

**SUMMARY OF
“A REVIEW OF SAFEGUARDING AT MUCKAMORE ABBEY
HOSPITAL – A WAY TO GO”**

Summary of “A Review of Safeguarding at Muckamore Abbey Hospital - A Way to Go”

Introduction

In late 2017, the Belfast Health and Social Care Trust commissioned an independent Review Team¹ to look at safeguarding practices at the Hospital between 2012 and 2017. They began their work in January 2018.

The reason for this was that there were allegations of abuse of patients by staff, which were raised in August 2017. There were also delays in the reporting of these incidents.

CCTV information gathered at the Hospital revealed staff behaviours, which resulted in harm to patients. This led to 19 precautionary staff suspensions and a large police investigation which is continuing.² Separately, a team of staff was commissioned to view over 5,000 hours of CCTV images.

This summary is based on the Independent Review Team’s report which was submitted to the Belfast Trust during November 2018 and shared with the families whose relatives are known to have been harmed.

What the Review Team did

There were five sets of activities. The Team;

- 1) Read the Hospital’s safeguarding files, the Regulation and Quality Improvement Authority’s (RQIA) reports and the Health and Social Care Board’s information about safeguarding in Northern Ireland
- 2) Met the Hospital’s managers and staff, patients, relatives, advocates, a Director and Inspectors from the RQIA
- 3) Discussed findings, emergent lessons and ways of setting these out in a report
- 4) Wrote and shared summaries about: the quality of care across settings; an updated history of the Hospital; the Hospital’s safeguarding allegations and their outcomes; the Hospital’s workforce; the themes within 61 RQIA reports; and the health needs of people with learning disabilities across the lifespan. These feature in the report’s appendices with the RQIA’s comments about the themes abstracted from inspection reports;

¹ Margaret Flynn (from Wales), Mary Bell (NI), Michael Brown (NI), Bryce McMurray (NI) and Ashok Roy (from England)

² At the time of writing, 23 January 2019

- 5) Facilitated multi-agency events during September 2018 to present the findings and build on the Team's recommendations.

What the Review Team found

- It is important to think about safeguarding "in context." The role of the Muckamore Abbey Hospital in improving the lives of people with learning disabilities and autism in NI and the limited availability of community based support and services characterised all meetings. The absence of adequate home-treatment, supported living and provider expertise is associated with people's crisis admissions to Muckamore Abbey Hospital. Delayed discharges mean that people become stuck in the hospital – which also means that the hospital's "assessment and treatment" main function is compromised.
- The RQIA reports do not provide a single overview of the Hospital since they focus on individual wards and produced hundreds of recommendations.
- Over a two-year period, the Hospital recorded 4,385 "adverse incidents." However, it is important to ask questions about these numbers because a single person may be associated with lots of incidents for example.
 - People's lives at the hospital are characterised by inactivity and boredom.
 - Hospital patients are significantly likely to be harmed by their peers.
 - A typical response to allegations of abuse made by patients about staff is 2:1 "observations." These create a demand for additional staff amounting to paying 50 more members of staff every week (50 whole time equivalents).
- Nurse staffing shortages feature in the hospital's Risk Register and there is a case that nurse staffing at the Hospital is insufficient to meet people's needs. However, a low ratio of registered staff was not a factor in the areas of the hospital where CCTV evidence show patients being harmed.
- People's families are hurt, distressed and angry that nobody intervened to halt the harm experienced by their relatives.
- It is possible that a policy requiring the involvement of the Police Service of NI (which has since been set aside) has skewed understanding of what proportionate responses to safeguarding allegations should look like.
- The extensive paperwork associated with safeguarding investigations and inspections did not uncover the abuses captured on CCTV.
- In parts of Muckamore Abbey Hospital, work practices were harmful and disproportionate, for example, the unmonitored use of seclusion. Its intensive

use by a small number of patients is anti-therapeutic. In contrast, families want it to be known that there are some staff who conscientiously provide compassionate care.

- It is not clear how closely Muckamore Abbey Hospital's safeguarding practice, as revealed in its files, align with the regional Safeguarding Operational Procedures.
- The credibility of patients' allegations is compromised by statements concerning their "history of making allegations", consultant's decision-making concerning their mental capacity as well as relative's views. .
- It is unclear how the Hospital dovetail safeguarding practice, RQIA inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes.
- Advocacy is typically absent from considerations of safeguarding.

Important Considerations Highlighted by the Review Team

- Since Muckamore Abbey Hospital is not being used for rapid and short-term admissions, a network of leaders inside and outside the Hospital is required to address the over-reliance on Muckamore Abbey.
- Any coalition for progress must begin with the experiences of people with learning disabilities and their families.
- All services must demonstrate their readiness to plan for the care, support and treatment of infants and children with extensive medical and health support needs. Early intervention services are vital to the health and well-being of the adults with learning disability in the future.

The Review Team Identified the Following Lessons

- a) The process of safeguarding should not be compromised by questions about a person's history, their mental capacity, the permission of their family or "thresholds"
- b) The Muckamore Abbey Hospital's senior managers and clinicians must evidence the support they provide to staff who report harmful events and practices

- c) Learning from people's families is invaluable. They must be treated as equal partners and heard on a continuous basis
- d) Muckamore Abbey Hospital is part of the wider system located in the Belfast Trust, within the totality of Trusts, the Department of Health and the Legislative Assembly. Change needs to happen in all parts of the system simultaneously to ensure maximum benefit for patients and families. The case for major change is incontrovertible
- e) Since it is not clear what the Hospital is achieving, it is highly unlikely that the families of infants and children with learning disabilities and complex neuro-developmental disabilities envisage Muckamore Abbey Hospital as part of their waiting future.

The Review Team's Recommendations

- Provide evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports
- An updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges is co-produced with people and their families. The transition to community-based services requires the contraction and closure of the Hospital...a life course vision of "age independent pathways," participative planning and training for service development remain to be described.

Patients' families recommended that:

- Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners
- Families and advocates should be allowed open access to wards and living areas
- There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use of seclusion at the Hospital
- The use of seclusion ceases
- The perception that people with learning disabilities are unreliable witnesses has to change
- People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives
- The Hospital's CCTV recordings are retained for at least 12 months

- Families are advised of lawful practices Muckamore Abbey Hospital may undertake with (i) voluntary patients and (ii) sectioned patients³
- Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives
- Families receive regular progress updates about what happening as a result of the review.

Hospital staff recommended that:

- An enhanced role for specialist nursing staff is set developed.
- Responses to safeguarding incidents and allegations are proportionate and timely
- Safeguarding documentation is substantially revised.

Senior managers from the Health and Social Care Trusts and the RQIA recommended that:

- A shared narrative is developed about the future of services
- Commissioners specify what “collective commissioning” means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all of our services is clear
- All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing
- The default “Friday afternoon and weekend admissions” to Muckamore Abbey Hospital have to stop⁴
- Time limited and timely Assessment and Treatment become the norm
- Trusts and Commissioners must be knowledgeable about the “user experience” and that of their families
- Trusts and Commissioners should set out the steps required in the Department of Health’s post Bamford plan: in the short and medium term.⁵

³ A family was advised by a clinician seeking to section their relative that “It doesn’t sit easy using seclusion on a voluntary patient”

⁴ At the time of the feedback events (September 2018), the Hospital was addressing its low threshold for admissions

⁵ For example, it may be helpful to distinguish the recommendations and points made in the review which may be addressed in the short term and in the medium term. For example, in the short term:

1. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed - perhaps as an accountable group
2. The flow of admissions - especially readmissions - into the hospital should be restricted to halt the “revolving door” phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals
3. Existing patients need to spend time in and be visible in the community
4. Families and advocates should be allowed open access to wards and living areas

-
5. Monitoring and reporting of all restrictive practice - the use prn medication, physical restraint and seclusion must be strengthened

In the medium term:

1. Trusts should begin to build "all age care pathways" which bring together children's and adult services, hospital and community services and health and social care and education services
2. Out of hours' services should be enhanced using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups
3. The professional development of all front line staff must be prioritised using educational approaches based on providing better care rather than on formal course based approaches
4. New approaches to enhance housing capacity need to be accelerated to deal with ever increasing demand