements the Trust developed a series of monitoring arrangements in respect of the operation of the Ennis ward. In the opinion of the Review Team the secondment of a Co-Director of Nursing (Education and Learning) to MAH with a responsibility to monitor practice and to analyse information was a key means of ensuring not only an oversight function, but also a dynamic analysis of information. The support role to the Service Manager was also critical given the additional demands and challenges resulting from the safeguarding investigation.

8.72 The Co-Director of Nursing undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files, and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;
- consideration of progress against draft improvement plans; and

- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provided of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided governance assurances to the Trust.

8.73 It is also evident that a previous consideration to fit CCTV in MAH, which was first raised in August 2012, was given added impetus as it was viewed as a means of addressing the factual discrepancies which emerged from the Ennis investigation. This matter is addressed further in the CCTV section from paragraphs 8.81 to 8.112.

8.74 No information was available in case records on how the safeguarding investigation was subject to governance controls. The DO's line manager attended a significant number of the strategy meetings/case discussions. From recorded comments it was apparent to the Review Team that there was no agreed approach about the nature of the investigation, what constituted evidence, and when disciplinary action should be initiated. The Review Team considered that while the DO must act independently, leadership support is required in discharging this challenging role.

8.75 There was no apparent reason for a number of the delays evident in the safeguarding investigation. From July to October 2013 the aim of the final two strategy discussions was to focus on the conclusions and recommendations of the Ennis report. A three-month period between reviews is within the policy requirements. The Review Team deemed that arrangements should have been put in place to ensure that no drift occurred in the investigative process. Delays in interviewing patients, and MAH and the private provider's staff, which the Review Team deemed unacceptable, should have been identified and remedied.

g. Observations and conclusion

8.76 The Review Team considers that the Ennis safeguarding investigation was hampered from the outset by the fact that the allegations were not disaggregated into complaints and abusive incidents. Such an approach would have led to a sharper focus on the safeguarding elements of the allegations and the potential for more timely reporting.

8.77 The extensive delay taken to complete relevant interviews compounded the time taken to produce the draft Ennis Report. From the dates available to the Review Team, interviews with MAH staff concluded on 15th May 2013. The draft report was then available for the strategy meeting convened on the 5th July 2013. At that time, one patient interview remained outstanding. In the opinion of the Review Team, all interviews should have taken place more proximate to the events which were the subject of the complaints in order to ensure that memories were fresh and that discussion over time had not coloured staff's perceptions of the issues being investigated.

8.78 The Review Team's opinion is that from the outset, the Ennis investigation should have considered whether the allegations were of an institutional abuse nature. The discussion at the last recorded case conference, nearly one year after receipt of the allegations, as to whether it was institutional abuse, remained unresolved at the end of that meeting. This lack of decision was unacceptable to the Review Team.

8.79 The failure to notify the HSC Board of the incident as an SAI, despite repeated requests from the HSC Board, was a missed opportunity to investigate the wider structural, staffing, and cultural issues within MAH. An SAI investigation had the potential to identify the nature of the issues which contributed to the allegations

made in November 2012 and to enable early remedial action to have been taken. It is conjecture to suggest that this might have prevented the events of 2017 captured on CCTV; but given that this was a potential outcome, the Review Team has not discounted this possibility.

8.80 The range of improvements in the environment, staffing, and care of patients during the Ennis investigation was considerable and did much to improve the ward as a living and working space. It is a matter of deep regret to the Review Team that the implementation of these changes came about only as a consequence of the harm caused to vulnerable patients. Our review of the records and discussion with staff confirm that the shortcomings in staffing, the ward environment, lack of access to a multidisciplinary team, and the conflicting needs of patients on the ward were known but not acted upon prior to the Ennis investigation.

Summary Comments and Findings

- **The Ennis investigation took an extensive period of time to complete which diluted its impact. The completed report was not brought to the attention of the Executive Team or the Trust Board.**
- **There was little evidence of multidisciplinary working in Ennis or patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs.**
- **Nurse to patient ratio were low in Ennis. A staff ratio of 20:80 of nurses to healthcare assistants pertained at times. This compromised the ability of staff to provide safe and effective care for patients.**
- **Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.**

- **The culture clash between staff who viewed the ward as a home and those who viewed it as a hospital resulted in tension between senior managers and ward managers and staff delivering care.**
- **The allegation should have been dealt with as an SAI. This would have ensured wider scrutiny.**
- **The Trust advised the HSC Board repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met.**
- **The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.**
- **One year after the report was completed the DO advised that she was proposing to update families. There is no evidence of feedback or the case having been closed.**
- **The DO's operational oversight into the day-to-day functioning of the Ennis ward served to weaken the focus on completing the investigation within an acceptable time frame.**
- **The tension between the DO and her line manager put the DO under pressure and led to imprecise conclusions in respect of the nature of the abuse.**
- **Positive changes were made to staffing and the environment in Ennis as a result of the Ennis investigation.**
- **The Review Team believed that not to have held an SAI investigation in respect of these allegations either in parallel or at the conclusion of the investigation constituted a missed opportunity to improve safeguarding**

arrangements for vulnerable patients.

- **There is no evidence of learning emerging from the safeguarding investigation as feedback was provided neither to staff, the Executive Team nor the Trust Board.**

ii. CCTV

8.81 The following section is divided into two sub-sections:

(i) a history of CCTV installation at MAH and the Assault on a Patient on 12th August;
(ii) the involvement of the PSNI; and
(iii) subsequent Trust handling of CCTV.

(i) A History of Implementation and the Assault on a Patient on 12th August

8.82 One of the first references that the Review Team could find regarding the installation of Closed-Circuit Television (CCTV) in the wards at MAH was in the minutes of the MAH Core Group meeting of August 2012. At that meeting the Senior Social Worker spoke of the 'amount of incidents involving patient on patient and patient on staff.' He suggested the installation of CCTV in communal day spaces, corridors, and quiet rooms. The Senior Manager Service Improvement and Governance manager agreed to look at existing policies around CCTV, check with the Directorate of Legal Service, and whether other Mental Health services used CCTV.

8.83 In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the 'Core' hospital. The business case proposed that CCTV would be installed in communal areas used by patients and staff in Sixmile and Cranfield male, female, and Intensive Care wards. The overall purpose was: 'CCTV surveillance is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012/13 there were 667 reported assaults to the PSNI from Muckamore Abbey Hospital.' Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80k on 13th January 2014. This allocation was approved in principle by the Trust's Executive Team on the 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services.

8.84 Funding became available In the later part of the 2014/15 financial year. After the appropriate procurement processes concluded, contracts were awarded to architects, design consultants, and contractors to proceed with the installation of CCTV. Work on CCTV installation commenced in February 2015 in Cranfield, comprising Cranfield 1 and 2 and the Psychiatric Intensive Care Unit (PICU), and in the Sixmile wards. The Business and Service Improvement manager and the Clinical and Therapeutic manager from MAH were in contact with the contractors throughout the installation and commissioning processes.

8.85 On 21st April 2015 the contractors informed the Business and Service Improvement Manager that the CCTV had been installed in Cranfield and Sixmile wards and was now recording; a demonstration of the equipment was offered. The contractor explained the need for a period of recording prior to the demonstration to allow the full system's functions to be illustrated at the demonstration. At this time there was also discussion about the need to add additional cameras to cover

the gardens that were attached to each building. These additional cameras were added to the schedule of work.

8.86 The Service and Improvement Manager responded immediately suggesting that he be accompanied at the demonstration by the Operations/Nurse Manager and the Adult Safeguarding Officer. The contractor confirmed that the demonstration would take place on Wednesday 13th May 2015.

8.87 From the information provided by the contractor, the Review Team can summarise that the CCTV installation comprised the installation of large fixed cameras mounted in the public areas of the wards. The cameras were motion activated which meant that they were not in continuous record mode, which made it more practical to view playback. Cranfield and Sixmile wards each had their own CCTV recording systems which were in locked communication rooms. Each of the recorders had at least two screens to facilitate viewing. The recording arrangements provided for 120 days storage of the video footage. It is not clear from the specification whether the system was designed to overwrite recorded video after 120 days or whether 120 days was the minimum time for the storage of video. In the opinion of the Review Team it is highly likely that the system stored video beyond 120 days. This view is confirmed by a Trust briefing paper dated September 2018 which stated that: 'all available CCTV footage was preserved from 1st March 2017 until 30th September 2017'; a period of 184 days.

8.88 Records show that the CCTV project was commissioned and handed over to the Trust on 9th July 2015. It is not clear from the records examined who represented the Trust at the handover. Reference is made however to the need for the Business and Service Improvement Manager to be in attendance.

8.89 An examination of MAH Senior Nurse Meeting minutes shows that the introduction of CCTV to the wards had been the subject of discussion and consultation for

some time. The Senior Nurse Meeting was chaired by the Service Manager for the hospital. It was attended by the Ward Sisters/Charge Nurses for each ward and other senior nurses on the MAH site. In April 2014 there was reference in these minutes to a webcam presentation and the benefits it could bring. No other details are given about the proposals. In May 2014 the Service Manager stated that webcams would be installed on the wards. The Review Team concluded that the reference to the webcams was a reference to CCTV. In June 2104 the Service Manager told those attending that webcams had been ordered for all wards.

8.90 In May 2015 the MAH Safeguarding Officer reported that there had been a demonstration of CCTV and it had been shut down until policies were agreed to support its use. In June 2015 he stated that CCTV was still not operational. He added that they would be helpful for adult safeguarding. The Review Team asked the company responsible for the installation of the CCTV cameras when cameras started recording. The company responded that: 'recording started at handover.' Handover was at 9th July 2015.

8.91 In December 2015 the Trust entered into a contract with the CCTV contractor to provide routine servicing, callout, and repair of security systems in their community facilities which included MAH. The contractor confirmed that this contract included CCTV in MAH. The Trust was paying for this maintenance contract from December 2015.

8.92 From August 2015 until August 2017 mention was made at the Senior Nurse meetings about the drafting of CCTV policies and the consultation process for its operation. In August 2017 attendees of the meeting were told that the CCTV policy had been approved and would be rolled out in Cranfield and Sixmile wards on the 11th September 2017. The meeting heard that communications sessions were planned for staff and patients and signage would be going up. There was a delay of 25 months between the commissioning of the CCTV in May 2015 and the

Trust's decision to post signs about the cameras becoming operational in September 2017.

8.93 In June 2017 the Trust approved a policy (ref SG 09/17) for the implementation of CCTV within MAH. Its purpose was to assist with investigations related to adult safeguarding issues. The front page of that document shows that consultation and finalisation of the policy began in September 2015 and was not completed until June 2017. The pathway towards approval was as follows:

- 24 September 2015 - Initial Draft of the policy
- May 2016 - Amended after first round of consultation
- 11 August 2016 - Amended after 2nd round of consultations and approved by Clinical and Social Care Governance Committee
- 1 March 2017 - Approved by the Standards and Guidelines (Committee)
- June 2017 - Approved by the Trust Policy Committee
- 28 June 2017 - Approved by the Trust Executive Team.

The review team could find no evidence that the Executive Team queried why it had taken so long for the draft policy to reach it for its final approval.

8.94 The Review Team heard a number of different versions of what happened following approval of the policy. It has been difficult to be specific about a timeline from 28 June 2017 to the meeting between MAH managers and Mr. B, a complainant, in August 2017. Several managers from the Trust who are now retired and who had central roles to play in the implementation of CCTV did not meet with the review team.

8.95 It was agreed that the CCTV would go live from September 2017, probably 11th September. The Service Manager told the Review Team that work had to be completed on a Communications Strategy with staff in August before the system

went live. The complaint by Mr. B in August 2017 resulted in the discovery that CCTV had been recording for some time previously.

8.96 Mr. B., the father of a young man who was a patient in PICU ward, received a call from the Belfast Trust to inform him that his son had been physically assaulted by a member of staff. Mr. B. advised that he was notified on 21st August 2017, although Trust correspondence suggested this could have been 22nd August. Mr. B was told that the assault occurred on 12th August. Mr. B. told the Review Group that he immediately got into his car and drove to MAH to ascertain what had happened. He told the Review Team that he could not understand why it had taken 9 days to inform him of the incident; normally he would have been contacted on the day of any incident concerning his son.

8.97 Mr. B raised the issue of the assault with the RQIA on his way to a meeting at MAH on 25th August 2017. At the MAH meeting Mr. B met with the Operations Manager and the Safeguarding Officer who explained to him what had happened to his son. Mr. B was accompanied to this meeting, at his request, by a patient advocate from Bryson House. Mr. B did not accept the explanation provided. He inquired whether there was CCTV coverage of the incident. As a regular visitor to MAH since his son's admission in April 2017, Mr. B had noticed the presence of CCTV cameras on the ward. After the meeting he sent a formal complaint to the Belfast Trust. The complaint that Mr. B subsequently raised and how it was dealt with is an important aspect of this review and is dealt with in this report (see Paras 8.113 to 8.126).

8.98 The Manager informed Mr. B that the cameras were not recording. Mr. B challenged this response. He told the Review Team that he had observed CCTV notices on the walls of the hospital and had assumed that there must be CCTV coverage. He also informed the Review Team that prior to his son's admission to

MAH he had been given assurance in relation to his son's safety at MAH by the his son's social worker who told him that that the CCTV in MAH was operational.

8.99 The Belfast Trust sent an Early Alert about the assault on Mr. B's son on 8th September 2017 to the DoH and HSC Board. There was no reference to CCTV in the Early Alert. An update on the Early Alert was provided on 22nd September 2017 which stated that: 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of the CCTV footage.' This appears to be the first acknowledgement from Trust HQ that there was CCTV footage at MAH.

8.100 Almost all those who were interviewed from the Belfast Trust were asked about the CCTV. Why was it introduced? When did recording start? No one was able to tell the Review Team when recording started. The assumption by local MAH managers was that it would go live in September 2017 following the period of consultation with staff. At Director level the Review Team could not find any knowledge of how or when CCTV would be the introduced.

8.101 The Review sought to establish how managers at MAH became aware of the existence of historical CCTV recordings and when these were first viewed in relation to the events of 12th August 2017. The person with most knowledge about the CCTV, the Business and Service Improvement Manager who is now retired did not communicate with the Trust or the Review Team. It is difficult, therefore, to establish a precise timeline.

8.102 When the Service Manager for MAH was interviewed she recalled that she was told by the Business and Service Improvement Manager two days after the meeting with Mr. B at MAH that there might be CCTV footage of the incident that occurred on 12th August. The Review Team concluded that the Business and Service Improvement Manager's comment was prompted by Mr. B's challenge

regarding whether CCTV was recording. It is evident that some senior managers at MAH must have viewed some of the historic CCTV footage as Trust records show that legal advice from the Directorate of Legal Services (DLS) was sought on the 4th September to clarify if they could 'view the footage as part of an investigation'. The DLS replied on 19th September 2019 that the recording could be viewed. The Review Team has no doubt that some senior managers at MAH viewed some of the historic recording in late August/early September 2017. The information about its the contents was not however, provided to a Trust Director until 20th September.

8.103 The Service Manager told the Review Team that she viewed the recordings on 20th September and immediately phoned the Trust's Director of Nursing to inform her of the content. The Director of Nursing advised her to phone the Chief Nursing Officer at the DoH to inform her of these matters. The CNO was advised the next day. The Trust subsequently submitted an SAI notification to the DoH and the HSCB on 22th September 2017.

8.104 The Service Manager told the Review Team that she wanted to raise an SAI as soon as she heard about the assault on Mr. B's son. She completed an SAI form on the 1st September 2017 which was returned to her by the Learning and Disability Directorate's Governance department. She stated that she was dissuaded from pursuing an SAI by the Co-Director Learning Disability Services as it did not meet the criteria for an SAI.

8.105 The complaint that Mr. B subsequently raised and how it was dealt with was an important aspect of this review; it is dealt with further at par. 8.113 – 8.126 below.

(ii) The Involvement of the PSNI

8.106 The PSNI were alerted to the allegations of assault on Mr. B's son on 22nd August 2017 under the Trust's Adult Safeguarding Policy and the Joint Protocol. The PSNI became aware of the existence of historic CCTV recordings by mid-September 2017, when notified of this by the Service Manager at MAH. Initially the police worked with the Trust and the RQIA under the Joint Protocol procedures. The police was not informed of the volume of CCTV footage that had been recorded until significantly later in the viewing process. The Review Team was told by the PSNI that due to frustration with the manner in which the Trust was handling the CCTV in February 2019 they seized the recordings. It eventually emerged that there was more than 300,000 hours of recording from CCTV in MAH.

8.107 The PSNI set up a large team to scrutinise the recordings, the largest team ever assembled for such work in Northern Ireland. The CCTV recordings viewed by the PSNI dated back to March 2017. There is no explanation as to why there was six months of CCTV footage when the specification for the retention of CCTV stated that footage would be retained for 120 days before being overwritten (see Para 8.87).

8.108 In 2019 the PSNI expressed concern about the presence in the investigation of the former Business Service Improvement Manager for MAH who had retired but had been brought back by the Trust on a temporary basis to look after CCTV cameras and security on the site. The Trust terminated this arrangement. The Review Team emphasises that there is no suggestion of impropriety in respect of this individual. The Review Team tried to speak to this retiree through the Belfast HSC Trust. He did not acknowledge any of the communication sent to him.

8.109 When asked about the level of co-operation they had received from staff in the Belfast HSC Trust, the police said it was mixed. The police seized the CCTV

recordings. Copies were however returned to the Trust to enable it to recommence viewing of the footage.

8.110 At the time of writing the PSNI had not yet completed viewing all of the historic recordings. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions. Sixty-two staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV.

(iii) Subsequent Trust handling of the historic CCTV recording

8.111 In a written report to the Trust Board in January 2018 the Director of Adult and Social Care reported that work was underway to install CCTV in the remaining wards at MAH and the swimming pool on the site. She went on to state that the team that was set up to view the historical CCTV had viewed 25% of the footage. This was inaccurate. It is clear that the Trust had still not grasped the enormity of the CCTV recordings that still had to be viewed.

8.112 By September 2018 a team of ten external viewers working five days a week were employed by the Trust to carry out retrospective viewing of CCTV. The Director of Adult and Social Care told the Trust Board on 6th September 2018 that the viewing of PICU footage would be completed by early September and that the remaining three wards (Cranfield I and 2 and Sixmile) would be completed by the end of September. The same Director reported to the Board in February 2019 that viewing was still not complete with an estimated 20% yet to be watched. Senior staff in the Belfast Trust consistently underestimated the task of viewing the retrospective recordings. This partially accounted for the PSNI's frustration about the Trust's approach which resulted in recordings being seized and taken off site.

Summary Comments and Findings

- **Evidence points to CCTV recording since July 2015.**
- **The Trust was paying a maintenance contract for a system that they had installed but did not make use of for over two years.**
- **It took 22 months, an inexplicably long time, to produce a policy to implement CCTV in MAH. Most of the delay was at local level where the Business and Service Improvement Manager was the lead.**
- **Had CCTV been operationalised earlier, harm to patients may have been prevented.**
- **It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.**
- **There was an unacceptable delay in bringing matters to the attention of the HSC Board and the DOH despite the situation being known to senior managers on the MAH site. It was not escalated off the MAH site for two or three weeks after footage came to light.**
- **The Trust Board consistently failed in 2017 and 2018 to identify the scale of CCTV footage as the information provided to it was incomplete and at times inaccurate.**
- **The Review Team is critical of the reaction of the Co-Director of Learning and Disability Services in resisting the suggestion to raise an SAI. It formed the view that this was an attempt to contain the matter**

within the MAH management team. This manager declined to meet with the Review Team. In the absence of an account from this staff member the Review Team is content to accept the account of the Service Manager.

iii. Mr. B's Complaint – August 2017

8.113 On 21st August Mr. B was advised that on 12th August 2017 his son, AB, had been the victim of an assault by a member of staff. Mr. B was concerned that it had taken nine days to advise him of the assault on his son, particularly as he was used to having early alerts regarding his son's behaviour since his admission to PICU in April 2017. Mr. B was understandably concerned about the delay and not unnaturally was fearful that the delay was to enable any bruising on his son to fade.

8.114 The Review Team examined a range of documentation and interviewed senior staff at MAH and Trust Board levels in an attempt to ascertain the events around the assault on Mr. B's son and the reason for the delay in bringing matters to the attention of parents, safeguarding staff, and the Co-Director of Learning and Disability services.

8.115 A timeline in respect of Mr. B's complaint was developed by the Review Team (see Appendix 8). The Review Team identified no duplicitous or surreptitious reason for the delay in notifying Mr. B about the assault on his son, AB. The incident of 12th August 2017 was immediately reported by the staff nurse who witnessed it to the Nurse in Charge. Thereafter, there was a failure to comply with the Trust's Safeguarding policy and procedures.

8.116 It was not acceptable for the Nurse in Charge to have emailed the Deputy Charge Nurse (DCN) requesting a meeting to discuss a concern. This caused delay in reporting an assault on a vulnerable patient and prevented the establishment of a protection plan for AB and others on the ward.

8.117 The delay was further compounded as the requested meeting with the DCN did not take place until 17th August. The DCN considered the information provided about the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN therefore emailed him, requesting more details about the incident. This caused further delay in invoking the Trust's adult safeguarding procedures. The incident was not escalated at that time to senior managers within MAH nor was advice sought from MAH social work staff who carried safeguarding responsibilities within the hospital.

8.118 On 20th August 2017 the DCN received a further allegation in respect of the healthcare support worker involved in the incident with AB on 12th August. This allegation was of verbal abuse of a patient. The DCN then emailed the Charge Nurse seeking advice. On the Charge Nurse's return from leave, immediate and appropriate actions were taken in respect of both allegations made in respect of the healthcare support worker (see Appendix 8 for details).

8.119 The Review Team understands Mr. B's reaction to such information being provided to him nine days after the incident. The delay has done much to undermine Mr. B's confidence in the Trust. The handling of his requests for information and details about the CCTV in PICU and his complaint to the Trust has further diminished his lack of confidence in the Trust's managers and processes.

8.120 The handling of Mr. B's subsequent requests for information about his son's care and details about the CCTV in PICU also further eroded his confidence in the

Trust's management. Mr. B resorted to his Member of Parliament and the Information Commissioner in an effort to resolve matters to his satisfaction. The Review Team considered that more responsiveness to Mr. B's requests, with due regard given to the data protection rights of others who may have appeared on the recordings, would have been appropriate.

8.121 Mr. B met with MAH's Operations Manager and a Safeguarding Officer on 25th August 2017, as arranged by him on 21st August 2017 following notification of the assault on his son. To ensure he had support, Mr. B arranged for an advocate to accompany him. At that meeting Mr. B asked about the potential for CCTV footage in respect of the assault in respect of his son. He was advised that the CCTV was not yet operational and would be going live on the 11th September 2017. Mr. B, whose work involves the use of CCTV cameras in an institutional setting, did not accept the information provided. He stated that since his son was admitted to PICU he had seen signage advising that the ward was covered by CCTV. Mr. B subsequently attempted to acquire details about when the CCTV was operational.

8.122 The Review Team appreciated that the absence of information must have caused Mr. B considerable frustration. The Review Team, as already stated (see Paras 8.81 to 8.112), experienced considerable difficulties tracking down the information that Mr. B sought about the installation and operation of CCTV at PICU. The Review Team did not have the benefit of information from the Business and Service Improvement Manager at MAH, now retired, who it considered the individual most likely to have intimate detail of the CCTV system from the initial concept during 2012, through to the approval of the business case, and the system eventually being installed in July 2015. The Review Team considered it unacceptable for information about the operation of the CCTV system not to have been provided to Mr. B. The Review Team concluded that the CCTV was operating from July 2015.

8.123 Immediately following the meeting of 25th August, Mr. B emailed a complaint to the Trust in respect of his son's care. As he received no acknowledgement of his email, he contacted the HSC Board on the 29th August enquiring about when he could expect a response. It transpired that the original email had been sent to an 'incorrect' email address within the Trust. Once the Trust located the email on the 29th August it took immediate action through its Complaints Department with MAH's Governance Department.

8.124 From the exchange of emails between the Complaints and the Governance Departments, the Review Team identified two distinct approaches to how Mr. B's complaint would be handled. The Governance Department's view was that as the matter was of a safeguarding nature, it was not a complaint. The Complaints Department correctly interpreted the safeguarding and complaints policies by recognising that the safeguarding investigation would conclude at which stage, 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009).'

8.125 The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the *A Way to Go* report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his complaint further from November 2018.

8.126 As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017.

Summary Comments and Findings

- **There was no deception associated with the delay in notifying Mr. B of the assault on his son, AB.**
- **There were breaches in compliance with Trust's reporting arrangements under the adult safeguarding procedures.**
- **Immediately the matter came to the attention of the Charge Nurse timely and appropriate responses were instigated informed by the Trust's adult safeguarding procedures.**
- **Mr. B's requests for information were not responded to in a timely or inclusive manner guided by the requirements either of Data Protection arrangements or the police investigations.**
- **Mr. B asked relevant questions about CCTV. At that time the Business and Service Improvement Manager was still employed at MAH. This retiree did not respond to requests to meet with the Review Team and it has no information about his recollections.**
- **Once Mr. B's emailed complaint was located within the Trust he received a timely response. The commitment to address any outstanding issues at the conclusion of the safeguarding investigation**

has not yet been honoured. The complaint remains open until closure is brought to the process.

- **The persistence of Mr. B in respect of the CCTV was significant. It is noteworthy that at the end of August, MAH wrote to the Department of Legal Services seeking legal advice on the use of CCTV footage. The Review Team was unable to ascertain whether at that time some MAH staff had identified that footage relating to the assault on AB was available (see Appendix 8).**

- **The involvement of Mr. B with a range of agencies including his MP may not have been required had the Trust shown more willingness to engage with him, and to share relevant information appropriately.**

- **The Trust Board was not provided with information about the existence of CCTV footage until 20th September 2017. The failure to escalate information to the Trust Board earlier was unacceptable professionally and managerially.**

9. Best Practice

9.1 The Review Team had planned to visit a number of centres of excellence to inform and develop recommendations. The lockdown caused by the Covid-19 pandemic necessitated a change of plans in this respect. The Review Team, therefore, has conducted a literature review which it considers pertinent to best practice developments.

9.2 Joe Powell, the CEO of All Wales People First which refers to itself as, the united self advocacy group for advocacy groups and people with learning disabilities in Wales, stated in the Foreword to the *Improving Care Improving, Lives* report, 'that we still deem it acceptable to house some people with learning disabilities within the hospital system, when it is no longer appropriate. If this situation is not remedied, we cannot truly claim that we have eradicated the unjust and deficit-centred culture of the long-stay institutions of the past.'[82] The Review Team was particularly struck by Powell's comments relating to 'the unjust and deficit-centred culture' as it underscored for Team members the need for a human rights based, patient-centred approach to planning with and for learning disabled patients. The Review Team regrets that due to the lockdown situation it was not in a position to meet more patients and their relatives and carers to assist in completing this review. We apologise that greater engagement was not possible. The Review Team will however, in its review of the literature, pay particular attention to the voice of service users and their families and carers.

9.3 As the history of MAH shows (Section 5), considerable change has occurred since it first opened its doors in 1949. A large institution caring for adults and children with at one time a maximum of some 1,400 inpatients, now cares for fewer than 60 patients. The resettlement agenda has placed considerable pressure on relatives,

[82] Improving Care, Improving Lives February 2020 https://gov.wales/sites/default/files/publications/2020-03/national-care-review-of-learning-disabilities-hospital-inpatient-provision.pdf

some of whom were anxious about their loved one's leaving the 'home' they had lived in for decades. Some staff also had anxieties as to their own future employment as the number of wards continued to reduce at the hospital. The Review Team heard evidence from one parent about the enhanced quality of care afforded to his son since he was provided with a tailored community care package.

9.4 The Review Team in the following discussion articulates principles which it believes will better meet the assessment and treatment of people with learning disabilities as well as informing the required community infrastructure and supports. The *Improving Care, Improving Lives* report made 70 recommendations targeted at: providers (35 recommendations); commissioners (33 recommendations) and the Welsh Government (2 recommendations). This was a more extensive review of learning disability services than the current review. The key learning from it which the Review Team considered relevant to MAH are summarised below:

- 'patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient. Detained patients should be aware of their rights';

- 'hospital support plans are reviewed regularly, within a maximum time period of three months. All care plans and hospital support plans are developed with specific objectives, measurable outcomes and clear timescales';

- 'a safe, effective, and therapeutic environment of care, [is in place] in order to reduce frustration and boredom which could lead to behaviours that challenge.. [S]taff are trained to recognise escalating behaviours and to deliver positive and preventative interventions. ... [A]ll patients have a plan in place identifying the outcomes to be achieved in order to transition to the next step on their care journey';

- ‘any restrictive intervention involves the minimum degree of force, for the briefest amount of time, and with due consideration of the self-respect, dignity, privacy, cultural values, and individual needs of the patient. A restraint reduction plan [should be] in place for each patient’;

- ‘patients, families, and carers have a voice in service design.... [M]easures of patient satisfaction are obtained and used as indicators of responsive and quality services’;

- ‘Commissioners ensure a sufficient level of staffing to provide safe and progressive care’;

- ‘Commissioners should consider investment in early intervention and admission prevention community services.’

9.5 In 2015 NICE published guidelines titled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges’[83] The guidelines, which have been endorsed in Northern Ireland by the Department of Health, ‘cover intervention and support for … adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and interventions for family members and carers.’ The general principles which underpin the Nice Guideline include:

1. ‘Working in partnership with … adults who have a learning disability and behaviour that challenges, and their family members of carers, and:

[83] https://www.nice.org.uk/guidance/ng11

- involve them in decisions about their care;
- support self-management and encourage the person to be independent;
- build and maintain a continuing, trusting, and non-judgmental relationship;
- provide information:

    - about the nature of the person's needs, and the range of interventions … and services available to them;
    - in a format and language appropriate to the person's cognitive and developmental level…;

- develop a shared understanding about the function of the behaviour;
- help family members and carers to provide the level of support they feel able to.

2. When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members of carers:

- take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems;
- aim to provide support and interventions:

    - in the least restrictive setting, such as the person's home, or as close to their home as possible; and
    - in other places where the person regularly spends time….;

- aim to prevent, reduce, or stop the development of future episodes of behaviour that challenges;
- aim to improve quality of life;
- offer support and interventions respectfully;
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person;
- ensure that they know who to contact if they are concerned about care or interventions…;
- offer independent advocacy to the person and to their family members or carers.

3. Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour challenges … should understand:

    - the nature and development of learning disabilities;
    - personal and environmental factors related to the development and maintenance of behaviour challenges;
    - that behavioural challenges often indicate an unmet need;
    - the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational, and occupational functioning;
    - the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

4. Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

5. If initial assessment … and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams … have prompt and coordinated access to specialist assessment, support, and intervention services….

6. Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges.

7. Health and social care provider organisations should ensure that all staff get personal and emotional support ….

8. Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff….

9. A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers, and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services. …

10. The designated leadership team should be responsible for developing, managing, and evaluating care pathways, …

11. The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

12. The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve, …

13. The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services …

14. The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information …

15. GPs should offer an annual physical health check to … adults with a learning disability in all settings, using a standardised template… This should be carried out together with a family member, carer, or healthcare professional or social care practitioner who knows the person …

16. Involve family members or carers in developing the support and intervention plan for … adults with a learning disability and behaviour challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public.' …

17. When assessing behaviour that challenges shown by … adults with a learning disability, follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. …

18. Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer, or advocate to support the person and help them to understand the feedback if needed.

19. If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services…

20. Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions …

21. Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach, …

22. Develop a written behaviour support plan for … adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour.

23. Consider personalised interventions for … adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time.

24. Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or

carers to be involved in planning and reviewing reactive strategies whenever possible.

25. Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and the need for restrictive interventions.'

9.6 The NICE guideline address the range of issues found by the Review Team in relation to: staffing levels and skills; the availability of safe, effective and compassionate care; the absence of behavioural support services resulting in over-use of restraint, seclusion and physical interventions with patients; the effectiveness of care planning and transition arrangements for patients; and the poorly developed multidisciplinary approach to patient care.

9.7 The use of seclusion and physical interventions with patients has been commented on throughout this report. Best practice in working with learning disabled patients who presented with aggressive and/or challenging behaviours did not underpin strategies relating to their management at MAH. Future practice in these areas was considered by the Review Team in terms of:

- RCN Advice issues in 2017, which is scheduled to be reviewed in 2020, which adopted a rights based approach to consideration and review of restrictive practices.[84] It states that, 'restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practices is therapeutic, ethical, and lawful.' It also acknowledges the benefit of early interventions

[84] [84] Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions, RCN, 2017 https://www.rcn.org.uk/professional-development/publications/pub-006075

and an understanding of the cause of such behaviours. The rights-based approach is seen as a means of placing the person at the centre of care;

- HM Government guidance of 2019 on reducing the need for restraint and restrictive practices[85] is directed at children and young people. The recognition in it of the traumatising effect of restrictive practices on children, young people, families, and carers, and the potential for long-term consequences for health and wellbeing are messages which are also relevant to adults. The core values, and principles upon which the guidance is based are also pertinent to adults:

  - 'uphold children and young people's rights;

  - treat children and young people with learning disabilities … as full and valued members of the community whose views and preferences matter;

  - respect and invest in family carers as partners in the development and provision of support; and

  - recognise that all professionals and services have a responsibility to work together to coordinate support …'

  In regard to restraint, the values stated:

  - 'every child or young person deserves to be understood and supported as an individual;

[85] Reducing the Need for Restraint and Restrictive Interventions HM Government, 27 June 2019 https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

- the best interests of children and young people and their safety and welfare should underpin any use of restraint;

- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people… should be considered and balanced with the needs and circumstances of others….; and;
- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned,' …[86]

- The Mental Welfare Commission for Scotland in 2019 issued a good practice guide to inform the use of seclusion. The purpose of the guide 'is to provide clear guidelines for the consideration and use of seclusion and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.'[87]

9.8 NICE has also developed a number of guidelines and quality standards specific to individuals with challenging behaviours and learning interventions. In developing inpatient and community care services for such individuals, the Review Team considered that the following literature should be used to inform a service model in Northern Ireland:

- Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges;[88]

- Learning disabilities: challenging behaviour;[89]

[86] Ibid, Pages 17 - 19
[87] Use of Seclusion: Good Practice Guide, Mental Welfare Commission for Scotland, October 2019, Page 5 https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf
[88] Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline, 29 May 2015 nice.org.uk/guidance/ng11

- Mental health problems in people with learning disabilities: prevention, assessment and management;[90]

- Learning disabilities: identifying and managing mental health problems;[91]

- Learning disabilities and behaviour that challenges: service design and delivery.[92]

9.9 A selected range of other resources which Commissioners and Providers of services for individuals with learning disabilities may find informative are listed below with links to the publication for reference purposes:

- Royal College of Psychiatry

  - People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services;[93]
  - Enabling people with mild intellectual disability and mental health problems to access health care services;[94]
  - Care Pathways for people with intellectual disability;[95]
  - Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results;[96]

[89] Learning Disabilities: challenging behaviours Quality standard, 8 October 2015, nice.org.uk/guidance/qs101
[90] Mental health problems in people with learning disabilities: prevention, assessment and treatment, NICE guideline 14 September 2016, nice.org.uk/guidance/ng54
[91] Learning disabilities: identifying and managing mental health problems, Quality standard 10 January 2017 nice.org.uk/guidance/qs142
[92] Learning disabilities and behaviour that challenges: service design and delivery, NICE guideline, March 2018, nice.org.uk/guidance/ng93
[93] People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, July 2013 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2
[94] Enabling people with mild intellectual disability and mental health problems to access health care services, November 2012 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr175.pdf?sfvrsn=3d2e3ade_2
[95] Care Pathways for people with intellectual disability, September 2014, https://rcpsych.itinerislive.co.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-05.pdf?sfvrsn=11e73693_2

- Standards for adult inpatient learning disability services;[97]

- The Joint Commissioning Panel for Mental Heath's guidance for commissioners of mental health services for people with learning disabilities;[98]

- Local Government Association, ADASS (adult services), and NHS England publication: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition;[99]

- The National Quality Board publication: An improvement resource for learning disability services: Safe, sustainable and productive staffing:[100];

- British Journal of Psychiatry article: Impact of the physical environment of psychiatric wards on the use of seclusion;[101]

- Journal article: Evaluation of seclusion and restraint reduction programs in mental health: A systematic review.[102]

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[96] Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results, 2015, https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-06.pdf?sfvrsn=5a230b9c_2

[97] Standards for adult inpatient learning disability services, July 2016 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-standards-3rd-edition-2016.pdf?sfvrsn=b181aa51_2

[98] The Joint Commissioning Panel for Mental Heath, Guidance for commissioners of mental health services for people with learning disabilities, May 2013, https://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

[99] Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, October 2015, https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[100] Safe, sustainable and productive staffing: An improvement resource for learning disability services, January 2018 https://improvement.nhs.uk/documents/588/LD_safe_staffing20171031_proofed.pdf

[101] Schaaf van der P.S. et al Impact of the physical environment of psychiatric wards on the use of seclusion, 2013. 202, 142 – 149, https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-the-physical-environment-of-psychiatric-wards-on-the-use-of-seclusion/ECF01A965156AF94A632E8436F13FD9D

[102] Goulet M-H, et al, Aggression and Behavior, 34 (2017) Pages 139 – 146 Evaluation of seclusion and restraint reduction programs in mental health: A systematic review https://www.sciencedirect.com/science/article/abs/pii/S1359178917300320

9.10 The future model of inpatient services for individuals with a learning disability requires that best practice guidance, standards, and models are considered and developed to inform a modern, person-centred, rights driven service approach. This review found that dysfunctional management and a lack of a shared vision impacted negatively on patient care. The initiatives taken by the Trust to engage patients, carers, and families in care planning and the oversight arrangements within MAH require further development to ensure that meaningful engagement can be maintained and promoted.

9.11 The *A Way to Go* Report stated that 'the CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management response.' [103] In the future, CCTV needs to be considered as a tool to prevent harm to patients rather than a means to ensure safe and compassionate care.

9.12 Finally, the above list of available materials has been selected in order to help inform a future commissioning and delivery agenda which promotes respect, dignity, care, and compassion for individuals with learning disabilities who are among some of society's most vulnerable citizens.

Summary

- Providing safe, effective, and compassionate care requires sufficient staff, with appropriate skills and ongoing access to training and professional development if it is to be more than a meaningless mantra.

- Services must be patient-centred informed by individualised assessment, planning and review processes to develop tailored care, protection, and

[103] Op. Cit par. 52, Page 18

transition plans for each patient.

- Patients, their families, and carers should be actively involved in decision making and in developing approaches to address behavioural or safeguarding concerns.

- Transition planning requires the active engagement of the patient, family/carers, and community support services to plan for a phased transition to life outside the hospital.

- The culture in the hospital should respect and promote patients' rights under the European Convention on Human Rights (ECHR).

- Advocacy services and family/carers and patients should regularly be asked to provide feedback on the standard and quality of care provided.

- All restrictive practices should be a last resort and used for the least time possible to comply with Article 5 of the ECHR (the Right to Liberty and Security).

- Locked doors for patients who are not detained under the provisions of the Mental Health Order are likely in to be in breach of Article 5 and such practices should be reviewed by the Trust to ensure compliance with legislative requirements.

- CCTV is an important tool in preventing abuse, however, it cannot be relied upon to ensure a culture of compassionate care.

- Clinical Leadership is essential for the promotion of patient safety and service quality.

- Multidisciplinary working and a strong leadership team are essential to the future provision of inpatient services for learning disability patients.

- An infrastructure of community support services is required to obviate, where possible, inappropriate admissions to hospital and to ensure that discharged patients' placements are well supported and sustained.

- Hospital as a permanent home for patients' capable of living in the community is no longer an option and every effort should be made to ensure phased, planned, and well supported discharges occur for patients who are inappropriately cared for within a hospital setting.

- Greater focus is required to working together with patients, relatives, carers, and community resources to ensure that in the future MAH is no longer a place apart.

10. Conclusions and Recommendations

10.1 The Review Team concluded that:

1. The Trust, given its size and scale, had extensive governance systems in place:

- the complexity of its governance systems hindered its agility and ability to be responsive;

- any system is dependent on those who implemented it, therefore in itself it cannot provide assurance;

- changes of senior management arrangements and titles resulted in confusion for front line staff, some of whom were unclear of arrangements which existed in the Trust in respect of MAH;

- the governance system became a tick box exercise at MAH;

- the Trust as an organisation championed practice development and quality improvement, as well as safer patient initiatives. There was however, limited evidence of how it influenced patient care at MAH;

- the SAI group was stood down in 2013 as a stand-alone Committee of the Trust Board. The Review Team was unable to ascertain to what degree, if any, this may have impacted on the priority given to adherence with SAI procedures or feedback to the Executive Team or Trust Board;

- there was a lack of escalation of issues from MAH to the Executive Team of the Trust Board. No issues regarding MAH were escalated to the Trust

Board or Executive Team between 2012 and 2017 despite its ongoing difficulties in relation to staff recruitment and retention;

- an extensive array of policies and procedures existed within the Trust. An external review of a number of policies and procedures relating to seclusion and restraint found the extant policies were out of date and that more recent best practice developments had not been taken into account;

- In 2005 the Department issued in draft form its Guidance on the use of Seclusion and Restraint. The Review Team knows that this Guidance was used to inform the Southern HSC Trust's policies in these areas. As the 2005 draft consisted of extensive guidance on monitoring arrangements, it is unfortunate that the Draft Guidance was not issued in final form by the Department as it had, through its monitoring mechanism, provided an opportunity to highlight and remedy excessive use of physical interventions.

- there was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walkabouts scheduled for all Trust facilities in 2012 did not result in a site visit to MAH until 2016.

2. Discharge of Statutory Function (DSF) Reports were provided annually by the Trust to the HSC Board:

– these were largely repetitive documents which did not provide assurance neither in relation to the discharge of Statutory Functions, nor to the standard of practice in relation to same;

- there was no reference to the Ennis investigation within the DSF Reports;

- there was insufficient challenge from the Trust Board and the HSC Board in relation to DSF Reports. Feedback provided to the Trust from the HSC Board related to failings in meeting resettlement targets;

- there was a recognition that the reporting format was leading to repetitive reports which lacked outcome data. Despite this, the reporting structure was not amended.

3. There was limited evidence of multidisciplinary working at MAH:

- nurses, including healthcare assistants, were for operational purposes the key workforce on site;

- there was evidence of nurses feeling unsupported by medical staff;

- there were ongoing problems relating to the identification and diagnoses of physical healthcare needs of patients which were not addressed until a service was procured from a local GP's practice;

- there was insufficient multidisciplinary team working with patients across the MAH site;

- the general absence of behavioural support staff, in particular psychologists, had a detrimental impact on patient care and contributed to challenging behaviours.

4. Failure to use data and learn from it:

   - information regarding physical interventions, restraint, vulnerable adults, and seclusion were regularly presented to Governance and Core Group meetings at MAH. There is no evidence of data being analysed or triangulated to inform practice, staff learning, or the workforce strategy. There was also no evidence of trends being analysed;

   - information from RQIA inspection reports was not used proactively to develop staff or improve patient care;

   - RQIA had no joined up approach to inspecting wards at MAH but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector.

   - there was evidence that priority was afforded to completing information returns rather than learning from them;

   - there was limited evidence of how patients' and carers/relatives' views were sought and used to inform patient care.

5. There were staffing difficulties in MAH particularly relating to nursing and Consultant posts:

   - inadequate nursing staff resulted in a heavy reliance on bank and agency staff which resulted in a skill mix ratio of nurses to healthcare assistants which at times was as low as 20:80 on wards. There was an absence of

clinical oversight of practice, particularly of healthcare assistant level on a 24/7 basis;

- the staffing difficulties were hindered by the moratorium on posts compounded by the lack of a workforce strategy;

- there was limited investment in staff training and development activity, with a focus on mandatory training. There was little evidence based upon: therapeutic education; education and development; or national strategies promoting reductions in seclusion and promoting behavioural support;

- wards were closed prematurely to cope with staffing shortages. Insufficient attention was afforded to the impact this would have on patients or the skill mix of staff;

- patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours;

- medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards;

- nursing workforce shortages were not escalated within the Trust or to the Department.

6. The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost:

- the physical environment in wards scheduled for closure was allowed to deteriorate, resulting in a living and work environment not conducive to high standards of practice;

- relatives/carers of patients and hospital staff's anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients' transition to care in the community;

- there was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community.

7. MAH had its own culture which was not informed by the leadership values of its parent organisation:

- the Trust had its values set out in *The Belfast Way* and in a range of other documents. There was no evidence that these had been cascaded successfully to staff at MAH;

- there was a culture clash within MAH between those who viewed it as a home for patients rather than a hospital with treatment and assessment functions;

- staff were more focused on maintaining the status quo at MAH rather than adopting the values of the Trust. The *A Way to Go* Report commented on the loyalties which existed within the staff team to each other rather than to their employer;

- there was a practice in MAH of keeping issues and their management on-site. Evidence of this is found in the failure to bring the Ennis investigation and subsequent report to Trust Board. Similarly, by dealing with it solely as a safeguarding issue, it meant that it could be addressed on-site;

- the HSC Board repeatedly sought an SAI in respect of Ennis from 2012 to 2015. This request was never implemented by the Trust which eventually accepted that it was in breach of the SAI procedures. The admission of breach was not brought to Trust Board level by Trust personnel or the HSC Board;

- the Review Team was unable to ascertain why Ennis had not been escalated to Trust Board or the Executive Team by the Governance Lead or the Co-Director of Disability and Learning Services or the Directors of Nursing and Adult Social Care;

- an absence of visible leadership from Trust Board and Directors which resulted in MAH being viewed as a place apart.

Recommendations

10.2 In making recommendations the Review Team has considered actions taken by Belfast HSC Trust since 2017 to ensure safe, effective, and compassionate care in MAH. To avoid repetition recommendations are not made where action has already been taken. The following recommendations are made to assist the Department, the HSC Board/PHA, and the Trust to enhance the care provided to learning disabled citizens in a manner which builds on their strengths and supports them to reach their fullest potential.

The Department of Health

1. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

2. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

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

The HSC Board/PHA

1. The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.

2. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

3. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust

considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

11. Acknowledgements

11.1 The Review Team wishes to thank all those who gave so generously of their time to meet with it. Without the assistance of parents, carers, advocates, past and present staff of the Department, HSC Board/PHA and the Trust, and RQIA, the PSNI, political representatives (MP and Health Minister) and the PCC the Review Team's task would have lacked both depth and insight. The Review Team also benefited greatly from input from one of the Professional Nursing Officer at the Department of Health in relation to best practice guidance.

11.2 The Review Team benefited from a site visit to MAH in February 2020 when it had the opportunity to meet with staff and patients. Due to the Covid-19 situation it was regrettably not possible for the Review Team to make further contact with patients and a wider number of relatives and carers.

11.3 The HSC Leadership Centre provided accommodation and technical support for the Review Team which was much appreciated.

11.4 Considerable documentary evidence was provided by the Department and the Trust. The Review Team wishes to thank those staff who supported it so ably by the timely provision of requested documentation.

Appendix 1

Terms of Reference - A Review of Leadership and Governance at Muckamore Abbey Hospital

Background

A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital (November 2018) is the report from the Independent Serious Adverse Incident Review of Adult Safeguarding incidents occurring at Muckamore Abbey Hospital between 2012 and 2017. Belfast Health & Social Care Trust (BHSCT) has commenced work on an action plan to improve the care, safety, and quality of life for patients in the hospital, and the Department of Health have developed an action plan to address the regional and strategic issues identified in the report. The three Trusts whose populations use Muckamore Abbey Hospital are also prioritising work to facilitate the discharge of people who no longer require inpatient care.

It is felt that the review did not fully explore the leadership and governance issues in the hospital. Therefore, the Independent Review of Leadership and Governance at Muckamore Abbey Hospital is being commissioned to address any leadership and governance issues that may have contributed to safeguarding deficits in the hospital.

A timeline for completion of the review will be agreed at the first meeting with the review team and HSCB/PHA lead officers.

Methodology

The Review team seek to establish lines of communications with all the organisations that are impacted by this review. The Belfast HSC Trust will be the main focus of the review, but other organisations may include the RQIA, other Trusts, as well as families and carers. The DoH will also be approached to ascertain what policies were in operation during that time period that would be relevant to the issues of leadership and governance. The HSCB/PHA will inform these parties of the mandate of the Review Team.

The Review team will seek to gather information for 2012 – 2017 from these relevant sectors that will help address the issues of how leadership and governance were exercised during this period. This will be carried out through interviews with individuals identified by the team and scrutiny of the relevant documentation. Documentation may include, Minutes of Board, Senior Management Team, and Hospital Management meetings; as well as risk registers; operational and strategic plans; service improvement plans; and financial strategies. Other documentation may include incident reporting, complaints, and organisational structures (this list is not exhaustive). The team will meet families and carers to ascertain their observations of matters of leadership and governance.

The Review team will identify good practice in the HSC/NHS and the public sector that can provide benchmarks to evaluate how leadership and governance was exercised within the Belfast Trust. The team will always act fairly and transparently, and with courtesy.

Purpose of the Review

This review is being commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department of Health. The purpose of this review is to critically examine the effectiveness of Belfast Health & Social Care Trust's leadership, management, and governance arrangements in relation to Muckamore Abbey Hospital for the five-year period preceding the adult safeguarding allegations that came to light in late August 2017.

The review should take cognizance of any relevant governance issues highlighted by other agencies such as RQIA and PSNI since 2017. Ultimately, the review seeks to establish if good leadership and governance arrangements were in place and failed and if so, how/why ; or were effective systems not in place.

Terms of Reference

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to quality, safety and user experience. Drawing upon families, carers, and staff's experience, conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

Strategic leadership

- Shared principles, values, and objectives across the Trust services for people with a learning disability
- The role of Belfast HSC Trust Board and Senior Management Team in providing leadership and oversight
- The role of Belfast HSC Trust Board and Senior Management Team in ensuring clarity of purpose for MAH

Operational Management

- Clarity of line-management arrangements
- Clarity of lines of accountability from ward staff through to Trust Board
- Clarity of roles and responsibilities of and between operational, governance, and professional leadership and management at the hospital
- Clarity of roles and responsibilities between staff in the hospital and community based clinical and key worker staff.
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour.
- Operational aspects of adult safeguarding arrangements.
- Operational systems for raising and addressing concerns about quality and safety of patient care.
- Operational aspects of service improvement arrangements.

Professional / Clinical leadership

- Professional adult safeguarding arrangements
- Clinical leadership within multidisciplinary teams
- Professional supervision (across all disciplines working in the hospital)
- Professional aspects of systems and supports for raising and addressing concerns about quality and safety of patient care (including those available to students from all disciplines on placement in the hospital).
- Continuous professional development arrangements for all levels of staff
- Process for introducing and monitoring the implementation of new evidence based professional practice and clinical updates
- Professional aspects of service improvement arrangements
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour

Governance

- Incident reporting and reviewing arrangements and how these informed patient care (to include restrictive practices)
- Clinical and practice audit
- Dealing with complaints
- Whistleblowing
- Inspection reports
- Health & Safety
- Risk assessment and management
- Arrangements for learning and improvement from the above.
- Monitoring and accountability arrangements for physical interventions
- Monitoring and accountability arrangements for seclusion.
- Multidisciplinary staff availability, working, and skill mix
- Delivery of evidence-based therapeutic interventions in line with NICE and other relevant clinical practice guidelines

Accountability

- Meaningful engagement with families of patients/carers
- Meaningful engagement with people who use the hospital's services
- Reporting and accountability arrangements
- Working arrangements with community-based services
- Openness to visitors and scrutiny

Hospital Culture and Informal Leadership

- Hospital culture across all staff in all professions/roles in all settings within the hospital.
- The extent of compassionate values based and human rights-focused practice in the hospital.
- The nature of the management approach to staff including the extent of formal and informal supports.
- Ward dynamics and relationships amongst staff teams including positions of power/influence in staff teams. This analysis should include any available information from the safeguarding investigation about the numbers, roles, grading, experience, training, length of service and shift patterns of staff alleged to have been directly involved in abuse and those alleged to have witnessed it but did not act on it.

Support to Families and Carers

- The DOH will engage PCC to provide independent support for families and carers who become involved in the review process.

Anticipated Outcome

Produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group in relation to the implementation of a governance and assurance framework for Muckamore Abbey Hospital & Belfast HSC

Trust; other HSC Trusts with Learning Disability Hospitals; and wider mental health and learning disability services.

Appendix 2

Curriculum Vitae of Independent Review Team Members

David Bingham

Before retirement from the NHS in March 2016 David was Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland. He had spent most of his career in the public sector, with a background of General Management, Human Resources or Management and Organisational Development. In addition to his health service experience he had spent eight years in the senior civil service.

Maura Devlin

Maura is a registered nurse and currently the Northern Ireland council member of the Nursing and Midwifery Council. She was Director of Nursing and Midwifery Education in the Clinical Education Centre and previously worked in a range of assistant director roles in the health and social care sector in Northern Ireland. Since retiring, she has served as an independent chair for Fitness to Practice proceedings at the Northern Ireland Social Care Council. She currently works as a professional advisor to the Northern Ireland GP Federations.

Marion Reynolds MBE, BSc, Dip Soc Work, CQSW, Cert Adv Soc Work

Marion worked from 1975 to 2009 at practitioner, management, inspection, policy development, and commissioning levels in Family and Child Care services in Northern Ireland. She commissioned the full range of statutory family and child care services for the population of the Eastern Health and Social Services Board from 2006 to 2009. In addition she chaired the Board's Area Child Protection Committee. Previously she

worked as a Social Services Inspector, at the DHSSPS (1992 to 2005). Marion contributed to the development of professional standards for children's services.

Since 2010 Marion has worked as an Independent Social Worker providing independent social work analysis and reports for a range of social services providers in both Northern Ireland and the Republic of Ireland.

Marion is currently involved as a: member of the Exceptional Circumstances Body of the Department of Education (2010 to present), member of the Northern Ireland Advisory Group of Homestart (UK) (2005 to present); Board Member Alpha Housing Association (2012 to present). Previously she was a Commissioner with the Northern Ireland Human Rights Commission (2009 to September 2017).

Katrina McMahon

Katrina is a former acting Head and Business Manager of the HSC Leadership Centre. She worked in the Health and Social Care sector for 37 years in various management roles within HSC Trusts and the Management Development Unit. Her particular areas of interest are in business systems and managing complex health care based projects.

Appendix 3

List of documentation received by the Review Team

File Number	Origin	Date Received	Comment
1	Belfast Trust	21/2/20	Policies and Procedures
2	Belfast Trust	21/2/20	Policies and Procedures
3	Belfast Trust	4/3/20	Policies procedures and reports
4	Belfast Trust	6/3/20	SAIs' and Incident reports
5 (File 1)	Belfast Trust	6/3/20	CORE minutes Modernisation Minutes
6 (File 2)	Belfast Trust	6/3/20	Professional Senior Nurse Minutes
7 (File 3)	Belfast Trust	6/3/20	Nurse Management Structure Re-settlement Information Audit Lead Minutes Governance Minutes
8 (File 4)	Belfast Trust	6/3/20	Learning & Children's Senior Managers Minutes
9	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits

10	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits
11	Belfast Trust	1/6/20	Assurance Standards Trust Board Updates + MAH Senior meetings
12	Belfast Trust	1/6/20	Ennis Investigation
13	Belfast Trust	1/6/20	Information relating to Ennis Report
14	Review Team		CCTV file
15	Belfast Trust	8/6/20	Nurse Training Plan Nurse Governance Structures KPIs' Nurse Governance Quality Reports
16	Belfast Trust	8/6/20	Nurse Management Plans Nursing & Midwifery Workforce Steering Group Assurance Framework
17	Belfast Trust	16/6/20	Trust Board Sessions, Exec Team minutes Statutory Function Reports Risk Registers
18	Belfast Trust	16/6/20	Quality improvement/Quality & Safety

			Improvement Plans
19	Belfast Trust	16/6/20	Adult Protection Policy Adult Safeguarding Policy Nursing KPIs'
20	Belfast Trust	26/6/20	Risk Registers Records of Leadership Walkrounds Nursing Governance Nursing Workforce Minutes
21	Belfast Trust	26/6/20	Minutes of Social & Primary Care Directorate Team meetings LD Senior Management Team Meetings

File Number	**Origin**	**Date Received**	**Comment**
22	RQIA	7/2/20	Documents A-G
23	DOH	28/2/20	Ennis documentation Early alerts received by DoH re Muckamore Whistleblowing Complaints Adult Safeguarding Restraint & Seclusion Statistics on Workforce Assaults

24	HSCB/PHA		Early Alert Position Report – Mr B Complaint
25	Review Team		Ennis Investigation
26	Review Team		Additional ad-hoc documents
27	Belfast Trust		Documents from Chief Executives office
28	Departmental Professional Nursing Officer		Best Practice Documentation

Appendix 4

Meetings held with key personnel

Date	Job title
4/2/20	Chief Executive, Regulation &Quality Improvement Authority
13/2/20	Chief Executive, Belfast HSC Trust
18/2/20	Director of Primary Care, DoH
18/2/20	Social Services Officer, DOH
18/2/20	Nurse and Specialist Learning Diasability Manager, seconded to MAH
20/2/20	Officials , DoH
20/2/220	Social Services Officer, DOH
21/2/20	Director of Neurosciences, Radiology and MAH
21/2/20	Permanent Secretary, DoH
25/2/20	Programme Manager, Mental Health & Learning Disability, PHA
27/2/20	Medical Director and Director of Improvement Regulation & Quality Improvement Authority
27/2/20	Director of Nursing & Allied Health Professions – PHA
27/2/20	Social Care Lead Mental Health & Learning Disability, PHA
2/3/20	Manager Independent Advocacy Service,Bryson House
2/3/20	Health Minister
3/3/20	Chief Nursing Officer, DoH
5/3/20	Complaint Support Manager, PCC

5/3/20	Director, Mencap
6/3/20	Former Director of Adult, Social and Primary Care
13/3/20	Director of Social Work/Children's Community Services
16/3/20	Deputy Director and DRO, HSCB
21/5/20	MP
21/5/20	Chair of Parents & Friends of Muckamore Abbey Hospital
22/5/20	Director, Northern HSC Trust
26/5/20	Parent and Aunt
28/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
28/5/20	Hospital Service Manager/Assoc Director of Learning Disability Nursing, MAH
29/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
2/6/20	Hospital Service Manager/ Assoc Director of Learning Disability Nursing, MAH
4/6/20	Executive Director of Nursing and User Experience
4/6/20	Parent
5/6/20	Senior Manager for Service Improvement and Governance, Belfast HSC Trust
12/6/20	Ennis Investigation Officer
15/6/20	Former Director of Adult Social & Primary Care
18/6/20	Chief Executive, Belfast HSC Trust
20/6/20	Chairman, Belfast HSC Trust
22/6/20	PSNI
23/6/20	Non-Executive Director, Belfast HSC Trust

23/6/20	Nursing Lead for Transformation, DoH
23/6/20	Clinical and Therapeutic Services Manager, MAH
25/6/20	Trust Adult Safeguarding Specialist
25/6/20	Social Services Officer, DOH
25/6/20	Executive Director of Nursing and User Experience, Belfast HSC Trust
30/6/20	Former Director of Social Work, RQIA
3//7/20	Former Director of Social Work, Family and Childcare
16/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Clinical Lead, former Clinical Director

Appendix 5

TIMELINE OF RELEVANT INCIDENTS: MUCKAMORE ABBEY HOSPITAL 2012 - 2020

November 2012 – Complaints made of physical and emotional abuse of patients in Ennis Ward. PSNI informed. Review took place under the Trust's Safeguarding Vulnerable Adults Policy.

October 2013 - Date of Ennis Safeguarding Vulnerable Adults Report.

August 2017 - Complaint by a parent of a non-verbal male patient that his son was being abused at the Intensive Care ward at Muckamore Abbey.

August 2017 - Information that video recording may be available in relation to the allegations of patients being ill-treated by hospital staff. PSNI and the Trust began investigating the allegations and reviewing the video recordings.

November 2017 - Four staff members had been suspended and the BBC reported that the allegations "centred on the care of at least two patients".

January 2018 - The Trust established an Independent Expert Group to examine safeguarding at the hospital between 2012 and 2017. The report's authors included Dr Margaret Flynn, who oversaw the review into the 2012 Winterbourne View hospital scandal in England which saw six care workers jailed.

July 2018 - The Irish News reported details of CCTV footage allegedly showing ill treatment of patients. The Trust apologised "unreservedly" to patients and their families. It further stated: "As part of the ongoing investigation and a review of archived CCTV footage, a further

number of past incidents have been brought to our attention. It confirmed that a further nine members of staff had been suspended at MAH.

August 2018 - The BBC reported that between 2014 and 2017, five vulnerable patients were assaulted by staff at Muckamore Abbey Hospital. In response to a Freedom of Information (FoI) request the Trust confirmed that in hospital between 2014 and 2017 there had been more than 50 reported assaults on patients by staff, with five investigated and substantiated.

November 2018 - The Independent Expert Group established by the Trust to enquire into the allegations of August 2017 completed its report, *A Way to Go*

December 2018 - The *A Way to Go* Report which enquired into allegations of abuse and neglect at Muckamore Abbey was leaked to the media. By this stage, 13 members of the nursing staff were suspended and two senior nursing managers were on long-term sick leave.

December 2018 - A mother of a severely disabled Muckamore patient gave her first broadcast interview to BBC News NI. She described the seclusion room her son was placed in as "a dark dungeon". CCTV footage from the Psychiatric Intensive Care Unit (PICU) showed her son being punched in the stomach by a nurse. The footage, taken over a three-month period, also showed patients being pulled, hit, punched, flicked and verbally abused by nursing staff. The Belfast Trust confirmed that the seclusion room use was being reviewed though it was still used in emergencies.

January 2019 - The chair of Northern Ireland's biggest review into mental health services, Prof Roy McClelland, told BBC News NI that the allegations emerging from Muckamore could be "the tip of the iceberg."

February 2019 - The Chief Executive of the Belfast Health Trust, Martin Dillon, tells the BBC "the buck rests with me" in his first interview on the Muckamore abuse allegations. "Some of the care failings in Muckamore are a source of shame, but my primary focus is on putting things right," he said.

August 2019 - The police officer leading the investigation said that CCTV footage revealed 1,500 crimes on one ward alone. The incidents happened in the psychiatric intensive care unit over the course of six months in 2017-18. The police revealed the existence of more than 300,000 hours of video footage.

August 2019 - Northern Ireland's health regulator, RQIA, took action against the Belfast Trust over standards of care at Muckamore. Three enforcement notices were issued by the Regulation and Quality Improvement Authority (RQIA) over staffing and nurse provision, adult safeguarding, and patient finances. In a statement to the BBC, the Trust said it was trying to develop a model of care "receptive to the changing needs of patients".

September 2019 - Northern Ireland Secretary, Julian Smith, apologises for the pain caused to families by the situation at Muckamore Abbey Hospital, during a meeting with the father of one of the patients.

October 2019 - Dr Margaret Flynn, co-author of the *A Way to Go* Report into safeguarding at Muckamore tells BBC News NI that the hospital "needs to close". Her November 2018 report found that patients' lives had been compromised. She revealed that some patients had been manhandled and slapped on some occasions. She said that she was disappointed that the facility was still open.

October 2019 - Police investigating abuse allegations make their first arrest in the Muckamore investigation. A 30-year-old man was arrested by officers in Antrim on 14th October but he was later released on police bail.

October 2019 - Belfast Health Trust reported that it has spent £4m on agency staff in order to cover vacancies at Muckamore, because so many members of staff have been suspended during the abuse probe. The current tally of suspensions on 18th October 2019 stands at 36. Agency nurses are being drafted in from England and further afield to care for patients. It is reported that they are being paid up to £40 an hour.

November 2019 - A 33-year-old man becomes the second person to be arrested in the Muckamore abuse investigation. He was detained in Antrim on 11th November but was later released on police bail.

December 2019 - Police make more arrests in the Muckamore abuse investigation. A 33-year-old man was arrested in the Antrim area on the morning of 2nd December. The following day, officers said the man had been released on bail pending further inquiries. In the same week, the Irish News reports four more suspensions, bringing the total number of Muckamore staff suspended by health authorities to 40. The Belfast Health Trust confirms that all 40 employees have been "placed on precautionary suspension while investigations continue". On 16th December, a 36-year-old woman became the fourth person to be arrested and questioned about ill-treatment of patients. She was released on police bail the following day.

December 2019 - BBC News NI reveals that 39 patients who should have been discharged will have to stay at Muckamore Abbey Hospital because there are no suitable places for them in the community. The same day, RQIA announces the results of a three-day unannounced inspection of Muckamore, including an overnight visit. The RQIA inspection finds there have been "significant improvements" but it

still has concerns about financial governance and safeguarding arrangements.

January 2020 - Muckamore patients' families meet the new Health Minister, Robin Swann, following the restoration of Northern Ireland's devolved government. A spokesman for the campaign group Action for Muckamore, says that he was disappointed that Mr Swann could not give them assurances that a full public inquiry would take place. The meeting followed a fifth arrest in the abuse investigation. A 34-year-old man was questioned before being released on police bail the following day, pending further inquiries.

January 2020 - Terms of Reference for a review of leadership and governance at Muckamore Abbey Hospital and at Belfast Trust were agreed by the HSCB and PHA which had been requested by the DoH to conduct such a review.

January 2020 - Man arrested as part of MAH investigation. The 5th arrest.

February 2020 - Male nurse who was suspended was arrested by the police; the 6th arrest.

February 2020 - Muckamore Abbey Hospital Review Team commence the review into leadership and governance.

March 2020 - A 28 year-old woman who was arrested in the police investigation of patient abuse at Muckamore Abbey, in Co Antrim has been released. This was the 7th arrest.

March 2020 - MAH Review Team temporarily stood down due to the Coronavirus Pandemic. Timescale for delivery of interim findings and final reports necessarily amended.

April 2020 - The Public Prosecution Service writes to families for the first time confirming that it has received an initial file from the PSNI in respect of seven staff members which it is now reviewing.

Appendix 6

Overview of Ennis Report Appendix 1 of that Report

Source	Incident Number(s) (inclusive)	Comments
B2	1 – 15	**1, 3, 5, 7, 8** relate to staff alleged inappropriate or rough handling of 3 patients (P39 P40 & P41 Others appear practice issues
B3	16 – 18, 52 - 53	Incident **16** relates to rough handling of P39 Practice issues: incident **17** similar to incident **50**; incident **18** similar to **37**, **51** and **59**. **Part of 52** may be the same incident as **49** expanded. **53** may be incident **17**.
B8	19 – 23, 59 - 63	**59 – 63** are repeats of **22, 20, 19 & 44** one is similar to **37**
B9	24 – 25	Describes 2 incidents relating to P39 unclear what the allegations are
B5	26, 45 - 48	**26** rough handling of P39 when redressing her. Not repeated in B5 statement to HR in 2014. **45 – 48** comments in respect of P39 stripping and belt issues. Should cross-reference with B5 's HR statement in May 2014
B7	27 – 28	In the statement to HR B7 stated incident **27** was not a concern and it was an Erne member of staff, not Ennis, who provided an explanation. In relation to **28** said staff knew patients well & '*I could not praise the staff enough for the work they do.'*
B6	29 – 31, 54 - 58	**29** in the interview with HR this comment was refuted: 'denied that staff had taken P39 s hand out of hers.' **30 – 31** practice issues.
B10	32 – 39	32 rough handling (? Of P39 Incident **34** similar to that described at **24**, form of restrictive practice as described. Incident **35** practice issue. Incident **36** similar to incident **48.** Incident **37** similar to **59.** Incident **38** practice issue.
Patient's	40	Rough handling allegation

brother		
Multiple Private Provider staff	41 – 44	Incidents relate to lack of induction, lack of engagement with patients, lack of adequate staffing, culture on the ward. Should cross-reference with B4, B7, B5, and B6's statements to HR in May 2014
B4	49 – 51	Incident **49** repeat of **59** and other allegations in relation to rough handling of P39 and fitting belt too tightly. In statement to HR states witnessed this on one occasion only. Following practice issues: incident **50** repeat of **17**; incident **51** similar to incidents **18**, **37** and **59**.

Appendix 7

Strategy Discussions/Case Conferences and Case Records– Information Base for Review Team's Analysis in respect of Ennis

Strategy Discussions/Case Conferences

1. In keeping with the Trust's adult safeguarding policy, the investigation was conducted on a multidisciplinary basis and jointly with the PSNI given the criminal nature of a number of the allegations. Strategy meetings and case conferences were convened under the Joint Protocol for Investigation 2009 arrangements and the Regional Adult Protection Policy & Procedural guidance (Safeguarding Vulnerable Adults) 2006 on the following dates:

   - 9th November 2012 Vulnerable Adult Strategy discussion;
   - 15th November 2012 second Vulnerable Strategy Meeting;
   - 12th December 2012 strategy discussion;
   - 20th December 2012 strategy discussion;
   - 9th January 2013 strategy discussion;
   - 29th March 2013 strategy discussion;
   - a meeting scheduled for the 14th May 2013 was cancelled as the investigation was not completed;
   - 5th July 2013 Adult Safeguarding Case Conference;
   - 28th October 2013 Adult Safeguarding Case Conference.

2. The Safeguarding Vulnerable Adult policy requires that where there is confirmed or substantial risk of abuse a case discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify

risks and the actions necessary to manage those risks.[104] The purpose of the case discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan.[105] Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the Core Group who will work together to implement and review the Care and Protection Plan.[106]

3. The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.[107] The Care and Protection Plan will identify the person who is responsible for monitoring its operation. It should be reviewed within 10 working days of its implementation and should be reviewed at a 3 monthly interval at minimum.[108]

4. The initial meeting was held within the required timeframe and comprehensively considered the allegations received by the Trust on the 8th November 2012. No patient or family member was invited to attend the meeting; no explanation was provided although from the discussion it was apparent this was in the patients' best interests. A Protection Plan was agreed, each task was not assigned to a named attendee.

5. At the second discussion convened on the 15th November 2012 MAH staff were excluded to 'facilitate a more independent investigation.' The meeting agreed that the Designated Officer would be the main link to hospital staff. The meeting noted that there were 'some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring

[104] Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance, 2006, Para. 14.10, Page 36
[105] Ibid par. 15.1, Page 38
[106] ibid par. 15.7, Page 40
[107] ibid par. 15.13, Page 42
[108] ibid par. 16.3 – 16.4, Page 43

culture in the ward.' The meeting considered the complaints made against individual staff and reached conclusions about whether or not a staff member could be reinstated or placed on precautionary suspension. Much of the discussion at this meeting surrounded perspectives on professional practice at Ennis. The meeting did not commence with feedback on how aspects of the Protection Plan had operated since the initial strategy discussion. A revised Protection Plan was agreed the staffing component of this was to be addressed by the Designated Officer with senior Trust managers. The Review Team considered that preliminary discussion with MAH managers and delegating the staffing issue to them to pursue with senior managers would have been a more inclusive working arrangement.

6. The third strategy meeting convened on the 12th December 2012 highlighted information still awaited from MAH medical staff. An update on progress with interviews was provided. As of that date the PSNI had not interviewed any staff employed by the Private Provider. The meeting was informed that a Co-Director of Nursing (Education and Learning) had been identified to lead and co-ordinate monitoring arrangements at Ennis. The Designated Officer confirmed that after checking she was now in a position to confirm that since the last meeting monitoring staff 'were in place 24 hours a day and that they were supernumerary.' There was considerable discussion about staffing levels at Ennis. It was noted that 2 of the 5 patients named might be able to provide some information at interview. The agreed Protection Plan remained 24 hour monitoring with the precautionary suspension of 3 staff members continuing The Review Team considered that greater focus was required on the alleged incidents in an effort to bring the safeguarding investigation to an early conclusion.

7. The fourth strategy meeting convened on the 20th December 2012 had in attendance a member of the Trust's HR Department and the Co-Director of

Nursing (Education and Learning). The MAH Service Manager also attended this meeting. During this meeting the police representative noted that it would only interview patients or staff in respect of criminal allegations not professional practice matters. The police confirmed that the Private Provider's staff have now all been interviewed and statements taken. The police noted that these staff had not raised similar concerns about other wards on which they had worked. The Designated Officer noted that this was positive she remarked that 'there were clear differences being reported between it [Ennis] and other wards.

8. Three staff were identified by the Private Provider's staff whose identify could not be confirmed as their names were unknown. There was a discussion about whether a patient being held constituted a safeguarding concern. In this respect the police confirmed that this matter would not be investigated as a criminal matter. It was decided that 'social services would continue to interview them in relation to the allegations.' The police asked the Trust not to proceed with disciplinary measures before the police interviews. HR asked for a police timescale as it was important for the Trust to move ahead with its processes, It was agreed that HR interviews would be completed independently of safeguarding interviews. Fourteen action points were agreed at the end of this meeting the majority of which were assigned to named members of the strategy team.

9. This meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run in parallel. It also highlighted that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considers it essential that at the outset each allegation is assessed on the basis of the existing information and categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

10. The fifth strategy meeting was held on the 9th January 2013. Both of the Designated Officer's line managers attended this meeting [a Co-Director for Learning Disability Services and a Service Manager for Community Learning Disability Services]. The Co-Director raised his concern about the list of allegations presented by the Designated Officer some of which were specific while others were negative comments. He stressed the need to obtain evidence and facts, which was difficult in relation to negative comments. The Review Team considers that had the initial allegation been disaggregated (see Para 8.29) that the safeguarding investigation would have been able to focus its energies on abusive issues. The RQIA representative sought clarity on MAH staff now attending the Co-Director stated that the Trust's senior management had 'concluded that it was important she was in attendance to clarify any issues specific to nursing practice on the wards in MAH…'

11. This meeting commenced with a consideration of progress against the actions established at the previous meeting. The Review Team considers such an approach commendable as it serves to focus attention on any matters which remain outstanding. Concerns raised by a patient's sister during contact were discussed and it was agreed to recommend that these be progressed through the Trust's complaints procedures. This meeting agreed an alteration to the 24/7 monitoring arrangement such that it could now be undertaken by newly appointed staff at Ennis at Band 5 and above. Fifteen action points were agreed. Each was assigned to a named individual; such practice is commendable. The next meeting was scheduled to be held on the 1st February 2013.

12. The next meeting was held on the 29th March 2013 nearly two months later than initially scheduled. Neither the Co-Director of Nursing nor the MAH staff member was in attendance. Consideration had been given to deferring the meeting due to their non-availability but as the police wished to provide feedback it had been decided to proceed. The focus was therefore an update from the PSNI and on

further investigation planning. The Co-Director observed that 'while recognizing that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse.' He further noted that neither the Co-Director of Nursing nor the MAH staff member feel there is indication of institutional abuse at this stage. These are the first references to institutional abuse in the records of these meetings. All staff in the Ennis ward are to be interviewed by two community based learning disability social workers using an 'agreed script with a semi structured interview questionnaire.' The meeting also considered progress against the actions agreed at the previous meeting. At this stage neither patients nor all staff working at Ennis had been interviewed by Trust staff; more than five months after the receipt of the allegations. The Review Team considers this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

13. The penultimate meeting was held on the 5th July 2013 at which copies of the draft final report was circulated. The Public Prosecution Service had still to assign a public prosecutor to the case. The Co-Director, Learning and Disability Services, asked that pressure is kept on the process as public money is being spent with staff members remaining on suspension. He asked if the disciplinary process could commence pending an outcome of the police investigations. He asked that a meeting take place with the Trust's HR Department to discuss proceeding with disciplinary proceedings. As the draft report had been circulated at the commencement of the meeting there was not time to consider it, although the DO 'advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the report. It was agreed to defer until after the meeting as there had not been enough time to go through the report prior to it. One of the patient interviews remains outstanding as there is no Speech and Language therapist during July.

14. The Co- Director, Learning and Disability Services, noted that the investigation had dealt with ‘a broad range of issues which were not part of the original allegations but arose during interviews with Private Provider staff. He asked for the outcome of the investigation in relation to these matters as ‘the report refers at various points to ‘no conclusion drawn’.’ The DO replied that no evidence had been found to substantiate the allegations but ‘the investigating team felt the [Private Provider staff] were credible.’ The DO agreed to make a distinction between Ennis prior to the allegations and after the Improvement Plan.

15. There was a discussion about whether there was evidence of a culture of bad practice. The DO replied ‘that the conclusions reached by the investigation team was there was enough to warrant considerable level of suspicion … although [the Private Provider staff] also identified good practice which would suggest that any poor practice was not totally widespread.’ The meeting concluded by a review of the protection plan and agreeing a series of changes.

16. The final case conference meeting [for which minutes are available on case records] was held on the 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation in Ennis ward. The purpose of the meeting was to:

- discuss the conclusions and recommendations following the safeguarding investigation;
- discussion of updates to families/relatives of service users named in the report; and
- an update on the police investigation.

The DO noted that amendments had been made to the draft report tabled at the previous meeting and had been emailed to participants. No feedback/issues were received in respect of the amended report.

17. The PSNI advised that it could be several months before the charges against the two staff came to trial. It was recommended by investigation team that the disciplinary action commence. MAH Service Manager confirmed that this action had commenced but was at an early stage. The Co-Director Learning Disability Services recommended advice be sought from Human Resources 'before staff were spoken to'.

18. The DO noted the difficulty the investigation team experienced in weighing the 'very different evidence provided by the two staff teams [MAH and Private Provider staff]. It was not possible to identify all the staff allegedly involved in poor practice. There was not enough evidence to warrant disciplinary action against some staff due to lack of corroboration and their own differing accounts. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the Private Provider's staff's report as evidence. Uncorroborated reports being viewed as evidence was discussed. 'There was considerable discussion in relation to having sufficient evidence to support the allegations made.' It was also noted that there were discrepancies in the reports received from the Private Provider's staff in relation to induction.

19. The staffing situation at Ennis prior to the events of November 2012 was discussed as was the arrangements now in place to 'check daily staffing numbers on a daily basis throughout the hospital.' Hospital management also accepted the recommendation that 'the hospital needs to review for any practice on Ennis ward that could be deemed restrictive.' A successful bid has been made for psychology support in resettlement wards to help with meeting patients' needs. Other professional services had also commenced in Ennis Ward.

20. The impact of the investigation on Ennis staff was recognised and consideration was afforded to meeting their need for information about the investigation and its

outcome. The PSNI noted that in respect of the charges it was pursuing this could not be shared with staff but more general feedback was possible. The Co-Director, Learning and Disability Services noted that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' RQIA supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked 'to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

21. A further meeting was arranged for the 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

Case Records

22. There is evidence on the files examined that the MAH Service Manager was at times reporting to the Operations Manager and safeguarding lead. An example was in as email of the 16th November 2012 when confirmation was provided that a number of actions had been taken in line with the findings at the Strategy Meeting held on the 15th November regarding the absence of supporting evidence in respect of a student nurse and a member of staff which would enable her return to duties. The Operations Manager was asked to 'confirm the following: 'the band 6 or above is required to be supernumerary; the monitor will be on shift 24 hours per day; that they will have no substantive role in Ennis in the past 3 months, 6 months, or year can you give a time frame; will the independent monitors be in place for the 24 hour period when you make the arrangements.'

23. The Review Team had some concern that the safeguarding investigation was extending its role into managing the situation at Ennis. The purpose of a case conference is to evaluate the available evidence and to determine an outcome based on balance of probability. In complex situations a strategy discussion is convened which comprises key people who meet to decide the process to be followed after considering the initial available facts. These meetings may conclude by making recommendations to the constituent agencies involved in a specific case. The membership of these meetings is independent of the management in each of the constituent organisations. Accountability rests with individual agencies for progressing recommendations. Failure to comply with recommendations can be brought by the safeguarding lead to the attention of individual agencies for it to take remedial action, where required.

24. The Review Team noted on the 5th March 2013 that the Operation Manager emailed her line managers and the MAH Service Manager noting that while 'many of the reports [monitoring reports] continue to be very positive' she wished to meet to discuss 'the greater number of quality concerns reported' since the withdrawal of supernumerary monitors. On the 6th March the MAH Service Manager's responded stating: 'in continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing… A weekly support meeting is in place to discuss concerns. We have a number of action plans in place to address [a range of identified issues].'

25. The Operation Manager's response of the same date while noting her continued preference for a meeting asked as an alternative for copies of the action plans and for details in respect of the weekly support meetings. She also noted that from the monitoring reports she could not identify whether or not staffing levels are appropriate. It is the opinion of the Review Team that the role of the DO in this respect was not appropriate. It carried the potential to undermine the

managerial system at MAH. In the view of the Review Team reporting on compliance with recommendations was the proper way to seek to monitor compliance levels. In situations where there concerns were identified the appropriate response would have been to seek further assurances either from the MAH Service Manager or the Director of Nursing or her nominee rather than assuming what appears to have been a quasi-oversight function. There was also evidence on file of the Operations Manager being kept informed of therapeutic input in respect of individual patients.

26. The Review Team also found in the community services Ennis files a series of emails about matters such as ward keys for Ennis which did not appear germane to the safeguarding investigation. The chain of emails was copied to the Operations Manager to inform her that 'keys for Ennis have now requisitioned and arrived'. Confirmation of capital funding approval was also provided along with a detailed internal inspection schedule of the ward. The degree of apparent oversight of the Ennis ward was higher than the Review Team would have expected. The safeguarding investigation took from the 8th November 2012 until the 23rd October 2013 which is longer than one would have expected, especially given the nature of the complaints. Given the significant amount of work carried by the DO the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation.

27. The Trust arranged for its Co-Director of Nursing (Education and Learning) to engage with managers at MAH in relation to safeguarding patients in Ennis. This staff member was independent of MAH. She undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;

- consideration of progress against draft improvement plans; and
- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

A comprehensive report was produced at the conclusion of the second visit made on the 9th January 2013 which is available on the safeguarding files. This staff member was also a member of the multidisciplinary safeguarding team. As the Service Manager from MAH was not, for a period, a member of that team this staff member acted as a communications link between the safeguarding team and MAH thereby ensuring that matters identified were communicated and taken forward within both processes.

Appendix 8

Timeline in respect of Mr. B's Complaint

Date	Information
12.08.17	Member of staff (healthcare support worker) assaulted Mr. B's son (AB) a patient in PICU. The incident was witnessed by a staff nurse who reported it to the Nurse in Charge. Neither of the staff completed an Adult Safeguarding Form (ASP1). The Nurse in Charge emailed the Deputy Charge Nurse (DCN) with a request to meet to discuss 'a concern'. This meeting occurred on 17th August. The DCN considered the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN emailed the staff nurse for more details. The incident was not escalated at that time.
20.08.17	The DCN received an allegation that another patient on PICU had allegedly been verbally abused by the healthcare support worker involved in the AB incident. The DCN emailed the Charge Nurse (CN) for advice. The CN was not on duty that day.
21.08.17	The CN returned of annual leave for a late shift. The CN immediately escalated the concerns to Senior Management and requested ASP1 forms be completed on the ward. The CN reminded staff of their responsibilities under adult safeguarding arrangements. The Acting Head of Service was contacted and action discussed. The precautionary suspension of the staff member was agreed. The Adult Safeguarding Officer was notified and an interim protection plan was put in place. The PSNI and the Community Designated Officer as well as patients' next-of-kin were notified about events in respect of the incidents. A single-agency, PSNI led investigation was confirmed. The police officer stated that interviews would be scheduled following his return from annual leave 11th September 2017.
22.08.17	At 7.30 am the healthcare support worker at the start of his shift was

	placed on precautionary suspension by the Service Manager and the Senior Nurse Manager. Associate Director of Social Work, as safeguarding lead, was notified of the incident by the Service Manager.
25.08.17	On the way to a scheduled meeting at MAH to discuss the assault on his son, Mr. B contacted RQIA about the situation. RQIA contacted the Senior Nurse Manager for confirmation that the safeguarding processes had commenced. Mr. B met with the Senior Nurse Manager and the adult safeguarding officer. The timing of the meeting was to facilitate Mr. B securing support from a Carer Advocate. Mr. B was provided with details of the Community Designated Officer in case he requires any further information. Mr. B at this meeting asked if there was CCTV footage of the incident. He was told that CCTV was not operational. He did not accept this response. Mr. B made a formal complaint in respect of events concerning his son. He was telephoned on 29th August 'to confirm we have now received the email he tried to send on 25th August' (email sent to wrong address). The Senior Nurse Manager and the Service Manager held a conference call with the PSNI to clarify an approach to investigation. The police-allocated case officer gave permission for the safeguarding officer to speak to the witness of the alleged incident of 12th August 2017 on that staff member's return from annual leave on 29th August 2017.
28.08.17	Mr. B met with his MP about his concerns about the treatment of his son. The MP immediately contacted the Chief Social Services Officer at the Department.
29.08.17	Mr. B emailed seeking a response to his complaint of 25th August 2017. It sent this email to the HSC Board. Within a half an hour of receipt of this

	email, an email was sent to the Belfast Trust stating that the HSC Board had called asking had it received the complaint and asking that someone contact Mr. B by phone. His mobile number was provided.
29.08.17	Mr. B's complaint of 25th August 2017 was received by the Trust as there had been an error in the email addressed used on 25.08.17. The safeguarding lead spoke to the witness who confirmed that he had seen a shove or possibly a hit to stomach area of Mr. B's son. This was not a formal interview as instructed by the police due to the ongoing PSNI investigation. Incident of alleged verbal abuse of a patient by a healthcare worker was being managed by the designated community social worker.
29.08.17	The Directorate of Legal Services (DLS) was contacted for a legal view on accessing CCTV footage. This was subsequently followed up in writing, possibly on 4th September 2017. At some point the possibility that the incident of 12th August had been captured on CCTV was discussed by senior managers at MAH. The Review Team has not been able to identify when this possibility was initially raised, nor when the footage was first checked. It would appear however, that by 29th August 2017 there was awareness that there was CCTV footage available and the question arose of what, if any, use could be made of it. There was a belief among the staff interviewed by the Review Team that the CCTV would become operational on 11th September 2017.
29.08.17	Trust Complaint Department representative forwarded Mr. B's complaint to the Co-Director of Learning and Disability Services, noting that the Governance Lead had already advised that it would be 'investigated under safeguarding in the first instance … When the safeguarding investigation is complete, we will respond to the complaint.'

29.08.17	The Co-Director of Learning and Disability Services emailed the Governance Lead at MAH in respect of Mr. B's complaint stating: 'Not a complaint. Being investigated under safeguarding by PSNI.' The Co-Director of Learning and Disability Services also emailed the Trust's Complaints Department in response to an email from it noting that 'when the safeguarding investigation is complete we will respond to the complaint'. The Co-Director of Learning and Disability Services stated in her response: 'Complaints need to write and tell [Mr. B] it is being investigated under safeguarding.
30.08.17	The Governance Lead at MAH emailed the Trust's Complaints Department stating: 'this is being investigated under safeguarding so is not a complaint.' In keeping with the email advice she had received from the Co-Director of Learning and Disability Services.
30.08.17	The Trust's Complaints Manager replied to Mr. B acknowledging receipt of his complaint. She advised that once the safeguarding investigation had completed that 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009)'. The letter also advised Mr. B that 'a member of the Adult Safeguarding team will be in contact with you shortly.' This letter was shared in draft with MAH Governance Lead and approved by same.
30.08.17	RQIA contacted the Trust's Director of Social Work seeking assurance about safeguarding training for staff.
30.08.17	Mr. B's MP met with the Departmental Director of Mental Health, Disability and Older People to discuss Mr. B's concerns about his son's care.
31.08.17	The Trust's Complaint's Department emailed the Co-Director of Learning and Disability Services advising that, 'complaints have written out to Mr. B [on 30th August 2017] and closed down as a complaint.' The letter to Mr. B stated however, that the complaint had been set aside pending the completion of a safeguarding review.

31.08.17	A representative of the Department and the HSC Board emailed the Co-Director of Learning and Disability Services following contact from Mr. B.
01.09.17	The Service Manager prepared an SAI form in respect of the incident regarding Mr. B's son. This was returned to her by MAH's Governance Department stating that it did not meet the criteria for an SAI.
06.09.17	The DLS responded stating that as the matter was of a safeguarding nature, the Trust was at liberty to access the CCTV footage.
07.09.17	Request to Service Manager from the Co-Director of Learning and Disability Services for an Early Alert following contact with the Department. There is no reference to CCTV footage in the Early Alert. Director of Nursing and CNO advised by Service Manager of the Early Alert by the Service Manager.
08.09.17	Director of Mental Health, Disability, and Older People at Department provided Mr. B's MP with preliminary information provided by the Trust.
17.09.17	Service Manager contacted the investigating officer upon his return from annual leave. She advised him of the possibility of CCTV footage.
18.09.17	Information on staff roster forwarded to PSNI as requested.
19.09.17	Service and Improvement Manager viewed CCTV footage to check if the incident of 12th August 2017 was available.
20.09.17	Service Manager and Service and Improvement Manager viewed the footage. The matter was then escalated to the Directors of Nursing, Social Work, and Medicine. This is the first evidence of information being brought to the attention of the Executive Team and Trust Board members. Hand written notes taken by the Director of Medicine confirm the date as 20th September 2017.
20.09.17	Departmental Director of Mental Health, Disability, and Older People provided Mr. B's MP with an update based on the Trust's Early Alert and advice from Belfast Trust
21.09.17	CCTV download completed. Viewing arranged to identify patients/staff.

	Present at the viewing were the: Clinical Director, Service and Improvement Manager, Senior Nurse Manager, the Ward Consultant, the safeguarding officer and the Assistant Medical Director.
22.09.17	Meeting held to discuss concerns and their management. Chaired by the Director of Adult, Social and Primary Care, attended by Service Manager, the Co-Director Mental Health Services, and the Assistant Service Manager, Learning Disability
24.09.17	The Co-Director Mental Health Services made an unannounced visit to PICU.
25.09.17	The RQIA lead inspector for MAH updated by the Service Manager and the Clinical Director.

Report into allegations made against Moira Mannion

Background

In late 2019 the Department of Health (DoH) asked the Heath and Social Care Board (HSCB) and Public Health Agency to commission a review of Leadership and Governance at Muckamore Abbey Hospital (MAH) for the period 2012 to 2017. The terms of reference of the review sought to ascertain to what degree, if any, leadership and governance arrangements in the Belfast Trust contributed to the abuse of vulnerable patients going undetected. A team was appointed in January 2020 to carry out the review. The team completed its work in July 2020 and its report was published on 5 August 2020.

During the course of its work the review team became aware of allegations made by Aine Morrison in 2019 against Moira Mannion and other members of staff. These allegations related to the events surrounding the “Ennis Investigation” that was carried in 2012/13. Allegations had been made in November 2012 regarding the abuse of several patients in Ennis Ward at Muckamore Abbey Hospital. At that time Aine Morrison was then Operations Manager in the Belfast Trust’s Learning Disability Service with responsibility for community multidisciplinary learning disability teams. On hearing of the allegations Aine Morrison stepped in to take on the role of Designated Officer (DO) and led the investigations into the allegations of abuse.

Moira Mannion was employed by the Belfast Trust for 12 years and retired from her substantive post in 2019 as Deputy Director of Nursing. She was subsequently brought back to the Trust as a Senior Nurse Advisor from November 2019 to support the Trust investigations into more recent allegations of abuse at MAH. Moira voluntarily stood down from this role when she became aware of the allegations made by Aine Morrison.

The Review Team

The Review team in its report gave extensive coverage to the investigation into allegations relating to Ennis Ward. The team interviewed Aine Morrison and Moira Mannion several times during its review but concluded that it could not deal with the disputed claims of either party in its report as they fell outside its terms of reference. It has been agreed with the review team and the Belfast Trust that the Chair of the Review Team would write to the Trust on this matter and provide his own views on the disputed allegations.

The Allegations

Aine Morrison provided a 9-page written account of her experiences in acting as the DO into allegations of abuse on Ennis Ward at MAH. This account was given to the review team in February 2020. It appears to have been written in December 2019 in anticipation of a review team being appointed. The review team understands that it was also given to the Belfast Trust. It contained a number of allegations against

other members of staff. The allegations as they relate to Moira Mannion can be summarised as the follows

- She was hostile to the DOs investigation including the monitoring plans that Aine had made for Ennis Ward,
- She opposed DOs view of the patient care plans,
- She opposed the Dos protection plan,
- She did not provide the DO with adequate support throughout the investigation,
- She claimed that nurses could not have been involved in abuse.

In all there were 10 allegations where Moira Mallon was named or it was inferred that she had a role. Moira Mannion provided the Trust with a detailed response to the allegations. She also provided the statement to the Review Team.

From the outset the written statement made by Aine Morrison raised several questions. The main question being why was it written some seven years after the events that it alleged. Aine was asked about this by the review team but failed, in their view, to give an adequate explanation. The team also found that the Ennis investigation, which she led, took an extensive period of time to complete which diluted its impact. The report of the investigation was not brought to the attention of the Trust Executive Team or Board.

The review team in its report stated that the DO appeared to have an oversight function in respect of the operation of the Ennis Ward during the period of investigation It was their opinion that this was not appropriate and had the potential to undermine the managerial system at MAH.

Moira Mannion, was seconded from her role as Co-Director of Nursing (Education and Learning) to MAH in the aftermath of the allegations with responsibility to monitor nursing practice and to analysis information and provide support to the Service Manager at MAH.

The Review recorded in its final report that “She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provide of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided ongoing assurances to the Trust.”

Conclusions

Although the Review Team did not comment in its report on the veracity of the claims made by Aine Morrison against Moira Mannion it did gather information, which I have used in reaching my conclusions.

Firstly, there is the matter of why these claims against Moira Mannion were documented some seven years after the event of the Ennis Investigation. There is no

record or hint of them being made at the time of the Ennis Investigation. The time gap and the apparent need of the author of the allegations to get her side of the story on record some 7 years later does not lend credibility to the allegations.

Secondly the Review Team found that the DO exceeded her brief in becoming operationally involved in the running of Ennis Ward. This may have brought her into conflict with other managers including Moira Mannion. The DO should have concentrated on completing the investigation in a timely manner.

Thirdly the Review Team found that Moira Mannion's input to MAH at the time of the Ennis Investigation was carried out in a professional and caring manner. There was no evidence that she sought to undermine the claims of abuse originally brought by the staff from an external agency. There was evidence that she made unannounced leadership visits to MAH, that she reviewed samples of patients notes, medical files and the drug Kardex. A more detailed account of her actions is included in section 8 of the Review Teams report.

Following her interview with the review team, the team concluded that her evidence was credible, clear and demonstrated a high level of integrity. Exercising professional judgment, it was the view of the nurse on the review team that Moira Mannion had exercised both professional leadership and professionalism throughout her role in the Ennis investigation.

In summary I would conclude that there is no evidence to uphold the claims made by Aine Morrison against Moira Mannion. It would be wrong to leave these allegations unchallenged. I believe that given the evidence that was collected during the Review Teams work the allegations can be refuted. It would be wrong to have such allegations hanging over the long and distinguished career of Moira Mannion. I believe she carried out her duties at MAH in 2012/13 (and later) in a professional manner that served the interests of patients and the Trust.

David Bingham August 2020

Synopsis of Ennis Report

This is a synopsis of the Adult Safeguarding Investigation Report regarding Ennis Ward completed by Aine Morrison, Collette Ireland and Carmel Drysdale on 23.10.13. The report provided did not have appendices attached.

Background:

The investigation was initiated because of a complaint by a staff member from Bohill Care Home who had been working into the ward in preparation for patients to be resettled into the community. The complaint related to allegations of a physical and verbal nature in respect of 4 patients.

7 initial allegations were made on 8.11.12 relating to 4 patients (although other parts of the report state 8.10.13). The allegations against 2 staff (H159 and H197) related to physical abuse and verbal abuse. A complaint was also made against a student nurse (H198) in respect of verbal abuse.

Investigation:

The investigation consisted of the following:-

1. **Interviews with staff from Bohill**

Nine staff were interviewed by the Trust and a number of interviews were also conducted by the PSNI. A number of themes emerged from the interviews with Bohill staff:-

- 22 incidents of Physical abuse of patients were identified. These included: pulling a patient from sofa onto floor; patient was witnessed screaming and accusing a staff member of hitting her and there was evidence of blood coming from her mouth; pushing a patient so hard into a chair that she hit her head off back of chair; not intervening when patients hit other patients; pushing/pulling backwards or grabbing clothes and wrists of a patient. (Staff involved were H159, H197, H205, H198 and unidentified staff)
- 10 incidents of Verbal nature e.g. shouting into patient face, condescending, shouting 'get out of my way', threatening a patient she would not get sweets /lemonade unless she put her clothes on, encouraging a patient to hit a fellow patient back (staff involved reported as H159, H197 and H198).
- 16 concerns raised about the management of behaviour of patients e.g. threats to not provide meals in order to manage behaviour; encouraging a patient to hit another who had assaulted her; not to give patients too much attention as they would want it all the time; making a patient sit in a chair with her legs up and restricting her ability to get out of it; belt tightening and; patient placed outside in rain.
- Lack of supervision of patients e.g. patients left unsupervised, patient left sitting outside in rain.
- Poor induction of Bohill staff e.g. care plan was inadequate and did not inform staff how to manage patients behaviour.

- Other issues e.g. management of meal times; patient had sore head and staff refused to give her a tablet as she hadn't eaten her dinner; putting two pads on patients; lack of stimulation and warmth on ward; lack of staff engagement and interaction with patients.

2. Patient interviews

There was limitations to the interviews conducted. Only 3 patients deemed to have capacity to participate in interviews. The first patient interviewed was in relation to an incident she had reported to her brother that staff member (H198) had grabbed her 'by the scruff of her neck and took to her bedroom. She said it was a 'jokey comment.' The second patient interviewed 'recalled her dinner scraped into the bin as she didn't like it and being refused a sandwich as an alternative' but could not identify the staff member. One other patient reported no concerns.

Other capacious patients were not interviewed because their family objected.

3. Contact with Relatives

7 families were contacted and on the whole raised no concerns. The following issues however, were raised-

The relative who had been advised by his sister that staff member (H198) had 'grabbed her by scruff of neck' felt his sister would not 'tell lies...and may not say anything that would get her into trouble'.

Another relative raised concerns regarding: low staff levels; lack of supervision of patients including an incident when 3 staff sat at a dining table chatting and not supervising a patient; patient was shabby in appearance- holes in cardigan; and one patient not allowed to go to Mass because of her behaviour.

Another relative was concerned about the number of times a patient had been assaulted by fellow patients.

4. PSNI Interviews

All staff interviewed denied the allegations however; the PSNI referred two staff (H59 and H197) to the PPS with a recommendation for prosecution.

In relation to first staff member (H59):

1. Two counts of common assault and ill treatment, one relating to fastening a belt tightly and putting a patient outside a fire door and the other pulling a patient from the sofa onto the floor.

2. One count of ill treatment - leaving a patient to sit outside without appropriate protective clothing on.

3. One count of assault occasioning actual bodily harm and ill treatment- Hitting a patient and blood was seen coming from her mouth.

In relation to the second staff member (H197):

1. Five counts of common assault and ill treatment relating to: fastening a belt tightly and putting a patient outside a fire door; grabbing a patient by the jumper and told to "Get the F* out of my face" and then pulling the patient across the room and pushed on to a sofa; pushing a patient into a chair causing her to hit her head of the back of the chair; unknown patient pushed onto a chair, blood wiped roughly from her mouth using a personal hygiene mitt.

2. Two counts of ill treatment: Patient left to sit outside without appropriate clothing on and; failure to intervene when a fellow patient was being assaulted.

5. Social services interviews of the involved staff

Four of the staff (H203, H205, H206 and H198) alleged to have been involved in some incidents where interviewed by the investigating team. They all denied the allegations made.

a. Bohill staff reported that 2 staff members (H203 and H205) were involved in pushing a patient, and 'yanked at her belt forcefully.' The investigating team concluded that the allegations could not be confirmed 'as there were no witnesses and MAH deny belt tightening practices.'
b. Another staff member (H206) was reported to have witnessed another staff member (H197) pushing a patient onto a sofa. The staff member denied any recollection of the incident.
c. Allegations regarding staff member (H198): grabbing a patient by scruff of neck- this was explained as 'a joke'; leaving patient unsupervised resulting in Bohill staff being assaulted – this was explained as staff shortages and; shouting at patients– this was unconfirmed as there were no witnesses.

6. Interviews with ward staff

8a, Band 7, Band 6, Band 5, Band 3, Band 2, Speciality Doctor and a Consultant Psychiatrist were all interviewed. All those interviewed raised no concerns about staff attitudes towards patients or of the quality of interaction with patients; or the quality of care provided to patients; however, they raised a number of concerns regarding staffing levels, removal of the ward transport and the physical environment of the ward.

7. Review of previous concerns

There was one previous incident reported in May 2012 by a Day care member that a Band 2 Nursing assistant from Ennis handled a patient roughly and was threatening towards them. This was investigated by the PSNI who took no further action and the Trust referred the matter to ISA but the staff member left the Trust before any disciplinary action took place.

8. Review of care plans

RQIA found that in the case of one patient the support plan was not detailed to her specific requirements.

Conclusions:

1. The investigating team acknowledged that 12 Bohill staff were consistent in their accounts but accepted that no concerns regarding care had been raised by MAH staff. The investigating team 'acknowledged that Bohill staff where working in a new environment were the context of some actions may not have been clear to them.. they were coming from a newly built.. environment in contrast to an older style hospital'. The investigating team "recognises...it can be difficult for (Ennis) staff team... to come forward with concerns about their own practice. However, the investigating teams experience is that this has happened in other investigations and therefore gives some weight to the fact that no MAH staff reported any care concerns. The investigating team also noted the apparent genuineness and caring attitude shown by MAH staff in their interviews".

2. 'Investigating team believe that of the named staff (apart from the two referred by the police) that there is not enough evidence to warrant disciplinary action against any of them..... (they) also believe that there is no way of knowing who, if any, of the other staff were involved'.

3. 'The investigating team .. in Ennis has changed substantially since the investigation began with approximately have the staff being new to the ward. While the investigating team is unable to draw definitive conclusions on many of the allegations, if there had been wider issues about practice on the wards the team believe that this would now be an important protective factor'.

4. As a result of positive comments made by monitoring staff about the care provided since the allegations were made the investigating team concluded that the 'current ward staff have the skills and abilities necessary to provide good quality care'.

5. 'The reports of staffing difficulties may have meant that it was difficult to manage the patients waiting outside the dining room.. (they) felt it was possible that visiting staff may not have known the rationale behind this routine'.

Recommendations:

1. MAH should pursue a disciplinary investigation in relation to the conduct of two staff ([redacted] and [redacted]).

2. The team recommended that all wards in the hospital are reviewed by staff external to the ward to see if any environmental changes are needed.

3. The investigating team recognise that there was an action plan in relation to the overall staffing crisis in MAH at the time which included Ennis, but recommend that hospital senior management review their response to these two specific incident reports to see if this was appropriate.

4. Staff from other facilities working into MAH should have a proper induction.

5. Two patient specific recommendations were made in respect of what criteria staff use for considering a referral to specialist behavioural support services and to review practice that could be deemed restrictive.

6. The staff team would be provided with some information in relation to the nature of the current investigation including the outcomes, conclusions and recommendations.

7. Staff at all grades including medical staff should receive appropriate adult safeguarding training.

8. Resettlement patients should have access to a full range of professionals.

Review of Ennis Investigation 2012

Family contact

In November 2012 medical record reports show that there were 31 patients staying on Ennis ward. This review showed evidence of

Telephone contact with the family of the 4 patients who the allegations referred to, there is a written recording in each of their notes showing they were contacted on 08/11/2012

There are meeting minutes noting that all NOK for patients on the ward should be contacted to be made aware of the allegations. This is recorded on the 9 November 2012 and confirmed at later minutes. This could only be checked by retrieving all patient files from November 2012.

11/31 patients had no NOK recorded or NOK was deceased.

6/20 patient who had NOK recorded were not contacted but no reason is recorded

There was contact made with the NOK of 3 additional patients who do not appear on the medical records report

There appeared to be good contact and regular updates with 14 NOK

In November 12 it was agreed that the NOK should have a letter sent to them providing further update, there are several entries on the table that shows a reluctance to send a letter to NOK. These letters are referenced up until the 28 December 2012 but there is no evidence of them ever being sent.

Delays in process

It is evident that the police investigation was lengthy, it was 142 days after the incident when the PSNI submit their report to the PPS recommending prosecution of 2 people involved.

Information available spans over 1259 days (3.5 years)

01/07/2013 236 days after incident – ER commissions leads for internal investigation

19/09/2013 Email from RS that internal investigation will be starting 316 days after incident

04/10/2013 PPS taking forward prosecution 331 days after incident

23/10/2013 Safeguarding report finalised & circulated 352 days after investigation

22/11/2013 ToR agreed for internal investigation 370 days after incident

19/05/2014 Bohill staff interviewed for internal investigation 571 days after incident (all statements and dates of meetings were not available)

April & May 14 Ennis staff investigation meetings 525-555 days after incident (all statements and dates of meetings were not available)

To note

- The initial investigation was detailed but it appears not all information gathered throughout the investigation was included in the Safeguarding report e.g. 7 concerns raised by a family member as part of telephone updates, a decision was taken to investigate these separately even though the issues raised would fall under safeguarding concerns. I can find no evidence that this was investigated or actioned.
- The Safeguarding report does not reflect a picture of the seriousness of the concerns raised by Bohill staff but it is evident that the investigating team faced challenges regarding their use of Bohill staff statements as evidence. There was a push to focus on the positive changes that had happened since the allegations and there were requests made to remove monitoring within the ward a matter of weeks after the allegations. From the outset there appeared to be reluctance to consider the possibility that there were cultural issues within the ward and that institutional abuse was a possibility. It is not possible from the records made available to track feedback on the various drafts of the report and what changes were made.
- There were various sources of evidence gathered throughout the investigation that when viewed together could have provided a bigger picture of the concerns within this ward – 1. Monitoring reports prior to the allegations, 2. the full description of the culture within the ward provided by Bohill staff, 3.seven concerns raised by a parent, 4. RQIA inspections findings, 5. an allegation previously reported by a day care staff member and 6. Reference to some Ennis staff behaviour during the investigation (one raised by Northern Trust staff member who was meeting with one of the patients involved).
  Each investigation looked at each allegation separately and didn't consider that although maybe only one person witnessed or reported single events there were consistent themes of the types of allegations across all those interviewed. Bohill staff also talked positively about practice and care in other MAH wards, this was not considered in weighing up the balance of probability that there were cultural concerns within Ennis ward. Most of the allegation investigation outcomes reference that there would be no reason for Bohill staff to make up these allegations and that their statements were credible yet each outcome was that the allegation could be substantiated.
- There are statements within each investigation reports saying that some Bohill staff had no concerns, in particular in the internal investigation report under some of the allegations listed the report references 3-4 Bohill staff having no concerns, yet their statements provided for the Safeguarding interviews refers to ' a culture of shouting', 'shocking, institutionalised, pushing patients, it was like a zombie movie'
- Some evidence provided by Ennis staff is contradictory to other sources of information e.g. in the internal investigation report it states 'All staff who worked shifts during the day were able to identify a range of activities ' Yet monitoring reports, RQIA reports, statements etc. all talk about the ward being short staffed and the lack of activities.

Descriptions within Bohill staff statements – consistent themes

Staff not approachable

Staff gossiping

Seemed to be the done thing

Found things strange

Wasn't pleasant, didn't get a homely welcome

Not much staff input

Old fashioned, dark and gloomy, not homely

Patients faces pressed up against the window of the dining room, watching others eating.

Staff always shouting

Threw patients shoes away to keep her entertained

Not good care plan recording

Culture seems its ok to shout, felt the ward was horrendous

Force used

Dismal, no sense of happiness, dark, no one appears happy, not much interaction, unwelcoming

Not a lot of love or compassion from staff

Swearing

It's like a prison, confined space

Shift depended on what staff was on, younger staff were more interested and did more with patients.

Veitch, John

From: Crutchley, Cynthia
Sent: 28 January 2013 14:02
To: Veitch, John
Subject: RE: Ennis investigation

John – yes happy to meet – I have now spoken to June Turkington and can give you her opinion

Cynthia

From: Veitch, John
Sent: 25 January 2013 16:24
To: McNeany, Barney; Crutchley, Cynthia
Cc: Harris, Lesley
Subject: FW: Ennis investigation
Importance: High

Reference recent discussions I think it would be extremely helpful if 3 of us could meet for an hour as early next week as possible and certainly before next strategy discussion next fri. I shall Lesley to check 1st thing Mon to try to confirm an arrangement.

Thanks

John

From: Morrison, Aine
Sent: 24 January 2013 13:46
To: Veitch, John; McNeany, Barney
Subject: Ennis investigation
Importance: High

John/Barney,
See below for info,
Aine

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

From: Hegarty, Deirdre
Sent: 24 January 2013 12:36
To: Crutchley, Cynthia
Cc: Morrison, Aine; Hegarty, Deirdre; Kernaghan, AnnC
Subject: Request for legal advice
Importance: High

Cynthia,

At the last Muckamore case conference, a further discussion took place in relation to the Adult Safeguarding investigation's previous request for information
in relation to any disciplinary investigations relating to staff working on Ennis Ward. I had updated the meeting re HR's position that Adult Safeguarding investigations would only be provided with information in relation to staff subject to current disciplinary sanctions and that information re spent disciplinary sanctions would not be provided.

John Veitch was present at the case conference and has asked that I go back to you to request that the Trust seek legal advice in relation to this issue.
Our concerns are that in order for a comprehensive adult safeguarding investigation to take place, information from a range of sources is required, including records from previous vulnerable adult investigations, accident/incident records to name but a few. The information in relation to any disciplinary investigations (current or spent) is seen as directly relevant to inform the present adult safeguarding investigation.

With reference to Muckamore there are serious and significant allegations re staff being investigated.
There is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis Ward is relevant in establishing both the current
position and determining whether there are issues in relation to patterns and trends.

In relation to John's request for legal advice could I ask that you take this forward as you relate specifically to a named legal person in relation to Employment Law issues. In terms of the legal advice it would be good to have a couple of specific questions answered which will help inform this current adult safeguarding investigation and future adult safeguarding investigations:

1. Current adult safeguarding investigation relates to regional hospital for patients with severe learning disability, many of whom have very
significant communication difficulties. Given the specifics of the above referral can we obtain required disciplinary information re all staff working in Ennis Ward?

2. If this cannot be accessed and in order to progress the Adult Safeguarding investigation can we at least obtain required disciplinary information re named staff presently under investigation?

3. In general terms where Adult Safeguarding investigations involve staff a full understanding of past employment history is essential to ensure a comprehensive investigation is conducted. This is particularly relevant when the vulnerable adults may have a range of communication difficulties and therefore have limited ability to contribute to the investigation. The Trust has a duty of care to ensure that all measures are taken to complete a full and detailed investigation, as well as ensuring the protection of the vulnerable adult and any other vulnerable adults who may be at risk.
Therefore the broader question is whether is it reasonable to expect this information to be provided if it is required as part of the protection planning within any Adult Safeguarding investigation, present or future?

I would appreciate if HR could seek the necessary legal advice. The next Muckamore case conference is on the 1st February and if would be very helpful if we could confirm the Trust position by this date.

Regards
Yvonne