MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 28TH JUNE 2022 - DAY 6

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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THE INQUIRY RESUMED ON TUESDAY, 28TH JUNE 2022 AT 10 A.M. AS FOLLOWS:

CHAIRPERSON: Before we start, I've got a few comments to make. I just want to set myself up... 10:04

Okay, good morning. This is the first day of the evidential hearings before this Inquiry, and before we start, I want to say a few words about my updated statement on restriction orders, and on Restriction Order Number 4, which was sub-titled "Staff Identification", and also to say a few words about how I am going to ask counsel to proceed when the witnesses are called, as is going to start happening shortly this morning. 10:04 10:05

This is, of course, a Public Inquiry, and I have said a number of times that I think it's very important that it is open to the public and that we are as transparent as possible. That needs to be balanced together with a number of factors, which includes the sensitivity of the subject matter of this Inquiry, the importance of encouraging witnesses to come forward, whether they are related to ex or current patients or whether they are ex or current patients or whether they're retired or current members of staff or, indeed, anyone else, and it also has to be balanced with the need to avoid trespassing on the territory of the criminal investigations which we know are ongoing. 10:05 10:05

Another factor is that I have to be cognisant of the press interest in this Inquiry, and the fact that if people are named who are directly or indirectly implicated in abuse, in whatever way, and their names are published, they may be subjected to public comment which may or may not be fair. 10:06

All of that would happen before those criticised have the opportunity to come to the Inquiry and defend themselves, or at least to give an account to explain the circumstances which led to their action or inaction. 10:06

Now, one approach which some other inquiries have taken would be to make all of these hearings closed and to exclude the public entirely. But, at this stage, I resist that approach because of the significant public interest which there is in these proceedings, and I want to allow the public to attend if they wish and, also, I think it's important to give the Core Participants or the CPs, as I will refer to them, as much information as will assist them in carrying out their role. 10:06 10:07

All CPs who have signed a confidentiality agreement have been provided with a link to Box, the documents system, to view the statements, and, in addition, all those whom I have designated as CP can ask for a link

via which they can view these proceedings.

Dealing with the question of the anonymisation of those criticised, for some people, any anonymisation order which protects staff will be too much. For others, no less than a blanket ban on naming anyone involved with the Hospital would be sufficient protection. The approach that I have taken, trying to balance these various actors, is as set out in Restriction Order Number 4. The naming in evidence of staff against whom allegations are made would, in my view, discourage staff from cooperating with the Inquiry and potentially risk trespassing on the fairness of the criminal process. And the order that I have made prohibits the identification of past and present frontline staff members who are directly or indirectly implicated in abuse on patients in evidence received by the Inquiry. Their names will be and have been redacted in statements and replaced by ciphers. They will not be named publicly, but Core Participants have been given the ciphers so that they know who is being spoken about.

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Now, the reason for that is that Core Participants have a wider role than just acting as witnesses. Part of the CP's function is to assist the progress of the Inquiry, and many of the Core Participants will have the ability to bring strands of information together which the Inquiry acting alone might not be able to do.

10:08

If, however, we find that the strict rules around the access are not being observed, I will have to take steps with regards to anyone breaching the rules, as well as tightening the rules around that protection. If people are Core Participants and haven't yet signed a confidentiality undertaking giving access to the documents on Box, which includes the cipher list, which explains, of course, who each witness is, I would encourage them to do so quickly; otherwise, I cannot see how they can perform the useful CP role. Those forms were sent out to all solicitors representing CPs on the 9th June, so about three weeks ago, so it is high time these were returned. 10:09 10:09

I have decided that that degree of anonymity does not apply to non-ward based hospital staff; however, I do not think it would be fair publicly to name others who are criticised at this stage of the Inquiry. I think that at this stage it is right to take a precautionary approach and so, where an individual is criticised, I am going to ask counsel to refer to those people by using their role or job title, rather than naming them publicly. There may come a time when that needs to be reconsidered and the names of those frontline -- sorry, non-frontline staff who are criticised do need to be given. But, at this stage, that could cause unfairness and I'm taking a cautious approach. 10:09 10:10 10:10

It is right to say, of course, that Core Participants

have full access to the statements, so they will not be disadvantaged in any way.

When we get to those in a leadership or governance role, including members of the Trust Board, that, it seems to me, is a different matter and their role relates far more to the organisational functioning of the Trust in the Hospital than direct allegations of abuse, and there is less danger of unfairness or significant public comment. Adopting this approach will not inhibit the Inquiry in doing the work that it needs to to address its Terms of Reference, but it will be fairer to those working at the hospital who are criticised but haven't yet had any chance to respond. 10:10 10:11

Can I then just very briefly turn to the witness who will be giving evidence -- witnesses who will be giving evidence over the next couple of days. Some witnesses have asked to remain anonymous and to give evidence without showing their faces or giving their names. Again, the Core Participants will have the cipher list, so they will know who the witness is but the general public will not. 10:11

In relation to this afternoon's witness, that individual has asked for and I have granted anonymity. Counsel to the Inquiry will discuss with that witness the most appropriate way for them to give evidence. One approach will be so that the Panel can see them. 10:11

That would mean that we would have to close this room so that only the Panel and counsel to the Inquiry and the witness remains and I'm afraid everybody else would have to move next door; or, alternatively, of course, they can simply view from their offices via the link. 10:12

The alternative to the witness being in this room will be that they will give evidence from a different part of the building, but that would mean currently that we would only be able to hear them. We will have the -- 10:12
we will have to deal with that once the witness gets here and we speak to them as to the best approach.

Now, I have to say, to some extent, we have to review how these processes work this week because we are 10:12
testing the waters to see how things work best and we will, no doubt, learn lessons and keep things under review.

The witness for this morning's session, however, is 10:13
content to give evidence in public and I will now turn to Mr. Doran to call that first witness.

MR. DORAN: Yes, thank you, Chair. Just briefly by way of explanation, when one looks at the schedule, one sees two witnesses for today and they are listed as 10:13
"Relative of former Patient P1", who will be giving evidence this morning, and then "Relative of former Patient P4", who will be giving evidence this afternoon.

CHAIRPERSON: Yes.
MR. DORAN: Now, the position as regards P1 is that his parents are his guardians. They are present today and they have given an indication that they would like him to be referred to by his first name, Martin, so I'm not going to be using the cipher "P1"; I'm going to be referring to Martin. 10:13
CHAIRPERSON: That makes your job a bit easier, I expect.
MR. DORAN: It does, indeed. And, moving on from that, the witness who is going to be giving evidence about Martin's experience is his sister, and I'm going to refer to her by her first name, Antoinette. So if the first witness to the Inquiry, Antoinette, could be called, please? 10:14
CHAIRPERSON: Yes, while that's done and the system that's used in the criminal courts with which I have some understanding is that the witness is asked to write down their name and then it's shown to all parties and we can all confirm we've got the right person. I am not going to adopt that approach here. I think we all know counsel to the Inquiry has met the witness, has confirmed the witness is the correct person and, unless anybody objects to that course, that's the course I am going to adopt. 10:14 10:15
MR. DORAN: I'm obliged, Chair.
CHAIRPERSON: Thank you

ANTOINETTE (SISTER OF P1), HAVING BEEN SWORN, WAS EXAMINED BY MR. DORAN, AS FOLLOWS:

Q. MR. DORAN: Antoinette, thank you for attending to give evidence today. I'm Seán Doran QC, Counsel to the Inquiry, and we had the opportunity of meeting briefly before your evidence this morning.

A. Yes.

1 Q. When we met, I explained the procedure briefly. Basically, I am going to read your statement in to the record and I'm then going to ask you some questions arising from it. Before we get started, I want to mention very briefly a few matters of evidence and procedure. I'm obviously addressing you by your first name, Antoinette. 10:15 10:16

A. Mm-hmm.

2 Q. And, as you are aware, the Inquiry has granted anonymity to patients. Instead of using the patient's name, we are generally referring to the patient by cipher number. Now, we know from your statement that your brother was a former patient at Muckamore, isn't that correct? 10:16 10:16

A. Yes.

3 Q. And in the Inquiry documents, you will see that your brother has been given the cipher "P1". 10:16

A. Yeah.

4 Q. So when we come to look at your statement, you will see that the cipher "P1" has been used in place of your brother's name. Now, while patients have anonymity,

that anonymity can, of course, be waived by the patient or by a person who has authority to waive anonymity on the patient's behalf, and the Inquiry understands that your parents are Martin's guardians, is that right, and you and your parents would like your brother to be called by his first name, Martin, throughout your evidence?

A. Yes.

5 Q. Thank you. So, that's fine. We can talk about Martin without having to use the cipher number and that makes it a lot easier for me and for you, I'm sure.

A. Yeah.

6 Q. Now, as well as the cipher "P1" that you will see in the statement, when we come to your statement you will also see that there are other names redacted and that the ciphers "H1" and "H2" appear. You may have seen that in the statement already?

A. Yes.

7 Q. And that ciphering is being used for staff members who may be implicated in the abuse of patients.

A. Yeah.

8 Q. So I'll be referring to those staff members as H1, H2, et cetera. And can I ask that when you're referring to them, that you do your best not to refer to them by name --

A. Yes.

9 Q. -- and to use the cipher numbers also?

A. I will try my best!

10 Q. Thank you. It's always a difficult exercise. Just to

10:17 10:17 10:17 10:18 10:18

assist with this, you should have, actually, a list of the ciphers.

A. I don't have the list but I know -- I know who you are referring to.

11 Q. Yes, well, we will ensure that a list of the ciphers with names is provided to you as you give your evidence. (SAME HANDED). Now, just one further matter, Antoinette -- the Chair has explained this morning that he will be taking a precautionary approach when it comes to naming other people who may be subject to criticism but who have not yet had an opportunity to comment, so I'm going to avoid using names where that is appropriate and I'm going to refer to certain individuals by their role rather than by their name, and can I ask you to adopt that approach as well, if possible? 10:18 10:19 10:19

A. Yes.

12 Q. Thank you. Now, I've mentioned that you made a statement to the Inquiry, and I think you have a copy with you now, isn't that correct? 10:19

A. Yeah.

13 Q. And is it right to say that it's a seven-page statement with 18 exhibits?

A. Yes.

14 Q. For the record, Chair, the Inquiry reference for the first page of the statement is MAHI-STM-014-1. And the "14" refers to statement number 14 and the "1" obviously refers to the first page of the statement, so we will be using that system of referencing throughout 10:19

the Inquiry.

Now, your statement is dated on the front the 24th March 2022, but it's signed the 9th May 2022, isn't that correct? 10:20

A. (Witness nods).

15 Q. And before you came today to give evidence, did you have a chance to have a good look through your statement again?

A. Yes, several times! 10:20

16 Q. Yes. And I think it's right to say that there are a few things that you want to bring to the Inquiry's attention in relation to the statement, isn't that right?

A. Yes. 10:21

17 Q. Are you happy enough for me to read the statement in first and then allow you the opportunity to make any additions or corrections that you might wish to make?

A. Yeah, that's the most straightforward, yes.

18 Q. Thank you. Maybe, actually, if you could draw the microphone a little bit closer, Antoinette? 10:21

A. Oh, sorry. Is that better?

19 Q. I think that's better, yes, thank you. So it's good to have got those formalities out of the way. I'm now going to proceed to read your statement in. This is the statement of Antoinette. It is dated on the front the 24th day of March 2022, but, as I have indicated, the statement was signed on the 9th May 2022: 10:21

"I, Antoinette, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. In exhibiting any documents, I will use 'A', so my first document will be A1.

10:22

My interview for production of this statement was conducted virtually over Zoom as I reside in..."

-- and then the location of your residence is redacted.

10:22

"Section 1: Connection with MAH

My connection with MAH is that I am a relative of a patient who was at MAH. My brother Martin was a patient.

10:22

Section 2: Relevant time period

The relevant time period that I can speak about is between 1990 and 2015.

10:22

Section 3: Information

Martin was born on..."

10:23

-- and your brother's date of birth is redacted, but I think it's correct to say, isn't it, that he was born in 1984?

A. Yes.

20 Q.

"Martin loves to listen to music, especially Daniel O'Donnell. He loves driving around in the car. He interacts well with babies and small children. He will engage by smiling and you can tell when he is enjoying himself. When he was more able, he loved going on the swing in the garden.

Martin's disability became apparent at the age of around two years old. Initially, he went to a local special education school. He then went to MAH at the age of six. We were told that he would have to be resident in MAH for an initial six-week period for assessment. This was insisted upon, even though it caused Martin distress, given his age and disability. We were told after the initial six weeks that he had to attend the Behavioural Therapy Unit as an inpatient, but my parents removed him because we were told by a staff nurse that another patient, a girl aged 16, liked to go into Martin's bed at night and sleep beside him. The staff thought this was acceptable and we were told it was sweet. My parents raised it as a serious issue and informed the staff that Martin would only attend as a day patient.

After that initial six-week period, Martin continued to live at home and he attended during school hours. My parents witnessed Martin being pinned down on the floor regularly. We raised this as an issue on several

occasions, but we were informed it was an acceptable form of treatment. Splints were also used on Martin to stop him hitting himself. We raised an issue as there was a serious risk that Martin could break his arms if he tripped, but we were told it was an acceptable form of treatment. I don't recall any particular names of people who were treating him at MAH at this time. 10:24

Martin deteriorated physically. He would throw himself down on his knees. This affected his ability to walk. He is in a wheelchair and requires two full-time carers. When Martin was 16, we were told by MAH that he needed to attend on a full-time basis as this was the only option due to him self-harming. Martin moved into Conicar where he lived during the week, coming home at weekends. 10:25 10:25

When he was 18, he moved to Greenan Ward, which was an adult ward. Martin lived in Greenan ward during the week from 2002 to approximately 2010. My parents visited every other day and my sisters and I would also regularly visit. At the beginning, there were only minor issues. He was happy enough. He had his own ward and his own room. My parents did not want to raise minor issues with the staff in case this affected the care that Martin received. 10:25 10:25

From 2010 onwards, he was moved to the Rathmullan Ward as Greenan was due to become a female only ward. He

had his own area. The wards were big and the set-up was good. He was there until in and around autumn 2013, when he moved back to Greenan, as Rathmullan was closing. At first, there was an open-door policy in Greenan, so my parents did not need to ring a bell when they were visiting. My parents were unhappy with a number of issues they witnessed when they arrived to see Martin. My parents cannot recall these. After raising these issues, my parents were told by the Nurse Manager that they would have to ring a bell to be allowed entry onto the ward. At this time, Martin was still coming home at weekends and my parents visited him every other day during the week. 10:26 10:26

On the 18th May 2014, my parents received a call from the Nurse Manager to say that there was an incident involving Martin and a number of staff were suspended. My parents recalled the Nurse Manager being in a very distressed state and saying that she never thought it would happen on her ward. My parents were advised that Martin had been assaulted, but they wouldn't give any more details or the name of the staff member who carried out the assault as there was an ongoing PSNI investigation. 10:26 10:27

We later found out from the PSNI that the staff member who assaulted Martin was called H1. Our Police Liaison Officer advised my parents that Martin was in the shower room and H1 pushed him into the wall and Martin 10:27

hit his head. She also verbally abused him. This was reported by another member of staff; I do not know who that member of staff was.

H1 was on suspension for a good while. She had a court hearing pending for the assault and was accused of assault at common law and contrary to the Mental Health Act. H1 was brought back to work in MAH before the court hearing date. My family and I were shocked that MAH allowed H1 to return to work at MAH whilst she was awaiting trial for an assault which occurred in the workplace that they were letting her back to work in. At the time, my parents pressed for more information but were advised by MAH that they were not entitled to know the outcome of the internal procedure. We only really properly heard what happened to Martin when we attended the court hearing. H1 was acquitted because the evidence which the staff member who reported the incident gave at the hearing differed to her initial statement given to the PSNI at the time of the incident. We were advised by our family liaison officer that H1 had also assaulted another patient on the same day that she assaulted Martin. H1 did not work with Martin again at our insistence.

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I attach a copy of correspondence received from the Victim and Witness Care Unit dated the 23rd February 2015 regarding the PPS's decision to prosecute H1 at A1 and a copy of our victim witness statement dated the

3rd March relating to H1's trial at A2..."

-- dated 3rd March 2015, I should have said.

"In June 2014, my parents received another call from the Nurse Manager in MAH to advise them of another incident. Martin had been sitting in his room with two carers. One of the carers took a bottle of water and threw it over Martin's head as he sat on the sofa. She said she did it for a laugh, as Martin enjoys a good laugh. The staff member was laughing and making fun of him. This was reported by another member of staff. We later found out that the staff member who threw the water was called H2. She received a police caution. I attach a copy of a letter received by my Mum from the Victim and Witness Care Unit dated the 10th April 2015 relating to the decision of the PPS confirming that a police caution had been given to H2 at A3.

10:29

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After this event, my parents complained to the Service Manager. The Service Manager acknowledged Martin's care was not up to standard and that a robust plan would be put in place. We asked for CCTV to be put in, but MAH refused. I also telephoned to complain and spoke to the Clinical Therapeutic Service Manager and the Service Manager on the 7th and 9th July 2014 respectively. Copies of my attendance notes of these calls are attached at A4 and A5.

10:30

10:30

H2 was put back on the same ward to work where she carried out the assault. My parents complained about this and were told by the Clinical Therapeutic Service Manager that he would make a note that H2 was not to work with Martin. 10:31

Again, in and around June 2014, my parents received a call from the Service Manager advising of what she referred to as a 'near miss'. This was where a staff member had given Martin too much medication. I 10:31
telephoned the Service Manager on the 10th July 2014 to complain. A copy of my attendance note is attached at A6. We were never told who the member of staff was. The Service Manager said she would investigate, but we never heard anything more about that. 10:32

Martin requires 24-hour care. He is constantly monitored, even when he is sleeping. A nurse will watch him on a monitor. On 5th September 2014, the Service Manager called my parents to advise that when 10:32
Martin woke that morning, he had a large gash on his head and that the doctor had to be called. Martin had to receive four sutures for the injury. The Service Manager was unable to give any information as to how the incident occurred. My parents complained and asked 10:32
how this could happen when Martin was under 24-hour care. I telephoned the Service Manager on the 5th September 2014 also to complain. A copy of my attendance note is attached at A7. The Service Manager

said she would investigate it, but nothing ever came of that. He was moved to Erne Ward in and around autumn 2014, as Greenan was closing. Erne wasn't good. It was a group of rooms in a small area outside. The rooms were really bad. The place was falling apart. 10:33
MAH were using rooms that really should not have been occupied. I remember my parents had to fix one of the windows at one stage as the room was so cold. Martin shared a common room with a female who would regularly lash out and who wrecked all of his CDs. I telephoned 10:33
to complain in December 2014 and spoke to the Service Manager and a colleague of hers. Copies of my attendance notes of the calls are attached at A8.

My parents lodged a complaint about Martin's living 10:33
conditions by letter dated 19th December 2014, and a response was received on 9 February 2015. The response came after my parents had ensured that Martin's windows had been fixed. I attach a copy of the letter dated 19th December 2014 from my parents to Belfast Health 10:34
and Social Care Trust at A9 and a copy of the response dated 9th February 2015 at A10.

In April 2015, my parents received another telephone call from a staff nurse at MAH. I don't recall her 10:34
name. One of Martin's carers had assaulted him. She had hit him several times on the head, verbally abused him, pushed him violently into his wheelchair and held him in there. This was by a female member of staff. I

do not recall her name. I telephoned to complain on the 15th April 2015 and spoke with the Clinical Therapeutic Service Manager. A copy of my attendance note is attached at A11. The PSNI were involved but no action was taken by them. Internal disciplinary proceedings were completed but, as usual, we were not told the outcome. Martin was not the same after the incidents in 2014 and April 2015. He became very withdrawn and depressed. He was put on anti-depressants. He enjoyed vocalising when he was happy, but he stopped vocalising at all. He would sit in his bedroom looking down. He never smiled. He used to enjoy coming out into the common areas but, especially after the wheelchair incident, he didn't want to engage with others. We raised the effect that the abuse had on Martin with the Consultant Psychiatrist at a meeting on the 3rd July 2014 (copy minutes attached at A12), but she brushed this off by stating there were other factors, without being able to point to any other factors. 10:35 10:35 10:35 10:36

My mother stated at a further meeting in MAH in 2015 at which Martin's psychiatrist, the Consultant Psychiatrist, was present, that there was systematic abuse happening at MAH. The Consultant Psychiatrist replied to my mother by saying 'Come on now, Mrs...'" 10:36

-- and your mother's surname is redacted --

"...and completely dismissed my mother's concerns. We complained to the Senior Nurse at the time. Mum went on the ward and was told by another nurse 'people lose their tempers'. We were told this comment would be investigated, but we did not hear anything further. Martin is so vulnerable. He cannot speak for himself. We could see the effect the abuse was having on him and it was breaking our hearts. I attach a copy of my attendance note of my call with the senior nurse dated 15th April 2015 at A13. 10:37

In or around 2015, we were advised that MAH was closing down and all of the patients were being resettled. We couldn't wait to get him out of there. There were a lot of meetings between my parents and MAH staff. Martin is now in a house in..." 10:37

-- and the location is redacted --

"...where he has his own living room. He lives with three other men. There are two staff members there who care solely for Martin 24 hours a day. After about three months of moving out of MAH, Martin started to smile again. 10:37

Each time an incident occurred, we were never given the full details of what happened or who was involved. No one cared what was happening in MAH. We raised serious concerns with politicians (see copies of the questions 10:38

which we raised at Stormont dated the 11th March 2015 at A14 and my letter to Jim Wells dated 20th April 2015 at A15, both attached), the PSNI and the Head of the Nursing Staff (see copies of our exchange of letters at A16 and A17, both attached). We also complained to a person at the RQIA (see copies of my attendance notes in April 2015 with that person attached at A18). 10:38

It was chilling that people knew but just accepted what was happening, such open abuse that was commonplace. I worried about what was happening when people couldn't see. It was so bad the staff were reporting one another. We pushed to get CCTV in, but were refused with the excuse of privacy issues. For the wards that did have CCTV, we were told by MAH staff 'Everyone knows the CCTV doesn't work'. A lot of the issues seemed to be around funding. They were using agency nurses who were not properly qualified or experienced to be dealing with the patients' disabilities. 10:39 10:39

Section 4: Giving evidence

I would like to give oral evidence to the Inquiry. If I am asked to give evidence, I do not require any special arrangements. I do not require a supporter to attend the Inquiry hearing with me. If I am asked to give evidence, I am happy to give my name." 10:39

And, at Section 5, we then have the Declaration of

Truth, which reads:

"The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are relevant to the Inquiry's Terms of Reference."

And then the statement is signed "Antoinette" and dated the 9th May 2022. 10:40

Now, Antoinette, as I mentioned earlier, having read the statement, you spotted that there were a few things that you would like to bring to the Inquiry's attention? 10:41

A. Yes.

21 Q. Would you like to go through those in turn at this stage?

A. Yes, well, one of them I have said there at paragraph 4 about where the pinning down happened -- 10:41

22 Q. Yes.

A. That happened in Conicar ward, that didn't happen -- I just -- my timeline was slightly out there. So it happened slightly after where I've said it's happened in my statement and I can go through that. 10:41

23 Q. Yes. And, Antoinette, can I ask before you move on from that, does that apply also to the use of splints?

A. No, I believe that splints were used intermittently there, but they were used more in Conicar, is my

recollection of that.

24 Q. Yes, thank you.

A. Also, when you went into Conicar Ward, we were called -- and it came about when we, I suppose, in the last few weeks when we've been hearing the opening statements we recalled something that happened to Martin -- a lot of things happened to Martin and a lot of things we had probably forgotten and suppressed probably, but one of the things was the weight loss, he had lost an awful lot of weight within the first couple of months of moving in there so -- 10:41 10:42

25 Q. And can you say when that was approximately?

A. He moved into Conicar Ward in or around September 2000 when he was 16 and, when he moved in, he was a wealthy weight. He had reached all normal height, normal weight and then within -- by the Christmas of being in Conicar Ward he had dropped to five stone, and we have pictures to show you -- will I go into the details of that? 10:42

26 Q. Yes. Yes, indeed. I think the Panel all have copies of the photographs, as do the Core Participants. 10:42

A. Sure.

27 Q. And I think, Antoinette, that you have a copy of those photographs before you now?

A. Yes. 10:42

28 Q. Do you want to go through them? You've numbered them 1, 2, 3?

A. So, Martin, he was -- he was in a school in the morning and then he went into the Behaviour Therapy Unit in the

afternoons, and that was up until around the age of 16. We were told at the age of 16 that he would have to go in for a period of about six weeks initially because Martin's medication wasn't suiting him particularly well, so they wanted to take him off all the medication 10:43
and he had to be monitored by nurses. So he had to get his blood taken at least once a day to make sure his bloods were okay. So he went in for an initial period of six weeks into Conicar Ward. That was probably the worst thing. When he was taken off all the medication, 10:43
he was unable to cope and he would -- it was not a good period for him. But when he went in, his weight started to drop dramatically. Now, Martin at that age would have been probably like a toddler. If you can imagine feeding a toddler, you have to kind of entice 10:43
them and sit with them. And he would have held food in his mouth so, you know, feeding him might have taken a period of an hour. You know, you had to be patient. He would run around and he would come back to it. So we think now that wasn't happening. He was probably 10:43
given a meal and, if he didn't eat it, he didn't eat it. So my parents raised concerns. His weight loss dropped dramatically. He was about seven and a half stone when he went in and, by Christmas, he was under five stone. And my parents insisted that a doctor be 10:44
called because, as you can see -- so the first picture you will see is him in around about August just before he went into Conicar. And the second and the third pictures is when he came home at Christmas. Just

before those pictures were taken, my Mum insisted that the doctor be called to Muckamore and the Ward Manager at the time said "I don't know what you're talking about, I think Martin looks well." Now, how anyone could look at a picture of this boy and say he looks well is beyond us but --

29 Q. So, Antoinette, can you just go through the pictures in turn? Now, the first one --

A. The first one is in or around the summer. I'd say it's August just before he went into Conicar. 10:44

CHAIRPERSON: Sorry, which year are we talking about?

A. 2000, when he was 16.

CHAIRPERSON: Thank you.

A. We have a book which the carer -- which the school did for him to say goodbye to him, so it's in -- that was part of his book, you know, of photographs. 10:45

30 Q. MR. DORAN: Yes.

A. And then --

31 Q. Who's with Martin in the photograph?

A. That's a carer from the school. 10:45

32 Q. Yes.

A. And then when he went in, the pictures number 2 and 3 are when he was home at Christmas; you see the Christmas cards in the background.

33 Q. I see that. And who is with him in the third photograph then? 10:45

A. My Mum.

34 Q. Yes. So the first photograph is in or around August 2000 --

A. Yes.

35 Q. And the second and third photographs, in or around Christmas or at Christmas 2000?

A. Yeah, there was a period of four months in or around. So when my parents insisted that the doctor be called and the doctor arrived and she said that Martin was at the stage where he'd have to be PEG-fed -- now, I'm not a doctor but I understand that's where they have to put a tube into his stomach because he was at the risk of organ failure at this stage. But because of Martin's disability, he wouldn't tolerate being PEG-fed, so we had to work with dieticians and he was put on a high protein diet. My parents were able to get him better over the Christmas period a little, but it was a long period of getting his weight up and I think when they were alerted to the fact that this is what was happening, then more attention was paid to the carers in Muckamore -- more attention was paid to him. 10:45 10:46 10:46

36 Q. And this was when he was in Conicar Ward, is that correct? 10:46

A. Yes.

37 Q. Yes. And, really, you're introducing those photographs to show the physical deterioration that Martin suffered between that short period of August to December 2000?

A. Yes. And, as I say, one of the reasons there's been so much that's happened to Martin that we've probably suppressed over the years, but, as I said, in one of the opening statements, counsel for the Friends of Muckamore had mentioned about the weight loss and that 10:46

triggered us to remember what had happened to Martin then. So that's why I had forgotten it initially when I went through the statement.

38 Q. No, that's very helpful. Now, I think there's another matter that you wanted to bring to the Panel's attention? 10:47

A. Yes, that was in relation to the -- the first period of abuse, the first H1 abuse in May 2014 --

39 Q. And that's dealt with in paragraph 7 of your statement, isn't that right? 10:47

A. Yes. The carer at that time, my parents entrusted implicitly. My parents were on the ward every other day. They were maybe on for two or three hours, and I think sometimes the carers forgot they were there. They would have chatted to them normally, as you would a co-worker. My parents with H1 would always have said "H1 is on, Martin's in good hands." But that week before the, that week of the abuse, H1 -- Mummy and Daddy were dropping Martin back after the weekend and H1 came in and she was very agitated, and she was saying -- and Mummy said, "God, what's wrong with you?" and she said "Aw, I've had a dreadful weekend. My kids are sick. I haven't slept. I'm up..." -- you know, as I would say, "I'm up to high doh, you know, I can't cope", and my Mum immediately said, "God, you know, H1, you need to -- like, you're very stressed. You would need to go and talk to the Ward Manager. Like, you should be on stress leave if that's what's happening. You can't -- you can't be functioning if that's what 10:47 10:48 10:48

you're like", and she kind of just dismissed it and said, "Aw, you know..." and then that's when we heard -- then that week we heard that she had abused two patients. But if that was readily apparent to my parents just by appearing on the ward, surely it was readily apparent and should have been apparent to her manager.

40 Q. And what did H1 say to your parents in that conversation?

A. Well, she just said "Ach sure, you know, what's the point", kind of thing and "You just have to get on with it" type of thing. I suppose it was happening in the context of there being a lot of sick leave and stuff at that time in Muckamore. A lot of staff were out on sick leave and things. So, no, she was just like "I have no choice, I have to keep going." 10:48 10:49 10:49

41 Q. But your parents' impression was that she was stressed?

A. She was very stressed, so much so that they even talked about afterwards. They said, you know, she's in no fit state, you know. I suppose, one of the options would be for my parents to go to her manager, but that just didn't seem to be, you know, an option at the time. You know, you wanted to keep good relationships as well, but, you know, we considered that if that was apparent to my parents in a brief conversation, it would have been apparent to anyone she was working with. And it transpired in the events that happened, you know. 10:49 10:49

42 Q. And how close in time was that to the incident

involving Martin?

A. That week.

43 Q. The same week?

A. The same week.

44 Q. Now, subject to those matters that you've helpfully brought to the Panel's attention, are you content to adopt your statement as the basis of your evidence to the Inquiry? 10:50

A. Yes.

45 Q. Now, I want to ask you some questions now about Martin and his experience at Muckamore, and also questions about your family's engagement with the Hospital and with others at the relevant time. In paragraph 2, you say that the time period you can speak about is from 1990 to 2015. 10:50

A. Yes.

46 Q. It seems from your statement that Martin was in -- a patient in the Hospital throughout most of that time?

A. All of that time, yeah.

47 Q. All of that time. 10:51

A. Yeah.

48 Q. And as we established when the statement was read out, Martin was born in 1984, isn't that right?

A. Yes.

49 Q. So he's now in his late 30s? 10:51

A. Yes.

50 Q. And I think you refer in one of the items of correspondence that are exhibited to your statement to Martin's four sisters?

A. Yes, yeah, he's the only boy.
51 Q. Yes. So you're a family of five?
A. Yeah.
52 Q. Martin's the only boy. And I wonder are you older or younger than Martin? 10:51
A. I'm older than Martin. So I've got two older sisters; then there's me; then Martin comes after me; and then we've a younger sister.
53 Q. Yes. And what age were you when Martin was born?
A. I was seven. 10:51
54 Q. You were seven. And you've already mentioned your parents, and I believe they have attended the Inquiry with you today, isn't that right?
A. Yes, they have.
55 Q. And we're going to be talking about representations made by you and your parents to the Hospital. Is it fair to say that really you are giving your account on behalf of the whole family? 10:51
A. Yes, I am.
56 Q. In paragraph 3 of your statement, you go on to provide a lovely summary of your brother's personality. 10:52
A. Yeah.
57 Q. You refer to his love of music, his rapport with children, and his smiles?
A. Yes. 10:52
58 Q. And I think you say he's one of Daniel O'Donnell's legion of fans?
A. Biggest fans, yeah!
59 Q. He's clearly a fun-loving and outgoing individual?

A. Yeah, and when he could walk, he loved to dance and he loves music and he loves movement. And, as I say, he tries to join in a conversation and he loves -- he hugs himself when babies are around or small children, he just loves them. And, yeah, he loves driving in the car, he'd drive around all day in the car. And he used to love the swing. And when he was younger, he was the most agile child you would ever see. He used to be able to run up stairs without -- he never fell over, he was just -- but, yeah, he's a -- he always, you know, always smiling. But then he had his issues as well, unfortunately. 10:52 10:53

60 Q. Yes. Well, in paragraph 4, in fact, you go on to talk about Martin's disability?

A. Yes. 10:53

61 Q. And I think you say that became apparent when Martin was about two years old, is that right?

A. He reached all his milestones up until around then, but then his speech didn't come on and a few other things -- like, he wouldn't wave goodbye, things like that, that we started to realise something was wrong. And he, initially, he attended the local special educational school, but around the age of six when, in 1990, they said that they couldn't -- they didn't have the skill set to deal with Martin's kind of complex needs. 10:53 10:53

62 Q. Yes.

A. And that's when Muckamore Abbey said that they would have to take him in for a period of observation for an

initial six-week period.

63 Q. Yes, I'll come on to deal with that in a moment, but I wonder could you give the Panel an impression of how Martin's disability affected him at that stage in his life? 10:54

A. Well, he didn't have any speech -- he had limited speech. He used to be able to say "Up there" when you asked him where the lights were because he always had his eyes in the corner. So he had no speech. He would have been, you know, doubly incontinent; he would never 10:54 have learned to use a toilet. He would have had -- I suppose they would have diagnosed hyperactivity because he was always on the go and always running around and just -- he was an intellectual disability, you know, at that time. And then around the age of five, he started 10:54 to become self-injurious, and that would mean he would hit himself quite a lot. He would try and -- any hard surface, he would, you know, when he got agitated -- because he couldn't communicate very well. You know, he could communicate his basic needs. If he needed a 10:55 drink, he would bring you to the cupboard, or food or -- but I suppose he was probably internally very frustrated and he brought it -- he was never violent to anyone else, unfortunately, because that would have been easier probably to deal with; he was only 10:55 injurious, you know, to himself. So that's, the self injury probably became apparent in or around then.

64 Q. And it was when he was six years old then when the family was told that he would have to be resident in

Muckamore for an initial six-week period, is that right?

A. Because they wanted to observe him. And, yeah, so he was brought in and that was traumatic. I can still recall, and I was only probably 12/13, it was traumatic for Martin because he was so cosseted within the family, he would have always even -- you would have had to lie with him for him to go to sleep at night. You know, one of his sisters would always have to lie with him. He was just doted upon and then to, at six years of age, for him to be left in a ward and -- I suppose, you can't really explain -- these were not residential wards, these were hospital wards at the time. It was quite traumatic to look at and to quite traumatic to see the people and how they were being cared for. So he would have to have been left -- we went up every day, in my recollection, and you used to -- I can still remember he used to hold onto you and didn't want you to go, and then there was a glass door and he used to, you know, be pawing at the glass door to come after you. 10:55 10:55 10:56 10:56 10:56

65 Q. Yes.

A. So it was completely -- there's no way, looking back now, my parents did everything they could to make sure it didn't happen.

66 Q. Yes.

A. But we were just told "There's nothing else, this is in Martin's best interest." We weren't consulted. We were told. We were always just told.

67 Q. Well, I think you use the word "insistent" in your statement so --

A. Yes, they just said "There's nowhere else in Northern Ireland, there's nowhere else" and there was always this kind of threat almost "There's no elsewhere in Northern Ireland" -- it was almost like "Could he be sent elsewhere?", and that still is a threat that's hanging over our heads to this day, like, could they send Martin, you know, somewhere else. 10:57

68 Q. And who was insisting that he kept be at Muckamore? 10:57

A. I suppose it was the nurse -- the doctors, sorry, the doctors at the time. It would have been his doctors and his psychiatrist -- -his multidisciplinary team, as they would call it. And so you were up against -- and I don't want to say -- like, it sounds adversarial -- we weren't, but we just felt that we were -- there was no one else really working for Martin throughout his life. So they were insisting that that was it, that was in his best interests, and we wanted to make sure Martin got the best care and the best opportunities in his life, so we didn't want to say "Oh, well, we know better", because we didn't. You know, we were just trying our best as well. So, yeah, there was that initial six-week period, which was just traumatic. And then we were told after the six weeks "Oh, he'll just have to stay here" and my parents were saying that can't be his life. In this day and age, that can't be the issue or that can't be allowed. 10:57 10:57 10:58

69 Q. And I think you were told he then would have to attend

the Behavioural Therapy Unit as an inpatient?

A. Yes. And my parents said that -- we just couldn't countenance it and we were asking if there was an alternative and they were saying "No". And then we were able to work around an alternative where he could go to a local Riverside School, the local special educational school, in the mornings, and behavioural therapy in the afternoons. But even then they said "Well, he'll have to stay in because there's no transport available" and we were saying -- because obviously you needed two people to transport Martin because he was self-injurious. So if someone was driving and Martin started to hit himself, we couldn't protect him, you know. 10:58 10:58

70 Q. Yes. 10:58

A. So they were saying, "Well, you know, that means he needs an ambulance and we can't put on an ambulance", but then my parents fought very hard and with local politicians and other families and we were able to get transport. So we were able to work around that problem, so he was able to stay at home until he was 16 and go up and down every day. 10:59

71 Q. Yes. Just about the Behavioural Therapy Unit, the Inquiry will learn more about that in due course, but how did that particular unit work and what were its objectives? 10:59

A. Its objectives were really to make Martin -- I suppose to try and, like, encourage him with life skills and to try and modify his behaviours and his autistic

tendencies. But even to feed himself or to hold a glass of water -- or he would do little tasks like bricks, you know, or things like that, you know, dexterity, things that, you know, just to try and make sure he didn't lose -- try and, I suppose, make him the best ability that he could have, you know, that kind of way. And he had no problems -- and I know I've mis -- I've put in the wrong date order there, but the Behavioural Therapy Unit we didn't have any issues with and he was coming home every day, you know. So, no, it was -- it was kind of trying to teach him, you know, just -- and trying to modify, I suppose, his self-injurious behaviours, trying to keep those under control. 10:59 11:00

72 Q. Yes. But I think you say that, at first, your brother was in the Behavioural Therapy Unit as an inpatient? 11:00

A. Oh, yes, sorry, that was kind of C1, I think, at the time as an inpatient -- that was that six-week period which was not good and, looking back, I don't know how much they did with him within that six-week period. But, yeah, we were told at that time then that a 16-year-old used to like to go into bed beside him and that that was sweet, they thought that was sweet. And my parents said "No" and that's why they were saying "We're removing him, we're not..." -- 11:00 11:01

73 Q. And was it on hearing that that your parents decided that Martin should really be staying at home?

A. Well, if people think that that's sweet, then, no, they're not fit to be...

74 Q. And, effectively, your parents then moved Martin from the Behavioural Therapy Unit?
A. Yeah, well, as best they could. They had to fight to put in an alternative, but, yes, they were able to do that. 11:01
75 Q. And the arrangement then was that he attended during school hours, but stayed at home in the evenings?
A. Yes, yeah.
76 Q. I just wanted to ask was there any resistance on the part of the staff at the Hospital to that change in 11:01 arrangement?
A. As I recall, it was a -- it was almost like "Why -- he can just stay in." It was almost like "Why would you want to do anything different?". It was, you know, they didn't seem to be cognisant of the fact that he 11:02 was six years old and that this was not a proper place for a six-year-old to be attending full-time. So, yeah, there was -- like, as I say, my parents had to fight. They had to get politicians involved and they had to get a news programme, had to go on a news 11:02 programme to get proper transport and stuff in place to make it happen. So there was resistance.
77 Q. So you had a lot of -- your family had a lot of work to do to get the necessary arrangements put in place for Martin to stay at home? 11:02
A. Yeah. Yeah.
78 Q. And you refer in that paragraph to Martin being pinned down, but you explained that, in fact, you think that occurred at a later stage in Conicar?

A. Yeah, it happened in Conicar.

79 Q. And I think you also explained, though, that splints would occasionally have been used at that point in time?

A. Yeah, yeah, to protect Martin, I suppose. We did, we questioned it and, now, splints -- Martin would hit himself, so the splint would run from elbow to wrist, so it would be completely -- you know, so he couldn't move his arms to hit himself. 11:02

80 Q. So the splints were used on the arms? 11:03

A. Mm-hmm. And we raised it because if he fell or anything like that, obviously he couldn't put his hands down or, if he did, he would break his arms. But we were told that it was an accepted form of treatment. As I recall, they even gave us a document to show when it would be used in such things and in what circumstances. But we thought it was -- you know, we brought up the issue that Martin has human rights here, like, that to be restrained in that manner, that it would cause more damage than good. And also when Martin would -- if he was self-injurious and did something like that, it would precipitate it even more because he would get frustrated. So we didn't think that it was a good way. 11:03 11:03

81 Q. And just looking back, I wonder can you actually recall seeing him being restrained through the use of splints? 11:04

A. Yeah, I can recall -- you know, I could draw you a picture of the splints, as such. Yeah, like, I seen it and it was -- you know, you could just imagine yourself

being restrained in that manner, it just...

82 Q. Now, you say that you were told that that was an acceptable form of treatment. Given your knowledge of Martin's disability, can you ever recall measures of that kind being necessary at home or in settings other than the Hospital? 11:04

A. No, we wouldn't have used splints at home or anywhere else. You would have sat with him. That's the thing -- Martin takes time and, if he's self-injurious, you sit with him and you don't lift your eyes off him. And I think the splints allowed people to just put them on and leave him and not monitor him. 11:04

CHAIRPERSON: Mr. Doran, I'll leave it to you, but probably if we do another sort of five or ten minutes -- we've been going over an hour. 11:05

MR. DORAN: Yes.

CHAIRPERSON: Could I just ask, before we leave that issue, did Martin's behaviour, self-injurious behaviour, got worse at any stage or was it on a continuum? 11:05

A. It got worse when he went into Conicar. It was manageable -- I suppose, it started around the age of five and it got, as he got bigger, I suppose the issues became more because he was stronger. But it got really bad when he was in Conicar when they took him off all the medication. He was left, I suppose -- we traced that back to he went in for six weeks but he was left in such a state that he could never come back out after that period. So, no, he got particularly bad as soon 11:05

as he went into the residential ward.

83 Q. MR. DORAN: And just in terms of Martin's physical deterioration that you referred to in paragraph 5 of your statement, was that a gradual process over a period of years or do you associate that with a particular point in time? 11:06

A. I associate that with him going in to the residential wards. When he was at home, he could walk, he had full use of his legs. Again, when he was self-injurious, we sat with him and made sure that he was safe. So his behaviours, like, he would always find a new way to injure himself. He was very ingenious in that way in that he -- so one of the things he started to develop was throwing himself on his knees, which then caused injury to his knees. But when he was at home, he had full use of his arms, his hands, his legs. He had his full eyesight. He didn't -- over the years, he has deformed his face in the points of it you can hit -- his cheeks, his chin, his temples of his head. But I associate the worst time is when he was brought in, when he went into the residential wards starting with Conicar -- he was starting to get really bad through Greenan. 11:06 11:06 11:07

84 Q. And what age would he have been then at the time?

A. He was 16 going into Conicar. Yes, and when they took him off the medication is when my Mum would say he went -- you know, he just went clean mad. He just couldn't handle it and he got very, very self-injurious. That was a huge mistake, to take him off the medication. 11:07

85 Q. And from the age of 16 Martin, basically, attended the Hospital full-time?

A. Well, during the week and still coming home at weekends because both my parents would be home at the weekend to care for him. 11:07

86 Q. Yes. And you talk about Martin's time in Greenan then from around 2002 to 2010?

A. Yeah, could I just look back to Conicar and the pinning down, sorry?

87 Q. Oh, certainly, yes, yes. I should have asked you to explain that further because you've explained to the Panel obviously that -- 11:08

A. That it happened in Conicar.

88 Q. -- the pinning down incidents occurred in Conicar?

A. Yeah, so my parents came in one day to visit Martin when he was in Conicar Ward, and this was in that first initial period, and they witnessed him on the ground. And Martin, as you can see -- this was around the time when I'll refer to picture number 1, so you can see his build, you know, he's slight, and he's being pinned to the ground by three men, three carers -- one over his legs, one over his middle and one holding his shoulders -- and Martin being red in the face and fighting them and sweating and trying to get up. And my Mum and Dad were so aghast at seeing that that they immediately removed him. They took him home. They said "This cannot happen." Now, you can only imagine the pain that -- because he was on -- they were testing medications and his bloods needed to be checked every 11:08 11:08

day -- they had no choice but to return him to the ward for his own safety -- you know, for his bloods and things like that. So they had nowhere else and he had nowhere else to go. But we tried and we argued and we fought that the pinning down -- one of the carers was over 6 foot tall, you know. Martin was, what, 5' 2"/ 5' 3", even if that. Again, we argued this was against Martin's human rights. This is a Victorian model of care that was being -- and it was only making him worse. Because if you imagine a child in a temper tantrum, a two-year old, if you restrain them and they -- you know, they'll just fight against you, you know. So we argued and again we were told it was an accepted form of treatment and that it would continue. And it did continue. We didn't witness it -- or we did witness it again, but maybe not to the same extent. But then a professor from England came in in around 2002 and she did a full report on Martin, which I can make available -- 11:09 11:09 11:10 11:10

89 Q. Did she come into the Hospital?

A. She came into the Hospital to see Martin and about his care needs -- that was around about when he was turning 18 -- and she said that the pinning down and the splints were doing more harm than good and that they should be discontinued immediately, and they were. So at least they took her word for it. 11:10 11:10

90 Q. Yes, but on the first occasion that your parents witnessed this, did they take him home immediately that day?

A. Immediately. They just couldn't leave him there with that.

91 Q. Now, before we move on to Greenan, is there anything else you want to say about Martin's time in Conicar?

A. No, I think that covers... 11:11

92 Q. I think perhaps we'll have a short break at this point in time, Chair?

CHAIRPERSON: Yeah, I think that's a good idea. I am not going to ask you if you need a break because witnesses are very bad at saying that they do or they 11:11
don't! So I'm afraid I'm going to take the decision. We're just going to take a short break. Could I ask everybody to watch the clock, please? If we have 15 minutes and we'll start again at twenty-five past. Thank you very much. 11:11

THE HEARING ADJOURNED BRIEFLY AND THEN RESUMED, AS FOLLOWS

CHAIRPERSON: Thank you very much. I gather last 11:29
week -- or two weeks ago, when we were far too warm, there are complaints about it being too cold in here! So at least we know the system's working. We'll put it up by one degree and see if that makes it better.

MR. DORAN: It's certainly significantly cooler than it 11:29
was on the first day, Chair.

CHAIRPERSON: It is, yeah. But because we've got a lot of people in here, obviously it's going to get warmer this afternoon, so we'll see how it goes.

CONTINUATION OF EXAMINATION OF ANTOINETTE BY MR. DORAN

93 Q. MR. DORAN: Antoinette, you go on in your statement at paragraph 5 to talk about Martin's time in Greenan from about 2002 to 2010, isn't that right? 11:30

A. Yeah.

94 Q. And I think you and your family, as ever, visited regularly during that period?

A. Yeah, my parents would have visited -- so he would have been home at weekends, and then my parents would have visited every other day. And we would have gone up, you know, regularly as well. So we can't recall from that period of time there being any major incidences in the ward. Any minor incidences, my parents always, you know, would have spoken to the carers or spoken to the Ward Manager and such things at that time. Martin went on to Greenan -- he moved from Conicar to Greenan because he turned 18. 11:30 11:30

95 Q. Yes. 11:30

A. So he would have been in there around 2002. And Greenan was an adult ward, it was for more elderly people -- because Martin was very, very vulnerable so he couldn't be with people his same age because of his vulnerabilities, I suppose. Mentally, Martin was only about, maybe, nine to twelve months old -- like a baby, a nine to twelve month old baby -- and he relied on carers and the care of individuals for everything, all of his needs, and he wouldn't have been able to tell 11:31

you if anything was going on or anything like that so...

96 Q. In general, is it fair to say that he would have had a happier time during that period than before?

A. Yeah. Yeah, definitely in Greenan he was happier than, yeah, Conicar and it wasn't the, ehm, the pinning down -- the splints were still used on Greenan, but not to the same extent -- I think maybe just at the beginning, if I recall it correctly. But, no, we wouldn't have had the same concerns in Greenan at that time. It seemed to be well-run. 11:31 11:31

97 Q. And, just to be clear, when you refer to minor issues, what do you mean by that?

A. Ehm, it's hard to even recall. It may have been -- gosh, I can't -- I can't recall any kind of -- just the level of care, maybe, he was receiving or if he received injuries. I suppose, we were always told at the time -- and now you look back and you think "I don't know". He would have been self-injurious -- if he had got a black eye, we were told he had done it to himself, you know, things like that, and we would have taken them at their word. But, you know, you would have raised "But how did he get the black eye? Was somebody not sitting with him?", things like that, which are not minor but are minor in the context of what else he had to go through. 11:32 11:32 11:32

98 Q. Yes.

A. Maybe, you know, how long he was sitting; maybe the activities he was involved in; just day-to-day kind of

just keeping things -- I suppose, from a family's point of view, my parents -- I suppose, we maybe felt that we always had to keep an eye and we had to keep things -- making sure things went well, you know.

99 Q. I just wanted to pick up on one point that you make. I think you say that your parents may have been reluctant to raise those minor issues due to concern that that may somehow impact on the care that Martin was receiving? 11:33

A. Yeah. 11:33

100 Q. Can you just explain to the Panel what you mean by that?

A. I suppose it's a bit like if you've ever had a child in creche or if you have an elderly parent in a home, you're reliant completely on carers to look after your loved one and you don't want their opinion of you impinging upon how they care for your loved one. So they, I suppose, didn't want them, maybe, if they were cross with us or if they thought we were being difficult, that they would maybe not care for Martin the same way, or would maybe be a wee bit more -- less gentle with him or anything like that, that they might take it out on him, which I think is a natural enough feeling, as it were. But, yeah, I suppose they felt very much that they wanted to make sure that things weren't taken out on him. 11:33 11:33 11:34

101 Q. Yes. Now, in paragraph 6, you describe a period that Martin spent in the Rathmullan Ward from around 2010 to 2013.

A. Yeah.

102 Q. And I think you say that there was more or less an open door policy, so a member of the family could arrive and visit without even --

A. Yes, just go straight -- 11:34

103 Q. -- without even having to make the arrangement, as such?

A. Yeah, we would have gone straight on to the ward and you would have just gone down -- so Martin had his own area. Because of Martin's vulnerabilities, he always 11:34 had his own -- he had his own bedroom and he also had his own living room, and he would have had two carers at all times, so you would have gone in and just gone down straight into his living area. But then my parents would have raised -- again, when I say minor 11:34 issues, they were serious issues but we just can't -- there were so many issues over the years that I can't pinpoint what they were, but my parents would have raised them and they were told by the Ward Manager, "Okay, it's not an open door policy for you any more, 11:35 you have to ring a bell." So they were made to stand at the front door and ring a bell if they wanted to come on to the ward.

104 Q. Was it made clear that that measure was specific to them, as opposed to a change of policy on the ward? 11:35

A. Yeah, and it was directly linked, as I recall, to raising incidences. And then I remember the conversation, we were saying -- my Mum saying "But it's an open door" and the Ward Manager saying "Not for you,

Mrs..." -- and my Mum's name. So it was directly -- there was no doubt that it was explicitly linked in that way, that they were not to come on without ringing the bell.

105 Q. And your parents felt that that was because they had raised issues? 11:35

A. Yeah.

106 Q. Now, from paragraph 7 onwards, Antoinette, you describe a series of specific incidents that occurred during Martin's time at the hospital? 11:36

A. Yeah.

107 Q. And that began in May 2014 when your family received a call from the Nurse Manager, isn't that right?

A. Yeah. So she rang and my parents remember her being very distressed when she rang and she said "Martin's been assaulted and several -- and a number of staff have been suspended." And they recall at the time her specifically saying "I never thought it would happen on my ward." And it stuck with my parents and it stuck with us because we were immediately "What does she mean by that, that she never though it would happen on her ward?". To us, now, looking back, you think, "So you were aware that it was maybe happening on other wards?", but that was the statement she made at the time and we recall it because it was unusual in the context of the conversation. So, yes, we were told that Martin had been assaulted. We were not told who the staff member was. We weren't told the details of what happened to him. We were just told that the staff 11:36 11:36 11:37

member had been suspended. We dealt with -- we had a police -- and it had been gone to the Police as well, the PSNI would be involved.

108 Q. Yes.

A. And we had a very nice Police Liaison Officer, who, I suppose, was the only person in this whole process that showed us any empathy or any shock because, ehm... 11:37

109 Q. And what do you mean by that? How did the liaison officer approach this difficult matter of telling you what happened? 11:37

A. She was just like, you know, "My God, I can't -- that's awful that that happened." From Muckamore, all we were getting was very much standard phrases, which, to me, kind of was quite chilling in that it was things like "We're sorry that the service has not been up to 11:38 standard on this occasion. This is -- you know, a robust plan will be put in place. We have procedures to follow." There was no human element like, "My God, something has happened to Martin and we are going to do everything to fix this." It was very, very cold and 11:38 very, very -- just detached, I suppose, is the word I would use. Whereas the Police Liaison Officer, she was able to tell us more information about what happened, but again we didn't know until we actually went to court with H1 actually what the full details of what 11:38 would happen. There seemed to have been a policy -- like, they would tell you on the day, like, say, when they rang my parents, they would tell us, but then there seemed to be a policy that they would not commit

anything to writing. You know, when we wrote to them and said "We need to know -- we want to know what happened to Martin", they wrote back to us, and it was the Chief Executive of the Trust that wrote back to us to say "You've been told verbally." 11:38

110 Q. Is that particular item of correspondence exhibited in your statement?

A. Yes.

111 Q. We'll come on to that in due course.

A. So, yes, our Police Liaison Officer was able to tell us 11:39 that Martin -- so the H1 had been in the shower room -- and Martin always needs two carers, so, thank God, because obviously there was always someone there to witness then -- and either she took Martin's head and hit it off the shower, or she shoved him -- and she 11:39 said she shoved him and he hit his head off the shower. The evidence was that she took his head and hit it off the shower, the tiled shower cubicle.

112 Q. And how did you find out that detail? Was it through the Police Liaison Officer? 11:39

A. A mixture of that -- and the court probably filled in more of the blanks.

113 Q. Was H1 was prosecuted for assault?

A. H1 was prosecuted -- and she also verbally abused him, she was cursing at him as well. Because Martin's like 11:39 a child in that you could say "We're going into the shower" -- he's not going to move too quickly and obviously she had lost patience with him. So, yes, she was prosecuted and you'll see there they prosecuted her

for assault at common law and under the Mental Health Acts.

114 Q. Yes. And you have exhibited the prosecution notice at -- I think it's at page 13 of the statement, the bundle of statements and exhibits. And, as you can see, the prosecution was for assault and the offence of ill-treatment under the Mental Health Order, isn't that correct? 11:40

A. Yes.

115 Q. Now, did you attend court yourself? 11:40

A. My parents did because I live -- I don't live in the North. So my parents had attended on that day. I was away.

116 Q. And was the prosecution in the Magistrate's Court?

A. Yes. And, yes, then we found out the full details of what happened that day. 11:40

117 Q. And H1 was acquitted, isn't that correct?

A. She was acquitted in that I think what had happened on the day was that the -- the other carer who had witnessed it had given a statement at the time, and then afterwards she had added more to her statement and that, I suppose, the Magistrate said, had put in a -- a small bit of doubt, so it didn't reach the criminal standard of beyond a reasonable doubt. But he certainly felt -- he went away first time because he felt that something occurred here that should not have occurred, and he went and actually took time out and went to research the law to see -- 11:41 11:41

118 Q. Who did that?

A. The Magistrate.

119 Q. Oh, the Magistrate.

A. He took time to go back and to find -- he said "I'm going to have a look at this and see if I can find -- you know, see what the legal basis is", and he came back and he said "I can't find her guilty on the verbal abuse charge either." I don't know how correct it is, but he had said that the law only allows it for members of the Police to be verbally abused or if they had to be a member of the Defence Forces, there's only legislation for that. I don't know how true that is but that's what he said at the time. 11:41 11:42

120 Q. So was the charge of ill-treatment based on the verbal abuse then?

A. Ill-treatment was ahead -- it was -- no, the -- yes, sorry, unlawfully assaulted, and then the ill-treatment was the verbal abuse, yes. 11:42

121 Q. Yes. And I think you say that the Police Liaison Officer told you that H1 had assaulted another patient on the same day as the incident involving Martin, is that right? 11:42

A. Yeah. So we hadn't -- we hadn't realised that at the time, but, yes. And when we got further details from the Clinical Services Manager later about the second incident of abuse -- sorry, against the other individual. But, yes, H1, had -- it was an elderly patient -- I don't know if -- will I go into what happened to him, or... 11:43

122 Q. You can do, if you wish?

A. So she -- H1 was in the dining area, so this was in full view of all staff and all thingies. But she had taken his hands and she had slammed them down on the table on top of cutlery, and I think she had done that on more than one occasion. 11:43

123 Q. And are you aware if she was prosecuted?

A. She was prosecuted for that, as far as I understand.

124 Q. And do you know what happened to that prosecution?

A. No.

125 Q. Now, one thing that you express shock at in your statement, Antoinette, is that H1 was allowed back to work at the hospital before the date of the court hearing? 11:43

A. Yeah. We couldn't believe, I suppose, like, in any workplace, that you would allow someone back in when they've got a court date pending in respect of assault which happened. And she was allowed back into the ward and how it came about was I would regularly call the Clinical Services Manager and the Clinical Therapeutic Manager for updates in relation to the internal disciplinary procedure. And I rang one day and was told "Oh, it's completed." And I was like, "Right, what's the outcome?". "We can't tell you the outcome." And I said "Well, can you tell me now what happened Martin?". "No, you'll have to write in to the Clinical Services Manager." And I was like "Right, is she -- is she back on the ward?", and he said "Yes, she's back on the ward." And I said "Is she working with Martin?", and he said "Yeah". And I said "But you can't have her 11:43 11:44 11:44

working with Martin". Like, you know, this just defied belief. And I remember his exact words were "I'll make a note of that now, the family don't want her working with Martin." And I was just, I was absolutely appalled. And we raised questions in Stormont. We had a politician raise questions on our behalf to say how can this be allowed to happen, if someone has a criminal conviction -- or a criminal prosecution pending, that they would be allowed back into work with the people who they have abused, or who they have allegedly abused? It just doesn't make any sense that that would be allowed to happen. And, also, the kind of -- again, the detachment, the kind of not even taking into account that that could be an issue for us, that she would be back working with Martin, you know. 11:45

126 Q. Well, you have very helpfully exhibited to your statement the attendance notes that you took in relation to conversations of that kind, and also the material relating to the issues that were raised at Stormont and we will come on to that in due course. 11:45

A. Yeah.

127 Q. Can I ask, as far as you are aware, was your family's wish complied with?

A. Yes.

128 Q. -- in terms of H1 not working with Martin? 11:46

A. Mm-hmm. I think if we -- God forbid if we weren't around or we had no one to speak for Martin, it would never have dawned on them that that was not acceptable. It just defies belief.

129 Q. Before we move on from that particular incident, I just want to consider how that impacted on Martin and the family. You deal with this a little bit later at paragraph 15, but I wanted to look at a document from 2015 that addresses the aftermath of the April 2014 incident. Your family was asked to make a victim impact statement, isn't that right? 11:46

A. Yes, yeah, for H1's prosecution.

130 Q. Yes, and this is exhibited at page number 14.

CHAIRPERSON: Can you give me the exhibit number, because mine, at the moment, don't have pagination on them? 11:47

MR. DORAN: Yes, the exhibit number is A2 or, as marked on the statement, P1 S2.

CHAIRPERSON: Thank you. 11:47

131 Q. MR. DORAN: And, for the record, the page number is MAHI-STM-014-014. Antoinette, have you had the chance to look at the statement?

A. (Witness nods).

132 Q. I just wanted to read some of that statement into the record. Now, we have heard that H1 was acquitted, but I think it's important that, in this Inquiry, you should have the opportunity of recording the impact that the incident had on Martin and your family at the time. 11:47 11:48

A. Yeah.

133 Q. So if we look at the document, the document outlines Martin's disability and gives a brief summary of his time at Muckamore. And then, in the third paragraph,

the statement says:

"It was in this context that we received news on the 18th of May 2014 that our son had been the subject of a physical and verbal attack. At first, we could not believe that one of the people entrusted with Martin's care, a person we personally knew, who we interacted with on an almost daily basis and who we trusted implicitly with our son's care, would assault our son. 11:48

The abuse suffered by our son has had a devastating effect on Martin, on us as his parents, and on Martin's four sisters. After the attack, Martin became depressed and he has been prescribed anti-depressants. The change in his personality has been noted by everyone who he interacts with. Prior to the attack, he took some pleasure in interacting with other patients on the ward by joining them in the dayroom. After the attack, he remained in his own living area and no longer wished to interact with patients or staff. Martin has autistic tendencies and it would not, therefore, be easy for him to interact with others. Prior to the attack, Martin would make sounds to verbalise his happiness or to indicate he was joining in a conversation. We have not seen Martin smile or verbalise since the date of the attack. Martin sits in his own room with his head down avoiding all interaction. Prior to the attack, our son's life was extremely difficult for him and he had only a few 11:48 11:49 11:49 11:49

pleasures in life. The lasting effect of the attack is that any pleasure our son seemed to take from his life is now gone.

Martin comes from a close-knit family. He has four sisters, older and younger, who adore him. The abuse has had a devastating effect on us all. We trusted Martin's carers implicitly and this trust in faith has been shattered. We cannot see how this trust can be rebuilt. Martin will be dependent on carers for the rest of his life, so we are left in the intolerable position of not knowing if he is safe. The distress and anxiety this continues to cause to Martin's family cannot be overstated. As Martin's mother, I cannot sleep at night." 11:49 11:50 11:50

Now, is it fair to describe this as a shattering episode in Martin's life and, indeed, the life of your family?

A. Yeah, absolutely. Martin had been in Muckamore all those years and, as I said, like, he had suffered self-injurious behaviours and we had just took everyone at their word that he had caused those injuries himself. And then to get a call to say -- and, I suppose, it was made worse by the fact that it was someone that my parents and my family have trusted so much. We thought she was a safe pair of hands. She knew us, she interacted with us, and she abused my brother, you know. If she could do it, you know, who else was 11:50 11:51

capable of doing it? It made us question everything. Martin was still in there. If we were able, we would have scooped him up and taken him out of there, you know, but we had -- we did not have the skills to look after Martin. He needed full-time nursing care. There was nowhere else for him. But just not knowing -- just not knowing if he's safe, you know, is -- is a torment. 11:51

134 Q. And in the following month, your family received news of another incident?

A. Yeah, so you could just imagine a month later then we get another phone call to say Martin's been assaulted again. Again, very little information. We had to piece together the information from talking to other carers and the Police and such things. But, on that occasion, H2, I think we've called her -- 11:51 11:52

135 Q. Yes.

A. So Martin, again, has two carers and he was sitting on the sofa and a third carer had walked past the door of his little living room and had witnessed H2 take a bottle of water and throw it in his face and over his head, and the other carers with him started laughing and then they were making fun of him. And we remain grateful to the person who witnessed it, that she came forward, because how often had this happened before that no one had seen? To us, to happen within a month, there was a complete breakdown in any kind of civilised behaviours amongst staff. If that's what was happening openly in front of other members of staff, what was happening when people couldn't see? That's what haunts 11:52 11:52

us still, because it seemed to be "anarchy" is only the word for it. For two incidents -- for to not hear anything for 16 years and then, suddenly, within a month, to have two incidences. And what makes it more shocking is that -- so H2 accepted a police caution. 11:53

136 Q. Yes.

A. And when we -- we talked to the Police or I talked to the Police Liaison Officer and I heard that she got a police caution and I rang his Clinical Service Manager to say "Is she back on the ward?", and she was. And I 11:53 said "She's had a police caution", and he said "What?!". I said "She received a police caution" -- "Oh, we didn't know that, we weren't informed of that." And, again, what is happening? What kind of breakdown in management is happening that you don't know that 11:54 your staff member has received a police caution for abusing a patient?

137 Q. And in what position was the person to whom you spoke?

A. Clinical Service Manager. So, as I understood it, they were the highest people that I could speak to within 11:54 that -- I spoke to Clinical Services, Clinical Therapeutic and the Head of Nursing. So they were part of management. You know, they weren't just the ward managers. They were the management structure within the ward, as far as I understand it. There was a very 11:54 helpful chart, which I wish I had, which I saw exhibited at the beginning last week -- two weeks ago. But, yes, they were very much the management of the ward, so they weren't aware of it. So again you're

thinking "What is going on?", you know, in there. And again we said "She's not to work with Martin" and she wasn't -- she was an agency staff member, as far as I am aware, and I don't think she continued to work there.

138 Q. And are you satisfied that, after that, she didn't work with Martin again?

A. Yeah.

139 Q. Now, you kept notes, didn't you, of all of those conversations that you had? 11:55

A. Yeah, I suppose, in my -- in my role in my job, you know, I keep notes of everything because it's one thing to manage -- and your memory as well. So, yeah, I always, when I was talking to someone, I always scribbled down a note because one of the things I found was if you said "Well, I was talking to the Clinical Service Manager last week", they would say "Were you? No, we have no record of that." So at least if you were able to point and say, you know, "As I was talking to you on the 14th May" or something, they would say "Oh, yeah", you know, so I always kept a good note of all conversations. 11:55

140 Q. Well, I'm going to ask you to go through those in a moment, but before I do that, can I -- can I just refer you to the further several incidents that you describe in paragraphs 11 to 14? 11:56

A. Yes.

141 Q. And if we could just go through those in turn. And if you can add any detail at this stage to the detail you

have given in your statement, please do so.

A. Yes.

142 Q. In paragraph 11, you say that in June 2014, you family was informed of what was described as a near miss?

A. Mm-hmm. 11:56

143 Q. And that was that Martin had been given too much medication, is that right?

A. Yes. He had been given, I think, double the dose of one of his medications. He had been given it twice on the same day. And when I spoke to the Clinical Service 11:56 Manager, she said there was a protocol put in place for what they would have called near misses, a near miss obviously being that it could have -- well, I took it that it could have killed him. But, again, all these statements being made that plans being put in place and 11:56 we would find out more -- nothing, we heard nothing more about it.

144 Q. You may not remember this detail, but can you recall what the medication was?

A. I don't recall. Martin is on a number of different 11:57 medications and they sometimes change and sometimes the names change but they're the same drug, if you know what I mean. So I wouldn't be able to hand on heart say -- I could find out, though.

145 Q. Yes, but the indication was that he had been given a 11:57 double dose of a particular medication?

A. Yeah, and it could have been -- the fact that they were calling it a near miss, to me indicated that it could have been fatal; that it wasn't a double dose of

paracetamol, you know, it was one of his, you know, quite strong medication.

146 Q. Yes. And, secondly then, in paragraph 12, you refer to being informed in September 2014 about Martin having a large gash on the head and needing stitches. 11:57

A. Yes. So Martin is -- so he has two carers during the day and then, at night, there's a monitor at his door and a nurse sits there -- two nurses sit there until he goes to sleep. And then one is supposed to monitor him -- I don't think she sits there all night, but maybe 11:58 half hourly monitoring to make sure -- because, Martin, he has an alarm mat beside his bed so if he gets -- if he starts to mobilise at night, an alarm goes off because, if Martin gets up in the middle of the night, he might start injuring himself, so somebody has to be 11:58 there with him if he's in any way awake. So, you know, we were telephoned to say that he had a large gash on his head, the doctor had been called and he had to put in four sutures, and they don't know how it happened. There was no -- nobody saw anything, nobody knew 11:58 anything. And we questioned how that could be when he's being monitored, when he had the alarm mat, and they are -- they just didn't know, weren't able to give us any information.

147 Q. Then, thirdly, in paragraph 13, after a move to Erne 11:59 Ward, you say that the accommodation that Martin was placed in was very cold and uncomfortable?

A. It was -- Erne Ward was absolutely appalling. It was -- in my view, it wasn't fit for human habitation. We

found out -- they had made the decision, or we only found out the day before and the carers on the ward only found out the day before that Martin would be moving to it. So it was very haphazard. They had given him a dining room for a bedroom and, as I say, if 11:59
Martin mobilises at night, he had an unsteady gait at that time, you know, he couldn't walk that well and if he mobilised, because of the expanse -- it was all wooden flooring -- it was an old dining area. When he went in, there was a hole in the wall. The windows 12:00
weren't properly fixed. It was November and it was cold and Martin was unwell anyway -- he had a high temperature the week before -- and my parents were saying we need to -- like, "He can't live in this." So my parents had to go and find people to try and fix the 12:00
windows and they found someone who was able to then put a hospital tile in the wall, hole in the wall to stop -- there was like a gale blowing in. And when my parents came in to see Martin that day, his body temperature -- because Martin can't move around or he 12:00
can't mobilise to get his body temperature up and he was so cold they thought he was going to be hypothermic because -- and they had to take him to the car and turn on the heat and wrap him to try and get his body temperature up. And when they said this to the nurse, 12:00
they had -- they got a thermometer and they said to the nurse "It's 18 degrees in here and there's also a wind chill coming in" and she said "I think it's more like 19 degrees", you know, and you're like, you're like

this is not... And the common area he was given -- he needs his own space and he was always given a common area, and he had to share that with a female patient who would lash out regularly and she would wreck his CD player and his CDs. And Martin needs music all the time and, if he doesn't get music, he gets self-injurious. So there was no thought given to who Martin was sharing his space with. Erne was appalling. We rang and we wrote in. We did an official letter of complaint and I think they ended up nailing the window shut and we were able -- they came back to us two or three months later to say "It's all been fixed", but only because my parents had made sure that workmen ha came in to fix it, you know, so...

12:01

12:01

148 Q. We'll look at that particular correspondence in a moment, but I just wanted to ask you about the arrangement for Martin's living in Erne and you referred to the female lashing out and wrecking his CDs -- was that a room in which Martin was living and sharing with one or two people or --

12:01

12:02

A. No, just the female.

149 Q. Just the female?

A. Mm-hmm. And just, I suppose, the effect that Erne had on Martin at the time, when my parents used to leave him back, as soon as he came to the gate of Muckamore he started to hit himself really violently. And then when he went into Erne, you know, when they left him back into the ward, he would lie down on the sofa and he'd turn his back to us and he would cry. And crying

12:02

is not something you'd see Martin do very often but he was just -- it was just appalling.

150 Q. That happened, I'm sorry, that happened specifically when he was brought back into the Hospital?

A. In Erne. 12:03

151 Q. And a final incident that I wanted to ask you about then you deal with in paragraph 14, and you say that your family was informed of another assault?

A. Yeah.

152 Q. -- on Martin? 12:03

A. Yes.

153 Q. And this involved a female carer hitting him on the head and verbally abusing him?

A. Yeah.

154 Q. Pushing him violently into his wheelchair and holding him there? 12:03

A. Yeah. Yeah, we were told again verbally, again nothing in writing, wouldn't give us any information. We were piecing it together from police, from other carers, from talking to people. But there seemed to be this policy of stone-walling, you know, and just giving as little information as possible and definitely not in writing. But, yeah, we were just told that, as you say, she pushed him into his wheelchair, hit him around the head, held him there and verbally abused him. And we weren't told who the carer was. We were told there was an internal investigation and we were actually told after -- she was an agency worker, and we were told "She won't work here again." But we questioned with 12:03 12:04

the agency workers -- bank workers or agency workers, by their very nature, are picking up work everywhere. They're picking up work in Muckamore, in care homes, and we questioned whether she could be working elsewhere, and they said "We don't believe so." But it's just something to bear in mind, this is not confined -- when these are agency workers, they're working all over the Health Service. So, you know, just not working in Muckamore is just not going to stop the issues, you know, that are there. But we weren't told anything again. 12:04 12:04

155 Q. And the PSNI were involved, but there was no prosecution?

A. No action, no prosecution on that occasion.

156 Q. But were you kept updated on the progress of that matter by the Family Liaison Officer? 12:05

A. I believe so. I don't have a note of it, but, yes, I think we would have been updated by the Family Liaison Officer. At this time, we were fighting to get Martin out as well, so we were fighting another battle on the other side to make sure where he was going was right for him and stuff. So we just couldn't wait to get him out of there. 12:05

157 Q. But in relation to that particular incident, I think you say you're aware that there were internal disciplinary proceedings? 12:05

A. Yeah.

158 Q. But you don't know the outcome?

A. Don't know the outcome. We were told that we weren't

to be given -- you know, that wasn't for us to know, that was internal, so...

159 Q. Now, you have detailed all of these incidents in your statement and you've told the Panel about them today. From your statement and your evidence, it seems that your parents took a very active role, indeed, and complained about these matters on an ongoing basis? 12:05

A. Yes, very active, that we -- he wasn't within our care but he was -- like, Martin's the centre of our family. He's on our minds 24 hours a day and, you know, we were always making -- trying to do whatever we could to ensure that he was safe. 12:06

160 Q. And if the family heard about an incident or had concerns, they would raise it with management?

A. Yeah. Yeah. 12:06

161 Q. And you also telephoned the Hospital about these matters on a number of occasions?

A. Yeah.

162 Q. And is it fair to say that, in broad terms, you weren't satisfied with how these matters were being dealt with? 12:06

A. No, there were -- we could see from a family -- we're one family of how many hundreds were there, but we could see that this was a pattern that was happening, that this was a pattern of abuse that was happening within the Hospital. We weren't the only ones. In the newspaper, you could see other people being brought up, carers being brought up. It's quite evident that there was a breakdown in all types of professional structures/standards within the Hospital. And there 12:06

was a complete lack of willingness to engage in any way. I can only assume that it had worked for them for years to continue to stonewall families. The shutters came down as soon as we raised issues. It was "Protect the institution at all costs", that's what I felt. And 12:07
from a legal point of view, hearing stock phrases of "It's not up to standard, yes", you know, these kind of like -- they came -- they tripped too easily off the tongue, that we were not the only family that this was happening to. But there seemed to be no willingness to 12:07
get to the root of the problem of what was happening in Muckamore Abbey. It was just very much these families -- we were -- like, my parents had four other children to look after. They were working. They were trying to look after Martin. They were trying to make sure 12:07
everything was all right. They had so much else going on that I think that, I suppose, Muckamore maybe thought, the management in Muckamore maybe thought "If we just keep stonewalling them, they'll just go away, they'll get exhausted." And you do get exhausted, you 12:08
know, because you're banging your head literally off a brick wall. Because I never got the sense that anyone cared. I got the sense that everyone knew and it was a case of "We just shut down Muckamore and they'll all go away and that will be the problem solved", but the 12:08
problem won't be solved because my brother is still being cared for by the Trust. The same structures are still in place. Martin will need care for the rest of his life and the Trust structures that enabled this

abuse to happen are still happening. You know, we knew about CCTV being in those corridors in 2013 and we were told "Everyone knows it doesn't work", and the day I heard the CCTV had been switched on and they didn't know, I said to my husband "They're in trouble now." I had no doubt in my mind as to what that CCTV cameras would show, and that is one ward out of fifteen. And to hear, to listen to "Oh, as soon as we became aware of the CCTV cameras, we sprung into action" is unbearable from a family's point of view to listen to. It makes me so unbelievably angry because they knew -- 12:08 12:09

163 Q. And why is it unbearable?

A. Because they knew and they didn't care. The only reason the Trust are here today, the only reason the Department of Health are here today is because the CCTV evidence is irrefutable. They can't turn around and gaslight the families and say this didn't happen because it's irrefutable. So they have to hold their hands up. But they knew, you know -- 12:09

164 Q. And, Antoinette, what I want to do is to come back to -- 12:09

A. I'm getting cross now!

165 Q. You're here to give your evidence and to give your account and I want to facilitate you in doing that. Now, what I do want to do is to come back to the records that you kept of the various conversations that you had. 12:10

A. Yes.

166 Q. Now, these are exhibited to your statement. For the

record, the exhibits are A4 through to A8, and then A11 and A13. And the page number references are 014, page 17 through to 22; and 014, page 28; and 014, page 30. Now, to be fair, your handwriting is better than mine, but I want to give you the opportunity to go through the notes because there can sometimes be ambiguity over whether the note is a record of what was said by the person you were having the conversation with or whether the note recorded what you were thinking at the time. So, if you don't mind, we'll take some time to go through the notes.

A. Sure.

167 Q. And, again, we'll avoid using names, if possible, and, even where initials appear, we'll refer to that individual by role, rather than by initials, if we can manage that.

A. Yes, sure.

168 Q. So we'll start with Exhibit A4 and this is dated the 7th July '14, and I think I can -- the first line fairly clearly refers to a voicemail being left with the Service Manager to return a call about a monitor.

A. Yes.

169 Q. Do you want to take up the note from there?

A. That's the monitor that looks after Martin at night, I suppose, where the nurses look at the monitor, and my Mum had come on to the ward and a nurse had said, "Oh, the monitor's been broken for some time." And my Mum, "Sorry, what?". So my Mum was taken aback because this was the only thing -- like, this was one of the

main things to keep Martin safe at night. So they just said "Oh, we just want to check we can take money out of Martin's money", and my Mum was like "There's a bigger issue here -- how long has the monitor been broken? Why has it not been replaced?". So, yeah, 12:12
apparently the nurse didn't know who to speak to -- I think it was the Nurse Manager said "I didn't know who to speak to to get it fixed." And we were going do we have to sit -- like, do we have to start working on the ward here to make sure Martin's safe? Like, it was 12:12
just unbelievable. So, as I was saying to the Clinical Services Manager, this was completely unacceptable, that if the monitor was broken and it's main safety tool for Martin, then it should have been fixed. And then they were saying -- the Clinical Services Manager 12:13
came back to say, yes, the monitor's been fixed and that they have got a back-up one in case it happens again. And you will also see there where I brought it to his attention about Martin's fingers being trapped in the door. Martin at that time was using a handling 12:13
belt, which is a belt which a carer can, either side, can use to help steady him, you know, when he's mobilising. And they had been walking through the door and the carers had let the door slam back on Martin and his fingers had got trapped, so we wanted an assurance 12:13
that that wouldn't be allowed to happen again. And the Clinical Services Manager had said that, yeah, they needed to get the door -- they had got the door fixed because the safety mechanism had been broken on the

door, so they got that fixed so it wouldn't happen again. His fingers were quite badly injured at that time.

170 Q. And I'm sorry to bring you back, Antoinette, but there is a line that says "Unacceptable. Lack of any professional standard. Should not be bringing this to Mum's door..." -- is that correct? 12:14

A. That's me, that's me telling him that that is complete lack of any professional standard and he shouldn't be bringing it to my Mum's door. It shouldn't be a matter for my parents to make sure the safety tools are working and in good working order, that that's -- it's just -- again, it defies belief. If that is needed for Martin's clinical care, then they should make sure -- they shouldn't be humming and hawing and looking at each other going "Yeah, we didn't know, we didn't know who to talk to." 12:14 12:14

171 Q. But I just wanted to be clear that's a note of what you were saying at the time?

A. Yeah, sorry, that was me. 12:14

172 Q. -- that particular line?

A. Yeah.

CHAIRPERSON: And, I'm sorry, that was actually in relation to the monitor, not the trapping of the fingers? 12:14

A. Yes.

CHAIRPERSON: Yes.

A. Although it...

173 Q. MR. DORAN: And just if we go to the next page then, on

9th July 2014 the Service Manager returns your call?
A. Yes, and this is to do with the second incident of abuse. And again she says -- so I'm just checking just because the timeline, just to make sure I've got my timeline right. Yeah, this was the second incident of abuse and she apologise -- well, she didn't apologise, she said she was disappointed the standard of care was not, in inverted commas, not "up to standard", which made me cross. "Not up to standard" is like a Tripadvisor review. He had been abused for a second time in a month. Saying something is not up to standard doesn't really cut it, you know, in my view. 12:15 12:15
174 Q. You've put those words in inverted commas in the note. Were they the actual words she used at the time?
A. Those were the actual words, yeah. And then she assured me everything was being done to ensure it doesn't happen again. But I was saying "But it's happened twice in the one month and those procedures didn't prevent it happening again, so stop, you know, throwing out stock phrases because they're not making any sense in the context." So she went through and said about the staff being placed on precautionary suspension and sent me out the Safeguarding Vulnerable Adults. She said a robust -- and again I've put "robust plan" in inverted commas because that's the word she used, a robust plan would be put in place to safeguard Martin. She said then that a full investigation of the procedures would take place. The Trust would do this. But nothing ever came of that. 12:15 12:16

You know, that was just talk. There was no -- there was talks throughout it that we would have meetings and that there would be, you know, it would be looked at and things, but that never happened. It just didn't. And then we were pushing for CCTV at that time, and we were told that, you know, there was other families and privacy issues. But Martin had his own areas and we were saying that he could safely have -- easily have CCTV within his own areas and it wouldn't compromise anyone else's privacy. But they wouldn't let us have CCTV or they wouldn't put in CCTV. 12:16 12:16

175 Q. And you say at the end that the Service Manager said she would make herself available for a meeting in August. Did that meeting actually go ahead?

A. We had meetings around that time to do with resettlement. I don't recall that meeting taking place. 12:17

176 Q. Just moving on to the note of a further conversation that you had then on the 10th July --

A. Yeah, that's to do with both the medication and to the -- and to do with the second incident of abuse that was notified as a serious adverse incident. So both the wrong medication and the second incident of abuse is what she told me would be a -- and in inverted commas again because that's the word she used, "serious adverse incident", which means it would be notified to the HSE -- now, I would call it the HSE because -- but that would be the Health Service here -- 12:17 12:17

177 Q. Oh, yes, so by "HSE", you mean the Department of

Health, essentially?

A. Sorry, yeah, because where I come from, that's what they call it. So the Department and the RQIA said there would be a major review of the incident; would invite family along; someone independent of the Belfast Trust. This never happened. All these things were just what's going to happen, but they didn't happen. We weren't, you know, we weren't given information like this.

178 Q. Well, I should say, in fairness to you, the Inquiry can, of course, in due course receive all relevant records from the Trust, and that's a matter that we can perhaps revisit at a later stage? 12:18

A. Yes, yeah. So they were saying that the incident caused major concern; that that for, you know, for a patient, that that's what they would do. 12:18

179 Q. What specific incident was being discussed at that time?

A. The second incident of abuse. And the medication. And then she said, she said they would look at the impact on Martin -- "Could we have avoided this?", "Are there procedures/other measures which could be put in place?", "What can we learn/what other procedures could be put in place?"; that they want to take a proactive role and open discussion. But that was all talk. That was not what happened, you know. It was all just stock phrases when I look back on it now, you know. It sounded promising at the time, but it didn't materialise. 12:19 12:19

180 Q. Can I ask you then about the note of the conversation again with the Service Manager on 5th September 2014?

A. And this is the sutures. So that's -- she indicated that the staff supervising Martin would be asked to put down a sequence of events, that they don't know how it happened. When they went in, he had a cut on his head. The sutures were stim -- is it stem strips were used that night to suture it together, so it was quite a deep gash on his head. It would be very hard for Martin to -- Martin would punch himself, but to -- a cut would be very hard to do through punching, so it was -- and the mat didn't go off, the alarm mat mustn't have gone off. So we were just at a loss to understand how he would have cut himself. There was nothing sharp or -- so it left a lot of questions in our heads. So the next morning then the Muckamore doctor glued the cut and then he -- Martin wears a helmet when he's mobilising so in case he falls or anything like that, and sometimes if she was self-injurious they'd put the helmet on to try and protect his head from self-injurious behaviour. But the helmet reopened the stitches that night. Again we were told they were going to try and ascertain how it happened, that they didn't know how it happened, and I was making the point but he has two carers with him during the day and, at night, he was monitored, so how could they not know -- and it was just, like, they didn't know, so it was, you know...

12:19 12:20 12:20 12:21

181 Q. And did they ever get to the bottom of this incident?

A. No, never.

182 Q. Can I just ask you about the two notes at the bottom of the page?

A. That's my notes where I have said to them when he's restless, you don't dare take -- like, my Mum would say he's like a baby in the bath. If Martin starts to mobilise at night, that's a trigger something's wrong because he sleeps like a baby. He goes to bed at half nine and he wakes up at half nine. If he mobilises at any time during the night, he is agitated about something, so you have to be with him. So, as I said, that note there is it's like leaving a baby in the bath -- you don't take your eyes off him in that situation. So how they couldn't have seen what happened to him that night is just beyond belief, and that's the point I made -- the other note at the bottom is a point I made to her, is that the camera trained on him and they have the alarm mat but yet -- and two people that should be looking after him and yet they don't know how it happened -- like, that's not acceptable. But, no, we didn't hear any more. 12:21 12:21 12:21 12:22

183 Q. And just the last page of this sequence -- or, sorry, two further pages in this sequence -- again, this one isn't dated, but this is when you're raising the point about the heat and the window being broken? 12:22

A. Yes, this is on the 17th December when I rang and I talked to one of the carers and he blamed the nurse in charge. He said it's, you know, that it was her -- it was her fault that it was so cold, that there was no

heat. What they said at the time was there was a problem with the heating. The rooms that Martin hadn't -- the rooms that Martin had moved into hadn't been used for a number -- I don't know how long -- but the radiators were air-locked so there was no heat in that part of the ward. And they said, when I spoke to him, he said, "Oh, it's terrible in this ward getting the heating right -- it's always too warm up the front and too cold down the back", where Martin was. When we raised the issue about broken windows, he was aware of that, and then I said to him there -- it's spelt badly, but I say we're at the end of our tether here, that we cannot continue. You know, it was just one thing after another and then he's moved into sub -- you know, just accommodation that you wouldn't want anyone to live in. 12:23

184 Q. And on the next page then, that's the -- that relates to the same date, I think, the 17th December?

A. Yeah, again, so talked to the Clinical Services Manager and she said that they were airing the ward, that's why it was so cold, and they are now monitoring the ward every half an hour. She said there was no fault with the heating, and we were arguing that there most certainly was a fault with the heating because we had to get workmen to fix it. And then she also said that part of the problem is they were preparing the room. Again, that because it was done in such a haphazard fashion, that no one was ready for Martin to move. They weren't aware he was coming, he didn't know he was going. And you'll see that in later correspondence

where they say -- so workmen were coming and going that when Martin was living those first couple of days to fix these.

185 Q. Yes, and we will have a look at that correspondence to which you refer. Just the final paragraph there, you say, "Took down. Investigated. Who investigated?" and I wonder could you explain that? 12:24

A. The carer took down notes and that this would be investigated, is what she was saying there. And I was saying again "Who?", and she said a senior nurse within the Trust, and to put in the complaints. Because one of the things we were coming up against is that we were making complaints, but they were investigating themselves. You know, there was no independent oversight here. We did complain to RQIA, but there's issues there, we felt, with RQIA as well, but we might come on to that. 12:24 12:25

186 Q. We will come on to look at the RQIA in due course. But just to complete this particular part of the evidence, if you can have a look at Exhibit 11, that's a further attendance note dated 15th April 2015, and I think that relates to the incident in which Martin was pushed into the chair, isn't that right? 12:25

A. Is that -- sorry, 15th April? 2015 with the clinical -- 12:25

187 Q. It's 15th April 2015?

A. Yes.

188 Q. And it's Exhibit 11.

A. Yeah, so that was the third incident. And that's all

we were told at that time, that he had been pushed into the chair, the Police had been called. Her attitude, I don't really recall the "non-compliance bit" -- I don't think she was too happy to take or need instructions, maybe that's -- I can't recall that. We were assured at that time that trained nurses -- because we said at that time Martin should have a nurse on with him at all times, a nurse and a carer, but what was happening is that two carers would be on with him. So we were saying we want a nurse on him, we want that assurance, and that's what he's saying, trained nurses will be on with him. And after this incident, if I recall correctly, a Band 5 nurse -- they made sure a Band 5 nurse was put on with him at all times. And the carer who assaulted Martin was going to be suspended that day pending an investigation and the Clinical Service Manager would speak to the Consultant Psychiatrist. 12:26 12:26 12:26

189 Q. Yes.

A. And then I asked who was dealing with it, and he said it might be the Head of Nursing -- again internal, again. 12:27

190 Q. Yes. And finally then just in this sequence of notes, if you can look at Exhibit 13, I think this is when you spoke to the senior nurse, is that right?

A. Sorry, what date is that one? 12:27

191 Q. That's 15th April 2015, and it's Exhibit 13.

A. Sorry, I don't have it numbered.

192 Q. Yes, the number at the top of the page should be 014-30.

A. Sorry, I'm going off my own notes, which is probably not the best! (Same handed).

193 Q. No, it's fine.

A. This one here -- yes, so that's where the Head of Nursing said that there would be a change to his supervision, that two staff during waking hours -- sorry, there would always be two staff during waking hours, but one of them was going to be a qualified staff, which she defined as a staff nurse, which is a Band 5 nurse. When my Mum had gone to the ward a couple of weeks before and had been talking about one of the -- they had been talking about the incident that happened to Martin -- one of the nurses said "Well, you know, people lose their tempers." 12:27 12:28

194 Q. Yes, and you explain that in your statement? 12:28

A. Yes.

195 Q. And what your reaction to that was or what your mother's reaction to that was?

A. Yeah, yeah. It's heartbreaking that that's the kind of attitude that's being taken. And I raised the issue with the Head of Nursing that one of the things we were talking about to the staff members at the time -- because we were trying to understand what was happening so we could take steps to try and stop it, and from what we were hearing from carers and from staff at the time is that they were advertising for temporary positions at that time because they were closing down the wards, so they weren't taking on full-time staff. So people that were leaving through natural attrition, 12:28 12:28

through, you know, retirements, through leaving, they were only -- they weren't advertising for full-time staff, so they're either taking on agency staff or they were advertising temporary contracts. But everyone knows in any walk of life if you advertise a temporary contract, you're not going to get the same calibre of person as you would for a permanent, full-time position. So the carers and the nurses were identifying to us that this is where they felt part of the problem was coming from. So I raised that with her, but I don't believe she said much or I would have written it down. This is where we were saying she met with the person who assaulted Martin and she assured us that she would not be working in the Hospital, and that she would not be offered any shifts in Belfast Trust. The Nurse Manager said it was in the carer's best interest to be honest, and she would ask the carer if she had any work in the public or private sector and she said "no". And then I was asking about other people to contact. 12:29 12:29 12:29 12:29

196 Q. Yes. But just in that paragraph that begins "Met with...", is that the senior nurse describing her meeting with the person --

A. -- with the person who abused Martin, yes.

197 Q. -- who abused Martin. Thank you for taking us through those. We are aware from your statement that during this period of 2014/2015, your mother was also in contact with the Consultant Psychiatrist who was treating Martin at the time? 12:30

A. Yes, yes.

198 Q. And I think you document those meetings in paragraph 15 of your statement, and you refer, first of all, to a meeting on the 3rd July 2014. Were you present at that meeting? 12:30

A. No, I wasn't there.

199 Q. Your mother was there, isn't that right?

A. Yes.

200 Q. And you exhibit the minutes of the meeting at Exhibit 12. Now, that's obviously a different kind of document from your attendance notes. Were those minutes prepared formally? 12:31

A. Yes.

201 Q. And then provided to the family after the meeting?

A. Yeah. So this meeting had happened as a kind of a side meeting during one of the resettlement meetings that my parents would have attended in Muckamore. And then they had asked to speak to the Consultant Psychiatrist to see what could be done to help Martin, really, at the time. And, as you can see there -- 12:31 12:31

202 Q. Well, let me just read through the minute, actually, and then I'll give you an opportunity of commenting.

A. Yeah.

203 Q. So the meeting took place on Thursday, the 3rd July 2014. The Consultant Psychiatrist was present with an advocate -- and was the advocate there to represent Martin's interests? 12:31

A. Yes, she would have been from Mencap, as far as I understand it. But could I just add here that she had

mentioned before -- I don't know how much interaction this advocate had with Martin. Certainly I wasn't very impressed speaking to her on a number of points because I felt she didn't know Martin, she didn't know our family, she didn't know the issues with Martin. But she also mentioned, and this is part of the problem in Muckamore, she also mentioned she was a very good friend of the Consultant Psychiatrist. So you're just -- you're constantly up against this kind of, like, everyone knows everyone and, you know, even someone who was supposed to be Martin's advocate mentioning that she was very good friends with the Consultant Psychiatrist is not helpful. 12:32 12:32

204 Q. And your mother was present at the meeting obviously?

A. Yeah. 12:32

205 Q. So the note reads:

"Martin's mother very upset and concerned about the incidents that have happened on the ward recently. The Consultant Psychiatrist assured Martin's mother that the incidents have been taken exceptionally seriously and the Police are involved. Good relations with the Police. An individual is involved as safeguarding officer..." 12:33

12:33

-- his name is given in the note --

"...and will be asked to make contact with Martin's mother."

And then the sentence:

"Seemingly, the incidents have had no effect on Martin. He has shown no signs of distress or agitation."

12:33

Now, I note that in the copy of the minutes that we have, there's an exclamation mark written to the side of that paragraph --

A. I had --

206 Q. Was that your exclamation mark? 12:33

A. -- and it was from the time because, when I went to my file, I found the minutes and I had highlighted that and put an exclamation mark because that's how we felt at the time. That wasn't in hindsight or anything like that. It just was shocking and we would have said it 12:33 at the time. That's not the case, you know, but obviously the minutes -- and we found it from the minutes of the resettlement meetings as well, that minutes would be done up, but they just record decisions or record outcomes. They don't record maybe 12:34 the exchange of views that happened or anything like that. So, you know, they said "Mrs. [redacted] is so angry and sad about these incidences" -- Mummy was very, very --

CHAIRPERSON: Sorry, we've just had a name revealed. 12:34

MR. DORAN: Yes.

CHAIRPERSON: Can we just pause the live feed, please?

A. Did I say --

CHAIRPERSON: That's okay, it's inevitable that it will

happen.

MR. DORAN: That's fine, Antoinette, you just mentioned your mother's surname.

A. Oh, did I? Sorry.

MR. DORAN: And there's no difficulty whatsoever -- 12:34

CHAIRPERSON: Just give it a second.

MR. DORAN: -- in ensuring that that goes no further.

CHAIRPERSON: Yes. So the transcript will need editing and can we just take that answer out? Are we okay to continue? We'll just give it a few moments. This is 12:34 the first time we're practising with this --

A. I know, I'm sorry!

CHAIRPERSON: Don't worry at all.

A. I was doing quite well with the names!

CHAIRPERSON: You were doing very well! There's no 12:35 worry at all.

MR. DORAN: It's good to test the system. If it seems that we need to go into the afternoon, I understand that the witness is available to spend a little bit more time giving evidence. 12:35

CHAIRPERSON: Okay. Are you all right to continue for the next sort of twenty minutes or half an hour?

A. Yeah, I'm fine. I'd rather give it the time.

CHAIRPERSON: Okay. Can we continue? Thank you. If you just go back to the last question, Mr. Doran? 12:36

207 Q. MR. DORAN: Yes, in fact, Antoinette, you were reading from the minute --

A. Yes, she refers to my Mum being so angry and sad about these incidences -- that would be my Mum trying to

express to the Consultant Psychiatrist how much upset this has caused, you know, and my Mum and Dad would be -- and it's part of -- you'll come across this more, you'll come across it anyway, but they'd be trying to be as deferential to the specialists as they can be within -- I may not have been as polite within it, but my Mum did express that that just made her so -- like, made the whole family so angry, and even that statement made by the Consultant Psychiatrist would have made her so angry, you know. But that's what we were up against, you know. We were up against "We think Martin looks well." He's five stone, he needs to be PEG-fed, you know. "We think there's institutional abuse happening at Muckamore Abbey." "Ach, come on." It was always like you're made to feel like you're being overly dramatic or -- it's a form of gaslighting, and that would have been the same -- and we've raised it a couple of times with the Consultant Psychiatrist where we said, "Okay, so why has he been put on anti-depressants after it?". "Oh, that's a number of factors." "Well, what factors? Please explain to us what factors." "It was just a number of complex factors." You know, as if we couldn't understand, you know, what kind of complex factors they may be.

12:36 12:36 12:37 12:37 12:37

208 Q. So you felt that you weren't getting satisfactory explanations of Martin's treatment?

A. No, just being frustrated at every turn, really.

209 Q. And I think you refer also to another meeting in 2015 at which the Consultant Psychiatrist was present?

A. Yes.

210 Q. This is in paragraph 15 of your statement?

A. Yeah, and that's where -- now, I was at that -- I was at that meeting and that's why I recall it. It was one of the resettlement meetings with -- the Consultant Psychiatrist would have been there as part of the multidisciplinary team, and we were talking about the abuse and my Mum had said there was systemic abuse -- 12:38

211 Q. And did your Mum use those actual words?

A. Systemic abuse, not systematic -- it's a misspelling -- systemic abuse happening at Muckamore Abbey, and this was in front of the multidisciplinary team and the Consultant Psychiatrist and her exact words were, "Ach, now, come on, Mrs. [redacted]", you know, as if "Really?". Not willing to engage on any level, just brushing us off at every turn. And, as I say there, we were completely dismissed. That's how we felt. I haven't come across it in any other part of our lives where any of your concerns were just dismissed. You were just -- you were just a nuisance, you know, "Stop, we've got a job to do, stop bothering us", you know, that's the kind of attitude we always got, you know. 12:38 12:38 12:39

212 Q. But it was clear that it was a period of constant concern for you and your family?

A. Yeah. It got so bad that every time the phone rang, when I was at home and the phone rang I would have to talk my parents -- if we weren't expecting a call during this period and the phone rang out of the blue, say at nine o'clock at night or something, I had to 12:39

tell my parents to calm down and to breathe and we were going to answer the call and see what had happened because they were, "Oh, oh my God, Martin -- oh, my God, something else has happened Martin." So the fact that they survived this period is beyond me because the amount of medication that they've had to go on because of it -- and even now the remnant of that with phone ringing, you see the hand go to the chest and Daddy going, "Oh God, oh God, oh God", you know, and you're like "We need to just deal with whatever situation's on the other end of that phone." So that's -- that didn't happen before these abuse, but there was so much happened within that period and there was probably more that we've actually blocked out. But so much happened. You were just constantly getting phone calls and constantly something else would have happened. Just the place was in chaos, as far as we could see. It was -- it was just -- I don't know. 12:39 12:40 12:40

213 Q. You've talked through many of the conversations that you had and many of the items of information that were being passed on to you at the time. 12:40

A. Mm-hmm.

214 Q. You also then went on to make a very detailed written complaint, isn't that correct?

A. Yes, in relation to Erne? 12:41

215 Q. Yes. And that was in December 2014, I think.

A. Yes.

216 Q. And you've exhibited the letter of complaint at Exhibit 9?

A. Mm-hmm.

217 Q. And the page reference is 014-23. I wonder if we could have a brief look at that, please?

A. Yes, this was shortly after Martin moved into Erne and there was a number of issues raised. The first was the lack of heat. So the rooms, as I had said, the rooms that had been allocated to him was a former dining room, and I think the other room was -- it was almost like a -- I think it was a staff room or something like that, a smoking room, the area, because the smell was atrocious. But when my parents went in on 21st November, Martin -- it was extremely cold and it was -- when they touched the radiators, one had only warmed up halfway and the other one was completely air-locked. So my Dad went off to find someone to try and fix the radiators. There was also a large hole in the outside wall, which was creating like a tunnel-like effect, so wind was coming in. When we asked the ward manager what was wrong with the heating, he said he didn't know, he hadn't checked the heating in that part of the ward. So my parents got a workman and they were able to -- the windows as well were hanging loose, so they were able, with the workmen, to push the windows shut and to stuff a hospital towel in the hole in the wall to stop the tunnel-like effect. And then that towel stayed there until the 24th, two or three days later. 12:41 12:41 12:42 12:42 12:42

218 Q. So that's the first matter you raised in the correspondence, the heating issue?

A. Yes.

219 Q. You then go on to refer to Martin being regularly restrained in a wheelchair, isn't that right?

A. So any time my parents went to see Martin, he would be in the wheelchair. Now, Martin at this stage had still limited use of his legs, but it was very important that he mobilise as much as possible and to ensure he didn't lose the use of his legs. But every time they came onto the ward, he was in his wheelchair and when they questioned "Why are you in the wheelchair?", "Oh, he's just finished his lunch", knowing full well lunch finished two or three hours previously -- or that "He's just finished getting changed." There was always some reason why he was being in his wheelchair, and my parents would recall at that time that he was being fed in his wheelchair and my Dad at one stage had to get someone to help him clean down -- there was food left all over his wheelchair from several days -- it was unsanitary, it was filthy the wheelchair he was being left in. So they raised that issue, that he was being restrained in his wheelchair in that he was being strapped in, so he couldn't move of his own free will, and that would precipitate self-injurious behaviour because he can't say "I want to walk" or "I want to get up", so the only way he can communicate is through hitting himself, you know. 12:43 12:43 12:43 12:43 12:44

220 Q. And was it the case that the care plan provided that the wheelchair was only to be used at meal times?

A. Yes, yeah, and very, very limited use at that time.

But --

221 Q. And then you also -- the third issue you raise then relates to a specific incident concerning soiled clothes being dumped on top of Martin's clean clothes?

A. And that may seem minor in relation to what we're talking about, but one of the things my Mum and Dad were always very -- to make sure of since Martin ever has set foot in Muckamore is that he would be very well turned out and that they took great pride in making sure that he was nicely dressed. They would change him -- make sure he was changed two, three, four times a day, if that was needs be, because Martin would, you know, saliva and stuff sometimes getting his jumper -- and it was make sure he had a clean jumper on -- the same as you'd look after your own children, making sure everyone was... So Mummy would take all his clothes and bring them home and wash them and launder them and then bring them back. And when she went up one of the days, Martin's old soiled clothes with, you know -- that maybe, you know, had different types of soiling on them, had been just thrown in with his freshly laundered clothes and, to us, that was just a complete lack of any standard of caring, that, you know, that you would make sure yourself that that wouldn't happen. And then when it was raised, we were told, oh, it was just that the carer wouldn't have known -- didn't know the difference between the dirty clothes and the clean clothes. And you think, well, what type of person is working there that doesn't know the difference between

clean clothes and dirty clothes? But, again, this kind of like, "Ohhh, my God, always raising issues." You know, it was almost as if, you know, "Why, you know, why are you bringing this to us? What concern is this?". But it was really we raised it in that letter to show that there's a complete lack of caring. It's just an example of the complete lack of caring shown by the carers.

222 Q. And then the final point at 4 that you raise relates to the standard of living conditions generally, isn't that right? 12:46

A. Yeah. It was horrendous. Like, we had said that staff and patients didn't know they were moving until the day before the move, so the rooms weren't ready. The rooms shouldn't have been lived in. The rooms were filthy. Martin got an eye infection. My daughter at the time was -- she's now thirteen, so she was maybe about six at the time and she turned around to me the other day and said "Mummy, I still remember the smell of that ward", and she would only have been five or six. The smell of ingrained dirt and my daughter likened it -- she said "Mummy, do you remember when the drained back up that time...", that's what it smelt like all the time. It was -- it was just horrendous. Also coupled with the fact that he was put into a room which was unsafe for him. He could have -- he could have fallen, he could have hit himself. It was not -- no thought or care was given to whether that room was suitable for Martin. And we said to them in the letter, you know, 12:46 12:46 12:47

"It's an immediate danger to his health and well-being, his current living conditions."

223 Q. And did you draft that letter yourself, Antoinette?

A. Yes, I would have drafted that from my parents -- I would have drafted it with my parents, and it would have been my parents' letter. But I would have helped them. 12:47

224 Q. And there was a response to the letter then on the 9th February 2015, isn't that right?

A. Yeah, what's curious about that, I suppose, is we wrote to the Complaints Department, I suppose, is the curious thing, but it was the person -- the Director of Adult Social and Primary Care wrote back to us on behalf of the Chief Executive, which struck us at the time as quite curious as to why it had reached the desk of the Chief Executive. But, I don't know, I'd say we might get more information about that. But this, the letter we got back was eight weeks later. 12:47 12:48

225 Q. Yes.

A. And we -- my parents had already made sure that the issues in relation to the heating and the windows had been fixed, you know, so it was coming too little too late, you know, but as they say there -- 12:48

226 Q. Well, let's just look at that, at the beginning of the letter? 12:48

A. Sorry.

227 Q. They say:

"A senior manager has investigated the issues raised

concerning the ward and your son's time spent in his wheelchair. Firstly, I would wish to apologise to you for any upset or distress caused. I will address each issue below."

12:48

So the letter begins with an apology.

A. Yes.

228 Q. The letter then goes on to deal with the -- with four issues in turn -- not in the order that you have raised them, but just, in shorthand, number 1, the heating has been fixed --

12:49

A. Yes.

229 Q. Number 2, regarding the dirty laundry, there's an acceptance, I think, that staff were not adhering to the system and an apology for the upset that that had caused?

12:49

A. Mm-hmm.

230 Q. Thirdly then, there's an acceptance that there had been a problem with the window seals, which has since been fixed?

12:49

A. Mm-hmm.

231 Q. And then, fourthly, in relation to the use of the wheelchair, the response says:

"During the course of the investigation, direct observations were made. On all occasions, the use of the wheelchair was deemed appropriate as per guidelines for the use of Martin's wheelchair and the use of the wheelchair straps highlighted in his nursing

12:49

assessment. Martin's daily routine and management document were reviewed and staff reminded of the requirements in relation to the use of the wheelchair by your son."

12:50

And then it goes on to say:

"I apologise for the upset and distress these issues have caused you and your family. I'm aware that it has been an anxious time for you and your son with the move to a new environment, but I hope that all of the issues of concern have now been satisfactorily addressed."

And can I ask you did you feel that the issues of concern had been satisfactorily addressed? 12:50

A. No. It was -- I felt when we got that letter, I didn't even go -- you know, there was no point engaging with them. I felt when I got that letter -- because, you know, they're saying things have been fixed -- we've already told them we fixed it ourselves, you know, some weeks prior. They talk about an investigation happening. They didn't speak to us. You know, who did they speak to? What level of investigation happened? What level of interrogation was around this? 12:50

232 Q. So from December to February when you received the letter in response to your letter of complaint, is it right to say that no one spoke to you about the matters that you had raised? 12:51

A. No. We made sure that the heating was right. We made

sure that he wasn't sitting in his wheelchair as much because we would -- we started to pop in -- because usually you could tell when we were going to pop in, but we started to kind of come in unexpectedly more so, just pop in, and that kind of improved the wheelchair situation. You know, we made sure that his clothes were hung properly and that there was a washing basket then for his dirty clothes. So we made sure that all the issues were fixed, as much as we could. We couldn't get him out of Erne, which is what we would have wanted, but again this happened in the context of us engaging in a resettlement. At that time, we were engaged in a number of conversations about getting Martin out. 12:51 12:51

233 Q. Well, I do want to move on and speak about Martin's move away from Muckamore and how he is getting on now, and I want to talk about that before we finish. But, before we do that, I do want to deal with the final series of items that you refer to in paragraph 18 of your statement. 12:52 12:52

A. Yes.

234 Q. And you've also exhibited those to the statement -- first of all, at Exhibit 16 and the page number is 014-36, there is a letter of March 2015 to the Service Manager? 12:52

A. Yes, this was following a conversation I had -- this was the conversation I had with the Clinical Services -- she's the Services Manager -- it's the Clinical Therapeutic Manager, the gentleman, where I had asked

-- so where he had said the disciplinary proceedings against H1 had been concluded and I said, "Well, can you now tell us what happened?" and he said "You'll have to write to the Services Manager for that information." So this is what this letter -- and, also, we wanted to make sure because it was following that conversation where the Clinical Therapeutic Manager had said "Oh, I'll make a note now that she's not to work with Martin", we wanted to make sure that that was in writing. 12:53

235 Q. So this was really all around your concern at staff who had been alleged to have caused --

A. Yeah, that's just shortly after we found out.

236 Q. -- were working on the ward?

A. Yeah, we had only just found out then because the H1's internal disciplinary had concluded in around March 2015. But the main point of the letter as well was to get the information because, I suppose, we were always told that once the internal disciplinary proceedings were concluded, then we would know more; then there would be the meeting; then all these things would happen. But then we had got to the point where the internal disciplinary was finished and we were still not being told anything. So the point of the letter was to try and get some information as to what happened to Martin. 12:53 12:53 12:54 12:54

237 Q. And let's have a look at the response then. It's exhibited at Exhibit 17 and it's dated the 20th April 2015. And that, again, comes from the Director of

Adult Social and Primary Care on behalf of the Chief Executive, isn't that right?

A. Yeah, which again struck us as curious because we had written our letter to the Clinical Services Manager and we were being replied to by the Chief Executive of the Trust, which indicated to us that he was more than aware of what was happening to Martin, because how did it make it onto his desk? You know, she was writing, the Director -- I'm not sure who the Director of Adult Social and Primary Care was. I would certainly have written to her if I had known before and before February. But certainly there was people higher on up the chain that knew about what was happening to Martin that weren't hearing it from us, so they must have been hearing it internally. 12:54 12:55 12:55

238 Q. Yes.

A. So my letter to [redacted] -- to the Clinical Services Manager that I had asked -- I had said:

"We require confirmation of the proceedings brought against the members of staff..." 12:55

-- and I told her:

"We note that we have not..." -- 12:55

CHAIRPERSON: Just pause for a second. You coughed at me quite rightly because I think you had half-named somebody.

A. Yeah.

CHAIRPERSON: But, in fact, it was somebody in a very senior position, in any event, and I think we're just going to move on. Can I ask that it's not transcribed and that we simply remove it from the transcript? 12:55

MR. DORAN: Yes.

CHAIRPERSON: And then I think we're going to move on.

MR. DORAN: Yes, I think that's the appropriate way --

A. I'm very sorry. I will try --

CHAIRPERSON: You were trying to alert me and I'm afraid I had missed it. So, that's fine. Thank you. 12:55

239 Q. MR. DORAN: And, Antoinette, in fact, you were just about to read from the final paragraph of your letter, where you say -- and this obviously was a letter from your parents -- 12:56

A. Parents, yeah.

240 Q.

"As Martin's guardians, we require confirmation of the proceedings brought against the members of staff involved in the allegations of abuse against our son and we require confirmation of the sanctions which have been imposed. 12:56

We note that we have not been informed of the details of the abuse suffered by our son. It is a fundamental right that Martin is informed of the details of the abuse which he suffered at the hands of the staff of Muckamore Abbey Hospital and this information should have been furnished to us as Martin's guardians. 12:56

Please now furnish the details of the abuse suffered by our son."

A. Yes.

241 Q. And we touched on the response then that was received to that, in which there is a reference to the conversations that you had? 12:56

A. Yeah.

242 Q. And then the response goes on to say:

12:57

"As you were made aware, the Trust instigated the Safeguarding Vulnerable Adult Policy immediately after both incidents. This allows the Trust to take appropriate action when complaints are made against staff in relation to their patient care duties. The 12:57
Trust fully cooperated and took advice from the PSNI on the timing and appropriateness of internal processes. The Trust's disciplinary policy permits the Trust to proceed with internal disciplinary action in situations where a criminal case is pending. The outcome of any 12:57
subsequent criminal proceeding will be considered in respect of what impact they may have on an individual's contract of employment. The Trust is unable to comment on an individual staff member's circumstances. However, in addressing any staff management or 12:57
disciplinary issue, the Trust's paramount consideration is the health, safety and welfare of its patients and service users. I can also confirm that, as part of the safeguarding plan, staff who have been involved in

complaints against them will not have access to your son."

And the letter finishes by saying:

"I hope this answers your queries and would urge you if you have any further concerns to contact the Senior Nurse Manager."

Now, from your perspective and your family's perspective, did that letter go any way to assuaging the concerns that you had? 12:58

A. No. That was just stock phrases, you know: We put our patients first, we will do everything within our powers, we can do -- we can carry out our disciplinary procedures and then we will take advices from the PSNI. Stock phrases you would expect anywhere. We specifically asked for information about what happened to Martin, and they came back and they just -- in that preceding paragraph and they said: Well, you were told on 18th May and 24th June what happened to Martin. Those were the two phone calls to inform us of the abuse, the two initial phone calls to say: your son has been abused. Could you imagine, in a phone call, trying to assimilate the information, any information, which they didn't give, in any event, but if they had given the information, how could you even take that in? All you would be hearing is "He has been abused." So we wrote to them and said: "Can you please give us

information?", and they wrote back to us and said "Ach, sure, you have been told."

243 Q. So, in summary, the letter really did nothing to --

A. Nothing. It's just, again --

244 Q. -- address the concerns that you had? 12:59

A. Again, it was just banging your head against a wall, just asking for the basic decency to be told as to what happened to Martin and being told -- again, deniability, don't put it in writing - that's the only thing I saw from this letter - whatever happens, don't 12:59 put it in writing. But they didn't even verbalise it to us. But to not even have the decency to say: this is what happened, this is what's investigated, these are the steps that were taken. That would have -- transparency, accountability, those words that should 13:00 be the cornerstone of any organisation, are just completely missing. That kind of transparency would have gone a long way to say these are the issues, this is how it was investigated, these are the outcomes. Instead, we are just told: ach, sure you have already 13:00 been told. So, basically, that's enough.

MR. DORAN: Chair, I am very conscious of the time.

CHAIRPERSON: Yes.

MR. DORAN: I think I would like to have about 20 minutes or so to complete Antoinette's evidence. 13:00 Should I continue now or might it be appropriate to rise?

CHAIRPERSON: I do think it's too long a period for any witness or indeed people to concentrate.

MR. DORAN: I agree, Chair.
CHAIRPERSON: So, what we may do, the witness this afternoon, we are going to need a bit of time to sort out how that person is going to give evidence, in any event. Let's take the break now. We will resume at 13:01
2 o'clock. In the meantime, it may be that you and the Inquiry Secretary can speak to the next witness and we can get those things in order.

You know, I think, not to speak to people about your 13:01
evidence. Of course you can speak to your parents if they are here or any other relatives, but please obviously don't discuss your evidence, and we will see you back at 2 o'clock. You can, of course, leave the
building if you want to do so, because I think the 13:01
opportunities here for refreshments are pretty limited.
THE WITNESS: Thank you.
CHAIRPERSON: Thank you very much indeed. All right. 2 o'clock.

13:01

THE INQUIRY THEN ADJOURNED FOR LUNCH.

THE INQUIRY RESUMED AFTER LUNCH, AS FOLLOWS:

CHAIRPERSON: Thank you. Mr. Doran, we will finish the current witness and then we will take a break.

MR. DORAN: Yes, Chair. 14:05

CHAIRPERSON: Thank you.

CONTINUATION OF EXAMINATION OF ANTOINETTE BY MR. DORAN

245 Q. MR. DORAN: Antoinette, before I go on to deal with the remaining part of your evidence, I just wanted to ask you briefly about something that we covered this morning, and it relates to one of your handwritten notes. 14:05

A. Okay. 14:05

246 Q. Can I just refer you to page 014-20? And that's Exhibit 7 and it's a note that was taken on 5th September 2014.

A. Yes.

247 Q. And you will remember the little note that we discussed in the bottom right-hand corner, where you say: 14:06

"Camera trained on him and alarm and two people at door, yet don't know what happened."

14:06

A. Mm-hmm.

248 Q. And I think you said that you were really expressing your surprise at how possibly what had happened could have been missed?

A. Yes.
249 Q. Now, when you refer to the camera in that context, what do you mean by that?
A. Sorry, it's a monitor.
250 Q. Right. So it's an individual monitor? 14:06
A. A monitor that is trained on Martin's sleeping and they can see the screen. It's probably about that size, and you can see the screen at the door. But you wouldn't be able to access it in any other way unless you were looking. 14:06
251 Q. Ah!
A. It's simply a monitor.
252 Q. Yes, I see, that's very helpful.
CHAIRPERSON: Thank you.
253 Q. MR. DORAN: And something else I ought to have raised with you earlier was the fact that you have been granted the status of a Core Participant in the Inquiry, isn't that correct? 14:06
A. Yes.
254 Q. And you are represented by O'Reilly Stewart? 14:07
A. Yes.
255 Q. Now, we have talked in detail about the matters that you raised with the Hospital and Hospital management, and your family also raised the matter at Stormont, isn't that correct? 14:07
A. Yes.
256 Q. And you tabled -- there were two tables -- or, sorry, two questions tabled at Stormont through Mr. Allister, isn't that right?

A. Yes.

257 Q. And the first -- one of those questions is exhibited at page 014-31, and that's Exhibit 14, and I'm going to ask now for page number 014-31 to be brought up on the screen, please? 14:07

CHAIRPERSON: I mean, just -- sorry to interrupt, but I think in general terms this is what we're going to try and do -- obviously if there are names that should have been redacted and we find they haven't, then we won't be able to put the exhibit up. But in general terms I 14:08 think it makes it easier if we --

MR. DORAN: This would certainly be my preferred approach, Chair.

CHAIRPERSON: Yes, thank you.

TECHNICIAN: I apologise, but I can't bring that up on 14:08 screen at the moment. The system has gone down.

CHAIRPERSON: Oh, right! Shall we move on?

MR. DORAN: Yes, I can assure the Chair that we did have a discussion about this ten minutes ago and the system was working perfectly at that stage! 14:08

CHAIRPERSON: That's always the way!

258 Q. MR. DORAN: Antoinette, do you see the first question there?

A. Yes.

259 Q. And the question is: 14:08

"To ask the Minister of Health, Social Services and Public Safety why the individual who is awaiting trial for alleged assault on a patient in Muckamore Hospital

and ill-treatment of the patient is back at work and not under suspension?"

A. Could I put that in context?

260 Q. Yes, please do? 14:08

A. The timeline for that was shortly after my telephone conversation, as I recall, with the Clinical Services Manager where I found out she was back working and we were shocked. And we raised it -- to our minds, we had raised it everywhere internally and we were thinking, 14:09 "what else can we do? Who else can we bring this to the attention of to try and stop it happening again?".

261 Q. Yes.

A. And we thought if we raised questions in Stormont, at least someone might say what is happening, keep that, 14:09 you know, keep Martin [redacted] safe because they keep --

CHAIRPERSON: Yeah, I think we just had --

A. Sorry.

MR. DORAN: Yes, it's absolutely fine, Antoinette. 14:09 This can happen so easily.

CHAIRPERSON: Just pause, if we pause the live feed, please, and tell me when you're ready to go again. Thank you very much.

262 Q. MR. DORAN: So you were talking about Martin and about 14:09 the context of the question?

A. Yeah, the context was, yeah, we had just found out that she was back working, that H1 was back working, and we just wanted to --

263 Q. Sorry, Antoinette, when you say "she", you're referring to H1, is that right?

A. H1 was back working on the ward and we were thinking "What else can we do to keep Martin safe?". It's -- it was apparent to us that no matter what we did internally in Muckamore no one, there was no -- they didn't care, you know, and it wasn't going to stop it. So that's why we raised the questions in Stormont to try and, I suppose, prompt Muckamore into saying there is a deeper malaise here in Muckamore. We need to -- we need to shine a spotlight on this. 14:10 14:10

264 Q. And the second question relates to another area of concern then and that's on the next page, 014-32. The question runs, as follows:

"To ask the Minister for Health, Social Services and Public Safety why were internal disciplinary proceedings against the individual in respect of alleged assault on and ill-treatment of a patient in Muckamore Hospital concluded in advance of the outcome of pending criminal proceedings?". 14:10 14:11

A. Yeah.

265 Q. And I think I'm correct in saying that the answer to the two questions is essentially the same? 14:11

A. Yes, and is very similar to the letters, very similar in the content to the letters we would have received from -- on behalf of the Chief Executive.

266 Q. Yes, and that's the letter that we went through in some

detail before lunch?

A. Yes.

267 Q. And just for the record, the answer reads:

"The Belfast Health and Social Care Trust has advised that it is unable to comment on any individual circumstances. However, in addressing any staff management and/or disciplinary issue, it is stated that its paramount consideration is the health, safety and welfare of its patients and service users. It is the policy of the Trust to investigate and take appropriate action when complaints against staff are made in respect of their patient care duties and to fully cooperate with and take advice from the PSNI on the timing and appropriateness of any internal processes. The Trust's disciplinary policy permits the Trust to proceed with internal disciplinary action in situations where a criminal case is pending. The outcome of any subsequent criminal proceedings is considered in respect of what impact it may have on an individual's contract of employment." 14:11 14:11 14:12 14:12

And, as you have said, that's the answer essentially that was conveyed to you in the correspondence that we considered? 14:12

A. Yes.

268 Q. And you also then wrote very lengthy correspondence to Mr. Wells at Stormont, isn't that right?

A. Yes, he was the Minister for Health at the time.

269 Q. Yes. I was going to ask you that. Presumably, that was the reason for addressing the letter specifically to him?

A. Again, we were just -- the amount of people that we told about what was happening to Martin and we told that this was part of a bigger picture of abuse happening in Muckamore, it can't be understated who we went through -- 14:13

CHAIRPERSON: Sorry, can we just stop for a moment? Sorry, can we not have conversations at the side? Sorry, Mr. Doran. 14:13

270 Q. MR. DORAN: Sorry, Antoinette. So you were talking about the background to the letter to the Minister at the time?

A. This is the first time we've ever written to any Government Minister. I suppose, it's an example of how exhausted and exasperated and how little attention was being paid to what we were saying. We had already said: "Martin is being abused. This is indicative of a greater malaise that's happening in Muckamore Abbey. There's people being abused openly in the corridors. What is happening to these people behind closed doors? You need to get your house in order. It needs to stop." You can see from the evidence -- so who did I tell? I told the Ward Managers, Consultant Psychiatrist, Clinical Services Manager, Clinical Therapeutic Manager, the Head of Nursing, the Director of Adult Social and Primary Care, the Chief Executive of the Trust, the politicians at Stormont -- this was 14:13 14:14

the Health Minister. I also copied this to the Deputy First Minister.

271 Q. I was going to ask you about that. The Deputy First Minister at the time was Martin McGuinness, isn't that right? 14:14

A. Yes, so he would have been in charge of budgetary concerns, and that's why we copied it to him, because again we were being told by agency workers about staff cuts, about staff being put under pressure, about sick leave, that these were all contributing to the abuse. 14:14 So that's why we copied it to him. And the PSNI knew through different assaults that were happening. The newspapers knew because these assaults were being reported in the newspapers. RQIA knew. So we were not shy and we told everyone we could about what was 14:14 happening in Muckamore and no one, no one cared. There was not -- as I say, the Police Liaison Officer in the PSNI was the only person who I felt in any way gave us any listening ear. It was always, especially within Muckamore was, it was "Protect the institution, shut 14:15 everything down at all costs and protect the institution." The barriers came down. So the letter to Jim Wells and to -- I can use his name, can't I, the Minister for Health --

272 Q. You can, yes. 14:15

A. -- and the Deputy First Minister at the time was really a last attempt to say, "Please, can you please do something to keep Martin safe?", you know.

273 Q. So essentially you're going now to the highest possible

level to voice your concerns?

A. Yeah, who else could we have told, you know?

274 Q. And I'm not going to go through the letter in detail but, basically, you document the history of Martin's stay in Muckamore, isn't that right? 14:15

A. Yes.

275 Q. And you set out in some detail the various steps that you took to bring your concerns about Martin to the attention of the relevant individuals and authorities?

A. Yes. 14:16

276 Q. And if I may just perhaps draw your attention specifically to one paragraph on page 014-35 -- it's towards the end of the letter?

A. Yeah.

277 Q. And you say: 14:16

"The people who perpetrated the abuse are carers and so could be working in hospitals, nursing homes or daycare centres throughout Northern Ireland. This is not an issue confined to those forgotten individuals who are 14:16 unfortunate enough to have a disability. It is not acceptable in 2015 for the State to stand back and accept no responsibility for what is happening in the largest facility for mentally handicapped people in Northern Ireland. The suffering endured by my brother 14:16 and the way it has been handled illustrates that the State cares as little about institutional abuse as it did 50 years ago."

So really in that paragraph you're saying "This is an issue that extends well beyond my brother."

A. Yeah, and this is what we told everyone, you know. It was readily apparent that there was institutional abuse, there was systemic abuse happening in Muckamore Abbey. This is in 2015. But -- and I suppose the reason why I say there, just to clarify as well, the reason why I say, you know, these carers can be working in hospitals, nursing homes or daycare centres, what I'm trying to say is it's quite apparent from my dealings with Muckamore Abbey Hospital that they did not care about disabled people. So I was trying to say to them, "Listen, it's not just affecting disabled people. You may not care about our family members, but there's other people involved as well" -- trying to get them interested enough to do something. And when I say about forgotten individuals, they're not forgotten by us. They're not forgotten by their families and I wouldn't want anyone to think that that is what that phrase means. They were forgotten by the system, they were forgotten by the Trust and the healthcare system, who just thought "We'll put them into Muckamore Abbey and we'll just do whatever we want and, that's it, you know, we'll close the doors and we won't have anything more to do with it. And if anyone raises any concerns, we'll just batter them down into submission until they go away and stop bothering us." So that's, I suppose, where it comes from. And as you can see in the paragraph as well, I've asked them directly:

14:17 14:17 14:17 14:18 14:18

"I want to know what your office is going to do to stop this institutional abuse and to keep my brother safe?".

Quite clearly, it was institutional abuse.

278 Q. And I think you say in the Index to Exhibits, you state in a short note that you didn't receive a written response to that letter, is that right? 14:18

A. No, never anything in writing.

279 Q. But you did receive a telephone call?

A. I received, yeah, two telephone calls. The first telephone call, and her name has probably been redacted, was from an assistant in Jim Well's office who rang me and said, "Okay, we have your letter", and she said it politely, she said "Can you just tell me what is it that you want?", and I remember thinking -- and I just replied "I want to keep my brother safe", and she said "I'll come back to you." And then she rang me back and she said, "No, the Minister can't get involved." 14:18 14:19

280 Q. And was that it? Do you recall any further details about that conversation? 14:19

A. That was it. And I said "Why?", and she said "Oh, it's just because, you know, there had been internal disciplinary proceedings and police proceedings, so, no, the Minister can't get involved." And we didn't hear anything from the Deputy First Minister's office. 14:19

281 Q. Now, you also raised your concerns then with the RQIA, is that right?

A. Yes.

282 Q. And if we go to 014-40 and 014-41, this is the last exhibit, I think, to your statement. You record details of the conversation that you had with an inspector at the RQIA, a Mr. Guthrie, isn't that right?

A. Yes. 14:20

283 Q. And it seems that, essentially, Mr. Guthrie explained that the RQIA doesn't deal with individual complaints?

A. Yes.

284 Q. And he set out the role of the RQIA?

A. Yeah. And told us to go to the Patient Client Council if we wanted to make an independent complaint, and that would be an independent complaints process. And then I'd asked if there was any other avenues and we were exploring those -- I don't have a record of talking to them, but, at this time, it was April 2015 and Martin was just about to move, he was just about to get out of Muckamore -- he was out within a couple of months. 14:20 14:20

285 Q. But did you speak to the PCC at that time?

A. I don't recall speaking to them at that time, no.

286 Q. And I'm going to go on in a moment to address Martin's resettlement. I just wanted to return to the final passage in your statement? 14:21

A. Sorry, could I just say one other thing just about RQIA I just remembered?

287 Q. Yes, indeed. One of the things we did over here when -- RQIA seemed to have quite a close relationship with a number of wards which kind of was a bit unsettling for us in that we had overheard on one of the wards that -- we had heard it on more than one occasion -- 14:21

that an inspection was coming from RQIA, but that it was X or Y and they'd be all right -- "They're grand, you know, they'll go easy on us" type of thing situation so --

288 Q. Like, where did you hear those conversations? 14:21

A. From a carer within -- it would have been my parents who would have heard it. My Dad overheard that. But that kind of worried us because we felt there was kind of a cosy enough relationship there as well and we thought they were supposed to be the regulators. So 14:22 that was a bit worrying from our point of view.

289 Q. Now, just going back to that final passage, you said:

"It was chilling that people knew but just accepted what was happening, such open abuse that was commonplace. I worried about what was happening when people couldn't see. It was so bad the staff were reporting one another. We pushed to get CCTV in, but were refused with the excuse of privacy issues. For the wards that did have CCTV, we were told by MAH staff 'Everyone knows the CCTV doesn't work.' A lot of the issues seemed to be around funding. They were using agency nurses who were not properly qualified or experienced to be dealing with the patients' disabilities."

Is it fair to say that that's a reasonable summary of the general concerns that you had over and above your concerns about your brother's position?

A. Yeah, because one of the things we were trying to get to the bottom of, because no one else seemed to be, was why this was happening, why was it happening now -- because we didn't hear anything about abuse for 16 years and then, suddenly, he's getting abused every 14:23
couple of weeks. You know, it was like "What is happening?!", and that was the carers and the nurses had identified that to us, by saying "There's a lot of agency nurses." Just to put it in context about what was happening at this time, Muckamore was shutting down 14:23
so they were -- they had closed -- they were closing down the wards. They were closing the swimming pool, all the social activities. Patients were really being confined to wards. And when you have patients with very complex disabilities and behavioural problems 14:23
changing their routine and making them confined to wards, it's going to create a stressor event, and it's going to great a stressor event for staff as well. So if you have that in the context, then you had unbelievable sick leave that was happening, which again 14:24
is indicative of something wrong within the structure. The use of agency nurses coming in. Staff had expressed to my parens that they were worried about their jobs as the wards were closing. So you have all this happening and it's creating like a perfect storm 14:24
of -- and the abuse was thriving within this, as far as we could see. So that's why we had raised those issues. And you will see it's raised -- parliamentary questions were raised as well, not on our behalf, but

on behalf of other patients about the use of agency nurses and how that was contributing not only to patients being injured, but staff being injured as well. So that was our view of it, that anyone we spoke to in Muckamore was very much -- it was almost a shrug of the shoulders. "It happens. People lose tempers, Abuse happens." It was just accepted and this was happening in open view of other people, so common sense tells you there was worse happening behind closed doors. And that's common sense and that's what keeps us awake at night because we don't know what was happening there. CCTV would have gone a long way to helping build a situation of trust, but again we were told no because of privacy and, you know, CCTV in the new ward, it doesn't work -- this was 2015, you know. Everyone -- the word on the street was that CCTV's in, but it doesn't work. Thank God they turned on the button, you know. So, I suppose, we just felt we had exhausted every possibility and we couldn't get anyone to care. And it's just for the families -- thank goodness for the Friends of Muckamore and the families who campaigned to get an inquiry because we wouldn't be here without them. We wouldn't be here if someone hadn't turned on that CCTV because they still wouldn't be listening, you know. 14:24 14:25 14:25 14:25 14:26

And so, I suppose, and just to put it in context, when Martin was 16 and he went into the ward in Muckamore Residential Care, he went in and he was able to walk.

He had full use of his legs. He had full use of his arms. He had full use of his hands. He could see out of both eyes. He could hear. His face wasn't deformed. He had teeth, which he doesn't have any more. He came out -- so we put him in there to be cared for; we were told it's the safest place for him -- he came out 15 years later and he can't walk, he's confined to a wheelchair. He doesn't have the use of his hands, he's the use of two fingers. He is blind in one eye. He has deformed his face from his cheeks, his temples and his jawbone. They've removed all his teeth, and that caused a problem with his swallow. He's in hospital at least twice a year with pneumonia now because food is getting into his lungs. When he went in -- I did say he's blind in one eye. When he went into Muckamore, he was able to feed himself a bit. He was able to dance. He was able to walk. 14:26 14:26 14:27 14:27

I suppose, from a family's point of view, we put him in Muckamore so he would be safe and looked after and they have failed him, absolutely. He has come out a shadow of the boy that was in there. And I hate to think if it wasn't for my parents tirelessly making sure every day that he was safe, I don't think Martin would be with us any more, and that's -- you know, that's my experience of Muckamore. 14:27 14:27

290 Q. Well, Antoinette, I was going to give you the opportunity to voice any other individual or general concerns that you have, but you have, in fact, done

that in your last answer. Now, I want to go back briefly to Martin's resettlement. You say that he is now living in a house with three others?

A. Yes.

291 Q. And there are two staff caring solely for him 24 hours a day? 14:28

A. Yeah.

292 Q. And I think you make the comment in your statement that after about three months, he started smiling again?

A. Yeah, I can remember it almost to the day. He -- he just lifted his head one day we were there, and we lifted his head and he just looked at us and he just gave us a smile and -- you just can't put into words how -- what that meant. We hadn't seen him smile in two years. We hadn't heard his voice in two years. They had taken his voice from him. They had taken any joy that he had. His life was so -- he has such, such a hard life and any ability he had, any capacity for joy was robbed by Muckamore. And I worry and my concern is if these systems remain in place, that it will happen again and it will happen in smaller institutions, it will happen in smaller houses. If there's not as many eyes in this residential house as there is in Muckamore, if it was allowed to happen there, it's going to -- common sense tells you it's going to be happening anywhere else. It's the same carers, it's the same structures. 14:28 14:28 14:29

293 Q. Can I ask you, Antoinette, did Martin go straight from Muckamore to his present accommodation?

A. Yeah, he did, and it's a lovely -- just to explain, he's in a nice -- it's a nice house, it's five minutes from my parents' house. And he has his own livingroom and his own bedroom, his own area, you know. He has CCTV. We had to fight tooth and nail, but we said he is not going anywhere without CCTV being trained on him 24 hours a day. So he has CCTV everywhere and that's gone a long way. 14:29

294 Q. And what about the transition from Muckamore to his present accommodation? You talk about multiple meetings taking place? 14:29

A. It was terrible. What -- we went through several meetings -- many, many meetings. There would be a full as they would call Martin's multidisciplinary team. You'd be brought into a room -- my parents would be made to wait outside while the professionals talked about Martin and what Martin needed, and then my parents would be brought in and they'd be told "We're all on the same page. We know exactly what Martin needs." They tried, I suppose, when -- to my mind, and we have minutes of the meeting, they tried to get us to accept less than what Martin needed in relation to staff ratios, CCTV, doors, the width of doors, things like that. It was always like, "He'll be fine, it'll be fine", you know, but we were -- made sure that every point was dealt with again, you know, and to our satisfaction because we were not going to allow Martin to go into the same situation again. Some of those meetings were some of the most adversarial meetings I 14:30 14:30 14:30

have been in, ehm --

295 Q. And what do you mean by that, when you describe them as adversarial?

A. Just that you were constantly being browbeaten. You know, Martin needs two carers 24 hours a day. He needs 14:31
a third carer for changing and things like that. Then they would say the house -- he shares a house with three people and the house ratio would be four carers, and you were like "That doesn't work out. If X needs one carer and Y needs one carer, then where are 14:31
Martin's two carers?". "Huuhh, the ratios work out -- we've worked this out, the ratios work out." You know, the things that would be available to Martin when he was in community care, like, you know, we wanted him to have access to the swimming pool, things like that, it 14:31
was all very like, "Yeah, that'll be done" and we were like "When?" -- "That'll be done." My Mum, I remember being reduced to tears on a number of occasions, and then the Consultant Psychiatrist who reduced her to tears coming over and asking her if she was okay, you 14:31
know, that kind of like situation. And then, like, arguing with you over points that they were clearly wrong on but they were -- they were just arguing with you for -- I don't know why, but -- and then the CCTV, that was a real sticking point. They were saying, you 14:32
know, about Martin's privacy takes precedence, and we were saying we were Martin's family -- Martin's safety takes precedence. But it was always very dismissive -- very, you know, "We know best about Martin and you're

just being difficult." So I found it a very, very adversarial situation. And even, like, my parents being made to wait while everyone else discussed how they were going to get on the same page, is just, you know, it's not right the way it's done. 14:32

296 Q. Presumably, great care would have been needed to assist Martin in leaving the Hospital where he had been for so many years to move to a new accommodation?

A. I don't recall a great degree. You would have expected, and I could be wrong in this, but I don't 14:33 remember carers bringing him over or settling him or such things like that. It was new carers in the house. We made sure he was settled. We made sure, I suppose, that the carers would be aware -- we would have sat and certainly my parents would have sat with the carers to 14:33 explain about what Martin liked and what he didn't like and how to keep him safe and things like that, and we would have made sure a care plan -- we did a lot of work in making sure that care plan was correct and that -- because sometimes they would slip in things that 14:33 were completely wrong that maybe related to another patient that maybe had been copied over or something, I don't know, statements that were not relating to Martin at all. So we had to make sure -- you just had to keep a very close eye on everything that was going on and 14:33 keep a good kind of control over it kind of thing. But, no, he settled in -- I think he was probably glad to get out of Erne. We were certainly glad that he got out of there. We couldn't wait to get him out of

there. And he settled in -- Martin's very, God love him, he's very amenable as well. You know, if you're saying "Martin, we're going to get changed", he would come up and get changed. You know, he wouldn't fight you. He would just, you know, he's very compliant, you know. So, no, I don't think he trusted that he wasn't -- that that was it, do you know what I mean, until he'd been there a few months, and then he was able to say, "All right, I'm happy now", and then he began vocalising again. We began to hear him talk. 14:34

297 Q. And how is he now?

A. He's good. He has the opposite problem in that he's putting on a lot of weight! So we need to take care of that because they like to feed him a lot of chocolate! He is happy. He has his music. He has his car. They take him out -- he goes shopping. My parents take him out two or three times a week. So they're so close. We see him -- he's always got a smile when we come up for us. And, yeah, no, he's somewhere where he should have been -- it was identified in 2002 that he shouldn't have been in institutional care, that he needed to be in residential care. So, finally, he is. 14:34 14:35

298 Q. Yes.

A. But, again, I suppose the lasting effect of this is we don't trust, we don't trust that this won't break, you know, so we have to -- that's why the CCTV is so important to us. We have to make sure -- and CCTV protects staff as well because Martin is self-injurious, so if he has an injury, at least we can 14:35

look at it and say, well, we know what happened. Everyone's clear, you know, and there's no accusations being thrown around and things like that. So, no, he's definitely happier and we're a lot happier.

299 Q. And does he still listen to Daniel O'Donnell?! 14:35

A. Unfortunately! He got to meet Daniel O'Donnell -- he was very happy, Daniel was very good to him.

300 Q. When did that happen?

A. Last -- no, it must have been before COVID. COVID wiped out two years there. So, again, his carers found 14:35 out that Daniel was coming to Antrim, I think it was, and they wrote to Daniel's management -- this is -- they're really nice the carers in his house -- they wrote to Daniel's management and told them about Martin and he sent Martin and the two carers tickets, front 14:36 row, and made sure he was all right and had wee drinks and everything like that. And then Daniel came and sat with him afterwards and took a lot of time with him -- not just a photo op, but took a lot of time to sit with him, and then Martin told him he was dismissed by 14:36 pointing a spoon at him! So, no, but we're glad that he's definitely a lot happier boy now than he was.

MR. DORAN: Antoinette, that's a great story on which to finish. Those are all my questions. Thank you very much for giving evidence. It may be that members of 14:36 the Panel will have some questions to ask you.

CHAIRPERSON: No, I have consulted both of the Panelists and they don't. So, Antoinette, it just leaves me to thank you very much for coming to be, as

it turns out, our first witness to this Inquiry.

A. Yeah, it's scary!

CHAIRPERSON: And we recognise that you have spoken not only for yourself, but also for your parents and your sisters and, of course, most of all, for Martin. So thank you very much, indeed. 14:37

A. Thank you. It was good to get the opportunity.

CHAIRPERSON: Yes. What we will do is we will take a ten-minute break now. I am a bit concerned about the timing for the next witness. We may well try and sit a bit later than normal this evening, but I won't push it, you know, too far. So, perhaps you could -- I think Mr. McEvoy is calling the next witness? 14:37

MR. DORAN: He is, indeed, Chair. I will speak to him during the break. 14:37

CHAIRPERSON: Yes. The next witness does wish to give evidence anonymously and does not want to come into the room, so we will remain here. We will be able to hear the evidence but I'm afraid we will not be able to see either witness or counsel. We are going to try and sort it out so that, in future, we can at least see counsel, but I'm afraid the system isn't in place yet. But we will take ten minutes now and, Antoinette, thank you very much, indeed. 14:38

14:38

THE HEARING ADJOURNED BRIEFLY AND THEN RESUMED, AS FOLLOWS

CHAIRPERSON: Thank you.

MR. DORAN: Chair, I understand that Mr. McEvoy is ready to commence the witness's evidence.
CHAIRPERSON: Great. And I think the Secretary to the Inquiry is downstairs and is going to administer the oath, which we will hear. 14:52
MR. DORAN: Yes, indeed.
MR. McEVOY: Thank you, Chair, and members of the Panel. Hopefully, I can be heard. I just want to indicate before we proceed what's anticipated over the course of the remainder of the session this afternoon. 14:53

With me in the room are P4's mother; her solicitor, Mr. Anderson; and, as you have indicated, the Secretary to the Inquiry, Ms. Richardson. I will, in a few short moments, ask for the witness to be sworn. I will then 14:53 proceed with the reading of her statement and then, obviously, some remaining questions at that juncture.

I can advise the Panel at this stage that P4's mother and P4 may be known as "Kirsty's Mum" and "Kirsty" 14:53 respectively, and all other ciphering and redactions which appear in the statements will continue to apply.
CHAIRPERSON: Mr. McEvoy, can I just say we can hear you, but if you can bring the microphone slightly closer to you and ensure that the witness has the 14:54 microphone close to her mouth, I think that will help us.
MR. McEVOY: Okay. Right -- hopefully, that is not an overcompensation?

CHAIRPERSON: No, that's better. Thank you very much, indeed.

MR. McEVOY: Thank you. So, Chair, I am going to ask now for Ms. Richardson to swear the witness in.

14:54

KIRSTY'S MUM (MOTHER OF P4), HAVING BEEN SWORN, WAS EXAMINED BY MR. MCEVOY, AS FOLLOWS:

301 Q. MR. MCEVOY: So, good afternoon, Kirsty's Mum.

A. Good afternoon. 14:54

302 Q. Before you is a document in the form of a witness statement to the Inquiry and it's got your name on it behind a redaction of "P4 Mother", but we're going to call you "Kirsty's Mum" today because you are the mother of Kirsty. 14:55

A. Yeah.

303 Q. And we can see that the statement is dated the 20th day of April and there's another date at the end. What I propose to do now is to read that statement back to you. I am going to read it slowly in order to allow 14:55 you to hear back and be content with everything that you said --

A. Yeah.

304 Q. -- when the statement was given some weeks ago. So I am going to proceed to do that now, all right? 14:55

A. Yes.

305 Q.

"I, Kirsty's Mum, make the following statement for the purpose of the MAH Inquiry. In exhibiting any

documents, I will use 'Kirsty's Mum 1', so my first document will be 1.

Section 1: Connection with MAH

14:55

My connection with MAH is that I was a relative of a patient who was at MAH. My daughter, Kirsty, was a patient at MAH.

Section 2: Relevant time period

14:56

The relevant time period that I can speak about is between 2016/17 and 2018.

Section 3: Information

14:56

My daughter Kirsty was born in June 1989 and died in 2020. She was 31 years old when she died. I have two other children who..."

14:56

-- and you give a name --

"...who is now 16 years old..."

-- and another name --

14:56

"...who is now 14 years old. Kirsty was a patient at MAH between 2016, 2017 and 2018. I cannot recall the exact dates. Kirsty went to secondary school at..."

-- and you give the name -- and then "to" and you give another name --

"...in third or fourth year. This was a more relaxed school and she got the support she needed. She left school at 16 years old. 14:56

When she left school, I noticed that she was acting strangely in the house and worked out that she was smoking cannabis. I got her a job in..." 14:56

-- and you give a name --

"...at the..." 14:57

-- and you give the location --

"...but she couldn't stick it and it didn't work out. Kirsty had drug and alcohol problems and got into some trouble. 14:57

When Kirsty was about 17 or 18 years old, she became unwell. She told me 'Mummy, I'm not well.' I didn't realise what was going on in her head and I didn't know what to do. I took her to our general practitioner, who recommended that she be admitted to..." 14:57

-- and then you indicate a healthcare facility for mental health.

A. Yes.

306 Q. "He signed her in and she was detained there for around six months. She had psychotic thoughts and was addicted to cannabis. They diagnosed her with paranoid psychosis and a personality disorder. The Hospital sent for me and for her grandfather and told us that they were going to send her to..." 14:57

-- another mental health facility. 14:57

A. Yes.

307 Q. "This was around 2007, 2008 when Kirsty was around 17 or 18 years old. I cannot recall the exact dates. Kirsty was there for years, and then, without consultation, she was moved to MAH. I got a phone call from Kirsty to say that she was waiting on an ambulance and was being taken to MAH. To this day, I do not know why she was transferred or who transferred her. I think it might have been..." 14:58

14:58

-- and then you give the name of a healthcare professional.

A. Yes.

308 Q. "Kirsty did not like it from the start. It was not the right place for her and I feel that the care team and the system failed her. Kirsty had mental health issues with addiction to drugs and alcohol, she heard voices and did not like to be on her own. She did not get any treatment for these issues in MAH. There was nothing 14:58

for her to do - no recreation, no walks, no gym or exercise. When Kirsty went into MAH, she was a size 10. I attach a photo taken of her around a week before she went into MAH at 'Kirsty's Mum 1'. When she left MAH, she was a size 20, and I attach a photo of her around this time at 'Kirsty's Mum 2'. Kirsty looked and was like a completely different person after MAH." 14:58

And pause there. We will come back to the pictures at the conclusion of the evidence, we can discuss them properly -- at the conclusion of the statement. 14:59

A. Yes.

309 Q. "I went to see Kirsty every Tuesday at MAH. I worked two jobs at the time and I had two other young children so I had to get a taxi there and back. It cost me £30 - £15 there and £15 back. The taxi waited outside for me. I asked the mental health team for support with the costs, they said no and that I should be getting the bus. I couldn't get the bus with the kids and I got no financial help at all. 14:59 14:59

MAH was not right for Kirsty from the start. The children were all in wheelchairs and had behavioural issues. Kirsty was not in a wheelchair and knew what was going on. I noticed on my visits that Kirsty was not her usual bubbly self. During my visits, Kirsty said to me, 'Mummy, this is terrible here. I cannot recall the ward that Kirsty was on in MAH, but she was on the same ward the whole time, so far as I know. I 14:59

had very little communication with the staff and they didn't let me know what was happening with Kirsty's treatment or care. They said she was an adult and I was never informed about things like medication changes. I would ask for family meetings but I never got an answer. Not long after she was admitted to MAH and during one of my visits, I saw that Kirsty had fresh bruises on her upper arms; I cannot recall the exact date, but I always signed a register when I arrived, so there should be a record somewhere of the dates of my visit. Kirsty said to me, 'Mummy, look at my arms'. I was shocked and asked her what had happened. Kirsty said that she was being put in seclusion and didn't want to go so they held her down and forcibly put her in, causing the bruises on her arms. I said that I would not stand for this and wanted to speak to someone. However, Kirsty said that no one would believe us and that there was no point. She said, 'You will never beat the mental health staff, they are too strong'. She said that no one listened to her in MAH and that no one would believe her. They controlled her and her life whilst she was detained, the staff were a law onto themselves and the kids couldn't speak out. I didn't report the incident and there was no investigation carried out. 15:00 15:00 15:00 15:01 15:01

I noticed the marks and bruises on her upper arms on several of my visits during Kirsty's time in MAH. I do not recall specific dates, but I do recall that Kirsty

told me that this happened all the time. Kirsty told me, 'They hold me down to put me into the seclusion'. I asked her what was seclusion and she said it was when she was put into a room on her own with no furniture, chair, TV or anything. She could be in there for hours on her own. I feel that this was physical and mental abuse. I do not know how many times this happened or the dates, but it was a regular occurrence. I do not know the names of the staff involved and, as Kirsty has now passed, I can't ask her. 15:01 15:02

During my visits, Kirsty would tell me about the treatment of the staff. She hated it in MAH. She would cry to get out of it. It was such a blunder for her to be in there as it wasn't the right place for her. She used to say that staff told her that our family didn't want her and that was why she was in MAH. She said to me, 'Yous don't want me'. I asked her why she said that and she told me that staff and social workers told her that. I do not know the names of the staff she was talking about and I didn't report it, but I thought what kind of people would say that to my child? 15:02 15:02

I noticed after Kirsty went into MAH that she became more drowsy and sleepy. Kirsty said, 'Mummy, they changed my meds'. They did not inform me or consult me about changes in her meds as they said she was an adult. There was never any consultation with the 15:02

family. However, I noticed during my visits that she became increasingly more drowsy and sleepy, so I thought they must be making them stronger to make her sleepy. She would be drowsy and sitting back in her chair. Kirsty was taking Seroquel, Pregabalin (Lyrica) and injections of some kind. She was doped up. She was on 22 tablets a day. As far as I'm aware, Kirsty didn't receive any treatment for her drug and alcohol addiction whilst in MAH. I thought that must have been why she was there, but she didn't get the help or support she needed. There was no help at all and nothing to do. She saw a girl called H7 on a Wednesday, they did colouring-in and made benches, books and things, but there was no other recreation. She had gone to the gym before in another mental healthcare facility, I think. Kirsty became very bloated and overweight. That made her very depressed. She became more and more quiet. She was very unhappy with her weight but she had nothing to do and no exercise. She went from a size 10 to a size 20, it nearly killed her. When she was in a previous mental healthcare facility, she could go for exercise, go for walks and get out, but everything went downhill at MAH.

15:03 15:03 15:04 15:04

Kirsty would tell me that the staff treated the other kids on her ward very badly on a daily basis. She said that they would grab the kids and, if they didn't like their food, they wouldn't get anything else to eat. I can't recall specific incidents or the staff members

involved. The only other patient I remember by name was a girl called P5. Kirsty said they tortured P5. Kirsty said that P5 had bad difficulties and that they would grab her by the arms and force her to eat her food. She said that she saw P5 being grabbed many times. She was in a wheelchair and was in her 20s. I am not sure of her age as it is hard to tell. However, Kirsty said she was pushed around by the staff a lot. I can't recall the names of any of the staff. There was a grey-haired doctor and what he said went. Kirsty was in and out of seclusion a lot. Kirsty knew the kids weren't being treated well and the staff didn't like it. After Kirsty was discharged from MAH, I met a former staff member called H8 down the street in the shops. I am not sure what her job was. I don't think she was a nurse, but she worked there. H8 told me that the staff picked on Kirsty as she knew what was going on. She told me that the staff mistreated Kirsty and that she had witnessed it. She said that she had heard a nurse say to Kirsty that our family didn't want her. She told me that the staff made Kirsty's life difficult as she could see what was happening to the other kids. H8 told me that the staff would say, 'Watch her, as she will say'. I didn't know this at the time when Kirsty was in MAH. I had no support and believed that the system and the social workers failed my daughter. Kirsty did not want to say anything to the staff or report the abuse when she was in MAH. However, when she got out, she wanted to tell people what was

15:04
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15:05

happening and that it wasn't right. She wanted to tell someone what she had been through and what she saw. She went to --"

And you name a firm of solicitors.

15:06

"-- and left messages for a solicitor within that firm to phone her back, but she never did.

Kirsty was eventually discharged. This was the only meeting I had with the MAH staff and it was shortly before she left. I don't know why she was being discharged as they didn't tell me. There was a doctor, a CPM, someone who makes sure that you take your meds, a support worker and a social worker. There were about six people around the table and they discussed a care package. I remember it was all negative and nothing positive was said about Kirsty. They used to say that Kirsty couldn't be around younger children unless there were two adults there, but I thought this was nonsense. The reports written about her were not right. She was not a nasty person and I didn't see it in our house. She was a bubbly girl before MAH. When she was discharged, there were two adults who had to bring her home.

15:06

15:06

15:06

15:07

I wanted to know why Kirsty was in MAH and why she had to change hospitals. MAH wasn't right for her. I wanted to know why would they change her meds and make her so dozy and sleepy. I never got the answers to

these questions.

Kirsty was discharged in 2018. I cannot remember the exact date. The care team failed her when she came out. She didn't get the support she needed and she was not herself after MAH. They didn't support her properly. She didn't like being on her own. The support worker would take her out sometimes. When she came out, she was put into --" 15:07

15:07

And then you name a place.

"She settled down for a while. Then H9 phone to say they were coming down with two bin bags of Kirsty's clothes and they were putting her out as she wouldn't work with the staff. There was nowhere for her to go and she had to sleep on my sofa. She got into some trouble after that. She went to court and was put in jail for assaulting a police officer, when she came out of --" 15:07

And you name the place she went to.

"In 2020, she was 100 times worse. She came home for a while, but they found her a temporary place in another healthcare facility for ten weeks. I believe it all went downhill after MAH with the medication and the mental and physical abuse. 15:08

After [the other healthcare facility], the social worker, H10, arrived with two black bags and said that Kirsty would have to stay with me as they had nowhere else for her. The eventually got her a flat on --"

15:08

And I think you indicate a place name where she took a flat, on the other side of the area where you live.

"I said it wasn't suitable and she couldn't cope on her own. She would come up to my house but I was at work during the day. I phoned H10, her social worker, and said it wasn't suitable as people would go out during the day and Kirsty needed 24/7 support. She said it was suitable and she was staying there. Kirsty text her support worker, H11, for help. She sent lots of messages and I saw them on her phone after she died. Kirsty gave up the flat as she didn't like it and I put her in a hostel in --"

15:08

15:09

And you name the location of the hostel.

15:09

A. Yeah.

310 Q. "She was found dead a week later, on --"

And you give the date in 2020.

15:09

"Kirsty was always up early at 7 a.m. every morning. She would ring me every morning. She didn't ring me that morning and I knew something was up. I went to work but I had a bad feeling and left. The police were

waiting for me when I got home. I asked to see the CCTV but the hostel wouldn't give it to me. I think her death was suspicious. The coroner said that she died of a massive heart attack, there were drink and drugs involved. The medication she was taking over the years and her stressful life were part of the cause of her death. I made a complaint to the Ombudsman but he said there was no evidence of foul play. 15:09

I would like to see some justice for Kirsty. She suffered mental and physical abuse at MAH and was failed by the system when she was released into the community without the proper support or help that she needed. 15:09

Kirsty wanted to tell people what had happened at MAH but no one listened to her and the firm of solicitors mentioned above never returned her calls. 15:10

I'm still grieving for my daughter and it is very difficult, but I want to tell the Inquiry what happened in MAH, for Kirsty." 15:10

Turning over the page then, at section 4, just in terms of giving evidence, you say: 15:10

"I would not like to give oral evidence to the Inquiry. If I am asked to give evidence, I am happy to give my name."

And then at the very end there's a declaration of truth, and I will just read that back:

"The contents of this statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are relevant to the Inquiry's Terms of Reference." 15:10

And then there is a signature and a date of 6th May 2022. So I have read that out to you -- 15:10

A. Yeah.

311 Q. -- Kirsty's Mum, and are you content to adopt that statement as your evidence to the Inquiry?

A. Yes. 15:10

312 Q. All right. Well, taking one of the very last things that you said first, you told us in your statement that you did not want to give oral evidence to the Inquiry.

A. Mm-hmm.

313 Q. But the Panel can hear you now? 15:11

A. Yeah.

314 Q. And you changed your mind?

A. Yes.

315 Q. Can you tell the Inquiry why you changed your mind?

A. I changed my mind because I wanted Kirsty's story to be told, the way she was treated, because she is not here to do it herself, and she tried to get people to listen to her and they didn't, so that's why I decided it was the best thing for me to do, to come forward and give 15:11

her statement.

316 Q. Now, when you were talking about Kirsty growing up, you pick up in your statement with her time at secondary school.

A. Yeah. 15:11

317 Q. It might help the Inquiry to know a little bit about what she was like when she was younger, as a younger child. Can you tell us a little bit about how she was?

A. Kirsty was a very bubbly child, a happy wee child, so she was. She done well in primary school and then 15:12 moved on to secondary school.

318 Q. And in terms of her education, did she meet all of her -- sometimes you hear the teachers talking about the goals. Did she meet all of her goals?

A. No, because she started smoking that cannabis and that 15:12 sort of held her back a bit and then they moved her to another school -- it was more --

319 Q. And how old was she when she started smoking the cannabis?

A. Well, I didn't find out until she was 17 or 18, but she 15:12 told me she started smoking it when she was about 14, so she came out and told me the truth.

320 Q. All right.

A. So she was on it a good couple of wee years before she went in. 15:12

321 Q. Yeah. And a little bit later in your statement, when you talk about some of the symptoms -- you describe some of the mental health issues that she had.

A. Yeah.

322 Q. You talk about her having an addiction to drugs and alcohol as well?
A. Yeah.
323 Q. But one of the things that you mention in particular is that she heard voices and didn't like to be on her own? 15:13
A. She didn't like being on her own and the carer team knew that. They were told on numerous times that she couldn't handle being on her own, living on her own.
324 Q. And in terms of not being on her own, can you tell the Panel a wee bit more about that. When did you first 15:13 start to notice that she didn't like to be alone?
A. I noticed it in her late teens when she was heading near 18, 19, you could see she couldn't cope.
325 Q. And when we were going through your evidence, you mentioned some other places where she was being looked 15:13 after, some other healthcare -- mental healthcare facilities.
A. Yes.
326 Q. Were the staff in there aware of her not wanting to be alone or not liking being alone? 15:13
A. Yes, they were aware of that.
327 Q. And how did they manage that?
A. They always put Kirsty in with somebody so she wasn't in a ward of her own, so she was always with a load of people in the different institutions. 15:13
328 Q. Yeah.
A. She was used to people around her.
329 Q. And in terms of her experience in those places, and this is before she went into Muckamore --

A. Yes.

330 Q. -- as her Mum, how would you sort of describe -- were you satisfied with the care that she was given?

A. I was satisfied, yeah, with the other two places, because they really worked hard with her. 15:14

331 Q. And in terms of those other places and their involvement of you as her Mum, was there communication with you on a regular basis?

A. There was communication until she was coming out of that place to go to Muckamore and it was Kirsty phoned me to say she was waiting on an ambulance. 15:14

332 Q. And you described in your evidence that there wasn't a reason that was given for that transfer to Muckamore?

A. No, I didn't know what the reason was, why she was going there. 15:14

333 Q. And as you are sitting here today now giving evidence to the Inquiry, are you aware of a reason?

A. I still don't know why she was there.

334 Q. And in contrast then to the -- you know, the inclusion of you in decisions and certainly making you aware of what was being done in terms of Kirsty's care when she was in those other places, there wasn't that same degree of communication then when she went to Muckamore? 15:15

A. When she went to Muckamore, there was nothing. There was no communication with the staff. 15:15

335 Q. And you indicated in your evidence then that the reason that was given -- at a number of junctures in your evidence you said that the reason that was given was

because she was an adult?

A. Because she was an adult, yeah.

336 Q. And without naming names, can you recall who it was who gave you that explanation?

A. No. 15:15

337 Q. Okay. One of the words that you have used a couple of times, and again this afternoon, to describe Kirsty in terms of her personality, is that she was bubbly?

A. Yeah, very bubbly, yeah.

338 Q. And was she still bubbly after she started to develop mental health issues around addiction? 15:15

A. Not as much, not as much as what she was.

339 Q. Was she bubbly when she was in those other institutions, the other mental healthcare institutions or facilities? 15:16

A. Yeah, she was, yeah, she was happy to take the help.

340 Q. Okay. And when she went to Muckamore?

A. It went downhill from Muckamore, yeah.

341 Q. And how soon after she went into Muckamore?

A. A couple of weeks I noticed that she was deteriorating and sleeping and dozy and she said they changed her medication, and I says, "Well, they never confirmed with me about medications". You never got to speak to any of the staff. 15:16

342 Q. Yeah. You have mentioned by name a couple of the medicines that Kirsty was taking: Seroquel, Pregabalin, or, as it's sometimes called, Lyrica. 15:16

A. Lyrica, yeah.

343 Q. Had she been taking those medicines before she went

to --

A. Yes, she was taking them.

344 Q. Okay. And can you remember when, roughly, she would have started taking those medicines?

A. Whenever she went into the other -- the first institution, that's when she started taking them. 15:17

345 Q. And did that other institution make you aware that she was taking those medications?

A. Yeah, yeah, it's in the paperwork.

346 Q. And then you mentioned your suspicion, if I can use that term, that she had maybe been given an injection then when she went to Muckamore? 15:17

A. Yeah. I don't even know what the injection was for. There was no communication with the staff at all.

347 Q. Okay. And did she tell you about being given an injection? 15:17

A. Yes, Kirsty told me herself.

348 Q. Okay. And did she tell you how often she was given it?

A. She never said. She just said they were putting it in her hip. 15:17

349 Q. Okay. And you are not sure of how often or what kind of injection it was or for what purpose?

A. No.

350 Q. Okay. And the -- after a period of time in Muckamore, you have described quite graphically how Kirsty seemed to put on a very significant amount of weight? 15:17

A. Yeah.

351 Q. And you say she had almost -- went up a number of dress sizes?

A. Yeah, she did; she went in a size 10 and came out a size 20.

352 Q. How quickly after she went into Muckamore did you notice weight gain?

A. I noticed after a couple of months that she had started putting weight on, loads of weight. 15:18

353 Q. Yeah. And in terms of her kind of going up to that size, that --

A. Yeah.

354 Q. -- how -- 15:18

A. She was distraught about the weight gain. She was always a slim girl, like.

355 Q. Yeah. And can you just -- we might, just so the Panel can get a bit of a picture of her - I know we have a photo of her and we will look at that in a moment - but, I mean, was she tall, small? What kind of build would she have? 15:18

A. She was tall, Kirsty was tall.

356 Q. Yeah. How tall?

A. Five ten. 15:18

357 Q. Which would be tall for a woman, certainly?

A. Yeah, yeah. And always worried about her weight, she didn't like putting weight on.

358 Q. Yeah, okay. And when she was in those previous healthcare facilities, you described how she had -- she got out for -- 15:19

A. She got out for walks and she was able to use the gym.

359 Q. Yeah. Those walks and recreation, that sort of thing, did you ever do that with her?

A. Yes, I did do the walks with her in the second one.

360 Q. Yeah.

A. But the first one you were walking just around because there was no walks really in the -- the first one was a smaller. 15:19

361 Q. Yeah.

A. The second one, yeah, I was allowed to bring her out for walks.

362 Q. So you had the opportunity to take exercise with her?

A. Yeah, and she really enjoyed it. 15:19

363 Q. Okay. And when she went into Muckamore, do you know whether there was any kind of a routine?

A. No, there was no routine there at all.

364 Q. Okay.

A. No gym, no walking, no nothing. 15:19

365 Q. And in terms of the weight gain, do you think that there is a link?

A. I would say there's definitely a link - overeating, no gym and then the medication as well, whatever it was they were giving her. 15:19

366 Q. Okay.

A. So there's three different things that are -- that I need for me to move on with my life, you know what I mean? That's why I want the Inquiry to know Kirsty's story. 15:20

367 Q. Yeah, okay. I know that you had said at a number of points in the course of the witness statement that you didn't speak to anybody, you didn't raise concerns.

A. Mm-hmm.

368 Q. But you also describe Kirsty telling you why --
A. Yeah.
369 Q. -- you shouldn't?
A. Yeah.
370 Q. Can you tell the Inquiry a wee bit more about that? 15:20
A. Well, she actually told me when I said I would have to speak to somebody about it, about their behaviour towards Kirsty --
371 Q. Yes.
A. -- and she said, "The mental health are too strong and 15:20 you will never beat them", and it sort of made me worry more --
372 Q. Yeah.
A. -- because that child was able to say that, you know?
373 Q. And was -- in terms of that particular concern, what 15:20 was that about? What was --
A. Just all about her medications and their behaviours, putting her in seclusion, but I think, personally, me myself as her mother, I think they put her in so she couldn't see all that was happening. 15:21
374 Q. Mm-hmm.
A. Kirsty was very verbal so she knew all along what they were doing --
375 Q. Mm-hmm, mm-hmm.
A. -- you know? 15:21
376 Q. Mm-hmm.
A. And I think that was part of why they kept putting her into seclusion.
377 Q. So the Panel can take it that what you are saying is

that the seclusion was being used as a way to keep Kirsty from seeing things --

A. Yeah, from seeing things, yeah, definitely.

378 Q. -- they didn't want her to see?

A. Yeah. Kirsty even thought that herself, too. 15:21

379 Q. Okay. And you mentioned some of the other, I think you called them "children". Just to be clear, were they children?

A. Kirsty told me they were no more than 20/25.

380 Q. Yeah, so children -- 15:21

A. They were children in my eyes, because I am 54, but they were young children, like.

381 Q. Yeah. And if you can sort of -- you obviously described Kirsty as being somebody who could talk, was verbal and -- 15:22

A. Yeah, very verbal.

382 Q. Yeah. And was there a difference between Kirsty and her co-patients, the others there?

A. Yeah, because she told me they were all, like, in wheelchairs and -- because you never really seen any of 15:22 them.

383 Q. Yeah.

A. I never seen none of the kids. It was all what Kirsty was telling me on the visits.

384 Q. And was she able to tell you whether -- were you able 15:22 to pick up from what she was telling you whether those --

A. Oh, I knew rightly what she was telling me; they were being abused, like.

385 Q. And was she able to tell you whether the other patients were able to speak for themselves or --

A. No, they hadn't; they're non-verbal.

386 Q. Okay. All right. Okay. Well, look, I want to bring you back just to the two photographs that you had mentioned in the body of your statement, okay? And I hope that the photographs are available to the Panel and should be available to Core Participants. So if you have the two photographs there. 15:22

A. Yeah. 15:23

387 Q. Now, the first photograph, that's Kirsty, the first photograph, Kirsty with -- she is wearing pigtails, pony -- pigtails, have I got that correct?

A. Yeah.

388 Q. Okay. 15:23

A. She told me that on that [redacted] they done -- for going in the ambulance, that was her the week before she went up.

389 Q. Okay, so this is just before -- she literally just before she went up to Muckamore? 15:23

A. Yeah.

390 Q. Okay. So turning then to the second photograph, overleaf.

A. Yes.

391 Q. So that's Kirsty as well? 15:23

A. That's Kirsty, yeah.

392 Q. All right. And when was that photograph taken?

A. That was whenever she was coming out of Muckamore, whenever she was home and all, and they still couldn't

get her fixed, they still didn't give her the proper help that she needed.

393 Q. Right, okay. I know it's a difficult question, but I know you are very, very keen to ensure that you speak on Kirsty's behalf because she isn't here -- 15:24

A. Yeah.

394 Q. -- but when you look at those photographs?

A. It breaks my heart. Her wee face breaks my heart.

395 Q. Okay. And you mentioned that Kirsty has -- Chair, the witness is just going to pause for a moment just to gather herself. 15:24

CHAIRPERSON: Yes, of course. I don't suppose you have got very much more to ask her?

MR. McEVOY: No, no.

CHAIRPERSON: So we will stay here, but we will just -- 15:24

MR. McEVOY: Will we take a five-minute break, Chair, if that's possible?

CHAIRPERSON: Yes, of course, if we need to. Would it be better to work through it or -- sometimes a couple of deep breaths and a glass of water -- 15:25

MR. McEVOY: No, the witness has indicated she is content to continue; she has gathered herself.

396 Q. So we have seen the photographs and you have indicated --

A. It breaks my heart. 15:25

397 Q. -- obviously, your feelings about matters. But if -- if there was a representative of the Trust here, for example, or of the Hospital authorities, and you had an opportunity maybe to say something to them, what would

that be?

A. I would just say it was a disgrace what they put my daughter through and the rest of the families. It's just been hell. To send a child out like that, it's heartbreaking -- 15:25

398 Q. Okay. All right.

A. -- to watch your child suffer and not get the help that she needed.

399 Q. And if -- you have the opportunity now, obviously, just to say anything that you would like directly to the 15:26 Chair and the Panel members. Just bear with me one second.

CHAIRPERSON: Are you okay to continue, Mr. McEvoy?

MR. McEVOY: We are, thank you, Chair, yes.

400 Q. I have just one final question then for the witness, 15:26 which is, Kirsty's Mum, is there anything just in conclusion you would like to say to the Panel now?

A. Yes, I would like to say that I would have liked to have seen, if Kirsty had have got the proper help, where she would have been with her life now and what 15:26 she would be doing, if she had have been put into the proper place.

401 Q. Okay. Thank you very much.

A. Thank you.

402 Q. So if you just remain there. Maybe -- we will just 15:26 check whether the Panel have any questions for you.

THE WITNESS WAS THEN QUESTIONED BY THE CHAIRPERSON:

CHAIRPERSON: There's just one question from one of the Panelists, but I am going to ask it. Kirsty's Mum, you have spoken about the mental health issues that Kirsty had --

A. Yes.

CHAIRPERSON: -- that may have been drug-related. Did anyone ever say that she had any sort of learning disability or autism?

A. No.

CHAIRPERSON: So it was more mental health -- 15:27

A. It was all mental - paranoid psychosis.

CHAIRPERSON: All right. And I suppose just this from me: You never actually formally complained about Kirsty's treatment. Can you just explain why you didn't? I think I do understand why you didn't, but I just want to have it in a -- 15:27

A. Well, when I said to Kirsty that I was going to complain, Kirsty put it straight out to me that nobody would listen because the mental health -- "Nobody will ever beat the mental health because they are so strong". That was that child's words to me. 15:27

CHAIRPERSON: So you didn't feel it would do any good to complain?

A. No. And any time you asked to speak to somebody, you never got -- there was nobody phoned you or came forward, there was nobody took it under their notice. 15:28

CHAIRPERSON: Sorry, I didn't quite -- did you ask to speak to anybody or not?

A. I asked to speak to staff, and Kirsty says, "Mummy, you

will never beat the mental health. They are too strong." So obviously somebody has pumped that into the child.

CHAIRPERSON: All right. Okay, Kirsty's Mum, can I just thank you very much for coming along to give evidence. I know how difficult it was for you to do so and I know you were a bit nervous when you started, but can I thank you very much on behalf of the Inquiry and you have done what you needed to do on behalf of Kirsty, so thank you very much. 15:28

A. Thank you.

CHAIRPERSON: Thank you.

All right. Mr. Doran, tomorrow, we've got two witnesses, I think?

MR. DORAN: Yes. 15:29

CHAIRPERSON: We are hoping they should be able to give evidence here in the room, but we will have to assess it at the time and make sure that there are no last minute wobbles, as it were.

MR. DORAN: Yes, Chair. 15:29

CHAIRPERSON: All right, fine. Well, we will try to start again at 10 o'clock tomorrow morning.

MR. DORAN: Thank you.

CHAIRPERSON: Thank you very much.

15:29

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 29TH JUNE 2022 AT 10:00A.M.