MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 8TH FEBRUARY 2024 - DAY 76

76

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

GWEN MALONE STENOGRAPHY SERVICES

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MR. SEAN MULLAN BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MRS. SARA ERWIN MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

WITNESS PAGE

THE INQUIRY RESUMED ON THURSDAY, 8TH FEBRUARY 2024 AS FOLLOWS:

IN RESTRICTED SESSION

14:18

THE INQUIRY RESUMED IN OPEN SESSION AS FOLLOWS:

CHAIRPERSON: Sorry, I gather we had problems with the screen in Room B. Right.

MS. BERGIN: Good afternoon, Chair, Panel. This afternoon's witness is James Wilson. The witness is not in the room yet because there is an application to be made so if could ask for the feed to be cut, please, and the application to be restricted in the usual way. 14:35

CHAIRPERSON: For these purposes just to preserve the order, if I make it, and it will only take a few minutes. 14:36

MS. BERGIN: Yes.

CHAIRPERSON: The feed to Room B is to be cut and it only applies I think to part of this statement. 14:36

MS. BERGIN: Yes.

CHAIRPERSON: Can you just take me to it.

RESTRICTED SESSION

14:36

THE INQUIRY CONTINUED IN OPEN SESSION

MR. JAMES WILSON, HAVING AFFIRMED, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: Can I just welcome you to the Inquiry. I am sorry you have had a bit of a wait today but we were finishing another witness and then we had technical problems but I can now hand you over to Ms. Bergin, thank you.

MS. BERGIN: Thank you, Chair. Good afternoon, James. So we met briefly before this afternoon and I have explained to you the procedure that we are going to follow this afternoon. As you know I am going to begin by reading out your statement and then I'll ask you some questions and the Panel may have some questions for you also. A couple of things just before I begin to read your statement. You have a copy of your statement in front of you and I've already explained to you that I'm referring to ciphers rather than names as I read through your statement, so if you could do the same and just take a moment to see if you need to refer to a name, if there is a cipher, and the secretary can assist you. In the event that you can't see a cipher or you can't see it quickly enough, just feel free to write the name down.

A. Okay.

MS. BERGIN: Another matter just briefly is that I have explained to you previously that there would be an application that may be granted. Just to let you know that the Chair has now granted that application. That means that there is a specific part of the evidence that I have already indicated to you that I am not

going to deal with at the moment in part of the main session, but I will indicate to you later when we are going to deal with that in a restricted session?

A. Okay.

1 Q. I am going to read your statement dated the 19th of December 2023. You state as follows. 14:41

"My connection with MAH was that I was a project manager for Cedar Foundation, a Belfast based registered charity for a project called The Mews, which was a bespoke supported living facility for patients from MAH. 14:41

The relevant time period that I can speak about is between September 2017 and November 2019. I am currently employed as manager with an organisation which provides a range of supported living and community based services." 14:41

CHAIRPERSON: We can make the organisation. 14:41

MS. BERGIN: We can?

CHAIRPERSON: It's a very well known national organisation, Leonard Cheshire?

A. It is, yes.

MS. BERGIN: Thank you, Chair. 14:41

"Which provides a range of supported living and community based services to include rehabilitation. I began working in this organisation, the Leonard

Cheshire, in December 2019. I hold Level 3 and Level 5 NVQs in health and social care. When I worked in MAH I achieved a Level 3 NVQ so I was relatively new to caring for individuals with learning disabilities. I have no personal connections to MAH. 14:42

prior to joining my current role I worked as a manager with the Cedar Foundation under a project called The Mews. The Mews was a pilot project that offered supported living accommodation for individuals with 14:42 learning disabilities. The Mews project was introduced in 2017 with a view to opening a supported living accommodation in February 2018. The Mews was purpose built for patients who were to be resettled from MAH. A lot of the residents required two to one care and 14:42 there were to be 14 individuals from MAH. The Mews was located on Glen Road, West Belfast, and was a facility of individual apartments where all residents would have their own living area with no communal areas.

14:43

To train and prepare the new staff for the resettlement of MAH patients it was agreed with MAH that we would attend the hospital to shadow the nursing and care staff while they looked after the residents so that staff could learn how they needed to be cared for. 14:43 Prior to September 2017, I had not knowingly cared for former patients of MAH or heard a lot about MAH so I was not aware of how complex patients' needs were. I later found out from my manager in another job that

there was one service user who I supported who was a former patient at MAH.

My line manager, H764, had previously worked in MAH and she told me the job is intense. In late October 2017, 14:43
I worked in both Cranfield 1 and Cranfield 2 at MAH. Both of these wards were men's wards. I worked 40 hours per week, which was in 12 hour shifts. I remained employed by the Cedar Foundation during this time. Sometimes my shift would be split between 14:44
Cranfield 1 and Cranfield 2 when required. I shadowed staff to understand the behaviours of the would-be residents and worked with them to build care plans and identify residents' needs.

14:44

Initially I worked on Cranfield 2 for a few weeks. I thought that both the day rooms and bedrooms on Cranfield 2 were clinical, however they did not seem to be in a poor state of repair.

14:44

On arriving at MAH for my first shift I was met by a registered nurse. She carried out the induction process. Although I was trained in MAPA techniques, which was provided by the Cedar Foundation, I was told that I was not to become involved in any interventions 14:44
or to place hands on patients using the techniques. I was told that if any incidents arise I was to report to the nurses office and a member of staff would assist me. I, along with my colleagues, were provided with

alarms and shown how and when to use them. I cannot recall the nurse's name but I do remember that she had an English accent.

As part of the shadowing exercise, I was allocated patients who were to be resettled in The Mews. Some patients needed one to one full-time care. I shadowed nurses who carried out the patient routines to find out how they liked their breakfast and when they liked their mealtimes. There were times when I was working with patients one to one on my own. During this time I was not supposed to be with any patients on my own. There were times when I was concerned about patients' presentations when they approached me and I did not know the patients and their needs. I did not know what the patient might do if they became agitated. I was not given a copy of the patients' file to find out why they were admitted but I was given a brief overview of their needs and learning disabilities. 14:45 14:45 14:45

I remember asking the nurse who was on duty, who was usually the head nurse or registered nurse, to see records to prepare patient care plans and I was provided with them. I do not recall their names. I do recall a key worker called H765 who was a good member of staff and was very knowledgeable. He talked through client needs with me. He called to The Mews to talk staff through how to care for the patients' needs. I cannot recall his surname but I remember he had black 14:46 14:46

hair.

As Cranfield 2 was a locked ward, most of my time was spent with patients playing board games or attending to their personal care. As patients did not usually leave 14:46
the ward there were times during my shift when I watched a lot of television with them.

On Cranfield 2 I found that the culture between the staff and patients was poor. Staff had low morale. 14:47
Staff on Cranfield 2 were very task orientated. For example, they said to the patient that they needed to be showered rather than interacting with the patient. Staff were dealing with high levels of patients' needs and I found that they had no tolerance for patients. 14:47
Some nurses and healthcare workers were stern with patients who had an outburst. I had worked in Cranfield 2 for one week when an incident between a healthcare worker and a patient, whose name I do not know as I did not work directly with him, occurred that 14:47
concerned me so I raised a safeguarding issue with H764. After I raised the safeguarding concern within my first week at MAH, I found that the attitudes of staff towards me changed. Although reporting safeguarding concerns was to be confidential it was 14:47
clear that staff had been made aware of my report. Nobody said anything to me but it was just by the way they behaved towards me that I knew that they knew I had reported an incident. Prior to reporting an

incident, staff spoke to me and my colleagues generally but after this they changed and our conversations were limited to talking about the working day.

Staff generally on Cranfield 2 were not supportive and I was left to my own devices most of the time. I was told whom I was allocated to for the day and I was left to work through my day. 14:48

I raised other concerns when I was working in Cranfield 2 with my manager, H764. I found that a lot of the staff spoke in a way to patients that I would consider verbal abuse. They also physically poked and prodded patients on the ward. This behaviour was carried out by both healthcare workers and nurses. 14:48

After a few weeks of working in Cranfield 2 I was allocated as a one to one carer with a patient called P33. P33 could communicate but he had a learning disability. P33 had a well known history of trauma. I became aware of this by reading P33's notes on the PARIS system. Although I did not have access to PARIS, the nurses would log on and permit me to read patient's notes. P33's hospital social worker was called H768 and he gave me a lot of good information about his past and current needs. P33 grew up in Belfast during the troubles and he had seen people shot when he was a child. One way to trigger P33 was to mention the IRA or bombing. There were times when staff members would 14:49 14:49

say to P33 that they would get the boys in to shoot his knees. I cannot recall the name of the healthcare worker but he was a man in his early 20s. Staff said things like this when he refused to do things or just whenever they seemed to feel like it. 14:50

There was one time during Christmas 2017 when P33 was watching the news when one member of staff elbowed him and said that "the boys" were coming for him. I remember that a registered female nurse would say 14:50
things like this to P33 and called him a "shithead". I cannot recall the names of the staff members who spoke to P33 this way or poked and prodded him but I felt that their behaviour was completely wrong.

14:50

I remember the registered nurse was an older lady with curly hair. Things that were said were not done in a jovial manner and was done with malice and as a means to provoke him. When they would say these things to P33 it triggered him and he reacted by punching and 14:50
slamming doors and overturning tables. I had a bond with P33 so I was able to talk him down. He loved Manchester United so I would say to him that we would check the results. Whenever P33 acted out, the staff who had annoyed him acted shocked and asked why he was 14:51
doing this. When P33 became upset, the staff who upset him would say to him that they were very disappointed that he was acting this way. P33 would apologise to them even though it was not his fault. P33 needed a

soft approach as he had had a very traumatic childhood. The staff did not use MAPA restraint on P33 as he was 6'3 inches and weighed around 20 stone. He was far too strong for staff to use MAPA.

14:51

I reported the behaviour of the staff to the ward sister at the time. I cannot recall her name but she was an older lady with dark hair. She asked me to write up a statement. She took my written statement but I do not know what was done next. I was not aware 14:51
if anything was done after I gave my statement to the ward sister.

There were other incidents that occurred between the nurse with the curly hair and P33. During one of my 14:52
shifts P33 and I were sitting in his room and she came in to ask why P33 was not out of bed. When P33 did not respond she called him a shithead, laughed and left the room. This was common.

14:52

I do not know the reason why staff focused on upsetting P33. When P33 did not comply staff threatened him repeatedly to send the boys around that night to get him. This upset P33 and he often asked me if someone was coming for him. I had to reassure him that they 14:52
were not. I was aware that P33 had a history of hitting the staff and injuring them. For example, he broke a staff member's jaw and at times it was scary for me to be with him one on one when they upset him.

However P33 did not ever hit out with me.

Staff on Cranfield 2 were very busy and would often say to me and my colleagues from The Mews during conversations that they were very under staffed. They told me that a lot of staff members were off work with injuries to include concussion, and some staff members were on long-term sick. Every day in Cranfield 2 was very difficult and intense. I could see it took its toll on staff's mental health as staff were exhausted and tolerance levels were poor due to the difficult working day. 14:53 14:53

Between September 2017 and February 2018 I also worked on Cranfield one. I am trained in MAPA and I have taught MAPA techniques since 2019. When I was in Cranfield 1 I noticed that some use of restraint was unnecessary. There was one patient who raised their voice and, as a result, was grabbed by two staff and brought to their room. The staff members grabbed them by the arms and carried them off. There was no risk of violence from the patient, simply the patient had an outburst. MAPA encourages allowing patients to shout and vent if they need to. Other de-escalation techniques to include talking to the patient are to be used before placing hands on them. Staff in Cranfield 1 were quick to put their hands on. Generally patients on Cranfield 1 were settled compared to Cranfield 2. My concerns related to Cranfield 2. 14:53 14:54 14:54

I did not feel comfortable when reporting incidents to the ward nurse on Cranfield 2. When I had concerns I reported them to my manager, H764, and she would take any further steps required. Before sending details of 14:54
the concerns she would show me her e-mail which I believe was sent to an adult safeguarding team.

I felt that staff on the ward did not want anyone from The Mews there, but at the same time they treated us as 14:55
if we were employed by MAH. I was treated as an extra pair of hands to help relieve staff pressures on the ward. For example, when I told the nurse in charge that I was taking lunch, they said to me that I had to arrange cover. I said that I did not know why I had to 14:55
arrange cover as I was not a staff member of MAH and was simply there to shadow nurses and healthcare workers. There was an older lady with dark hair who was a senior nurse, I think she may have been a ward sister as she wore a red tunic, who made it clear that 14:55
she did not want The Mews staff on the ward. One day my colleague and I were late to MAH because of traffic. She scolded us for being late. We were quite surprised at this as we were not MAH staff and she was not our manager. 14:55

I was aware that there was CCTV in the communal areas in Cranfield 1 and Cranfield 2. I was told by a healthcare worker that CCTV in Cranfield 2 was not

operational. This was during a conversation. I do not know why it was not operational. The fact that CCTV was recording did not seem to deter staff behaviour."

CHAIRPERSON: Just pause for a second. 14:56

INQUIRY SECRETARY: I have just been advised that it is Chinese New Year and they are doing a thing on the streets.

CHAIRPERSON: I thought it might be the Ulster Scots practising. Right. Well we can't get round Chinese 14:56 New Year. I think we will have to plough on.

INQUIRY SECRETARY: Just in case anybody is wondering what the noise is.

CHAIRPERSON: Sorry.

MS. BERGIN: The last line I read was: 14:56

"The fact that CCTV was recording did not seem to defer staff's behaviour. For example, at the time of the incident that occurred during my first week on Cranfield 2 I believe CCTV may have been recording. 14:57

The Mews opened in February 2018 so my time working on the MAH site came to an end. When the project was up and running I, along with my team, did not have time to go to MAH and work with prospective residents before 14:57 they moved to The Mews. Initially there were three or four admissions. A behavioural nurse called H177 within MAH completed a support care plan for each resident that we would follow. H177 offered a lot of

support and she knew the patients very well. She helped me and The Mews staff complete behavioural plans for the residents. As the admissions increased, things moved very fast. Where possible, staff did some in-reach with MAH but due to the demands of caring for residents there was little time to do this. So that staff within The Mews could understand the care needs requirements of residents it was agreed with MAH that they would come down to The Mews and discuss these with staff. This included details of help residents needed with personal care and if they attended day care. We agreed a rota with MAH to do this. Within a short period of time staff from MAH stopped coming to The Mews. When I telephoned MAH to ask why they were not with us as planned, I was told that the wards were short staffed so they had to stay on site. This meant that staff in The Mews had to care for the resident based on limited information. Residents were aware of the rota and which member of staff was due to come from MAH. For residents who built reliant relationships with staff at MAH they became upset when they did not appear which led to behavioural outbursts. As a result behavioural plans became reactive rather than pro-active. This impacted care plans that were written up by staff at The Mews. Care plans were based on information made available by MAH. As staff did not always attend, this information was sometimes limited.

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When patients moved from MAH and became resident with

the Cedar Foundation, there were times when I had to call to MAH as some residents needed to be brought back because of their behaviours. There was a patient called P159 who was admitted to PICU from The Mews. Due to her behaviour, she had to go back to MAH for in-patient treatment. Staff in The Mews were afraid of P159 so they refused to go to MAH. As team leader I attended MAH to see what was happening with her treatment and reported to reception. I told a member of staff that I was a Deputy Manager at The Mews and was there to see P159. I was allowed onto the PICU ward to meet with P159. There were five or six patients on PICU. A nurse, who was a blonde haired lady, gave me an alarm and she said that the nurses station is over there if I needed them. It was protocol to give me an alarm but I noticed that there were no staff on the ward. I was with P159 for an hour and a half and was painting her nails when patients surrounded us. One patient started to drink the nail varnish, another came over to me and started to grab my shoulder to get my attention whilst another patient started to masturbate in front of me. One patient became aggressive and started a fight with the patient who was masturbating. I pulled the alarm and four members of staff came in and restrained the patients who were fighting. I was told by one of the staff who came in in response to the alarm that I should not be there and had to leave. Staff in MAH were keen for P159 to move back into the Cedar Foundation, however, I

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wondered if she was medically fit to return.

I attended a care review meeting in MAH to discuss P159's move. I was aware that she was receiving intermuscular injections daily to manage her behaviour. 15:01
As The Mews is a care facility staff are not medically trained so they could not administer interamuscular medication. P159 also needed three to one care which The Mews could not offer. P159 did not return to The Mews. 15:01

As part of my managerial role I attended a number of care review meetings. When patients were first resettled from MAH they came into The Mews as undischarged patients which meant that if they were 15:01
unable to settle after a trial period they could go back to MAH and would not have to be re-admitted. If, however, the patient settled and things were going well, they would be discharged from MAH. The care review meetings were usually held with 12 to 14 people, 15:02
to include social workers, care managers, community social workers and psychiatrists. I remember that the Review Team were keen for patients to be discharged from MAH. The medical experts would say that, based on reports about the patients, that they seemed to be 15:02
doing well and were ready to go back to The Mews, in spite of the fact that I had told them that the patient had outbursts and a number of staffer had been injured. A lot of my team were off sick as a result.

Family members often attended care review meetings. Some families did not have favourable opinions about MAH. There was one family that protested outside MAH. I remember meeting their son in Cranfield 1 but I cannot recall his or their names. They raised concerns about the use of the seclusion room in PICU. Other family members during the review meetings would feedback their concerns about how MAH staff cared for their loved ones. They raised concerns about bruises on patients that were not explained. When concerns were raised, the social worker who was at the care review meeting usually told them that they were looking into it. I do not know if they ever followed up with the family members after this. 15:02 15:03 15:03

I remember attending a care review meeting on behalf of P158 where his mother and sister advocated on his behalf. P158 was on Cranfield 2 and was the first resident in The Mews. The meeting was held before he moved to The Mews. His mother and sister were responsible for P158's finances and were required to produce receipts to the court. They flagged that there were times when staff in MAH were unable to produce receipts for money taken from P158's allowance and it seemed money was missing without explanation. When they asked staff to explain how P158's money was spent they could not and could not produce receipts. They also said that staff on Cranfield 2 continuously asked for more money. 15:03 15:03

Patient money was kept in the nurse's office on each ward. There was a safe on each ward which the nurse had access to. I was aware of the process of using patient's money when I was in MAH before The Mews opened. When a patient was taken out for the day or to the onsite cafe, staff request money from the charge nurse on the ward. I remember that the process was not overly particular but whatever money taken out, a second signature was needed from staff at MAH. When I returned with the patient, I gave the receipt and any change to the charge nurse. I never heard staff talking about patient money or how it was spent. 15:04 15:04

I worked in Six Mile ward in and around November to December." 15:04

And that should read 2017, the witness has confirmed.

"As I rotated with other The Mews staff I only had a few visits to the ward. I believe this is a forensic ward. There was a patient called P140 who needed either two or three to one care as there was a query about a manslaughter murder charge in respect of his mother. He was a frightening character. I was aware that he could grab or try to bite someone if they were in a room with him. His behaviour was very unpredictable. He was a prospective Mews resident. My colleague, who I think was H770, and I met with P140. 15:05 15:05

When meeting with potential residents MAH staff were to stay with us but they often left us alone. A nurse on the ward gave an overview of the patients, however we were not given a sense of how violent the patient was. I cannot recall her name. It was determined that P140 was to move into The Mews. When he became a resident he often assaulted staff. To stop him, I, along with four or five members of staff, had to use MAPA techniques to restrain him. I remember one time trying to hold his head steady using MAPA techniques to stop the biting and he head-butted me. I sustained a concussion from this injury. He became particularly violent between 2:00 p.m. and 3.00pm every day. To protect staff and other residents in The Mews, the Cedar Foundation purchased a van so that he could sit in it during 2:00 p.m. to 3.00 p.m. each day. 15:06 15:06 15:06

I raised concerns about P140's violent episodes at his care review meetings. I reported all incidents to MAH, the team at his care management reviews. During one meeting MAH medical staff said that he seemed to be settling well and they wanted to try to discharge him as an MAH patient. I told them I did not agree and that he should go back to MAH. My team reported the incidents to me daily and I would complete the relevant form that was sent to MAH social worker, discharge coordinator, psychiatrist and all involved in his case. I recall at one of the care management review meetings a psychiatrist said that we seemed to be managing his outbursts and it does not sound too bad. The 15:06 15:07

psychiatrist was on the Six Mile ward. I cannot recall his name, but his solution was to deliver reflective sessions with staff members in The Mews. The aim of these meetings was so staff could talk about how they feel. I remember my colleague, H770, attended the care review meeting where this was suggested. She got upset and left. Her reaction highlighted the severity of the situation. I told the care review meeting team that we were losing staff because of the resident's behaviour. The Mews is a supported living facility to integrate individuals back into the community but we had decided that we can no longer take P140 off site due to fears that he might hurt someone in the community. Reflective practice sessions were held but they did not help. The resident stayed with us for three months. As we had warned he attacked a member of staff so we had to call the PSNI because we were unable to stop him. The PSNI came out and he was transported to MAH by ambulance. P140 was apologetic but staff at The Mews simply could not manage him anymore. MAH did put pressure on The Mews to take him back and they offered support from MAH staff to look after him and take him out. They said that he was settled on the ward, however this was because he was medicated. The resident said he wanted to come back and would behave. I understood that in many ways he could not control his behaviours and we agreed that if MAH staff came and looked after him and took him out, he could return to The Mews. A rota was drafted appointing a relevant MAH

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staff member to attend with P140, however they only attended for about two weeks after his return. We marked the rota to confirm if staff were MAH attended and the rota showed that staff did not attend with P140 for weeks. When we rang MAH to see where the staff member was, they told us that the staff could not come as they were busy on the ward. The resident settled for one month but his behaviour started again. I was transitioning out of the Cedar Foundation at this time so I do not know if he went back to MAH. 15:09

Prior to patients being discharged from MAH, The Mews had direct contact with the residents' care team in MAH. A discharge plan meeting was held. Once a patient was discharged from MAH contact was moved to the community within the Belfast Health and Social Care Trust. 15:10

Patients who moved from MAH to The Mews as residents had severe learning and disability needs. Residents hit staff regularly, which often resulted in staff being hurt and upset. As I was their line manager, they reported to me and said that they were afraid to care for some patients as they were worried about being injured. It was difficult for me to hear that staff were afraid in work. Due to the high demands of the job there was around a 70% staff turnover within The Mews project. In this environment working as a healthcare worker was not a long term career as it is 15:10 15:10

very difficult to manage behaviours every day. This is the main reason I left the Cedar Foundation.

Overall, I would say that it was obvious that MAH was short staffed. Staff I encountered during my time at MAH were less tolerant of patients and they seemed to be suffering from fatigue as they were under pressure, which I have referred to earlier in my statement. It seemed to me that staff did not see their role as caring for the individuals, but rather to manage their behaviours. 15:11

The culture within MAH generally was that where staff displayed negative and, what I am aware, are unacceptable behaviours in terms of safeguarding, these behaviours were deemed acceptable. Staff who did this were comfortable enough to do so in front of staff who were not part of MAH and to me this suggests that these behaviours were ingrained in their practice. This included healthcare workers and registered and head nurses. Based on what I saw and heard during my time at MAH I would not want a family member to be admitted there." 15:11

And, James, you then on the following pages of your statement sign the declaration of truth dated the 19th December 2023 and there are no exhibits to your statement. So, James, having heard me read out your statement and, subject to the correction that I 15:12

identified, are you content to adopt that statement as your evidence before the Inquiry?

A. Yes.

2 Q. And I'm not going to go through every single matter in your statement, you will be glad to hear, but there are some issues that I do want to pick out, okay? 15:12

A. Okay.

3 Q. So if I could begin by summarising and hopefully you will be able to tell me if I have got this correct. Your involvement with MAH, so you were the project manager of The Mews project. The project was introduced in 2017 with a view to the accommodation actually opening in 2018. And between September 2017 and February 2018 you shadowed staff at MAH and during those four to five months at MAH you spent your time in Cranfield 1, Cranfield 2 and you had a few visits to the Six Mile ward? 15:12 15:13

A. That's correct, yeah.

4 Q. And then when The Mews opened in February 2018 you didn't attend full-time on site? 15:13

A. No, no, I transitioned out to return back to set up care plans and things like that then.

5 Q. But you would have been up and down a few times?

A. I would have been up and down, yeah, to attend reviews.

6 Q. So then you worked on The Mews project and were involved with MAH for approximately two years? 15:13

A. Yes.

7 Q. Okay. So the first thing I want to ask you about, James, is in terms of how you first became involved in

The Mews project. So were you hired specifically as project manager for The Mews project or can you tell us a little bit about that?

A. No, sorry, I should clarify. The project manager, I don't know why it says that, I was initially hired as a Team Leader. Then over time I stepped up to the Deputy Manager, but initially I was a Team Leader, there was two Deputy Managers and a Service Manager. 15:13

8 Q. Apologies, I have to remind myself of this also but if you could just slow down slightly just so the stenographer can take a note okay? 15:14

A. Certainly, so at the time I was brought on as a Team Leader and I was invited to kind of just in part with the Service Manager and Deputy Managers to start building care plans then for prospective residents that were coming into the service. 15:14

9 Q. Okay, so if I can just take you back, when you say you were brought on as a team leader?

A. Yes.

10 Q. So at what stage of the planning in terms of The Mews project was that? 15:14

A. The construction was still ongoing.

11 Q. Okay?

A. At that point, yeah.

12 Q. You mean specifically a Team Leader for not just generally in the Cedar Foundation but specifically for The Mews project? 15:14

A. For that project.

13 Q. Okay?

DR. MAXWELL: Can I clarify, so you were a Team Leader leading a team of staff who were going to be delivering the care; is that right?

A. That's correct, yes.

DR. MAXWELL: So you weren't involved in the design of the system or the policy -- 15:15

A. No.

DR. MAXWELL: It was actually supporting and leading a team of staff?

A. Yes, yeah, but I was involved in kind of the initial stages of setting it up. I was invited to attend those reviews at Muckamore and then establishing the care plans that staff would follow. 15:15

DR. MAXWELL: Thank you.

14 Q. MS. BERGIN: And so, just then if you could tell us a little bit more about that. So in terms of your involvement in the planning, so I suppose you've said that the accommodation was being built at that stage. I want to move on to ask you a bit about the staff in terms of The Mews. So were you involved, for example, in setting up a team of staff or was there already an established team of staff for The Mews project? 15:15 15:15

A. I was one of an initial kind of batch of staff, so there was I think about four of us recruited at the start and then there was ongoing recruitment following that. I would have been involved in some of the interviews for staff that were coming in. But yes, no, there was an established team as such there. 15:15

15 Q. Can you just tell us briefly, so in terms of what the

project team looked like, so you had described in your statement that there was a manager above you?

A. Yes.

16 Q. The if project sat within the umbrella of the Cedar Foundation and The Mews project was a specific project, what was your line management structure there and what staff did you have then in your team? 15:16

A. So there was a Service Manager, two Deputy Managers at the time initially because they felt that the project was quite large so they felt the need for two Deputy Managers and then there was myself as a team leader. I think once we had opened, I think they had employed around 10 Team Leaders, so it was quite a large team, quite a number of support workers and each team lead would have line managed about five or six of those support workers each. 15:16 15:16

17 Q. Okay. And, in terms then of the staff who were working in say each team, okay, you have referred in your statement to the fact that at the time when you began the role you had held an NVQ Level 3 and I think you said you went on to get a Level 5? 15:17

A. Yes.

18 Q. So in terms of those qualifications did they include topics, for example, in learning disability specifically or managing challenging behaviour? 15:17

A. Yeah, yeah they would have, yeah. So there were elements of E-learning modules but then there was quite sort of focused positive behaviour support training sessions that were offered then, obviously we had the

MAPA techniques as well were provided.

19 Q. Just so I'm clear about that, when you started in the post you already had the NVQ Level 3?

A. Yes.

20 Q. He also 5 or did that come later? 15:17

A. No, no the 5 came as I progressed.

21 Q. You did some further specific training on the job?

A. Yes.

22 Q. Okay. You said in your statement that you were relatively new whenever you took on the post at caring 15:17 for individuals with learning disabilities. Had you had any previous experience directly of caring for people with learning disabilities?

A. Yes I had, I worked for another company which I began in may of 2016 and worked there for roughly about a 15:18 year and that was for individuals with learning disabilities and autism.

23 Q. Okay, you've referred to then doing your NVQ Level 5 and MAPA. Can you tell the Panel a little bit more about any formal training that was offered to you or 15:18 that you maybe were involved in organising during your time at The Mews in terms of specifically what I am focusing on is learning disability, dealing with challenging behaviours, autism awareness, MAPA?

A. Yeah, well as you say, so there was on-line learning 15:18 modules with a focus on learning disability and autism, some kind of active support training as well. Then the primary focus was the MAPA training which was very, very helpful for the staff in terms of deescalating

behaviours, understanding the reason for behaviours and kind of trying to reinforce ultimately it's how staff manage their own behaviours rather than managing the behaviours of others and that was the main focus of it, so.

24 Q. And I think you've spoken about your training and also staff?

A. Yes.

25 Q. Can you give us a better picture in terms of the types of staff that you had in the team and the types of learning disability training or experience that they had, would all of the staff have been the same level or could you talk just about that?

A. No, no, we had a wide range of staff from all different backgrounds. Some came to us with kind of very limited experience in care. Some that had, you know, a wealth of experience over a number of years. But ultimately they got the same kind of package of learning whenever they arrived at Cedar Foundation. So they all would have done the same training modules. They were all at that level in that respect.

26 Q. And just to pick up, when you say the Cedar, were they all specifically again recruited for this specific project on The Mews?

A. Yes, they were, yeah.

27 Q. You say at paragraph 6, I'm just going to read out a little bit of it. You refer to the following:

"To train and prepare The Mews staff for resettlement

of patients it was agreed with MAH that we would attend the hospital to shadow the nursing and care staff while they looked after the residents so that staff could learn how they needed to be cared for."

15:20

And you go on in the following paragraph to say that you shadowed staff:

"To understand behaviour of would be residents, work with them to build care plans and identify residents' needs." 15:20

First of all do you know, I know you have already indicated the sort of stage of planning you were involved in but can you tell the Panel a bit about how that arrangement came about in terms of the agreement between MAH and The Mews to have staff based up at MAH? 15:21

A. To be honest I wouldn't have been privy to that, I wouldn't have been involved in that and arranging kind of what we would call in-reach going up and shadowing those patients. That would have been my line manager and or indeed above that. 15:21

28 Q. Okay?

A. That would have made those arrangements. We were simply given a rota of attendance, told what days to attend, which ward we would be on and that's what we did. So that was my responsibility. 15:21

29 Q. Okay. And in terms then just, you've said when you came into the organisation, I suppose others in the

organisation were involved in the planning stages more so, and you were brought in but you did attend some meetings, so do you know or can you assist us with, at that time when the physical accommodation was still being built and staff were being recruited and starting, I think, to be trained in relation to The Mews, was there any sort of formal process in terms of resettlement that you had been given by your line managers or made aware of in terms of how this was all going to work in practice? 15:21 15:22

A. Well, I suppose yes, I mean we were given a really good overview of the expectations of the service, what we kind of hoped it would be, the vision that we had for it. They did let us know, before anybody was moving in, they kind of let us know who they were, what the patient was, what their needs were going to be, what level of support they needed, so whether it was one to one, two to one, whatever it might have been. So we did, yeah, we did get a good overview of any patient or any resident that was due to move in. 15:22 15:22

30 Q. Okay. And you've said in your statement that there was an intention that there would be 14 residents from MAH coming to The Mews. Are you aware if there were 14 residents who were essentially earmarked as being ready for resettlement who were coming to The Mews or was it that as and when patients became available, if you could tell us about that, please? 15:22

A. Again I don't really, I don't think that they were necessarily earmarked, no. As far as I understand it

was just in terms of kind of a referral process, you know, that they kind of met the criterion and it was felt that they were suitable for the placement.

31 Q. In terms of who decided, you referred to criteria, do you know with who decided which patients from MAH were to be resettled to The Mews as opposed to somewhere else for example? 15:23

A. I would presume that would have been the Service Manager would have been involved in that, in consultation with Muckamore. 15:23

32 Q. Did you personally have any involvement in those types of decisions or --

A. Not in those kind of decisions, more so just the attending the care review, the pre-kind of admission, discharge planning meetings, things of that nature I would have been involved in. 15:23

33 Q. And just going back, you mentioned in terms of criteria and I know you have already answered my question but if I could just ask you a bit further about that. Do you have any idea in terms of your experience there whether it was a case of MAH identifying patients and saying that the patient was to be resettled to The Mews or whether The Mews, it was a two-way street that The Mews could say well, we don't consider that that's a patient that would fall within the support that we can provide, do you have any idea how that looked like in terms of those decisions? 15:24 15:24

A. I don't to be honest with you. I don't really know what sort of way it would have worked insofar as that.

My impression was that it was a two-way street. I don't know of any cases now where somebody was maybe presented and The Mews felt that maybe they weren't suitable for the placement. So I couldn't really comment unfortunately. 15:24

34 Q. Okay, no, that's absolutely fine. It is best to say you don't know if you don't know. I think you identify several purposes for the shadowing at MAH and I just want to ask you about each of those briefly. So, in terms of physically being up at MAH or Muckamore and 15:25 learning about patient needs, you describe being up actually at Muckamore for around 40 hours per week in 12 hour shifts and also rotating with colleagues. Can you tell the Panel a bit more about what that arrangement actually looked like, how often you were 15:25 there, how many days per week, was that throughout the entire period?

A. Yeah, there was a bulk of time over the kind of Christmas period where we were there every day effectively. Now there were periods of times where we 15:25 were called back into the head office and that was again to start typing up care plans or to complete training that we had. But, yeah, again the rotation was that we were simply given a rota for the four or five staff members who were recruited at that time and 15:25 we would maybe go up in pairs or go up individually and it was, generally speaking, Monday to Friday that we would go up. Very occasionally it would be a weekend that we might attend.

35 Q. Okay. And one of the things I wanted to ask you about was in relation to challenging behaviour and we'll come on to talk about dealing with challenging behaviour in a moment. During your time at MAH was there any sort of either formal or even more on the job informal training by MAH staff in terms of you dealing with challenging behaviour? 15:26

A. No, no. It was made very clear to us that we were not to intervene. So although we had training through my organisation that we were very much told that in any sort of event where there's behavioural incidents that we were not to intervene in any way. 15:26

36 Q. Okay. One of the other purposes I think that's been identified in relation to going physically up to Muckamore and shadowing staff was to identify patient needs and analyse how much support patients needed. So again can you tell us a bit more about that, who made those types of decisions and who analysed patient needs? I think you referred to you were part of that? 15:27

A. Yeah, we were. Ultimately I mean it was information gathering, that was ultimately the purpose of us going up and it was also kind of to establish relationships with the residents who were going to be living with us. That was what was informed to me from my manager was to go up and look at care plans or to ask to see care plans or notes on the individual. So that's what we would inquire about when we went up. Now, very seldom would we get an opportunity to speak with a staff member who was there to actually gather any 15:27

information. Verbally we were generally kind of just sat at a computer, the system was opened and we were kind of just told to look through and take notes.

37 Q. Okay. So I suppose just in relation to, I suppose, you said about getting to know and familiarise yourselves with the patients themselves and then also your interactions with staff. Was there any sort of formal or sort of structure in terms of you being up there and the resettlement process itself, in terms of preparing these patients for resettlement. Presumably you were introducing yourselves and explaining why you were there, but was there any sort of system that you followed for all of the patients where you were preparing them for the transition? 15:28 15:28

A. Not necessarily. I mean we did speak with them about it, you know. One of the gentleman that I spent quite a great deal of time with was actually very, very, keen to join us, so would ask fairly consistently 'when am I moving, do you have a moving date for me, when can I come and live with you?' We did openly talk about it and we kind of gave them an idea of where they were going to be living, what is local to them and really kind of just sold the service that we were going to provide, so we did discuss it with them, yeah. 15:28 15:29

38 Q. The final or one of the final, I suppose, purposes that I think comes through your statement is that you were working with MAH staff to build care plans and you have referred again there to support plans and behavioural plans. Can you tell us a bit about that. So whenever 15:29

you are talking about looking at care plans and behavioural support plans, do you mean in terms of planning for the patient to be resettled to The Mews?

A. Yes.

39 Q. And what input did you have in that process? 15:29

A. So, the behaviour support plans would have primarily come from a behavioural nurse or someone through Muckamore who would have assisted that, because we didn't have experience in that, so they would have assisted us in putting those together. In terms of the 15:30 support plans, I mean it was your general kind of personal care. What does their day look like, what daily living skills they needed support with. That would have been where I kind of came on board and put those together. 15:30

40 Q. So in terms of then what you were physically doing at Muckamore to prepare for The Mews, you have indicated you were meeting with patients and familiarising yourself with their care, and then also meeting with the behavioural nurse, was there any other type of 15:30 structured meeting? You said you didn't really get an opportunity to speak to staff. Were there set meetings where, apart from the care reviews, where you would sit down with staff and start to plan through the care planning? 15:30

A. No, no, I mean the only sort of formal meetings that I would have attended, or that we would have had, would have been those kind of preadmission planning meetings.

41 Q. Was the expectation then that the care plans and

behavioural plans would both be created by or in Muckamore and that you would then take those and use them in The Mews or could you tell us about that?

A. I suppose the behaviour support plans would have come from Muckamore and that was to give staff an indication of, you know, what an individual's behavioural escalation looks like and to give them strategies then to manage that if they required. The care plans, we were to gather the information, so we could handwrite it, make notes and then bring it back to, say, the office and that's when we would start to type them up, so that was, that was on us to create that information, create those plans. 15:31 15:31

DR. MAXWELL: Can I just ask, there would have been a manager from Cedar or The Mews going to the multidisciplinary planning meetings? 15:31

A. Correct.

DR. MAXWELL: Although you didn't go, there was somebody else?

A. Yes. 15:32

DR. MAXWELL: It was not that nobody from The Mews was involved in planning the care, it was just it wasn't your job to go to the planning team meetings?

A. I didn't attend every meeting.

DR. MAXWELL: But there were other people that would go to the resettlement planning meeting. 15:32

A. Correct, yes.

42 Q. MS. BERGIN: Thank you. In terms then of those plans, so then that's something would you go back to The Mews

and essentially type up and then your line manager or someone more senior would then take over for actually preparing the care plans; is that right?

A. Yes, yes.

43 Q. And do you know, we're going to move on to this in a moment, but do you know, I suppose, when the patients were resettled from Muckamore to The Mews, that was on a trial period, so they were still patients, they hadn't been discharged. So when then the patients came to the end of the trial period and they were essentially handed over to the community care team, then did the care planning and behavioural planning, do you know what happened with it at that stage, who was responsible for it then? 15:32 15:33

A. I suppose, the care plans again would have been established and then we would have just reviewed them kind of ad hoc whenever they needed to be updated. In terms of the behavioural input, again I don't actually know who arranged that but we did have, we did have some input from, oh, gosh I can't recall the lady's name but they would have given us sort of ongoing support with any behavioural plans. We did have an individual who was kind of on the books or on the payroll as such and he was a MAPA instructor so he would have helped us with any sort of ongoing behavioural incidents and that would have informed, kind of, any sort of changes to behaviour plans and things like that. 15:33 15:33

44 Q. Great, thank you, it may be that, as you have already

indicated, there were matters I suppose that your manager was dealing with?

A. Yes.

45 Q. Do you know if there was a lead contact person or a lead team in terms of resettlement that was your direct liaison with The Mews at Muckamore? 15:34

A. There was a discharge coordinator who was sort of a main contact that I know would have been involved quite heavily.

46 Q. And if you know their name if you could just check for the cipher or just write it down for the secretary please? 15:34

A. I don't actually recall their name, I apologise.

47 Q. That's okay, don't worry at all, no problem at all. If it comes to you, you can tell us later, okay, thank you. In terms of how the preparation for resettlement actually worked in practice, if I could describe it this way, you seem in your statement to describe what goes from a very intensive period of patient familiarisation with three or four members of your team up at Muckamore meeting and shadowing patients and observing their behaviour, to then very, very limited information coming through to The Mews about patients. So I want to ask you about essentially how that process evolved or deteriorated over time. So to begin with when you were up at The Mews, do you know whether the intention was always in the planning to have Mews staff familiarising themselves with the patients at Muckamore before they came, or was it always the intention that 15:34 15:35 15:35

after the first patients actually came to The Mews that that would have to stop?

A. No, I believe the intention was always to have that level of in-reach, yeah, and for the opportunity to kind of get up and meet the individuals and spend a bit of time with them familiarising ourselves with them before they joined us. 15:35

48 Q. Sorry had you --

A. No, no, you are okay. It was just going to say it wasn't always the case because on occasion there was a quick turnaround, so there were some quite fast admissions and we didn't get the chance to do that. 15:36

49 Q. Yeah, and if I can just then ask you about that. You describe in your statement a period of time where you and your team then didn't have time to go up to Muckamore because you already had residents on site and then there was a period when Muckamore staff then it was agreed would on a rota would come down and essentially inform your staff about the various residents who were due to arrive. But then within a short period of time that fell away because the staff weren't able to leave due to staffing pressures, you said. So when, during that period of time if you can maybe tell us more about that period of time, but during that period of time when no-one was going to Muckamore and Muckamore weren't coming to you, how was that information about patient specific care plans and their behavioural needs communicated to Mews staff? 15:36 15:36

A. Via e-mail primarily.

50 Q. And if you can tell me about were you still getting the same volume, were you still getting the same types of information, was it still care plans?

A. It was. It was just whatever they could really filter through to us but primarily it was about their general presentation, their day to day needs, those types of things. 15:37

51 Q. You've indicated in your evidence that there were several members of staff from Muckamore who were very helpful and I think you refer to one key worker as actually coming down to The Mews. But on other occasions then you had very limited information which impacted your behavioural or care planning. Can you tell us a bit more about that in terms of how you came up with those behaviour or care plans? 15:37

A. Sorry, could I ask you to repeat that, apologies.

52 Q. Absolutely. You indicated that at certain times staff were able to come and assist and tell you information about patients but then at other times that didn't occur. I think you refer in your statement to the lack of information coming to The Mews making it difficult for to you care plan and formulate behavioural plans. So, at that stage, was it still the case that Muckamore staff were sending through behavioural or care plan information and that your staff were still formulating them? 15:38

A. Yes, I think the idea, or the plan at least, was for any sort of individual that came in to live with us, there was going to be an initial period where the

Muckamore staff would attend to basically kind of give directives to our staff and kind of show them how to work so it was ultimately kind of our staff again shadowing them. But that sort of dwindled very, very quickly. So what we relied on again was we had that individual who was kind of on our payroll who was providing us with ongoing behavioural support, so it was again ad hoc. In the event of sort of major incidents or any changes, he was contactable and would have come in and looked at the situation, kind of analysed what was happening and gave his own view on how to manage it. 15:39 15:39

53 Q. In terms of information coming from Muckamore, and you've indicated these patients were still actual patients, they hadn't been discharged, in terms of information coming to you from Muckamore, did you see that as a Muckamore responsibility or the responsibility of you to go and find that information out or both? 15:39

A. I suppose a little bit of both. But, yeah, ultimately, you know, the expectation would have been that Muckamore would have provided that information to us. 15:39

54 Q. And when Muckamore staff were unable to attend, did you ever, I suppose, complain to your manager or make any complaints to Muckamore or try to follow through? 15:40

A. We did. I think I did put in my statement that there was a few occasions where we attempted to telephone or to phone call them and that was ultimately because we had a rota posted on the notice board, we knew who to

expect. When they didn't arrive then it was a matter of phoning to find out only to be told that either they weren't available or they just didn't have another staff member to send in their place. So, yeah, that was how we found out.

55 Q. And when you and your team stopped going to Muckamore in February, and I think you indicated that you thought that the intention would have been for a high level of engagement, did you or any of your team try and, I suppose either get more staff on board or try and make efforts with your line manager to try and keep that, I suppose, process going of staff going up to Muckamore?

A. I suppose at that point I was deeply involved in the service so it wasn't really my remit to look at staffing and recruitment in that respect.

DR. MAXWELL: Can I just ask, when you were initially there quite a lot was that as much for you to familiarise yourself with these sort of patients, because you said you were not very experienced in care, as it was to learn about individual patients' needs. Was there a dual function, the familiarising the staff who are going to work at Mews about working in that environment?

A. No, I think it was more, I think the primary focus was information gathering and also, yes, to familiarise yourselves with the actual patient.

DR. MAXWELL: There will have been written discharge plans that will have been shared and a discharge letter and we have seen some of those in other evidence, so

there was written communication of these patients' needs and care plans as well?

A. Yes.

DR. MAXWELL: So I'm just wondering if, as the staff at The Mews got more familiar with working with this sort of patient, the need to be at Muckamore perhaps was a little bit less than it was when you were establishing the service and you had some staff who had not worked in that sort of environment before? 15:42

A. Yes. 15:42

56 Q. MS. BERGIN: And you referred, just picking up on Dr. Maxwell's point, you referred to at the start there was a team of a few people and then more and more staff came on board for The Mews, I think you were saying groups of 10. Were any of the subsequent teams who were recruited also going up as well or was it just the original team? 15:42

A. Yeah, no, some of the subsequent team would have gone up in portions, yeah.

57 Q. Then you had indicated that when the accommodation opened in February 2018 there were around three or four patients, can you tell us a little bit about how the actual physical resettlement occurred? So was it that patients, you've already indicated you went up to see them, did patients come and do a day visit, did they have a phased sort of move or was it that they were simply moved? 15:42 15:43

A. Yeah, no, none of them had a phased move. It was just directly into the service, yeah.

58 Q. In terms of this trial period, so I've already sort of gone over that, but patients who were still patients of Muckamore but they were on trial period at The Mews and if that worked out then they were discharged, do you know anything about how long that trial period was or how was the trial period determined in terms of when a patient was ready to be discharged? 15:43

A. I don't think there was necessarily a set period as such. We would have had the follow up reviews where we discussed their progress and ultimately it would have been an MDT decision at that point, whether we feel that they had settled well enough or whether we felt there was still maybe ongoing concerns regarding their placement. 15:43

59 Q. And when there were issues with patients on trial periods, you had indicated in your statement that you then created reports, sometimes daily, in relation to patients and that some of those reports were then fed back to MAH. Did you feed those back through your own line manager or were you sending -- 15:44

A. A combination of both. So whenever I was a team leader I was filtering them through to my manager and then when I took on the Deputy Manager role then I would have directly sent them as well. 15:44

60 Q. Okay. And in terms of the reports, I think we're going to come on in a moment just to very briefly discuss the care review meetings that you attended. But you have referred in your evidence to some patients having to be brought back to Muckamore during the trial period if 15:44

there were issues because challenging behaviours maybe could not be managed at The Mews. Can I ask you first of all, is there any correlation at all between the patients that you went up and shadowed and got to familiarise yourself with versus the patients that you didn't in terms of being able to manage those challenging behaviours?

A. No, no correlation. One of the individuals that did return to Muckamore, we did do a level of in-reach with. 15:45

61 Q. And during the trial period, what level of any sort of input on a daily basis or weekly basis would the patients have had, or residents have had from Muckamore staff? Was there any ongoing psychiatry input or nursing input or social work? 15:45

A. As and when needed, yeah. You know, we were able to contact the community social worker or, sorry, the hospital social worker I should say, if required, but again it was just on as needed basis that they would be contactable. 15:46

62 Q. During that trial period, I think you have indicated it could last varying sort of periods of time, were there any set interactions with those other types of professionals that occurred periodically?

A. Yeah, some of the hospital social workers would come down to visit and to visit the residents. But again it was sort of as and when. 15:46

63 Q. And did any of the residents at that stage have any access to day care or anything while they were on trial

period?

A. No.

64 Q. No. And did they have any input at that stage from the community teams?

A. No. 15:46

65 Q. So that only kicked in when they became a discharged patient?

A. Yes, yes.

66 Q. Okay. For example, if a patient was displaying very challenging behaviours or challenging behaviours 15:46 rather, was there ever an occasion that you or your staff members could pick up the phone to somebody in MAH and sort of ask them about a patient or was there any level of dialogue during the trial period more informally? 15:47

A. Yeah, no, there was. There were occasions where we did pick up the phone to the ward to actually ask them how to support an individual through sort of maybe a specific scenario. So yeah, we did, we did.

67 Q. Okay. And in terms then of those patients who 15:47 displayed challenging behaviour, you have referred to some patients having to return to MAH. Was there anything that you, through the lens of hindsight, think could have been done differently or any other support or training that might have enabled your team to be 15:47 able to keep those residents with you in The Mews?

A. I don't think so. I mean, you know, there was an expectation that we knew -- I mean it was a service that we knew there was going to be high levels of

intense behaviour but also we knew that there was a threshold as to what we could expect our staff to meet every day. So in terms of the training, no, I think it was fairly comprehensive.

68 Q. In terms of then the decision, and I appreciate you had a manager above you, but in terms of the decision as to whether or not a patient would need to be returned to MAH from The Mews, do you know how those decisions were taken, was there a criteria or a risk matrix? 15:48

A. I couldn't tell you, no, I'm sorry. 15:48

69 Q. And then you have referred to attending care review meetings, so those occurred with both patients who left MAH and were resettled but still on trial period and also then the patients before they were, before they even got to that stage while they were still inpatients? 15:48

A. Yes.

70 Q. And did you attend both types of care review meetings?

A. I did.

71 Q. And did you ever provide reports or input that was then dealt with during those meetings or was it more fed into your line manager's report? 15:48

A. It would have been more fed into my line manager's report, yes.

72 Q. And in terms of I suppose the views of you and your team, how do you feel that they were listened to or responded to during those meetings by the MAH staff? 15:49

A. I mean, I suppose the discharge planning meetings that were held up in Muckamore, I never really had any

concern with. The issue that I had was then the planning meetings whenever it would have been coming to the time where they were going to be discharged as patients to ourselves and in our care. There seemed to be kind of an ongoing pressure to discharge them relatively quickly. 15:49

73 Q. Where do you think that pressure came from or what do you think the reason for that was?

A. I mean I would only be speculating, I don't know, I don't know. 15:50

74 Q. If I could ask you in these terms, did you feel that pressure was a general pressure that you encountered throughout your meetings in relation to various patients or was it focused just on particular patients, do you have any -- 15:50

A. It was various patients, yeah, yeah. It just seemed to be a general theme of looking at quick discharges.

75 Q. Okay. I just want to ask you a brief question just in relation to attending the care review meetings or the case review meetings. You describe in your statement some families raising various issues in relation to their relatives' care. Just one question I wanted to ask was if you were ever aware of anyone at those meetings that you attended identifying themselves as an advocate or being there to advocate on behalf of patients, did you ever? 15:50 15:50

A. There was, yes, there were advocates at some of the meetings.

76 Q. Thank you. That is all I wanted to ask you about that

point. Now in terms then of the patients, there were difficulties, I suppose, in terms of managing their behaviour with. You have referred in particular to one patient, P140 and I think in your statement you indicate that at one point The Mews or the Cedar Foundation had to buy, purchase a van for this patient to essentially contain his behaviour during a particular time of the day. Can you tell us a little bit more about that in terms of, I don't want to put words in your mouth, but certainly putting someone in a specific space for a set period of time would seem to be akin to the types of scenarios that the Inquiry has heard about in terms of seclusion and you haven't used that word but if you could just describe to me how did that scenario come about or were you involved in terms of that decision? 15:51 15:51 15:51

A. I wasn't involved in terms of the decision but, as I understood it, ultimately this was an individual who we had tried to support in the community but would have become quite violent. Ultimately his presentation was at a level of risk that we just felt he really kind of couldn't go into the community. So in a sort least restrictive measure we looked at introducing an outing every day. We knew he would have behaviours during a certain time between 2 and 3 every day and that's when he tended to become a little bit agitated which would result in generally, sort of, quite violent behaviours. In terms of how the decision was made, I don't know. I know the pretence behind it was obviously to try and 15:51 15:52

make sure that he was having some level of quality of life by making sure he does get out in the van every day and go out.

77 Q. So he was actually going out?

A. He was going out on the trips, yeah. 15:52

78 Q. That's helpful to clarify that, thank you. Before we move on to just the second topic I want to ask you about which is much shorter. Before you left The Mews project in 2019, do you have an idea of roughly how much patients from MAH had been resettled to The Mews 15:53 at that stage?

A. I couldn't tell you, I know every resident that was there came from Muckamore Abbey, so I know that much in terms of discharge.

79 Q. Was it full capacity? 15:53

A. Yes, sorry, it was full capacity at that point.

80 Q. So 14?

A. Yes.

81 Q. And you say in your statement that the residence who came to The Mews had severe learning and disability 15:53 needs and you describe staff regularly being assaulted, yourself having I think sustained a concussion at one stage and there being a 70% staff turnover at The Mews. Is there anything with reference also to P140 and those challenging behaviours, is there anything else that you 15:53 feel could have been done differently in terms of preparing your team for managing those types of challenging behaviours?

A. I mean I really don't think so. It was more so the

level or the intensity of the behaviour, it was just unmanageable. You know, the staff were highly well trained, there were lots that they managed incredibly well. But with this specific individual it was just at a point where I mean it was incident reports almost daily, quite intense sort of injuries being sustained. Most days I had a staff member in my office crying, you know, saying that they just can't do it anymore. So it kind of got to that point where it was really drastic. 15:54

CHAIRPERSON: I am just thinking about timing, the witness has been going on for an hour half. How much longer do you think you will be? 15:54

MS. BERGIN: We have I'd say 20 minutes maybe.

CHAIRPERSON: Is that a barrister's estimate.

MS. BERGIN: Maximum 30, we really don't have very much further. 15:54

CHAIRPERSON: Because there is also other material under the Restriction Order.

MS. BERGIN: That is including that.

CHAIRPERSON: Shall we take a short break now? It is long enough for any witness and certainly for the stenographer so we'll take 10 minutes now. 15:55

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS: 15:55

CHAIRPERSON: Thank you. Yes.

MS. BERGIN: Thank you, Chair. All right, James, I want to move on now to ask you about your experiences

at Muckamore specifically, okay, and we're going to be focusing on Cranfield wards. So, you refer to at paragraph 10 to having been left alone with patients in Muckamore and also to attending to patient care needs. Was that, do you think, a staffing issue in terms of staff shortage or was that just the staff not making themselves available to be with you?

A. I can't really say either way to be honest. I know, you know, with a gentleman, P33, he needed kind of very heavy one to one support. I was left to do his personal care on one occasion. I had never been shown what kind of level of support he needs, how to prompt him for it, how to encourage him into the shower, whether he needed hands-on support with that or not. So, I don't know if that was a staffing issue or just simply I think just the staff that needed us as an extra pair of hands so it meant that they could go off and do other things then on the ward.

82 Q. Okay. And you refer to your time at Cranfield 2, a lot of it being spent with patients playing board games and often spending a lot of time watching television, did you ever see or were you ever involved in any welfare activities with patients or were patients --

A. No, generally speaking it was on the ward. There was very little, the most that we did was there was an on site cafe that we could take some of the individuals to. But in terms of outings or anything like that, no, no, I didn't see any of that. It was primarily on the ward.

83 Q. And at paragraph 14 and 15 you describe a particular incident of staff on Cranfield 2 having provoked patient P33 by calling him names and that you reported this to the ward sister. Did you ever ask your line manager within Cedar or any of the Muckamore staff what the outcome of your complaint was? 16:12

A. I didn't, no, no. I simply kind of gave my statement and that was it, I didn't follow up on it.

84 Q. And you also describe an incident on Cranfield 1 with a patient being grabbed by staff and carried to their room, did you report that or was there, I suppose, a time that came when you just stopped reporting things? 16:13

A. No, that was reported to my manager.

85 Q. In terms of, I won't go through every single one, but in terms generally of the complaints that you reported to either your own line manager or Muckamore staff, did you ever find out what the outcome of any of those were? 16:13

A. I didn't. I was actually invited to a safeguarding meeting at Finaghy Health Centre with myself and a colleague of mine and we were invited to give our statement based on a couple of issues that we had raised. I don't know what came of that, however. That was just again simply we gave a statement and I didn't hear any kind of outcome or what resulted from that. 16:13

86 Q. Practically in terms of the staff that you saw, so if you reported staff would you have always then still continued to see those staff, for example, still working on those wards?

A. Yeah, there was certainly nothing that stood out that I recognised any staff suddenly disappearing or anything like that. It seemed to be routinely the same faces working.

87 Q. You say in your statement that the fact that there was CCTV recording didn't seem to deter staff's behaviour, can you explain to the Panel why you say that? 16:14

A. Well I suppose based on what I observed and where I knew the CCTV coverage to be overlooking, it didn't, it seemed to be within where the CCTV area would be. So it didn't seem to work as a deterrent. 16:14

88 Q. And the impression that you give in your statement was not only that poor behaviour was tolerated, but that it was actually ingrained in the wards that you were on in Muckamore and you refer to behaviour occurring even whenever head nurses were present. What about whenever psychiatrists or other, I suppose, senior managers were present, did you ever notice a difference in staff behaviour? 16:15

A. No, nothing specifically that I can sort of pinpoint, no. 16:15

89 Q. And do you ever recall anyone more senior from the Trust or any external inspectors ever coming round and inspecting whenever you were there?

A. No, not to my knowledge. 16:15

90 Q. And I just want to ask you briefly about the patient care plans and the notes on PARIS in terms of your preparation. You said that informally you would ask nurses to provide you with copies and then they usually

would. Did you always see a summary of a patient and notes in relation to them before you started to work with them on Muckamore?

A. No, it would have been not always, there would have been kind of some level of induction, a little bit of a handover, an overview of a person. But we could have been working with somebody or supporting somebody for weeks before we got around to actually seeing the PARIS notes. 16:16

91 Q. And this is really in the same vein which is did you see the behavioural support plans which were in place for the patients you were working with in Muckamore? 16:16

A. No.

92 Q. No, okay. You say, and this is my final question in terms of this section which is that, you saw what you thought was unnecessary use of restraint and that, in particular, in Cranfield 1 that staff were quick to put their hands on patients. Did you ever see, for example, staff engaging in de-escalation or alternative approaches? 16:16

A. Yeah, there would have been. I mean some of the individuals maybe would have approached the nurses station and they would have been quite upset about this or that and there would have been that division obviously where the nurses station was. So there would have been staff that would have deescalated with that barrier in place and would have kind of tried to talk the individual down. So, yeah, there would have been occasions where they used verbal deescalation. 16:17

93 Q. Picking up on that, so why do you say they were quick to engage in more physical restraint?

A. I suppose because of that occasion that I saw and because there were other occasions where they were quite dismissive of the individual maybe and didn't really engage quite appropriately. 16:17

CHAIRPERSON: Sorry to interrupt, can I just ask, you say that poor behaviour, misbehaviour if you want to call it that, continued even when head nurses were present and then you said, then you were asked what about psychiatrists or senior managers, did you notice a difference and you said no. But, I think we need to know, did you see poor behaviour by staff in the presence of doctors? 16:17

A. No. 16:18

CHAIRPERSON: Right.

DR. MAXWELL: Can I also ask, so you've talked about certain behaviours being ingrained, do you think that the staff perceived what they were doing to be wrong or did they think, ill-advisedly or against what you would expect, did they think that what they were doing was appropriate and necessary? 16:18

A. It seemed to be, I mean certainly my impression was that they were okay with doing it in front of staff who weren't employed. 16:18

DR. MAXWELL: But is that because they thought it was okay do or because they didn't care about being observed?

A. That would have been my impression.

DR. MAXWELL: And this is maybe why they were doing it on CCTV, because they didn't perceive it as being wrong?

A. Yes, that would have been my impression.

DR. MAXWELL: When you saw more senior nurses observing that, do you think they didn't perceive it as wrong? 16:19

A. It is very possibly the case, yes.

MS. BERGIN: Unless there is any further questions from the Panel we can now deal with the restricted session.

CHAIRPERSON: Is there anything else? 16:19

PROFESSOR MURPHY: I think you have covered all mine, thank you.

CHAIRPERSON: Just give me a second. No, that's fine. All right, thank you very much. What we'll do then is we will then move into restricted session. There is 16:20 nobody in Room A who has not signed a confidentiality agreement but we will have to cut the feed to Room B. And ensure nobody is online who has not signed a confidentiality agreement.

16:20

RESTRICTED SESSION

THE INQUIRY RESUMED IN OPEN SESSION

CHAIRPERSON: That is all that I have to ask. Unless 16:26 you have? Well that's been very helpful. Can I thank you very much for coming to assist the Inquiry, making a statement and coming, albeit some days late, to assist us, so thank you very much indeed. If you would

like to go with the secretary to the Inquiry. Right, that is all the evidence that we have obviously for today. I can indicate that we will be sitting in the week of the 19th. The schedule, I'm sorry the schedule is going to be a day late because the schedule will not be published until Monday of next week so apologies for that, and it may be a short week, but we do hope to be sitting on the 19th, all right. Can I thank everybody for their attendance and we will see you all in a week's time. Thank you. 16:27 16:27

THE INQUIRY ADJOURNED