MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 13TH NOVEMBER 2023 - DAY 68

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THE INQUIRY RESUMED ON MONDAY, 13TH NOVEMBER 2023 AS FOLLOWS:

CHAIRPERSON: Good afternoon, thank you. Well, welcome back to everybody. I'm going to make a few comments just about the session that we're about to start but I'll keep the remarks brief as I'm very conscious of course that we have a witness waiting to give evidence, but I just want to say a few words about our approach to staff evidence which of course is starting this week and will then continue in December. 13:57 13:57

On the 6th of November I issued a statement dealing with how the Inquiry proposed to deal with staff witnesses and statement taking. That was published via the website, it was quite lengthy and I'm not going to repeat it here. But we will start today to hear evidence from members of staff at MAH. It's obviously an important part of the Inquiry and it's important that we do everything we can to encourage staff to come forward. 13:58 13:58

As I've said repeatedly, we need to hear about good practice at the hospital. I'll carry on, as I said repeatedly we need to hear about good practice at the hospital as well as poor practice. We have already identified a number of individuals we want to speak to and that process of identifying witnesses will continue. 13:59

We have thought carefully about whether this module of evidence could be streamed via the website in a similar way to how we streamed the evidence in modules 1 to 5 which we heard earlier in the year. I've decided not to do that and to treat this in much the same way as we heard the patient experience evidence. So this evidence will not be streamed live outside the Inquiry centre. There are a number of reasons for that decision but foremost in my mind is the importance of encouraging members of staff to come forward and express themselves freely and, in my view, streaming this evidence live would not necessarily assist in that.

Secondly, I have to be constantly vigilant to ensure that we do nothing to interfere with the criminal investigations and the criminal trials. Live streaming of that type of evidence may attract significant attention and that could have an adverse effect on the criminal trials.

Unless I place further restrictions I will not prevent the press from reporting on the evidence, they have their own rules and standards and they are also conscious, no doubt, of the importance of ensuring that they do not report material in such a way as to offend the rules laid down to protect criminal trials.

I have also considered whether we should publish the statements of staff witnesses on the website. Obviously all CPs have those statements in any event. Every public inquiry has to be aware of its responsibilities to be as open and transparent as possible. This particular public Inquiry faces fairly unique issues, in large part because there are concurrent criminal proceedings. Statements often require redaction and no doubt we will receive applications from either the PSNI or the PPS further to redact statements beyond just the ciphering of patients and staff names. 14:00 14:01

The safest way to proceed and the one that runs least risk in my view is to allow the transcripts to be published, but not the statements. In that way he can ensure as best we can the publication of potentially prejudicial material is avoided. 14:01

It's for that reason that we will keep to the system which was used for the patient experience witnesses of reading parts of the statements into the transcript. In my view that meets the public expectation of openness and transparency in relation to the material which will be taken into account by the Panel. 14:01

Counsel will have a discretion as to what to shorten or to precis, but in general terms I would expect anything

of significance in a statement to be read into the record.

We will also continue to take a precautionary approach to the ciphering of staff names in the statements and evidence as we have to date. 14:02

Further, counsel will adopt a precautionary approach to referring to staff names generally where the use of names in public isn't necessary for the Inquiry's purpose. 14:02

This is our first week of staff evidence and it is to some extent a test run. We'll be hearing evidence in various formats. Some witnesses will simply appear and give evidence from the witness table as this afternoon's witness is going to do. Others may be screened from view. One witness will give evidence remotely. Another may be read. That is a demonstration of what I've said repeatedly at engagement sessions; the Inquiry will do what it can to ensure that witnesses can give their evidence in a way which is, as far as possible least stressful, just as we did with the patient experience witnesses. 14:02

All right. 14:03

That concludes those brief opening remarks and are we ready for the witness, Ms. Briggs?

MS. BRIGGS: Yes we are, Chair, yes.

CHAIRPERSON: Let's get her in.

MS. BRIGGS: For the purpose of the record panel the statement reference is STM-183-1. Evidence of Christine Keenan.

14:03

CHRISTINE KEENAN HAVING BEEN SWORN WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

1 Q. MS. BRIGGS: Your name is Christine Keenan but you have told me today that you are happy to be known as 14:04
Christine; is that right?

A. That's right. Can you speak up because my hearing is not very good.

2 Q. Okay. Let me know if at any time you can't hear what I'm saying. Is that a good volume for you? 14:04

A. Yes, that's good.

3 Q. Christine, we've met earlier, okay. I've explained to you the process in respect of your evidence and the first step in that process is that I'm going to read the statement that you provided into the record, okay. 14:04
So if you're happy I'll start doing that now?

A. Okay.

4 Q. "My connection with MAH is that I worked at MAH initially as an enrolled nurse, then as a Staff Nurse, then finally as a behavioural nurse therapist. The 14:04
relevant time period that I can speak about is between 1973 and 2015, '16. I worked at MAH and then moved to the Iveagh Centre once it opened in 2010.

I began working at MAH as an enrolled nurse, not banded or graded at the time, in or around 1973. I undertook additional training and worked as a Staff Nurse, not banded or graded at the time from 1986 until 1993/ 1994. I undertook further additional training and worked as a behavioural nurse therapist Band 7 from 1993/1994 until my retirement in 2016. 14:05

My introduction to MAH was as a volunteer with the Gateway Club Larne, a charity or voluntary group run by [name], who did a lot of charity work and whose daughter had Down Syndrome. He brought me to MAH and I was impressed with the place and the care provided by MAH staff which gave it a family atmosphere. I had intended to do general nursing but realised that my calling lay in learning disability nursing. Thereafter almost all my nursing career has related to nursing children. 14:05

At the beginning of my career when my children were young I trained at MAH and worked there as an enrolled nurse and then as a Staff Nurse on night duty. I worked in MAH on the children's wards which were Conicar, C1, C2 and C3. I also worked on occasion with patients from the female hospital ward called the hospital block. 14:05 14:06

In around 1990 I came off night duty. I retrained in the social training centre, MAH, as a behavioural nurse

therapist. This enabled me to work as a specialist nurse therapist. I then completed a foundation course in family therapy and a diploma in teaching. I worked with in-patient children and also children from the community on an out-patient basis. I did not retain any documentation but the dates of my various roles will be found in MAH records. 14:06

The children that I worked with on an out-patient basis were ones who had been excluded from mainstream education. The patients that I worked with on an in-patient basis had either a mild learning disability, (MLD) or severe learning disability (SLD). The parents would have brought the children to MAH on a daily or regular basis. These parents would not have wanted their children in care situations. There were only two or three patients like this, P1 and P153 were two of these patients. 14:06 14:07

My first impressions of MAH when I began working there was that the older nursing staff mothered us. By this I mean that I felt that we were well supported." 14:07

You name a sister and you say she was particularly supportive. 14:07

"The first place within MAH that I worked was Abbey House which consisted of steel Nissan huts. Abbey House was a large room with a stage at one end. There

were around 30 children in each ward. I recall singing songs with the children and being caught on stage by a senior nurse."

who you name. 14:07

"He was senior to me and I was embarrassed being caught performing to the children but they enjoyed it. We also played with the children on swings, made mud pies, did paper crafts and painted. Before bedtime we sang 14:08 nursery rhymes and played little games to relax the children. I met my husband through my work at MAH, he was a clinical nurse tutor there. We married in 1975. The social training centre consisted of two large classrooms." 14:08

And you say who they were run by.

"Although they have the same name they were not related. I completed a diploma in education which 14:08 enabled me to deliver the curriculum to school age patients. While the school age MAH patients had learning difficulties and may have had behavioural challenges we at MAH still had to implement the curriculum and deliver some teaching and ensure that 14:08 they acquired some skills.

I worked on Conicar Ward as an enrolled nurse in the 1970s and then as a staff nurse from around 1992 and

felt the overall level of treatment and atmosphere to be good. I felt that it was a good ward to work on. For example, a patient, P1, was admitted to Conicar Ward. He was wearing a facial mask and splints on both his arms and his arms and legs. This was for his protection as he was intent on injuring himself. He would punch himself and restrain himself by putting his arms behind his back. I worked very hard to address P1's behavioural issues so that these items could be removed. We used redirectional approaches, things like singing, walks and massages. It was almost impossible to work with P1 at times. I could have cried at times. P1 remained needing two MAH staff to be present with him at all times. I remember one incident. I cannot recall when this was, but it was lunchtime in Conicar Ward and P1 was agitated and was trying to hurt himself. He was doing this by punching himself and kneeing himself in the face. He was hitting his head and biting his tongue. This incident required four members of MAH staff to deal with, I cannot remember their names. I am referring to this incident as I do not understand what the general public's expectations are and whether they appreciate how challenging it is dealing with people with learning disabilities at times. I and other MAH staff worked very hard with P1 so that he would redirect himself when he felt that he wanted to injure himself. In the end he would use a plastic spatula to flap and this distracted him. He was always accompanied by two members of MAH staff. I

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14:09
14:09
14:10

understand that he was resettled out of MAH."

And you refer to where he is now.

"I do not know about the adult care that P1 received but I understand that they are considering putting splints back on P1 as I know staff who currently work in the nursing home where he now lives. I feel this is relevant as MAH delivered support and care for P1 in a way that may not have been delivered to him in the community. 14:10 14:10

I remember a patient P154 who was from Ireland. She had previously been in a mother and baby home run by nuns. I cannot recall when she was admitted but I believe it was in the 1970s. She was a lovely child. She was fascinated by mirrors as there had been no mirrors in the convent. P154 really wanted a teddy bear. Myself and a number of my colleagues pooled our money and we went to Alf Giddley's toy shop and bought a panda. When we gave it to P154 she went outside to the swings and tried to put the panda in the swing and push it. She just wanted to take care of something. We ended up having a funny time trying to attach the panda to the swing so she could push the panda without it falling down. 14:11 14:11

Another MAH patient who I particularly recall was P11. He was admitted to MAH when I was on night duty. I

cannot recall the precise date but it would have been the mid 1980s. I was asked to help special him, which meant that he required additional nursing care and supervision. P11 was the most beautiful child. He punched his own face and eyes. I, along with other MAH staff, tried to prevent him from doing this as he was at risk of seriously injuring himself. I tried to sing to him to divert his attention. I prayed for help. It was so physically draining trying to nurse and supervise P11 that we had to rotate staff as it was too tiring doing it for any length of time." 14:11 14:12

You then name a person and you say that she put in a lot of effort in the care of P11. He.." that's P11 "Constantly hit himself. She.." that's the person you named... 14:12

"...had a large rocking Chair made, the orthotics department at MAH to try to soothe him and distract him. After a while we discovered that P11 found being in water to be calming." 14:12

The person you named...

"Would be in the pool so often and for so long that we used to comment that she was turning into a prune. 14:12
I find it difficult to talk about some of the patients. As mentioned, P11 was a beautiful child and we worked very hard with him. I was not involved with his adult

care. I do know that he eventually blinded himself. I found out about P11 blinding himself through punching himself. I am not sure what could have been done to prevent him from blinding himself.

14:13

It has been difficult for me to hear about incidents of abuse in the media coverage of the MAH Inquiry. I cared very passionately about my work and I would not have stayed if I had seen abuse of patients. I am not sure whether I was treated differently by the other MAH staff, whether they knew that I would not tolerate abuse and so were careful around me.

14:13

I would say that the physical care at MAH was very good. I did not ever see a bed sore on any MAH patient, however we would sometimes have patients return from other hospitals after as little as two weeks and those patients sometimes had bed sores.

14:13

I had a lovely, large office in MAH, it was very peaceful and looked out on fields. I could see hares playing in the fields. I would have met patients sometimes with their families there. Sometimes the patients would have been brought to me by MAH staff and other times I would have collected them from the wards. From 9.30 am in the morning the children would have been with me. I delivered work schedules based on the curriculum. After lunch, we had afternoon sessions. On Wednesday evenings I delivered social skills

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14:14

sessions to patients. I sometimes had family therapy sessions and we used a two-way mirror so that I could observe the patient with their family and provide guidance. We had supper dances for the patients. The staff got involved and a number of us brought in ribbons to do the female patients' hair and got them all ready for a special occasion. We had a hospital radio station." 14:14

And you name two people involved with that station. 14:14

"The radio station would play requests for the patients and staff members. I was a hippy and I remember being shocked at people under 30 listening to country music. 14:14

We would sometimes take the patients to pick their own potatoes at Greenmount Agricultural College, Antrim."

You name a charge nurse on the ward. 14:15

"...and then have fresh potatoes. This is another example of the family atmosphere that existed at MAH.

In relation to standards on wards one aspect of care that I was not comfortable with was the lower standard of care in the early days as there was less privacy for patients. In the dormitories and in the showers there was less privacy than there is now. For example, we 14:15

would have to bath ten patients at once. This improved with the refurbishing of MAH. Patients then had their own rooms with their own bathroom facilities en suite. This meant that they had greater privacy.

14:15

I do not think I ever saw neglect. Had I witnessed any neglect I would have reported it.

In around 1990 or 1991, the report "People First" was issued by the Department of Health, Social Services and 14:16
Public Safety and this triggered a large number of changes in MAH. Some of these changes were minor, for example, meaning we had to stop calling patients "patients" and had to call them "clients" and then we had to re-start calling them "patients". Some of these 14:16
changes were more significant for MAH meaning, for example, that the old institutional buildings had to be closed. These were large, red brick buildings with large dormitories. 20 children would sleep in a large dormitory. I understand that these may have looked 14:16
imposing but we used to have great fun and deliver great care in them. I put the children to bed and sometimes we pushed all the beds together and I read stories and recited nursery rhymes with them. The more senior MAH nurses would come around to check that 14:16
everyone was in bed and was asleep and they would find me reading stories. I feel that these old buildings lent themselves to a better sense of community. The older buildings were replaced with self-contained units

and I feel that this is isolated the MAH patients somewhat. I do not know who made these decisions.

My patients at MAH had a range of activities that they participated in, namely walks were very popular and everyone went on walks frequently on around a daily basis. We had a film club and frequently, around a weekly basis, which showed films. Every Saturday mass was held in MAH so that MAH patients could attend. On Sunday we had church that MAH patients could attend. I recall that a number of patients went to both mass and church. The patients seemed to enjoy church had as it had an organ and there was music at it. We had a group of MAH patients who played pool. The patients participated in pool/snooker competitions in England and won prizes there. We got them waistcoats and bow ties to wear. I recall that the awards were put into an award cabinet. 14:17 14:17 14:17

Each month MAH would have a supper dance. Once per year we had a special Indian event where Indian musicians would come in and play for the MAH patients. There were catering options including the Cosy Corner, a canteen located in MAH, and there were vending machines with drinks and snacks. MAH patients met with their girlfriends and boyfriends. There were a number of romances between patients at MAH. Two patients eventually married. 14:18 14:18

On the first Saturday in June each year there was a gala day which was attended by MAH staff, patients and their friends and families. This was a wonderful event and had a lot of community support. MAH staff all got involved in this. I brought in ribbons for some of the MAH female patients' hair. The Army came along to meet everyone. There were donkey rides, cake sales and bric-a-brac. This day served as a fundraiser and the money raised was used to pay for days out for MAH patients. These days out included trips to Bangor and Portrush. 14:18 14:18

There was a ladies' football team that patients could join. They were very good and played in many competitions. 14:19

All of these activities were removed as part of the modernisation of MAH. I think MAH patients had a better patient experience before these changes. Patients had greater opportunities to develop various skills such as social skills and domestic skills. The removal of these at MAH meant that the patient experience was diminished. 14:19

There were some patients who were at MAH, not because of the MAH's staff's decisions but because there were no suitable locations for them to be housed in the community. For example, I recall a number of patients with needs such as behavioural issues who also had 14:19

learning disabilities as well as superimposed mental health problems. It was challenging to go resettle these patients because of their complex needs. With the development of MLD and SLD schools these patients who would have been at MAH could now be resettled and 14:19 educated in the community.

I did not work with forensic adult patients. I do not know how many MAH staff dealt with them and I do not know what training they had to deal with these 14:20 patients. I did not have any training to deal with forensic adult patients.

There were a few forensic child patients at MAH. I recall one whose first name was P155 who was quite high 14:20 functioning and who had Smith-Magenis syndrome. He wrote very sexualised letters to members of staff and he threatened to rape me. He was of a larger build so was a risk and he was always nursed or supervised on a one to one or even two to one ratio. He stubbed 14:20 cigarettes out on nurses' heads. I remember one very serious incident, I do not recall the date, a number of staff were responding to an alarm for another patient and while they were dealing with that patient, P155 was being nursed or supervised by two nurses called H727 14:20 and H728. P155 assaulted H728, smashing her face with his knee and pinning her to the floor.
He was eventually sent to a facility somewhere..."

And you say where that is.

"I do not think H278 ever went back to nursing.

I make a general observation here in that were this incident to happen in a general nursing setting it would be on the news. As this incident happened in a learning disability nursing situation, the public never hears about it. The fact that the public do not hear about these assaults annoys me. 14:21

I wrote behaviour programs for MAH patients. These programmes were included in their patient notes and were available to all MAH staff. In writing these programmes, I would look at the patients antecedents, the frequency of incidents, the intensity of incidents and the various things that would impact the a patient's behaviour. This included looking at a range of factors, including family relationships, relationships with MAH staff and the patient's own surroundings. 14:21

During my time at MAH, physical intervention training, in MAPA for example, became increasingly prevalent in the training and development of staff. This was due to increased aggression by patients and lack of opportunities for patients created by policy changes at government level. In my view, physical intervention is sometimes necessary to avoid serious risk of harm, but 14:22

it is not necessary in all circumstances and should be used as a treatment of last resort. I feel that with the training and physical intervention this became more used. Conversely, staff did not have behavioural training so were not equipped to use diversionary strategies to divert patients away from causing harm to themselves, other MAH staff, or patients or property. Staff were given some training in diversionary strategies and children would have had behavioural support plans which staff would have had access to. 14:22

I remember one incident, although I am not sure of the date, when a patient, P115, bit on the arm a member of MAH staff, H729, he then got her into a headlock. She was at risk of serious injury. I distracted him and he ended up chasing me around the gym. I love running and he ended up running until exhaustion after around 25 minutes. With P115 physical intervention did not work and, for him, he found playing with someone else's fingers to be relaxing and distracting. 14:23

I attended my general practitioner due to injury sustained at work. He asked me why I stayed at my job at MAH. As a Christian I felt at the time and since that MAH was where I was meant to be. 14:23

I was informed at one stage by a staff member of the Belfast Health and Social Care Trust that I was the most injured member of staff within the Trust area. I

cannot recall when that was or the name of the member of staff who told me that.

I remember an MAH patient named P34. He was the most loveable child. His mother and I have kept in touch. 14:24
I recall him being admitted as a child. He was a beautiful child and a real character. He used to wink at me. I felt that he was well supported in children's service in that he received good care which supported his development and needs. I used behavioural 14:24
techniques with him. Seclusion, as in the use of the seclusion room, and physical intervention would not have worked with him. To me, isolating someone causes other difficulties and problems, but sometimes it is necessary. P34 was not able to communicate his 14:24
feelings and when he became frustrated he would use his behaviour to communicate. For example, he became agitated and frustrated. He expressed this by taking a fire extinguisher off the wall and throwing it at me. It landed inches from me. I had to sit down because of 14:24
the shock. Had the fire extinguisher hit me, I believe that I would have been seriously brain damaged or possibly dead. Harming me would not have been P34's intention, he simply wanted to throw things for attention and to express himself." 14:25

At paragraph 33 then, which I am not going to read in full, you refer to another patient who you say was a difficult and aggressive child and you describe

incidents where you were assaulted and threatened by that patient. Picking up towards the end of paragraph 33, you say:

"I was treated at Antrim Area Hospital for eye injuries. I was off work for a period of around six weeks. This incident triggered panic attacks and I returned to work on a phased basis which included working with adults. 14:25

I worked with another patient during this period whose nickname was "happy feet" as he was always happy. I cannot recall his actual name but I do recall that his brother was a famous footballer. He was a lovely, funny man. I recall baking with him and he really loved this. I taught him how to make a small meal for himself. How to go to Tesco and how to budget and order a meal in a restaurant. 14:25

Most of the time when we were injured we would not have filled out accident forms as it would have taken too long. The accident forms were time consuming to complete. I filled out forms when the injuries were more significant. If I was given a slap or was hit by patients I would not have always reported this. I think I was injured hundreds of times. 14:26 14:26

My work at MAH had an impact on my family. My eldest child, my daughter, said that she hated my job as she

saw my injuries. I disliked the impact that my work at MAH had on my family.

My son got married in 2010. In the run up to my son's wedding he told me I needed to stay away from the MAH patients who were prone to physical outbursts. He said that he did not want his wedding photos to have me showing me having facial injuries. Shortly before the wedding I was assaulted by a patient and broke my scaphoid bone. This required me to have a plaster cast. I had to ask for this to be removed prior to the wedding so that it would not be in the photos. 14:26 14:26

In relation to support for staff, I found MAH to be difficult at times. The work was demanding and we were always busy. Patients could be demanding and challenging to deal with and to nurse. I felt that I had a free reign in the delivery of my behavioural nursing services because I got on well with the parents because I got results with the patients. Patient's parents were pleased with the progress that their loved ones made. 14:27 14:27

In relation to other MAH staff I raised issues around food and this got me into trouble. I was concerned at the quality of food being provided to MAH patients. I thought the food was rubbish, essentially junk food. Other MAH staff knew that I could be challenging but that I was honest and true. For example, when I raised 14:27

the issues about the patients' food I was told by H359 to apologise. I refused to do this. Shortly afterwards Jamie Oliver did a lot of publicity about poor quality hospital food. H359, in response to my comments, created a working party which looked at healthy eating. 14:28

I received the Farmer Prize two years in a row for my development of the Picture Exchange Communication System, PECS, at MAH. I had been nominated for this by the consultants at MAH. I received Learning Disability Nurse of the Year in 2008. This was very special as I had been nominated by parents of patients at MAH. The awards were a lovely evening at the Culloden Hotel, Cultra, and had television cameras. I was shocked when I won and did not have a speech prepared. Another MAH nurse [name] was also nominated. I thought he was a great nurse as he was very caring. 14:28

In relation to the approach to patients and information about patients, I felt that I was clear on the reason for patients' admissions. My role meant that I was involved in the admissions process and I attended multidisciplinary team meetings. I conducted home visits to people in the community. These home visits were required to assess whether someone needed to be admitted to MAH. This was the normal route to admission to MAH for the patients whose care I was involved in. I recall that there were a few emergency 14:28 14:29

admissions, but this was a relatively rare occurrence. I remember two emergency admissions. The first parent was P156 whom I recall trying to run away from MAH. The family found it difficult managing P156. I cannot recall the date of her admission. 14:29

The second patient was P77. I recall his admission which was in around 2000. I had carried out a number of home visits and the family found it very difficult managing P77. P77's siblings would sleep in the attic at night due to P77's behaviour. 14:29

In the first few weeks following a patient's admission I was involved in the assessment process. I carried out functional analysis and a historic assessment. 14:30 This involved getting details about the patient's birth, illnesses, genetic factors, acquired injuries and considering the patient ease family and relationships. I assessed patients using a number of tools, including adaptive behaviour scale, personal education plan, motivational assessment scale and reviewing a patient's circle of friends. I also used a risk assessment tool which I designed myself. My assessment resulted in a behaviour management plan which was included in the patient's notes and records accessible by all members of MAH staff. Sometimes my plan would be to treat the most serious and urgent behaviours. Other times my plan was to treat some of the easiest first, to build confidence and rapport. 14:30 14:30

In the media coverage of the MAH Inquiry I have heard a lot said about the use of seclusion rooms. There were no seclusion rooms on any of the children's wards. There was a seclusion room on Six Mile ward. This was the only seclusion room of which I was aware. I have heard criticism in the media coverage of the MAH Inquiry that there were no toilet facilities in the seclusion room. I would respond by saying there were toilet and shower facilities beside the seclusion room on Six Mile ward. On a practical point, I have had a toilet removed from the wall by a patient and thrown at me so this was a serious risk. I cannot recall the date of this incident or the name of the patient. Seclusion rooms were specially made without edges, corners and skirting boards, for example, as these posed risks to the patients. The padding and mats were specially sealed so that patients could not rip them apart and eat them or cause other harm to themselves.

Patients were placed in a seclusion room when they were a risk to themselves or others. They were placed there by MAH staff and supervised. Seclusion rooms offer a place where patients can be safe and can calm themselves. When considering seclusion rooms, I would like the MAH Inquiry to consider the following: When you are in a bad temper, what do you do? You do not stay in a crowded room of people. You self-regulate and take yourself out of the situation so that you calm

down. This is self-regulation and a number of the MAH Inquiry patients could not do this.

Upon reflection, in light of what I have heard from the evidence during the MAH Inquiry, I am now not sure what the families of MAH patients expected of the MAH staff in relation to care. The patients in MAH are people who could not be cared for by their families and could not be cared for in the community. The patients in MAH were challenging. I have received a large amount of verbal abuse throughout the years, including of the most serious kind. I recall one MAH patient shouting "I wish your husband dies". I recall one patient pinning me to a wall. I have been grabbed, hit in the face and told by an MAH patient that he was going to rape me. 14:32 14:32 14:33

I ran a social skills group on Wednesday evenings in MAH. I believe that leaving social skills training until people with learning disabilities are adults is a mistake. I introduced MAH patients to some simple social skills like how to queue, how to introduce themselves and how to order a meal in a restaurant. I did a lot of baking with MAH patients. I used this as a form of treatment and engagement. This was a positive sensory experience, with something tasty to eat at the end. I taught MAH patients how to do simple things like how to butter bread and how to wash dishes. Cookery was a way of rewarding positive behaviour. I 14:33 14:33

had a points system where positive behaviours received points and the points could be used to make things like chocolate muffins.

In around 2008 we set up a car wash at MAH. MAH patients and MAH staff worked as a team to wash cars and received a payment in return. I felt that this was an important part of normalisation. It helped MAH patients understand that in return for doing a task they received a reward. The money that was earned from car washing was kept in a jar and the patients decided what they would spend is on. They would have selected things like ten pin bowling, a cinema trip or go to McDonalds. 14:33 14:34

A number of MAH staff and I had circle time with the children every day and we used primary movements. This involved acknowledging and encouraging positive behaviours. We talked about the good things and bad things that we did at the weekend. This involved MAH staff sharing their own experiences. For example, I may have said to the children that I was grumpy with a member of my family. This was also a way of building trust with patients. 14:34 14:34

Looking back on my career at MAH I think that one of my greatest successes as with a patient called P157. I worked with P157 for around three years immediately prior to my retirement in 2013. P157 was a very

difficult patient who had autism and obsessive compulsive disorder. His behaviour included dismantling things. His father and his mother would have had to call a plumber at least once per week. H would also bite people's noses and grab people between the legs. This was particularly distressing for some of the staff. He tried to take out his own clavicle bones on one occasion. I was able to manage his behaviour by doing baking with him. I made scones with him and he never once tried to bite me. P157 also reacted well to social skills training. We had a range of rules and I understood him well. We would sometimes take all the books off the shelves and P157 would love to arrange them back in order. I remember one particular breakthrough that I had with P157. It does not sound like much to many of us but I met with P157 and his father and we put on aprons, each of them at an end of the bench, and they made buns. This was a major achievement for them and marked an improvement in their relationship. P157 called me "Queen Christine" and he is now living very successfully in the community in supported living. 14:35 14:35 14:35 14:36

There was a push to resettle patients from MAH in the 2000s. I advised patients' parents that they did not have to accept anything if they did not feel it was right for their loved one. I felt that it was sometimes my position to advocate for them. I printed out bits of "People First" and other pieces of 14:36

guidance. I gave these to parents so that they understood their rights. I think that the families appreciated this. I think that the other MAH staff felt that I was very dedicated. I felt that I had to be an advocate for those patients who were struggling. 14:36

I did not have any say on medication of patients. However, consultants may have considered my views at looked after children and multidisciplinary meetings. I had no input into the use of PRN. However, I looked 14:36 at the use of PRN post-use and considered whether there were any learnings from incidents. These reviews included me looking for learnings and understanding of factors that led to the incidents and/or use of PRN. I also made recommendations about how to deescalate in 14:37 the future. My recommendations were put into a risk assessment which was a form that I had designed. This included a process of assessment, delivering a planned programme, evaluating the effectiveness of the plan and reassessing. I looked at restrictive practices and 14:37 considered and made recommendations about redirective approaches for the patients. This information was available to all staff. These recommendations were implemented by staff caring for patients. Implementation of these recommendations were carried 14:37 out by the named nurses for each patient and consistent with the behavioural support plans.

In relation to ward allocation, patients under 18 years of age stayed on children's wards.

In relation to CCTV, there were no CCTV cameras in MAH when I worked there.

Children's services were moved from MAH to the Iveagh Centre, part of the Royal Victoria Hospital Belfast in around 2010, this was a significant change. I moved from being surrounded by fields and peace and tranquility to a flashpoint. The Iveagh Centre is located in an interface area, meaning it had the potential to become violent. I was surprised at the large number of flags in the environment. 14:38 14:38

At MAH the staff and I had to build up our children so that they could lead the best lives that they could lead. I found it difficult to leave MAH as I found my work with patients very rewarding. I felt that this was my calling. Now, with the ongoing MAH Inquiry, I find it difficult to say that I worked there. I had been proud of my work at MAH. Now I am not sure when and where I can talk about my nursing career." 14:38 14:38

Over the page then on page 20 you sign and date that statement, Christine, okay.

I am going to take you back to paragraph 21 because before I have you adopt the statement formally, we had noticed an error in respect of your statement, a typographical error, if we put it that way at paragraph 14:39

21 on page 7, the numbers are at the top Christine.

A. Yes.

Q. Okay, that should read:

"We would sometimes take the patients to pick their own potatoes at Greenmount Agricultural College Antrim." 14:39

You name a nurse who was the charge nurse on the ward. That should be a full stop and then said "we then had fresh potatoes" is that right? 14:39

A. Yes.

Q. Christine are you content to adopt the contents of that statement as it is to the Inquiry?

A. Yes.

Q. I am going to start by asking you a little bit about your most senior position and the position you spent the most time in, which was as a behavioural nurse therapist okay? 14:39

A. Yes.

Q. That was a Band 7 role; isn't that right? 14:40

A. Band 7 role, yes.

Q. You were in that role, am I right, between 1993, 1994, until 2010 when you moved to the Iveagh Centre is that right?

A. Yes. 14:40

Q. And throughout that whole period you were a behavioural nurse therapist?

A. Yes, I done most of my training during that period of time, over that period of time.

11 Q. Your job title during that time would have been behavioural nurse therapist?

A. Behavioural nurse therapist, yes.

12 Q. Could you very briefly describe what a behavioural nurse therapist does? 14:40

A. Right, we would have looked at, because I worked with children, it was always children that I was with so children, the youngest child I ever worked with was I think maybe around about 2 years of age, the only one ever that came into the hospital at that age. But most 14:40 of them were around young teenage years, from maybe 10 years of age up to 18 years of age. The children would have been referred to us either by social workers or by the school, by parents or from the GP to the multidisciplinary team. I was tasked usually to go out 14:41 to assess that child, so I would have gone out to the child's home or to the school or to, if they were maybe in a respite care facility, to assess the child. We would have brought back the information and from the multidisciplinary team meeting there was a decision 14:41 made whether the child was suitable for admission into the care setting. Sometimes we felt that a child could be looked after, maintained at home and in school. At other times, because the behaviour was very difficult and sometimes it's hard to change a behaviour if they 14:41 stay in that same setting so we have to change the environmental setting to relook at the behaviour. So my job was to assess and then to programme plan. So I would have programme planned for the children.

13 Q. If it was deemed that a child didn't need to be admitted to Muckamore, would you still have had a role in relation to that child on an out-patient basis, is that fair to say?

A. If I was, yes, I could have seen them on out-patient basis as well. 14:42

14 Q. Where would that have taken place, in the home or in Muckamore, in the day care centre or where would that have been?

A. There were children who came in, we only had a few children who came in on a daily basis, they would have lived at home and came in on a daily basis and then gone home again every evening. The majority of children that were admitted into Muckamore stayed there, maybe went home at weekends or maybe once a month. Some of them went home every weekend, some of them once a month. 14:42

15 Q. You talk in your statement about writing behavioural plans and behavioural programmes you call them?

A. Yes. 14:42

16 Q. I want to ask you about how effectively they were implemented because you say they were included, those behavioural programmes in patient notes, and were available to all of the staff?

A. Yes. 14:42

17 Q. But are you aware as to how well they were put into practice by the staff who would be looking at those?

A. When a behavioural programme, when you design a behavioural programme there is a lot of assessment work

goes in prior to that, so the staff would have been involved in that assessment work. They would have been tasked to look at the motivation assessment scales. The staff were involved in the assessment process. When we completed the assessments and we looked at the behaviour support plan, they were worked along with the staff that were working with the child and they were taught. If there was specific issues that we needed to look, I would have been doing direct treatment with the child, so we would have worked along with the child with the nursing staff as well. On some occasions we would have had direct teaching sessions, if we were implementing a communication system like PECS, we would have done training sessions with the staff as well. 14:43 14:43

18 Q. Would you have been satisfied then that whatever you put into the programme was actually being implemented on the ground when you weren't around? 14:43

A. Usually, yes it was, because we had the children's LAC Review meetings, or we had team meetings every week and we would look at how the programme was being implemented, if things were working. Sometimes we would find the staff, we would report back that something really wasn't working, so we had to readjust again. Because once you right write a programme it doesn't always follow that the child is going to fall in with the programme, you had to readjust again to suit in with the child's needs and with the staff. 14:44 14:44

19 Q. You refer to "we". Who are you referring to when you say we would have to look at it again if staff reported

there was a problem?

A. The staff because every child had a named nurse and then they had a team that would work with them, we would have liaised with the named nurse, because they were with the child maybe more on the ward basis because I wasn't always based on the ward. 14:44

CHAIRPERSON: Can I just ask, my two colleagues will know this very well, but can you give me an example of what might go into a behavioural programme?

A. Sorry? 14:44

CHAIRPERSON: Can you give me an example of what might go into a behavioural care programme.

A. What would go into a behavioural care programme?

CHAIRPERSON: Yes.

A. When you look at the behavioural programme initially you are looking at, you have to identify the behaviour first of all, so you are identifying that particular behaviour. There could be a range of behaviours. So you look at that behaviour, you look at the antecedent for their behaviour, what their behaviour is, what they actually do during that behaviour. 14:45 14:45

CHAIRPERSON: So it might be, what, putting something in your mouth or it might be, what sort of thing would it --

A. What sort of behaviours? Mostly the children that would come to us would have, their behaviours would be quite difficult, so you had to look at that behaviour. It could be, I'm trying to think of something, self-injurious behaviour, where a child would be self- 14:45

injurious. So we were looking at maybe what triggers that self-injurious behaviour. So they could be punching themselves, pulling their hair, banging their head off the floor, jerking themselves. We are looking at that behaviour and what is the antecedent for that behaviour and then the consequences of the behaviour.

CHAIRPERSON: The plan would be how to respond to that behaviour?

A. How to respond. You look at how you can change the antecedent and the consequence for -- those are the two things that maintain the behaviour, the antecedent and then the consequence. You look at what you can manipulate and can change about that behaviour. We had to look at it in a very ethical way, in why we were changing the behaviour, if the behaviour was functional for that person. So if a behaviour, somebody was using the behaviour to gain attention or to communicate something, like sometimes children would use their behaviour if they were wanting to get a drink, but they didn't know how to communicate that. We had to look at the whole function of their behaviour and look at what we could replace that behaviour with.

CHAIRPERSON: Thank you.

A. Look at what we were replacing was better for that person.

CHAIRPERSON: Thank you, okay, sorry Ms. Briggs.

20 Q. MS. BRIGGS: I am going to ask you now about the wards that you worked on okay?

A. Mm-hm.

21 Q. You tell us in your statement about the children's wards, the wards that you worked on, it was Conicar, C1, C2 and C3. What were the staffing levels like on those wards comparative to the number of patients on them? 14:47

A. When I was working on those wards, it was going right back in before I started as a behavioural therapist. Those wards were the big red brick building wards and they were quite full of patients at the time. The staffing levels, I'm trying to remember back, maybe 14:47 there would have been quite a number of staff on the wards and they were very busy, very busy wards. But they were always, particularly in the children's wards, they were always very happy places.

22 Q. Were you satisfied that there was enough staff to 14:47 handle the number of patients that were there?

A. Yes.

23 Q. And you mentioned there that you were working on those wards before you were a behavioural nurse therapist. Can I take it when you became a behavioural nurse 14:47 therapist, you are working across more wards than that, is that the case?

A. Sorry?

24 Q. You mentioned in your evidence there that you were working on those specific children's wards you said in 14:48 your answer, before you came a behavioural nurse therapist?

A. Yes.

25 Q. When you became a behavioural nurse therapist were you

working in different wards or more wards?

A. No.

26 Q. Those same wards?

A. Whenever I became a behavioural therapist I was based in the social Training Centre. We had rooms like large classrooms so the children would come from the wards to us. We would have picked them up in the morning time and brought them to the classrooms, taken them back at lunchtime, picked them back up again and brought them back again so they were back and forward. I would have been on the ward sometimes to help out maybe if they were short staffed maybe to supervise over lunchtime or something, but other than that, I didn't work in the general wards. 14:48 14:48

27 Q. Okay. That's helpful, thank you very much. And it's right to say that you also worked with adults as well at times, I think you mention that in your statement? 14:48

A. In some cases, there was one stage where we actually had to work with adults after the children went back to the ward at 3 o'clock and we were tasked to work to 5 o'clock so then we had some adults that we were bringing in at that time. 14:49

28 Q. Those were adults that were engaging in behavioural therapy would come to you, is that the right way to put it? 14:49

A. They would come normally to us, but they were never -- we didn't have adults there when we had children there, they weren't allowed to mix.

29 Q. DR. MAXWELL: But you didn't work on the adult wards?

A. Pardon?

30 Q. DR. MAXWELL: You didn't work on the adult wards. The adults came to you in the Social Training Centre?

A. The adults came to us, yes, we didn't work on the wards. 14:49

31 Q. MS. BRIGGS: Were there behavioural nurse therapists that worked on ward, be it in childrens' wards or in adult wards?

A. There was no behavioural therapists on the children's ward, no. The adult services did have behavioural 14:49 therapists as well, they had two trained behavioural therapists and two assistants.

32 Q. Were those individuals placed on the wards, can you say, if you can't, that's okay?

A. I think they worked on the wards at some stage but they 14:50 weren't based on the wards at that time, no.

33 Q. When you say at that time, do you mean the time when you worked in Muckamore?

A. Pardon?

34 Q. When you say at that time -- 14:50

A. At that time when I worked in Muckamore, yes, they weren't there.

35 Q. The Inquiry has heard some evidence about children being placed on adult wards, being admitted to adult wards. Were you aware of that? 14:50

A. Yes, there were a number of, well two children that I know of that had gone into adult wards and in those cases it was because their behaviour was so difficult that they couldn't really be managed within the

children's ward and the children that were in the children's, they were, children were at risk from that behaviour.

36 Q. Okay. I want to ask you --

A. They weren't young children, they were children maybe coming up to 18. 14:50

37 Q. Okay, I want to ask you then about admissions, okay, because you describe your role in admissions and in fact you have given oral evidence today already about your role in admissions, okay, and you described carrying out home visits to assess whether someone, a child, needed to be admitted to Muckamore? 14:51

A. Yes.

38 Q. What was the criteria for admission to Muckamore as an in-patient? 14:51

A. Generally the criteria was if the child wasn't being able to be managed at home, if their behaviour was causing such a disruption within the home environment with the parents or the siblings or the school couldn't manage the behaviour within the classroom setting of the school. Sometimes if I went out to a classroom setting, it could have been very difficult for a teacher, classroom assistants to manage that behaviour within that setting and it was having a detrimental effect, the behaviour was having a detrimental effect not only on that child but the other children in the classroom. And a lot of, in many instances the behaviour was blocking the child's potential to learn so we had to look at the behaviour so the child could 14:51 14:51

learn and develop.

39 Q. Thank you, Christine. What about adult admissions then. Would you be aware whether there was a behavioural nurse therapist who was carrying out a similar role to you in respect of adults? 14:52

A. I was never involved in adults' admission.

40 Q. Okay. And you described in your statement how you were involved in the assessment process after the first few weeks of admission during that initial period when a child is admitted? 14:52

A. Mm-hm.

41 Q. I want to ask you about the family side of things during those initial few weeks after a child is admitted to Muckamore. The Inquiry has heard evidence that families were told not to visit during those 14:52 initial number of weeks. What was the rationale for that?

A. With the children?

42 Q. Yes, so the Inquiry has heard evidence that on admission to Muckamore a family may not have been 14:52 permitted to visit in the first number of weeks and the Inquiry has heard evidence about that in relation to children and adults, okay. Were you aware of that practice first of all?

A. Not with the children. 14:52

43 Q. Not with the children?

A. Not with the children, no. The parents would have been encouraged to be -- to see the children.

44 Q. That would have been for the period you were working in

Muckamore, the whole time you were there?

A. Yes.

45 Q. Thank you, Christine. And what about the support that was offered to families whose loved one was admitted to Muckamore? For example, what were they informed about the likes of advocacy services, can you speak to that? 14:53

A. Well the parents were always encouraged to be part of the children's LAC review, the children that were there. They had access to advocacy services, I know the children did have. The parents were fully involved in their care because any behavioural support plan had to be, the parent had to be comfortable with that as well, they had to be able to implement that at home, so they would have been fully involved in that and they would have attended the meetings. So they would have been there, generally the parents were there on a monthly basis and they were part of the meeting or any other time that they need to be there. And certainly the parents could have seen us at any time if they wanted to speak to me, if they wanted to go through anything, they could have met with us or if they wanted to see the consultant. 14:53 14:53 14:54

46 Q. Did parents or family members of child patients, did they regularly do that, did they come to you and seek that kind of help? 14:54

A. Yes.

47 Q. We touched on advocacy services there briefly and if I digress for a moment just on to advocacy generally, was the presence of advocacy groups felt as a staff member,

did you feel their presence at Muckamore?

A. I didn't so much at Muckamore but when we went to the Iveagh Centre we had more involvement with the advocacy services.

48 Q. And in terms of visitation then on the children's wards for parents after those initial period, how often was visitation, were there rules around that or was visitation allowed whenever parents wanted it? 14:54

A. Generally the parents came whenever they wanted to come. We would have parents come up to take their children out for the afternoon, out to the Cosy Corner, out for a walk. A lot of the children went home at weekends, their parents would have come up and taken them home for weekends. 14:55

49 Q. Were visits ever restricted for any reason? 14:55

A. Not that I ever knew of.

50 Q. And the Inquiry has also heard some evidence about the lack of ability to go and see where patients slept, their rooms, their beds, actually where they were. Was that what it was like on children's wards can you speak to that, were parents allowed? 14:55

A. I wasn't aware of that. I think that the parents were allowed to see around, they were shown around the ward. I know certainly within the Iveagh Centre, the children were taken around -- they were taken to the child's room. A lot of the parents were able to put things into the room that they wanted to put into the room. We had some parents that preferred to take their children's clothes home themselves to wash them, 14:56

because they felt that they were still caring for their child if they were doing that, that was actively encouraged. A lot of parents put in particular food stuffs that they wanted their children to have.

51 Q. That was the situation in Iveagh, can you speak to what it was like in Muckamore? 14:56

A. The same in Muckamore, the same in Conicar in Muckamore.

52 Q. I want to ask you about what Muckamore was like for the staff who worked there, okay. First of all, what were the arrangements for clinical supervision within Muckamore? And the Inquiry specifically is looking at the period 1999 onwards, okay, you left in 2010. So if you think about that period 1999 to 2010, what were the arrangements for your clinical supervision for example? 14:56 14:56

A. I had clinical supervision by the psychology department so I was supervised by a grade higher than myself from psychology because I worked under Psychology at that time.

53 Q. Was that clinical supervision effective or not effective in your view? 14:57

A. It was grand because we got to talk about our work and about what I was doing and what I wanted to improve or what were my goals for my, for the work I was doing.

54 Q. Okay. You describe in your -- I am going to pass over to Dr. Maxwell. 14:57

55 Q. DR. MAXWELL: You probably remember, as I do, there was a big introduction of clinical supervision for all nurses in, I think it was around '92, '93, '94. Do you

know what sort of supervision the ward nurses were getting in terms of clinical supervision?

A. They also supervision.

56 Q. DR. MAXWELL: How did that work, who was providing it, how often did they get it? 14:57

A. In the wards it would always be somebody of a grade higher than you. If it would have been a staff nurse, it would have been a senior, maybe the charge nurse or the ward sister that would have done the supervision. Generally it was always maybe the charge nurse or ward 14:58 sister being supervising or doing it with the nursing staff or senior staff nurse.

57 Q. DR. MAXWELL: So it was individual because there were a couple of different models, some places had group supervision, some had individual supervision, are you 14:58 saying it was individual?

A. I think it was nearly all individual. I know certainly my supervision was always individual.

58 Q. DR. MAXWELL: Did you have supervision before you made the transition to be a behavioural nurse therapist, did 14:58 you have clinical supervision when you were working as a Staff Nurse on the ward?

A. When I was staff, they didn't have supervision then at that time I don't think before I became, before I trained as a behavioural therapist. There wasn't 14:58 generally supervision, I don't think at that time. I think they would have just been, I don't remember that ever when I was nursing.

59 Q. MS. BRIGGS: You describe in detail in your statement

about physical injuries you sustained, assaults or threats that you received from patients while you were working at Muckamore. You actually say in your statement you were injured you think hundreds of times. Did you regard injuries as inevitable given the environment that you worked in or was there more that could have been done by other staff or management to ensure your safety?

A. I think it was difficult because I was constantly I suppose in the frontline and everybody I worked with had challenging behaviour and were presenting with behaviour difficulties, so when you were there and you were working with them, you were the person there directly with that person, you were going to get those injuries, you were going to get -- it was, I mean none of the children, there were very few of them ever that it was a deliberate attempt to harm you. A lot of it was to do with their communication. A lot of it was to do with they had a history. One of the difficulties, if you are working with a young teenager who has a long history of using their behaviour to effectively maintain their environment and to get their needs met and that behaviour has got a long history, it is really hard to change that kind of behaviour. But you can't change the behaviour without building a relationship with that person. You have to build that relationship, you have to have confidence with them, they have to have confidence with you. So have to be in direct contact with them and a lot of the times you are

14:59 14:59 14:59 15:00 15:00

putting yourself in the firing line because you are going to get the behaviour and sometimes you just accept it.

60 Q. Hindsight is a wonderful thing, but looking back now do you think there is anything that could have been done by those above you to help protect you physically from that type of harm? 15:00

A. I think in the early days we never had alarm systems or anything so we couldn't have had anybody to call on. So you didn't always have that kind of back up support. We didn't have any specific training in physical intervention so if you have a big 16 year old fella coming to attack you, we didn't have, you weren't taught anything of how to actually get out of that or how to manage that or how to restrain that person. And I know there's a lot around the sort of MAPA training, sometimes it was necessary and you had to feel confident in whenever you're faced with somebody that's going to actually attack you and going to injure you, you have to feel confident in how you can manage that and that person. 15:01 15:01 15:01

61 Q. DR. MAXWELL: So I understand what you're saying, it's difficult to prevent this?

A. Yes.

62 Q. DR. MAXWELL: And that the patients did not intend to harm you, but some of the injuries you had sound quite serious and what sort of support did the Trust give you after you had been injured, because it must have been very frightening as well as physically painful? 15:02

A. We didn't really get any support.

63 Q. DR. MAXWELL: And so that could be quite challenging for staff if they had been injured, even if they understood the patient didn't mean to do it and they weren't getting support, they presumably quite fearful of being injured again, some staff? 15:02

A. It was. They just didn't seem to be that -- I don't know, in many ways I think people just accepted it and felt it was part of our job. So we didn't really get -- there were, on a few occasions, I can remember one of the senior nurse managers being fairly concerned after I had an eye injury and he had to take me to the hospital and he was really concerned just at the level of abuse that I was taking. But, as far as anything specific happening about it, there really wasn't anything. 15:02 15:03

64 Q. DR. MAXWELL: There wasn't any debriefing, because we now have a system where if there has been an incident there is quite often a debriefing session?

A. No. 15:03

65 Q. DR. MAXWELL: Nothing like that?

66 Q. CHAIRPERSON: Can I just pick up on that, you explained in your evidence how you once had a fire extinguisher thrown at you?

A. Yes. 15:03

67 Q. CHAIRPERSON: So what happened, it was very shocking for you, it could have done you a lot of harm?

A. It was very shocking. When I say I sat down, I actually had to run to the ladies toilet and sit down

there and cry my eyes out for a couple of hours.

68 Q. CHAIRPERSON: Was there any investigation around that?

A. No.

CHAIRPERSON: And what had happened.

A. No. 15:03

69 Q. CHAIRPERSON: But you did report it?

A. Yes, it was reported and I mean it was so, it was actually when the fire extinguisher hit the floor in front of me, they actually had to put a big patch on the floor because it actually broke right through the 15:04 covering that was on the floor. And it was quite a shocking incident, had the fire extinguish hit me I probably wouldn't be here.

70 Q. CHAIRPERSON: Can you remember when that was?

A. That was in the Iveagh Centre. That was, I can't 15:04 remember the exact year. I'm retired seven years. It's about 10, 12 years ago.

71 Q. CHAIRPERSON: Right but as far as you know there was no investigation of that?

A. No. 15:04

72 Q. CHAIRPERSON: And you were offered no support?

A. No.

CHAIRPERSON: Thank you.

73 Q. MS. BRIGGS: Christine, you also say that when you were injured that most of the time accident report forms 15:04 weren't filled out because you say it would have taken too long and you do say that you filled out those forms when your injuries were more significant?

A. Yes.

74 Q. What about other staff, did they kind of follow the same rules that you did in that regard?

A. I think a lot of times, you take it like if somebody just slapped you or hit you, you know, if you have to fill in an accident form for that there would have been so much. But whenever somebody really injured you or hurt you, you would have filled in an accident form. I suppose it's, I think maybe it becomes acceptable. 15:05

75 Q. And was that acceptance or tolerance of those kind of lower level injuries, you've given the example of a slap, was that something those in management supported? 15:05

A. I don't know that management particularly supported it. I think that it was one of those things that when you're working with learning disability, you are working with the people, the children, you had a relationship with them and you don't, I suppose you didn't -- you didn't want to make them be seen in a bad way, you know. You didn't want them to be actually targeted all the time or saying negative things about them and that can be quite difficult. 15:05 15:06

76 Q. DR. MAXWELL: Management may not have been happy with it but --

A. Sorry. I can't hear you.

77 Q. DR. MAXWELL: Sorry, management may not have been happy with that but do you think they understood that there was under reporting? 15:06

A. I don't think so, no. I think it was just, I don't know, I don't think the patients ever thought about whether we filled in forms.

78 Q. DR. MAXWELL: No, the management side?
A. The management.
79 Q. DR. MAXWELL: The 8As, would they have understood that there were a number of assaults on staff?
A. Yes, that there were some at low level that didn't get recorded. 15:06
80 Q. DR. MAXWELL: So the 8As would have known that was happening but not being reported on incident forms?
A. Yes.
CHAIRPERSON: I am just thinking, the witness has been there about an hour, would it be sensible to take a short break? 15:07
MS. BRIGGS: I spoke to the witness before and she had indicated she would like to keep going if possible, but we said we would keep it under review. Christine, we'll leave it in your hands and also the hands of the Panel and stenographer might need a break as well, Chair. 15:07
CHAIRPERSON: I think we should take a short break.
A. Okay. 15:07
CHAIRPERSON: I think just for 10 minutes. I think it is a long time for anybody to focus, but also for the stenographer who is working almost as hard as you are. All right. So can we just take 10 minutes please and then we'll be back. 15:07

THE HEARING ADJOURNED FOR A SHORT PERIOD

THE HEARING RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you.

81 Q. MS. BRIGGS: Christine, I'm going to move on to something else now, okay, you raised in your statement that you had raised issues around the food at Muckamore okay? 15:19

A. Sorry?

82 Q. You had raised in your statement and you said in your statement --

A. About the food. 15:19

83 Q. That you had raised issues about the food at Muckamore?

A. Yes.

84 Q. And you say that when you raised your concerns about the food you got into trouble and you say you were asked to apologise? 15:19

A. Yeah.

85 Q. When was that roughly, can you say?

A. That was, gosh that must have been about, about 2008 or that. And it was around the time, Muckamore used to have its own kitchens and all the food was sort of made 15:20 there and it was always fresh food. Then things changed, the kitchens were closed down, food was being brought in so they were bringing food in. I think at that time it was coming in from Scotland. It was being brought in. We had our own caterer in the children's 15:20 ward that worked in the kitchens and he would have, he would have cooked the food but he would have always added extra bits to it. If it was pizzas he would have put on more tomatoes and things like that, just dressed

things up and made it really nice. Then they took [name] away from the kitchens and the food was coming in and it was cooked in another ward and put in a heated trolley and then brought to our children's ward and sat there, so it could have sat for an hour before it was served out to the children. So I would have brought the children over to the ward for their meal. It just didn't look very appetising, it didn't look very good. Because I was always trying to -- because I worked in behavioural work, you are trying to encourage healthy eating and good food, no additives, no colourants and things like that, because a lot of those things affected their behaviours. So I did complain about it and, the fella in charge, I can't remember his name, was in charge of the catering, he wasn't very happy with me and I was asked to apologise to him. I said I really couldn't apologise because my mind hadn't changed, the food wasn't acceptable so I wasn't happy with it. It was discussed and, to be fair [named] the Director of Nursing Services at the time. 15:21

CHAIRPERSON: We will stop there.

MS. BRIGGS: It happens all the time. We'll pause the feed now?

CHAIRPERSON: And get the cipher number.

MS. BRIGGS: You were about to carry on in respect of the food and the issues you had raised in respect of the food, if you pick it up there with what you were going to say. 15:22

A. Yes, when we raised it then, I raised it with H359, she

then started a working party. So there was a group set up then to look at the diets and the food and to bring in more healthy eating and exercise as well was brought in.

86 Q. CHAIRPERSON: And did it change the food? 15:22

A. It changed the food, yes, slightly. But the food was still being brought in because we had lost our kitchens, but the food was being brought in so they tried then to get it into a more healthy diet for the children particularly. 15:23

CHAIRPERSON: I'm sorry, Dr. Maxwell.

87 Q. DR. MAXWELL: Can I just ask you, using the cipher number, who was it that asked you to apologise for your comments in the first place?

A. H359. 15:23

DR. MAXWELL: Right.

88 Q. CHAIRPERSON: And who were you meant to apologise to?

A. The head of the Catering Department at Muckamore.

89 Q. DR. MAXWELL: And when you were asked to apologise, did you think that was unusual or was there a general 15:23 culture of we don't really complain about things?

A. I think it was they didn't want to upset the -- because.

90 Q. DR. MAXWELL: The individual?

A. They didn't want to upset him because I had challenged 15:23 him about the diet, about the food, and maybe they felt that I was being maybe out of order in doing that.

91 Q. DR. MAXWELL: So if you had had occasion to suggest some other things that could be improved, do you think

that that would have been well received?

A. Generally it was, yes. Generally things that I would have looked at when we -- I know certainly that when we introduced exercise programs, we introduced the circle time with the positive movements and things like that, they were all well received and sort of promoted and whenever I would have looked at things like when I wanted to introduce the PECS communication system with the children as well, when I could give a rationale for that, they were quite happy. They could see what it was doing, what was the end result of that. It was the same whenever I went to train as a family therapist to do some family work, because I was involved so much with families and I wanted to go on the course and when I approached management about it, initially they weren't going to release me for it but then when they looked at it they felt yes, it was good and supported me in doing that and actually funded that as well, which was good. 15:24 15:24 15:24

DR. MAXWELL: Thank you. 15:25

92 Q. MS. BRIGGS: What about specific concerns, you have given the example of wanting to bring in the PECS system, the Picture Exchange Communication System but what about other times when you had something negative to say about Muckamore? Were there other times other than the food that you can recall making a negative comment or a suggestion about something that wasn't quite up to standard and how was that received? 15:25

A. Generally things that when we would have brought them

up, particularly when we had team meetings, we had a team meeting and you brought up concerns, they normally were always looked at and sort of addressed.

93 Q. What type of concerns might you have raised?

A. I'm trying to think now about concerns that I would have had. I think sometimes things around the resources that were available to us, particularly with children and the range of activities that we could have. We didn't always have -- as Muckamore became more going along the lines of being a specialist hospital, the children were being, we were being pushed out and that was quite a concern because we were, we didn't have access to some of the facilities at the hospital, we didn't have access down to the gardens in the same way because there were adults there and the children weren't allowed to be where the adults were. But it felt as if we were actually being penalised because we were there. And, you know, we were just seen as being problematic that we were there within this adult environment which really wasn't our doing. So we had a bit of a, sort of to stand up for ourselves a wee bit and the children, until they moved us we had the right to be there. 15:25 15:26 15:26 15:26

94 Q. When you raised that issue was that dealt with, was the issue resolved? 15:27

A. Well it was only resolved when actually we moved out of the hospital and we had to take the children out of the hospital, we were moved from there. So we always had to plan everything about what we were doing with the

children. Like if I wanted to use the Social Training Centre in the evening time, if I wanted to use the kitchens or the gym or anything I had to make sure that there were no adults in that building at the same time. It got then that we had to be careful of where we were walking the children because of Six Mile, because it was a forensic unit, I couldn't take the children down past that area. So things became difficult then until we moved out.

95 Q. I am going to move on at this stage and ask you about supervision, okay. At paragraph 13 of your statement you talk about a patient? 15:27

CHAIRPERSON: Keep your voice up, Ms. Briggs, sorry.

96 Q. MS. BRIGGS: Sorry, at paragraph 13 of your statement you talk about a patient okay, it's at page 5, all right. The patient has been given the cipher P11. You say at paragraph 13 there that you were asked to special him? 15:28

A. Yes.

97 Q. Meaning that he required additional nursing care and supervision? 15:28

A. Yes.

98 Q. Was that phrase "specialing" or being "specialed", was that used among staff generally?

A. Yes, special, that meant you were actually on a one to one with that child or that person so you would have been with them at all times, they had to be within arm's length or within your view at all times and you had to, you couldn't move away until somebody else came 15:28

to take over to so that they could move away.

99 Q. So on each shift then would there be one staff member who was specialed with the child in question?

A. Yes, but it might have changed, depending on how difficult the child was to manage, that person, that might have changed or rotated if it was decided maybe that somebody could only cope with that behaviour for a half an hour period of time, so there would have been a rolling basis where they swapped over. 15:28

100 Q. Could there have been a scenario where one staff member was specialing with a child the whole day and how would things like breaks be facilitated in that way or would it always have been swapped around? 15:29

A. Sometimes there were people that were on a special and you might have been on that special for a whole shift, now that would never have happened, I wouldn't have been in that position once I moved on as a therapist. But, if somebody was on for the full shift there would always have been somebody that would have come to take over for break times and for lunch times and things like that, so that would have swapped over at that particular time. But I would not have been in that position. 15:29 15:29

101 Q. And who would have decided that a particular patient needed to be specialed, who made that decision? 15:29

A. Generally the multidisciplinary team but mostly the consultant.

102 Q. And if I digress for a moment from the topic of supervision, you mention P11 injuring himself, you say

that he punched his own face and his eyes?

A. Yes.

103 Q. How were self injuries like that recorded by nursing staff?

A. They would have been recorded in just as being, unless we were doing a function analysis, we would record how many times they would have hit in that period of time but the self-injurious behaviour would have been recorded, the person was being self-injurious during that period of time with multiple punches. With that particular child it was very hard to, unless you were watching the whole time and somebody counting, because somebody else had to be blocking him the whole time. If you let go of his hands or weren't blocking him he would have got in the punches either to his chin or to his eyes. 15:30

104 Q. But the expectation was that each time a particular patient engaged in that type of behaviour, that it would be recorded by nursing staff?

A. Yes. 15:30

105 Q. DR. MAXWELL: Would that be recorded in the nursing notes or on the Datix?

A. They would have been recorded in the patient's notes.

106 Q. DR. MAXWELL: But not on Datix?

A. Not in? 15:31

107 Q. DR. MAXWELL: On the instant reporting system?

A. I think, yes, it should have been reported on the incident reporting system.

108 Q. DR. MAXWELL: You have told us that sometimes the staff

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

restraint and certainly the staff would have used redirectional things as activities or 'do you want a drink a water' or 'do you want something' or taking them away from the situation. Sometimes it would have been as simple as asking if they wanted to go for a walk or taking them out of the environment they were in.

190 Q. Then can I take it from your evidence in an emergency situation or if there was a patient acting in a certain way it would be left to whatever staff member, whatever level they may be, as to whether or not restraint was appropriate in that particular circumstance? 15:55 15:56

A. Yes, yeah.

191 Q. DR. MAXWELL: Can I just clarify, are you saying that a healthcare assistant could make that decision? 15:56

A. Sorry?

192 Q. DR. MAXWELL: Are you saying that a healthcare assistant could make that own decision to use restraint or would it have to be a registered nurse?

A. If a healthcare assistant was in a situation where they were being attacked, would have been trained with MAPA so they would have been trained to -- but normally at that stage they would have been carrying alarms so they could have pulled an alarm to get other people there which would have been bringing in senior members of staff. 15:56 15:56

193 Q. DR. MAXWELL: So if you had a healthcare assistant, and as you said, they hadn't all always had the full training, would they be able, as a self-defence

mechanism, use restraint?

A. Only if they had MAPA training.

194 Q. DR. MAXWELL: Only if they had MAPA training. But healthcare assistants with MAPA training could decide to use restraint without reference to a register nurse -- 15:57

A. If they were then --

195 Q. DR. MAXWELL: I understood why, I am just clarifying --

A. They would be able to use it, yes, they would have to.

MS. BRIGGS: Christine, that's all the questions I have for you at this stage. The Panel might have some questions and I am going to hand over to them. 15:57

<u>MS. KEENAN QUESTIONED BY DR. MAXWELL:</u>

15:57

196 Q. DR. MAXWELL: I just wanted to ask a general question about how prepared staff are. We know most people with learning disabilities will not get into a setting like Muckamore or even the Iveagh Centre. Do you think that the learning disability registered nurse training really prepares people for these very complex patients or would they need additional training? 15:57

A. I think that there is certainly, that I know in my experience over this number of years, the level of behaviour, the intensity and the frequency and the violence has really increased. It has become much more violent and certainly from what I would have started with in behavioural work 20 years ago. I think that we're not really prepared for it. We really don't have 15:57

-- I don't think there is a great understanding of the level of behaviour and how to cope with it and how to manage that. I don't really know what the answers are. I think certainly people, it needs to be addressed, the sort of high levels of behaviour that people are coping with and how, what is their expectation of how they respond to that. I'd be fairly concerned that so many people now are walking away and sort of saying we're not going to do this job because it is becoming increasingly difficult, because they are frightened of litigation and all the sort of things around it, they don't want to work in behaviour work and it' become increasingly difficult. Like I know even for myself in the Iveagh Centre, we would have worked a lot on incentive plans where we would have worked on building up the reward based system and on these incentive plans and we worked very closely with the children on those plans and with the families. But we were getting very much like RQIA were saying they didn't want incentive plans, that it was a child's right to go out to the cinema on a Friday night even if they had displayed all of this negative behaviour, which was quite difficult because we always worked under the principles of normalisation. And certainly under the principles of normalisation if your own child at home, if they misbehave, if they were going to the cinema you would say well I think we'll have to leave that or you are grounded. And it's not that anybody ever wished to be hard. I always felt for our children we wanted the

15:58 15:58 15:59 15:59 15:59

very best for them and we wanted them to have the best life they could lead. You have to have those kind of boundaries set round them. I think that they have all become eroded away now and I don't know how they are going to manage it.

197 Q. DR. MAXWELL: Would it be fair of me to say that you feel that perhaps these patients with very complex needs who present quite a challenge to staff?

A. Yes.

198 Q. DR. MAXWELL: They need more preparation than the first registration for a learning disability nurse currently provides?

A. Yes, I think there certainly needs to be more input put into the complexities of their behaviours, the function of their behaviours and how the staff actually address those behaviours, there needs to be a lot more training.

199 Q. DR. MAXWELL: That might be a post-registration qualification to work in these very intense environments?

A. Yes, I think so.

MS. KEENAN QUESTIONED BY THE CHAIRPERSON:

200 Q. CHAIRPERSON: Could I just pick up something you just said which was that the RQIA didn't like incentivisation or stopping a child, for instance, going to the cinema because it was the child's right to go to the cinema, how did the RQIA indicate that they

didn't like that?

A. Maybe not, they rarely went so much, they weren't very keen on incentive plans. They felt that incentive plans, that a child didn't have to work to do anything to gain rewards, that it was their right to have them, that they didn't have to earn them. And so it left you, it left you in a position that how do they want us to change behaviour, how do they want us to manage behaviour. We can't just wave a magic wand and change somebody's behaviour. We have to look at all of the things that we can use to help that person live the best life. 16:01 16:01

201 Q. CHAIRPERSON: I just want to follow this through. How did you find out that the RQIA didn't like incentive plans? 16:02

A. They said it.

202 Q. CHAIRPERSON: In a report?

A. In a report, they didn't like incentive plans.

203 Q. CHAIRPERSON: But of course it is up to the management of the hospital what they actually do, what they don't do, you don't have to follow what the RQIA say, so how would it have been fed down to you? 16:02

A. How did it filter down to me?

204 Q. CHAIRPERSON: Yes?

A. Because I was the one writing incentive plans. It was just -- and coming around that time, that was when I was coming up to retirement and I was leaving then and so -- 16:02

205 Q. CHAIRPERSON: So without naming names, who would say to

you the RQIA don't like incentive plans so we are not going to do incentive plans anymore?

A. Management.

206 Q. CHAIRPERSON: Did that happen?

A. Yes, mm-hm. 16:02

207 Q. CHAIRPERSON: And did you argue back or how did it work?

A. Well I felt that the incentive plans were the only way we could manage and I didn't know what else they could put in place of the incentive plans. Certainly if 16:03 anybody could have advised me on how to manage extreme challenging behaviour in any way, I would have done it. I would have used whatever.

208 Q. CHAIRPERSON: And when you push back in that way, what reaction did you get from management? 16:03

A. Well we continued to use our behaviour support plans right during the time that I was there.

209 Q. CHAIRPERSON: And management allowed you to do that?

A. Yes.

210 Q. DR. MAXWELL: Can we ask who management are? 16:03

CHAIRPERSON: Yes.

211 Q. DR. MAXWELL: Management is bit of a broad term?

A. Yes, management is a broad term.

212 Q. DR. MAXWELL: Who do you mean by management, do you mean your line manager? 16:03

A. Line managers, yes.

213 Q. DR. MAXWELL: Or do you mean the clinical director?

A. No, not the clinical director, it came from my line manager.

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