didn't fill in the instant reports because they take a long time to fill in?

A. They wouldn't have filled it for themselves but certainly if it was for a patient injuring themselves, they would always have been reported. 15:31

109 Q. DR. MAXWELL: You think that would always have been filled in for patients?

A. They would always have been reported, yes.

110 Q. MS. BRIGGS: Christine, I am going to ask you about the personal care of patients so things like washing, 15:31 dressing, dental care, that type of thing. Was there any aspect of physical care like dental care or personal hygiene that was more difficult than others, can you speak to that from your experience of working in the wards, way back when? 15:31

A. When we worked in the wards in around about the 70s and 80s, there were big wards, and great big bathrooms and things like that. It says there ten patients, there weren't ten patients in the bathroom at the time.

CHAIRPERSON: Can you just slow down a little bit, 15:32 sorry.

A. Sorry, there weren't ten patients in the bathroom at the one time but there would have been only maybe two bathrooms in the whole building. So somebody would be bathed, they would be taken out of the bath and then 15:32 somebody else would come into the bathroom. But with the new wards, they had en suites built on to them, so they had individual showers put in the wards.

111 Q. And do you know what those later nursing staff did, the

ones that came after you, what would they have done if a patient declined, for example, a wash that day, do you know what the procedure would have been in that situation? And if you can't speak to it, Christine, you don't have to, you can say you don't know, okay? 15:32

A. Because I wasn't working in the wards, I really wouldn't have been aware, but I know certainly in the children's ward in the Iveagh Centre, all the children would have had a shower nearly every morning or a bath if they preferred it, just some of them, their personal 15:33 choice, you know.

112 Q. DR. MAXWELL: But if they declined?

A. Pardon?

113 Q. DR. MAXWELL: If a child in the Iveagh Centre said 'I don't want a bath today' but the nurse felt, well 15:33 actually, you need one?

A. They would probably have offered them to maybe just have a body wash if they didn't really want, they would have encouraged them.

114 Q. DR. MAXWELL: If they really, really declined, would 15:33 the nurses have to respect that?

A. I think, yes, they would have respected it, but it was very rarely that children ever did. Most of them, the children liked having a bath, they liked playing in the bath. 15:33

115 Q. DR. MAXWELL: We have heard evidence that a lot of people didn't get good dental hygiene, if there were concerns that somebody was not getting, was not complying with good dental care, what would the nurses

do?

A. If they weren't complying with the dental care, let me think of it there, normally we would have maybe used, because that would have been seen maybe as a behavioural issue. I know that one child we worked with, going back quite a number of years ago in Muckamore, in the children's ward, and we actually worked with the First and Then system that we worked with them, they actually learned how to clean their teeth as part of their work system where they, first this and then that. We had to teach them how to clean their teeth and then they got their reward at the end of that. So there were times when we would have used a behaviour support plan to help them with personal care because it is very important. 15:34

116 Q. DR. MAXWELL: As an experienced professional nurse, would you expect a nurse to record if a patient consistently refused to have personal hygiene care?

A. Yes, they would.

117 Q. DR. MAXWELL: You would expect them to put that as a problem in their records? 15:34

A. It would be expected to report that on and issue that into their care plan.

DR. MAXWELL: Thank you.

118 Q. MS. BRIGGS: Christine, I want to ask you about the use of sedation and PRN, okay. You talk about that in your statement and you describe how you didn't have input into the actual use of PRN? 15:35

A. No.

119 Q. But you would look at its use after the event and see whether there was anything to learn from the use of PRN?

A. Yes.

120 Q. Who was responsible for actually making the decision on the ground to administer PRN in the first place? 15:35

A. Well the PRN would have been prescribed by the consultant, but the issue of when to administer the PRN would have been done by the nurse that was in charge of the ward at the time. 15:35

121 Q. Did you look at or review all of the instances when PRN was used?

A. No, no.

122 Q. What brought about you conducting a review, when would that have taken place? 15:35

A. If we were looking at, when we would have had the team meeting, we normally had them on a Thursday, we would have looked at the use of PRN maybe if it had been used and what was the impact of that PRN, whether it was effective or non-effective. 15:36

123 Q. But you would expect to be made aware at that team meeting of every use of PRN or is that not accurate?

A. If PRN was used it was always brought up at the children's review meeting so it was always brought up on a weekly basis if PRN was used. 15:36

124 Q. When you conducted your exercise of looking back at its use, what reasons were provided for the use of PRN typically?

A. Well PRN would be used as prescribed for the behaviour

that was documented. So if a child was particularly aggressive or very disruptive or very agitated, PRN might have been used then.

125 Q. And did the reasons for the use of PRN ever change over time or did they roughly remain the same, it was in response to a behavioural issue? 15:36

A. If behaviour, if you put in a behaviour support plan and once it starts to work and once the programme would hopefully be working, PRN should become non-effective.

126 Q. Should become not effective at all? 15:37

A. Not be used.

127 Q. Not be administered?

A. You always hope to reduce the use of it.

128 Q. And did you see success with that?

A. Yes. 15:37

129 Q. Or were there certain patients were PRN had to keep being used, notwithstanding the fact there was a behavioural plan in place?

A. In most instances PRN, you didn't really want to have PRN being used out in the community so you really didn't want a child, if a child was going back to school and back into a classroom or back home again, you didn't want them going back having to be on PRN because it meant their behaviour was not being managed properly or being managed appropriately. 15:37

130 Q. So you refer in your statement to deescalation techniques?

A. Yes.

131 Q. Can I take it from your evidence then that the aim was

to decrease the use of PRN while increasing the use of those diversionary kind of techniques?

A. Yes.

132 Q. Did that occur with all patients or were there simply some patients where PRN was necessary throughout the time at Muckamore? 15:38

A. Mostly, well any of our children that we were moving on and going out to school, that we were using redirectional and deescalation and all of those things, the behaviour support plan would have been effective before we would have moved them on. PRN was only ever used I think long-term with some children who were very self-injurious and that's -- very serious self-injurious behaviour is one of the most difficult behaviours to change or turn it about and they could continually be on PRN, continually. 15:38

133 Q. The Inquiry has heard evidence about abuse suffered by patients at Muckamore and abuse is defined widely in that sense, physical abuse or sexual abuse or financial abuse or neglect or things like interference with belongings. You say in your statement that you wouldn't have stayed at Muckamore if you saw patients being abused? 15:39

A. I definitely wouldn't, and it's something that I had not experienced and certainly it was something that if I ever felt if I had seen any kind of level of abuse or that, I would have certainly spoke up about it. I've never been known for being quiet about what would bother me. So if something that I felt was untoward I 15:39

certainly would speak up about it.

134 Q. What about neglect, did you ever see anything like that?

A. No.

135 Q. Because you say in your statement you don't think you saw neglect? 15:39

A. No.

136 Q. You never saw neglect?

A. No.

137 Q. Okay. I want to ask you about some changes you say that you saw to Muckamore during your time there and you've provided at paragraph 25 of your statement a long list of the types of activities that patients did. You refer to walks, film clubs, playing pool, that kind of thing and you say that ultimately they were removed, 15:39 15:40 okay?

A. Yes.

138 Q. When did the removal of those activities take place?

A. When Muckamore went through that period of change when they decided that it was going to become a specialist hospital. It was to become a hospital and we had to go back to calling them patients. We had gone through all those periods of changes with learning disability from when I started there in the 70s, there were different changes come along. Firstly they were patients. First it was mental handicap, then it was not allowed to be mental handicap, then it was learning disability, then it was learning difficulty. First it was patients, then it was clients, then it was residents, then back 15:40 15:40

to patients again. So it just seemed to swing by whatever the people up here decided these changes would be made. The hospital was a really big large hospital with lovely grounds. There is lots of activities that took place in it. It was a very homely, friendly atmosphere about the hospital then. The nurses trained there, we all lived in nurses' homes it was just a very -- quite community minded. The activities, Muckamore going back in the 70s, the 80s had its own radio station that the patients were fully involved in. You could have put requests on or gone down and sat with [name]. 15:41 15:41

139 Q. We will just stop a wee second. There was a name used. We'll just pause for a moment?

A. Right, yes, sorry. 15:41

CHAIRPERSON: We're not too worried about the disc jockey are we?

140 Q. MS. BRIGGS: Fine, all right. We'll not pause then and we'll keep going, sorry to interrupt you Christine?

A. It was always very, the activities, if you had gone around the grounds then you would have always seen patients out walking, out with staff, out doing things, having picnics in the grounds. We would have taken the children away down by F7, away down there and spent a couple of hours down there playing games. They had cinema on a Friday night, they had church, they had chapel, they had discos, parties, their own snooker team, ladies dance groups, football teams, everything. 15:41 15:42

141 Q. You referred, Christine, to the 70s and 80s when it was

like that?

A. 70s, 80s, 90s.

142 Q. It is the 90s onwards that you are talking about these changes taking place?

A. Right up until they started to build the new part of the hospital, all those activities were taken away and they knocked down the recreational hall. The big recreational hall was the heart of Muckamore. It was this big centre that everybody used and the big stage on, they had pantomimes, they had drama groups, everything was going there. They took that all away. They knocked it down. Everything had to stop. There's nowhere to walk now because they have fenced off all the grounds, so there only just this wee nuclear in the middle. You take away activities. When our people with learning disabilities, a lot of their problems are social problems. A lot of their problems are communication. A lot of their problems are around being accepted. When they were in Muckamore, they were accepted. They were, the hospital at that time, nobody ever -- they seen them walking around the grounds and they were making strange noises or doing what other people would class as unacceptable behaviour, nobody challenged it, nobody thought anything of it, they went and supported them and looked after them. All of those things started to change. When staff have nothing -- when they have no activities for the staff to do with the patients, when they have nothing to do with them, when they can't take them swimming or when they can't

15:42 15:42 15:43 15:43 15:43

take them to the cinema, when they can't take them -- what do they do?

143 Q. What about, Christine, when you left Muckamore in 2010 what kind of activities were available to patients at that time? 15:44

A. When I left Muckamore?

144 Q. Yes?

A. All those activities were gone. When I left they started, when Six Mile was built and the other wards, Cranfield and all were built, all those activities had to stop. 15:44

145 Q. Was there anything left for patients by way of recreational activity?

A. Because they were seen as patients in a hospital, and patients don't play snooker, patients don't do this, it was said if you want to play snooker go out to the community and do it so all of those activities are gone. 15:44

146 Q. And there was nothing left for patients, is that what your evidence is? 15:44

A. No, they go to daycare and they go down to daycare and they just do small activities in daycare but they certainly don't have their cinema or discos, where they socialised and interacted and learned all those skills, that's all been taken from them. 15:44

147 Q. Was that because there was a change in the philosophy of care, or why did that happen, why were those activities taken away from patients, can you understand that?

A. I can't understand it and I think the majority of staff at Muckamore couldn't understand it. We didn't have a big say in the decision making of it. Those decisions were made away above our head.

148 Q. Was any justification provided, or could you have asked for a justification? 15:45

A. They were just termed that now it was a specialist hospital and they were patients and they were to be treated as patients.

149 Q. DR. MAXWELL: What would you have called it before this change to call it a specialist hospital? 15:45

A. What did I?

150 Q. DR. MAXWELL: How did people refer to it before it came this new specialist hospital?

A. It was just The Abbey. 15:45

151 Q. DR. MAXWELL: It was just called The Abbey?

A. The Abbey.

152 Q. DR. MAXWELL: You were working there, did you think of it as a hospital or did you think of it as a community or did you think of it as a home? 15:45

A. More of a community. It was, at that stage, going through, and I think a lot of the nurses felt that it should have become more of a community setting. It should have been a community where our people with learning disability could live happily and quite contentedly within that environment. 15:46

153 Q. DR. MAXWELL: So if it became a specialist hospital did that mean that this was now more about medical treatment, because you talked earlier about a lot of

the people's issues were around social activity?

A. Yes.

154 Q. DR. MAXWELL: If it became a specialist hospital did this now become somewhere for medical treatment?

A. It seems to be more about treatment, but certainly because I had moved away then, we were in the Iveagh Centre, so we had moved out of the hospital. We were able to organise our own activities and things with our children. But I think within the hospital setting it was more seen as treatment that people that were there were patients and they were there to be treated and not, it wasn't social. 15:46 15:46

155 Q. And how long before you moved to the Iveagh Centre did this change to a specialist hospital happen?

A. It was already starting before these wards were being built and it was already starting then where activities were sort of being stopped, you know, like the sort of cinema and that. The recreational hall was knocked down after I had left. 15:47

156 Q. DR. MAXWELL: So the change started at the same time they decided to build new wards? 15:47

A. Yes.

157 Q. MS. BRIGGS: All right, Christine, the final two topics I am going to ask you about are seclusion and restraint, okay. If we start with seclusion, all right. You mention one patient in particular, it's P34, it's at page 12, paragraph 32 of your statement if you want to go and refresh your memory. It's P34 we're talking about, and you describe them as someone on whom 15:47

seclusion would not have worked?

A. Right.

158 Q. In what circumstances and on what sort of patient would seclusion have been helpful?

A. Particularly with patients that maybe, that suffered from autism, that maybe had to be, that physical intervention certainly wasn't helpful with them. If somebody that had a difficulty with people in their close proximity or people holding them, that it wasn't helpful for them and could maybe make the behaviour escalate, they can become more agitated. So to go into a seclusion room where they could bring themselves down was positive for them. 15:48 15:48

159 Q. And who made the decision whether or not seclusion should be used on an individual patient, was it left to nursing staff on the ward to exercise discretion or were those kind of decisions made at a higher level? 15:48

A. It was normally, I think in the sort of adult side it would probably have been in their care plan.

160 Q. You would have expected then to see some sort of reference to seclusion in the care plan that would have said whether it's a helpful or unhelpful intervention for that patient? 15:48

A. Yes, yes.

161 Q. DR. MAXWELL: But then, the timing of it, so if the care plan said that seclusion might be a helpful intervention? 15:49

A. Yes.

162 Q. DR. MAXWELL: Who then made the decision about enacting

that care plan?

A. In?

163 Q. DR. MAXWELL: Who would make the decision to use that, would that be the nurse in charge of the ward, would they have to call a doctor? 15:49

A. It would be within the multidisciplinary team and probably with the ward staff. Sometimes seclusion would have been used, it would have had to be used in an emergency situation. If somebody came and was quite violent or attacking, seclusion would have to be used 15:49 in an emergency situation like that. But always, any time that I seen seclusion used it was always for the shortest time possible until the person actually settled down. And they were always -- it was always documented and there was always somebody that viewed 15:50 them all the time, so they were viewed all the time they were in that seclusion.

164 Q. DR. MAXWELL: In an emergency situation, if seclusion wasn't included on the care plan, would it be appropriate in an emergency for the nurse in charge to 15:50 decide to seclude somebody?

A. Yes.

165 Q. DR. MAXWELL: It would?

A. Yes.

166 Q. DR. MAXWELL: But obviously then recorded and 15:50 discussed with the MDT?

A. Yes, it always had to be recorded, yes.

167 Q. CHAIRPERSON: And can I just pick up on what you were just saying about somebody being there all the time?

A. Yes.

168 Q. CHAIRPERSON: To be able to see the person who was in seclusion?

A. Yes, yes.

169 Q. CHAIRPERSON: What's your basis for saying that, is that because that was what was meant to happen or did you see that happening? 15:50

A. Well I seen that happening with somebody, they would view, they would always watch the child and that was recorded every 15 minutes that that was recorded, that that child or that person had been watched. 15:50

170 Q. CHAIRPERSON: And was seclusion used for children?

A. Pardon?

171 Q. CHAIRPERSON: Was seclusion used for children?

A. In some cases, yes. 15:51

172 Q. CHAIRPERSON: Right?

A. Not with very young children but sometimes with the teenagers, yes.

173 Q. DR. MAXWELL: Can I just ask...

MS. BRIGGS: Go ahead Dr. Maxwell. 15:51

174 Q. DR. MAXWELL....you say it had to be recorded, was there a central register of all the incidents of seclusion, or was it just recorded in the patient's notes?

A. It was recorded in the notes, but if seclusion was used and the person had to be taken to seclusion and they had used physical intervention to take them to seclusion, that always was recorded, that always had to be recorded on a sheet and they would have had a recording sheet where you had to record what hold you 15:51

used and how long for and everything else, that would be recorded. And the person that was maybe in seclusion, that was recorded and for the length of time they were in seclusion and then what happened then afterwards.

175 Q. DR. MAXWELL: That was all in the patient's record rather than in some other ward-based register?

A. Yes, it should have gone into then a central register as well.

176 Q. DR. MAXWELL: There was a central register? 15:52

A. Yes, I think so.

177 Q. DR. MAXWELL: Was that only when restraint was used? So if you suggested to a patient that seclusion would be helpful for them?

A. Yes. 15:52

178 Q. DR. MAXWELL: And they went into the room without any assistance, would that go on to a central register?

A. That would be registered as well, yes, if they went into seclusion. If they went into seclusion themselves because sometimes -- 15:52

179 Q. DR. MAXWELL: We have heard some people asked for it.

A. ... would go into seclusion themselves. I think that would just go into their care plan. I don't know whether they would have filled in like a recording sheet for that. 15:52

180 Q. DR. MAXWELL: You think that if we were to ask for the ward register of seclusion incidents, there should be a document?

A. It should be in the person's care plan, yes.

181 Q. DR. MAXWELL: Would there also be a separate register? You know how in the olden days, you and I would remember the bath book and things like that, would there have been a central record like that?

A. I know there was a central register for all the physical intervention. 15:53

182 Q. DR. MAXWELL: Restraint but not necessarily seclusion?

A. I'm not sure if there was one for that kind of seclusion, I'm not so sure.

183 Q. MS. BRIGGS: Okay. You were touching there on the use of seclusion on children's wards when the Chair was asking you a question. You say in your statement that there weren't seclusion rooms on the children's ward? 15:53

A. Yeah.

184 Q. So how was seclusion carried out in the absence of a seclusion room? 15:53

A. There was no seclusion room when we were in Conicar but we would have taken the child maybe, if they were in the main day room we would have taken out into another room, the dining room or the kitchen or out to the garden or somewhere else, but they weren't in any seclusion. There was a seclusion room in the Iveagh Centre, a specific seclusion room. 15:53

185 Q. And turning back to Conicar, do you know after you left that, being on the ward yourself, whether a seclusion room was ever introduced there? 15:54

A. No.

186 Q. It was never introduced?

A. They never had a separate seclusion room.

187 Q. Okay. And then on the topic of restraint, which we've touched on a little bit, I just want to be clear about your evidence, okay. When you talk about restraint in your statement you refer to using diversionary strategies rather than using restraint? 15:54

A. Yes.

188 Q. And you say that staff didn't have behavioural training which would equip them to use those diversionary strategies; is that right?

A. Not all staff would have had, it depends on if they were -- just not all staff would have had training. If you have got nursing auxiliaries coming in, not all staff would have had behavioural support training. We did start, and certainly when we moved to the Iveagh Centre we did start doing training sessions with staff on behavioural support plans and de-escalation techniques and things to use, yes. 15:54

189 Q. Who would have then made the decision, if a patient was acting in a certain way, whether to go for restraint or whether to try to use a diversionary tactic, would that have been left to the individual staff member present on the ward with that patient or was that decided at a different level? 15:55

A. Generally restraint was only ever used with us if in a more emergency situation, if there was going to be harm to the individual themselves or there was going to be harm to another person. You wouldn't have used restraint if there was nobody going to come into any direct harm or anything. You wouldn't have used 15:55

214 Q. DR. MAXWELL: Your line manager who is in Psychology?
A. Not from Psychology, from the nursing end.
215 Q. DR. MAXWELL: Your nursing line manager?
A. Psychology would have been okay.
216 Q. DR. MAXWELL: I would be surprised at Psychology saying it. 16:04
A. Psychology was quite okay with them.
217 Q. DR. MAXWELL: It was your line manager within the nursing management?
A. In the nursing end, yes. 16:04
DR. MAXWELL: Thank you.
CHAIRPERSON: Can I just thank you very much for coming to assist the Inquiry. You are, as you probably know, our first witness in this module dealing with members of staff and getting the insight into life at Muckamore 16:04
from a staff perspective is obviously of great importance to the Inquiry and it certainly seems, to me at least, you have been very frank and very balanced and it has been very useful to hear from you, so can I thank you very much indeed. 16:04
A. Okay, thank you very much.
CHAIRPERSON: Is it 10 o'clock tomorrow?
MS. BRIGGS: 10 o'clock tomorrow, Mr. McEvoy is taking the witness.
CHAIRPERSON: Excellent. Okay, thank you very everybody. 10 o'clock. 16:05

THE HEARING ADJOURNED