MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 6TH FEBRUARY 2024 - DAY 74

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

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THE INQUIRY RESUMED ON TUESDAY, 6TH FEBRUARY 2024, AS FOLLOWS:

CHAIRPERSON: Good morning, thank you. So this morning we don't have to rely on a witness turning up.
MS. BRIGGS: Yes, we don't have to worry about that this morning, Chair. This morning I am reading a statement and then Ms. Bergin is reading a statement after me, the first statement is a statement of Eileen McLarnon, it is reference STM-193.
CHAIRPERSON: Okay. Sorry, just give me one second actually. Is anything going to be put up on the screens or not?
MS. BRIGGS: I think the statement will be coming up on the screen, the technical team are just putting that up now, Chair.
CHAIRPERSON: Can you just give me a second, I want to find a document. Yeah, okay, thank you.

STATEMENT OF EILEEN MCLARNON

MS. BRIGGS: Thank you, Chair, the statement is dated the 4th January 2024.

"I Eileen McLarnon make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.
My connection with MAH is that I was a nurse at various grades working at MAH from 1972 until I retired in

2016. The relevant time period that I can speak about is from 1972 to 2016.

I did not have any family who worked at MAH during the whole of my career. In 1972 I had a friend from my local youth club who had been working for MAH for about 18 months. She talked about special people who needed special care. I had already decided that I was not returning to college to undertake further study following my GCSE exams and I recall that she brought me an information sheet about MAH and advised me that they were recruiting. 09:58 09:59

I applied for a post as a nursing assistant. I recall being shown around a couple of wards with other candidates prior to attending my interview. I recall the Finglass ward was one of the wards that I was shown around. I was surprised and saddened by what I saw. This was my first experience of MAH. I had not come across people with disabilities who were in MAH before. I recall seeing a lady with bad paralysis who could not move any of her body parts. I was successful in my application. 09:59 09:59

I started my career in MAH when I was 17 years old on 3rd July 1972 as a nursing assistant. The first ward I worked on was Finglass and I recall that we had 53 patients, all with a learning disability and some form of mobility restriction and physical disability. 09:59

I assisted the qualified nursing staff on all aspects of care such as washing, feeding and dressing patients and I assisted with activities during the day. At that time nursing assistants also helped with ward chores such as cleaning toilets, baths and mopping floors." 10:00

In the remainder of that paragraph, Panel, the witness describes going to her nursing training school at Muckamore in 1972 and she describes how she qualified in December 1975 as a Staff Nurse. 10:00

At paragraph six on the next page, page 3, the witness describes her first placement as a Staff Nurse on Conacre ward and she says that in 1977 she became a ward sister and she worked on Fir Grove ward. She describes the patients who were there and one of the changes that she brought in in terms of allowing the ladies, the patients to sleep in on the weekends. 10:00

Picking up then at paragraph 7 which is at the bottom of page 3: 10:00

"The role of a ward sister, charge nurse, included managing staff, drawing up rotas, organising staff meetings, liaising with medical staff, feeding information back to the consultants, liaising with pharmacy regarding medications, ordering meals for the patients and making sure that maintenance was looked 10:01

after."

The witness names the Muckamore Abbey matron, describing her as the senior nurse for the female patients, and the witness also names the senior nurse for the male patients. She says: 10:01

"The MAH matron ran a tight ship. Nurses were expected to deliver a high standard of care as of course they should. She expected nurses to be presented properly in the appropriate uniform for their grade. The nursing officers on their respective wards reported to the senior nurses. Nursing officers were allocated various wards to oversee. When I worked in Fir Grove my nursing officer was..." 10:01 10:02

And the witness names that person.

"I recall there were around 900 patients in MAH at this time. Fir Grove had a dual charge nurse ward sister in place. This means there were two ward sisters in charge of the ward with one on most shifts during daytime hours. The other ward sister when I worked in Fir Grove was..." 10:02

10:02

that person is named.

"Sometimes both ward sisters would work at the same time to discuss patients. In 1982, I moved to the

Fintona North ward as a ward sister. This was a semi-secure female ward with locked doors. This ward took admissions directly from the community. Fintona North also had a dual charge nurse ward sister in place. The other ward sister in place when I worked in 10:02
Fintona North was H180 followed by..."

Another person who is named.

"This ward had patients with learning disabilities and 10:02
mental health issues. Many of the patients were aggressive and had challenging behaviours. They could no longer be managed at home or any other facility, hence their admission to MAH. Many of the patients left the ward during the day to attend day care, dental 10:03
appointments, outpatient appointments or to use the pool facilities. I was there until 1988.

In 1988 a new scheme of clinical grading was introduced for nursing staff. Some charge nurses, ward sisters 10:03
were given a grade F and some were given the more senior grading of G. I was given a grade G and was moved to Movilla B ward. All of the patients in Movilla B were male. The F grade nurse working with me in Movilla B was called H774. He died earlier last 10:03
year. Movilla B was the open side of Movilla compared to Movilla A which was a semi-secure locked ward, the male equivalent of Fintona North. Movilla B was not locked and some patients could leave ward without nurse

escort and many could look after themselves to a certain degree. I recall there were 20 patients on this ward. There were two members of staff on during the day and one member of staff at night-time. I was the first female nurse to be in charge in Movilla B. 10:04
Initially I felt that the male staff working on the ward had the idea that a woman would not be able to look after these male patients. However, through time I convinced them otherwise.

10:04

I was concerned that we needed to look at the levels of staffing. I took this up with senior management at the time, being H485, Site Director, who had a nursing background. I told him that we were short staffed. On one occasion one of the nurses on duty during a night 10:04
shift was attacked by one of the patients and another patient had to intervene. After this occurred the staff numbers were three nurses during the day and two nurses at night-time. I was in Movilla B until 1993.
As a ward sister, I tried to organise more activities 10:05
for the patients. I worked with the multidisciplinary team to help patients develop their full potential.

In conjunction with Movilla A I recall that staff went to Lough Melvin in County Fermanagh on holiday from 10:05
Monday to Friday. Everyone slept in hostel type accommodation. The patients did sports and played games. The focus was on physical activity which was good for both body and mind. This was done once

yearly.

Patients in Movilla B were more able and could help with chores around the ward such as setting the table at meal times. This was in addition to their daytime facilities at day care. 10:05

I recall between 1988 and 1993 there was a high demand for male admissions. There were 20 beds in Movilla A and 20 beds in Movilla B. There were less opportunities to move patients out of Movilla A and B 10:05 as there was a focus on resettlement into the community and wards were beginning to close. I recall that new patients were admitted to Movilla B but there were not enough beds. Therefore, the patients lived in Movilla B ward during the day, including having their meals 10:06 there, but were then transported to a different part of MAH for bedtime where there was a spare bed. I recall at one stage we had 12 to 13 Movilla B patients "sleeping out" as it became known of the ward in spare beds around the hospital and they were bussed to and 10:06 from Movilla B in the morning and the evening. One of the old children's wards in the C3 building was freshened up with some paint and this became known as Movilla C. For any new patients that were admitted to Movilla A or B, if there were no free beds they would 10:06 sleep in what became known as Movilla C. I managed Movilla C as well as Movilla B. I recall H774, F grade, went to Movilla C with other staff in the evenings, this went on for at least one year.

In 1993 I was moved to Moylena ward. This had 29 challenging men with moderate to severe learning disabilities but they were mostly physically able. I had heard rumours that there had been an allegation of cruelty to one or more patients and that three male enrolled nurses had been dismissed from their permanent posts. I had heard rumours that there was an investigation but I did not know anything more than that. 10:07

I recall speaking with H485 before I was due to start on Moylena ward. He confirmed to me that three nursing staff had been dismissed. He requested for me to ensure that the patients would be well looked after and not abused under my supervision and to win back the confidence of the family and friends of the patients on the Moylena ward. This was a ward where the patients had regular visitors. I told him that I would do my best. The charge nurse prior to me, H98, had been moved out of Moylena. The deputy charge nurse called H774, F grade, stayed when I took over. All of the staff on this ward were male except for two female nursing assistants who had a housekeeping role and assisted in some aspects of patient care. 10:07 10:07 10:08

As expected, when I started in the aftermath of the investigation and the dismissal of three members of nursing staff, the morale on the ward was low. I was

the first female nurse to have a senior position on this ward. I was in Moylena ward until 1997.

I recall in December 1993 the Hospital Advisory Team were on site at MAH for three to four weeks. This was 10:08
a team of senior people from different professions. I do not recall any specific names. They visited all of the wards and departments and were compiling a report. Moylena ward was visited by a lady from this team, I do not recall her name but she was from a medical 10:08
background and she asked me how I was getting on. I had not been in this post very long at this time. I told her that I was taken aback by the lack of activities available for the patients on this ward compared to what was available on other wards. The 10:09
ward was clearly run down and in bad need of repair. Only 12 of the 29 men on this ward went to day care. Whilst the staff on the ward were excellent, the ward had been bypassed in respect of resources by way of money and staff. Some windows were made of perspex. 10:09
The ward was overcrowded and dilapidated. The staff were so dejected. Staff told me that there were official visitors to MAH regularly but none of them were ever shown on to Moylena ward. I pointed all of this out to the lady from the Hospital Advisory Team. 10:09
After this we secured £600,000 of funding for the refurbishment of Moylena ward. We moved out of Moylena ward and into one of the vacant children's wards while Moylena was refurbished and this took six to seven

months. Moylena ward as given a modern kitchen, toilets, wash basins, some single bedrooms and double glazed windows. We had a lovely refurbished area with a lift and increased staffing.

10:10

As I noted above, the patients on Moylena ward were physically able men, very challenging and difficult to manage. There were not enough staff and not enough places in day care. I asked H485 that I wanted a qualified Staff Nurse working 9 to 5 to manage and 10:10
facilitate day-time activities. The member of staff was not to be included in the staffing numbers to maintain a safe ward. I was clear that this person was to be focused solely on the provision of day care activities. I also asked £300 to purchase day care 10:10
activities such as puzzles and games, et cetera. I was persistent in my approach. I was given both the nurse, H16, and the money to purchase the day care equipment.

Some of the patients in Moylena ward had not been out 10:10
of the ward ever, which I did not think was acceptable or good enough care for these patients. I separated the patients into morning and afternoon groups. At the start it was a long process. We started by putting the patients' coats on and going as far as the front door 10:11
of the ward. These men had plenty of money in their accounts from Disability Living Allowance. I wanted to encourage them to spend it on treats for themselves which had not been encouraged previously by H774.

My aim was to try to get some of these patients to the Cosy Corner, the MAH on site cafe, to buy a treat of a bun or a scone. Each day we tried to lengthen the period of time that they would be out of the ward. At the start a patient may get as far as the Cosy Corner and want to go back to the ward before they even purchased something. We built this up to some of the patients sitting in the Cosy Corner to enjoy their snack. We had to have patience as some of these patients had not left Moylena ward for a very long time. Eventually we were able to refer a number of these patients to mainstream day care and a large number of them were accepted. 10:11 10:11

Patients in Moylena ward were brought to meal times in groups. Some patients would steal food from other patient's plates. The staff on duty needed to make sure that everybody had enough to eat. The plates were made of melamine and were very scratched. When Moylena was refurbished I changed the structure of meal times. We still kept the patients apart, but I introduced normal crockery and set the tables with knives and forks. I introduced bringing a teapot onto the table. I wanted to make meal times more pleasurable but it meant that the staff had to be very vigilant. 10:12 10:12

As I noted above, a number of these men had thousands of pounds in their accounts held at MAH. I wanted to encourage them to take pride in their appearance by

having nicer clothes, better quality toiletries and treats as opposed to the low standard basic items that MAH supplied. MAH had a mobility scheme whereby you could book a vehicle for your ward to facilitate day trips through the Transport Manager. We started using this mobility service every day to take the patients out for a day trip, to go shopping, have ice cream or go to the park or the lough shore for a walk. The emphasis was getting the patients out and integrating them into society. I would say that Moylena was the biggest challenge in my career but the most rewarding. It was great to see previously dejected staff more enthusiastic again. 10:13 10:13

I generally felt supported in my various roles at MAH. However, there was one occasion when I worked in Moylena ward that I did not feel supported. I cannot recall the exact date, but I think it was some time in 1997. There was a patient called P160 who was discovered to have a fractured jaw during a dental appointment. I recall it was a Thursday morning. P160 was in his twenties at the time. He had limited speech and did not like noise. There was an investigation into how this had happened and how we did not know about it prior to the dentist appointment. P160 was taken to Antrim Area Hospital. There had been an incident the previous Monday whereby P160 had been aggressive and was annoyed at the other patients as they were making too much noise. A Staff Nurse, I do 10:13 10:14

not want to disclose his name, asked P160 if he wanted to go to bed. P160 advised that he did want to go to bed. On the way up the stairs to the bedrooms P160 had grabbed at the curtain, the curtain pole gave way, as they are designed to stop the risk of strangulation, and P160 fell back onto the stairs. The Staff Nurse checked him over and noticed an abrasion on his back. An incident form was completed. The broken jaw was being linked back to this fall incident and the patient's mother was accusing the Staff Nurse of being responsible. There was a police investigation and the police interviewed every member of staff on duty from the Monday when the fall incident occurred to the Thursday when P160 had his dentist appointment. The Staff Nurse was charged with assaulting P160. I recall that the court sat in Ballymena Courthouse. I was called to give evidence as the ward sister. The outcome was that the Staff Nurse was found not to be guilty. Every member of staff had to put in their statements that P160 was normal on the Tuesday and Wednesday following the fall incident. It was indicated that there was a bit of blood on P160's pillow on the morning of Thursday prior to visiting the dentist.

10:14 10:14 10:15 10:15 10:15

During that time, H485 was in charge. I did not feel supported by him. I got the impression that he had formed the view that the Staff Nurse was guilty and needed to be dismissed. I recall the day before I was

due to give evidence to the court, H485 visited our ward. He mentioned the court case to me and said something along the lines of 'I hope we will be singing off the same hymn sheet.' I responded that I would simply be telling the truth. 10:16

In 1997 I was moved back to Fintona North. This was a difficult move for me. The patients had all changed from the time I was previously the charge nurse. The patients were much younger and had aggressive behaviours. Some patients only stayed for a short period of time and others needed to remain in MAH for a longer periods of time. I was a G grade nurse in charge and I was there for 15 months. 10:16

In 1998 I moved to Cushendall ward. At this time I recall there being a focus again on resettlement of the patients out of MAH. There was a list of wards drawn up by more senior management detailing the sequence of wards which were prioritised for resettlement. The idea was that all patients out of a ward would be resettled before moving to the next ward on the list. This list was shared around all of the staff. Cushendall ward was the second ward on this list. We actively resettled patients out of this ward. There were weekly resettlement meetings attended by the multidisciplinary team, which included doctors, nurses, social workers and consultants. I recall that patients were being resettled one or two at a time. One of the 10:16 10:17

patients called P161 was ready for resettlement. His parents always chatted to me and wanted to know about P161's day. P161 was their only child. He was non-verbal, autistic and self-harmed. I remember P161's parents asking me why P161 could not remain in 10:17
MAH. I explained that there was now a policy in place where no patient should have MAH as their home address. They advised me that when P161 was six years old he was not able to go to school and they had been told by the doctor looking after P161, they did not provide me with 10:17
the doctor's name, that P161 would never amount to anything but he would be well cared for in MAH. P161 had been a patient since he was six years old and at this stage he was in his 30s. His parents advised me that they would love to have kept P161 at home but they 10:18
did not have the support they needed. They advised me that P161 was happy in his own wee world in MAH in that he did not know any better. They were concerned that when he left MAH he would go out into the world where he would be looked at and possibly mocked. I cannot 10:18
recall where the nursing home was where he was to be resettled. P161's mother asked why after all these years was her son now to be moved out of MAH. She also asked what would happen if the nursing home chosen for her son were to close. I tried to reassure her and 10:18
tried to explain the shift in government policy and that it was no longer acceptable for any person with a learning disability to have MAH as their permanent home. I worked on the Cushendall ward until September

1999.

In September 1999, I was given the opportunity for promotion to an H grade to lead the children's service in MAH. H135 had held that position and she retired. There was an advertisement for the position and I applied. My interview was in Muckamore with a three person panel but I cannot remember anything else about the recruitment process or who was on that panel. I got the promotion. 10:19

The children's service was seen as a different entity in MAH. It had 20 beds and the ward was called Conacre. By that stage children should not have been in MAH. Children under 18 years old should not have been admitted to an institution. Targets were set at the Belfast Trust level to have children removed from MAH and these targets were fed through to me by senior management. These targets were not met, however, due to financial constraints and lack of resources in the community. 10:19 10:20

I was located in an office in the children's area. I dealt with issues of managing the children and the staff that looked after them. Some of the children in MAH still attended special schools and were taxied to and from MAH. These included Riverside School in Antrim and Torbank School in Dundonald. 10:20

Activities for the patients in MAH took place in the

Portmore building. It provided different activities for different groups of patients. I had a concern about children meeting adult patients in Portmore building as it provided day care facilities for some patients in adult wards. H471 was the senior day care worker in charge of Portmore building. I worked with H471 to identify a wing in the Portmore building which could be made child friendly and dedicated to the provision of day care facilities for children. The wing was refurbished with child-friendly toilets et cetera. Children who could not go to school attended this wing in the Portmore building instead. This was overseen by H588, a grade G behavioural nurse. She managed challenging and modified behaviours which improved the service. 10:20 10:21 10:21

On the 11th September 2001, I interviewed for a Grade I post which would be the equivalent to a Band 8A today. The post became available due to the retirement of a member of staff, I cannot recall the name of the individual. The post was advertised. I had my interview at Glendinning House, Belfast which was part of the Belfast Trust headquarters at the time. There were four people on the interview panel. H477, MAH Director was one of them. H775, Nurse Education was another. I cannot recall the name of the other two people on the panel. I was successful. 10:21 10:21

I was responsible for the children's service at MAH.

Funding was being considered for an off site children's service for children with learning disabilities who needed additional support who could not be catered for in the community. At that time, if all else failed, the child was being admitted to MAH for assessment and 10:22
treatment and their discharge was being planned from the day of their admission. This is where things fell down. Resettlement of children back home was difficult because the families of children with complex needs needed support in the home. For some children school 10:22
was refused as the schools could not cope due to a lack of resources for the required additional staffing. It is easier when children are small as they can be more easily managed, but as they become older and stronger they are more difficult to manage and they can start to 10:22
interfere with the quality of life for their siblings. In turn, this makes resettlement of children back home difficult.

H333, Business Manager was taking the lead in preparing 10:23
a business plan to be submitted to the Department of Health for funding for the offsite childrens service which ultimately became the Iveagh Centre. The business plan was a detailed project. Once the funding had been secured from the Department of Health everyone 10:23
with an interest was invited to come along to meetings to share their views so they could be taken into consideration. There were several of these meetings which took place in MAH which were attended by

families, professionals and others with a vested interest who worked in the provision of services to children with learning disabilities."

In the remainder of that paragraph the witness goes on to describe the various project planning meetings leading to the creation of the Iveagh Centre and the construction of the building and its facilities. I am going to pick up at paragraph 24 on page 13. 10:23

"During this time of planning and developing Iveagh we still had children in the Conacre ward in MAH to look after. In 2003/2004 there were new wards being constructed at MAH. Some of the older wards were demolished. New wards called Cranfield woman and 10:24
Cranfield men, ICU and Six Mile ward were created. The recently built Six Mile ward was located at the back of MAH and this ward treated patients with an offending background. Conacre was located to the rear of Six Mile ward and the children's nursing staff were 10:24
concerned that it was not appropriate for children to be walking past this ward.

The Mallow ward became empty due to patients being resettled and space being available in the newly 10:24
created wards which was in and around 2005, therefore Mallow ward was refurbished and the children were relocated to Mallow ward which was located at the front of MAH. The children remained in Mallow ward until

Iveagh was opened in and around 2008.
H397 was the charge nurse in Mallow ward. H397 and his team created a policy file specifically for Iveagh which dealt with the running of Iveagh and I oversaw creation of the policies." 10:25

In the next two and a half paragraphs, Panel, the witness goes on to describe the training required for the staff at Iveagh, inductions for those staff and the reduction of child patients in Muckamore from 20 to around six or seven as that was Iveagh's maximum capacity. She describes how the admission criteria to Muckamore for children were tightened. 10:25

I am going to pick up at paragraph 28 which is at the bottom half of page 14. 10:25

"MAH had community nursing staff who were employed by MAH but worked in the community. This was with a view to trying to avoid unnecessary new admissions to MAH. They were like district nurses but they specialised in people with learning disabilities. They would assess the patient in the community and try to offer support to help the patient remain at home and try to keep people living in the community. This worked well as families had someone to reach out to when things were becoming difficult for them to manage at home and without resorting straight to admission to MAH. 10:25 10:26

When Iveagh opened in and around 2008, half of my working week was dedicated to managing Iveagh. I was still located in MAH and was managing Iveagh from off site. H189 took over as nurse manager and he was located at Iveagh. He reverted to me if he had any queries or needed assistance. H397 was the charge nurse on the Mallow ward and he transferred over as charge nurse in Iveagh. He moved back to work in MAH at some stage at his request because he found managing the children stressful. I do not know when this was. At times charge nurses or ward sisters did request a transfer out of wards. This may have been to allow them to gain further experience or to allow them to move to a less stressful work environment." 10:26 10:26 10:27

At the next paragraph the witness describes the challenges presented by the Iveagh Centre's location. Picking up at paragraph 31.

"The other half of my working week was spent looking after some wards in MAH. I cannot recall the specific wards that I looked after. I was not hands on, that was the responsibility of the charge nurse, ward sister of the specific ward. I did this for a few years. I recall that I looked after the Donegore ward and the Killead Ward from when they opened as new wards in and around 2009. At this time there was a lot of refurbishment going on at MAH and a lot of contracting work was taking place. When an area of MAH was being 10:27 10:27

worked on the whole area had to be cut off from the patients. Any contractors coming in to do work had to be informed about the do's and do nots of carrying out work at a hospital which looks after patients with a learning disability. The contractors had to be vigilant not to leave any equipment or tools about which could be picked up by patients who were out and about in the hospital grounds. 10:28

In the summer of 2010 I got the opportunity to job share. Patient numbers in MAH were reducing and I was looking to work less hours, therefore it suited me. When patients were admitted to the new buildings at MAH they still required treatment and were not ready for discharge. Those who were ready for resettlement remained in the old wards as their resettlement was being organised. 10:28

H377 was my colleague who job shared with me. Due to the job share arrangement MAH were able to go from two Grade I staff to one. We had one day where we both worked together. We had a number of resettlement wards and our role was to support staff who were actively engaged in resettling patients. We assessed the viability of wards staying open. We helped facilitate the movement of patients to other wards and also moving staff into different wards if this was necessary. H377 retired in 2013. The resettlement process at MAH was still ongoing at that time. 10:28 10:29

In the last few years prior to my retirement in 2016 I was responsible for managing staff absences and managing sickness. Staffing resources were frequently an issue. There were many factors which impacted staff 10:29
levels such as staff being off sick due to stress, injury, long-term chronic illness, extended maternity leave, requests from staff to reduce working hours for various reasons, including returning from maternity hours, reduction in working hours during a phased 10:29
return following injury, trauma, serious illness, introduction of paternity leave, releasing staff for mandatory training, volume of work needed to close, secure closed wards, increase in annual leave entitlement for staff in service more than 10 years and 10:30
staff requesting career breaks which could be any period up to five years.

There was a three year period between 2012 and 2015 when we were only permitted to offer temporary 10:30
contracts as we were told that the hospital would be retracting and eventually closing. Opportunities were lost during this time to employ newly qualified younger staff. I recall staffing being such an issue one year, I cannot recall the specific year, that the Belfast 10:30
Trust agreed to pay staff for outstanding bank holidays as the number of days owing continued to increase as managers struggled to allocate time off in lieu of working bank holidays as they were trying to maintain

safe levels of staffing on wards.

From what I can recall, payment was made to staff for somewhere in the region of 3,000 shifts worked.

10:31

I also dealt with litigation cases where staff had an accident at work. I worked closely with an individual [named] who specialised in employment law in the Belfast Trust. I attended court proceedings where appropriate and was involved with assisting with 10:31
personal injuries settlements. During the course of one of my investigations I asked the Information Officer for figures of assaults on staff by patients. The records showed more than 600 recorded assaults on staff in a six month period. These included punching, 10:31
kicking, slapping, pushing, biting, hair pulling and being spat on. Some assaults resulted in bruising, bites, some of which needed medical attention, and hair loss. I recall serious injuries to a staff member's eye, broken noses, broken toes, broken bones in the 10:31
hand, serious injury to a jaw resulting in prolonged period of dental treatment. Staff were advised to report injuries or assaults in MAH and encouraged to report the matter to the police. This did not always happen in the case of more minor assaults as many staff 10:32
accepted these occurrences as part of the job and thought that it would be unfair as the patient did not know any better.

I was also undertaking investigations into staff conduct. Senior staff at Band 8A received training on how to conduct an investigation and presenting officer training at a disciplinary panel. I was responsible for obtaining witness statements from anyone who had witnessed staff misconduct. My senior was H507 from 2012 to 2016. H507 was a Band 8B. I reported to her. My previous manager was H359. H359 retired in 2011. I recall H77 acted in the role from September 2011 to January 2012 when H507 took over. H507 was from a mental health background. She was new to learning disability. I recall that prior to her interview I took her around MAH. Both H359 and H507 actively engaged with all senior nurse managers. They both had an open door policy. They checked in with us regularly and asked for updates. When H507 started I did not know her as she came from a mental health background. She was an approachable person. She acted as a buffer between the senior nursing managers, being H290, H77 and H189 and I, and the Belfast Trust. 10:32 10:33 10:33 10:33

H290, H77, H189 and I were the most senior nursing people in MAH. We had formal weekly meetings with H507. We discussed everything at these meetings which usually lasted around one to two hours. Attendance at these meetings was compulsory. We also had monthly meetings attended by ward sisters and charge nurses from each ward who were Band 7, representatives from day care, ward support and social workers. We met in 10:34

the Board room at Muckamore. There could be 25 to 30 people attending. A representative from the medical staff also attended. We discussed anything and everything to do with the running of MAH and the assessment and treatment of the patients in it. H777, a qualified nurse Band 6 post was the Information Officer. She compiled reports on lots of matters for discussion, including safeguarding and the use of seclusion and these types of issues were discussed at this monthly meeting. There was then a core meeting which H507 attended with her boss, H730, the Director of Learning and Disability Services, the consultants and H287. They discussed more strategic things and budgets. I was not party to these meetings. 10:34 10:34

Ward sisters and charge nurses reported to me. They came to me about any issue including staffing, sickness and leave, change of hours requests, changes in their relevant wards, and they reported any concerns to me. If there was a concern relating to a patient, this was investigated. If, by way of example, a member of staff slapped a patient, this would be reported to the nurse in charge who then reported the matter to the Duty Officer Band 8A nurse who then informed their line manager or the senior staff on-call out of hours. The immediate response would be to remove the member of staff out of the situation and put them in a patient free area. The doctor would then be called to conduct a physical examination of the patient to check for any 10:35 10:35

harm or injury. Any witness would then be approached to give a witness statement relating to the incident. The alleged perpetrator would then be asked to give a statement together with the victim patient if they were capable of making a statement. A safeguarding referral would be made along with a PSNI referral and Human Resources would be informed.

I recall one specific example in January 2012 whereby a member of staff called H778, Band 3, punched or slapped a patient on Killead ward. There were three witnesses to this incident. H779 was the Band 5 nurse. The protocol would be to tell the alleged perpetrator to go to an area with no patients. The doctor was called to assess the patient for any harm or injury. This was reported to me and I reported this to H507 which was her first day in her job. I recall that H507 met with H778 and suspended him straight away. I was also in attendance at this meeting. H507 advised H778 that he should consult with his union representative. I was the officer designated to investigate. I had to meet with the witnesses and obtain statements from them. The information in this case was quite clear cut. The PSNI were informed and a report was made to safeguarding. I recall the PSNI making contact with me to advise that they would be investigating the matter from a criminal perspective. I raised the matter with Human Resources, an individual who worked in the Human Resources department of the Belfast Trust who advised

on the employment law issues. She gave me advice in respect of the procedure to follow to take statements from the witnesses. I carried out the investigation. I obtained the account of what had happened from each witness and put forward any mitigating circumstances. If applicable, the estates team would be asked to take photos of where the incident took place and provide a location map. I obtained measurements of the room where the incident took place just to make sure that the witnesses who gave witness statements could have observed the incident from where they were located. My report was given to H507 and in turn she provided it to H730. It was deemed there was a case to answer. 10:37 10:38

I was asked by H507 to present the case to a panel of three members made up of mixed sex and one person from outside of MAH and a person from another profession. The panel consisted of senior people. I recall H778 being invited in and it was very formal. The panel introduced themselves. I recall H507 was on the panel and two other members but I cannot recall who they were. I was asked to introduce the case and bring witnesses forward. H778 union representative then presented the case on behalf of H778. I believe the outcome of the case was swayed by the fact that the PSNI had finished their investigation. In the criminal investigation H778 admitted the case against him and was given a conditional discharge. I understand that to mean that he would not have a criminal record, that 10:38 10:38 10:39

if he did anything else to break the law it could be relied on and taken into consideration. I presented a short summary of my investigation. It was up to the panel to make a decision and they decided to dismiss him. He received a formal letter dismissing him. H507 advised me that H778 was going to appeal, but I was later told that the appeal would not proceed as his union were not prepared to support the action. 10:39

Some allegations reported to me were minor in nature as in a verbal comment made to a patient by a member of staff. These types of allegations may not have gone to a formal Panel and may have been dealt with by the nurse in charge suggesting the member of staff received some training or moved to a different environment or work under supervision for a period of time. 10:39 10:40

I cannot remember how many investigations I carried out. I recall two dismissals from investigations I was directly involved with. One was H778, and the other was H578. H578 involved an incident where the patient victim had a cut on their lip and H578 had a cut on his knuckle. There were no witnesses to this incident. I investigated this with H377. There was a disciplinary hearing and the outcome of this was that he was dismissed. Allegations were also reported to the other Band 8A staff and the same process would have been applied by them. 10:40 10:40

I recall one time when H507 was in her post for about six months and she had just completed a round of the wards. She said to me that she could not think of a mental health nurse who could do the job the nurses in MAH do, implying that the nurses in MAH worked very hard and were met with very different and difficult challenges in caring for the patients in MAH. She said to me that she thought working in mental health was difficult until she witnessed what the staff in MAH faced on a daily basis. It was a difficult time because at this stage in and around 2012 there were lots of resettlement issues for patients with very complex needs and there were staffing issues. We were losing a lot of staff because most of the contracts were temporary and the staff did not see the prospect of obtaining permanent posts at MAH. We were also down to the most difficult of patients with the most complex needs. 10:41 10:41 10:41

As a practising nurse, I was required by the Nursing and Midwifery counsel to keep a portfolio of the training that we undertook each year and evidence of continuing learning and hours of practice. I had to show proof of the training that was completed in order to be reregistered each year. I did a lot of training at MAH. All of the staff, including me, were given physical intervention training which had to be completed every 18 months. We had onsite trainers who in turn updated their training every 12 months. The 10:41 10:42

first physical intervention course lasted five full days and refresher training every 18 months lasted three full days. A lot of the staff were MAPA trained, however I did not undertake the full training due to a medical conditioning. I observed the full training as I needed to see what my staff were being taught. We learnt breakaway techniques. If physical intervention retraining had lapsed I had to form a view on whether the relevant member of staff could continue their role until the training was refreshed. We received training on fire safety. There was a designated fire safety officer on each ward. Fire safety checks were undertaken every evening and we had regular fire drills.

Each ward had to keep individual training records for their staff. If a hospital policy was updated, every member of staff had to sign to record that they had read the policy. There was training in infection control. I oversaw this and worked with the Senior Infection Control Nurse in the Belfast Trust. I cannot recall her name. I met with her every two months. There was a Staff Nurse on each ward designated to infection control and I met them monthly to ensure standards on infection control were met. We made sure there were adequate signs up around procedures for washing hands, wearing aprons and gloves et cetera.

Relevant staff undertook training on child protection,

vulnerable adult training, hygiene and food preparation training, control of substances hazardous to health, manual handling, palliative care, dental nursing support, epilepsy, reporting of injuries, diseases, dangerous occurrences regulations, induction for new staff and National Vocational Qualification 2 and 3. 10:44

In addition, some staff went on to complete general nurse training and psychiatric nurse training after completing their registered nursing learning disability course. In more recent years some staff also completed health visitor training. 10:44

The culture on the wards was different, depending on which ward I worked on and also my grade at the particular time. When I started in 1972 when I was learning the focus was on providing a high standard of care for all patients. The more senior staff kept me right. From the beginning, and as I moved through the various wards in MAH, there was always an initial element of getting to know the patients. On all wards that I have worked on throughout the years there was always a focus on team work. The more experienced staff looked out for the younger, newer and less experienced staff on the ward. Conacre ward was a happy ward with the focus being on getting the children out to play as well as indoor play activities. We also spent a lot of time on the basics of care being washing, dressing, brushing teeth, supervision at 10:44 10:45

mealtimes and choking supervision.

It was the practice on all wards that the staff had their lunch and tea breaks staggered, either before or after the patients' mealtimes so that all staff would be on duty to supervise during patients' meal times. Meal times were supervised depending on the ward. In wards like Greenan and Rathmullan there was a high level of feeding due to the physical disabilities of the patients. Feeding was one to one. Food was minced or liquidated. We always tried to make meals more appealing for patients on these types of diets and various moulds were used to try to make the food look good and appetising for the patients. 10:45 10:45 10:46

The ward sister and charge nurse had a degree of autonomy and they led the team on their ward. Each ward was different and needed different levels of supervision. The type of care provided depended on the patients' needs and this reflected on how you worked and the type of training you required. 10:46

Back in the 70s and 80s when H771 was in charge the running of MAH was very formal. Everyone had starched uniforms and called each other by their title, sister or doctor. Once H771 retired MAH was more relaxed. I do not mean that the patients did not receive as good or the same high level of care, but it was implemented in a less formal way. We did away with the starched 10:46

uniforms and started calling staff by their first names. This led to a culture of being more approachable to other staff, especially senior staff, and also for the patients to engage with staff. The level of care was still consistently good but in a more relaxed atmosphere. I think this was just a change in the times as opposed to anything specific to the running of MAH. 10:47

There was always an open door policy at MAH and there were no set visiting times. 10:47

overall, I think there was a good, positive atmosphere on the wards. I noted in my statement above that my only reservation to this statement was when I went to work on Moylena ward after the three members of staff had been dismissed. 10:47

On all wards there were staff who worked above and beyond and other staff who did the basic minimum to perform their role but you get that in any organisation. In general however, most of the staff worked hard in what was a difficult job. Most of the staff were there because they wanted to be there and wanted to care for the patients. 10:47

The patients in Greenan ward mainly had been there most of their lives and the staff became close to them. The families with patients in MAH for a long time sometimes

felt some guilt that the patient was in hospital. Resources were limited in MAH and as a charge nurse on any ward I felt that I really needed to speak up if I needed resources. I had no problem in asking my superiors for resources if I thought it would enhance the patients' experience and care. 10:48

I believe that the care provided by the staff in MAH was good if not excellent. I did not ever witness abuse. I did see poor care where a staff member was perhaps not pulling their weight or taking the time that they should to perform a task or not engaging with the patients as much as they should have. I did witness staff on occasion reading a newspaper when they should have been performing another task. I cannot remember any specific examples or staff names, but any time that I personally witnessed poorer care I took the staff member aside and told them that this was not good enough and that they needed to do better. I offered training if it felt appropriate. 10:48 10:49

When working on any ward the nurse in charge allocated work amongst the team members. There was an allocation book on each ward and the nurse in charge would prepare the rota listing the names of each staff member on shift and a list of tasks that they had to specifically perform whilst on duty on that particular day or night, for example, having to accompany a patient to a dental appointment. There were other general duties that all 10:49

staff needed to complete such as putting away the laundry. All staff reviewed the rota at the start of the shift to identify the specific tasks allocated to them and also to assist in the general duties required on the particular shift. 10:49

When I became a senior nurse manager, Band 8A, I was responsible for managing certain aspects pertaining to staff throughout MAH. There were at least four Band 8As and there was a rota for one Band 8A to act as Duty 10:50
Officer on any shift. The role of the Duty Officer was to sort out staffing issues or, if there was an incident or accident on a ward, it was reported to the Duty Officer or any other unusual issues were reported to the Duty Officer. If, for example, a member of 10:50
staff had phoned in sick on one ward, the Duty Officer would need to assess if that ward could cope with the level of staffing available or if staff needed to be moved from one ward to another. The Duty Officer reviewed duty sheets and had to make judgments. 10:50
Sometimes there may have been extra staff on a ward due to a staff member returning earlier than expected from sick leave and cover was already booked, that meant that the Duty Officer could take staff from that ward to the understaffed ward. 10:51

If there were not enough staff, activities needed to be streamlined. For example, instead of ward nurses taking patients to day care, the Duty Officer may have

asked for day care staff to come to the ward and collect the patients or complete the activities on the ward.

Sometimes patient appointments had to be rescheduled. If the Duty Officer really was in difficulty to cover wards safely, the Duty Officer reported this to our manager, H359 up to 2011 and H507 from 2012 until I retired in 2016. They then made a decision and asked me to implement it. The Duty Officer also visited the wards to see what staff needed. Sometimes there were jobs that could be left until the next shift, et cetera. Sometimes relief was requested for an hour to cover meal times. We moved staff about as and when necessary. At times it may have been necessary to close part of the day care and relocate staff towards, but only after discussion with the senior nurse. This included the staffing of Iveagh. At times it was necessary to move staff from the main MAH site to Iveagh to ensure the safety and wellbeing of the patients and staff there. 10:51 10:51 10:52 10:52

As a Band 8A, I monitored compliance regarding patient property and finances. I completed regular random checks on wards. There was a locked cash cabinet on each ward. Each patient had a drawer with their wallet or purse and a spreadsheet which showed all money in and out for that patient. I checked at least three patients' cash drawers on each random visit which were 10:52

conducted at least monthly. I checked what the spreadsheet recorded and checked the amount as against the exact amount of money in the purse or wallet. Staff knew that these checks were being done therefore they were careful to make sure and record what the money was spent on, provide receipts and ensure that the exact money was in the wallet or purse that should have been there. I sometimes reviewed some of the payments to make sure they looked correct, such as if it was recorded that a patient asked for £40 to buy ice cream, I would have said that this was a lot of money and asked for an explanation which was usually that the patient had purchased something else such as an item of clothing when they were out. I would have asked to see the item of clothing. Formal requests also had to be made by nursing staff for larger sums of money. I believe the limit that I could approve per patient was £250. Frequently coming up to Christmas requests would come from staff for up to £250 to be released from the patient's funds to buy clothes. I expected detail as to what the patient intended to buy. I looked for receipts once the items were purchased and I also asked to see the items that were purchased. Any money left over was either returned to the cash office or to the patient's wallet or purse if it was a small amount. In addition to my checks, checks were made at the handover of each shift by the incoming charge nurse. 10:53 10:53 10:53 10:54 10:54

I felt that I had a good support network during my time

in MAH. I felt that I was listened to. As an example, I recall at one time when I was ward sister on Moylena ward that I was having some difficulty with a trainee nurse who was training on one of the wards. The trainee was not completing the tasks that were required of them. The Staff Nurse, who was the trainee's mentor, was reporting this to me and in turn I had to report this to the trainee's tutor. I was being put under pressure by the tutor to sign the trainee off as having performed the tasks which they had not done. I recall speaking to my nursing officer at the time, I cannot recall her name, about this and she told me that if I was not comfortable that the trainee had completed the tasks, then I should not sign the trainee off. I felt supported. I was firm with the tutor advising that if the trainee did not perform the tasks then the trainee would not be signed off as having performed them. I felt supported by my senior on this occasion. 10:54 10:55 10:55

I also recall another occasion that a ward sister, H214, rang me to complain about a doctor refusing to see one of the patients when the nurse was of the view that the patient needed seeing by the doctor. I cannot recall the doctor's name. H214 advised me that she wanted this reported to the consultant, H30. We never needed to make an appointment with more senior management. H214 spoke to H30 and she ordered the doctor to check the patient over. An apology was given by H30 to me and H214. 10:55 10:55

The senior members of staff would listen to what you had to say. I felt that I could raise concerns if I was ever unhappy about something and my concerns would be taken on board and addressed insofar as was possible. I perhaps did not always get what I asked for due to limited resources, but I felt if my request was achieve able it was made to happen. 10:56

Generally some of the managers were more outgoing than others and, as in any jobs, some were better at their jobs than others. Generally the senior management were focused on caring for the patients and making MAH as good as it could be. Senior managers supported and attended all events at MAH, even when they were not on duty. For example, they would call in on Christmas day, even if they were not working, to wish all the patients and staff who were working a merry Christmas. Most of the senior managers came up through the ranks in MAH and knew the challenges experienced by staff looking after the patients. 10:56 10:56 10:57

Admissions to MAH went to Movilla ward if the patient was male and Fintona North ward if the patient was female and children went into the childrens' ward. The nurse in charge generally received information on patients who were being admitted from the consultant who had authorised the admission. For patients who had been admitted to MAH previously there would be a 10:57

clinical file centrally located in MAH with detailed nursing care plans and notes of the patient's health and learning disability. In the last 10 to 15 years of my career there were comprehensive care plans listing all of the patient's needs. It would be very detailed. 10:57
For patients who had not been previously admitted to MAH sometimes the information that was available on admission was limited. I checked what information that I had and completed the admission form. If a new patient came in with family, I would speak to the 10:58
family and record whatever information they could provide to me on the patient. I wanted to understand the individual needs of the patient. I would discuss the patient's diet and sleep patterns and record all of the information that was provided to me. Once the 10:58
patient was admitted I would then attend to any referrals which the patient needed, such as a dental appointment or meeting with a dietician. A day care referral would also be made, if suitable, and a referral to a social worker if the patient did not have 10:58
a community social worker. Observations on the patients would be carried out, such as temperature and blood pressure. The doctor would carry out a physical examination of the patient.

10:58

From about 10 to 15 years before I retired, the focus was on resettlement of patients out of MAH. Therefore, for any admissions to MAH at that time, plans for resettlement of the patient started from their

admission to MAH. Some patients came to MAH for admission by ambulance or police or a social worker."

At the rest of that paragraph the witness gives an example about that type of admission, an emergency type of admission. 10:59

CHAIRPERSON: Are you okay to keep going on, do you need a break?

MS. BRIGGS: I am okay if the stenographer is okay and the Panel is okay. 10:59

CHAIRPERSON: You have got another sort of 25 minutes, 20 minutes.

MS. BRIGGS: I am content to take a break if --

CHAIRPERSON: If we can keep going, that's great, but if you need a break obviously you must have one. 10:59

MS. BRIGGS: No, thank you, Chair. I am okay, thank you for asking. Picking up then at paragraph 51 at page 27.

"In the 10 to 15 years before my retirement, admissions were planned where possible and with a view to the patient staying in MAH for the shortest period of time possible. Discharge planning started from the time of admission. The criteria was stricter for admissions as there was a focus on trying to get the existing 11:00 patients resettled out of MAH instead of taking more patients in.

I recall when I was a senior nurse taking calls out of

hours. I took a call from a doctor in the Causeway Hospital Accident & Emergency department. He advised me that a person with a learning disability had broken his leg and this patient would have to be admitted as his mum would not be able to manage him with the broken leg and an upstairs bedroom. Following discussion with the on-call consultant admission was refused and said that the mum would have to make some adjustments so that she could manage. This was certainly not a crisis scenario. 11:00

I also recall taking a call from a social worker, I do not remember their name, who was attending a patient in a nursing home and the patient would not co-operate. Again, following discussion with the on-call consultant this admission was also refused. 11:01

Once the patient was admitted to MAH a file was obtained from the medical records for each patient. The patient would be allocated to a named nurse who was in charge of the patient. The file contained a description of the patient and a photograph. Patients did not wear name wrist bands. A prescription card sheet listed all medications, doses and the timing of medications. All of the patient's clothing had to be listed and itemised. Their clothes were marked with their name on them. For any valuables such as jewellery and money, these were itemised and deposited into the cash office for safekeeping if appropriate. 11:01

If patients were admitted out of hours we had a night safe to store valuables until the cash office opened the following morning.

The file developed as we learned more information on the patient. It listed everything from diet to activities that the patient liked to do. Everything was recorded in the patient's file, including what and how much they ate at meal times. The file contained information on the patient's physical condition, sleep activity, such as how many pillows they liked to sleep with, and behaviours. It contained an eating plan. The file grew as we learned more information on the patient. It contained details on the patient's spiritual preference. It listed the patient's preferred drinks. It was down to the finest of detail. For longer term patients the staff got to know the patients and their next of kin really well. 11:01 11:02 11:02

I was aware of the risks which each patient could pose, some of which was based on the information in the patient's file and some was from my observation of the particular patients. Some patients had pica, a mental health condition where they lift non-food items and put them into their mouths. This is very dangerous because there is a risk of choking. Some patients did not understand the difference between hot and cold, therefore you would not leave a hot drink beside a patient unsupervised. We had to be careful that the 11:02 11:03

temperature of the water during baths and showers was not too hot or too cold. The patients may not tell you if they were experiencing pain. We had to be vigilant with patients who had a history of self-harm or could attack another patient or staff member. The care plan reflected all of this information. Some patients required one on one supervision. 11:03

The environment we worked in played a big part and it was our responsibility to guarantee patient safety. In Movilla A and Fintona North, the cutlery was counted after every mealtime and put into a locked drawer. If a piece of cutlery was missing we needed to find the item. If it did not turn up we really needed to watch the patients. 11:03 11:04

I recall in the 1980s we had a patient in Fintona North who swallowed batteries. This restricted what the other patients could have as the patient would take the batteries from a radio or Walkman and eat them, which is obviously very dangerous. We did not use proper glasses. We had to be careful to prevent patients hanging themselves therefore curtain poles and shower curtains were designed not to take weight and would come down if weight was attached to them. All staff wore alarms and a fire safety check was conducted on each ward every day. 11:04 11:04

There were risk registers kept at H507's level which

were updated monthly. H507 advised me that she recorded lack of staffing and temporary posts for staff was a risk to the continuation of the service that MAH provided.

I was always happy to see families and visitors to MAH for patients and they were made welcome. There was nothing worse than having a patient who no-one came to visit. I felt sorry for these patients. Families and visitors varied from ward to ward and from patient to patient. Some families talked to me about having guilt that their loved one was in MAH. We had some families whose relatives kept it a secret that the patient was in MAH. Some families were dedicated and visited two or three times per week. There were a number of families who had more than one child in the hospital at any one time."

11:04 11:05 11:05

And the witness in the remainder of that paragraph describes one such family. I am going to pick up at the next paragraph which is paragraph 56 on page 30.

11:05

"Some families or family members felt that we did not provide the care which they expected, it was not good enough. I recall a patient in Fintona North called P165, she had very challenging behaviours. She had been in MAH for a long time. Her brother visited her as often as he could. I recall him approaching me on one occasion and he was annoyed and agitated as P165

11:05

had reported some things to him about her treatment that he was not happy about such as not being allowed to do certain things by the staff. I responded to him to say that P165 was perhaps embellishing the truth a little. I recall P165 had run away from the ward one time. I told P165's brother that I was doing my best but if he was not happy then he was free to take P165 home and care for her himself. He refused and told P165 to behave better for the staff. 11:06

I recall receiving some complaints from family members that the patient's clothes were stained or torn when they came to visit or the patient was not clean. I cannot remember any specific examples, but if I felt that was complaint was warranted I would apologise, if that was necessary, or give an explanation and say that we will try not to let that happen again. I always believed in putting things right with the family if I could. I offered the families the option of making a formal complaint which would be recorded in the complaints book. In fact, sometimes I even encouraged people to make a formal complaint if I felt the issue was justified. I got to know families well as they talked to us when they visit. 11:06 11:07 11:07

I recall investigating a complaint, I cannot remember the name of the patient but he was in Movilla A. But the patient had complained that some of his good clothes and his Walkman had gone missing. Firstly I

had to assess whether he actually had the items he claimed to have lost in the first place. I asked staff if they had seen them. I asked the family if they had taken them home. I recall the patient's brother put a post about me on Facebook saying that he hoped that I was a better nurse than I was an investigator. I recall that if you searched my name on Google this post appeared for a few years afterwards. I was annoyed about that but I let it go in the end. Human Resources did what they could to try and have it removed but they were unable to get the post down. 11:07 11:08

I recall CCTV being talked about for a year or two before I retired. It was always the plan for it to be installed on the newer constructed wards. Some staff had concerns that the installation of CCTV was an invasion of privacy for the patients as sometimes patients would strip off and staff did not think it was appropriate for this to be recorded, I cannot recall who thought this specifically though. H77, Grade 8A, was to be in charge of the CCTV. He was working with ward sisters, charge nurses and medical staff to see how it would be introduced. I cannot recall anyone formally discussing CCTV with me. I was not aware of CCTV being up and running prior to my retirement from MAH but it could have been and I just was not told. 11:08 11:08 11:09

Safeguarding in MAH was taken very seriously. In my experience the health, safety and wellbeing of all

patients was foremost for staff. Staff received training in child protection and care of vulnerable adults. This training was delivered to all staff on site, including non-professional staff. Incidents of physical assault were reported immediately and recorded in accordance with the safeguarding protocol. All completed safeguarding forms were completed by a social worker. The volume of safeguarding incidents were such that a social worker was appointed and given the sole task of managing safeguarding, which was a very complex role. The police were involved and there was a dedicated Police Liaison Officer for MAH. A large proportion of the reported assaults were patient on patient. In those scenarios both families would have been advised of the incident and the police also have been advised. 11:09 11:09 11:10

At some point, I think this may have been in and around 2015, I was told by my senior manager, H507, that the police had asked that not all report forms should be forwarded to them. Apparently D Division, which was a division within the police in the Antrim Area Police Station, had recorded the most assaults in the UK. I believe this was reported in the media at the time. From then on only the more serious assaults or assaults by staff on patients were to be forwarded for consideration by the police." 11:10 11:10

In the first half of paragraph 60, Panel, the witness

describes resettlement in 1970s and 1980s. I am going to pick up about half way through that paragraph, it is about 14 lines down.

"When I was a Band 8A I fed into the multidisciplinary meetings on resettlement. I facilitated staff who knew the patient well to go out on a placement of, say, three weeks to ensure that the patient settled into their new home. I also facilitated care home staff coming into MAH to get to know the patient before they were discharged. The practical side of discharge was the admission process in reverse. The patient was bathed and observations were checked, temperature and blood pressure. The doctor conducted an examination. Patient's belongings, including clothes and valuables, were listed and unpacked. I provided an update to the family and/or the facility that they were being resettled into on the patient's daily routine to include medication, behaviours, sleeping and eating preferences. Sometimes transport was arranged and on occasion a nurse from MAH may have travelled along with the patient to their resettlement residence. I cannot recall any formal training being conducted in respect of the admission or discharge process. It was something that I learned along my career. In the early years I watched how more senior nurses conducted the process and I followed what they did. A lot of this came down to knowing the patient and knowing what they needed on the nursing side to have them discharged.

There were a number of types of restrictive practices used in MAH. They were used as a measure of last resort and with the sole purpose of keeping the patient safe from harm. If they did need to be used, they were 11:12
used for the least amount of time necessary to have the desired outcome. The least restrictive measure was used for the least time as possible. Distraction techniques were always used first, such as taking the patient out for a walk or getting them interested in 11:12
another activity. There were mechanical restraints used such as arm splits, special helmets, bed rails and wheelchair straps. Arm restraints were used for patients who would continually punch themselves in the head or other types of severe self-harm. Helmets were 11:13
used for patients who would repeatedly bang their head against the wall or something else. Sometimes these had chin guards or extensions at the back of the neck to prevent patients from either banging their chin or violently throwing their head back to the point they 11:13
would injure their neck. Helmets were also used for patients with severe epilepsy, if they were mobile, as they were at risk of having a fit and falling to the grounds and banging their head.

11:13

Bed rails were used for patients who were at risk of falling out of bed due to mobility issues. Sometimes these were padded to make sure patients did not bang against them with their arm or other body part and

inflict injury upon themselves. Wheelchair straps and other adaptions were used for patients who had a physical disability which meant they may fall out of a Chair due to poor muscle co-ordination or strength. Every type of mechanical restriction apparatus was made 11:13
onsite in the Orthotics Department. Each device was specially designed for the needs of a particular patient. I never would have used one patient's device on another patient. Each mechanical device was
prescribed by the consultant in charge of the patient 11:14
in MAH. The multidisciplinary team would discuss the issue and we would come up with a way to overcome the problem. The reasons for the introduction of the requirement was recorded in the care plan. The
multidisciplinary team would work with orthotics to 11:14
ensure that the correct device was made. The ability to use the device was recorded in the patient's notes. Each and every time staff decided that they needed to use the device, this was recorded in the patient's
notes and also the period of time that it was used for. 11:14
If the member of staff was junior then they would report the need for the device to be used to the charge nurse prior to using the device. Devices were not used during meal times or going to the toilet. The main
focus was making sure that the patient was safe. The 11:15
need for the use of a particular restrictive practice was continually reviewed by the multidisciplinary team.

The use of PRN medication was another restrictive

practice. This medication was only prescribed by the medical staff, usually the consultant. I do not recall any nurse prescribers in MAH during the time that I worked there. Again this was only used as a measure of last resort with the focus of keeping the patient safe. 11:15
Patients had their usual prescribed medication that they would be given routinely. There was also other medication, such as diazepam, that was prescribed but not to be used routinely. This was only to be used if necessary. All patient medication was listed on a 11:15
Cardex card prescription sheet. It was very comprehensive and listed all medication. Every time medication was given to a patient it was recorded in their clinical notes.

11:16

In the 70s and 80s a written daily report was prepared by the charge nurse for each ward and this was collected at 7 pm each evening and delivered to the nursing office to be reviewed by the nursing officer, which would have been either a Band 8A or an 11:16
experienced Band 7 nurse. As the system became digitised the information was available on the MAH computer system. The daily report would have included if PRN medication was given to a patient, the reason, what we did to try to avoid giving PRN, the dose and if 11:16
the medication had the desired outcome. The nursing officer would have followed up with the charge nurse on each ward, depending upon what was recorded in the daily report. The daily reports were then discussed

with the senior nurse, either H359 or H507, at the 9 a.m. handover.

The daily nightly reports were also available and read by all nursing staff when they came on duty. The content of the report was also discussed at the weekly multidisciplinary meetings in the admission wards. The use of medication generally was also reviewed by the pharmacists in MAH. The pharmacists were the drugs specialists and they understood how one drug interacted with another. If a pharmacist thought that a ward was asking for too much PRN medication they would have asked questions of the charge nurse and also raised this with the consultant. 11:17 11:17

Seclusion was another form of restrictive practice. I recall when I worked in Fintona North in 1983 there was a seclusion room which was a single bedroom with very little in it other than a bed frame and a mattress. Again the use of seclusion could only be used if it was prescribed by the consultant for an individual patient. It was used as a last resort to stop patients harming themselves or other people around them such as other patients, staff or visitors. I recall that staff had two minds on the use of seclusion. It was sad that it needed to be used but it was the last resort if everything else failed. It was used for the least amount of time possible. When seclusion was being used the nurse in charged had to telephone the doctor who 11:17 11:18

would have questioned as to why you were using seclusion. If seclusion was used it was recorded in the care plan and in the clinical notes for the patient. The time seclusion started and the time it ended would all be recorded. We also had to record how 11:18
the patient reacted whilst in seclusion. I recall that a seclusion record book was introduced at some time in the 1990s and then a seclusion care plan was introduced some time in the 2000s. This was a detailed and comprehensive document for each patient. The nurse 11:18
would have initiated the seclusion but it always had to be reported to the doctor. A nurse had to remain outside the seclusion room at all times and had to do a visual check every 15 minutes by engaging with the patient and making sure the patient knew that the nurse 11:19
was there. There were prescribed timeframes, the specific details I do not recall, however if a patient had been in seclusion for more than two hours there had to be a review of the decision to maintain the seclusion by a medical officer. If the patient was in 11:19
seclusion for four hours, both the nursing officer and the medical officer had to visit the ward. I believe that all of the staff in MAH followed the seclusion policy and procedure. The practice of nurses and ward staff was checked by senior management. The number of 11:19
times that seclusion was used on a ward was collated into the weekly and monthly reports and we discussed this at multidisciplinary meetings. We looked at trends and we considered the outcome for the patient.

On many an occasion patients requested seclusion. This is where the patient would be taken to a seclusion room but the room would be unlocked. Some of the patients wanted away from the noise of the ward and wanted some quiet time. This later became known as "time out". This was very much at the patient's request. Through the years patients' doors to their bedrooms operated on the basis of a lock which needed a key to be opened from the outside but the patient could open it without a lock from the inside. Patients liked this as it made them feel safe in their bedrooms. The use of patient requested seclusion was also recorded in the notes, the reason why it was requested, the time it was used and how long it was used for. 11:20

I do not believe that any form of restrictive practice was used by any staff in the hospital until unless the staff member believed that it was needed and it was a measure of last resort. The care plans prescribed it, absolutely everything to do with the patient's day and what they did was recorded in the care plan. It was recorded in the same way as the patients' eating, sleeping, bathing and general caring for an individual with a focus on safety. 11:21

I recall one occasion when the RQIA came on an unannounced inspection in the 2000s. Children were in the Conacre ward. There was considerable building work

taking place in MAH at the time. A lady from RQIA, I cannot recall her name, was irate with me as the front door to the childrens' ward was locked. I explained to her that all of the children were mobile and some were hyperactive. I advised her that there was the usual traffic driving around MAH, but also the traffic from the building works. She was suggesting to me that the door should not be locked. I advised her that I was prepared to live with her criticism as long as I knew that the children would be kept safe from harm. 11:21 11:22

RQIA made regular visits, including unannounced visits to MAH. These visits were followed up with detailed reports on the area or ward expected. These reports were useful for management and staff teams as it provided focus for improvement and at times helped to secure additional funding to undertake these improvements. It was important to have external monitors and to have recommendations as to how we could improve our services. 11:22 11:22

I recall an unannounced visit from RQIA to Greenan ward which was again some time in the 2000s. Two members from RQIA, I cannot recall who they were, appeared in Greenan ward in 6.30 a.m. There was an alleged tip off that nursing staff in MAH were getting the patients out of bed too early due to short staffing of day nurses so that patients would be up and ready for the day when the day staff came on duty. They did not find anything 11:22

on their visit. They did find one or two patients who had decided that they wanted to get out of bed earlier and go to the day room in their dressing gowns to watch some TV. This would have been a norm for some patients who liked to get out of bed early. This was detailed in their care plans. 11:23

Not all wards in MAH were locked. Some wards had capable patients who would get up in the morning, get themselves dressed, have their breakfast and then inform a member of staff that it was their time to go to day care and attended day care themselves. The general rule was that the ward door was locked when it became dark. If the ward door had to be locked at some time during the day in a ward that usually would not be locked, this would have to be reported to the nursing officer with reasons. It could be that a patient was at risk or that there was a security issue. I recall on one occasion a patient had run away from day care and entered Greenan ward and assaulted two vulnerable patients. After this, senior management decided that it was best to have entry pads on the doors. The code was given to all MAH staff who would have required access to that particular ward and also to families who visited frequently. This was to stop strangers coming in to the wards. There was a balance of maintaining safety with the freedom of choice. 11:23 11:23 11:23 11:24

When I was a Band 8A I visited the wards regularly. I

was supervised by my band 8B, H359 and later H507. There were appraisals. I did the same supervision and appraisals with the ward sisters and the charge nurses who in turn undertook these with their staff which included unregistered staff. I would review unqualified staff conducting their work during ward visits. I reviewed ward records and minutes of ward meetings and discussed these with ward sisters and charge nurses. 11:24

I expected staff to adhere to Belfast Trust and MAH policies. There had to be an element of Trust between the ward staff, team and the managers. We tried to recruit the best person for the position. I examined records of the wards and overall how staff managed record keeping. Audits and regular monitoring was conducted by me. One of my best tools was observation when I visited the ward. First impressions told a lot during a ward visit, such as was the ward clean, bright, tidy, warm, well maintained. I also observed whether the patients looked happy. I observed whether the patients were clean, well dressed, well nourished and whether patients were involved in any activities and if staff were engaging with patients. I was also aware of any complaints or compliments received about wards." 11:24 11:25 11:25 11:25

In the first half of paragraph 72, Panel, the witness describes more formal team building exercises. I am

going to pick up about 16 lines down towards the bottom of page 38.

"There were also less formal team building, which I conducted in MAH. For example, if an incident occurred on a ward, I made sure to visit that ward and get all of the team members together to check in on them and make sure they knew that management were aware of the situation. I felt this was important to make sure staff felt supported. I tried to support staff as much as possible, as did the other nurse managers. Sometimes staff were injured and on occasion badly injured performing their duties. I made sure that I met that member of staff and checked to see if they were okay or if they needed to go to hospital. Most of the time the staff member just needed an hour to themselves to come round, but I would have organised for them to be driven home if I thought it was appropriate. There was a counselling service available and I made sure to tell everyone who I thought could benefit from it about it. Attendance was confidential. If staff were off sick or as a result of an injury at work I made sure to keep in touch with them. I facilitated people's return to work by offering them if they wanted to work in a different ward to where the incident took place, but most staff just wanted to return to their usual ward as they liked it and knew the patients. I offered a staff a phased return if that would help. I accommodated any reasonable

11:26 11:26 11:26 11:26 11:27

requests. I made sure that the incident form was completed and this was sent to the Belfast Trust. I encouraged staff to report incidents to the PSNI. Most staff members did not bother. They would respond, "Sure the patient did not mean it." But I felt it was important to have these issues documented even if the PSNI did not advance matters due to the lack of capacity of the patient.

11:27

Staff were entitled to compensation if they were injured at work and it was not their fault. There was a lot of support for nursing staff. I wanted to make sure that I held onto the staff that I had and I wanted to make sure that they were kept safe.

11:27

I, like many staff, was shocked, saddened and a bit angry at the news reports about abuse at MAH. This was not the hospital I remembered or experienced, the hospital that won awards, was referred to as a centre of excellence and visited by other professionals who wanted to learn from us. I worked with and later managed many staff over my time in MAH. I found the majority of staff to be dedicated, caring, and prepared to give their time for the benefit of the patients in their care, despite the lack of resources and the fact that we sometimes felt we were overlooked.

11:28

11:28

I also want to take this opportunity to comment on a paragraph I read in a statement provided to the Inquiry

regarding the people who worked in MAH. It was said in another staff statement that MAH was located in Antrim and run by the people of Antrim. MAH was a regional facility and the only place in Northern Ireland that offered training to become a registered nurse for the mentally deficient, as it was then called in the 70s and 80s. This was later changed to registered nurse for the mentally handicapped and finally registered nurse for learning disability. Staff came from all areas of Northern Ireland and some staff lived in hostel type accommodations on the MAH site. I worked with people from all over Northern Ireland, including Strabane, Derry, Greysteel, Randalstown, Bangor, Belfast and Glengormley. Staff travelled from all over Northern Ireland to work in MAH." 11:28 11:29 11:29

Over the page then, Panel, the witness gives the declaration of truth and signs and dates her statement and that's the end of the statement, Panel.

CHAIRPERSON: Right, thank you very much indeed. I think it's Ms. Bergin who is going to be dealing with the next witness who is also going to be read. We will take a break now. The next statement is much shorter I think. 11:29

MS. BRIGGS: It is. 11:29

CHAIRPERSON: If we come back in at 12.00 and then we'll get that statement read and then we will wait for the afternoon's witness who is coming at 2.00. Yes, thank you.

THE HEARING ADJOURNED FOR A SHORT PERIOD

MS. BERGIN: Good afternoon Chair and Panel. The second statement to be read this afternoon is that of the Witness A8. You will be aware, Chair, that you have already granted two orders in respect of this evidence. The first is a Restriction Order on the 29th of January which is a full reporting Restriction Order 41 and the second is an anonymity application order that you granted on the 29th of January also, so those are orders number 40 and 41. 11:57 11:58

CHAIRPERSON: I'm sorry, I did grant it, but does the Restriction Order that I granted cover the whole statement? 11:58

MS. BERGIN: Yes.

CHAIRPERSON: So we'll have to cut the feed to Room B.

MS. BERGIN: Indeed, before we start.

CHAIRPERSON: And there is to be no reporting in relation to this, okay. 11:58

IN RESTRICTED SESSION

THE HEARING CONTINUED IN OPEN SESSION

11:58

CHAIRPERSON: Okay, thank you. This afternoon's witness is not anonymised and is attending at 2,00,. 2 o'clock.

MS. BERGIN: Yes.

CHAIRPERSON: Okay. Excellent. Thank you very much indeed. Okay, 2 o'clock:

12:26

THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you.
MS. BRIGGS: Afternoon, Panel. The witness this afternoon, is Anne Laverty and her statement reference is at STM-195. 14:00
CHAIRPERSON: Great, shall we get the witness in. There are no issues around restriction orders?
MS. BRIGGS: No issues, Panel.

14:00

ANNE LAVERTY HAVING BEEN SWORN, EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: We've met very briefly in that little room next door, just to welcome you to the Inquiry and thank you very much for coming to help us. And I'm going to hand you over to Ms. Briggs. 14:01
MS. BRIGGS: Thank you, Chair. An, we've met also, I've explained how this works to you earlier. It's going to start with me reading out your statement into the record, okay. After that, I'll have some questions for you, all right. As I've mentioned to you earlier, if you can try to avoid using names where possible, and consult that list in front of you and if the name that you want to use, if it happens at any point isn't on that list, just take a second, pause and you can give us that name at a later stage, okay, and you can refer to a woman or a man or something like that, okay. So, if you are comfortable, I am going to start by 14:01 14:01

reading your statement out, okay. There is a screen in front of you, and you can follow along and also there is a paper copy in front of you there. The statement is dated 23rd of January 2024. And it reads as follows: 14:02

"I, Anne Laverty, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.
My connection with MAH is that I was a dietician at the 14:02
hospital. The role was part-time and equated to 0.6 WTE, whole time equivalent. I was a Senior 1 dietician which is equivalent of a Band 6 today.

The relevant time period that I can speak about is 14:02
between July 1995 and August 2004.

I obtained a degree in dietetics from Queen Margaret University, Edinburgh, and qualified as a dietician in 1979. I worked as a dietician in Scotland and England 14:03
and in a range of roles in hospital and community settings as well as in research. I was a member of the British Dietetic Association and a member of the Mental Health Group before my retirement in 2017. I have conducted research and was co-author of papers on 14:03
various topics, including a study on sunshine, diet and vitamin D for healthy bones and nutrition in Cri-du-Chat syndrome. I contributed to a section of the Manual of Dietetic Practice, various policy

statements for the British Dietetic Association as well as Nutritional Guidelines and Standards for Care Homes for Learning Disability Patients in Northern Ireland.

My husband is from Northern Ireland and we decided to move here from England in 1995. I was looking for a job and I saw an advertisement for a role at MAH in the Belfast Telegraph newspaper. I applied for the role as it was relatively close to our home. I did not have any learning disability experience and did not know anything about MAH. I did not have any learning disability related training as I do not think this existed at the time. I was called for an interview at the Royal Victoria Hospital Belfast, the RVH. The panel consisted of..." 14:04

And there are two females there who you name.

"... and a third person whose name I do not recall. One of the females had been doing the role for some time.

I did not have any friends or family or know anyone at MAH. My induction consisted of that same female showing me around MAH introducing me to staff members and patients, explaining processes to me and the work that she had been doing. Historically, there had never been a dietician in MAH but I understand there was some statement of need in the 1990s which led to the

creation of my role. My line manager..."

And you name that person.

"... was based at the RVH. I attended the RVH for team meetings, for talks, training and networking events. I had regular feedback sessions with the dietetics manager and my appraisals were held in MAH. My first impressions of starting work at MAH was that I was a little apprehensive. I did not have an in-depth knowledge of learning disability. I was a bit taken aback by some of the clients as some of them were quite loud. The appearance of some patients can even be a little shocking. Once I got beyond these initial impressions, I felt that it was a really well run place and the patients were quite content. The locked wards were new to me and it took a little getting used to but I got on with it. 14:05 14:05 14:05

My workload consisted of MAH patients referred by their consultant for dietetic assessment and advice and treatment. There were one or two wards, such as Moylena and perhaps one other, I cannot recall the name of, which may not have needed me and did not refer patients to me, but I was available to all. The reason they would not have needed to refer patients to me may have been because these patients were higher ability, more independent and perhaps unreceptive to dietary advice. There were some wards, such as Rathmore and 14:06 14:06

Rathmullan, which referred more patients to me. Typically, these patients had more complex needs and would require things such as texture modification so I tended to be in these wards a lot. Similarly, Greenan ward referred a more significant number of patients to me than some other wards. These patients required assessment and then texture modification, supplements and obesity management. My typical day would have consisted of checking referrals, assessing patients and making recommendations. 14:06 14:07

I did see variations in culture between wards. For example, wards such as Rathmore or Rathmullan being more like a hospital environment, whereas Fintona or Movilla was a more charged atmosphere which could be attributed to the types of patients and their varying nursing requirements. Certain patients required a different approach, such as on Fintona and Movilla wards, as they were more able bodied with psychiatric needs and with a greater potential for aggression. Their needs were a lot different to Rathmullan and Rathmore where the patients had additional needs and required greater nursing intervention. The differences in culture were related purely to the type of patients they were looking after. 14:07 14:07

I feel that I delivered good care during my time in MAH. Caring for some of the patients was challenging, managing patients obesity, for example, was very

difficult. Relatives would bring in picnics and lots of food treats while we were trying to get patients to eat healthily. Patients also had their own liberty to spend their own money. This was an issue as they brought things which were unhelpful to their diet. 14:08
Other contributing factors to patient obesity included too many sweet treats available, lack of exercise and medications leading to a reduction in metabolic rate.

Another example of good care that I delivered was to 14:08
patients who required tube feeding. I assessed and made recommendations to keep them healthy and to prevent skin breakdown. These were patients with profound physical disabilities and keeping them nourished, their skin healthy and preventing bed sores 14:08
was all down to good nutrition and good nursing. This was delivered by me and other by other MAH staff.

In cases of weight management there were some patients who did lose weight but it was difficult to keep up the 14:09
momentum. Weight maintenance may have been the best possible outcome in many cases.

The children's ward would have had some difficult patients. Fintona had a small number of patients who 14:09
had eating disorders. Many patients had conditions which were difficult to address. I would have used a range of solutions to try to deal with these. For example, I had some patients with autism and I tried

specific diets to help such as a casein free and/or gluten free diet. These had varying degrees of success but there were some who responded quite well. I assessed patients and considered their nutritional requirements, texture modification requirements, swallowing ability, how they tolerated various foods and preparations. This assessment was done in conjunction with a speech and language therapist, SALT, and sometimes with examination at Antrim Area Hospital, Antrim which could include video fluoroscopy. 14:09 14:10

Following decisions made by the SALT regarding texture, I advised on how to provide the prescribed texture including advice on thickening fluids. This advice specified whether food should be pureed, minced, soft, modified texture and whether fluids should be thickened and to what extent. I worked with the kitchen and ensured that nurses were provided with the guidance and training to deliver the required food. I delivered some training for nurses and, in addition, sales representatives from companies providing thickeners would sometimes assist with training. I used thickeners to thicken liquids. These were a gum based substance which had to be used correctly. Not enough and it would be ineffective, too much and it became unpalatable. I also used pre-thickened drinks to deliver nutrition to patients. The pharmacy would get these products in and the nurses would prepare and provide them to the patients. These were all very helpful in keeping patients healthy. 14:10 14:10 14:11

I did not witness any abuse. Some of the patients were very difficult to handle in a way that kept both staff member and patient safe. I would say that nurses dealt with these patients to the best of their abilities. 14:11
Bruising to patients may have been as a consequence of the restraining measures required to keep them safe, but it would not be intentional and I do not think this would be considered abuse. The restraining measures I saw included a lap belt on chairs to prevent patients 14:11
falling forward when rocking as quite a few would exhibit rocking behaviour. Also, one patient had splints on his arms to prevent him bringing his arms up to his face to forcibly hit himself.

14:12
I recall a patient, P1, who had splints on his arm. He was a patient on the children's ward and he was constantly hitting himself. If his splits had not been applied, either in the ward or at home during his home visits, it was evident in a weeping wound on his chin. 14:12
The self-inflicted damage to himself was, therefore, reduced by him wearing splints. A trial of the gluten and casein free diet did seem to help a little with his behavioural problems but not sufficiently so to persevere with such a restrictive regime. It should 14:12
also be noted that someone who continually inflicts pain on themselves does get a satisfying high from it due to release of endorphins, feel good hormones, which makes it difficult to control the behaviour. The MAH

orthotics team would produce various remarkable things to help people, as they did with P1.

I recall once or twice coming to a ward and a patient was being handled out of the ward to a seclusion room. 14:13
This would have been in Fintona and Movilla. I cannot recall exact years this would have taken place. If such incidences were occurring on the ward, I would leave the ward and return at a later date as the nursing staff were often all involved with calming the 14:13
patient. I did not consider it appropriate for me to get involved in any incidents as I was not trained to offer anything towards the situation.

The seclusion rooms were padded and used for the person 14:13
to allow them to calm down without incurring injury to themselves or other patients. I did feel uncomfortable on these occasions. Any time I did witness something like that, the patient would have been supervised by a nurse. I was not aware of patients being kept in the 14:14
seclusion room for longer than absolutely necessary.

In relation to atmosphere on the wards, I was not on a ward long enough to see any differences in culture and atmosphere between shifts and nurses in charge. I 14:14
worked day shifts so I had no insight into care delivered at night. My caseload consisted of patients considered requiring dietetic assessment and referred to me by their consultant.

I felt supported in my role. There were one or two members of staff who I felt could not be bothered with dieticians and got the impression they felt dieticians were a waste of time. However, most of the staff were very co-operative and appreciated what I was trying to do. 14:14

My line management was from the RVH. I had an annual appraisal and these were conducted by the business manager of MAH, H333 and H41. My appraisals were generally all positive producing good outcomes. 14:14

In terms of the culture of management, I would say that MAH was well managed. Each ward was managed by different consultants so there were naturally variations between wards. I got on better with some consultants than others, but generally they were all appreciative of my work. I did have a few differences of opinion with H41. I remember being belittled by H41 in front of two ward sisters. I do not recall specific details, but I remember being spoken to in a condescending way in front of other MAH staff by H41. All other consultants very good to work with, in particular, H90, and another doctor. 14:15 14:15

I felt that I could speak up or report anything about which I was uncomfortable. I felt that I had the facility to report anything of this nature to my line

manager in the RVH or to more senior people in MAH. If something had happened, I would have discussed it with H333 who had responsibility for the Allied Health Professionals, AHPs. AHPs included the SALTs, pharmacists, physiotherapists, dentist, podiatrist, orthotist as well as myself. We regularly met to discuss things such as case loads, working practices, new ideas for service delivery relevant to each specialty such as group sessions with patients or combined sessions between, for example, the SALT and dietician. 14:16 14:16

I do not recall ever complaining to management or otherwise. I would have had serious discussions, which may have been firm, but not complaining as such. An example of this would around my working hours as I felt that the post should be full-time in view of the size of my case load. Another issue would have been around facilitation of research into improving bone health in the patients. At times it was difficult to get full support of all the consultants. My recommendations were largely followed by staff, for example, the texture modification, as they understood the risks were so great. Other recommendations, such as obesity management, may have been more challenging for staff to apply consistently. By and large the nursing staff were as cooperative as they could be. It was a bit of an uphill battle with relatives bringing in food gifts of high calorie snacks. I feel that overfeeding is a 14:16 14:17 14:17

form of abuse really. Some patients were physically sick after a day out with their relatives as they had been overfed. These are things which are not to do with the nurses. Satiety would be deadened with some learning disabilities. A number of patients would not know when they were full and should stop eating. Patients' families may have provided junk food, but some would have fed patients inappropriate textures for someone with a texture modification diet. This represented a choking hazard. I had no control over them and families may have felt that some restrictions, like texture modification, were unnecessary. 14:18 14:18

For the patients who were referred to me, I was aware of their background and their reasons for admission. For the patients on my caseload, I attended ward reviews. These took place at least once a year. For these meetings, I prepared a dietetic report and attended the meeting. I gathered my information for each patient from their notes and records, their referring consultant and from the nursing staff and, where possible, I communicated with the patient where they had the verbal ability. 14:18 14:18

Some families were very involved and they came to the reviews. I think this was a very individual thing. I spoke with those who came to the reviews. With others, it was the opposite and the families did not visit their relative or engage with us. I recall for 14:19

example, one patient, I think it may have been P174, who had no family input. He had Down Syndrome and was at MAH from a very early age. He had no family. I appreciated family involvement as they could understand what we were doing with their family member, and the patient care we were providing to them. 14:19

Many patients were long-term so I would not have been aware of their communication and general ability on admission. When a patient was referred to me I would need to know their level of communication. After receiving the referral I would establish the patient's abilities, including feeding ability, by talking to the nursing staff and reviewing the file. 14:19

I would establish each patient's challenging behaviours and mental health needs upon referral during my first visit to the ward. Doctors, by their nature, tend not to submit all relevant information on the referral and it would be up to me to establish all these points during my visits. I had discussions with nursing staff who were a source of knowledge and insight into the patient. 14:20

I took height, weight, skin integrity, mobility and other measurements during my assessments. I continued these assessments as required. Everyone would be checked regularly on a monthly basis to see what progressed had been made. 14:20

I saw the patient and assessed each individually. I recorded my observations and assessment in my own notes and then on the patient notes. I left dietary information, made sure the nurse was aware and liaised with family members where appropriate. I wrote a reply to the referring doctor to say what I had recommended. I would have obtained information on each patient's vulnerabilities by talking to nursing staff and from the referral itself. 14:20 14:21

An example of recommendations I would have made would be in relation to texture modification. I provided information to the MAH staff caring for a patient and made sure they understood that a patient who was not able to clear their food meant that there was a risk of choking and aspiration pneumonia in the lungs. I provided the information by giving written instructions along with the SALT's information and discussed with the nurse in charge who, in turn, should relay the information to other relevant staff. If a patient attended day care, the staff there would also be informed of the recommendations. The assessment of the risk of choking would have been led by the speech therapist. She would have been telling the staff why to modify the diet. I would have been telling them how. 14:21 14:21

I created diet plans for the patients who needed them

and inserted these into the patient's notes. These included advice and guidance on weight reduction if a person required a diabetic diet. These notes were guidelines for staff. Some patients had specialised diets due to the medication they were taking. This was because of the risk of drug interactions. For example, warfarin and broccoli or cranberry juice would enhance the effect of warfarin. Where a patient was going to be or was already prescribed anti-epileptic or anti-psychotic medication, particularly older types of drugs, I would have advised that the medication could cause weight gain. An example of this was where a patient was going to be prescribed lithium. I would have advised on their diet in advance of going on these medications or when an increased dosage was prescribed. 14:22 14:22 14:23

I would have been advised of the risks that each patient may pose to me, to other staff, to patients, or themselves by the nursing staff. I would not have seen a patient who posed a physical risk to me without being accompanied by another member of MAH staff. 14:23

My examinations normally took place on the ward or in a side room. I would have had a nurse with me who was familiar with the patient and could assist me in my assessment and communicating with the patient in a way that they could understand. 14:23

I recall one incident on Fintona where I needed to

weigh someone in the common area and a patient came for me from behind and hit me between the shoulders. I cannot recall precisely when this happened but would estimate it was in the late 1990s.

14:23

One or two patients came up to the office. These were patients who wanted to attend my office for weight checks and advice. They were higher ability patients who would present with no known risk to my safety. It was to give them a feeling of greater independence and to provide a more personal level of care. My office was quite secluded between Rathmore and Rathmullan wards.

14:24

I would not have been involved in the supervision of patients mealtimes or being fed. I did see some patients being fed and may have occasionally attended patients with a speech therapist to watch a patient swallow, but otherwise I did not regularly input into mealtimes. For more vulnerable patients it would have been an added distraction, having someone like me watching them eat.

14:24

In my role I would not have had any input in relation to restrictive practices. I am not aware whether patients received food in seclusion rooms. I understand that patients were removed from seclusion rooms as soon as they had calmed down. My knowledge of seclusion room use came from conversations with the

14:24

psychologist as well as staff on the wards. I was never asked about food or feeding in seclusion rooms.

There was no CCTV in MAH during my time working there. If one of my referred patients was being made ready for discharge and resettlement, I would have been made aware. I attended meetings about discharge and resettlement. Most of the meetings would have been attended by representatives of the various bodies; MAH staff involved with the patient, the home where the patient was moving to and the patient's family. I was actively involved in discharge planning where appropriate. 14:25 14:25

I always felt that my care was safe and compassionate. I think that the nurses had a hard time to control the patients at times. I did not see any form of abuse but I would not have seen everything. I never worked nights so do not know about that period of time. 14:25

As a dietician, it is part of my job to ensure that dietary advice is tailored to the person's needs, taking into account their likes and dislikes. I cannot just hand out a diet sheet and expect it to suit everyone. For example, for the patients on supplements I worked with the patients and nursing staff to get one that the patient liked. Some liked fruity flavours, some like milky supplements. I would adjust the plan according to the patient. The pudding supplements were 14:26 14:26

probably the most popular as they were sweet and people with learning disabilities often have a sweet tooth.

When I was at MAH I felt that I did get training opportunities. I attended a learning disability 14:26
conference in Seattle in the United states of America. A number of us went there as there was a presentation of our paper on sunshine, diet and healthy bones. I had the opportunity to attend conferences in England and Scotland that were relevant to my work as well as 14:27
meeting with other dieticians in Northern Ireland to keep up-to-date with general advances in dietetics.

I periodically saw management walking on the wards. H333, business manager, and H359 whose role was manager 14:27
of nursing services, I think, were present on wards on a regular basis. I recall Jeffrey Donaldson walking around the wards on one occasion with some of the Belfast Trust Board members.

14:27

The ward changes and mergers happened after I left MAH. Rathmullan and some other wards closed while I worked there. I felt that the ward changes and mergers were handled as best they could be. For example, the patients in Rathmullan were high dependency so it was 14:27
difficult in some cases to get individuals to settle into a new environment.

I feel that the public are not fully aware of some of

the patients that the MAH nurses had to treat. It takes a lot to handle some of these patients. It is very difficult to keep the patient and the staff member safe. I did not see any nursing staff physically abuse any of the patients. I cannot praise the MAH nursing staff highly enough for what they do."

And over the page then, Anne, you give a declaration of truth, you say the contents of this witness statement are true to the best of your knowledge and belief and you say that you produced all the documents which you have access to and which you believe are relevant to the Inquiry's terms of reference. Then you have signed and dated the statement. Okay. 14:28

The first question, Anne, I am going to ask you is a very easy one. Are you content with the contents of your statement, are they true and correct to the best of your knowledge and belief?

A. Yes, I think so, yeah. 14:29

1 Q. Do you wish to adopt that as your evidence to the Inquiry?

A. Yes.

2 Q. All right. I am going to ask you more specific questions about the statement now, okay. The first kind of topic I want to ask you about is your specific role in Muckamore, okay. You mention in your statement how your role was created and you understand that there was a statement of need in the 1990s. Can you recall 14:29

anything more about how your role came into existence?

A. As far as I know there was just a statement of need. Somebody must have said that they would like to investigate the possibility of dietetic services in Muckamore. I don't know how it arose that they actually turned to The Royal for advice on it because, I mean, because it was North and West Belfast Trust at that time, I mean there was a community dietetics service in North and West Belfast. But they turned to The Royal anyway and there was one of the dieticians seconded from The Royal to work in Muckamore and see what the layout was like and what the need was and, once that was established then they advertised my post. 14:29 14:30

3 Q. Okay. So, as far as you are aware before you came into Muckamore then, there wasn't a dietician based in Muckamore, you were the very first; is that right? 14:30

A. Yeah, mhm-mhm. Yeah, the girl that did it, she would just come down on days from The Royal to Muckamore.

4 Q. Yes, you mentioned in your statement someone who showed you around Muckamore at that time, is that the person from RVH that you're talking about? 14:30

A. Yes.

5 Q. And she was based in RVH?

A. Yes.

6 Q. As a dietician; is that right? 14:30

A. As a dietician, yes.

7 Q. You describe in your statement how you didn't have specific training about learning disability because you didn't think it existed at the time. Did you feel that

that hindered you in any way at the start?

A. Not really. I just knuckled down and read as many papers as I could get hold of. There was a psychologist there that had a great interest in nutrition and she was actually doing a degree in nutrition and she had a lot of knowledge between learning disability and the effects of nutrition or poor nutrition on their behaviour, so she was very helpful. There was also a very good library and I could access written articles. 14:31

8 Q. Okay and what about in the years that followed, did you receive any LD, learning disability specific training?

A. I can't think now. I joined the Mental Health Group, which is a subgroup of the British Dietetics Association, so liaising with other dieticians within the same field and attending meetings of the Mental Health Group, that all helped broaden my training. 14:32

9 Q. Your knowledge?

A. I landed up sort of giving more training than what I would be receiving in the end. 14:32

10 Q. You actually gave training, was that in learning disability or in nutrition you mean, when you say you gave training?

A. Nutrition in learning disability. Once I gained the experience over the first probably four or five years then, you know, I would be called upon to give talks to the Mental Health Group. 14:32

11 Q. Okay?

A. About nutrition and learning disability.

12 Q. What training did you get at the very, very start? Was there any formal training process and what did that involve?

A. No formal training in learning disability.

13 Q. Okay? 14:33

A. It was mainly gained just by reading and the knowledge that the dietician that was doing it in these interim years, she was passing on and that psychologist greatly helped me as well.

14 Q. Okay, thank you, Anne. You mentioned in your statement 14:33 about having feedback sessions with the dietetics manager. Was that somebody based in RVH as well?

A. Yes.

15 Q. What would those feedback sessions typically involve?

A. She would have come down every, I don't know, couple of 14:33 months or so just to review my caseload, how I was getting on and how the job was going basically and any problems that I would have had, the types of referrals I was getting.

16 Q. And did you find those sessions useful for yourself? 14:34

A. Oh, yes.

17 Q. And you mentioned how your line manager, they were also based in the RVH, did you have any line management structure within Muckamore itself or was it all out there in the RVH? 14:34

A. Apart from the ones I mentioned that would have kept an eye, basically it was the RVH.

18 Q. So perhaps you had more informal structures within Muckamore but the formal ones were in RVH, is that a

fair way of putting it?

A. Yes, that would be.

19 Q. I want to ask you a little bit about the profile of your patients and how patients came to be referred to you, Anne, okay. Can you tell the Inquiry a little bit about how a patient came to be referred to you, for example, who made the decision to refer? 14:34

A. I would say probably the nurses, you know, the charge nurse, the ward sister might highlight an issue, or the doctors. I mean, obviously senior house officers. I'm trying to think now, it's that long since I worked. 14:35

20 Q. I know it is a long time ago, I appreciate that?

A. I mean if there was a problem with a patient highlighted that they required a specific diet, then there would be a referral card. 14:35

21 Q. That came through on a card written down, did it?

A. Yes, they used the stationery that was originally in The Royal for their dietetic referral at the time.

22 Q. So that would have been filled out by the person referring and that would have come to you? 14:35

A. Yes.

23 Q. Can you recall what kind of information would have been on that card?

A. Basically just the patient's name, date of birth, what else goes on? Sex, where they were, which ward they were on and then reason for referral, whether it be texture modification, diabetic, whatever. Some of them would be very good if they had put on the names of drugs that they were on and whether they were epileptic 14:36

or their sort of diagnosis. But quite often it was maybe just "reduction diet required" or something like that.

24 Q. Okay?

A. Doctors just aren't very good at filling out referral forms. 14:36

25 Q. So it varied a little bit, what you were getting in?

A. Yeah.

26 Q. How many patients would you have had at any one given time, can you recall? 14:36

A. I can't remember. I remember the caseload, I think there was about, what, probably about 350 patients in Muckamore at the time and I would have had probably about 80 on the caseload at one stage. Then it was getting a bit much to handle so began to sort of reduce 14:37 the numbers by taking off the ones that could be managed on the ward just by nursing care and, you know, they were sort of stable and things were going along fine, like their textured diets or whatever. If they were stable then they could just be left to the nurses 14:37 to watch and it would be up to the nurses to call me again if they wanted me to see them again, to try and control the caseload. Because obviously I wasn't getting the hours I worked increased so I had to do something -- 14:38

27 Q. To assist. And did any other dieticians come in to assist with your caseload and take on --

A. No, no.

28 Q. Okay. You describe later on in your statement what you

did when you got a referral and you say you would look at the patient file and speak to nurses and visit the ward. What file did you look at first of all, was it just a general patient file or what was that, can you recall? 14:38

A. It would be the medical notes, all the details.

29 Q. A full set of medical notes for the patient?

A. Yes.

30 Q. Okay. Did you feel that by and large the medical notes and the referral card, that gave you enough information 14:38 or was the visit necessary to see the patient?

A. Well, I would see the nurse as well, whoever nurse was caring for the patient. I would obviously like to see the patient, could not always communicate, but at least if I could put a face to the name, I always liked to be 14:38 able to do that, see who I was talking about, you know. Then discuss with the patient where appropriate.

31 Q. And you say in your statement that Rathmore and Rathmullan wards, they would have made regular referrals to you; is that right? 14:39

A. Yes.

32 Q. The patients there had greater needs, is that a fair way to put it?

A. Yeah, there was a lot of them would have been maybe underweight and needed supplements. 14:39

33 Q. Okay?

A. And texture, modified diets.

34 Q. Okay?

A. I think there was a couple of tube feeds.

35 Q. Would those patients typically have had choking risks as well, those types of patients?

A. Yes.

36 Q. Those types of patients with the greater needs, did they make up the majority of your referrals or less or how many would you say? 14:39

A. Yeah, that would probably have been the majority.

37 Q. Okay. And you mention also Fintona and Movilla wards where you were referred more able bodied patients with psychiatric needs. Did those types of patients, what type of care did they need from you typically? 14:40

A. It would be weight management, obesity, weight management, that's the main ones there, you get the occasional diabetics and that as well.

38 Q. Would some of those patients have displayed challenging behaviours and that was an issue for you to deal with? 14:40

A. Yes, there could have been challenging behaviour but I would always be made aware of it and nurses would accompany me if I was speaking to the patient.

39 Q. Okay. And with those more able patients, how did you balance the need for their autonomy -- or with all patients, how did you balance their need for autonomy with their need for a healthy diet, how do you strike that balance? 14:40

A. It's quite difficult but trying to get them to make small changes in their diet and, you know, you might not achieve much weight loss but if you can at least achieve a weight maintenance, rather than following a strict weight reduction diet that most of us could cope 14:40

with, but they might just be able to, you know, cut out a snack or reduce portion sizes, just making small changes that could make a big difference.

40 Q. Make a difference. Could it be the case that, for example, there was just a food that a patient just couldn't have even though it was their favourite perhaps or how did you strike that balance? 14:41

A. Just reducing quantities and keeping things for special treats. Trying to get them to recognise more that there is no bad foods, just to reduce the quantities and treat it as a treat rather than a regular meal. 14:41

41 Q. Okay. You mention in your statement, you talk about the culture differences between the likes of Rathmore and Rathmullan compared to Fintona and Movilla. You say that the former wards were a bit more like hospitals. Can you tell the Panel a little bit more about the culture differences between the wards? 14:42

A. Well, I suppose Rathmore and Rathmullan were more like a hospital situation in that, you know, they looked in their appearance more hospital-like with the beds and long wards and all. Some of the patients, I mean some did maybe go out to some form of day care or whatever, but, you know, some of them would just be in the ward all the time. Whereas Movilla, Fintona, they would be more abled, they would be going out to day care. Well, there were probably a certain number sitting around in their common rooms and that, you know, they might be watching TV whereas the ones in Rathmullan and Rathmore, they might be watching TV but they wouldn't 14:42 14:42

be able to acknowledge what they were watching or anything like that.

42 Q. Okay.

A. It's probably difficult to explain.

43 Q. No, I understand and you've given us a good overview there, so thank you, Anne. I am going to ask you a little bit more about your assessment of the patients which you describe in your statement when they are referred to you and you make your assessment. You mention in your statement having a speech and language therapist involved in the assessment. Was that the case for every patient that was referred to you? 14:43 14:43

A. No, it would just be the ones required texture modification, if there was any indication that there might be a swallowing problem. 14:43

44 Q. You mention later on in your statement that you would be taking measurements and after assessment you would make regular checks on a monthly basis. What did those type of checks involve?

A. It would be mainly weight we would be looking for, weight monitoring, especially for those on weight management, obviously a monthly weight check. Just to discuss with nurses if there was any sores or that, if some of them would be on supplements and that, any sores developing, bed sores and pressure areas sort of thing. 14:44 14:44

45 Q. Okay?

A. Then initially you would be taking their height as well, obviously you can stand up, you get a height but

otherwise you are doing a sort of demispan, working out the height from.

46 Q. From across here?

A. Across here.

47 Q. One hand to the other? 14:45

A. Yes.

48 Q. All right. You mentioned the day care staff would be informed of your recommendations. Can I ask how would they be informed, would that be through the nurse in charge or was that yourself talking to them or was that 14:45 somebody else?

A. Probably both. I mean, I would have gone into day care to make sure that they knew what was going on. But, I mean, it was also up to the nurses, the nurse might be able to get to the day care staff quicker than me so it 14:45 was up to them as well to inform them.

49 Q. Okay. So it was up to both of you really or was there --

A. Yeah, it would be.

50 Q. Was it expected that the nurse in charge would do that 14:45 or was it expected you would do that or was there any rule about that?

A. It was really up to both of us to inform.

51 Q. You talk in your statement about the difficulties in managing patient obesity and one of the contributing 14:45 factors you describe as being a lack of exercise, okay. Was there anything put in place to try to assist patients with getting their exercise, like exercise classes or an exercise regime?

A. Yeah, well I think walking was about the best they could do really because, you know, there was no sort of exercise classes unless sometimes in the evenings I think some of the nursing staff might have encouraged some sort of exercise video or something.

52 Q. Did you see that happening?

A. No, I never saw that but getting them out to walk a bit more.

53 Q. Is that something you saw happen, Anne, sorry to cut across you? 14:46

A. Yeah.

54 Q. Would you have seen staff members taking patients out for a walk for the purpose of exercise?

A. Yes, trying to get them to walk more. By nature learning disability often tend to be quite lazy and if there is a bus available, they would jump on it so trying to get them to walk to even day care and that. 14:46

55 Q. Was there anyone in charge of that to say this patient should go for a walk on this day and this patient should do this amount of walking, was there anyone who had overall responsibility to ensure the patients got an adequate amount of exercise? 14:47

A. Not really I don't think, unless it was in their care plan to encourage walking a bit. I don't think there was sort of walk this patient for 10 minutes or whatever, you know. 14:47

56 Q. Okay?

A. I don't think there was anything formal set up.

57 Q. Okay. Did you talk to staff about the importance of

exercise or was it more of a nutrition focused role that you had as well as the thickening and the safety for the patients. Did you ever have discussions with staff about the need for a certain patient to take their exercise? 14:47

A. Well I would encourage it, and trying to also get the physiotherapists involved as well to encourage exercise within their capabilities, you know.

58 Q. Okay?

A. I wouldn't want to be advising, you have got to walk somebody if they are not absolutely capable of it, so the physio could have had a bigger role in that part of it to encourage what type of exercises were best. 14:48

59 Q. Were there any policies or set of rules at Muckamore that guided your job, that told you what the dos and don'ts are of working with these patients. Was there anything like that at all that you were aware of, guidance, policy, anything like that at all? 14:48

A. I can't think off-hand, I can't remember.

60 Q. It was a long time ago, okay, all right. Thanks Anne. You describe the difficulties with relatives bringing in treats and picnics for patients and patients being overfed by their relatives. How prevalent was that? 14:48

A. Well, it happened on quite a few occasions but given the size, the number of patients in Muckamore, it wouldn't be a huge problem, but there were certain ones that it was an issue with. 14:49

61 Q. And did you have conversations with the families about that?

A. Again, well, I would seldom see the family, but nurses would, you know, encourage the family not to overfeed. I mean often the families might just turn up at weekends to take them out and, of course, I wasn't there at the weekends. It would be up to the nurses to give them advice and I know that nurses did say they had spoken to the families regarding overfeeding. 14:49

62 Q. Okay. What about the likes of the Cosy Corner, the cafe in Muckamore, did that cause difficulties for you if you had a patient who was on a diet plan? 14:50

A. Yeah.

63 Q. How did that cause difficulties, can you tell us about that?

A. Especially the more able ones would have had their own money to spend and they would go and get treats and chips or whatever they fancied out of the Cosy Corner, yeah. 14:50

64 Q. Was there anything you could do about that to try and mitigate against that?

A. Not really. I mean, you know, they have to get a degree of independence and you can just discourage it or try and restrict it, you know, try and encourage them just to go maybe once a week instead of every day or something like that. 14:50

65 Q. Is that something would you have done, had those types of conversations? 14:50

A. Well just trying to discourage them, yes.

66 Q. You also describe the issues with some types of medication which would slow metabolism. Would you have

been aware before that type of drug was prescribed or increased, I think you mention in your statement that you would be; is that right?

A. Sometimes.

67 Q. Sometimes? 14:51

A. Yeah, often the doctors wouldn't get in touch when they were prescribing it so it would be overlooked until a later date and when the weight had gone on. But, you know, I kept trying to emphasise somebody's medication is being increased or a new one introduced, it is going 14:51 to cause a side effect of weight gain, let's try and step in at the initial point and prevent it, but it didn't always work.

68 Q. Would you have ever had any input to the prescribers to say there is another type of drug which won't have the 14:51 same impact?

A. No, it was really the doctors had the final say in the drugs and you just had to go along with it.

69 Q. Okay. You describe in your statement how you made the diet plans for the patients and you gave information to 14:52 the nurse in charge about the likes of thickening and so on when patients required that, okay. Were you able to monitor how your diet plans and other recommendations like thickening were being used in practice by staff? 14:52

A. Yes, I did see, watch staff making up drinks and things like that, not all the time but, yes.

70 Q. I think you say in your statement that you weren't around at meal times so how would you have known, for

example, that your diet plan was being followed by staff in Muckamore?

A. Again you are just sort of relying on staff having the sense to plates up the correct type of meal for them, you know.

71 Q. Okay. Did you ever worry that your recommendations weren't being followed?

A. Yeah, I think you would be concerned about that, yeah.

72 Q. And what would you do when that type of concern might arise? 14:53

A. Again, the nurse in charge and the referring doctor would discuss it at reviews, sort of thing.

73 Q. And you would raise at reviews -- I don't want to put words in your mouth but you would say you have some concerns that this patient is perhaps not following the 14:53 diet plan or not being permitted to follow the diet plan, is that something that might have happened?

A. Yes.

74 Q. How often did that occur?

A. Well reviews were usually, might have been every six 14:53 months or three months, depending on the individual, you know, but I mean obviously the doctors were all approachable enough in between times if you had concerns.

75 Q. How often would you have had those types of concerns 14:54 that your diet plans weren't being followed?

A. I don't know, I mean just now and again it would crop up as being extremely evident, you know, I can't say how often.

76 Q. Would you say in general there was a concern among Muckamore staff for the nutrition and health of their patients in terms of a healthy diet?

A. Yeah, I would say so because I would say that's why the role was created originally, because the staff saw a need for a dietician to promote a healthy diet to the patients. 14:54

77 Q. I want to move away from dietetics on to a couple of other topics before we finish off, okay. In your statement you talk about some restraining measures that were used on patients and you give the example of lap belts and you describe a patient who had splints on his arms and you mention the orthotics team who made devices like that for patients. Did any of those types of restraint that you saw, those devices, did they ever cause you any concern? 14:55 14:55

A. No.

78 Q. And the Inquiry has heard from an occupational therapist who said that when she arrived in Muckamore, and this was in 2012, okay, she said that she saw comfort chairs with sewn on belts, that they were made on site, okay. Was that similar when you were at Muckamore, 1995 to 2004? She said that the belts were sewn on in the Muckamore site, would you have any knowledge of that or whether that was the case when you were there? 14:55 14:56

A. No, I wouldn't know. I mean there was lap belts but I don't know if they were actually sewn on to anything.

79 Q. You touch upon seclusion in your statement and I want

to ask you a little bit about that. You say you didn't really get involved in seclusion as you weren't trained in it and you describe taking yourself away from the ward whenever an issue arose, isn't that right?

A. Yeah, well I mean if I was wanting to talk to a patient or a nurse, you know, if all that was going on it tended to be all hands on deck to, you know, sort the patient out that was causing the problem. So I mean, I just went away and came back at a more appropriate time. 14:56

80 Q. And did you see anything that caused you concern? I think you mentioned in your statement feeling a little uncomfortable but was there anything that caused you concern when you witnessed that type of thing happening? 14:57

A. Not from a safety point of view. It was just a bit harrowing to watch sometimes, somebody is thrashing out and shouting and screaming.

81 Q. Okay?

A. I mean I could see why they were being taken to the seclusion room because they were thrashing out. They may hurt themselves or distress other patients, so. 14:57

82 Q. And you talk about seclusion and you say the patient would have been supervised by a nurse and you say you weren't aware of patients being kept in a seclusion room for longer than was necessary. 14:57

A. Mm-hm.

83 Q. How did you know those things. Was that based on your conversations?

A. That was based on the conversations that we had with nurses and psychologists.

84 Q. Okay. So it wasn't based on anything that you specifically saw yourself?

A. No. 14:57

85 Q. On the topic of discharge and resettlement, you describe attending meetings about resettlement?

A. Mm-hm.

86 Q. And discharge for your referred patients. Who was your role, can you tell the Panel a little bit about your 14:58 role in relation to resettlement and discharge?

A. Just making sure that the resettlement team were aware of the dietary requirements of that particular patient. You know, these meetings would have been multidisciplinary with the Muckamore staff and the 14:58 consultant and any of the AHPs involved, plus the community team wherever they were being resettled to, whether that be staff from the nursing home or supported living or whatever and even the possible GP that might be taking them on and any other AHPs in the 14:58 community involved, but not dieticians, it was just me because there was no specific learning disability dieticians in the community either.

87 Q. Okay.

A. And we would just then have a meeting and discussing 14:59 the various needs of that patient, so just prepare a report and make sure they knew of the dietary requirements.

88 Q. And would your involvement then end at that stage when

they moved out of Muckamore?

A. When they moved out, yeah, that would be it.

89 Q. The last topic I want to ask you about is just about the management at Muckamore, okay. You talk in your statement about the culture of management and you say that you felt Muckamore was well managed. You describe the AHPs and you say that if something had happened you would have discussed it with H333 whose name will be on that page there, who had responsibility for the Allied Health Professionals, AHPs, and you describe what they included, the SALTs, the pharmacists. You said, "We regularly met to discuss things." When you refer to those meetings are you referring to meetings with H333 or do you mean with the other AHPs? 14:59 15:00

A. We all got together. 15:00

90 Q. Okay and how often was that?

A. It might have been every three months or so, I'm just guessing, it is that long ago.

91 Q. Okay and when we think about all those AHPs and the various different professions that were there at Muckamore, did you feel that all the different types of professions were well respected and equally valued in Muckamore? 15:00

A. Yes, I think so, yeah, we all had a role to play.

92 Q. And you also say in your statement that you felt you could speak up or report anything about which you were uncomfortable and you give some examples of that and I will come to one of those in a second. Can you recall having to ever speak up about anything or report 15:00

anything that related to patient care, patient safety?

A. Em, I can't think of anything, quite honestly.

93 Q. You do give the example of speaking about your workload and that you felt your post should be full-time and you mentioned that earlier. What was the response like to that when you raised that? 15:01

A. A fairly negative response if I recall it. They didn't see that there was a need for any more hours, that I should control my caseload a bit better.

94 Q. Okay? 15:01

A. And I think probably the financial side of it, that there was -- they weren't willing to up the post because of the financial side of it.

95 Q. And, without naming any names, who was it that you spoke to about that, what position were they in? 15:02

A. It would have been a joint discussion between probably H41 and H333, and probably my manager from RVH as well type of thing, round table discussion.

96 Q. Okay. Thinking back to the likes of patient care and patient safety, okay, did you ever have any training or guidance in how to raise concerns or where you should report things to or anything like that, if you saw something that did cause you concern such as a safeguarding incident? 15:02

A. I don't think so, no. 15:03

97 Q. And, Anne, you mentioned seeing the Trust Board and you said you saw them walking around the wards with Jeffrey Donaldson once, did you see the Trust Board walking around the hospital on other occasions?

A. No, I just happened to be on the rounds that day and I met them all outside and was introduced.

98 Q. You spoke to them, did you?

A. Yes.

99 Q. That was the only time that you saw them that you can recall? 15:03

A. Yeah, but I mean that was probably coincidental more than anything.

100 Q. Okay. The last question I have for you is a very, very broad one. Overall how would you describe your experience working in Muckamore? 15:03

A. I enjoyed it. I mean I was enjoying my job and everything, it was just, just before I left Muckamore, well when the job came up in Causeway, I was getting a bit dissatisfied generally because things just weren't the same. There was changes underfoot and the structure of the hospital. The pharmacist was getting shifted to Knockbracken. The physiotherapist that I worked closely with as well, she had gone off, she was in the TA and had gone off to Iraq or somewhere and that sort of disrupted the project that we hoped to do with the sunshine, diet and exercise for healthy bones because we had got a bone scanner and we were beginning to do work on scanning the patients and trying to improve their bone density through healthier eating and getting outdoors a bit more and more exercise. That all just went to the wayside as well because people started moving on. Then the psychologist that I worked closely with sadly passed away in 2001, she was a big 15:04 15:04 15:04

loss as well. Things just started changing from about 2001 onwards.

101 Q. Okay.

A. So I was keen to look for something else and then the job came up in the community, learning disability in Causeway.

102 Q. All right. Anne, that's all the questions I have for you. The Panel might have some questions for you at this stage. Okay? 15:05

15:05

MS. LAVERTY QUESTIONED BY THE PANEL:

103 Q. CHAIRPERSON: You made one comment that some might object to, that by nature learning disability patients tend to be quite lazy, I'm not sure, you are making that as a generalisation or? 15:05

A. Yeah, well some of them obviously are hyperactive but many would be quite lazy, yeah.

104 Q. CHAIRPERSON: It might be said of the general community as well. 15:06

A. They need to be urged to exercise, urged to move.

105 Q. CHAIRPERSON: Well that's what I wanted to ask you about, because diet and exercise are sometimes thought to go hand in hand. If you were recommending a particular diet, was there anybody you would speak to about trying to arrange exercise for patients, was there any -- 15:06

A. Well the physiotherapist would be the one. As I said, I didn't want to be recommending exercise to someone

that has maybe got some physical reason that they can't do lots of walking or whatever. So I would be liaising with the physiotherapists as well over that and trying to promote more exercise, I mean we did do that.

106 Q. CHAIRPERSON: So you would liaise with the physiotherapist? 15:07

A. Yes, mm-hm. But I can't recall any proper, structured form of exercise, it was just trying to get -- I mean the physios would be on the wards anyway and just trying to promote exercise. 15:07

107 Q. CHAIRPERSON: And just so as I understand, you would always only act on referral?

A. Sorry?

108 Q. CHAIRPERSON: You would only act on a referral from the staff at the hospital? 15:07

A. Yep, mm-hm.

109 Q. CHAIRPERSON: Could relatives come to you and ask you to look at their patient relative? Did that ever happen?

A. I mean there is no reason why they couldn't if they had concerns. 15:07

CHAIRPERSON: But did it happen?

A. It never happened, no.

CHAIRPERSON: Was there any channel for that to happen?

A. No, there was no -- I can't recall any relatives directly getting in touch. I mean usually the patient would have been referred and I would have been maybe talking to relatives after the referral, but they wouldn't have. 15:08

110 Q. CHAIRPERSON: They wouldn't have come to you direct?
A. They wouldn't have come to me direct, no.
111 Q. CHAIRPERSON: And you wouldn't aware of any sort of system by which that could be enabled.
A. No. 15:08
CHAIRPERSON: All right. Nothing else. Can I just thank you. I think you are our only dietician, so far at least, so can I thank you very much for coming to assist the Panel. You can now go with the secretary to the Inquiry. 15:08
A. Okay, thank you.
CHAIRPERSON: Right, tomorrow we've got one witness, A5. Can I just say publicly that it is not proposed that the entirety of A5's statement, which is very long, is simply going to be read through, we are not 15:09 going to take the same course with that for obvious reasons. But instead, Mr. McEvoy who is going to be taking the witness will be alighting on various topics as it were. Can I also just say this, I think Room B is open at the moment but it will not be able to be 15:09 opened tomorrow because there will be a full Restriction Order over the evidence of that witness. All right. Can I that thank everybody for their attendance, we'll see you tomorrow at 10 o'clock.
15:09
THE HEARING ADJOURNED UNTIL 10.00AM ON WEDNESDAY, 7TH FEBRUARY, 2024