MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY 4TH MARCH 2025 - DAY 122

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THE INQUIRY RESUMED ON TUESDAY, 4TH MARCH 2025 AS FOLLOWS:

CHAIRPERSON: Good morning, thank you. Good morning, Mr Robinson.

CLOSING SUBMISSION - MR. ROBINSON:

MR. ROBINSON: Morning, Sir, morning, members of the Panel. I appear with my learned friend, Ms. Eilis Lunny on behalf of the PSNI and we are instructed by CSO. We are grateful this morning for the opportunity to make closing submissions to the Inquiry.

We had the privilege of addressing the Panel in June 2022 and we recognise that the families are at the heart of this Inquiry. We would again wish to recognise their determination, their drive and their dignity throughout these years.

The investigation under Operation Turnstone has examined over 300,000 hours of CCTV. To date 274 members of Muckamore Abbey Hospital staff have been triaged, 97 have been interviewed, 68 files have been submitted to the Public Prosecution Service and there are two further files awaiting submission.

The first eight staff members to be charged have been committed for trial at the Crown Court in Laganside and

a further eight await committal to the Crown Court in the coming weeks.

Sir, when reading and hearing the evidence of the families, one could not imagine trying to carry even an ounce of their pain through this time. The senior investigating officer and dedicated officers of the Op Turnstone team have helped as best they can. They've helped them walk through both the criminal justice proceedings and the Inquiry proceedings. We say it's important to place on the public record that relationship. The police team value their open, transparent and supportive relationships with the families that have been affected by the issues discussed and considered by this Inquiry. 10:05

Since 2017 the police have worked closely with the families, supporting them in every way that they can. And what does that actually mean in practice? That ranged, Sir, from initial individual officer contact with the families and it has evolved into an understanding that a bespoke family liaison strategy would be required to manage and co-ordinate communications with them. 10:06

It has been of the utmost importance to the PSNI that the families are updated in a consistent, timely and compassionate manner. Each family has a named officer to update them and act as a point of contact to answer

any questions they may have.

As the Op Turnstone investigation enters its seventh year, the PSNI Family Liaison Officer or FLO strategy has proven effective and beneficial with many families continuing to reach out to their PSNI contacts for information and support, even after their loved ones have successfully been resettled in the community. 10:07

The police recognise that criminal proceedings can be difficult, confusing and overwhelming to navigate. All the members of the Op Turnstone team have gone to considerable lengths to support the families in court. There are two dedicated Op Turnstone Detective Sergeants who have attended every court hearing and mention alongside the family members and are always on hand to explain proceedings due to the unprecedented size and complexity of the investigation. 10:07

PSNI would also wish to acknowledge and thank the small team of experienced social work professionals who have concurrently been working as family liaisons appointed by the Trust. The PSNI has formed a very positive working relationship with the group based on their respective and complimentary aims of achieving the best possible criminal justice outcomes and supporting the patients and their loved ones in understanding and recovering from their experiences at Muckamore Abbey Hospital. 10:07 10:08

The Inquiry has heard evidence from several of these dedicated and compassionate professionals and the PSNI would wish to acknowledge the legacy of compassion and advocacy left by the late Geraldine O'Hagan who will not be forgotten by the PSNI officers who had the privilege of working with her. The PSNI echoes the moving tributes conveyed by the family representatives at hearing yesterday. 10:08

Moving, Sir, to the engagement with the Inquiry. It is highly unusual to hold a public Inquiry whilst there is an ongoing live police investigation. In the Hyponatraemia Inquiry the proceedings were paused pending the outcome of the police investigation and that took a number of years. 10:08 10:09

There have been significant complications arising in relation to disclosure obligations, obligations under PACE and the navigation of those issues has been something that the PSNI has been focused on along with your team. 10:09

In our opening submissions we urged all parties to jealousy and robustly guard the investigation and we can say that that has been answered in a collaborative and effective fashion. 10:09

We have had the benefit of the memorandum of understanding between the PPS, the PSNI and the

Inquiry. We have met regularly to review that process, to address evolving issues, all with the fundamental aim of protecting the integrity of the criminal process.

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It will not be a surprise to anyone in the room that on multiple occasions the Chief Constable has announced that the PSNI is facing a resourcing crisis, and those words are not said lightly. Notwithstanding that, the PSNI has engaged to the fullest degree with the Inquiry and that is in tandem with servicing the largest UK safeguarding investigation.

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The PSNI has provided significant volumes of the investigative material to the Inquiry for its consideration which demonstrates the PSNI's commitment to transparency and accountability in this process.

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Further assistance has been evidenced through the reviewing of thousands of pages of material in advance of oral hearings so that the police can consider moving an application for a restrictive reporting order, again to ensure the integrity of the investigation. All of this has been undertaken whilst making progress with Op Turnstone, but also assisting and supporting the PPS in the administrative tasks of preparing matters for trial.

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Given that it is a small team within the Public

Protection Branch, they have also been frequently required to assist with operational matters. At all times the police have sought to balance transparency, assistance and disclosure with the ongoing demands of operational need. 10:12

I'll touch, Sir, on two issues that arose during the evidence and they relate to patient safety and supervision of Muckamore Abbey staff. It was suggested during evidence heard by the Inquiry that within the 10:12 context of Operation Turnstone in particular that Trust colleagues tasked with the supervision of staff under investigation were not given sufficient information to allow for effective supervision and safeguarding. With respect, the PSNI refutes this suggestion. It is clear 10:12 from the evidence that the Trust had the footage and carried out viewing of the footage. It also had the viewing logs and associated records pertaining to their staff. Therefore, the police say that the Trust was in possession of all the information necessary to ensure 10:13 appropriate safeguarding of patients.

In addition to having the specific footage of the incidents, the Trust had their own policies to apply and ought to have advised their supervisors of what was 10:13 expected.

We make the further following observations:

The alleged offending for which all Muckamore Abbey

staff have been investigated falls within four discrete categories, namely willful neglect, ill-treatment, false imprisonment and fraud or forgery in respect of medical records. The Trust supervising colleagues from a professional background within the Trust should have no difficulty in identifying actions that amount to ill-treatment or willful neglect of patients, nor any difficulty in identifying inaccurate or misleading records. It is also reasonable to expect a supervising member of staff to ensure adherence to the Trust's own policy on seclusion without the need for PSNI instruction. 10:13 10:14

On the issue of suspensions it has also been suggested that large numbers of suspensions in 2020 and 2021, as the police investigation progressed, may have led to unsafe staffing levels within the hospital placing patients at further risk. Whilst the PSNI is not blind to the issue of resourcing challenges brought about by staff suspensions, once CCTV has been viewed and a staff member is suspected, based on that viewing, of criminal behaviour towards a patient, we say it would present an untenable risk to allow the staff member to continue to have access to patients. The staffing levels are not a matter for police, they are a matter for the Trust. The alternatives to suspension would be permitting someone to have continued access to patients whilst under suspicion. This would obviously compromise the safety of patients. We have included in 10:14 10:14 10:14

our submissions that the staffing levels are an issue for the Trust and not the responsibility of law enforcement.

The Inquiry and Core Participants have had access to written evidence from Dr. Cathy Jack, reaffirming responsibility for staffing at Muckamore and assuring the Department of Health that safe staffing levels were and would be maintained. In evidence given to the Inquiry on 16th October 2024, Dr. Jack's evidence states that it would be indefensible from a Trust position to keep staff on the wards if they were seen to be abusing staff and she further confirms that issues within staffing in Muckamore Abbey Hospital went beyond Op Turnstone related suspensions. 10:15 10:15 10:16

In submissions we referred to a question posed as to whether the police investigation took precedence over the protection of patients. We say that's a helpful vehicle to clarify the PSNI position in relation to safeguarding. 10:16

The steps taken by the police and the PSNI investigation serves to protect patients by ensuring they are not in the care of staff members who are suspected of mistreating them. 10:16

In our submissions we also talk about the alternatives which would have been bail for the entirety of the

investigation. We also say that it's worth noting that in all versions of the Joint Protocol it is the local health Trust which is charged with taking the lead on safeguarding, whilst PSNI takes the lead on investigations. That is in accordance with the skill sets of both agencies. 10:17

We also say that safe staffing levels can be considered by the RQIA who have conducted inspections at the hospital during the lifespan of the investigation. 10:17

The Panel has heard from the Detective Chief Superintendent Fisher who detailed the challenges both in identifying and investigating adult safeguarding offences in Northern Ireland over the last two decades. 10:17 There can be no doubt that historically there have been significant barriers to the successful detection and prosecution of offending against the most vulnerable members of society.

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What the PSNI has tried do through its evidence to the Panel is provide an overview of the improvements and evolution of the Joint Protocol. We've described the collaboration with the Department of Health and Department of Justice to promote the use of registered 10:18 intermediaries and there is also further ongoing work with the Department of Health in relation to the Adult Safeguarding Bill.

The PSNI is fully engaged in these steps to make Northern Ireland a safer place for members of the community with learning or mental health disabilities.

We also say that it is important to put on the public record the steps the PSNI have taken. There are 12 dedicated Adult Safeguarding Officers within the Public Protection Branch. The PSNI has also put in place additional training to all uniform and student officers to recognise and respond to adult safeguarding incidents and concerns. This has resulted in steadily increasing positive criminal justice outcomes. 10:18 10:18

Within the Public Protection Branch there now exists, Sir, a dedicated adult safeguarding policy role in recognition of the importance of skills, development, training and consistency across Northern Ireland's five Trust areas. 10:19

The adult Safeguarding Policy Sergeant also plays a key role in supporting the PSNI's Adult Safeguarding Lead in the development of Northern Ireland's first Adult Safeguarding Bill and also is heavily involved in related work streams, for example the review of the Adult Safeguarding Joint Protocol. 10:19 10:19

If I may, Sir, address the issue then of CCTV. But for the discovery of the CCTV in August 2017, none of us in the room would be here. We say that the

presence of CCTV affords the most vulnerable additional protection and ensures they have a voice in the criminal justice process. The PSNI has read and understood and listened to the family's submission calling for mandatory CCTV and the PSNI supports that. 10:20

The PSNI have put in the submissions that it is disappointed that there is no provision within the Draft Adult Protection Bill for the mandatory installation of CCTV in settings where care is 10:20 delivered to those with severe learning disability or mental health needs and trusts that the Inquiry will consider this important issue when making their recommendations.

10:20

Without that CCTV there would be no police investigation, no prosecutions, no public knowledge or awareness of the issues uncovered in Muckamore Abbey Hospital and the conclusion of that would be the circumstances giving rise to the allegations of abuse 10:21 may indeed be continuing to this very day. That has been said before to this Inquiry, but we say it loses nothing in repetition.

In conclusion, and my submissions this morning have 10:21 been brief, Sir. In conclusion the PSNI has dedicated significant resources to the investigation, to the Inquiry and to the assistance of the families. We have sought to act with transparency, accountability and

co-operation at every stage of this process, balancing safeguarding responsibilities and the need to preserve the efficacy and integrity of the police investigation.

Our final point, Sir, is that the PSNI is a learning organisation and we welcome any recommendations that will assist the police in improving the provision of care to adult safeguarding issues and those most vulnerable in this society. Unless there is anything further. 10:22

CHAIRPERSON: Thank you very much indeed, thank you. That is slightly shorter than we had timetabled for. The next speaker will be Mr Neeson. Is there any reason we shouldn't start that, if we take a short break and allow people to move around. 10:22

INQUIRY SECRETARY: [Inaudible].

CHAIRPERSON: We are going to waste otherwise 45 minutes. Is there any way of alerting people?

INQUIRY SECRETARY: [Inaudible].

CHAIRPERSON: We'll wait until 11.15. Okay, thank you. 10:23

AFTER A SHORT ADJOURNMENT THE INQUIRY RESUMED AS FOLLOWS:

CHAIRPERSON: Yes, Mr Neeson. 11:16

CLOSING SUBMISSION - MR. NEESON:

MR NEESON: Yes, thank you, Sir, members of the Panel.

I provide these submissions on behalf of the RQIA. I appear with Mr Lyttle instructed by DWF solicitors. I should say that the Chair, Ms Collins and the Chief Executive, Ms Donaghy are in attendance.

11:17

First of all the RQIA wishes to restate its acknowledgment in respect of the suffering and distress experienced by the victims of abuse in Muckamore Abbey and the devastating impact upon their families.

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RQIA acknowledges the bravery and dignity of those who have come forward, the victims and their families, to assist the Inquiry in meeting its aims.

RQIA has sought to engage actively and thoroughly with 11:17
the Inquiry and has listened intently to the evidence. RQIA wishes to express its thanks for the invaluable assistance received from its employees, both past and present, in presenting evidence to the Inquiry.

11:18

A full written submission has been submitted. It is not my intention to read that submission in full, there are certain aspects of that which will be better dealt with by way of summary in ease of those people listening. 11:18

The RQIA wishes to arrange its submissions in the manner described within its written statement and does so really in seeking to address the themes which it

believes have emerged from the evidence, from questioning by the Inquiry, its legal team and the Panel.

The Terms of Reference identify the core objectives of the Inquiry as examining the abuse of patients at Muckamore, determining why the abuse happened and the circumstances in which it did and seeking to ensure that such abuse does not occur again within any other institution providing similar services in Northern Ireland. 11:18 11:19

In seeking to achieve those objectives, the Inquiry will consider whether the abuse resulted from systemic failings within Muckamore Abbey or within the wider healthcare support system in Northern Ireland. 11:19

With particular interest to RQIA, the Terms of Reference direct the Inquiry to consider the operation of supervisory and regulatory agencies and to examine the response of a number of bodies, including the RQIA, when allegations of abuse of patients at Muckamore Abbey were reported to them. 11:19

RQIA welcomes the Inquiry's investigation into the reasons for the abuse experienced by patients within Muckamore and the Inquiry's opportunity to provide recommendations which may serve to safeguard patients entrusted to the care of mental health and learning 11:19

disability services.

The organisation has provided evidence to the Inquiry in the form of witness statements augmented by oral evidence. Evidence was provided by Ms Donaghy, the Chief Executive, Ms. Lynn Long, the Director of Mental Health and Learning Disability in Prison Healthcare. Ms Wendy McGregor, the Assistant Director of Learning Disability in Prison Healthcare. Mr Guthrie and Ms Cullen provided a statement, although was not called to provide oral evidence. 11:20 11:20

In addition the Inquiry has received substantial disclosure from RQIA relevant to the timeframe identified within the Terms of Reference. 11:20

The RQIA is the independent health and social care regulator, a non-departmental public body of the Department of Health of Northern Ireland. It is accountable through the Permanent Secretary of the Department to the Health Minister. The Inquiry has already received considerable evidence in respect of the evolution of the statutory duties and powers of the RQIA under the 1986 Order and the Health and Personal Social Services Order (Northern Ireland) 2003 and I do not propose to repeat those in any detail here. They have been set out within the written submissions and have been received in significant detail in Ms. Donaghy's first statement to the Inquiry. 11:21 11:21

It is worth, however, repeating that from the 1st April 2009 RQIA assumed statutory responsibility for the functions previously exercised by the Mental Health Commission under the 1986 Order. Until that transfer RQIA had no function or powers under the 1986 Order and prior to assuming the function of the MHC, RQIA discharged its role in relation to hospitals operated by HSC Trusts solely under part four of the 2003 Order. 11:22

As Ms Donaghy's first statement made clear, RQIA's role and powers differ depending on whether or not the relevant establishment or agency is required to be registered with RQIA. In the former case RQIA has the power to take enforcement action against registered services up to and including cancellation of registration. Hospitals, including MHLD hospitals that are operated by HSC Trusts, are not governed by part three. However, in respect of those institutions, RQIA is under a duty to review and inspect HSC Trusts and the services they provide with particular reference to their adherence to the statutory duty of quality. 11:22 11:22 11:23

Similarly, significant evidence has been provided to the Inquiry in respect of the powers available to RQIA specific to Muckamore and MHLD facilities. These need not be repeated in full, however arising under the 2003 Order, particularly in relation to Muckamore, the RQIA had available the following methods of seeking to ensure compliance: 11:23

The power to provide information relating to the service which RQIA considers necessary or expedient to have for the purposes of its functions.
The power to enter and inspect premises which are used by a service and inspect and take copies of any documents or records. 11:24
The power to require HSC Trusts to provide RQIA with information which it considers necessary or expedient to have for the purposes of its functions.
The power to recommend that the Department implement special measures in relation to the body or service provider in question with a view to improving the health and social care for which it is responsible. 11:24
And finally the power to serve an Improvement Notice in accordance with Article 39 of the 2003 Order which will require a service to take steps within a specified time period where it has failed to comply with the statement of minimum standards published by the Department. 11:24
The nature and extent of the RQIA's duty under Article 86 has been provided elsewhere and I don't propose to repeat that, save to observe that it is under a duty to keep under review the care and treatment of patients. 11:25

Ms Donaghy explained in her evidence that the purpose of the inspection is to check compliance with the 2006 standards and, where they failed to comply, to require them to address those issues through an improvement plan or we can take the most serious step we can to issue an Improvement Notice. It is the extreme limit 11:25

of the RQIA's direct action against a service. The RQIA do not have the power to restrict the service or set conditions on it. Beyond that, the only other enforcement option is to recommend to the Department of Health that they should consider special measures for an organisation within a particular service.

Now, Sir, these actions are designed to protect the safety of service users and to address situations where there is significant failings or a lack of improvement in the quality of service provision. 11:25 11:26

The Inquiry has received evidence in respect of the evolving nature of RQIA and its approach to inspection. As Ms Donaghy's first statement to the Inquiry observed: 11:26

"At the time of its establishment in 2005, RQIA did not inherit or have prescribed any detailed or robust regional inspection methodology in respect of the services that it was tasked to regulate." 11:26

RQIA sought to develop its own inspection methodology for regulated services and later MHLD hospital facilities from 2009 onwards. 11:27

Significant evidence has been received in respect of the inspection methodology developing from 2009 onwards. The evidence provides that following assumption of the responsibilities of MHC, RQIA had

developed a full inspection methodology between 2010 and 2011. The methodology was characterised initially by a programme of mainly announced inspections of wards, patient experience reviews, analysis of return questionnaires and self-assessment forms, speaking directly with patients and responding to concerns or intelligence received. 11:27

The RQIA submits that the evidence it has provided displays a willingness of the organisation to continue to review its inspection methodology and consider improvements aimed at assessing quality and encouraging improvements. Ms Donaghy has provided detailed evidence of the adoption of a pilot methodology between 2014 and 2015 which led to the commissioning of an external, independent evaluation methodology by Professor Roy McConaghy that informed further development to the inspection methodology of MHLD wards. 11:27 11:28

The desire to improve and develop its methodology led to further refinement of the methodology process between 2018 and '19. That methodology was informed largely by the inspection methodology which was being deployed by RQIA in acute hospital settings across Northern Ireland. The potential benefits of implementing the whole site approach were reinforced to by RQIA by the findings of Dr. Margaret Flynn and the A Way to Go Report. The report undertook analysis of 11:28

RQIA's inspections, findings from a whole site perspective allowing themes and trends that indicated wider concerns with the management of governance of MAH to be identified and explored.

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The adoption of the new methodology in 2018 and 2019, about which evidence has been received by the Inquiry, saw the implementation of a systems based approach to inspection which focused on the entirety of the hospital site rather than inspection of individual wards. The inspections were undertaken by multidisciplinary inspection teams and were unannounced, lasting between two and three days. Evidence of the extent of the changes and advantages brought by the systems based approach have been recorded in the second statement of Ms Long to the Inquiry.

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RQIA's continued review of its methodology has improved the nature of those inspections and what the organisation has been able to identify. In this regard Ms Long observed in her evidence that:

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"Some of the matters that RQIA were raising were beyond the remit of the individual Ward Managers and staff within these wards and actually related to some of the systemic and governance issues with respect to the Trust. So although they were made about the individual ward the previous inspection methodology limited the

11:30

ability of the individual Ward Manager to make those changes. I think that when we moved to the multidisciplinary site inspection where we were able to have very robust evidence that these matters were evident across a range of wards and they needed to be addressed through leadership and governance arrangements within the Trust, it was at these points in time we had an ability and evidence base to bring the Trust to those intention to serve meetings, serve Improvement Notices and request recommendations from the Department to place the Trust in special measures." 11:31 11:31

Evidence has further been received from the Chief Executive in her statement of the range and sources of expertise considered and which informed development of the inspection methodology between 2009 and 2019. RQIA respectfully invites the Inquiry, having heard and considered the evidence, to conclude that RQIA is a learning and reflective organisation which has created and developed an inspection methodology drawing upon research from a number of resources both within and outside of the jurisdiction. 11:31

The Inquiry is further invited to conclude that RQIA has been responsive in seeking to refine its systems, including its inspection methodology, with a view to improving MHLD facilities, including Muckamore, and enforcing the minimum standards set by the Department. 11:32

If I may, Sir, I wish to make some observations in respect of the nature of the inspections.

The Chair recorded in his opening remarks that it was obvious that bad practices were allowed to persist at Muckamore. We have heard a considerable amount of evidence about the effects and consequences of those practices upon the patients and their family. 11:32

Unquestionably the mistreatment of vulnerable patients by those charged with their care ought not to have occurred or been permitted to occur. 11:32

Inspection is an important tool deployed by RQIA in seeking to discharge its statutory functions and obligations. As the inspection reports which have been submitted show, inspections were being undertaken throughout the period of the Terms of Reference. The Inquiry has received evidence that inspections were carried out regularly and with diligence in accordance with the methodology in place at the time. 11:33 11:33

The inspection process may act as a deterrent for abuse, however, inspection alone will not be effective in preventing abuse and bad practices from occurring. Inspection may highlight, as it has done, poor practice, identify that there are risk factors which indicate that abuse may be able to occur, and recommend appropriate mitigations and safeguards aimed at 11:33

reducing that risk.

Frontline abuse was not detected in the course of inspection as the evidence has established.

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The RQIA is independent of those it inspects. Inspection by RQIA in terms of the bad practices is but one in a range of safeguards which ought to be in place. Inspection alone cannot be a substitute for effective management and internal oversight by a 11:34
service provider of a facility and its operation.

The effectiveness of inspection is necessarily reliant upon the evidence that the inspections uncover. The Inquiry has received evidence from RQIA in respect of 11:34
the manner in which evidence is managed. RQIA seeks to triangulate information received from various sources to ascertain whether there is robust evidence supporting a certain conclusion or a basis for taking steps aimed at improving a service. 11:35

As the Chief Executive observed to the Inquiry in her oral evidence, evidence influences our position. Inspection by its nature is limited in what it can achieve. RQIA continues to strive to improve its 11:35
systems and methodologies, however as Ms Long observed in her evidence, inspections are limited in what they can do, you are there for a period of time, you get a snapshot of a service during that time. A system of

inspection cannot guarantee the prevention of abuse and the limitations inherent in inspection must be properly acknowledged. The limitations underline the need for RQIA to rely on other sources of information. As RQIA has continued to evolve its methods it has, since 2019, 11:36
in reliance upon its statutory power required that the Belfast Trust notify it of specified safeguarding incidents at Muckamore.

In terms of evidence of inspection and response, the 11:36
RQIA has received evidence of effective engagement with stakeholders and intervention. Although a detailed assessment of those steps and the inspection reports themselves is beyond the scope of these submissions, the statements of Ms Long and Ms Donaghy detailed a 11:36
number of examples of steps taken by RQIA following inspections of wards within Muckamore.

An important part of the Inquiry's focus has been the role of RQIA and others arising from allegations of 11:37
abuse at Ennis Ward in 2012 and the subsequent Adult Safeguarding Investigations between 2012 and 2014. Those steps have been fully set out within the evidence received and I do not propose to repeat them, they appear within the written submissions on pages 9 and 11:37
12.

Sir, it's right to acknowledge that the actions taken by the RQIA in respect of Ennis arise only in the

context of a snapshot of the time considered by the Inquiry in accordance with its Terms of Reference. However, it is clear that the RQIA took those allegations seriously, liaised appropriately with other agencies and was heavily involved in seeking to effect improvement at Muckamore.

RQIA invites the Inquiry to find that the steps set out within its evidence demonstrate evidence of an organisation which acted promptly in committing a significant amount of its limited resource to require Belfast Trust to improve the issues which arose from the allegations of the abuse in 2012.

It was suggested by counsel for the Inquiry that the concerns which led to the allegations of abuse in 2012 in fact led to an increase in the number of inspections undertaken at Muckamore. However, as the evidence supports, regular inspections were being undertaken by RQIA across Muckamore since 2010, not solely in Ennis, and prior to the allegations being made in 2012 and 2017.

While it may well on occasion be the case that receipt of intelligence and evidence of risk of bad practice can result in increased inspection frequency over a period, effectiveness of inspection and regulation is not best measured with reference to frequency of inspection alone. As inspection methodology has

developed, it has informed RQIA's view that improvement of methodology will be more effective at identifying risk and ensuring that service providers comply with minimum standards than simply increasing the frequency of the inspections. 11:39

A further theme which developed through RQIA's evidence and from the questions posed by the Inquiry's counsel and the Panel members, was the issue of RQIA's independence. That issue arose in two respects 11:40 primarily. First, in the manner in which RQIA seeks to inspect and make recommendations independently of the services which it inspects. Second, in respect of the degree to which RQIA can be satisfied that those undertaking the inspection, who may previously have 11:40 been employed by an HSC Trust, can do so independently.

The Panel questioned whether the fact that engagement takes place with the service provider or the relevant HSC Trust in considering whether to take enforcement 11:40 action, such as the issue of an Improvement Notice, could serve to influence its decision and perhaps compromise its independence. It was further suggested by counsel for the Inquiry that in seeking to encourage resolution and work constructively with those bodies, 11:41 there is a risk that inviting the provider to convince it of compliance may have the effect of watering down RQIA's concerns.

RQIA believes that its engagement with service providers involves the purposeful presentation of evidence and feedback obtained during the inspection. Engagement with service providers serves the dual purpose of ensuring factual accuracy and providing the opportunity for a service provider to act upon areas of concern as early as possible with a view to securing the safety of patients.

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That engagement does not involve advance warning or early sharing of conclusions, but of information obtained in an inspection. It is important to recognise that an inspection is not concluded on the day of a given visit and will include consideration of evidence gathered before, during and after physical attendance at the service.

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The timeline and evidence provided in respect of Ennis, evidences the independence of the RQIA's discharge of its functions. The RQIA respectfully invites the Inquiry to find that the actions outlined in respect of Ennis Ward in 2012 evidence an organisation which was unwilling to accept assurances of other bodies unless they had been supported by evidence of improvement in the areas identified as requiring action.

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11:42

As the Chief Executive stated in her oral evidence:

"Service providers will not persuade us by their words,

they will persuade us by the evidence they present and effort they have put in. The evidence must be there. We are seeking to achieve improvement and if that can be achieved through us pointing out the non-compliance and the provider acting upon it immediately, that is the outcome we are after. "

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During Ms Donaghy's live evidence the Chair expressed possible concern about the independence of RQIA employees who had previously held roles in HSC Trusts or services which they ultimately were tasked with inspecting. In that regard, RQIA continues to reflect on its processes as part of its wider learning from this Inquiry. It does recognise that a blanket recusal policy in a small jurisdiction with a small team of MHLD inspectors could not be implemented easily. There would be significant capacity and resource implications and this would only tackle one aspect of the potential conflicts of interest which may arise.

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RQIA values its independence and has taken steps to mitigate any risk or perceived risk to that independence through a suite of measures. These include peer to peer review of Inspector outcomes, review of outcomes and decisions by both a senior Inspector and Director or Assistant Director of the MHLD Directorate and, as necessary, ensuring that inspections are undertaken in groups rather than by individual Inspectors.

11:44

RQIA considers its independence vital to the effective performance of its statutory functions and obligations and shall continue to take all steps reasonably available to it to protect that independence through its operational practices and inspection methodology. 11:44

A very important part of the Inquiry from the RQIA's point of view has been what it can learn, areas of improvement which it may identify and looking towards the future. In that respect the RQIA has listened to 11:45 the evidence and notes the valuable opportunity to self-reflect upon areas of potential improvement. It continues to reflect upon the evidence the Inquiry has received and, while not intended to be an exhaustive list of all matters under review by RQIA, here are a 11:45 number of areas which it shall seek to develop:

The Inquiry has queried the effectiveness of RQIA's system of inspections in analysing key themes over time. The Inquiry has heard much evidence of how 11:45 RQIA's methodology changed to allow for analysis of themes across wards and RQIA is continuing to explore ways that it can improve its ability to identify and analyse themes over time. 11:46

The limitations and age of the RQIA's IConnect data management system have been acknowledged openly in the evidence of Ms Donaghy, Ms Long and Ms McGregor. Its effectiveness in identifying key themes and trends

relies upon the Inspector's knowledge in the first instance. While Inspectors will always be a key part of that process, and there is no substitute for their knowledge or experience, RQIA would welcome an IT system that has the ability to support RQIA in the identification of emerging trends over time, not only on a service by service basis but identifying trends across Northern Ireland. 11:46

The Inquiry has received evidence in respect of the resources available to RQIA both across the organisation and specific to MHLD facilities. RQIA receives a relatively small budget. The lack of resources across the health and social care system is well documented. 11:46 11:47

Ms Long has provided evidence to the Inquiry in respect of resources which have been allocated for the purposes of development of an improved IT system and RQIA strongly welcomes the allegation of resource in this regard. 11:47

In her second statement to the Inquiry, Ms Long regretted that many families had never received contact with RQIA and indeed others did not know of the existence of RQIA or the role that it performed. RQIA, having reflected upon that evidence, acknowledges that it must do more to ensure that its function is known to all stakeholders across the HSC system. 11:47

Ms Long explained that raising the RQIA's profile has been an objective of the organisation in recent years and will continue to be so.

RQIA has held a series of on-line engagement sessions open to members of the public to explain its statutory role relating to MHLD and RQIA will consider ways in which to raise the profile of the important work that it undertakes. 11:48

The organisation wishes to restate its understanding of the importance of communication with families. It has already taken steps to improve the way that feedback is sought from those families. 11:48

The Panel queried whether information was received from families and given sufficient weight in preparation of inspection reports. RQIA acknowledges the views of family members must be afforded greater visibility in its reports while being mindful of issues of confidentiality. RQIA will continue to consider ways in which the important views of family members are captured and recorded. 11:49

The Inquiry has heard from RQIA that the opportunities for seeking feedback from families are much improved. In 2023 RQIA began requesting contact details of relatives from service providers to allow RQIA to contact relatives directly. While mindful of the fact 11:49

that not all families wish to be contacted, RQIA remains committed to seeking involvement from patient's family members where it is wanted.

Ms McGregor in her oral evidence referred to the need to develop RQIA's work with mental health advocates and their involvement in the inspection process. RQIA recognises the need for the support and development of advocacy services. RQIA will continue to consider what improvements can be made in seeking the views of mental health advocates about the care and treatment received by patients in MHLD services. 11:49 11:50

As Muckamore nears closure and patients are being resettled into community settings, RQIA acknowledges the need to adapt to the evolving care model within Northern Ireland. RQIA's role of inspecting and reporting of in-patient hospitals is already well established. 11:50

RQIA continues to use its existing statutory powers under the 1986 Order and the 2003 Order to promote and monitor the safety and wellbeing of those living outside of in-patient facilities including those being resettled from Muckamore. 11:51

The Inquiry has heard evidence of RQIA's use of a range of regulatory responses at Muckamore, including formal notification to the Department of Health, such as that

which has led to the establishment of MDAG in 2019. As RQIA observed earlier in these submissions, the flow of information into RQIA is essential to the effective discharge of its functions. The discharge of the statutory duty of reviewing the care and treatment of patients will be assisted by the provision of more information from HSC Trusts, particularly in respect of accommodation based services.

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However, RQIA is conscious that receipt of that further information will only be effective in improving oversight and patient safety if additional financial investment is also provided for the regulatory capacity needed to process it and act upon it appropriately.

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The Mental Capacity Act 2016 provides for the provision of information to RQIA about the deprivation of an individual's liberty and will increase the number of notifications to RQIA about people deprived of their liberty in community settings, including care homes and supported living settings. RQIA has concerns about its capacity to react effectively to receipt of the additional information it will receive in accordance with the Mental Capacity Act 2016 as additional resources to enable it to do so have not yet been provided.

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An impact of the 2016 Act is that RQIA will be more informed about those persons deprived of their liberty

and restates its concern that viewing the provision of this information in isolation ignores the corresponding duties which arise under the 1986 Order and 2003 Order. Unless RQIA is appropriately resourced to enable it to meet its statutory duties further to receipt of additional information, its capacity to assess and act upon information it receives will be limited and the protections envisaged in the legislation ineffectual. 11:53

RQIA adopts a risk based approach to the exercise of its regulatory functions and continues to focus on the welfare of individuals, whether detained under the 1996 Order or receiving treatment voluntarily in a hospital setting. It must be mindful of how best to use available and limited resources to fill its statutory duty to keep under review also the welfare of people living in a wide range of community settings. 11:53 11:54

The organisation recognises there are also many individuals living in their own homes or with their families who are in need of the protection that regulation affords. The task of effective regulatory oversight in those settings represents a formidable challenge. 11:54

RQIA will continue to make use of existing legislative powers within the confines of the available resources. However, it is proper to observe that there is insufficient capacity or resource available to RQIA to

fulfil the requirements of its regulatory role across the varied environments in which increasingly people are now being supported. The provision of services in community settings has evolved considerably since the enactment of the 1996 Order, yet it is this legislation within which RQIA continues to operate. Whilst the 1986 Order confers a broad range of duties and powers to RQIA, there are regrettably limitations upon RQIA's ability to make full and effective use of its powers and duties given its current funded capacity. In addition, the 2003 Order and the overall framework for regulation of all health and social care services in Northern Ireland have been in place largely undisturbed since commencement and no longer reflect the changed service delivery landscape. A review of the legislation is necessary to meet the needs of that landscape.

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RQIA welcomes the Inquiry's consideration of legislation that seeks to safeguard vulnerable individuals. RQIA is involved in the development of proposals for legislation with regard to adult safeguarding arrangements in Northern Ireland which is led by the Department of Health.

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In 2022 the RQIA review of the systems and processes for learning from serious adverse incidents in Northern Ireland recommended reform of the current procedure for reporting and following up of series adverse incidents

in Northern Ireland. The review was commissioned as part of the implementation of recommendations from the Independent Inquiry Into Hyponatraemia Related Deaths conducted by Mr Justice O'Hara. The Minister for Health accepted the specific recommendation that the Department should expand the remit and resources of the RQIA in order that it might maintain oversight of the SAI process, be strengthened in its capacity to investigate and review individual cases and scrutinise adherence to the duty of candour. 11:57

RQIA wishes to ensure that in any development of patient safety process, the role of regulation is not reduced and the importance of independent regulatory oversight is fully recognised. 11:57

The Inquiry will doubtless consider the range of powers available to RQIA and the degree to which those powers enable it to fulfil adequately the role of regulator. The organisation believes it is equipped to continue to effect change and improvement within MHLD and other services. Ms Long in her oral evidence observed that when RQIA deploys the enforcement powers available to it, they are considered serious by service providers and further, they have been effective in securing positive responses from HSC Trusts. That being said, the limitations upon the powers have likewise been observed. The RQIA does not enjoy, for example, the same powers available to the CQC in England and Wales. 11:58 11:58

The Inquiry has received evidence on behalf of the Department of Health that the Department, although it has not yet undertaken a full comparison of the powers of RQIA and CQC, intends to give further consideration to this work upon completion of a current review and report into the operational effectiveness of CQC in England. 11:58

RQIA welcomes any such work that considers the modernisation of regulation in the health and social care sector in a modern landscape and across various settings. 11:59

RQIA remains committed to its core purpose of securing and improving safety and quality in HSC services across Northern Ireland. 11:59

RQIA thanks the Inquiry for the valuable opportunity to participate actively in the production of evidence. It will continue to consider the evidence that the Inquiry has heard and will carefully reflect upon the Inquiry's findings in due course. 11:59

Thank you. 11:59

CHAIRPERSON: Thank you very much, Mr. Neeson. I think for the same reasons that were raised earlier, we won't ask the Department of Health to start early because I

know that there are people who are watching on-line and are sticking to the timetable and then I suspect there may be a number of people who want to ensure that they listen to what the Department of Health have to say. So we will reconvene, please, at 2 o'clock. Thank you very much. 12:00

LUNCHEON ADJOURNMENT.

THE INQUIRY RESUMED AS FOLLOWS: 13:44

CHAIRPERSON: Thank you. Mr McGuinness.

CLOSING SUBMISSION - MR. McGUINNESS: 14:01

MR. MCGUINNESS: Good afternoon Chair, Inquiry Panel members, Core Participants and, in particular, family members and carers of those with adult learning disabilities. The Department is grateful for this opportunity to make an oral closing submission. 14:01

As you will know, my name is Andrew McGuinness. I am one of the two counsel instructed on behalf of the Department of Health and Ms Tremlett is with me to my right. 14:02

Can I say at the start that I have submitted on behalf of the Department a written closing submission, however, this oral closing doesn't follow the written

closing submission so for those who might try to follow on that, it will not be possible. We are hoping to say something slightly different, but we are not deviating and we will cover a number of the topics that have been included in our written closing. 14:02

As you are aware the Department for whom I appear is responsible for the integrated system of health and social care in Northern Ireland. It sits at the pinnacle of the health and social care system which is 14:02 operationalised via a system of delegated powers and duties by independent arms' length bodies. In particular health and social care trusts. Each of those Trusts is responsible for exercising the statutory functions delegated to them and each of those 14:03 Trusts is accountable for its own performance.

It is the responsibility of each of the Trust Boards to manage local performance, and manage issues in the first instance when they arise. 14:03

Notwithstanding this system of delegation, the Department accepts its ultimate responsibility for the system and in particular its general duty under section 2 of the Health and Social Care Reform Act Northern 14:03 Ireland 2009, as amended by the Health and Social Care Act Northern Ireland 2022. The 2022 Act is of particular relevance as it dissolved the Health and Social Care Board, who I'll refer to as The Board

throughout this submission unless it becomes confusing with the Trust Board, and the Board's relevant powers, duties and responsibilities are now exercised within the SPPG Group of the Department.

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Whilst this occurred after the end of the Terms of Reference, the Inquiry has heard a significant amount of evidence about SPPG given, amongst other things, its relevance to any recommendations that may be made.

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I want to, and in terms of managing your expectations today, it's important for me to outline a number of matters that this oral closing statement does not seek to do. It's not an attempt to summarise all of the evidence heard by you, nor all of the evidence given by 14:04
the departmental witnesses, nor even to repeat verbatim our written closing. You have all of those. You will undoubtedly assess them carefully, comprehensively and fairly and you will reach your conclusions in due course. 14:04

This oral closing statement will also not seek to avoid responsibility. Like the written submission and it is hoped the manner in which the Department provided its written and oral evidence to the Inquiry, this 14:04
submission is part of the ongoing process whereby the Department continues to listen to, to reflect upon, and to effect change in the journey of protecting our most vulnerable individuals, thereby ensuring for them the

optimum conditions in which to live their fullest life.

The Department has not waited for the outcome of this Inquiry, rather where it has identified improvements in respect of legislation, policy and engagement, it has sought to undertake these. 14:05

This is properly described in the written closing as a journey rather than a destination to reflect the ongoing need to ensure safety and quality of service. 14:05

Finally, this is not a defence with a capital D of the acts of the Department nor is it an attempt to shift responsibility or blame on to others. Like our written closing, it's intended to focus on the acts and omissions of the Department and the Board which will no doubt inform the Inquiry's learnings and recommendations and say a small number of things that it considers to be important. 14:05

I intend to address a number of issues in turn, firstly I want to apologise, I will then address governance, the Department's response to the 2017 abuse, I'll say something about resettlement, staffing and funding and then I'll make some general observations. For the purposes of housekeeping Chair it may well be that I'll only get to the end of resettlement before we have to take a break. 14:06

CHAIRPERSON: Sure, you just let me know when you'd

like a break.

MR. MCGUINNESS: Turning to those issues, firstly, we are sorry. The Department has ultimate responsibility for the health and social care system. Where the health and social care system has failed patients and families who were resident in Muckamore, and it has undoubtedly failed them, then we unreservedly apologise, we are sorry. 14:06

This is not an apology coming late in the day, rather this has been its consistent position reiterated by the most senior officials and the Minister. If I could just remind the Inquiry that in the absence of an Executive in December 2018, following the Leadership and Governance Report, the Permanent Secretary accompanied by the Chief Social Work Officer and the Chief Nursing Officer apologised face to face to the families and they considered that it was important to do so. 14:06 14:07

Further the Minister, Robin Swann, apologised when he announced his intention to establish this Inquiry in September 2020 and I repeated this apology in my opening statement to the Inquiry and noted that the Minister suggested that the families want more than apologies. 14:07

The senior departmental witnesses reiterated these apologies in their evidence and you will recall the

apology of Professor Sir Michael McBride, and I think it's worth repeating his apology where he said:

"I want to take this opportunity to apologise unreservedly as Chief Medical Officer, as former Chief Executive in the Belfast Trust for the systematic failings that occurred, the abuse that occurred and the harm and distress that has been caused to individuals who had a right to expect better. It was a fundamental breach of Trust. It was an abuse of power. It was fundamentally wrong and it should never, ever have happened and I think this is an opportunity to ensure that those lessons are learned and corrective action is taken so that, as insofar as is possible, this never, ever happens again." 14:07 14:07 14:08

Professor McArdle said on the same day:

"While the Permanent Secretary did apologise to families for what they have experienced, I would want to reiterate absolutely my apology as the most senior nurse dealing with the situation for the role that nursing had in causing harm and abuse." 14:08

However the Department also recognises that apologies without accompanying actions are hollow, they are meaningless. The Department suggests that when the Inquiry examines its response to the revelations of abuse in Muckamore in 2017, that this is evidence of 14:08

its intention to ensure that the health and social care system was properly held to account and to reflect on what has occurred.

The Department hasn't waited for this Inquiry, although it eagerly anticipates its recommendations. Rather it has taken a number of steps to reflect on, to learn and most importantly to continue to strive for improvement in respect of legislation and policy, all with the aim of improving the quality of life and safety of those with a learning disability. 14:08 14:09

The manner in which the Department has engaged with this Inquiry is hoped to be further proof of its intention to act upon its apology. In my opening statement I noted that: 14:09

"The Department reiterates that it stands ready to cooperate with and assist the Inquiry in any way that it can. In particular, given the important tasks of this Inquiry, the Department welcomes the difficult questions which are likely to come and recognises that these will be essential to ensure that fulsome answers and recommendations are produced." 14:09

The outworking of that pledge has resulted in the Department identifying more than 60,000 documents of potential relevance, providing at various times more than 9,000 documents to the Inquiry. Witness

statements have been provided from the most senior departmental officials, both past and present. These include two Permanent Secretaries whose joint tenure as the most senior officials in the department span 17 years and the Inquiry has also heard from the former Chief Social Work Officer, the Chief Nursing Officer, the Chief Medical Officer, the Current Director of Disability in Older People, who has provided himself five statements, and the former Director of Social Care and Children in the Board, later the Director of Community Care in SPPG who provided oral evidence and three statements. Can I suggest the comprehensiveness of these witness statements is reflected by their volume which is approximately 29,000 pages with exhibits. 14:10

In addition to the invaluable work for this Inquiry by departmental employees, the Department wishes to recognise the assistance of its past employees who gave oral evidence and gave up their time to engage with Inquiry process and evidence as it proceeded, notwithstanding that many no longer work for the Department, many no longer even work within the health and social care sector and one witness was suffering from significant ill-health. 14:10

In addition to employees and former employees of the Department, the Department has provided assistance to other witnesses, for example, Ms Mongan and Mr

Sutherland, notwithstanding the report which they spoke to will have made for difficult reading for some departmental employees.

As well as acting collaboratively and cooperatively with the Inquiry, the Department's determination to reflect on the evidence for the purposes of improvement, which includes the often difficult task of being self-critical, should be clear from the manner in which its witnesses gave evidence. To take as an example, governance issues. Witnesses did not step away from identifying that something could have been better or where insufficient steps were taken. For example, Dr. McCormick on day 117 accepted that during his period the process tended to revert to activity measures rather than look to good outcome measures. But this is one example of a balanced self-reflection, hopefully of an open and inquiring rather than a defensive mind set. 14:11 14:11 14:11

Another issue is integration of learning disability with other services, for example, acute services. The departmental witnesses provided a variety of often differing personal opinions on this issue setting out the competing arguments. Mr. Holland on day 118 described the merits of a separate learning disability trust, but also the risks of making structural change. He identified the risk that this could perpetuate differences rather than ensuring integration and 14:12

thereby equality.

Dr. McCormick did not shy away from the challenge faced in ensuring an effective governance structure for Belfast Trust, notwithstanding the consequence that it could lead to mental health and learning disability struggling to get attention. It's also of note that Professor McArdle had been following the Inquiry to identify issues and was in a position to reflect on the structures of other comparable organisations in other parts of these jurisdictions and how they were able to address such issues. 14:12 14:12

If I could turn secondly to governance.

The Inquiry will consider the evidence heard around the systems of governance in place in the Department and the Trusts to include the roles of and actions of the various regulatory organisations. It's likely to consider if the systems of governance were appropriate, if not. How they could be improved. If they were appropriate, how did they fail to identify abuse that was clearly being perpetrated. Was it a fault of an individual's or were there other cultural reasons. It will also consider what changes can be recommended to prevent a recurrence of this heinous abuse. 14:13 14:13 14:13

Significant evidence has been provided by the Department around governance structures and processes

to ensure oversight at Muckamore at departmental level and by the Board. I do not intend to repeat swathes of the evidence, rather I will address a number of issues considered by the Inquiry and identify how the Department has not stopped the process of listening, learning and improving whilst the Inquiry has been ongoing. 14:13

If I can say something firstly about abuse. Abuse against vulnerable adults is deplorable. It manifests itself in various forms and the Inquiry in its Terms of Reference has set out a non-exclusive list at paragraph 5. It can be overt and violent. It can be covert and exploitative. It is all the more heinous when perpetrated on vulnerable adults who are unable to report the abuse due to their vulnerabilities. The insidious nature of abuse against vulnerable adults and the ability of abusers to adapt to procedures designed to protect against such abuse underscores the need for proper policies and procedures to ensure continuous vigilance and proactive safeguarding. 14:14 14:14

The Department of Health is clear that it was and all those who work with vulnerable adults should be aware of the risk of abuse in institutional group living settings, this is not something new. This doesn't mean it was complacent and if we look at the response to the Winterbourne View scandal, in my respectful submission it suggests that the Department was proactive in 14:14

considering an oversight in governance response to this emerging scandal. The Chief Medical Officer wrote to the RQIA seeking assurances around regulated Learning Disability Services. In addition, the Chief Social Work Officer contacted policy and professional leads asking them to consider if there were any lessons arising which might have applicability in Northern Ireland and this produced an assessment of the actions in the Winterbourne Report and how they were being addressed locally. 14:15

However, in this and everything that I say it will ultimately be a matter for you as to whether the Department was sufficiently proactive and whether the steps the Department took were appropriate. 14:15

Richard Pengelly clearly and unequivocally recognised that despite the system of governance in place abuse occurred and it should have been detected. Whilst the fact of abuse is a failure of the system, I respectfully suggest that it is too simplistic to argue, as some have, that the entire system must be condemned because of this failure. 14:16

As indicated earlier the Department has identified and recognised where the system was not operating as it should, where it could have been improved and those operating the system could have taken further steps. It does not say this or any system was perfect or is 14:16

perfect, rather it seeks to continuously learn and improve and I will outline the improvements which continue to date within this oral submission. It is hoped these improvements show that the system can continue to evolve and the system can change. 14:16

On this the Department has not been deaf to the pleas of the families and the carers in their closing and oral submissions. 14:16

In respect of the architecture of the system of governance, I suggest that the Inquiry will have to carefully consider whether there was any contemporaneous evidence that the governance arrangements in place at the relevant time were inappropriate. Richard Pengelly's evidence on this issue is important. It emphasised firstly that the governance arrangements in place were in line with the relevant requirements for public bodies in Northern Ireland and, secondly, notwithstanding he recognised abuse that clearly occurred, it wasn't evident to him that the architecture of the system was not effective. 14:17 14:17

You will recall the evidence of Andrew McCormick who suggested that the purpose of the RPA was integration. That was an ongoing theme throughout the health service reform in the United Kingdom. 14:17

At the time it was concept that was radically different

and pioneering. This meant not separating mental health and learning disabilities from other services with the intention of providing a better service to patients and clients through having an opportunity to address their needs holistically. Further, in the design of the system his intention was that the RQIA were to be a scary regulator. Ultimately again it will be for you to consider whether that came to pass. 14:17

The Inquiry has heard considerable evidence around the accountability structure of governance arrangements and the routes by which concerns could be escalated to the Department. This accountability structure ensured engagement at a number of levels, some of which I'll mention. 14:18

Firstly interaction with arms' length bodies who include amongst others the Trusts, RQIA and PHA provide an important opportunity and conduit for information relevant to governance. An example we make in our written submission sets out how RQIA Sponsor Branch is the Chief Medical Officer's group. This group held by bimonthly liaise in meetings with the RQIA which the CMO attended on occasion. 14:18

RQIA provided updates on its activities to include Muckamore and, in addition to directly liaison with the relevant policy and professional leads, a bimonthly summary of RQIA activity was prepared and circulated to

the top management group for its consideration.

RQIA was an important means of information and assurance for the Department, providing assurance following the investigation post the 2005 abuse civil claims, providing assurance during the Ennis Investigation and its engagement with the Trust post 2017, albeit you may wish to consider the robustness of the information and the assurances that were being given and received. 14:19

With the dissolution of the Board which had been an arms' length body, the SPPG Group now discharge its performance management, financial management and planning roles from within the Department. Along with the PHA it will continue to regularly consider the performance of Trusts against service delivery plans until the Department fully implements the proposed new strategic outcomes framework and system oversight measures. The measures are intended to be less bureaucratic and have a more outcome focused approach to accountability. They will provide a more comprehensive view of performance across the health and social care system, and they will facilitate a better understanding of what is driving current issues and challenges, for example in performance, safety and quality and in governance. 14:19 14:19 14:20

The relationship with learning disability is most

clearly expressed within the statutory functions domain. Each Trust will be required to deliver against actions and targets agreed with SPPG at the annual DSF meetings and quarterly follow up meetings.

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The dissolution of the Health and Social Care Board was designed to ensure more direct accountability within the Department itself. I'll speak later in respect of SPPG learning and improvements in holding Trusts to account, but I note at this stage the evidence of 14:20
Mr. Sutherland and Ms. Mongan who considered there had been a change of tone. They suggest there was an emphasis on performance management and interaction with the Trusts, greater clarity around expectations and engagement at a higher level with the Trusts. 14:20

I am going to say something about the accountability meetings which sit at the apex of the governance arrangements. They are a formal, structured way of holding Trusts to account involving the most senior 14:21
officials from both bodies. The Inquiry has heard evidence around how, prior to these meetings, Sponsor Branch considered the Trust assurance statement with input from professional and policy officers where required. The manner in which these meetings were 14:21
carried out changed over time. Initially under Dr. McCormick as the Permanent Secretary the meetings were time consuming, they involved large teams from the department and ALBs and on occasion only a small number

of participants would be engaged in particular issues at any time. Ground clearing meetings were introduced as part of the new approach to accountability meetings introduced in 2014 and it's important to note that issues and topics are only raised in these meetings if they are not being adequately addressed in other fora, when you come to consider the contents of those meetings. 14:21

A ground clearing meeting is chaired by the departmental sponsor supported by others if necessary. The Trust is represented by several senior executives. The agenda has standard headings, corporate governance quality, performance, finance and others. Agenda items were and are sought in advance of the meeting, both from the Trust and from the Department at grade five level and in 2017/18 this would have included all grade six and grade sevens. The minutes of the ground clearing meetings would be reviewed by the Permanent Secretary before the accountability meeting so he or she would be aware of the issues that are being considered. The purpose of the change was to streamline the meetings making them more efficient with only issues that couldn't be resolved at the ground clearing meetings escalated. One of the main changes to the format was that professional officers would not necessarily be in attendance, however the Chief Social Work Officer confirmed that he could and did raise any issues they wished to with the Permanent Secretary 14:22 14:22

prior to the meeting. The Chief Nursing Officer confirmed she had the opportunity to feed issues into the meet through sponsor branch. Of course the professional officers had their own engagement with the Trusts. 14:23

The Chief Social Worker described considering the DSF overview reports, meeting the Directors of Social Work regularly and challenging them on issues of concern.

The Chief Nursing Officer also regularly engaged with senior nurses encouraging a close connection where they could contact her directly, outside of the formal CNO business meeting and the Central Nursing and Midwifery Advisory Committee meetings. 14:23

It is submitted that the change of approach to meetings reflected a sense of frustration with the previous meetings and the risk that the value in the meetings could get lost in the noise was described by Mr. Pengelly. 14:23

The ground clearing meetings allowed the Department to address issues with senior members of the Trust in a manner similar to what was occurring in the earlier process. It is submitted that nothing was lost by the change in approach, rather it allowed for more focused and potentially effective holding to account, especially when the Department had the ability to adapt 14:23

its processes to reflect important issues, as an example, the formation of MDAG.

Whilst it's clear there was little mention of Muckamore in these meetings prior to 2007, this is not necessarily a reflection of failure. In particular, it's consistent with the strategic nature of the meetings and also with the evidence that significant unaddressed Muckamore-specific issues were unfortunately not being formally escalated to the Department prior to 2017. 14:24 14:24

A significant issue which has arisen in the Inquiry is around the nature of the information which was being provided or obtained by the Department. To set the context: It remains the responsibility of the relevant provider to ensure the services provided are safe, effective, and high quality in line with all relevant statutory requirements, standards and good practice. In effect this involved the provision of, amongst other things, assurances by the relevant Trust by way of delegated statutory function reports, engagement with its sponsor branch or on direct request to the Department. These assurances were triangulated with other oversight mechanisms. This is not an abdication of responsibility, rather it is submitted it is a proportionate response to governance, balancing the various responsibilities against the need to focus the budget where it is most effective, in particular in the 14:24 14:24 14:25

front line.

I would like to pause and look at the departmental response to the 2005 historic allegations. This identifies the various ways in which the Department 14:25
engaged with Trusts, obtained information and assurances and triangulated these. We set out in paragraph 52 of our written closing statement the background to the historical allegations arising from the 1960s and the 1970s and how the review into this 14:25
case prompted wider concerns in respect of sexual abuse of other patients in the 60s, 70s and 80s.

The response to these allegations can be broadly categorise had under three limbs. Firstly, an 14:26
historical file review undertaken of cases from the 60s, 70s and 80s. Secondly, a sampling exercise undertaken in each mental health and learning disability hospital covering the periods 1985 to 2005 and, thirdly, work undertaken by the RQIA to provide 14:26
the Department with assurances as to the extant procedures.

I won't set out the evidence already heard about these investigations which took place over eight years, 14:26
however the following is important to note: On being alerted to the allegations of abuse a strategic management group, an SMG, was established in May 2006. The Permanent Secretary met with the head of the Civil

Service and senior police officers to coordinate and take forward an investigation. A review was carried out of current practice in Muckamore which confirmed that relevant policies and procedures in relation to safeguarding patients were in place. The SMG produced five recommendations, these were endorsed by the Department and issued to the health and social care system for immediate action in October 2008. In September 2006, Dr. McCormick wrote to all Chief Executives of Trusts with learning disability in-patient facilities seeking assurances that appropriate preventative procedures were in place and highlighting the need for a retrospective review of patient notes. Despite the allegations from the civil actions being historic in nature, alongside the investigative processes the Department engaged the RQIA in September 2006. RQIA was asked to provide independent assurances that appropriate procedures were currently in place to prevent abuse of children and vulnerable adults in mental health and learning disability hospitals. 14:27 14:27 14:28

In response the RQIA provided an overview report to the Department in August 2008. This report identified a number of examples of good practice, but also concerns regarding outstanding work in relation to staff training and the number of children being treated in adult wards at the time. 14:28

In October 2008 the Department sought the production of action plans from the Trusts in response to the RQIA report and in January 2009 sought assurance from the RQIA that the action plans produced were appropriate. These assurances were provided in November 2009. 14:28

The final SMG report of December 2013 provided assurance to the Department that all matters which were identified as abuse were appropriately actioned with any criminal issues appropriately referred and any HR 14:28
and regulatory issues appropriately taken forward. The SMG was stood down in 2014 following PSNI confirmation the aims of the retrospective sampling process had been achieved.

Whilst there was no direct input by family members of those within the hospital at the time of this investigation, this was very much of its time. Family members would now have a direct voice. Evidence of this is found, if you need it, in how the Department 14:29
reacted to the 2017 abuse revelations and, in particular, the substantial participation of relatives in both MDAG and with the department prior to the inception of MDAG.

14:29

If I could suggest this example illustrates not only a range of practice steps being taken by the Department to include obtaining positive assurance from RQIA in terms of governance, but also the importance of the

information being received alongside assurance and performance management.

Dr. McCormick reflected that the Department did not have very good outcome measures and tended to revert to activity measures, not least resettlement as a metric, but that's quite limited in its regard, he said. The Department has reflected on all of the evidence and considers more could have been done to proactively look for comfort and assurance around positive metrics to support the assurances being provided. It's not clear the extent to which such positive metrics were being utilised in other jurisdictions throughout the period covered by the Terms of Reference and this could be a matter which is relevant to your consideration of what might have been considered, when, and what the effect of that consideration may have been. 14:30 14:30 14:30

The Department was, however, receiving some information around positive metrics. To give some examples: It received an annual quality report from each Trust pursuant to Quality 2020. It received information from the PCC, the 10,000 Voices initiative. It also received reports from RQIA who inspected against relevant issues like culture, leadership and values. This is not to say it could not have been obtaining more information which reported the presence of safety and not just the absence of concerns around safety. 14:30 14:31

Professor McArdle suggested that the better use of data starting with the Trust interrogating and better understanding its own data so that meaningful analysis could be provided to its Board alongside departmental access to the Trust data would assist to identify trends and analysis. 14:31

Since the emergence in 2017 of abuse the Department has reacted more robustly in respect of indicators of concern and continued to learn by looking for information to confirm safety. Some examples might be mentioned. When the Department engaged with the Trust following the revelation of abuse, it insisted that relevant up-to-date data was provided. This is evidence of its concern, not only to merely accept assurances of safety, but to interrogate the evidence of this. 14:31 14:32

From January 2018 monthly reports were required from the Trust. MDAG assurance reports consider information presented in graphical terms in respect of the review of CCTV, this includes incidents where good practice is identified, trend data on patient adult safeguarding referrals is considered, the daily tasks undertaken by the Safeguarding Team at Muckamore are set out. 14:32 14:32
A weekly safety report is provided to provide assurance on patient safety metrics. Safety dashboard graphs include incidents reported in Datix, the number of restricted interventions and staffing levels to include

those shifts covered by agency staff; this remains in place.

Work on a Regional Learning Disability Assurance Dashboard facilitated by the Northern Ireland Practice and Education Council has been ongoing since mid 2023 to enhance existing arrangements in place across each Trust and to agree a standardised model to from an integral part of future regional assurances. 14:33

A dashboard has been created to standardise how Trusts view their data. A presentation setting out progress to date was provided at the December MDAG meeting and a further update has been circulated for the February meeting. These can be provided to the Inquiry and we recognise that when it comes to making recommendations, the steps the Department have taken will be important in respect of any recommendations that the Inquiry might make. 14:33

14:33

The Learning Disability Dashboard Oversight Board meets monthly. Learning disability teams in the Trust have been testing proposed measures since October 2024. The proposed measures sit within five themes: Quality of care, experience of care, workforce, harm free care or patient safety, and bed capacity. 14:34

In November 2024 the Northern Ireland Practice and Education Council anticipated it would take a further

four to six months to complete testing, scale up and ensure clear governance and accountability is in place. Over the coming months the measures should be scaled out across all Trusts.

Similarly, the Department has continued to learn and evolve in respect of delegation of statutory function reports. We have heard that DSF reports from Trusts were provided to the Board. Professional officers in the Board would identify themes and issues and meet with the Trusts where these would be discussed with their Executive Director of Social Work and senior team. An action plan would be agreed for the Trust to take forward. Ultimately, an overview report dealing with the themes was prepared, approved by the Board of the HSCB and provided onwards to the Department. 14:34 14:34

Within the Department the overview report was considered by the relevant professional officers who could seek additional information and highlight issues to the Chief Social Work Officer which would be raised with the Board. An adult Safeguarding Report would have accompanied the DSF overview. 14:35

Limitations in the process were recognised even before they were identified in the Leadership and Governance Review. Mr. Holland described how he held regular meetings with the Directors of Social Work in the Trusts and issues with the reporting process were 14:35

discussed. At a stage he proposed abandoning the DSF scheme and incorporating reporting into other accountability lines. However, Trust Directors were clear that the report did provide an opportunity to give a profile to an activity which sometimes struggled to get a profile within the Trusts. A revised circular was issued in 2015 to provide more outcome orientated information. Mr. Holland gave evidence that the reports remained of value. He gave an example of his interrogation of a report allowing him to identify where there was no evidence of a statutory duty being discharged and to remedy that. 14:35 14:36

The Department has accepted the criticism of these reports, namely they were largely repetitive, they were not providing assurance in terms of the discharge of statutory functions or the standard of practice. There were concerns that the format was leading to repetitive reports which lacked outcome data. 14:36

In 2017 a further review of DSF was requested, this was delayed by the Covid pandemic. However, the Board did secure additional statistical support to improve the statistical analysis.

Bringing things up-to-date, a revised DSF circular has now been issued to Trusts. It was considered at a workshop held in October 2024. This has resulted in comments and amendments which are currently being

advanced. It is accepted this will be launched in the near future.

The Department have not, however, just waited for the DSF review. To address concerns that DSF action plans would at times be rolled over without sufficient clarity that they had been executed by the Trusts, for the last three years SPPG have RAG rated the action plan in terms of its assessment of how effectively the Trust has delivered against the actions. 14:37

This more rigorous approach means SPPG interrogate and critique a Trust assessment of how it has performed. This is addressed in now regular meetings with the Trust as opposed to a single event meeting and shared with the Trust Chief Executives. Trust boards now have SPPG ratings to compare to the internal assessment in respect of the action plans. 14:37

I want to say something about SAIs. Of themselves, SAIs are not a positive indicator of safety. They do serve to promote safety and quality. A robust and consistent approach to SAIs is important to ensure that issues of concern are properly identified and relevant learning is distributed. 14:37 14:38

The Inquiry has heard evidence of the evolution of the SAI procedure aimed at continual improvement. The departmental position is that the Ennis

Investigation ought to have been an SAI and the Board should not have accepted the decision not to submit one. Had there been an escalation within the Board and to a Trust Director, to the Trust Chief Executive or thereafter to the Department to address the issue, the SAI would have been provided and, via that clear procedural route, would have come to the attention of the Trust Board. The Health and Social Care Board could ultimately have given a direction to the Trust if necessary, but it didn't do so. Similarly the Department doesn't shy away from the suggestion that it could have been more inquiring in respect of what it erroneously understood was an SAI. Of course, this is only one element of the significant Ennis Investigation which the Inquiry will have to consider. It is not clear what the consequences of any further steps taken might have been or their effect. However, the Department considers it represents a lost opportunity to escalate the investigation and concerns within the health and social care system and potentially to have identified learning or at least to have promoted increased vigilance.

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Given the importance of SAIs for regional learning and improvement and consistent with the department endeavouring to constantly learn, the evidence of Mr. Whittle demonstrates the now more robust responses to failures within the process than at the time of Ennis. He described a present day issue around the

reporting of an SAI investigation. This led to RQIA investigating the process and the incident reporting thresholds. The Inquiry and those listening should take confidence that he described a more robust challenging approach with matters being escalated to the SPPG Deputy Secretary. She wrote to the Trust highlighting her concerns around untimely submissions, however she was also proactive. She supported the Trust with the engagement of the clinical leadership solution to assist and mentor Trust staff. 14:40

Whilst the timescale he was describing is outside the Terms of Reference, it is nevertheless important that the Inquiry understand the changes of processes of the Department which have improved so that the Inquiry can form any recommendations. This SAI issue is now on the SPPG Support and Intervention Escalation Framework since November 2024. This is a new performance management tool where key performance metrics are addressed in regular meetings with the Chief Executive of the Trust. 14:40

The ongoing SAI redesign programme aims to introduce a new overarching regional framework with supporting guidance to deliver a more flexible, streamlined and simpler review process. The focus will be on learning and improvement, framed within a culture of safety, openness and compassion and a 12 week consultation on the draft framework is due to be launched in the coming 14:40

weeks.

Whilst I note there has been criticism in some written closing statements around the SAI focus on improvement rather than culpability, there is a risk that blame and culpability are counterproductive to learning. That is not to say there is no accountability. Suspected criminal offences will continue to be investigated. Further, where it occurs, misconduct by staff will be subject to the appropriate employment and professional body procedures. 14:41

A key focus for the proposed new draft is to provide meaningful and compassionate engagement and support for all of those affected, including patients and families. In fact, one of the five key themes is engagement, involvement and support for all those affected. 14:41

Organisations will have to engage with all those affected in a collaborative, personal-centred way. Those affected must be listened to. They must be involved as active partners in the process throughout. This will include ensuring that reasonable questions are answered. Those questions will have to be answered. It is hoped this will address many of the entirely valid complaints this Inquiry has heard from loved ones in the initial evidence modules. In addition, those affected must be signposted to support services and to the independent advocacy services. 14:42 14:42

All this should be seen in tandem with the duty of candour. The Minister For Health has indicated to the Northern Ireland Assembly his intention to introduce a statutory organisational duty of candour before the end of the legislative mandate, if the legislative programme permits it. A key aim of this duty and the framework around it is to ensure that individuals are fully empowered to exercise candour and openness and that health and social care organisations have in place the necessary support and systems required to enable and nurture a truly open culture.

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You have heard about two other significant improvements in governance in respect of the Learning Disability Service Model and the Adult Protection Bill.
The Learning Disability Service Model is designed to address long standing regional variations in the provision of Learning Disability Services. The Inquiry has heard evidence that in January 2023 the Department proved a strategic plan which aims to finalise the Learning Disability Service Model and ensure better integration with children's disability services. A Task and Finish Group was established in March 2023. A draft service model has been developed in collaboration with Trusts, independent sector providers and, importantly, people that use health and social care services.

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The current draft model has the support of all Trusts and has received positive feedback from providers and the families engaged. By way of update, work is progressing to produce an implementation plan in collaboration with key partners across the sector. In parallel to this work, officials are finalising a financial review of Learning Disability Services which will form the basis for costings to implement the Learning Disability Service model. 14:44

In terms of next steps, the Department is undertaking pre-engagement on the service model and implementation plan ahead of the wider consultation anticipated subject to ministerial decision in the coming months. 14:44

I mentioned the Adult Protection Bill as it is intended to provide a statutory footing to the policy around adult safeguarding. It will introduce additional protections to strengthen and underpin the adult protection process and bring this in line with other parts of the UK where such legislation already exists. 14:44

An issue has been raised in the closing submissions as to why the bill is not proposed to require CCTV as mandatory in care facilities. This is particularly important given what was revealed in Muckamore. My first point is that the Department recognises the value of CCTV in the identification of abuse in Muckamore. It's use is not being discouraged and the use of video 14:45

recording equipment is currently governed by RQIA guidance.

Secondly, the issue of CCTV has been given significant consideration over the last number of years. However, 14:45
advice has been taken in respect of the issue and the import of that legal advice is that it's not possible to legislate for mandatory use of CCTV in what is, after all, someone's home.

14:45

Notwithstanding that difficulty with making it mandatory, the Department should be able to bring regulations governing the use of CCTV in social care settings. The Transformation Board has agreed to recommend such a power in the bill to the executive. 14:45

If I could turn to the Department's response to the 2017 abuse. I repeat again what I have said about abuse. Abuse in any form cannot and should not be tolerated. The Department recognised that the risk of 14:46
abuse, whether by way of neglect, incompetence or malign act, is persistent in all care settings. It recognises that no system is infallible and efforts to eradicate or minimise this risk must continuously evolve. 14:46

The inherent risks in running services for vulnerable individuals, particularly those who often cannot speak for themselves are well known.

Following the 2017 CCTV revelations, the Department was both proactive and determined to ensure that the conditions which permitted any abuse to occur were identified and properly addressed. The Inquiry has heard substantial evidence in respect of the outworking of these revelations, but I want to identify the most relevant steps taken by the Department in its attempt to understand how this had occurred to ensure that those within the hospital remain safe and ultimately to identify how things could be improved to prevent it happening again. 14:46 14:47

It will ultimately, of course, be a matter for this Inquiry whether those steps were sufficiently timely or adequate and the Department welcomes any recommendations which prevent abuse occurring and/or go to how bodies should react when and where abuse is uncovered, cognisant that no system is perfect and the health and social care system must always be vigilant. 14:47 14:47

Upon becoming aware of the allegations immediate action was taken by the Department. The Chief Nursing Officer contacted the Executive Director of Nursing via phone call to seek assurances there was adequate surveillance and supervision. As a result this had an immediate effect and there was an increase of senior nurse presence from drop-in cover to 24/7 ward cover. The Department sought further information around the 14:47

allegations and the delay in issuing Early Alerts. This information resulted in developing concerns around information flow and the information being provided. Further steps were taken.

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The joint correspondence from the Chief Nursing Officer and the Chief Social Work Officer on 20th October represented what we would submit is an exceptional step to express concern and to ensure that all appropriate steps were being taken in respect of patient safety. 14:48 Further meetings and correspondence resulted in the Department formally directing the provision of Terms of Reference for a Level 3 SAI. The Department required the provision of fortnightly progress updates. The Department expressed concern around the delays in the 14:48 production of the SAI report which was eventually published on 6th December 2018.

The recommendations of this report were accepted in full by the Department and at a meeting with families 14:49 on the 17th December 2008 the findings of the reports were shared and the Department considered that it was appropriate to formally apologise face to face to the families for the failings in their relatives' care.

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A health and social care summit meeting was held on 30th January 2019 chaired by the Permanent Secretary. Its purpose was to plan and expedite a robust and coordinated response to the report, including the

establishment of an action plan. Following careful consideration between the Department, PHA, the Board, the Department concluded that whilst the SAI report provided some helpful information, the areas of governance and leadership were not sufficiently addressed. 14:49

The Chief Social Work Officer noted that the information being provided in good faith by the Trust leadership was not fully correct, in particular when triangulated had with what the families were staying. As a result the Leadership and Governance Review was commissioned. 14:50

From January 2018, the Belfast Trust was required to provide monthly update reports to the Department. As a result of concerns arising from these reports formal monthly meetings between the Belfast Trust and the Department were commenced to provide the required assurance on these arrangements. 14:50 14:50

The Department's response to the CCTV revelations was, in my submission, unprecedented at all levels and reflects the magnitude of the safeguarding investigation. It is submitted that the Department was proactively involved in the process from the outset, adopting a wide-ranging response with an intensive focus outside of the normal oversight arrangements. One example of this intensity is that in 2017 the Chief 14:50

Social Work Officer and Chief Nursing Officer were discussing Muckamore staffing issues almost daily. Staff suspensions and staffing pressures were also a live issue for the Department with the consequences of these suspensions a standing agenda item for the highlight report provided to MDAG. 14:51

The RQIA Article 4 letters of March and April 2019 resulted in the Chief Nursing Officer identifying Mr. Rice who was appointed to work alongside clinicians and management. He assisted in the stabilisation of the nursing workforce and as a result of his work with Belfast Trust the RQIA Improvement Notices were lifted in December 2019. Indeed his methodology remained in use in Muckamore in October 2024. 14:51 14:51

MDAG was set up in August 2019 to address the RQIA recommendations. The role of MDAG has been extensively explored in evidence. One of the intentions behind this group was to provide support to the Belfast Trust and a mechanism for escalating any concerns that it was encountering. 14:52

Another key feature was the overview of the Muckamore Action Plan which had arisen from the A Way To Go Report. Importantly, MDAG includes relatives of those cared for at Muckamore. The significance of their input has been identified in evidence and Professor McArdle suggested that, amongst other things, family 14:52

representatives provide incredible sources of evidence to MDAG and provide a real-time check on issues which are being raised. This was particularly useful to the Department given the issues with information flows experienced both before and during the lifetime of MDAG described by Mr. Holland. 14:52

The Chief Social Work Officer described the establishment of MDAG as unprecedented and, whilst there was significant engagement prior to its formation, the Department recognises that this Inquiry may consider what, if any, difference it would have made had this body been set up earlier. 14:52

Consistent with the theme of continuous improvement MDAG was not the end. The Department continued to review its response and where it was identified that MDAG itself was not producing the desired result in respect of Muckamore and resettlement, further steps were taken to commission the Mongan and Sutherland Review and thereafter to implement its recommendations. 14:53 14:53

In moving away from this part of the submission the Department acknowledges that trust has been broken following the revelations of abuse. It also recognises that this trust must be re-earned through continuous and continued action, through accountability and a demonstrated commitment to sustained improvement. I submit that the engagement by the Department following 14:53

the CCTV revelations is a clear example that demonstrates its continued action and commitment to sustained improvement on the journey of the whole health and social care system to re-earn the Trust that has been lost. 14:54

I am going to turn to the issue of resettlement Chair. I probably have another 30 minutes. I see it's 2.55, I'm not sure whether this would be an appropriate time.

CHAIRPERSON: I mean you are a long way through the written submission, but I appreciate you are not sticking closely to that and I think we should all have a break, give the stenographer a break. If we have our usual sort of 15 minutes, we will be back at 10 past. Thank you very much. 14:54

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

MR. MCGUINNESS: Sir, I think I need to correct two points for the record just before I continue. 15:13
Ms. Tremlett helpfully brought to my attention, firstly at the start of my submission I linked the Permanent Secretary's apology in December 2018 to the Leadership and Governance Report, it was of course the A Way To Go Report in 2018. And when I was talking about the 15:13
delegated statutory function and the second review, that was delayed by Covid, I think I said 2017, it was in fact 2018, it is referred to in our written submissions and it is footnoted.

CHAIRPERSON: Thank you for those corrections.
MR. MCGUINNESS: Turning, Sir, to the issue of resettlement. I have already mentioned the Mongan and Sutherland Review which dealt with more recent difficulties. However, going further back in time, the 15:14
impact of the global banking crisis meant that the additional funding secured for learning disability during the comprehensive spending review period of 2008 to 2011 became unavailable. The knock-on effect was an underspend in the housing allocation for the 15:14
resettlement programme without the reciprocal health funds to match. This misalignment of budgets between the Department and the DSD led to a reluctance to commit to new building projects without the guarantee of reciprocal funding to support the patient in 15:14
placement. Ultimately departmental budgets were aligned. A joint bid for funding was submitted along with an agreement to transfer resources from the supported living budget to the resettlement budget, however this undoubtedly acted as a barrier for 15:15
resettlement for some time.

Community infrastructure has been a barrier to the full achievement of the resettlement programme. I mean by this the placements required for those awaiting resettlement and also the services required within the community to support and maintain those placements.

The Trusts faced challenges in securing the bespoke

placement arrangements for those remaining in Muckamore and who have the most complex presentations, but this is just one factor in what is a multifaceted issue. We know those with the most complex needs had enjoyed successful placements throughout the period of the Terms of Reference of the Inquiry. Mr. Holland confirmed that progress has been made in the establishment of specialist support services, behavioural support teams and Psychology teams within the community. Notwithstanding this, further investment when funding is available will be required to address issues that remain in terms of, for example, out-of-hours services and I'll say something about funding later on. 15:15 15:15

The resettlement policy has been notable for ambitious annual targets along with backstop completion dates to reflect the policy priority. An example is the Permanent Secretary's response to the A Way to Go Report. Mr. Pengelly described how these targets were deliberately ambitious and aimed at encouraging bodies to step out of their comfort zone, to inspire innovation and drive change. He intended his deadline to be a call to action but again the meeting or not of the targets will be a matter ultimately for you to consider. 15:16 15:16

Progress in resettlement was made but it remains incomplete. Taking, for example, the priority list

target patients, this figure moved from 347 in-patients in 2007 to 25 in 2016. You will, of course, be aware this figure doesn't take into account those subject to delayed resettlement. Notwithstanding the efforts of MDAG, which through its oversight of the resettlement group and use of the dashboard actively monitored resettlement, the Department continued to recognise concerns regarding the slow progress of the resettlement programme and in October 2021 asked the Board to commission a review of the resettlement programme. 15:17 15:17

The Mongan and Sutherland Review that I have already discussed considered all three learning disability hospitals and the Inquiry will consider its findings and their evidence. 15:17

Whilst this review found evidence of a positive set of working relationships and a well articulated commitment to work collaboratively within the Mental Health and Learning Disability Leadership Group, that was not borne out in practice. In addition to the criticism of the approach of individual Trusts, this review criticised the Board's oversight of the resettlement programme as at best representing performance monitoring rather than performance management. 15:17

On the positive side, it was noted that the Board had created a structure of groups and meetings to progress

resettlement and address issues. Further, it noted that there was a clear commitment by senior leaders to support the programme and to work jointly to address the significant challenges. In my respectful submission this is inconsistent with any suggestion that there was an abdication of responsibility. 15:18

The review concluded that whilst MDAG represented a robust mechanism by which the system could be held to account and monitored, in respect of resettlement there had been an inertia which in turn had resulted in slow or negligible progress with a lack of urgency and focus in the delivering of the resettlement programme. 15:18

The Department did not, however, stand still waiting for the review recommendations and a review noted the significant organisational changes which had occurred during the time frame of the review and, importantly, that a change in tone and approach to performance management responsibilities had been witnessed both prior to the transfer to SPPG and subsequently. 15:18 15:19

The recommendations flowing from the review were accepted by Minister Swann. As recommended a summit was convened in July 2022 with stakeholders across the HSC including Trusts and the Northern Ireland Housing Executive representatives, as well as provider, parent and user organisations. 15:19

A Regional Oversight Board for resettlement was immediately progressed with the new Chair engaging with the authors of the review in advance of her taking up her post.

15:19

This new Board was successful in reducing the patient numbers from 34 to include delayed discharge patients as well as the priority target list patients to 15 over a period of 18 months to two years. At the time of writing there are currently 15 patients remaining 15:19 within the hospital. The current projections of the Resettlement Oversight Board are that 11 of those patients have plans in place with resettlement dates up to June 2025 and planning is continuing at pace in relation to establishing resettlement timelines for the 15:20 other four patients.

Following an assessment provided to the Minister by Resettlement Oversight Board in May 2024, which made clear that not all the remaining patients in Muckamore 15:20 would be successfully resettled by the proposed closure date in June 2024, on the 5th June 2024 the Minister announced a short extension to the time frame for the closure of the hospital.

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The safety and wellbeing of the remaining patients is of paramount importance to the Minister and he is determined that each of the remaining patients is afforded the necessary time to enable them to

successfully transition to their new homes, particularly for those who have spent a considerable part of their lives in Muckamore. In recognition of this, he decided that setting a further deadline for the hospital's closure was not helpful, but he did make clear that this does not mean there is any change to the policy position which remains that no one should be required to live in a hospital. 15:21

While the completion of the resettlement programme was the clear policy direction it must not be forgotten that at the heart of this programme are vulnerable individuals, many of whom viewed Muckamore as their home and had done so for the majority of their life. Mongan and Sutherland noted that the impact of institutionalism upon these individuals, alongside the prospect of resettlement, presented one of the genuine barriers to resettlement. Their review cautioned that primary importance should be for a successful resettlement and the Inquiry has heard evidence of unsuccessful resettlements. The Department recognises the impact of failed resettlement on patients and their families. In addition there is significant cost in terms of finance and effort. 15:21 15:21

Following a meeting with families, the Chief Social Worker wrote to the Trusts in January 2020 indicating that resettlement must proceed on the expectation that a placement will succeed, a mere possibility of success

was not enough.

I now want to turn to staffing and funding. I will say something about both nursing and the community workforce. 15:22

The Trust in its closing has set out the difficult backdrop against which it was recruiting and trying to retain staff. It refers to statistics from the 2019 Northern Ireland Audit Office report around nursing 15:22 vacancy rates. This report makes the point that demanded had risen faster than available staffing levels. It pointed out that available projections suggested that demand on the health and social care sector would continue to increase as the population 15:22 continues to live longer and present with more complex needs. Whilst the Department is responsible for longer term strategic workforce planning and review, operational workforce decisions and planning remain the remit of the employing Trust, including service 15:23 deliver, safe staffing levels and operational vacancies and recruitment.

The Department has taken a number of steps in respect of staffing, both in respect of training and 15:23 recruitment and recognises that ultimately it will be for the Inquiry to assess their effectiveness and to make recommendations. However it is submitted that the evidence shows an ongoing attempt to improve the

situation.

The Inquiry is invited more generally to review the work of the Central Nursing and Midwifery Advisory Committee and the Nursing and Midwifery Task Group to address workforce challenges and the learning disability initiatives progressed by the CNO Group set out in detail within the evidence. I want to reminds the Inquiry of some of these steps now. 15:23

In respect of the former CNO the Inquiry has also heard how she spent a significant amount of her time investing in, engaging with and building connections with learning disability nursing within all sectors of care. 15:24

In 2015, the Chief Nursing Officer established a regional Learning Disability Nurses Network to include the Trusts, the education sector and independent voluntary sector. The Deputy Chief Nursing Officer led a workforce review which completed in 2016 with 11 recommendations. As part of that review, a separate learning disability nursing event was held and the finalised review was significant as it provided evidence to increase the number of student nurses in Northern Ireland from 2016. 15:24 15:24

The Nursing and Midwifery Task Group commenced work in

2006 culminating in the production of full report in March 2020. One of the key themes was the stabilisation of the nursing workforce to ensure safe and effective care. These recommendations were supported by a five year implementation plan and the 15:24
then Minister agreed 60 million would be invested in Nursing and Midwifery. 25 million of this agreed investment has been allocated in years one and year two of the five year intended delivery period and this investment has resulted in the recruitment of 15:25
consultant learning disability nurses and more senior nursing posts. There remains an outstanding 35 million commitment and, unfortunately due to ongoing budgetary pressures, the Department cannot currently commit to a time frame for its delivery. 15:25

Despite the impact of the pandemic, the Department was able to influence improvements in learning disability nursing by delivering on the recommendations in the following ways: The Department commissioned more 15:25
undergraduate places. This is intended to continue until the Department has achieved a position of over supply.

By 2021, the undergraduate places in mental health and 15:25
learning disability had increased by 21% and an additional 20 learning disability posts were delivered in 2021, 2022 through Delivering Care. The additional consultant learning disability nurses and more senior

nursing posts were designed not only to support existing staff, but it had the effect of identifying a significant pathway to individual professional career development. This, it is hoped, will assist in recruitment and retention by developing nurses for leadership positions.

The Delivering Care Nurse Staffing in Northern Ireland Programme was launched in 2014. Priorities for the framework were agreed through the Chief Nursing Officer with Executive Directors of Nursing in health and social care trusts and the PHA.

Following the 2017 revelations the Department commissioned work in respect of the systems, policies and procedures in place to provide assurance to Executive Directors of Nursing in Trusts, in particular in respect of mental health and learning disability nursing. A report was provided in 2018. It recommended the inclusion of learning disability nursing in Delivering Care. This was accepted, however, at that stage a number of critical phases were already under development and could not be stood down. The professional assessment was that the learning disability service model would invariably change the nursing staff requirements of phase nine. It was considered that there was also a need for a fundamental review of learning disability nursing services and the outcome should inform the development of phase nine.

In 2019, a review of learning disability nursing was commissioned. The pandemic has affected the work which was undertaken, however importantly, it included the involvement of families and carers. It's findings were 15:27
incorporated into four key themes with one of those themes being workforce planning. NIPEC was asked in 2022 to undertake a review of the work and a report, Equality of Access and Outcomes, was published on the 1st November of last year. 15:28

More generally, in respect of workforce planning and community infrastructure in June 2009 the Department published a DeLoitte Workforce Planning Report. This independent report ultimately concluded that, given the 15:28
economic climate and the restraints upon budgets, a considerable proportion of the change required within the mental health and learning disability workforce should be achieved through the reform and modernisation of the current workforce. 15:28

In response to the Bengoa Report in 2018, the Department published the Health and Social Care Workforce Strategy 2026, Delivering for our People. This strategy contains a detailed analysis of health 15:28
and social care workforce problems and challenges including the learning disability workforce. It aims to meet workforce demands and needs by 2026.

Action 37 of the Muckamore Action Plan relates to the development of an evidence based plan for recruitment, training and retention of a suitably skilled multidisciplinary workforce. A Regional Workforce Planning Review of Adult Learning Disability Teams and Services was commenced in October 2021 and a baseline report on the current workforce produced in June 2023. 15:29

The next stage is to map the required service change for Learning Disability Services regionally. This will define the workforce composition and skill mix needed to deliver. This work will inform the development of a workforce action plan to put in place the required workforce to deliver the agreed service changes. 15:29

The required service change for Learning Disability Services will be defined by the Learning Disability Service Model which will provide the strategic plan for the future infrastructure of Learning Disability Services and address regional variations in the provision of these services. 15:29

An issue which has been raised is the investment and wages in the social care sector. Minister Nesbitt has publicly announced his intention to make the social care sector a real living wage sector and to commence introduction in 2025/2026, subject to available funding. At this stage it is estimated that delivery will cost 50 million per year. This is being supported 15:30

by the Fair Work Forum whose aims include embedding fair work initiatives and enhanced terms and conditions for all employees across the social care sector. The Forum is developing an evidence based case for improving pay terms and conditions for the social care workforce in the community and for the voluntary sector.

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To conclude this section on staffing, and looking back at Muckamore Abbey Hospital specifically, it is submitted that following the 2017 revelations, the Department engaged with the Trust and operational staffing issues in an unprecedented way. In 2017, the Chief Social Work Officer and Chief Nursing Officer were discussing staffing issues almost daily, as I mentioned earlier. Staff suspensions and staffing pressures was a live issue for the Department with the consequences of these suspensions a standing item for the highlight report provided to MDAG. In addition, the Department took a number of significant steps to assist the Trust to include the appointment of Mr. Rice, as I've mentioned earlier, and the 15% pay enhancement in November 2019. This was offered both to registered nursing staff from other Trusts and those registered nursing and healthcare assistants currently working within Muckamore. In addition, for those staff willing to relocate an agreement was reached for travel costs to be reimbursed.

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If I can say something about funding; the allocation of funding is a key element in the prioritisation of services, in the allocation of resources and in the planning and progression of a long term policy commitment. 15:32

The learning disability population are a relatively small group as a proportion of the population with approximately 9,000 people known to the Trust or Trusts, but it is the third largest of the Health and 15:32
Social Care programmes of care expenditure.

The Northern Ireland Executive response to the Bamford Mental Health and Learning Disability Recommendations, was set out in 2009 in the action plan which was to 15:32
cover 2009 to 2011. As a result of the 2008 to 2011 comprehensive spending review, the Department allocated from within its resources an additional 44 million to Mental Health and Learning Disability Services. This was despite the Northern Ireland Assembly also 15:32
requiring an annual service-wide efficiency saving of 3% for the same period requiring a delivery of savings totalling £700 million across the public sector.

Initially, notwithstanding the efficiency saving 15:33
required during the period, expenditure on Mental Health and Learning Disability Services increased by more than allocated with expenditure and Learning Disability Services rising by the end of 2010 to 11 by

£31.1 million from a 2007 to 2008 baseline of 200.2 million with an additional comprehensive spending review uplift of £12.4 million. Can I ask you to note the figures quoted in written submission are in respect of mental health rather than learning disability and I ask the Inquiry to compare the tables at MAH-STM-0892405. You will see that the two tables, there is a mental health table and a learning disability table and we've taken the figures from the wrong one. I am also reminded that in fact the expenditure on Learning Disability Services rising by the end of 2010 to 2011 is in fact 32.1 million. 15:33 15:34

In addition, a commitment within the Bamford Action Plans to achieve a spend balance of at least 80% in favour of community LD services was also achieved and surpassed in both review periods. However, budgetary constraints became ever more acute, in particular following the effects of the global financial crisis. The Department has been faced with single year budgets since 2015 to 2016. This has impeded long-term financial planning and resulted in a focus on the short-term. In addition, the Department has been required to identify significant reductions in costs on an annual basis leaving the Department increasingly reliant on securing non-recurrent funding to maintain existing services. The Department acknowledges that this is far from ideal in terms of planning and management of its services. As a minimum, a recurring 15:34 15:34 15:34

source of earmarked funding is needed to close the capacity gap while long-term surety of funding at a significant scale would enable innovations both in-house and with independent sector providers.

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The Department's position in respect of funding for Muckamore and for learning disability can be summarised in the following terms: Whilst at a macro policy level there were significant restraints in respect of funding, in particular after 2010, operationally the 15:35
Department ensured that the Trust was provided with the funding it requested and the Trust was supported to break even through deficit support funding.

The Inquiry will be aware that it remains the 15:35
responsibilities of Trusts to operationally manage their budget to ensure that they can provide appropriate care to all service users. Where required, Trusts have formal mechanisms by which they can raise concerns about funding and make requests using business 15:36
cases or IP templates.

The financial model for resettlement was premised upon the permanent retraction of budgets from resettlement wards to fund community infrastructure and care 15:36
packages with a proportion of retracted funds bridged back to ensure continued provision of care. This process followed an agreed model whereby 90% of retracted funds were bridged back in Year 1 and 50% in

Year 2 with these timeframes open to extension to account for delays. In total, approximately 4.3 million of additional non-recurrent bridging funding was provided over a 10 year period from 2011/12 to 2021/22. As well as non-recurrent bridging funding to support resettlement, significant additional non-recurrent funding was provided for resettlement pressures, staffing pressures and advocacy services at Muckamore. 15:36

The Department at all times sought to be financially responsive to any requests from the Trust and to provide a reasonable level of base funding to support the LD acute service.

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The Department operated a significant and ongoing dialogue with health and social care Trusts regarding essential services and in-year funding requirements. In many financial years the Belfast Trust projected overspends, however, it was always supported to break even through deficit support funding. 15:37

Turning to the situation at present, funding in the health and social care system unhappily remains difficult. The Department recognises that funding is required to implement plans, but there is a finite pot that is received from Westminster which is transferred to the Northern Ireland Executive and from that Executive an allocation is made to the Department of 15:37

Health.

The Department of Health's draft budget allocation for 2025/26 represents a 2.6% increase in funding compared to the 24/25 position after reflecting in year allocations. However, when the Department has taken account of significant increases in cost which they will face in 2025/26 as a result of pay and price inflation, increased National Insurance contributions for GPs, pharmacists and social care providers and rising demand, a significant shortfall remains. 15:38 15:38

The proposed draft budget for Health represents a smaller increase for Northern Ireland than that provided in other UK regions. That will inevitably mean that the already unacceptable health outcomes in Northern Ireland will fall further behind those of the rest of the United Kingdom. It also sees the level of funding for health in Northern Ireland fall below the 4% to 7% premium above England that the Northern Ireland Fiscal Council estimated may be necessary to take account of our higher levels of need. While the draft budget 25/26 has provided an additional allocation of some £686 million, the Department is still projecting a funding gap of some £400 million. However, essentially the resource allocation provided for health has only given the Department an additional £200 million of funding when compared to 2024/2025. 15:38 15:39 15:39

The Department continues to work within a restricted funding envelope across the Health and Social Care Service and learning disability is also subject to those pressures. The Minister has noted the 400 million gap in the health and social care budget so current and indeed future funding will be challenging. 15:39

It was anticipated that the closure of Muckamore Hospital would free up substantial funding, however to date the cost of highly complex care packages of those discharged from Muckamore have made significant calls upon funding to the extent that the future financial picture remains very challenging, even in the context of the hospital closure and any cost savings likely to accrue from that. In terms of the Learning Disability Service Model, costing for this is ongoing and a specific funding line has yet to be confirmed. 15:40 15:40

Health is not the only department, of course, to be facing significant financial pressures and, while every effort will be made to break even, there will be challenging decisions to be taken. Given the quantum and the funding gap, Trusts may have to propose measures with high and catastrophic impact on a range of services which would undoubtedly have direct patient consequences. 15:40 15:40

The Northern Ireland Fiscal Council estimate that health spending in Northern Ireland should be 4 to 7%

premium on the health spend in England. The draft budget outcome is estimated to put the premium at 1.5%. Following the 2025/26 draft budget outcome, to bring the spending on Health in Northern Ireland to 7% would require approximately an additional £300 million of resource and £100 million of capital with both targeted specifically to health rather than social care. Including social care would require additional resource of around £375 million. 15:41

Despite the difficulties in funding, the Department's commitment to learning disability is reaffirmed and is reflected in the fact that funding for Learning Disability Services has increased consistently over recent years with an increase in spending from approximately £200 million in 2010/11 to an expenditure in 2019/20 of £412 million. 15:41

Before I conclude I should like to make some general observations. Whilst the Inquiry will undoubtedly take great care to consider all of the evidence, it's nevertheless important to remind ourselves of the danger hindsight plays in evaluating this evidence. Sidney Decker suggests there is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself or herself constantly aware of that fact. This is important in the context of this Inquiry when looking 15:42 15:42

back at decisions taken in light of what we now know occurred and we are confident that you will take that into account.

The Department's opening statement apologised to those who experienced abuse and we have repeated this today. I also want to acknowledge and pay tribute to the families and carers of those who were resident in Muckamore Abbey and those themselves who were resident within Muckamore Abbey. The Department has listened to their evidence. Their devotion and dedication to their loved ones is obvious. They deserve answers. It is hoped this Inquiry can provide those answers and make recommendations which assist in rebuilding their Trust in the health and social care system. 15:42 15:43 15:43

Whilst not losing sight of the abuse which occurred, it is also important to acknowledge the dedicated health and social care staff who work tirelessly to deliver high quality care and safe services to families and people with learning disabilities. Professor McArdle described being invited into the lives of and supporting the most vulnerable people as a privilege. The staff who enjoy this privilege have been hurt and ashamed that abuse could have occurred. The task of ensuring trust is rebuilt is also important to them. 15:43 15:43

The Department also wishes to acknowledge and express its gratitude for the hard work, dedication and

patience of all who it has worked with in this Inquiry, from the Core Participants to the Inquiry itself and to its staff.

The Department hopes that this submission reflects that it has listened and continues to learn and implement improvements on the ongoing journey to ensure those with learning difficulties have the optimum conditions to lead their fullest life and it awaits the Inquiry's recommendations. 15:44

We have reached the end of this stage of the Inquiry but the Department remains committed to engaging with the Inquiry in whatever way it might consider necessary to ensure the most appropriate findings and recommendations. 15:44

Before I finish I am reminded of one further erroneous comment that I have made, and just to correct the record, the increase in spending on learning disabilities has gone from approximately £240 million in 2010/11, to £412 million in 2019/2020, but otherwise thank you for listening to me today. 15:45

CHAIRPERSON: Mr McGuinness, thank you very much indeed, thank you. 15:45

Right, that concludes our business for today and we will hear from the Trust and Mr. Aiken tomorrow morning at 10 o'clock. Okay, thank you everybody very much.

See you tomorrow at 10.00.

THE INQUIRY ADJOURNED UNTIL 10.00 ON WEDNESDAY, 4 MARCH 2025