MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 14TH MAY 2024 - DAY 82

# 82

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

GWEN MALONE STENOGRAPHY SERVICES

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THE INQUIRY RESUMED ON TUESDAY, 14TH MAY 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Right, good morning. Before we start with the witness, I want to deal with a couple of things. The first is to tell you all that I am afraid we are not sitting next week, and I want to apologise to everyone for that because I know how frustrating it is for everybody when you're told that we'll be sitting and we're not. The intention was next week to deal with Modules 1 and 2, but unfortunately we can't serve those statements in time for you to consider them. And, so, we thought it was better to deal with those in the week of the 27th. Now we're not sitting on the 27th itself, of course, because that's a bank holiday, but we will hope to deal with Modules 1, 2 and 3 -- this is obviously the organisational modules -- on the 28th, 29th and 30th.

09:54 09:55 09:55

Can I just say a few words about how we propose in general terms to deal with the modules. The statements will be published -- obviously they'll be sent, first of all to CPs, and they will also be published on the website, and there will be a short presentation in relation to each module by counsel to the Inquiry and, where necessary, witnesses will be called. But I ought to say straight away that it is unlikely that all witnesses will be called in each module, we will assess that as a Panel, and obviously you'll be told when

09:55 09:56

witnesses are coming to give evidence.

Secondly, can I just mention tomorrow. I've already mentioned briefly Geraldine O'Hagan, and I assume that everybody has now read her statement and will know the 09:56
difficulties that she faces. She has indicated that she is very keen indeed to be able to come to hear her statement being read and to be given the opportunity of adding a few words. I have asked for medical evidence to ensure that she is, as it were, safe at least to 09:57
travel and that she will have medical support, but if she does come, then her statement will be read into the record, or precis at least, and then she'll be given the opportunity of adding a few words.

09:57

I am sorry that her exhibits are not yet in a state to be sent to CPs because they need redaction, but you will understand, I hope, why we have taken steps to accelerate her being able to give evidence.

09:57

Can I then deal with what I said I was going to deal with yesterday, which is the Inquiry's approach to staff criticisms of other members of staff.

On the 2nd November last year, I made a statement in 09:58
which I set out how the Inquiry propose to deal with the criticisms of members of staff by patients and their relatives, and it maybe helpful if I now address the similar topic of how the Inquiry proposes to deal

with criticisms of members of staff by other members of staff.

In general terms the principles which I set out in November 2023 are applicable to this issue in much the same way. The Terms of Reference require the Inquiry to look beyond the circumstances of individual witnesses and individual incidents. The Inquiry is required to conduct a careful analysis of how the issue of abuse in its multiple forms developed and impacted on the life of the hospital and its patients. 09:58 09:59

The nature of the Inquiry's work is such as to require a much more holistic type of examination of the facts than in many other legal proceedings. And as for the scale of the Inquiry's work, one can see immediately that it would be impossible, within any reasonable timeframe, for the Inquiry to seek to make findings of fact about individual incidents that have been or may be discussed in the evidence. And, as I said in November last year, no Inquiry of this kind could reasonably be expected to drill down into the multiple incidents and interactions that have been brought to the Inquiry's attention with a view to making specific findings of fact or adjudicating on them. This may come as a disappointment to some. Individuals may very naturally wish their own particular circumstances to be investigated, including some against whom allegations of poor practice have been made. Organisations and authorities too may take issue with some of the 09:59 09:59 10:00

accounts that have been given by witnesses about individual incidents or interactions with staff and others with responsibility for care at the hospital.

It's important, however, that the Inquiry doesn't lose sight of the larger picture. As counsel to the Inquiry noted in his opening remarks back in June of 2022, the Inquiry will need to adopt a suitably proportionate approach to the issues in order to complete its work within a reasonable timeframe. 10:00

It is inevitable, perhaps, that some of the evidence from members of staff will be critical of the actions of other members of staff. Some may wish to recount positive experiences of their time working at the hospital, others maybe highly critical of their colleagues. Some may have critical things to say about how the hospital was managed or about how they were treated as staff. Some may wish to criticise the Trust, the Department or other organisations and authorities responsible for care, inspection and regulation of the hospital. What we as a Panel must do is to focus on the Terms of Reference and the evidence which is most likely to assist us to meet them. It would neither be helpful nor edifying for the Inquiry to attempt to explore or investigate the numerous disputes, either professional or personal, which will inevitably arise in any large organisation employing a large number of people.

So when statements are taken and when those witnesses are called, they will not be asked to deal with complaints or allegations made against them unless an examination of those complaints or allegations will assist the Panel better to understand some feature of the work or management of the hospital which falls within the Terms of Reference. It's important that the Inquiry does not get lost in a quagmire of cross allegations which do not assist the Panel in relation to the Terms of Reference. 10:02

As the Inquiry has progressed we have moved away from the process of having entire statements read into the record. Counsel to the Inquiry, whose job it is to call the evidence, will be expected to focus on that material which is most likely to assist the Panel. This is a Public Inquiry and so its important that anyone listening can understand in general terms the evidence upon which the Panel will focus its attention. There may, therefore, be material in the witness statements which is important to the individual witness to express, but which in fact will not be adduced in evidence because it is unlikely to assist the Panel in its primary function. Although individual witnesses may want to use the Inquiry's process to raise issues or allegations which are of great personal significance to them, it is not part of an Inquiry's function to resolve such issues. 10:02 10:02 10:03

Finally, it's worth bearing in mind that all members of staff who may find themselves criticised have been given or will be given a cipher to protect them as far as possible from public exposure, a very precautionary approach has been taken to that issue of ciphering and that will continue. But it is important, however, to bear in mind, the Restriction Order No. 4, which allowed for the ciphering of members of staff, was explained by the remarks I made on 20th June 2022 and, indeed, in the order itself. This order prohibits the identification of past and present staff members who are implicated in abuse on patients in evidence received by the Inquiry. Their names will be redacted in statements and replaced by ciphers. This does not apply to non-ward based staff in a management or governance role, including members the Trust Board. 10:03 10:03 10:04

All right. Well I hope that that is helpful to you, and Mr. McEvoy are we now ready for the witness?

MR. MCEVOY: Yes. Morning, Chair. Morning. Panel. We are indeed. It is H284. And her statement is 204. 10:04

H284, HAVING AFFIRMED, WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

10:05

CHAIRPERSON: As you probably know you're going to be referred to as H284, which you might find quite difficult, and you'll also have been told that in general terms we're ciphering all members of staff who

you might mention. Please don't get in a panic if you do slip up, mention a name, almost every witness has done so, I'm afraid. But we have a system whereby we can stop the feed that goes to the public hearing, and everybody in this room has signed a confidentiality agreement. But in general terms please, try and stick to the cipher system, and I'll hand you over to Mr. McEvoy.

MR. MCEVOY: Thank you, Chair. Well, good morning H284. We met briefly a little time ago, and as you know my name is Mark McEvoy, I'm one of the Inquiry counsel. I'm going to take you through your evidence this morning. Before you H284 is a little folder with a statement dated 19th February 2024, it's 20 pages in length. Do you recognise that statement as being a statement that you have provided to the Inquiry? 10:06

A. Yes, I do.

1 Q. Is there anything you'd like to add to or amend in that statement?

A. Yes, please. Paragraph 28, the first sentence. 10:06

2 Q. Yes.

A. Commencing with "Recruitment and management" and learning ending with "learning disability structure", that if I could remove that? Just that speaks to a period before I was actually recruited and employed. 10:07

3 Q. Okay. So can we just be clear, you'd like to take out the sentence which starts with what words?

A. "Recruitment and management of social workers".

4 Q. Yes. That first sentence? Yes.

A. Yep.

5 Q. Mhm-mhm.

A. Down through to, ehm...

6 Q. And the next sentence is?

A. "Learning disability structure". 10:07

7 Q. The next sentence as well.

A. Yeah, the next sentence.

8 Q. So it's the first two sentences and you'd like to remove those. All right. Was there anything else?

A. I just would like to add to paragraph 39. 10:07

9 Q. Yes.

A. Just I suppose with further reflection, I recalled -- just to add in, just that I recalled one member of staff commenting to me at one period regarding the patient and staff incidents that were being viewed on 10:08 CCTV for the -- am I allowed to say the ward names?

10 Q. Yes, of course?

A. Yes. The Six Mile Ward.

11 Q. Mhm-mhm.

A. And just that there may have been a misinterpretation 10:08 that this was banter and rough play, rather than what, you know, could be a change to how that was interpreted.

12 Q. Well how about when we go through your evidence I'll take to you that paragraph and I'll allow you to maybe 10:08 discuss that in a more natural way?

A. Okay. Okay.

13 Q. That might do better justice to what it is that you want to add.

A. Okay.

14 Q. But with that initial amendment in mind otherwise are you content to adopt the statement as your evidence to the Inquiry?

A. Yes, I am. 10:08

15 Q. Okay. So H284, you begin your statement then, helpfully, by setting out your background and your connection with Muckamore Abbey. You describe then how you were initially an approved social worker candidate between 2002 and 2003 for two months. You then talk 10:09 about how between 2007 and 2017 you worked as an approved social worker within the Belfast Trust, and then you became an approved social worker within Muckamore Abbey from November 2017 to July 2019. And, therefore, the relevant periods you can tell the 10:09 Inquiry about are between 2002 and 2003, for approximately two months, and November 2017 to July 2019?

A. Mhm-mhm.

16 Q. You then tell us how you have a particular interest in 10:09 learning disability, you have specific family experience of it, and it was one of your motivations to take up a career in social work. You had done some voluntary work, indeed, and then you go on to set out your qualifications and your professional experiences, 10:10 and you ask the Inquiry to note that you did not have family members or friends working at Muckamore. And then you talk about your recollections of that initial placement in Muckamore as a social work

candidate in 2002 for two months, and in paragraph 5 then you say:

"The aim of the placement was to gain professional understanding of working with service users who had learning disability and gain knowledge and skills required to work with this service user group. It was also an opportunity to develop a working knowledge of the Northern Ireland Mental Health legislation and to gain an understanding of what it means for an individual who is detained as a patient within a hospital setting."

If I could ask you, please, to help us with a little bit more around that, so principally your objective being there on placement was learning disability, learning disability education, and so on. You've made reference to developing a working knowledge of the mental health legislation in Northern Ireland and gaining an understanding around individuals who may have been detained. Can the Inquiry take it that there was a mental health aspect to your training, or do you mean this in some less formal way?

A. I suppose social work training means you can work within any programme of care.

17 Q. Yep.

A. But to become an approved social worker you complete this more specific course, and within that you are, do you know, you would have placements within mental

health programme of care and learning disability, obviously they are the two programmes of care that you'd be needing to gain increase in knowledge in order to fulfil the role of an approved social worker.

18 Q. Okay. And, so, even within a two month period in 2002, you got experience of detentions, or seeing detentions at least, mental health detentions that is? 10:12

A. The course itself would have been a longer period of time.

19 Q. Yes. 10:12

A. But you just would have had, you know, shorter placements.

20 Q. Yes.

A. So I wouldn't have been -- at that stage I wouldn't have been witnessed to any detentions to the hospital, to Muckamore, within that course, but I would have been involved -- oh, glory, it's going back so many years now, but I would have been involved with observing detentions to mental health wards, general mental health wards. I can't recall -- there was none during my placement. 10:12 10:12

21 Q. But you had no first hand exposure to detentions and so on during --

A. Not during my placement.

22 Q. That's very helpful. Thank you. Okay. And then you go on in your statement to give us a little bit more detail around your recollection of that placement, which you indeed describe then I think at paragraph 9 as "brief", but you do recall at paragraph 9 that the 10:13

social workers within Muckamore Abbey enjoyed what they did. Thank you. You say that:

"The social workers were committed and passionate about their patients. They put significant effort into progressing discharges and took great enjoyment when a patient was successfully settled into the community. I remember where a resettlement was not successful, staff were disappointed. During this placement I did not see or witness behaviours that caused me concern about the treatment of patients by staff. As a qualified social worker at this time if I observed any risks I would have reported them to H834, the senior social worker, and ensured an adult safeguarding referral was progressed." 10:13 10:13 10:14

You then go on and say that your:

"...first experience of individuals with severe learning disability who had..." 10:14

-- this was your first experience of individuals with severe learning disability who had a diagnosis of mental illness. You tell us that: 10:14

"For many of the patients they viewed Muckamore as home. They were settled with the routine afforded to them and did not want to leave."

You say that you:

"...did not have any individual discussions with many of the patients as my work was task specific but, in general, my experience in Muckamore Abbey at that time was positive." 10:14

And then in the following few paragraphs you talk about your subsequent working experiences as a social worker and, indeed, you mention one in paragraph 12 where you talk about your encounters and contact with a former patient of Muckamore, and that's P206. 10:14

If I could pick up, please, at paragraph 15 then on page 7, and here -- I'm just waiting for it to come up on screen. Yes. Thank you. 10:15

"In August 2017 I applied for a social work position in Muckamore Abbey. It had been advertised on HSC Recruit, the recruitment portal. Having had a positive placement experience before in Muckamore, and knowing that H93 and H84 continued to work in Muckamore Abbey and enjoyed it, I was keen to secure the role." 10:15

I suppose asking more generally about your impressions and, indeed, your colleagues' impressions of Muckamore at that time, would it have been seen as a positive working environment, a positive place for social workers? 10:15

A. When I commenced or prior to my commencement?

23 Q. Prior. I mean obviously it was a factor in your decision to apply for the role. Would that have been a general impression.

A. Prior to my commencement at that time I did link in with H93 and H84, and both of them were very positive and were, yep, 'be great to have you on board' and, you know, just gave that encouragement. I suppose at that stage you're linking in and making sure that it's a place you still would like to work. 10:16

24 Q. And by this stage you've a number of years' experience obviously?

A. Yep. Yep.

25 Q. Yes.

A. On commencement, on the day I did commence, I think I walked into 'Goodness, H284, things have changed here', because at that point things 10:16

26 Q. We'll just stop there. Just one wee second. It's okay.

CHAIRPERSON: Just take a moment. It's fine. Don't worry. It'll come out of the transcript. 10:16

27 Q. MR. MCEVOY: You're okay. So you were telling us then about your first day, I think, is that right?

A. So I suppose on my first day arrival, I think things -- I don't think things had really been released to the media at that stage, but there had just been 'Goodness, this is what's happened and things have changed very quickly'. 10:17

28 Q. Yes. Yes.

A. So, it wasn't where I thought I was going to be working.

29 Q. Yes.

A. Or it wasn't what -- I wasn't going to be doing the work that I thought I was going do. 10:17

30 Q. And in your conversations with is H93 and H84, there was presumably, therefore, no hint that -- they weren't saying to you 'It's a ghastly place to work. There are all sorts of issues', nothing like that?

A. No. I mean it was more this is what has been, or there has been something discovered. They never went into detail of what had been discovered, but just there has been something going on and this is what... 10:17

31 Q. Okay.

A. You know, there'll be changes sort of. 10:18

32 Q. Yeah. In the following paragraphs then you talk about your designation, and you had secured a role as a Band 6 social worker, but as you were an approved social worker your pay scale fell within Band 7, and then you describe where that situated you within the hospital, both physically and what your role was. You remained in that role then, on page 8 paragraph 17, until March '18, and you then say that: 10:18

"I was involved in contributing to care plans to support patients who were to be resettled in the community. I linked in community social workers..." 10:18

-- you say:

"...to obtain a history regarding newly admitted patients and what resulted in hospital admission."

Pausing there for a moment. What was the, or was there, I suppose, a pattern where these patients with learning disabilities, were they patients with perhaps what might be more accurately seen as mental health needs, was there a combination? Can you give us an idea? 10:19

A. Usually admissions would have been around I suppose service users had a deterioration either in mental health, or there had been an increase in their behavioural needs and the support, the level of support that was required, and their current placements not being able to provide the level of support that was needed, so it was a combination of both deterioration in mental health with an increase in behaviours that challenged. 10:19

33 Q. Were there -- thinking back to that time, did you notice any patterns around the issues being experienced by those patients who, for example, had been in placements or had attempted a resettlement, and whether or not those were working as well as had been hoped? 10:19

A. I can't say I noticed any patterns, no. I think it was very isolated incidents of, you know, families, different family circumstances, maybe changes in those circumstances or whatever that led to admissions. 10:20

34 Q. You said that sometimes, and still on paragraph 17:

"Sometimes the resettlement process was without complication and discharges could progress in a timely manner, and other times it took longer depending on the patient's need and available resources." 10:20

Were there any challenges facing you and your colleagues around resettlements at this stage?

A. Ehm, I think for some patients who came in they were able to come in, have a short period of admission and 10:21 become regulated, you know, on medication or whatever, those changes were made, and then they were able to be discharged back to their previous placement. There would have been other service users who would have come in but their placement might no longer be available for 10:21 them going back to, and that would have been problematic then trying to find and identify a suitable placement going forward, and impact then, yes, on resettlement.

35 Q. So would it be fair then to say that the issues were 10:21 more case by case rather than...

A. Absolutely case by case.

36 Q. Rather than structural in terms of...

A. Structural in terms of there wouldn't have been maybe the number of placements, you know there wasn't an 10:21 available infrastructure in the community, but there would have been -- for those service users who came in and had a placement to go back to, do you know, there was no delay and there was no block, but it would have

been for those people who couldn't return home for any particular reason or there just wasn't the available supported living within the community.

37 Q. In paragraph 18 you talk about ward rounds, these were held in an office on given wards, and then you describe the MDT team consisting of a consultant psychiatrist, a medical doctor, a nurse, a day care representative, positive behaviour nurse and social worker. And then you describe the process: 10:22

10:22

"The ward manager or the deputy ward manager provided updates to the team about each patient on the ward. Each patient would be individually discussed with a review of the their current health and medication. They would also report on general behaviour on the ward." 10:23

So that we're clear, is general behaviour the behaviour of all patients?

A. No, it would have been specific to, do you know, you would have went through and discussed that patient and discussed that specific patient. 10:23

38 Q. That specific patient. And that's probably a blindingly obvious question, but we just need to get it clear on the record. And: 10:23

"If there were any incidents that required PRN medication to be administered."

And then you go on to discuss considering interactions between patients on the ward and if there were any safeguarding incidents and discussion around protection plans and input, where necessary, from Allied Health Professionals and psychologists.

In paragraph 19, you go on to talk a little bit more about the use of PRN medication and the need for restraint and seclusion, and you mention how these were discussed with the MDT during the ward rounds. 10:23

"If there was an increase in the use of any of these methods..."

-- you say: 10:24

"...consideration would have been given to the potential cause for escalation and attempts to ascertain alternatives to support appropriate behaviour management." 10:24

Again, when you talk about an increase in the use of any of those methods, i.e., PRN restraint or seclusion, is that with regard to specific patients or?

A. Again it would be specific. If somebody's behaviour had escalated to the level where they required that level of intervention, then it would have been looking at that person as an individual. 10:24

39 Q. Yeah. Outside of -- perhaps even within or outside the

MDT, do you know whether there was any methodology or system in place for cross-referencing rises, for example, in the use of PRN, or indeed restraint or seclusion?

A. I, again, my time on the wards was very time specific and quite time limited, so I'm not sure what was used or what system. I couldn't give... 10:24

40 Q. Yeah. Just so you understand what I mean, like if there had been a concern perhaps, or maybe some method of keeping track of an increase in the use of PRN throughout a ward, would anybody have been apt to pick up on rises across patients in a given ward? If the answer is you don't know, you don't know? 10:25

A. To be honest, I mean, it would be something that the consultant level would probably have been looking at that. 10:25

41 Q. Right.

A. And I don't know, to be honest. I would be...

42 Q. So you think if any thought was given to that it would have been a matter for the consultants? 10:26

A. I think we would all have been, you know, if there had been dramatic increase or something, I would have been, you know, I think everybody has a responsibility to look at that. But I can't say that I noted a time where something peaked to that level where you would have went 'Oh, goodness, there's a pattern here', you know. 10:26

43 Q. Yes. All right. Okay, that's helpful. You then talk about your experience on the Donegore Ward in paragraph

20. You had visited two days a week, one for the MDT meeting and another to speak to patients, and you describe your recollections of your contact with one patient, which you describe as positive, and your impression that the patient really looked forward to the contact. And then again you talk about your time on the Erne Ward. You visited to the patients from the Erne Ward after the ward rounds. You say that:

"For some patients on this ward having another person on the ward tended to escalate behaviour and others were less able to engage with me. When visiting this ward..." 10:26

-- you tell us: 10:27

"...that to complete any individual conversations I would have planned in advance with the ward."

I suppose if it is legitimate to presume, presumably, that would have required good communications with the ward staff? 10:27

A. Mhm-mhm.

44 Q. Was that your experience? Would you have had good communications with them? 10:27

A. Yeah, on the time I worked I would have linked in. It would have been the main -- the ward manager would have been the person I would have linked in with.

45 Q. And in more general terms, throughout your time both in

Donegore and Erne, how would you describe your relationships with the nursing staff?

A. I would have had a positive working relationship with the nursing staff. I'm trying to think, you know, some more would have been more relational than others. I wouldn't have really -- it would have been more the ward managers that I would have had contact with, and a number of the staff nurses, you know, I wouldn't. And I suppose because you were coming from that social work department, it would have been a different kind of relationship, you know, because you were coming to link in to see how protection plan was going. But it would have been positive relationships I would say. 10:28 10:28

46 Q. Okay. At paragraph 22 then you talk about how discharge planning was always on the agenda at MDT meetings: 10:28

"Social work had continued links with the community team to determine what the appropriate placement options were. Community staff would be invited to attend discharge planning meetings to ensure there was a plan in place when the patient was deemed medically fit to discharge. Unfortunately there was not always a suitable option as this was dependent on the complexity of need." 10:29 10:29

Can you give us some idea of the kind of complexities that you're referring to there and how those might have created obstacles to discharge, in your own

recollection?

A. Yeah, I mean from my own recollection it was the level of support required if a patient would become aggressive, you know, and it was that management of behaviours that would have quickly escalated, you know, that would have been then difficult to find that level of support in the community and staff that were able to provide that support.

47 Q. Yeah.

A. I suppose within the hospital environment you had those positive behaviour nurses and that level of support, and you wouldn't really have had the same, you know they would have -- when people were discharging you would have had Out-reach going in to different places.

48 Q. Yeah.

A. For a period of time. And I think it was just trying to find the infrastructure in the community to be able to manage and support that level. You would -- also you've obviously the behaviour side of things, but there's a lot of complex medical needs there for people as well. So it was looking, trying to find a placement that was able to support all of those needs.

49 Q. In paragraph 23, you give a specific example of your involvement in the discharge planning for P109, who had been a patient on the Donegore Ward. You describe how the nursing staff had devised her care plan.

"It was reviewed by the MDT and it ensured that her needs were all considered to ensure the staff due to

support her had insight and understanding into the best way to support her."

You then go on to describe how the MDT provided recommendations and ensured any updates were made. That the patient's mother was a provided with a copy of the care plan and risk assessment and was given time to add any details, as her view was integral to a positive discharge. 10:31

You recollect that: 10:31

"P109's mother was delighted that her daughter was out of Muckamore as she reported she had a number of negative experiences and she clearly stated that she came to harm in Muckamore. I was aware that there were a number of incidents between 109 and another patient on the ward." 10:31

You recollect that: 10:31

"Following safeguarding investigations there was a protection plan in place and that nursing staff found it difficult to implement the plan and incidents continued to happen." 10:32

You recollect that:

"It was always frustrating when another incident was

reported as if the protection plan was implemented comprehensively it may have reduced the potential for further incidents."

You then tell us that: 10:32

"The plan not being implemented was in part due to staffing levels within the hospital. The nursing staff would have confirmed they had not enough staff. I would have held the view closer supervision and 10:32 appropriate engagement could have reduced further incidents."

How aware would you have been of staff shortages?

A. Very aware, because every time you tried to implement a 10:32 protection plan, that would have been one of the things 'We don't have staff to be able to do this', and I suppose for the like of this situation that I have described, I would have been of the view if we were able to keep both of these patients separated and 10:33 engaged in different activities.

50 Q. Yes.

A. That would have reduced the risk of incidents. Whereas they were both maybe sitting in the same ward and, do you know, they didn't get on. And then there were 10:33 other occasions they did get on as patients. But if you had the staffing there and had --

51 Q. There was a risk there that needed to be managed with appropriate numbers of staff?

A. Yeah. Yeah.

CHAIRPERSON: Could I -- sorry.

DR. MAXWELL: Can I ask how you then escalated the fact that the protection plans couldn't be implemented because of lack of staff, who did you tell? 10:33

A. Well, I would have discussed it with the ward manager. H --

DR. MAXWELL: We don't need the name.

A. H835. I would have discussed with her this particular incident or incidents that we're discussing here, and 10:34 then I would have raised it to my line manager, and they would have been aware as well. That would have been H411.

DR. MAXWELL: Did you ever consider filling in a Datix incident form? 10:34

A. Ehm, no, I didn't. I didn't. I would have raised it with my managers and would have had that discussion, and also the consultant psychiatrist would have been aware as well, and probably hindsight, yes, probably a Datix form would have been... 10:34

DR. MAXWELL: Do you know if that ever got put on the Risk Register for Muckamore? I mean Muckamore I think was --

A. Muckamore would have been on the Risk Register for staffing. 10:34

DR. MAXWELL: No, but the lack of staffing being a reason why protection plans couldn't be implemented, do you know if that specifically got onto the Risk Register?

A. I don't know.

DR. MAXWELL: And this was after the concerns had come to light?

A. Yes.

DR. MAXWELL: So implementing protection plans was a very high priority? 10:34

A. Yep, would have been.

DR. MAXWELL: Okay. And can you just tell me the cipher for your manager you reported this to?

A. Ehm, H411. And it would have been -- H425 would also have been aware. 10:35

DR. MAXWELL: Thanks. And did this situation of not having enough staff to implement the protection plans improve or get worse over your time?

A. I wouldn't -- I don't believe it changed over my time there. We tended to try and look at other ways of, you know, as an MDT was there other ways that we could implement protection plans, do you know? We would have tried to have been as -- and I suppose I know that the lack of staffing on the ward as a whole would have been recognised, and there would have been, you know, my seniors would have been having those discussions with their managers. I suppose I would have been aware that those discussions would have been taking place at that more senior level. 10:35 10:36 10:36

DR. MAXWELL: Thank you.

CHAIRPERSON: I was just going to ask a very simple question which is this; was this a common topic of conversation?

A. The lack of staff?

CHAIRPERSON: Yes.

A. Yes, it would have been.

CHAIRPERSON: So you'd be talking about it, the nurses would be talking about it, you escalated it to the manager, the consultant psychiatrist knew about it, and nothing changed? 10:36

A. I know they tried to bring in, or bank staff would have been brought in, but we wouldn't have seen significant changes, no. Staffing remained an issue during my two and a half years. 10:36

CHAIRPERSON: Thank you.

A. At the hospital.

52 Q. MR. MCEVOY: So H284, before we leave this paragraph can I just take you back to, I think it's the third last sentence: 10:37

"The plan not being implemented was in part due to staffing levels within the hospital."

10:37

Were there any other factors?

A. I would have felt there wasn't possibly enough activities on the wards being done, engaging activities on the wards. Service users, patients, would have went to day care and done that, but I think there was too long a period of time with nothing to do, and I think that was the other part then that I would have been -- there just wasn't enough engagement would be my feeling. 10:37

DR. MAXWELL: Was that related to not having staff to do those activities?

A. I think, this is in my view, I think the staff that were there could have been more creative in what they were doing on the wards. 10:38

53 Q. MR. MCEVOY: Okay. At 24 you talk about the potential for patient-on-patient incidents:

"All incidents that resulted in harm or potential harm to a patient was referred within the adult safeguarding 10:38 policy."

And you then go on to discuss how that then would have meant you working in partnership with ward staff to devise a protection plan dependent on the incidents 10:38 referred and how those were tailored to individual needs and so on.

In paragraph 25 you have a specific incident recollected relating to P207 on the Killead Ward who 10:38 was involved in patient-on-patient incidents, and:

"In an effort support her and reduce the attacks on other patients it was recommended by the Social Work Department that an unused area of the ward could be 10:39 modified for her to use as a..."

-- and you put the word in quotes "flat":

"She would still engage with the ward and have meals but when activities had ended she would return to her own area having access to her own living space television and bedroom."

10:39

And you say then:

"The recommendation was presented to the ward manager and the MDT and initially we were advised that it could not be done as there were not enough staff to put it in 10:39 place. As the incidents continued to escalate, this recommendation was eventually put into place. This proved to be a positive step towards the rehabilitation and there was a clear reduction in incidents relating to this patient. Had there been the infrastructure to 10:39 put this plan in place sooner, incidents could have been avoided."

So in this instance you recollect how the reason given by the ward manager was that there weren't going to be 10:40 enough staff to put in place. What changed?

A. Again, that would have been the nursing side of things as to what changed. We are -- recommendations would have been there, and I think it was because the incidents just continued, kept happening and, you know, 10:40 we continued to escalate it that 'we need to do something here'.

54 Q. Yep?

A. And I think it was recognised, 'Yes, this might help

support this patient', for this, you know. And I supposed had she gone into that flat and it not worked, you would have reviewed that and would you have thought, you know, maybe this isn't the right thing.

55 Q. Yep. 10:40

A. But I think it was good that we were able to afford her the opportunity, and it was a more positive experience, and we were able to then progress with this charge and so on because we were able to see and evidence that this sort of environment worked for her. 10:40

56 Q. Yes. And do you recollect whether indeed staff were able to be found to allow it to be put into place?

A. We're going back a long time. So how that all fell into place, I can't remember, to be honest. But staff were obviously -- I don't know whether they needed to 10:41 bring in extra staff or needed extra bank staff or whatever, that bit of it wouldn't have been under my radar, it was just we were told 'yes, we can go ahead and do this', and that's what happened. So how they got the staff, I don't recall, sorry. 10:41

57 Q. That's okay. That's okay. At 26 you tell the Inquiry that it was your view that:

"...patient-on-patient incidents were often a result of boredom. There was a lack engagement with patients. I 10:41 observed this when visiting the ward or viewing incidents on CCTV."

I suppose picking up on the first part of that last

sentence first, that's something that you would have known or would have observed physically being on the ward?

A. Mhm-mhm.

58 Q. Give us an idea of what you would have seen based on your physical appearances or presence on the ward? 10:42

A. There were -- I have to say there was positive experiences as well. I'm not going to say it was all negative.

59 Q. No. Of course. 10:42

A. And there was nothing happening on the wards, because there were occasions definitely when we went in and service users, patients, would have been engaged, and there would have been, you know, games being played, or crafts being done, and programmes being watched, just things that... 10:42

60 Q. Yeah. I mean in fairness you go on in the next sentence to say:

"Not all staff, but on some occasions staff were either not engaging with patients or there was not enough activity." 10:42

A. And it was hard -- I didn't spend all day on wards. I was walking in on, do you know, on occasions. So I could have been walking in and something has just been done and there has been engagement. But on the times then when I'm talking about, you know, you would have had just people sitting, you know, patients sitting 10:42

about. Jerry Springer or whatever on.

61 Q. Yes.

A. Whatever equivalent on, which wouldn't have been an engaging programme, do you know, or This Morning being on -- maybe Jerry Springer is going back too long -- but something like that being on, that wasn't a programme that wasn't engaging for the service users. So it was just, just that wee bit more of creativity. 10:43

62 Q. Would you have passed those observations on?

A. I would have discussed that with ward managers, do you know, 'Is there anything more that can be done?', and again it would have been something that would have been raised and escalated through my own line management structure, yes. 10:43

63 Q. And what sort of response did you get? 10:43

A. Again, the staffing would have become the, you know, 'there's not enough staff', or 'there's not' -- but I suppose for me, as I said sort of previously there, there was creative ways that I felt...

64 Q. Yeah. 10:43

A. Things could have been more engaging on the ward.

65 Q. To use your TV example, your television example, it wouldn't presumably have taken a huge amount of staff to put on a slightly more --

A. Appropriate. 10:44

66 Q. Engaging or appropriate TV programme.

A. That would have been my feeling, yes. And I suppose I'm coming -- I was not a manager on those wards, so I had to escalate to the managers. It wasn't, you

know...

67 Q. Yes.

A. You were being careful not to step on the toes of others as well, because it wasn't my place to go in and say 'Right, let's start doing this', that wasn't my job to do that. So I would have been asking other people to take on that role. 10:44

68 Q. And by "others" whose toes do you mean?

A. If I was to go in and start organising -- as a social worker I wasn't there to -- I wasn't the caregiver for the service users, for the patients. It would have been the role of the nursing staff, the nursing auxiliaries, do you know, to have made sure, and the ward managers to make sure that their staff were... 10:44

69 Q. But I guess a simple and well-intended small measure, like your television example, something you could have -- 10:45

A. Would have been suggested by myself.

70 Q. Yes. You could have suggested that and conveyed it?

A. Yeah, I would have suggested that. 10:45

71 Q. And did you encounter -- I mean was there -- what made you feel that you might have been stepping on toes with other recommendations?

A. Because going in and doing that I was managing their nursing staff, do you know, I'd be telling nursing staff what to do, and that wouldn't have been the role of the social worker on the ward to direct that. 10:45

72 Q. Yeah. And do you say that because somebody told you that or that was your understanding?

A. No, no, it would have been my understanding, just it wouldn't have been --

CHAIRPERSON: Could I just --

PROFESSOR MURPHY: Could I ask -- sorry. Could I just ask about people's day care activities at Moyola? Because we understood at one time people would get like eight sessions a week there, but latterly it went down to five sessions a week. So were there a lot of patients on the ward during the day as opposed to in Moyola when you visited? 10:45 10:46

A. It would have been ward dependent, I think, you know. I wouldn't have been -- I don't recall there being a change in how many sessions people got at day care, and it would have been dependant on what time you would have visited the ward as well whether there would have been a higher number of patients on the ward at any given time. There would have been opportunities to go out and, do you know, there would have been maybe a service user would have gone out with an individual staff member on an activity, or whatever, so there would have been other opportunities that Moyola wouldn't have been the only way off the ward, do you know, there would have been other activities sort of going into the town and so on as well. 10:46 10:47

PROFESSOR MURPHY: Sure. Thank you. 10:47

CHAIRPERSON: I just wonder, did you see any activities on the ward apart from watching Jerry Springer?

A. Again I'm going back a long, you know, because I was a short limited period within Muckamore. Ehm, in my

experience, no.

CHAIRPERSON: I mean you've said you thought people, staff could have been more creative. It wasn't purely a staff shortage issue.

DR. MAXWELL: But you did say that you saw them playing games and doing some crafts on the ward? 10:48

A. There would have been occasions that you'd have know --

DR. MAXWELL: So there was some activity.

A. There were some things that did happen, yes, but there was -- there would have been lots of times there wasn't. But, again, I wasn't on the ward all day, so I can't be sure had they just had their meal and then this was a wee bit of a down time before they went into another activity, do you know. 10:48

CHAIRPERSON: Yes. No, I understand. You weren't spending your entire day on one ward, so you wouldn't get the picture. 10:48

A. Yeah. And hindsight, maybe that's something I could have done. But, again, you had to -- you were in a, you know, you were in a -- I was in, and my job wasn't -- my job wasn't to facilitate, do you know, activities. 10:48

CHAIRPERSON: No, I understand that. Okay.

A. But I do feel that would have been one thing, that if time had of been spent having somebody engaging service users more on the wards. 10:48

CHAIRPERSON: Okay. Thank you.

73 Q. MR. MCEVOY: I think at paragraph 27, H284 -- page 12, thank you. You talk about how some patients, as we

know, had been in Muckamore for a long time and were institutionalised you say:

"When they move into the community they can struggle to settle into their environment." 10:49

And you give the example of a male patient discharged from Muckamore to the community.

"I remember I attended review meetings as a senior social worker in his new accommodation." 10:49

You say that:

"When he was in Muckamore he was supported well with qualified nursing staff and input from PBS nurses and had a robust positive behaviour support plan in place." 10:49

You say then that:

"Despite the level of support on the ward, incidents against staff did happen. The ward staff who cared for the patient had the training and skills to recognise his triggers and engage him as per his PBS plan and thus to reduce the risk of an escalating situation." 10:50

"However, then you say that:

"In the support living unit there were a number of

incidents that developed and placement was at breaking point. Within that unit the staff recruited were Band 3 staff. Although they were provided with a level of training they did not have the knowledge and expertise of a qualified nurse with experience of managing incidents. This experience was not limited to this one service user's experience as generally I found that staff in the community were not adequately skilled to care for the complex needs of our service users. There was not the appropriate infrastructure in the community to have safe discharges. In my view, if qualified nursing staff worked within the community settings appropriate resettlement maybe achievable." 10:50 10:50

So that's a very specific sort of diagnosis and prescription by you of a situation in and around supported living. Did you feed that back to your line managers or to others within Muckamore or broader afield in the management scheme of things? 10:51

A. Yeah, I mean in situations like this it would have been escalated that, you know, there were concerns. I would have held concerns in relation to discharges. Obviously there are very skilled people who work within supported living units, and maybe reading that back it sounds more critical than I intended it to be. There are very very gifted and experienced staff working within units. 10:51 10:51

74 Q. No, of course. Yes. Yes, you're not being personal in what you're saying?

A. No. No, I'm not.
75 Q. That's understood.
A. But I know for, do you know, we had patients within Muckamore who required very high specific care, and staff who maybe, you know, positive behaviour support nurses would have had a very high level of nurse training, they would have had their nurse training and then gone on for further training, and then we were going out to staff who had basic care need training. 10:52
76 Q. Yep. 10:52
A. And managing the same incidents that were being managed.
77 Q. So you'd have escalated the concern that you've described in this paragraph. To whom would you have done that? 10:52
A. I know I reference in a further meeting that I was in that I raised my concerns in the MDT meeting to say 'look, this is' -- I didn't feel that it was -- I felt that the risks were too high to keep a particular service user within the community. So I would have escalated it. 10:53
78 Q. Yes.
A. But that's probably -- you know, what they did with that, I don't know.
79 Q. Yeah. At paragraph 29 then you tell us that you continued to have social worker responsibilities on Donegore Ward until another social worker was recruited. Your manager was now H411, who you've already identified, who was a Band 8A locality manager 10:53

based in the Everton complex.

"H425 was a Band 8B who formed part of the management structure. Neither of them were based on the Muckamore site. Although H411 and H425 were not based on the site they were easily contactable." 10:53

-- you tell us.

A. Mhm-mhm.

80 Q. Would they have visited Muckamore from time to time? 10:54

A. They would have done, yes.

81 Q. How often?

A. Ehm, I would be guessing at how often and how regular.

82 Q. Guess away.

A. Oh, I don't like to guess. I don't know, honestly. 10:54
Weekly. I would say possibly weekly.

83 Q. Right. Okay.

"As a senior social worker..." 10:54

-- then you tell us at paragraph 30:

"...I completed DAPO training. This enabled me to manage referrals under the Adult Safeguarding Policy. H155 was the full-time DAPO and when she was 10:54
unavailable or on leave I managed the safeguarding referrals that progressed in relation to patient-on-patient incidents."

-- you tell us.

"...and any staff-on-patient allegations then went to the community team."

10:55

Overleaf then on page 14 at paragraph 31, as part of your day-to-day role then you describe how you:

"...looked at patient-on-patient incidents and how this could be managed and discussed your observations with ward managers. If incidents were persistent, the situations would have been escalated to Band 8A nurses. I would also have approached the senior male member of staff, whose name I cannot recall, and he took over the management role previously held by H507. When appropriate I would request that he watch CCTV or discuss my proposals in order to help prevent any further patient-on-patient incidents."

10:55

10:55

10:55

I suppose in general terms, from the summer of 2018 and after you became, after you were trained as a DAPO and in your DAPO role, what were your -- in general terms what were your relationships like with nursing staff at all levels?

10:55

A. My relationship wouldn't have changed with them. I do know that, you know, there probably was that feeling, 'Oh, here comes social work again', but we were accepted. Do you know as ward staff we were -- or as staff in the hospital, we were accepted, and in some

10:56

ways were valued, do you know, as part of the team. I think within this working relationship that I would have had, and viewing CCTV when there was patient-on-patient incidents, it was, you know, they appreciated, you know, when I would have come back and said 'Look', do you know, maybe reviewing those situations that we were discussing where, 'Look, this person, this member of staff sitting doing this, but if they were engaging that person that situation may have been avoided'. So when you looked at that with the two members of staff here, they were, you know, able to witness that then on CCTV. Because obviously they, as managers, were not always on wards as well. 10:56 10:56

84 Q. Yes.

A. So this was an opportunity to look at and sort of break down situations, and hopefully have that learning achieved. So our protection plans would then have been based on what we would have witnessed and you would have tried to, through those protection plans, sort of say, 'Look, if the service users could be engaged, do you know, this might not happen', you know. 10:57 10:57

85 Q. Yes. Okay. And so you say then, just on down in paragraph 31 that:

"It was common practice on receipt of safeguarding referrals that the Social Work Department were applicable to review the CCTV footage of the incident to understand the severity, the impact, and ascertain the facts of what happened." 10:57

For the incidents for which you were DAPO then you say that you would have devised a protection plan:

"...and the purpose of the plan was to reduce the likelihood of incidents going forward. The plan would have been shared with the nursing staff and the expectation was that these would be implemented." 10:58

So I guess a little bit earlier you described a reluctance to want to step on toes with suggestions and recommendations when you had physically picked things up on the ward, or picked things up from physical visits to the ward is maybe a better way of putting it, and here now you're making, I guess, recommendations and so on, based on what you've seen? 10:58

A. Based on the safeguarding. Yes. Yes..

86 Q. Yes.

A. I mean I wouldn't have been --

87 Q. Was there a shift? 10:58

A. No, there wasn't a shift. I suppose maybe I haven't described myself properly earlier. It is not that I would have been reluctant to say -- I wouldn't have gone on to a ward and gone to the nursing auxiliaries 'look, you need to do this, you need to do that'. 10:58

88 Q. Yes.

A. I would have went after I would have been on a ward, if I had seen people, and I would have went and spoke to the ward managers and said 'Look, they're doing very

little out there. They maybe need to be.' But then in a safeguarding situation, whenever I was looking at safeguarding and was able to pick up 'Look, this is because A, B and C wasn't happening, or this' -- you know, I was then able to go 'Right, we need to put this in place.' So you were dealing with a very specific situation where social work were looking in on a situation and had to address things. 10:59

The other bit was, you know, I couldn't go in and speak to nursing auxiliaries and Staff Nurses and tell them what to do, but this was a different -- this was a protection plan, where it would have been shared with the nursing staff, the ward managers, and then that would have been fed down to the nursing auxiliaries. So there was a process that we would have went through for this. 10:59 10:59

89 Q. Yes. Yes, and the nurses --

A. If that -- I don't know if I'm differentiating that enough, but that's -- 10:59

90 Q. No, no, no, no. And essentially you're relying on the nursing chain of command to do --

A. Yes. Yes.

91 Q. Yes. On that, the last sentence that I read out there: 11:00

"The plan would have been shared with the nursing staff and the expectation was that these would have been implemented."

Was there any mechanism for following up to see whether or not the plan had been implemented?

A. That would have been discussed then at the ward rounds. We would have been looking at that.

92 Q. Right. Okay? 11:00

A. And there might have been, do you know, yes, linking in with the ward managers and going 'How's things going?', and they would have given you feedback, 'Look, there's no way' -- sorry.

93 Q. It's okay. Just take a moment. It's okay. I don't 11:01 have a transcript, so you were mid-flow there, but maybe someone can just jog us with where you were, but if you're content to pick up where you were?

A. Yeah, no, I'm content. No, they would have come back to me 'Look', you know, and honestly if they would have 11:01 presented a protection plan I obviously would have discussed it with them, but they would have come back and gone 'We don't have the staff to do this', do you know, so that would have been --

DR. MAXWELL: Can I ask, given the nursing staff had 11:01 lots of responsibilities, implementing safeguarding plans was only one, and there were shortages of staff, was there an opportunity for the ward manager to have a discussion you about 'Well, actually, there's another way of achieving the same end'? 11:01

A. Yes, that's where we're talking about. We would have talked through the protection plans in partnership and we would have, do you know, been --

DR. MAXWELL: So it wasn't a social worker saying 'You

must do that', and leaving.

A. No. No, it wasn't. It was we worked together.

DR. MAXWELL: It was, 'Okay, we need to protect the patient. What about this? We adjust it', until you came to something that was workable. 11:01

A. Yes, we would have come to an agreement that was workable, and then even at that sometimes it was just not -- you know. So it wasn't that we were just dictating a protection plan, this was something that was done in partnership with them, or you would have 11:02 gone to them and said 'What do you think we can do here to, you know, to avoid this happening again?'.

DR. MAXWELL: And you had a pre-existing relationship with the nursing staff, so that made it easier to have that conversation? 11:02

A. Yes. Yes. Yes. No, I mean I would have had no problem, would have gone over and just walked into the wards, you know, or the nurses station, and had those conversations with them, you know, and you would have -- as soon as you got something in you'd have done your 11:02 CCTV view, then I would have maybe given them feedback as to what we seen, and worked through what we felt could have been a protection plan.

CHAIRPERSON: And when you're devising a protection plan and you're speaking to nurse managers, or whoever 11:02 it is, presumably you have to take account of the fact that there may be short staffing and you have to be pragmatic about it. So does that form part of the protection plan, as it were? Do you have to take that

into consideration, or do you devise a protection plan which is bells and whistles and icing on the cake?

A. No, you're taking that into consideration, because you've never going to get those bells and whistles and icing on the cake, it wasn't going to happen. So that was all taken into consideration. 11:03

I know the previous incident that we spoke about, referencing P207, that was a very well wished protection plan, but it was the only thing that we as a service felt that we could come up with to protect, because the number of incidents that were happening without that sort of "flat", we weren't going to be able to say that incidents weren't going to happen, and I suppose that's what you're wanting to get to that point where we're reducing the risks of incidents. That was obviously, as I say, turned down by -- initially where they says 'We just can't facilitate that', because in the end because of the number of staff that were needed to manage the incidents, that actually worked out better in the long run. So you were, you know, this was a bit of working with staff and trying to make sure working with the nursing staff and nurse ward managers. 11:03 11:03 11:04

CHAIRPERSON: Okay. I'm just thinking about timing. We've been going an hour and ten minutes. Are you going to finish in the next 15 or 20? 11:04

MR. MCEVOY: Another half an hour possibly.

CHAIRPERSON: Another half an hour. I think we ought

to take a break then. And we've just lost the Secretary to the Inquiry. Could I ask your solicitor to assist and just take the witness to the witness room and we'll see you back in about 15 minutes.

A. Okay. 11:04

CHAIRPERSON: Thank you very much.

A SHORT ADJOURNMENT

THE HEARING RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:04

CHAIRPERSON: Thank you.

MR. MCEVOY: Thank you, Chair. So H284, I'd just like to move on now to discuss with you the topic of the 11:24 CCTV footage, which starts at paragraph 32 of your statement on page 14, and here you tell us that the footage that you reviewed included incidents on Donegore, the forensic ward, Cranfield 1, Cranfield 2 and the Killead Ward. You say that: 11:24

"When reviewing the CCTV you did observe some positive nursing responses to incidents. However, I observed times that patients were not being engaged in activity and it was occasions like this that incidents were more 11:24 likely to take place. I remember watching CCTV footage in relation to an incident on the Killead Ward."

And you go on to describe it then as follows:

"There were two patients involved in this incident. Both were outside in the smoking area. One of the patients was on one-to-one supervision. They should have had a staff member next to them." 11:25

Then you say that:

"The nurses were all standing together and did not have full attention on the patients. It was evident on the 11:25
CCTV that the dynamic between the two patients in the smoking area was escalating and they became physical with each other."

You say that: 11:25

"There were approximately seven staff members at the nurses station when the incident occurred. Given the prescribed one-to-one supervision, staff should have been nearby." 11:25

You say that:

"Had this been the case, this incident would have been avoided. The CCTV showed that the staff reacted within 11:25
a few minutes of the altercation."

You express the view that:

"Their reaction could have been quicker. If the staff had been engaging the patients they would have prevented the incident."

You say that: 11:25

"If staff had been vigilant with their observations they would have noted the change in behaviour and could have de-escalated the situation in an effort to avoid the incident." 11:25

You then say that you feel that or felt that:

"...senior management should view the CCTV footage in order to review the practice and have valued learning 11:26 from the incident. It would have been beneficial to consider the incident and in partnership review what actions on the ward could be improved."

You recollect that you invited H294, the Service 11:26 Manager in Muckamore Abbey, and H426, to watch the footage. You explained to them that:

"...viewing the CCTV footage was a good opportunity for learning and then viewing the incident would ensure 11:26 they could factually consider the details with their senior staff and managers."

And you recall then that you arranged for H294 and H426

to watch the CCTV footage:

"...but they refused to watch the footage on the morning arranged."

11:26

Then you go on and say in the next paragraph:

"I do believe there was a reluctance about watching CCTV. It was seen as a social work tool and not as a means of learning. They expressed that they did not feel nurse managers should be watching CCTV." 11:26

You say that:

"Although H294 and H426 did not watch the CCTV footage I was still keen for them to understand the learning points from the incident you had viewed..." 11:27

And you wrote out a minute by minute detail of the incident, setting out where the staff were standing and what had happened. You were hopeful that some learning was achieved, but you were disappointed by the outcome and refusal of the nurse managers to watch the CCTV, and you expressed the view that: 11:27

11:27

"It was important that you worked together..."

And you feel that you had lost a collaborative connection with senior managers at this time.

Now, were you made of any specific reason, other than one the described, in other words a general -- a view that nurse managers should not be watching CCTV, any specific reason why? 11:27

A. No. I mean on that morning it was all set up, you know, and the nurses were -- the two managers were across the corridor and, you know, then made it clear they weren't coming to watch the CCTV. And as I said, I felt it would have been a good opportunity for 11:28 learning to be achieved. But I felt it was a significant observation of where staff weren't engaging service users and, you know, that there wasn't the activity levels on the ward that should have been on that morning. 11:28

94 Q. Yes.

A. And I suppose the fact that there had been a one-to-one in place, probably from a protection plan, that had that been happening, this incident wouldn't, you know -- 11:28

DR. MAXWELL: When you say "probably from the protection plan", a lot of patients were on different levels of supervision who weren't on protection plans.

A. There would have been, but that could have, you know -- that's what I'm saying -- 11:28

DR. MAXWELL: It might have been, but it might not have been.

A. Yeah, it might have been something from a previous protection plan.

DR. MAXWELL: But it might not have been.

A. It might not have been.

95 Q. MR. MCEVOY: Were you aware of any sort of policy around the viewing of CCTV?

A. There was a long time waiting for the CCTV policy coming into place and I can't recall... 11:29

96 Q. Yeah.

A. ...at that time whether it was in place or not. I would have had -- I suppose the relationship I would have had with the previous managers that I indicated to in earlier parts of my statement, they would have come in and watched the CCTV with me and then would have went to their ward, their respective ward managers, and indicated that this didn't happen, you know, and I felt this was such a significant incident. 11:29

97 Q. Yeah. Yes.

A. That could have been prevented, and I felt that it would have been important for them to have viewed what I had viewed, because it just gave you a better understanding. No matter what I wrote, no matter how, you know, clearly I described it in a report, to me seeing it gave you much better understanding. 11:29

98 Q. Yes. Of one's own --

A. Of where the staff were and what, you know, what should have taken place. 11:30

99 Q. One's own objective viewing, or subjective, indeed, viewing on the CCTV, and what's on the screen in front of you?

A. Yes.

100 Q. But can we take it then, since you haven't made mention of it, that neither H294 nor H426 made reference to a policy or anything accurate in a policy as a basis for not watching the CCTV?

A. No. 11:30

CHAIRPERSON: Were you shown a policy or did you look for a policy?

A. There would have been a policy, and I remember reading a policy, but I can't recall where it fitted with this timeline. I remember reading, it might have been a 11:30 draft policy still at that point, I know it took a long time for the CCTV policy to be finalised, and to be honest I can't fit the timeline.

DR. MAXWELL: We do know that it was approved in June 2017. So there was a policy from June 2017. Are you 11:31 saying that you, when you became a DAPO and were starting to access it, that you weren't aware of the policy?

A. I would have been aware there was a policy, but there was definitely amendments being made to the policy 11:31 during my time, because I remember reading policies that were needing to be -- because I think the June '17, that's how it made H155 I think.

DR. MAXWELL: So you think the policy was updated after June 2017? 11:31

A. Again, we're going back in time here a few years ago, but I think there was discussions around that, yes.

DR. MAXWELL: Because the June 2017 policy is very clear about the purpose for looking at CCTV, and that's

purely as part of an investigation and not as an educational tool?

A. But in my view this was an investigation, do you know, where this was a safeguarding investigation where a patient-on-patient incident had taken place, and this would have been forming part of a protection plan to inform, and it's not an educative tool, but it would have been part of a protection plan to inform. 11:32

DR. MAXWELL: But there is potentially grey area about whether nurses who weren't in the list of people doing the investigation could look at the CCTV? 11:32

A. Mhm-mhm.

DR. MAXWELL: And are you, are you suggesting there might have been an amendment of the policy when this was identified to actually include it as educational tool? 11:32

A. No. No, I'm not. I'm not suggesting that, no.

DR. MAXWELL: Can I ask you just a little bit more about the CCTV viewing, because you mentioned that one of the patients was one-to-one supervision. How much context for a clip of CCTV did you look into? So I recognise it was a long time ago, but would you have actually known why that patient was on one-to-one supervision? 11:33

A. At the time would I have done. 11:33

DR. MAXWELL: You would have done. And there's no sound on the CCTV, I understand. So would you have asked the staff what they were doing at the nurses station, or would you have just observed there was a

group of them there not interacting with the patient?

A. You would have observed. I mean it could have been it was a handover, or it could have -- you know, there could have been any number of reasons. I wasn't just being critical in the fact. 11:33

DR. MAXWELL: Yeah. Yeah.

A. But it was just there were staff standing around the nurses station, but there were patients who were also not being --

DR. MAXWELL: Yeah. Whatever the reason, the point was the patient was left unsupervised. 11:34

A. Regardless of that one-to-one -- what was happening at the nurses station, that one-to-one should have been in place.

DR. MAXWELL: Yes. Thank you. 11:34

101 Q. MR. MCEVOY: Dr. Maxwell I think has already asked you the question, but I just want to give you the opportunity to make sure we have a clear answer from you on it. Where you say in paragraph 33 that in relation to the CCTV it was seen as a social work tool, not as a means of learning. Were you using it as a means of learning? 11:34

A. No, it would have been, as I said, about the -- that -- you know, we would have been reviewing it to see what happened and, yes, there would have been learning come out of it, absolutely. 11:34

102 Q. Yes. Okay. In paragraph 35 on page 16, you say that -- yes, thank you:

"Ward staff knew that witness statements were required when a safeguarding referral was made. I, along with the DAPO, highlighted the importance of these statements..."

11:35

-- you say:

"...and the need for the detail of the incidents to be recorded accurately, and these were recorded on an APP1 Form." 11:35

You observed then or note that:

"Often nursing assistants who were not registered nurses were the witnesses to the incidents. However, 11:35 as they did not have access to PARIS, the recording system to complete the APP1 Form, a senior member of staff entered details on to the system. This meant that there were times information on the system may not have been as accurate as information was relayed to 11:35 them either in person or at a staff handover and recorded at a later stage. The reports recorded on the APP1 Forms did not always reflect what was viewed on CCTV. I recall an incident..."

11:35

-- which you describe:

"...where a patient had a visitor on a ward one weekend and the patient told staff that her brother pulled her

hair. The APP1 recorded that her brother pulled her hair and staff witness statements also recorded that they witnessed the patient having her hair pulled by her brother. When I watched the CCTV footage I saw that her brother put the flat palm of his hand over her head and did not pull her hair. I said to the nursing staff that it was important that staff only record what they see and that they provide accurate information. It was not clear from the CCTV footage where the nursing assistants were, and if they viewed the incident subsequently only writing what the patient stated, not what they witnessed."

So, you had an important message to communicate to the nursing staff, you did that directly? 11:36

A. Did that to the managers of the nursing auxiliaries, yes.

103 Q. Yes. And how was that message received?

A. No, they -- it was received. There was no issue. They understood the importance that, you know, I think given the environment and the anxiety around safeguarding, staff felt they had the right, you know, whereas if they didn't actually see the incident I'm going 'Look, only tell me what you see'. 11:37

104 Q. Yeah. 11:37

A. And that was kind of the message I was trying to convey. Don't just write, because, you know. So that would have been, do you know, I would have been outlining to the managers.

105 Q. And you say that the reports recorded on the APP1 Forms did not always reflect what was viewed on CCTV. How much of an issue was it, this discrepancy?

A. If I'm looking at this particular incident, you can't -- where the CCTV cameras were I couldn't be sure where the staff were, you know, but as I described there it was rather than a hair pull, do you know, it was just the gentleman just did that, you know. I suppose it was something his family member didn't want to be done, but it wasn't the hair pull that had been described, and I suppose the APP1 was indicating that he did pull the hair, so it should have been maybe that this was, you know. 11:38 11:38

106 Q. Yeah. So I suppose maybe I'll put my question to you in a slightly fairer way, which is, you've recorded or recollected one example in a statement here in this paragraph. Were there many such incidences or was it a fairly infrequent occurrence that you would notice a discrepancy between the account and the APP1 Form and what you saw on the CCTV? 11:38 11:39

A. Ehm, I think the --

107 Q. It's your general impression.

A. The general impression is what was said on the APP1 Forms would have been what -- a description to the best of their ability of the incident. I think what I'm trying to get at in this part of the statement, the people who were actually the witness of the incidents weren't always the ones recording, because it was the Band 3 staff, or whatever, the nursing auxiliaries, 11:39

they weren't recording on the system, they didn't have access to the system, so they were telling nursing staff 'This incident happened, this is what happened', and when it happened, do you know.

108 Q. So it was essentially a secondhand account? 11:39

A. It was a secondhand account. I would have preferred it to have been that they had access to record what happened themselves, do you know. I think that would have been -- rather than it be somebody else's interpretation, because then, you know, the witness 11:40 statements then didn't always tally up with what was recorded on the APP1, so you were trying to get that clarification.

109 Q. And Band 3s would have had to, if it got that far, and make witness statements anyway, is that correct? 11:40

A. They would have made the witness statements, yes.

110 Q. So there would have been a requirement for a written statement from them at some stage anyway?

A. Yes. Yes.

111 Q. And so is your point then 'Well, why not just do it?'. 11:40

A. And sometimes you weren't always maybe getting the witness statement immediately, do you know, because obviously they're busy doing other duties as well.

112 Q. Yes.

A. So, you know, you were maybe trying to chase the 11:40 witness statement. So...

113 Q. Would there have been -- I know you're coming from a different discipline, but can you see any practical difficulty with a requirement where a Band 3 might have

been required to there and then, or as close as possible, make a written record?

A. From memory the issue would have been that the nursing staff maybe weren't -- they were busy doing -- you know the Band 5/6s, whatever they were on the ward, would have been busy doing other things, so that they wouldn't have time to go and write the information down as and when the incident actually happened. So. But Band 3 staff were not given access to write in the -- 11:41

DR. MAXWELL: Do you think that made a material difference to your investigation of the incident? 11:41

A. I think it was where there was room for potential misinterpretation from what the, you know, because Chinese whispers sort of thing, where secondhand information. So you're maybe sometimes having to tease out what actually did happen. 11:41

DR. MAXWELL: But by this time you were able to access the CCTV, so you were able to see...

A. Yeah. Yeah.

DR. MAXWELL: ...independently. So it didn't materially affect the outcome? 11:42

A. It didn't materially affect the outcome, no. But it was just -- well maybe I just like everything in square boxes where you like everything to say the same thing, you know. 11:42

DR. MAXWELL: But the challenge was the fact that the Band 3s didn't have access to the PARIS system, which was part of the corporate and regional IT programme?

A. Yeah, I felt that was a part of the challenge. It was

a part of it, yeah.

CHAIRPERSON: Can I just understand how this actually works in a chronological way. If there's an incident and a Band 3 reports it, who then asks for the witness statement or the record? 11:42

A. It would be their manager. It would have been part of the process.

CHAIRPERSON: Right.

A. Because...

CHAIRPERSON: And would you have access to that statement? 11:42

A. Yes.

CHAIRPERSON: Right. Would it be as a result of that, that you would then go and look at the CCTV?

A. It would have been dependant on what was written, do you know, on the APP1 Forms. 11:43

CHAIRPERSON: Right. Would you go further and interview the witness?

A. I don't recall a time that I needed to. Again, I wasn't the only -- you know, I was a sort of step in DAPO, I wouldn't have been the main. 11:43

CHAIRPERSON: Yeah.

A. It wouldn't have been my main responsibilities, so... I think probably H155 would have been more likely to have done that. 11:43

CHAIRPERSON: And...

A. There wasn't an occasion that I needed to -- that I felt that I needed to go and speak to those providing the statements.

CHAIRPERSON: No. Then having gone through that process, presumably there was somewhere a member of staff would need to be reported?

A. Sorry, give me that again?

CHAIRPERSON: What would happen -- if you watched the CCTV, it seemed to be backed up by the statements that you had received, there was an incident, how would you take that forward? 11:44

A. Again, I was -- patient-on-patient incidents.

CHAIRPERSON: No, I'm asking about staff-on-patient incidents. 11:44

A. I wasn't involved on staff-on-patient.

CHAIRPERSON: Right. Okay.

A. They went to -- I was just patient-on-patient. I worked within the hospital. So any staff-on-patient went to the community team investigations. 11:44

CHAIRPERSON: Yes. In relation to patient-on-patient, how would you then take it forward in terms of a protection plan or whatever you needed to do?

A. Yep. So patient-on-patient then we would have linked in with the ward managers, highlighted what, you know, we felt was the issues, and how this had escalated and become -- what happened. And then we would have tried to devise a protection plan. Some of the protection plans we would have seen or, you know, we would have come up with something and then took it to the ward and discussed it with them. 11:44 11:45

CHAIRPERSON: And how quickly would that happen after an incident had been reported?

A. You would have been looking at it -- for patient-on-patient incidents you would have been looking for like something to happen immediately, do you know, to try and get things into play. You weren't waiting days. Things needed amended then, potentially, as you went through. I wouldn't have been going and looking at CCTV and then coming back. You would have looked at the incident from what was written on the APP1 Form, linked in within -- as soon as you seen it.

CHAIRPERSON: So it would be within a day. 11:45

A. Oh, absolutely, yes. Yes, it would have been within a day you would have been...

CHAIRPERSON: Okay.

A. Weekend would have been different, because we weren't there. But the wards themselves had responsibility to put, you know, an initial protection plan, and let us know what they did. 11:45

CHAIRPERSON: Right. Okay. Thank you.

A. Do you know, there would have been that onus on the ward managers to go 'Right, this is an incident that has happened. We need to try and avoid this happening again.' So they would have had that immediate responsibility and then we would have come alongside them. 11:46

CHAIRPERSON: Thank you. 11:46

114 Q. MR. MCEVOY: Now, in paragraph 36 then you say that:

"As part of safeguarding investigations I also met with the patients involved in the incident to get their view

of what happened and consider how safe they felt on the ward. It was important to get patient views on incidents. Capacity and communication could sometimes be a barrier. We developed a tool to support communication and determine that patients felt safe following the implementation of protection plans. This was developed alongside speech and language and behavioural support nurses. When I spoke to patients I asked them how safe they felt before an incident they were involved in and how they felt after the incident. I asked if they felt safer after the protection plan was put in place following the incident. I found that when service users knew what was put into place to protect them that they provided positive feedback." 11:46 11:46 11:47

So can you tell us a little bit about this tool and how it worked?

A. I will tell you, this was devised while I was still in employment, and this was sort of only being piloted and trialed as I was leaving. 11:47

115 Q. Okay.

A. So whether they kept it, I don't know. It was sort of social work led to try and just get that feedback from service users. So I probably spoke with a couple of service users after incidents, and then my social work staff would have followed on then, that would have been their responsibility then. So I don't know how widely used this was following my departure. 11:47

116 Q. Mhm-mhm.

A. But you did -- I mean even before this was devised you would have been going over and finding out how a service user was following an incident, and making sure that they felt okay and that they felt safe.

117 Q. Yes. 11:48

A. So, you know, you would have been sort of discussing that with them. But this tool sort of did help break it down.

118 Q. Okay. Was it just for use by you and your team on patient-on-patient incidents? 11:48

A. Yes, patient-on-patient. It wasn't -- it didn't go wider. Whether it did eventually, I don't know, but this was just us on our patient-on-patient incidents.

119 Q. Okay. And then in paragraph 37, you tell us that several months before you left Muckamore: 11:48

"...it was determined that social workers were to move to the wards they supported..."

And you then moved from the administration building to the Cranfield building with your office situated between Cranfield 1 and Cranfield 2: 11:48

"H155, the DAPO, remained in the administration building." 11:49

One of your other colleagues, H84, worked in Killead, and H93 covered Cranfield 1 and 2.

"There were agency social workers recruited at this time and they moved to their respective wards."

The move didn't change your role, although your office was closer to the ward you feel it didn't impact on day-to-day functioning on the ward from a social work manager's perspective. What about its effect on relationships with the nursing staff? 11:49

A. I mean this was -- for me, as the social work manager, it didn't change, because I was -- instead of being in one building I was in another, and it was an extra five steps possibly, do you know, it wasn't a significant, you know, change for me. 11:49

120 Q. Yes.

A. I still would have been going over to the wards and speaking to them. So that move itself didn't have an impact for me. Possibly for some of the social work staff, they were, you know, sitting on their wards, so they maybe would have been there, you know, and able to engage. I think there was more maybe ability for the nursing staff to come in and say 'What do you think?' Or, you know, or maybe more available to patients. But for me as a manager I don't believe that where my office was situated made a difference to those relationships that I had. 11:50 11:50

121 Q. At paragraph 38 then, you describe how protection plans were often put in place in conjunction with the ward staff, but you say that you were weren't always confident that these plans were effectively

implemented. You say that you raised this with your management and hospital management:

"I would have been told by hospital management they could not always implement the strategies due to staffing levels. In part I accepted this, however, I did not feel this was strictly the case as indicated in the incident mentioned above. As a social work department, families would contact our service on the ward and inform them of yet another incident involving their loved one. Following safeguarding incidents we would have informed families of the strategies put in place to protect their loved one. It was very difficult to continue to provide reassurance that something would change on the ward and plans would be implemented fully. I remember one family were distraught about incidents that had occurred despite plans clearly agreed." 11:51 11:51 11:51

And then you go on to describe one put in place in relation to a sort of a PICA, that it was required in respect of one patient. 11:51

"...not always completed and led to the patient's safety being compromised. We would have been told that due to staffing levels the route could not be checked." 11:52

Can you tell us about how, or can you tell us, I guess in your own words, why you think it was that such plans

were not always effectively implemented? You express some acceptance around the explanation of staffing levels, but what other factors were at play?

A. A lot of the protection plans were about that engagement of service users and, you know, trying to keep one person engaged in an activity at one part of the ward and another person engaged in an activity at another, to try and keep them separated. So some of it was down to, as we said, the inactivity on the ward, and to me that, as well as staffing levels, all of it, it is a bit interlinked and so on, but that I think was the impact. 11:52 11:53

122 Q. So if I could characterise it this way, and you can disagree with me if it's not correct, but one part of the criticism which you're prepared to accept is quantity related in terms of levels of staff, the amount of staff available, but there's another concern that you're expressing and which is really around the quality of what's being provided by the staff -- 11:53

A. The level of engagement. 11:53

123 Q. And do you know whether over the medium or longer term that was, or can you say whether that was addressed to your satisfaction?

A. It would have been raised and escalated through line management structures. Did I see improvements and changes? Sometimes you think you did see glimmers of hope, but I can't say whether that happened for the longer term, you know. 11:53

124 Q. Okay. Now in paragraph 39, you go back to mention the

CCTV findings and you say that over your time in Muckamore Abbey:

"...I did have some nursing staff raise general discussion regarding the CCTV findings. I found that the nursing staff found it impossible to believe that colleagues who had been suspended could have been abusive to patients on the ward. They would have suggested that all that could have been seen on the CCTV was perhaps bad MAPA technique." 11:54

You say that:

"I would not comment on any of these discussions as I did not have any informed information to provide. I was not involved in the viewing of the historical CCTV from 2017, or indeed staff patient incidents. I knew from what was in the media and due to the level of investigation and police involvement..." 11:54

-- you've said in your statement: 11:55

"..that this was indeed more than bad MAPA."

Now you expressed at the outset of your evidence this morning maybe a wish to add something to that? 11:55

A. Yeah, it was just a further one comment from a staff member from the Six Mile Ward, who did say that potentially, do you know, I suppose people were talking

about 'Oh, it's just bad MAPA' --

125 Q. I just want to make sure you get this across correctly, okay, and accurately. So you recall a comment from a staff member on Six Mile?

A. Yep. 11:55

126 Q. Okay. And can you recall roughly when the comment was approximately?

A. Oh, goodness. Ehm...

127 Q. It doesn't ...

A. Probably about the middle of my time, because I was still in the office space. 11:55

128 Q. Your time as a?

A. In the admin building.

129 Q. Yes.

A. So I was senior social worker at the time. And it was just a comment, do you know, that he would have held concerns that there was people viewing the staff-on-patient incidents would misinterpret some of the banter on their ward and their rough play as abuse or whatever. I don't know that you would use that word, but just that their way of engaging the staff or the patients would have been mis -- you know, could have been misrepresented from the banter and the rough play that they might have had on the ward, and their method of communicating and engaging. 11:56 11:56

130 Q. Okay. So was this said in the context of a discussion or conversation?

A. Just said as I was walking out the door one evening, and I sort of pulled back and chatted with him, you

know, and I just said 'Like, you know, I'm not a part of that.'

131 Q. You said that?

A. Yep. 'I don't see that, so I don't know what they're viewing, but that it should all come out', you know, whatever happened after. 11:57

132 Q. And it's something that's resonated with you?

A. It's just been a comment that stuck, yeah.

133 Q. Yeah. And why is that, do you think?

A. I suppose anything that was around those comments, you know, because I mean staff -- there was a lot of it where they were like in disbelief because they couldn't understand that there was anything wrong, so I was getting that as a social worker going on to the ward, it was like 'They couldn't have seen anything', do you know, 'nothing bad has happened, it must be just bad MAPA that's been witnessed', do you know. So that was the sort of feel from staff. But -- and I think for me, as being a member of staff working within that hospital context, having that removal and not being a member of staff watching the CCTV of those staff-on-patient incidents, I think that was a good call, because it kept that very, you know, those boundaries clear. 11:57 11:57 11:57

134 Q. Yeah. And I suppose just to give you an opportunity to clarify it, if you want, but your final sentence in the paragraph is: 11:58

"I knew from what was in the media and due to the level

of investigation and police involvement that this was indeed more than bad MAPA."

A. Mhm-mhm.

135 Q. You hadn't seen the CCTV yourself? 11:58

A. No.

136 Q. So what allowed you to form that opinion?

A. Just because it wasn't, you know, if it was just bad MAPA it wouldn't have become what it was.

137 Q. Yes. Okay. 11:58

DR. MAXWELL: So that's your personal view rather than based on having seen any of the evidence about it?

A. I wouldn't have seen any...

CHAIRPERSON: It's what you picked up from the media?

A. What I picked up from the media, yeah. 11:58

CHAIRPERSON: Yes. Okay.

A. And what I picked up from the anxiety in the hospital and the escalation of, you know, everything was under the microscope and you knew it was because of what was happening. I certainly... 11:58

138 Q. MR. MCEVOY: So given the level of seriousness that was being.

A. Yeah, yeah. So you knew from that it certainly wasn't -- because it was -- there was very strict, do you know, boundaries in what was shared. 11:59

139 Q. Yes.

DR. MAXWELL: Can I just ask you about that, because we've heard from some of the nursing staff that there was a real culture of fear at that time because they

didn't -- they were really shocked at these findings, and people were being sort of suspended, they were sort of there one minute and not another. Were you aware of that and was that --

A. That people were being suspended? Oh, absolutely. 11:59

DR. MAXWELL: No, were you aware of the fear amongst the staff who were not suspended?

A. Yeah. Yeah.

DR. MAXWELL: And we have also heard them say that that made them reluctant to engage with patients in case it 11:59 was misrepresented on CCTV. Were you aware of that?

A. Nobody would have said they would have been reluctant to engage with patients because of fear. That certainly wasn't anything that was commented or spoken to me. I would have been aware of the fear, and I 11:59 think the like of those witness statements, people were going 'Oh, I better write a witness statement here', do you know, you felt -- because that was part of that fear that they felt that safeguarding would come down on them with a big stick if they didn't write this 12:00 witness statement, you know. So you were trying to engage and make sure that they knew 'Look, no, this is about us working together and this is about us having that partnership working.'

DR. MAXWELL: So, was it the case for some staff that 12:00 they weren't quite clear where the threshold for abuse was? What was banter and what was abuse. That they were --

A. I think they -- I mean we would have done -- there

would have been training, they would have known what was safeguarding and what was -- you know, they would have known what those boundaries were. I think that would have been, do you know. We would have taken training sessions. Well, there would have been training sessions within the hospital.

DR. MAXWELL: So in the training sessions how did you describe to staff what the threshold was?

A. I wouldn't have. Now the training session that I did alongside H4 -- sorry, my eyesight here, H425, was more for the ward managers and sort of their safeguarding and what was appropriate to put. You know you would have found you were getting APP1s on stuff that wasn't safeguarding, you know, so that would have been very clear. So we would have done training around that. Because there were, you know, there are things that happen on wards and it's not safeguarding, and there are things, you know -- so it's trying to just get that across to the staff, you know.

DR. MAXWELL: We have also heard from another social worker that at some point the threshold changed that there was, if I can recall it correctly, there were some incidents which were vulnerable people who came to harm which ward managers would investigate, and then there was this higher threshold where intentional harm was done to patients, and the example we were given is that somebody who is vulnerable who kept getting bruises because they were running into walls or chairs or whatever, would have been managed by the ward

manager, but that a decision was made that those -- because of the concerns at Muckamore, that these would all now be investigated by a DAPO. Do you remember that?

A. I don't remember a threshold changing, unless that changed before I started or whatever. I know that the training we done was, you know, I think it was that the ward managers felt they had to write everything up as safeguarding, and a bruise and a mark, do you know, so that's part of that training that I did alongside the number I called out a minute ago, 425. That was about trying to bring it back to 'it's not every bruise, it's if, you know, if there's an incident that has been witnessed, you know, that's when you report on', you know. So that was, again that was around the end of my time. But, you know, I think people were concerned and were putting everything in as a safeguarding because there was that anxiety around, and then you were trying to sift out what was safeguarding. 12:02 12:02 12:03 12:03

140 Q. MR. MCEVOY: Now, at paragraph 42 then you recollect one RQIA inspection during your time in Muckamore Abbey, and it was towards the end of your time, and you don't know the outcome of the inspection but you do remember having a discussion with someone from RQIA who asked you questions: 12:03

"Nothing stands out..."

-- you say, about the questions that you were asked.

"The Social Work Department as a whole was open and honest with any queries made by the RQIA. I do not recall any significant recommendations being given for the Social Work Department." 12:04

A. And that is possible because this was right on my departure, do you know.

141 Q. Yes.

A. It was getting -- 12:04

142 Q. All right?

A. So it's not that I just don't recall or that I left and...

143 Q. I had hoped to ask you to jog your memory just a wee bit about the questions. I know you say nothing stands 12:04 out, but can you help us to understand whether those were questions relating to specific matters, incidents, or issues, or whether they were more broader or more general in scope?

A. I would say, and this is me going -- like I don't know 12:04 how many years ago this is now, but my memory is it was wider processes.

144 Q. Right.

A. Not specifics.

145 Q. Okay. That's fine. Now on paragraph 44 then, which is 12:04 almost at the end of your statement, almost at the end of your statement, you said that you chose to work in Muckamore as you had a personal interest in learning disability, and when the opportunity arose to work

there you were excited about the opportunity and hoped you could help enrich the lives of the patients on the ward.

"Unfortunately, due to the circumstances within the hospital my positivity started to fade." 12:05

Now pausing there. Can you tell us when you started to feel that positivity fading? What was it? And around what time you started to feel that? 12:05

A. I think it was not an easy environment to work in. As much as you tried to maintain positive relationships with the staff on the wards, and there were a number that I would have, you know, have said I would have had positive relationships with, you knew there was always 12:06 that suspicion of social work because of safeguarding, do you know. When I reflect back on the times where you were working through the, do you know, that initial stage and you were seeing some people being discharged out, do you know, that was all good and, you know, I 12:06 enjoyed that. But it just was difficult. It was -- there was things you wanted to see improved and it didn't happen.

146 Q. Yes.

A. I think that -- and why, I don't know. What I wanted 12:06 to see improved, you wanted to see...

147 Q. There's a contrast -- over the breadth and the time period of your statement there's a marked contrast to the reader where you, as you say, you described early

experiences of successful discharges, sometimes things didn't work out, perhaps inevitably there are going to be difficulties and issues, and of course it's in the nature of what you were dealing with. But as time went on... 12:07

A. I suppose my role and function changed as well within that, you know, because initially at the beginning of my statement I was social worker on a ward...

148 Q. Yep.

A. ...facilitating discharges and so on. So then possibly that's when the reading starts to change, because my role changed where I became the manager and managing the staff and trying to support them. So you were trying to support them in an environment where it was very difficult, and trying to implement some changes which you hoped would be to improve... 12:07

149 Q. Yeah.

A. ...the information and the quality of information maybe that we were receiving.

150 Q. The difficulties with regard to resettlement and the increasing pattern of problematic or even inappropriate resettlements... 12:08

A. And I suppose you were getting to a point...

151 Q. Sorry. That's something that starts to increase over a period of time as we read your statement, and I suppose it would help if we could gauge, if you could help us understand what the causes or what the patterns were, what were the pressures, if there were any, that created the issues around resettlement? 12:08

A. The issues around resettlement. I suppose you were -- there was pressure from, do you know, Department or whatever, to get people out of Muckamore. There was -- you know, because of the change, the shift...

152 Q. By "the Department" you mean? 12:09

A. Well there was just pressure. Do you know everybody, it was all -- the focus was all on 'let's get people out of Muckamore and into the community', and --

153 Q. Yeah.

A. And the focus needed to be on -- 12:09

154 Q. I'm sorry, I know I'm interrupting you, but when you say the focus was on, is that as opposed to something else?

A. No, no, the focus -- but there was -- I don't know how else to describe it, but there was an expectation that 12:09 we were -- that Muckamore -- there was that rumour that Muckamore is closing and we need to get everybody out. We need to -- you know, there was that. And, you know, you had meetings where there was specific people would just come where there were specific people that just 12:09 come in from different community Trusts to talk about the resettlement, and who they still needed to resettle, and how many people still needed resettled, and you were getting to a point where it was those people with the more complex needs that were then 12:10 needing to find placements and, to be honest, in my view that infrastructure, and I think I tried to make that clear in my statement, that infrastructure to me isn't and wasn't there at that time. I don't know what

it's like now, but -- I don't know what would make it better, but those, to me, having units where there are qualified staff, not necessarily that hospital environment, but smaller units with qualified staff and positive behaviour nurses who can support people with those very complex needs. 12:10

155 Q. Yeah. Any other proposals or changes based on your experience that you would like to see in place to make resettlement work better?

A. It's that continued engagement with family, you know, they are key to -- and I mean we always tried to make sure that they had their voice in the care plan and that risk assessment, because they are key, they know their loved one best, and it's making sure that they are listened to and that they are very much a part of that process. I think we did, you know, for some of these people being resettled. 12:11 12:11

156 Q. We can see from some of the examples that you've given in your statement that that wasn't always the case, that family -- or the extent of family involvement wasn't ideal, and that's what you are -- 12:11

A. I don't know that that is in my statement. Because I know any time I was involved in any discharges, we would have been engaging and working with families to progress it, but... 12:12

157 Q. Well I mean, is it your evidence that families have always been properly engaged, properly involved in resettlement?

A. I probably wasn't involved in enough to be able to give

a wide breadth of statement on that, but I know the ones that I worked alongside I would have felt that there was inclusiveness there.

158 Q. In the one that you talk about, in the example you talk about in paragraph 44, you say that -- you go on to say that you feel your professional opinion was not always listened to: 12:12

"I recall attending an MDT where a patient had been resettled. Did not feel the service user was appropriately placed. He was placing himself and others at risk due to escalating behaviours." 12:12

Did that patient have a family, do you recall?

A. I don't recall in that one. 12:13

159 Q. Mhm-mhm.

A. I don't recall. I just remember that I, I felt for that one service user that there was too great a risk for him remaining in the community at that time, possibly some reassessment or in relation to what support could have been provided. 12:13

160 Q. Yep. And I suppose in fairness to you, the issues with dialogue and contact with families that you describe, were more about care in the hospital rather than in resettlement, is that maybe a fairer way? 12:13

A. No, well, no, we would have been very much involved in -- but I wasn't the social worker in this case.

161 Q. In this instance?

A. No, I wasn't the social worker. So the social worker

who would have been on the ward would have had that. You know, in this instance I was the manager, so I wouldn't -- that's why I'm saying I can't recall, because I was not this service user's social worker. The social worker would have had, you know, those contacts --

162 Q. Yes. Okay. You're talking about this obviously from more of management perspective then --

A. And to be honest, we're going back time, so I can't recall the specifics. 12:14

MR. McEVOY: That's fine. Okay. Well, look, those are the questions that I have for you, H284. It may be that the Panel have some more questions for you.

CHAIRPERSON: I don't think so. No. I think we've asked our questions as we've gone along. So can I thank you very much, unless there's anything you wanted to add? 12:14

A. No, I think I'm happy enough.

CHAIRPERSON: All right. Can I thank you very much indeed for coming along to assist the Inquiry. I know there is always a bit of anxiety around it, but I hope you feel a lot more comfortable now, and I hope you're glad that you've come to assist us, and we are glad that you did. 12:14

A. Thank you. Thank you. 12:15

CHAIRPERSON: Thank you very much indeed. If you would like to go with the Secretary to the Inquiry. I think the next witness is 2:00 o'clock?

MR. MCEVOY: Yes.

CHAIRPERSON: Okay. Thank you very much. 2:00 o'clock.

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT

CHAIRPERSON: Thank you.
MS. BERGIN: Good afternoon, Chair and Panel. This afternoon's witness is H73. A restriction order was granted in respect of this witness also on the 26th April, and they are to be referred to by cipher. The statement reference is STM-215 and the witness can be called in.
CHAIRPERSON: Sorry, can you just give me the page, again? 13:58
MS. BERGIN: The statement reference?
CHAIRPERSON: The cipher. No, the cipher.
MS. BERGIN: Yes, it's H73.
CHAIRPERSON: Thank you. 13:59

H73, HAVING AFFIRMED, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: H73 is what we're going to call you. 13:59
A. That's okay.
CHAIRPERSON: And can I welcome you to the Inquiry. You'll find, and you probably know this already, you've probably been warned, any other members of staff are in general being ciphered as well. If you do refer to 14:00 another member of staff by name, don't panic about it, because we have a system to stop the public feed, and it can be removed from the transcript, and almost every witness has done that so far, but we'll just carry on.

But if you can use ciphers, please do. And you should have a cipher list nearby.

A. Okay.

MS. BERGIN: The witness in fact doesn't refer to anyone in her statement, so she doesn't have one, but thank you, Chair.

CHAIRPERSON: Right. Fine. Okay. Well we'll see what happens. Okay.

MS. BERGIN: Yes, thank you. Chair and Panel, I should say that the witness does have a copy of her statement with her, an additional copy that she's brought with her, just with her own notes, just so the Panel are aware.

CHAIRPERSON: That's fine. Thank you very for telling us.

MS. BERGIN: Yes. Thank you. Good after, H73. We met briefly this afternoon and I explained to you the procedure we'll be following in relation to your evidence this afternoon.

The first thing I'd like do, as the Chair has already indicated in relation to the ciphers, is then turn to your statement. So you have a copy of your statement in front of you, and it's dated 20th March 2024, and you've signed a declaration at the back of the statement.

A. That's right, yeah.

163 Q. Are you content to adopt that statement as your evidence to the Inquiry?

A. I am.

164 Q. Thank you. And as I've already explained to you, I don't intend to read your statement out in full this afternoon, because all of the Core Participants and the Panel have your statement already. I intend to read a summary, or summarise your statement briefly, and then as we move through the questions that I have, I will then summarise the paragraph that I'm referring to. All right? 14:01

A. Okay. 14:01

165 Q. And as I said before, I will have questions, but the Panel may also have questions throughout and/or at the end. Okay?

So in your statement, turning to it now, you outline 14:01 that you were a doctor in training and also a consultant psychiatrist at MAH, between August 2000 and May 2019. And it's really broken up over four periods of time. The first is 2000 to 2001, where you worked as an SHO, that's a Senior House Officer. Between 2001 14:02 and 2007, you worked as a Specialist Registrar. Between January and August 2008, you were a consultant psychiatrist in learning disability at MAH, and you had previously acted up into the consultant post the previous year. And from 2008 to May 2019, you 14:02 continued to cover on-call out-of-hours for Muckamore, alongside your role as a community consultant psychiatrist in learning disability with the Northern Trust. Is that all correct?

A. That's all correct.

166 Q. I'm going to now briefly summarise in a bit more detail those four I suppose roles or periods, before I begin to ask you some questions. So in your first role as an SHO in 2000, in your statement you describe working on 14:03
Fintona South three days a week, and spending two days a week in the community, supervised in both roles by your consultant. Fintona South was an all female ward and patients there had been transferred from Fintona North before being moved into the community. When 14:03
patients were transferred into Fintona South when you were an SHO there, the consultants, you say, worked closely together to ensure a smooth transfer, they reviewed patient treatment plans to ensure that they still applied or if an updated plan was needed, and 14:03
your role as an SHO included helping patients to settle in and to complete mental state assessments. You were part of the MDT, multidisciplinary team, and you attended weekly MDT ward rounds on Fintona. Day-to-day when you attended the ward, the nurse in charge would 14:04
update you as to any patients who might need prioritised for mental health assessments. After these assessments you drew up preliminary treatment plans in patient's medical notes, and any changes to plans would have to be agreed at MDT ward rounds, and also agreed 14:04
with patients and their families or carers. If a patient required further physical examination after your assessment, they were generally referred to Antrim Area Hospital. As an SHO, you prescribed PRN such as

Paracetamol, but where PRN for agitation or aggression was prescribed, this had to be approved at MDT and was recorded in the care plan and the prescription was recorded on Kardex. You reviewed patient's Kardexes on a three-monthly basis.

CHAIRPERSON: Can I just interject there? Are you saying that PRN could only be prescribed after it had been discussed at the MDT, or that you could prescribe it at any time and then it would be discussed at the MDT? 14:05

A. It could be prescribed and then it would be discussed, yeah, but more often than not it was sort of pre-discussed.

DR. MAXWELL: Yeah. But you didn't require a discussion at the MDT before you could prescribe it? 14:05

A. No, no. If the patient was distressed enough, yeah.

DR. MAXWELL: Thank you.

167 Q. MS. BERGIN: Thank you. So remaining with your role as an SHO. In addition to medication, the MDT led treatments also focused on treating behavioural aspects 14:05 through the behavioural team and psychology or therapeutic treatments.

During your time as an SHO on Fintona you completed your Royal College of Psychiatry exams in 2000, and a 14:06 small element of this included learning disability. You describe, to summarise your time on Fintona South, as somewhere where the atmosphere was pleasant, the patients and staff were friendly with good

relationships, and the consultant was committed to providing a high quality service and excellent support to you, and you finished your SHO training on Fintona South in February 2001. Is that all correct?

A. That's all correct, yes. 14:06

168 Q. Moving to your next phase then. You applied to a training programme to specialise in psychiatry of learning disability with the Northern Ireland Council for Post-Graduate Medical and Dental Education, and that's now called the Northern Ireland Medical and 14:07 Dental Training Agency, and during this training you had the title of Specialist Registrar, SPR, and that would now be known as a higher trainee. And at that time, around 2001, all learning disability SPRs spent time working in MAH. This was usually a three-year 14:07 programme, and you've explained why you completed it over six years.

You worked short fixed periods in MAH as an SPR between 2001 to 2007, under the supervision of three 14:07 consultants in MAH and in the community, and during that time consultant psychiatrists worked both in MAH and in the community. Your time in that role on MAH, or at MAH rather, involved you working in a resettlement ward, a forensic ward, and in Conacre 14:08 Children's Ward, and you also covered MAH on-call out-of-hours, supervised a consultant, one in every five nights, and you worked part-time four weekdays per week, but you spent little time on the wards at MAH,

most of your time was spent in the community.

The next phase then of your work at MAH was that you completed specialist training in June 2007, and you took up a position as acting consultant psychiatrist in MAH and in the community, and then in January 2008, you took up the consultant psychiatry position. 14:08

You worked part-time as a consultant psychiatrist at MAH and in the Northern Trust community three days a week. Initially you were responsible for Movilla A Ward, which was a longer stay male patient ward, and you oversaw their continuing care and discharge and the patients there were generally well settled. You were the most senior medical member of staff on the ward and responsible for other medical staff, including junior doctors. You Chaired weekly MDT ward rounds, and you were also on the ward at least one additional day per week, and you say that: 14:09 14:09

"The staff on Movilla A worked well together."

You saw a high quality of care being provided, with a culture of nurses being actively interested in caring for their patients, and you had no safeguarding concerns. 14:10

Then the next phase of your work at MAH -- apologies, I think the same phase still but just afterwards, between

January and August 2008, you also then looked after a resettlement ward at MAH, you can't recall the name of the ward, and it was closing as resettlement of that ward was coming to an end, but it had a dedicated resettlement team led by another consultant. And, again, at that time you were also working in the community with the Northern Trust.

Your role as a part-time consultant psychiatrist in MAH ended in August 2008, but you remained employed by the Belfast Trust until 2017 in your day-to-day clinical role in the community within the Northern Trust and doing out-of-hours on-call for MAH, and during this time, your office and administrative support remained on the MAH site, and you attended monthly medical staff meetings in MAH to discuss any medical issues, such as training needs for junior doctors, but, overall, your continued presence at MAH was for administrative purposes and to attend those meetings. 14:10 14:10 14:11 14:11

And you then say that you ceased employment with the Belfast Trust in 2017, but you continued to do on-call out-of-hours at MAH until 2019?

A. That's correct.

169 Q. Is all of that correct? 14:11

A. That's all correct, yes.

170 Q. Thank you. So first of all, in terms of your time as a specialist registrar, who would have been in your team in terms of the doctor make up at that stage, if you

can recall? I appreciate it is some time ago.

A. There would have been a consultant and myself and sometimes an SHO as well.

171 Q. And the consultant at that stage, and we're talking I think back then about Fintona, would they have been learning disability specialist consultants? 14:12

A. Yes, they were. Yes.

172 Q. Yes. And in terms then of your clinical oversight or the management of you, what would the hierarchy have been? I appreciate you were training at that stage. What would the hierarchy have been within MAH? 14:12

A. There would have been the consultant, then the SPRs then the SHOs.

173 Q. Okay. And would there have been just one -- was there just one of each in your team? 14:12

A. The SHOs, due to staffing issues, sometimes were shared across a couple of wards. So you might have had to share the SHO with another team.

174 Q. So there would have been multiple sets of each of those, I suppose teams, throughout the hospital then? 14:12

A. There would have been, yes. Yes.

175 Q. And where were those teams, the psychiatry teams, in terms of doctors and consultants and training doctors? Were you based on wards or based in a different building in terms of offices? 14:13

A. My -- our offices were over in the administration building.

176 Q. Okay. And then whenever you became a learning disability consultant, was the team structure -- I

appreciate it was some time later -- was the team structure largely the same?

A. It was, yes.

177 Q. Okay. And was there -- I suppose within each of those teams was there, in terms of the hierarchy or the management structure, was there a lead consultant, or how did that work, if we try to sort of understand the picture in terms of psychiatrists working in the hospital overall? 14:13

A. There was a Clinical Director who would have been the consultant sort of overall, all the teams, if you like, and then a number of teams consisting of consultant SPR, SHO, and the SHOs would have been shared a bit. 14:13

178 Q. And were they, the teams, broken down into wards, or were they broken down to into, for example, levels of need, or how were they broken down? 14:14

A. It would have been -- the consultants would have been assigned a ward, or a couple of wards to look after, and a community patch. So the SPR, if they had one, and SHO would have, you know, been part of their team and, therefore, worked on the same wards and the same community patch. 14:14

DR. MAXWELL: Can I just ask, did any of the consultants have different specialist interests?

A. Ehm, yes, one of the consultants would have had the forensic interest, another consultant looked after children with a learning disability. 14:14

DR. MAXWELL: And so would the SHOs rotate? Because the SHO post is a sort of general learning post

usually, isn't it? Would they have rotated around different wards so they got experience of different sort of specialities?

A. Yeah, I can't recall how many SHOs there would have been at a time, usually though an SHO would have more than one ward to look after, so they would have maybe looked after a general admission ward and a longer stay ward, or they would have been looking after forensic ward or, you know, a mixture of wards, but they didn't -- they were only with us for six months at a time, so they didn't necessarily rotate around -- each of them didn't rotate around all of the wards. 14:15 14:15

DR. MAXWELL: So during that six months, potentially an SHO didn't come in contact with any forensic patients?

A. Yes, that would have be true. Yes. 14:15

CHAIRPERSON: And for the consultants, was that a full-time post at MAH?

A. For all the consultants?

CHAIRPERSON: Yes.

A. Well, no, mine was a part-time post and there was another part-time consultant. 14:15

CHAIRPERSON: So how long would they spend? You know is it two days a week or...

A. Well, each consultant looked after a number of wards and also looked after the community, so it was probably 50/50. 14:15

CHAIRPERSON: Right.

A. But I was part-time, so I had a smaller number of ward responsibilities, and then lost those responsibilities

pretty quick, pretty soon after I took up post, and was just out in the community.

CHAIRPERSON: Thank you.

DR. MAXWELL: Can I ask, was that your choice to give up the ward work and focus on the community, or was that a restructure of the medical workforce? 14:16

A. I think it was a bit of both. Like I preferred working in the community, and there were restructure, there was restructures every time there was a new appointment quite often, because when I first came along our staffing levels were quite low, so whenever there was a new appointment we were able to restructure a bit to ensure an even workload. 14:16

DR. MAXWELL: Was it at all related to the rate of resettlement as the number of wards reduced? 14:16

A. Possibly, but it was probably -- from my perspective it tended to be more when a new consultant was appointed.

DR. MAXWELL: Thank you.

179 Q. MS. BERGIN: Yes, thank you. Picking up on the specialisms. At paragraph 13 you say that wards and also community patches were allocated to consultants based on their strengths and also service needs. In terms of strengths and expertise, you've indicated that your learning disability, that's your specialism, so would it have been the case that all of the other consultants would have also been learning disability specialists, or as the Panel have indicated, would it have been that there would have been a consultant who was more forensically specialist and they would have 14:17 14:17

been allocated on that basis?

A. No. Everybody was a learning disability consultant psychiatrist and some then had additional areas of interests or specialisms.

180 Q. Okay. 14:17

A. For example, forensic or children. But everybody was a learning disability psychiatrist to start with, yeah.

181 Q. Just picking up on what the Chair asked you about, I suppose the allocation or division of time. Can you explain to us -- I did sort of summarise your statement 14:18 in relation to the break between working for the Trust but then within the Northern Trust also, can you explain to us a bit more about how that worked or how that came about, those arrangements, where you were working in Muckamore but then in the community for the 14:18 Northern Trust?

A. Yeah. That's sort of a historic arrangement really. It had been in place for a long time prior to the formation of the Trusts, as they are now, and I suppose Muckamore was a semi-regional hospital, I suppose, and 14:18 this is prior to my time, and the consultant psychiatrists in learning disability would have been based there but provided out-patient services out into the community, so that arrangement just continued. And at a time when I started working there, you know, 14:18 numbers were small enough that we had to work across both the hospital and the community, but that's changed somewhat now.

182 Q. Okay. Thank you. Moving on then. Throughout your

statement you discuss various positions, or responsibilities, or aspects of your job, including admissions, mental state assessments, MDT ward rounds, PRN prescriptions, referrals and resettlement, and I'm going to go through I suppose each of those now in turn. Okay? 14:19

So starting with admissions. In your role as an SHO and then a registrar and consultant, what was your I suppose role, and I appreciate it may have fluctuated throughout those different positions, but what was your role in admissions? 14:19

A. Well as the -- I suppose the agreement for an admission to come in would have been taken at consultant level, and then when the patient arrived on the ward it was the SHO who would have been the first doctor to see them and to assess them from a mental state perspective and their physical health, and would have drawn up sort of preliminary, a very preliminary treatment plan, because they would have quite often been reviewed by the SPR over the next day or so, so that by the time we came to the multidisciplinary team meeting enough information had been gathered that was able to be shared with the team and then the case would have been discussed at the team meeting. 14:20 14:20

183 Q. And in terms of some of the evidence that the Inquiry has heard, some of that has been from relatives who have thought that -- sorry, from relatives of patients who thought that the patients would only be in

Muckamore for maybe a short period of time, but then it ended up being longer. Did you have any role in terms of any of your positions in Muckamore in the actual explaining to patients and families what was happening in terms of the detention or the admission? 14:21

A. As an SHO admitting somebody, if their family were there you would have explained to them the process, and the nursing staff would have explained the process, and there were leaflets available to explain the whole process of the Mental Health Order and the detention 14:21 process.

184 Q. Was there a formal procedure or anything to be followed in respect of that?

A. I think there was. It was the role of the nurses. I'm trying to recall, it's quite a while ago, but I think 14:21 there was, and the nurses -- it was really on their check list on admission that one of the things they had to do was to discuss with the patient and the families the Mental Health Order, if they were being detained.

185 Q. And what about then in your role as a consultant, would 14:21 you have had any involvement in terms of the direct admission or detention of a patient immediately when they were coming into the hospital?

A. Well, when I was the consultant on the ward I was working on, it wasn't an admission ward, so that didn't 14:22 arise.

186 Q. Okay. And one of the things that the Inquiry has heard about is that some families have said that they had been told by the hospital that when their relative

first was admitted to Muckamore that they ought not to come and visit them for a set period of time to allow them to settle in. Is that something that you're aware of?

A. Ehm, I can't really recall. I can't recall specifics. No, I don't. 14:22

187 Q. Okay. No, you're better to say if you can't recall?

A. Yeah, I just can't recall. Sorry.

188 Q. Yes. And you say at around paragraph 42 that: 14:22

"Around the year 2000 some patients were coming to Muckamore for two weeks respite, but a few years later that was no longer offered."

And then after 2000 the rates of admission to MAH changed. In what way did the rates change of admission? 14:23

A. Well they've changed very gradually over the years, and it's really as the number of beds have decreased in the hospital, there hasn't been as much availability. And then there have been the more recent changes as well. So I was sort of referring to how my role in the community has changed over the years, because there are now patients that we care for and support and treat in the community that previously would have been admitted. So it's more a comment on how the community has changed rather than how Muckamore has changed, if you understand? 14:23 14:23

189 Q. Yes. And just picking up on that -- sorry I cut across

you -- in terms of I suppose your perspective on why that has changed, do you see that as more of a success in terms of patients being able to move into the community and people with learning disabilities being able to be cared for and treated in the community is the success of that, as opposed to an institutionalised setting, or why do you think that is?

A. Well I think I mentioned in my statement that from the medical staff point of view we were always keen that people were discharged when they were ready for discharge, and that it was preferable that people were managed in the community. It's one of the reasons I enjoyed working in the community. In my opinion I think there will always be a role for a small number of beds to be available, hopefully not as an old style institution, but the vast majority of people hopefully can be managed in the community.

190 Q. And in terms then also of the rates of admission, were the purposes -- I mean you've referred to one example which is that respite was something that was offered at a time and now isn't. Were the purposes of admission MAH, have they, in your experience, changed a lot?

A. Well, in my experience there haven't been any admissions in the last number of years, and the years prior to that, the immediate years prior to that, it would have been very ill people, you know, with psychosis and so on, that were being admitted, which was different to away back in 2000 when people would have been admitted for respite and so on.

191 Q. And in terms then of how that affected the treatment and care provided at the hospital generally then, if the types of patients coming to the hospital were changing, then did that then consequently impact upon the types of treatment that were necessary, or the types of care or therapeutic interventions that were required at the hospital if there was a slight change of focus? 14:25

A. Well I suppose those ill people always would have been admitted. I'm not maybe explaining very well, but it's just the proportion of people who were ill was greater, I suppose, because the overall number was decreasing. 14:26

192 Q. Okay. And if I can move on then, and I will come back to resettlement and discharge which you refer to, in just a moment. If I can move on to the MDT ward rounds and the mental state assessments. In terms of your interaction with patients, and I appreciate this is probably quite a broad question, but how regularly would patients have been seen by a psychiatrist during their time at Muckamore on a weekly or monthly basis, whatever is easiest for you to demonstrate? 14:26

A. Yeah. That's a bit difficult to explain. It depended on a number of factors, such as whether the ward was an admission ward that had people who were acutely unwell or distressed, compared to a ward that people were more settled and had a regular routine. And some of the wards obviously there were more patients on the ward than others. When people were unwell they would have been seen at least once a week by the SHO, for example, 14:26

and by the SPR, and on occasion by the consultant as well. So if they were quite unwell, maybe three or four times a week. But if they were settled and weren't unwell, and were in a nice routine and appeared quite content, oh, I don't know. 14:27

193 Q. Well in terms of the MDT weekly ward rounds that you refer to in your statement, you've described that a range of staff were involved in those. So consultants, specialist registrars, nurses, social workers, and there was also input from day care staff, behavioural 14:27 nurses, psychology and occupational therapy. What did those weekly ward rounds actually involve? Was it both a physical walk round and also a meeting, or could you tell us a bit more about what they actually involved, please? 14:28

A. No, it wasn't a physical walk round because that doesn't help in mental health in psychiatry. It was a meeting, a sit down meeting with the members of the team. Not all of those people would have been available at all the meetings, and sometimes with staff 14:28 shortages not all those people were available in the hospital, but the admission wards would have had, I suppose, more a wider variety of professions available for them, because the patients were unwell. But, yeah, it took the format of a meeting that would have lasted 14:28 for the entire morning really, and each of the patients would have been discussed, the consultant Chaired the meeting, the SHO or the specialist registrar would have been writing in the medical notes, the nurse in charge

would have been at the ward round and making notes as well, and then a representative from day care, the social worker attached to the ward, if there was behavioural input they would be at attendance. If there were -- if there was staff that were actively involved with a patient, they might come for one or two particular patients and leave again. But, yeah, they were busy mornings, yeah.

194 Q. And in terms of how frequently they occurred, the substantive period I think when you were on wards was between 2000 to 2008, was it the practice that they occurred weekly throughout that period? 14:29

A. Yeah.

195 Q. Was that always...

A. Yes, it was, yes. 14:30

196 Q. Yes. And in terms then of change to patient treatment plans, I think that's one of the things that you said would be discussed at the MDTs. In terms of then families, you've said in your statement that changes would be discussed with families. Did that occur at MDTs? Were families present at those? 14:30

A. Were they? No, I don't think they were present at them. I think it was generally the nurse in charge or the named nurse would have fed back to the family after the ward round and would have discussed any change in the treatment plan with them. 14:30

197 Q. In terms, I suppose, of your involvement with families, I think you've said in your statement that you did have some direct contact with families. For example, when a

patient was transferred to a new ward, you might have a phone call or speak to a relative on the ward to find out the patient's history, or to provide an update on them, but that you had less of direct involvement in some of the nursing staff. 14:31

A. Mhm-mhm.

198 Q. Can you give the Panel an idea of what level of interaction you would have had with patients families? Like how often would you have met with them? Was it formal or informal? In what contexts? 14:31

A. Well, when somebody was admitted to the ward, quite often if the relatives weren't there with them you would have phoned them to get a bit of a collateral history and to give an update. It sort of varied very much case by case really. As I say, it was mostly the 14:31 nursing staff, the named nurse that would have been in touch with the family. If there were say a major deterioration in the person's presentation, we might be in touch with the family to discuss that with them, or if we were making significant changes to the treatment 14:31 plan. But, yeah.

199 Q. So throughout your time as a specialist registrar or as a consultant, would you have frequently, or infrequently I suppose, actually directly face to face met patients relatives? 14:32

A. Probably infrequently rather than frequently.

200 Q. Okay. In terms then of the mental state assessments, you've indicated that they were carried out by you. Was that in all of the roles? So would they have been

carried out by SHOs, and specialist registrars, and consultants?

A. Mhm-mhm. That's right.

201 Q. Yes. And then in terms of the frequency or the need to carry out a mental state assessment, one of the examples you have given to us is when a patient is transferred on to a ward, or if a nurse had alerted you to the fact that there was an issue. 14:32

A. Mhm-mhm.

202 Q. Were there periodic times when a patient was to have mental state assessments in relation to their treatment at Muckamore or was it more ad hoc than that? 14:32

A. It was case by case really. I think I mentioned earlier that if somebody was very unwell they maybe would be seen three or four times a week, and on each of those occasions you'd be doing a mental state assessment. 14:33

203 Q. Okay. Thank you. If I can move on now to look at the use of PRN medication. So the paragraphs that I am referring to, they're 14, 15 and 34. So I appreciate there is some jumping around there, but if I can summarise it in this way: At these paragraphs you say that when you were in SHO you prescribed medications such as Paracetamol, and as you've already clarified in response to the Panel questions, PRN, which was required for agitation or aggression, formed part of a treatment plan and this could be approved at MDT. 14:33 14:33

A. Mhm-mhm.

204 Q. And some patient's treatment plans would have included

the use of PRN?

A. That's right, yeah.

205 Q. And this, when PRN was used, that would be recorded in their medical notes. Is that --

A. That's right, yeah. 14:34

206 Q. Yeah. And in their care plan, the care plan within the medical notes, is that it?

A. No, the care plan and medical notes were two separate documents.

207 Q. Separate. Okay. 14:34

DR. MAXWELL: Can I just check? Wouldn't it actually be recorded on the prescription sheet.

A. On the Kardex, yes.

DR. MAXWELL: Yes. So as the nurse administers it, they record it on the prescription chart and not on 14:34 care plan or the medical records?

A. That's right. Oh --

DR. MAXWELL: At the point at which they administer it.

A. At the point that it is being administered, yeah, it would be on the Kardex, yeah. 14:34

DR. MAXWELL: The prescription chart, yes.

A. Yes. Yes.

208 Q. MS. BERGIN: And then when the prescription was recorded on the Kardex, as I've already indicated, you would have, at one stage in your role, have actually 14:34 reviewed the Kardexes every three months I think you've said.

A. That's right, yeah.

209 Q. And you said that you weren't aware, in your statement,

of the use of PRN -- unapproved use of PRN that wasn't part of a patient's treatment plan?

A. That's correct.

210 Q. So I just wanted to ask, in terms of the effect of a prescription of PRN, that meant that PRN could be given as needed? 14:35

A. Mhm-mhm.

211 Q. So if there was no prescription, then a member of staff, for example, a nurse, couldn't just administer PRN. There had to be a prescription in place first of all? 14:35

A. There had to be a prescription in place. On some occasions if somebody unexpectedly became very distressed or agitated, and they didn't have it written on the Kardex, the nurse in charge would contact the consultant, or the SHO, or the reg who were working on the ward, or if it was out-of-hours they would contact the doctor out-of-hours. 14:35

212 Q. Okay.

A. So that a verbal agreement could be made, and it was then written up when the person was next available to do that. But that would have been rare. 14:35

213 Q. Okay. In terms then of what was approved by way of PRN, was it first of all the use of PRN at all that had to be approved generally in MDTs, apart from those exceptional circumstances you've described, but what about the frequency or the dosage, was that something? 14:36

A. Yeah, that was all prescribed on the Kardex. So you would say what the dose was, how often they were to

have it within a 24 hour period, and how many hours between doses that you were to give it.

CHAIRPERSON: Can I ask a really basic question. We're talking about PRN as though it is a drug.

A. That's right, yes. 14:36

CHAIRPERSON: Well PRN, as I understand it, is a drug to be delivered as required.

A. That's right, yeah.

CHAIRPERSON: That's the meaning of it. What was the drug actually used? 14:36

A. It tended to be either Diazepam or Lorazepam.

DR. MAXWELL: But presumably there was PRN for other drugs like Paracetamol.

A. Yeah.

DR. MAXWELL: There were a number of drugs that could be prescribed PRN. 14:37

A. PRN, yes. Like Paracetamol, yes.

CHAIRPERSON: That's exactly what I'm asking. PRN isn't actually a drug, it's the delivery.

A. It's the delivery, yeah. That's right. Sorry. 14:37

CHAIRPERSON: But if you've got an agitated patient, or the danger of an agitated patient, would the prescription actually be generally either Diazepam or Lorazepam?

A. Yes, it would be, yes. 14:37

CHAIRPERSON: Yes. And would you specify a dosage?

A. Yes.

CHAIRPERSON: Forgive me, but is there a standard dosage or...

A. There tends to be. For Diazepam it would be either 2mgs for 5mgs. And for Lorazepam it could range from 0.5 to 1 or 2mgs.

CHAIRPERSON: Right. And you can prescribe a range, can you? 14:37

A. Oh, yes. Yes.

CHAIRPERSON: And then it would be for the nurse in charge to decide what to deliver to the patient?

A. That's right. And the frequency and the gap between doses will have been specified as well. 14:38

CHAIRPERSON: Right. So not more than one dose in four hours or something like that.

A. It would usually be four hours between doses and a certain maximum within the 24 hours.

CHAIRPERSON: Yes. Okay. Thank you. 14:38

214 Q. MS. BERGIN: Thank you, Chair. In terms of the use then, continuing with the use of PRN, at paragraphs 14 and 34 of your statement you've said that you weren't aware of the use of PRN which hadn't been approved and that you weren't concerned about inappropriate use of 14:38 PRN medication, based on the notes you reviewed and the patients you met. How were you made aware that PRN had been administered in terms of, were you notified or was it simply when you went to review patient's notes generally that you could see that? 14:39

A. Well, it would have been discussed at ward rounds, or if you, you know, arrived on the ward to get an updated day-to-day update, the nurse in charge would have explained that a particular patient had been unsettled

and required PRN.

215 Q. And was there any form of monitoring in terms of, you know, whether a patient had required an increase or a decrease over a period of time?

A. Yeah. 14:39

216 Q. In terms of PRN.

A. Yes, because every time the dose would be administered its recorded in the Kardexes, the recording sheet, and those sorts of patterns would have been looked for at the ward round. So if you saw that somebody was 14:39 requiring more frequent doses, or less frequent doses, that was something that we would have picked up on.

217 Q. So just I suppose to finish off PRN then. So I've already said what your statement indicates. So your evidence is still that you, or is, rather, your 14:40 evidence is that you didn't have any concerns about PRN levels?

A. No.

218 Q. Or frequency, throughout your time at MAH with the patients? 14:40

A. No concerns, no.

219 Q. Okay. Moving on then to referrals for psychology or therapeutic treatment.

A. Mhm-mhm.

220 Q. So at paragraph 16, 34 and 36, you say that: 14:40

"In addition to medication, MDT looked at psychological and therapeutic treatments and these were completed when clinically indicated and if resources were

available."

And you say that:

"As part of treatment plans, referrals to specialists were made and the specialists then decided what interventions might be appropriate." 14:40

In terms of the types of interventions, you've referred to CBT, and you've said that DBT -- and those are cognitive behavioural therapy and dialectical behavioural therapy, which you say the latter wasn't really used as much? 14:40

A. I don't think it was. I don't recall it being used. In some parts of, or rather my whole statement is really based on answering specific questions that I was posed by Inquiry counsel, so that's why the DBT is mentioned, because I was asked specifically about that, but I don't think it was used, but I'm not 100% sure. 14:41

221 Q. What other types of therapeutic referrals would you have made, or in terms of other types of therapy, apart from CBT or DBT was there anything else that you... 14:41

A. Well we made the referrals to the other specialists and they then would have carried out an assessment of the patient, and they would have come to their professional decision about what work they would do with them. A lot of the, or some of the work that psychology colleagues carried out would have been CBT based that was adapted for people for learning disability, or 14:41

supportive psychotherapy. The behavioural nurses obviously looked from a more behavioural, purely behavioural perspective, and then the other allied health professionals had their own areas of expertise, such as occupational health and physiotherapy and so on.

222 Q. And I've referred there to the part of your statement were you say that these treatments would have been provided where the resources were available. So would it have been your experience that you had made a referral, or your colleagues in psychiatry would make a referral that you thought was appropriate, but a patient wasn't able to avail of it because of resources? 14:42

A. I can't recall details, but I think, although my memory isn't great, but I think at times there wouldn't have been staff in post to be able to accept the referrals, so the referrals wouldn't have been made. 14:42

223 Q. And would that -- I appreciate you've already said that you can't remember specifically. 14:43

A. Yes.

224 Q. But I suppose if you are able to answer this, would that have been more about or more in terms of the treatment or the therapy not being able to be provided at all then to the patient or that there was a delay? 14:43

A. Possibly both. They maybe would have had waiting lists.

225 Q. Okay. Moving on then to referrals in relation to physical health issues, and at paragraph 18 you've said

that:

"If a patient required further physical examination following assessment, they would be referred generally to Antrim Area Hospital." 14:43

Now, the Inquiry has heard evidence from relatives about failures or delays in patients being diagnosed or referred for treatment outside of Muckamore. During your time at MAH, was there a GP on site, based on site at Muckamore? 14:43

A. Not a GP based on site. Latterly GPs -- I'm trying to recall. They would have been present on Saturday mornings, and there was GP out-of-hours cover throughout the week and at weekends. Day-to-day, Monday to Friday, nine to five, the SHOs would have carried out basic medical assessments and treatments that were needed, and if anything needed more complicated care, or care, secondary care, that then went through to Antrim Area Hospital. 14:44 14:44

226 Q. So just so that I'm clear the doctor specialisms on site would have been psychiatrists?

A. That's right, yeah.

227 Q. And then the SHOs who were potentially going to become psychiatrists, but they were more generalist as part of their training, is that correct? 14:45

A. That would have been correct. They would have, quite recently have worked in medical wards and surgical wards.

228 Q. And you've described the Saturday, I suppose clinics, or GP attendances on a Saturday being on site?
A. Yeah. I can't really recall those.
229 Q. I suppose what I was going to ask you, because I appreciate you've said you can't really recall that, is, were you aware of patients having sort of scheduled or periodic physical examination check-ups alongside psychiatry input? 14:45
A. Patients would have had physical assessments on admission and prior to discharge, or transfer from one ward to another, or if they were presenting with physical health symptoms and signs. 14:45
230 Q. Great. Thank you.
DR. MAXWELL: Can I just pick up on that? So we've heard from a number of families that their relatives would often have unexplained injuries, bruises and cuts and things. Would you be aware of those, and particularly when you were an SHO would you have done a physical examination of a patient who had these unexplained injuries? 14:46
A. Yeah. If it was brought to our attention, yes, we would have done a physical examination, and I think there were body charts with -- any bruising or injuries would have been recorded on the body charts.
DR. MAXWELL: And we've also heard from some families concerns about personal hygiene, concerns about dental care and foot care. As an SHO, I suppose, would your -- would you have periodically checked people's physical health, or would you only have done that if 14:46

the nurses had asked you to?

A. It was carried out on admission, prior to discharge, or if there was a transfer between wards. I'm trying -- I think actually was there -- people who were there longer stay, if I recall, had an annual review, which would have included a physical health check, any bloods that needed done, and a mental health assessment. 14:47

DR. MAXWELL: And was that the SHO --

A. That would have been the SHO. It would have been the SHO. And I'm thinking as well that -- and we would have made sure that, you know, the general screening that happens for people, that the patients in Muckamore were accessing that as well. 14:47

DR. MAXWELL: So checking their blood pressure periodically? 14:47

A. Yeah. Yeah, and like breast screening and so on, cervical screening. Yeah.

DR. MAXWELL: Thank you.

231 Q. MS. BERGIN: In terms -- just staying with I suppose medical doctors, specifically, staff on site. You've referred to out-of-hours. Were there any doctors on site overnight at Muckamore? 14:48

A. No.

232 Q. And so you've referred to an example of an out-of-hours call, which might be if a patient had become particularly agitated in your evidence, and that might require a consultant on the phone to authorise PRN. What other types of situations would arise that would require you to -- I think you had said in your 14:48

statement that generally out-of-hours cover in your experience would have mostly been telephoned based?

A. It was, yes.

233 Q. It would have been call. Only very rarely would you have been required to go to Muckamore. 14:48

A. Mhm-mhm.

234 Q. What types of scenarios would you require you to go to the site?

A. It tended to be if a patient had been admitted.

235 Q. Okay. 14:48

A. And you would go to carry out an assessment and sign the relevant Mental Health Order forms.

236 Q. Okay. Thank you. Moving on.

DR. MAXWELL: Sorry, can I just add to that? So if there was a medical emergency, would you have expected 14:49 the nurses to call the out-of-hours GP service?

A. If it was -- they were --

DR. MAXWELL: Physical health.

A. Yeah. There were a number of GPs in the Antrim area who shared on-call specifically for Muckamore. 14:49

DR. MAXWELL: So there were two on-call systems. One for physical health, the GPs did?

A. Yes, that's right.

DR. MAXWELL: And one for mental health, which the psychiatry team did? 14:49

A. That's right, yes. Yes. And then obviously if it was an emergency it would have been 999.

DR. MAXWELL: Yes.

MS. BERGIN: Okay. Thank you. Moving on then to

restraint. At paragraph 35 you indicate that if restraint had been used on a patient then that would have been discussed at ward rounds, as part of the MDT meetings, and the team would explore possible triggers and collaborate with staff in terms of how to support the patient. How common, in your experience, was the use of restraint? I know that's a very broad question, but if you can give us some idea? 14:49

A. That's quite hard to answer, because again it's case by case. 14:50

237 Q. If we look at your time as a consultant more laterally that's probably the most recent experience you have at Muckamore.

A. Yeah.

238 Q. Would there have been, in your experience, a lot of restraint used that you were aware of, or are you able to tell us about whether there were patterns of restraint in terms of were you aware of it being more prevalent on certain wards or in relation to certain types of patient? 14:50 14:50

A. Yeah. Yeah, it was probably more patterns than anything. I suppose it's -- I am finding some of the questions a bit difficult because it is 16 years ago that I was a consultant.

239 Q. No, I appreciate that. I appreciate that. 14:50

A. And I didn't, you know, expect that I would be questioned on it. Yeah, I suppose it probably did vary ward to ward, because some wards were -- they would have had people who were more acutely unwell and so on,

and certainly if restraint was needed, that's when, you know, the whole team really would have been tended to be involved, and you would have had the behavioural team, or the behavioural nurses involved, and that's what I was referring to, you know, the antecedents behaviour and consequences, and they would have been looking for triggers, and the hope and the plan was that we would be able to identify triggers so that they could be addressed so that the behaviour didn't happen. 14:51

240 Q. In terms of restraint itself, would you, in any of your roles, have been involved either in the immediate restraint, for example, in relation to medication, or in the immediate aftermath, would that have triggered the involvement of a doctor? 14:51

A. I wouldn't have been involved on the immediate actions. We, the medical staff, we were trained with breakaway training, but we weren't trained to be involved in restraint. You would have been involved afterwards on occasion, you know, to be involved in the conversations and discussions about what might have triggered that and so on. 14:52

241 Q. But would there have been some type of -- did that trigger any type of, for example, mental state assessment? Was there a procedure where if a patient had undergone a particular type of restraint, or just a restraint, would that have triggered psychiatry involvement specifically? 14:52

A. I can't remember. Possibly SHO assessment.

242 Q. Okay. Are you able to say anything -- one of the

themes that we've explored in your evidence is the different types of admissions and the changes in admissions to Muckamore. Can you say anything about in your experience or your view whether the use of restraint increased, or decreased, or remained the same throughout your long period of involvement at Muckamore?

A. I can't really answer that. I don't know. I don't know.

243 Q. In terms then of -- one of the things that you've indicated that consultants and doctors would be involved in relation to is PRN. 14:53

A. Mhm-mhm.

244 Q. In terms of involvement around care plans, or treatment plans for seclusion and restraint, is that something that doctors would have had any input into? For example, about whether or not it was suitable? I appreciate it's often a safety matter, but whether it's something that would be suitable to be used on a patient, or was there any input from doctors in relation to seclusion and restraint? 14:53

A. It would have been discussed at the team meetings, the multidisciplinary team meetings.

245 Q. But in advance I'm referring to, in terms of whether -- you know, if you're saying PRN is something that would generally be prescribed for, is that something that would have been discussed in the course of MDTs in relation to a patient about whether that's even -- whether there were particular types that would be 14:54

suitable, or anything in particular that needed to be borne in mind by staff who would be carrying out restraints or seclusion in relation to patients?

A. Oh, okay. Well, I'm not really sure. I'm not sure.

DR. MAXWELL: Can I ask you, I probably got the benefit of reading the seclusion policy more recently than you. 14:54

A. Yeah. Yeah.

DR. MAXWELL: I think it did require, if seclusion went on for an hour or more, that a member of the medical staff was telephoned. 14:55

A. Would be -- uh-huh.

DR. MAXWELL: Do you remember being telephoned because a patient was in seclusion?

A. I think I must have been as an SHO, but it was 20 years ago and I can't remember. 14:55

DR. MAXWELL: You can't really remember. Okay. Thank you.

A. I'm sure I probably was, yes, but...

DR. MAXWELL: Okay.

246 Q. MS. BERGIN: At paragraphs 37 and 43 you have said that you didn't have any safeguarding concerns, but you knew how to and to whom to report any concerns that you had. 14:55

A. Mhm-mhm. I knew at the time. I can't remember now.

247 Q. Yes. Well, I wanted to ask you, you've said that you can't recall if, during your induction, and I appreciate it was some time ago, whether you undertook safeguarding treatment. But throughout the course of your time at Muckamore, between 2000 and 2008 substantively, can you recall doing any additional 14:55

safeguarding training in terms of the procedures to be followed and what to look out for?

A. Yes, I can particularly remember some safeguarding training with regards to children, but we would have had it for adults as well, but I don't really remember the details of it now. 14:56

248 Q. And can you recall if patients, and, again, no particular names are to be mentioned, but can you recall any patients, or relatives, or staff, ever bringing any concerns to you as a consultant? 14:56

A. No, not to me. No.

249 Q. And what then was your reaction to the revelations of abuse at Muckamore?

A. I found it very upsetting and quite shocking. That's all I have to say about it really. It is very distressing. 14:56

250 Q. Just picking up on that, did it cause you to reflect at all on anything that you had observed during your time at Muckamore?

A. No, it just -- I suppose it caused a lot of us to reflect on what we thought we were providing as a service, and we thought we were providing a service for people, very vulnerable people who really needed it, and it was just very distressing to find out what had been going on. 14:56 14:57

251 Q. If I can ask you, continuing I suppose on the same line in terms of -- well I suppose in the context of abuse, but also in terms of inspections, were you involved in relation to any RQIA inspections during your time at

Muckamore?

A. No. No.

252 Q. And I don't mean that RQIA specifically were looking at your department even, or you, but just generally did you have an awareness -- 14:57

A. Oh, I would have had an awareness. Yeah, I would have had an awareness that inspections were going on, but it wouldn't have involved me.

253 Q. You weren't involved. Okay. And what about your engagement then either as a registrar, or more 14:57 particularly I'm thinking about your role as a consultant, what engagement, if any, did you have with senior management or Trust Board members? Did you have any?

A. I would have had some engagement. But there would have 14:58 been other consultants that were more involved in the management end of things. And because my work from 2008 was all, all my clinical work was in the Northern Trust, I tended to have engagement with Northern Trust managers. 14:58

254 Q. And during your time then actually on the wards in Muckamore, do you recall, for example, you know any walk-arounds by any of the Trust Board or management, in terms of inspecting or walking through the wards? Is that something you can recall? 14:58

A. I think occasionally there were walk-arounds, yeah. But, again, I wouldn't have been involved, or I would have -- you know more latterly I wasn't -- you know, since 2008 I wasn't there really.

255 Q. If I could move then to, and we're almost finished, to resettlement and discharge of patients, and you've referred, and I'm not necessarily going to go through all of this, but at paragraphs 7, 38, 40 and 42, you refer to, I suppose, the times whenever you were involved in resettlement, or patients who were preparing for resettlement, and you've already said in fact in your evidence today that there was an eagerness to discharge people as soon as treatment was finished, but that resources weren't always available in the community to do so. You've said in your statement that resettlement is a long process and can take up to two years. In your experience, what factors caused that to be the case in terms of that length of time? 14:59 14:59

A. I suppose a number of factors. I suppose one of the factors is the patient themselves, because you have to try and find a placement that suits the patient and is able to accommodate the patient, and then on the other side of that, it's for the community to have the resources to be able to put that package together. 14:59 15:00

256 Q. And how common was it in your experience for patients to be ready to be discharged or for resettlement, but to be unable to do so because of that lack resources, how frequent was that or how common was that?

A. Well, there were sort of two categories. There were the people who were delayed discharge and then there were people who were on the resettlement list. When I was working on the resettlement ward as consultant, it was at the very end of that process, everybody in that 15:00

ward had been deemed to be resettled. Sorry, what was the question? Sorry.

257 Q. Just how frequently that would have occurred that you would have patients who there had been a delayed discharge, or they were ready to be resettled but they weren't able to be yet because of resources or... 15:01

A. Yeah, it was quite frequent. Yes, it was quite frequent.

258 Q. And can you say anything about the impact that that delay had on patients who were then remaining in Muckamore? 15:01

A. Yeah, yeah. For some patients that they would have been maybe ready for discharge, and from a mental state point of view quite healthy, but if there was quite a delay sometimes they could become unwell again. 15:01

259 Q. Okay. And one of the things you refer to in your statement is that when patients were discharged, sometimes on a trial basis, or resettled rather on a trial basis, their bed in Muckamore would have remained open for a period to see how the trial went, and 15:01 sometimes they would have returned, and when they did, you've I think said in your statement that then you would revisit the care plan and see if there was any fine tuning needed before attempting the trial again. Again, how frequently would that have occurred that 15:02 patients would have had to come back during the trial period?

A. Well, my experience was just on that one ward for about six or seven months. It was maybe one or two patients.

But that was at the very end of the resettlement process for that ward, it was the last number of patients being resettled from that ward. But maybe one or two or three patients maybe.

260 Q. In terms of staffing levels. At paragraph 45 you mention low staffing levels. When did you become aware that that was an issue? 15:02

A. I can't recall.

261 Q. Well, when you refer to low staffing levels are you referring to one type of staff, for example, nurses or care assistants, or is it general? 15:03

A. It would be generally, you know.

262 Q. General?

A. But it's the sort of the way it is across the NHS really. 15:03

263 Q. And are you able to tell the Panel anything about how that affected, if it did, the care and treatment that was provided to patients then with your staff? Did you see an impact?

A. I didn't directly see an impact. I suppose, as we referred to earlier on, if there wasn't enough, say, for example, psychology input, it might have meant that there were waiting lists, or people maybe weren't able to access the therapeutic work that they needed. So there would have been instances like that. 15:03 15:03

MS. BERGIN: I have no further questions, unless the Panel do?

H73 WAS QUESTIONED BY THE CHAIRPERSON AS FOLLOWS:

CHAIRPERSON: Just on that, the period that you're talking about, of course, in relation to low staffing levels, is pre-2008? 15:04

A. Mhm-mhm.

CHAIRPERSON: So it was a problem even then.

A. Yeah. Yeah.

CHAIRPERSON: Yes. Can I thank you. We've asked you to stretch your memory back quite a long way, and we're 15:04 aware of that, and you have helped us pre-2008. As you'll appreciate, our Terms of Reference go back to 1999.

A. That's right, yes.

CHAIRPERSON: So it's important that we get a span of 15:04 evidence covering the whole period. So can I thank you very much for coming along to assist the Inquiry. Thank you.

A. Thank you.

15:04

THE WITNESS THEN WITHDREW

CHAIRPERSON: Tomorrow, Ms. O'Hagan is going to be coming to give evidence. She's going to be supported, she's going to be brought by hospice staff and 15:05 supported by hospice staff. Can I say this, it is not proposed to examine her in any length, for obvious reasons. She is going to be given the opportunity of saying anything in addition to her statement that she

wishes to, and I'm not going to encourage lengthy questions being submitted to counsel for the Inquiry, for I hope obvious reasons. So, we will start with her at 10:00 o'clock and then carry on with the schedule. I apologise again for the late service of her statement, but everybody will understand why we're doing it in the way that we are. Thank you very much. See you tomorrow at 10:00. 15:05

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 15TH MAY 2024 AT 10:00AM 15:05