1 supportive psychotherapy. The behavioural nurses
2 obviously looked from a more behavioural, purely
3 behavioural perspective, and then the other allied
4 health professionals had their own areas of expertise,
5 such as occupational health and physiotherapy and so 14:42
6 on.
7 222 Q. And I've referred there to the part of your statement
8 were you say that these treatments would have been
9 provided where the resources were available. So would
10 it have been your experience that you had made a 14:42
11 referral, or your colleagues in psychiatry would make a
12 referral that you thought was appropriate, but a
13 patient wasn't able to avail of it because of
14 resources?
15 A. I can't recall details, but I think, although my memory 14:42
16 isn't great, but I think at times there wouldn't have
17 been staff in post to be able to accept the referrals,
18 so the referrals wouldn't have been made.
19 223 Q. And would that -- I appreciate you've already said that
20 you can't remember specifically. 14:43
21 A. Yes.
22 224 Q. But I suppose if you are able to answer this, would
23 that have been more about or more in terms of the
24 treatment or the therapy not being able to be provided
25 at all then to the patient or that there was a delay? 14:43
26 A. Possibly both. They maybe would have had waiting
27 lists.
28 225 Q. Okay. Moving on then to referrals in relation to
29 physical health issues, and at paragraph 18 you've said

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1 that:
2
3 "If a patient required further physical examination
4 following assessment, they would be referred generally
5 to Antrim Area Hospital." 14:43
6
7 Now, the Inquiry has heard evidence from relatives
8 about failures or delays in patients being diagnosed or
9 referred for treatment outside of Muckamore. During
10 your time at MAH, was there a GP on site, based on site 14:43
11 at Muckamore?
12 A. Not a GP based on site. Latterly GPs -- I'm trying to
13 recall. They would have been present on Saturday
14 mornings, and there was GP out-of-hours cover
15 throughout the week and at weekends. Day-to-day, 14:44
16 Monday to Friday, nine to five, the SHOs would have
17 carried out basic medical assessments and treatments
18 that were needed, and if anything needed more
19 complicated care, or care, secondary care, that then
20 went through to Antrim Area Hospital. 14:44
21 226 Q. So just so that I'm clear the doctor specialisms on
22 site would have been psychiatrists?
23 A. That's right, yeah.
24 227 Q. And then the SHOs who were potentially going to become
25 psychiatrists, but they were more generalist as part of 14:45
26 their training, is that correct?
27 A. That would have been correct. They would have, quite
28 recently have worked in medical wards and surgical
29 wards.

1 228 Q. And you've described the Saturday, I suppose clinics,
2 or GP attendances on a Saturday being on site?
3 A. Yeah. I can't really recall those.
4 229 Q. I suppose what I was going to ask you, because I
5 appreciate you've said you can't really recall that, 14:45
6 is, were you aware of patients having sort of scheduled
7 or periodic physical examination check-ups alongside
8 psychiatry input?
9 A. Patients would have had physical assessments on
10 admission and prior to discharge, or transfer from one 14:45
11 ward to another, or if they were presenting with
12 physical health symptoms and signs.
13 230 Q. Great. Thank you.
14 DR. MAXWELL: Can I just pick up on that? So we've
15 heard from a number of families that their relatives 14:46
16 would often have unexplained injuries, bruises and cuts
17 and things. Would you be aware of those, and
18 particularly when you were an SHO would you have done a
19 physical examination of a patient who had these
20 unexplained injuries? 14:46
21 A. Yeah. If it was brought to our attention, yes, we
22 would have done a physical examination, and I think
23 there were body charts with -- any bruising or injuries
24 would have been recorded on the body charts.
25 DR. MAXWELL: And we've also heard from some families 14:46
26 concerns about personal hygiene, concerns about dental
27 care and foot care. As an SHO, I suppose, would your
28 -- would you have periodically checked people's
29 physical health, or would you only have done that if

1 the nurses had asked you to?
2 A. It was carried out on admission, prior to discharge, or
3 if there was a transfer between wards. I'm trying -- I
4 think actually was there -- people who were there
5 longer stay, if I recall, had an annual review, which 14:47
6 would have included a physical health check, any bloods
7 that needed done, and a mental health assessment.
8 DR. MAXWELL: And was that the SHO --
9 A. That would have been the SHO. It would have been the
10 SHO. And I'm thinking as well that -- and we would 14:47
11 have made sure that, you know, the general screening
12 that happens for people, that the patients in Muckamore
13 were accessing that as well.
14 DR. MAXWELL: So checking their blood pressure
15 periodically? 14:47
16 A. Yeah. Yeah, and like breast screening and so on,
17 cervical screening. Yeah.
18 DR. MAXWELL: Thank you.
19 231 Q. MS. BERGIN: In terms -- just staying with I suppose
20 medical doctors, specifically, staff on site. You've 14:48
21 referred to out-of-hours. Were there any doctors on
22 site overnight at Muckamore?
23 A. No.
24 232 Q. And so you've referred to an example of an out-of-hours
25 call, which might be if a patient had become 14:48
26 particularly agitated in your evidence, and that might
27 require a consultant on the phone to authorise PRN.
28 What other types of situations would arise that would
29 require you to -- I think you had said in your

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1 statement that generally out-of-hours cover in your
2 experience would have mostly been telephoned based?
3 A. It was, yes.
4 233 Q. It would have been call. Only very rarely would you
5 have been required to go to Muckamore. 14:48
6 A. Mhm-mhm.
7 234 Q. What types of scenarios would you require you to go to
8 the site?
9 A. It tended to be if a patient had been admitted.
10 235 Q. Okay. 14:48
11 A. And you would go to carry out an assessment and sign
12 the relevant Mental Health Order forms.
13 236 Q. Okay. Thank you. Moving on.
14 DR. MAXWELL: Sorry, can I just add to that? So if
15 there was a medical emergency, would you have expected 14:49
16 the nurses to call the out-of-hours GP service?
17 A. If it was -- they were --
18 DR. MAXWELL: Physical health.
19 A. Yeah. There were a number of GPs in the Antrim area
20 who shared on-call specifically for Muckamore. 14:49
21 DR. MAXWELL: So there were two on-call systems. One
22 for physical health, the GPs did?
23 A. Yes, that's right.
24 DR. MAXWELL: And one for mental health, which the
25 psychiatry team did? 14:49
26 A. That's right, yes. Yes. And then obviously if it was
27 an emergency it would have been 999.
28 DR. MAXWELL: Yes.
29 MS. BERGIN: Okay. Thank you. Moving on then to

1 restraint. At paragraph 35 you indicate that if
2 restraint had been used on a patient then that would
3 have been discussed at ward rounds, as part of the MDT
4 meetings, and the team would explore possible triggers
5 and collaborate with staff in terms of how to support 14:49
6 the patient. How common, in your experience, was the
7 use of restraint? I know that's a very broad question,
8 but if you can give us some idea?
9 A. That's quite hard to answer, because again it's case by
10 case. 14:50
11 237 Q. If we look at your time as a consultant more laterally
12 that's probably the most recent experience you have at
13 Muckamore.
14 A. Yeah.
15 238 Q. Would there have been, in your experience, a lot of 14:50
16 restraint used that you were aware of, or are you able
17 to tell us about whether there were patterns of
18 restraint in terms of were you aware of it being more
19 prevalent on certain wards or in relation to certain
20 types of patient? 14:50
21 A. Yeah. Yeah, it was probably more patterns than
22 anything. I suppose it's -- I am finding some of the
23 questions a bit difficult because it is 16 years ago
24 that I was a consultant.
25 239 Q. No, I appreciate that. I appreciate that. 14:50
26 A. And I didn't, you know, expect that I would be
27 questioned on it. Yeah, I suppose it probably did vary
28 ward to ward, because some wards were -- they would
29 have had people who were more acutely unwell and so on,

1 and certainly if restraint was needed, that's when, you
2 know, the whole team really would have been tended to
3 be involved, and you would have had the behavioural
4 team, or the behavioural nurses involved, and that's
5 what I was referring to, you know, the antecedents 14:51
6 behaviour and consequences, and they would have been
7 looking for triggers, and the hope and the plan was
8 that we would be able to identify triggers so that they
9 could be addressed so that the behaviour didn't happen.
10 240 Q. In terms of restraint itself, would you, in any of your 14:51
11 roles, have been involved either in the immediate
12 restraint, for example, in relation to medication, or
13 in the immediate aftermath, would that have triggered
14 the involvement of a doctor?
15 A. I wouldn't have been involved on the immediate actions. 14:52
16 We, the medical staff, we were trained with breakaway
17 training, but we weren't trained to be involved in
18 restraint. You would have been involved afterwards on
19 occasion, you know, to be involved in the conversations
20 and discussions about what might have triggered that 14:52
21 and so on.
22 241 Q. But would there have been some type of -- did that
23 trigger any type of, for example, mental state
24 assessment? Was there a procedure where if a patient
25 had undergone a particular type of restraint, or just a 14:52
26 restraint, would that have triggered psychiatry
27 involvement specifically?
28 A. I can't remember. Possibly SHO assessment.
29 242 Q. Okay. Are you able to say anything -- one of the

1 themes that we've explored in your evidence is the
2 different types of admissions and the changes in
3 admissions to Muckamore. Can you say anything about in
4 your experience or your view whether the use of
5 restraint increased, or decreased, or remained the same 14:53
6 throughout your long period of involvement at
7 Muckamore?
8 A. I can't really answer that. I don't know. I don't
9 know.
10 243 Q. In terms then of -- one of the things that you've 14:53
11 indicated that consultants and doctors would be
12 involved in relation to is PRN.
13 A. Mhm-mhm.
14 244 Q. In terms of involvement around care plans, or treatment
15 plans for seclusion and restraint, is that something 14:53
16 that doctors would have had any input into? For
17 example, about whether or not it was suitable? I
18 appreciate it's often a safety matter, but whether it's
19 something that would be suitable to be used on a
20 patient, or was there any input from doctors in 14:53
21 relation to seclusion and restraint?
22 A. It would have been discussed at the team meetings, the
23 multidisciplinary team meetings.
24 245 Q. But in advance I'm referring to, in terms of whether --
25 you know, if you're saying PRN is something that would 14:54
26 generally be prescribed for, is that something that
27 would have been discussed in the course of MDTs in
28 relation to a patient about whether that's even --
29 whether there were particular types that would be

1 suitable, or anything in particular that needed to be
2 borne in mind by staff who would be carrying out
3 restraints or seclusion in relation to patients?
4 A. Oh, okay. Well, I'm not really sure. I'm not sure.
5 DR. MAXWELL: Can I ask you, I probably got the benefit 14:54
6 of reading the seclusion policy more recently than you.
7 A. Yeah. Yeah.
8 DR. MAXWELL: I think it did require, if seclusion went
9 on for an hour or more, that a member of the medical
10 staff was telephoned. 14:55
11 A. Would be -- uh-huh.
12 DR. MAXWELL: Do you remember being telephoned because
13 a patient was in seclusion?
14 A. I think I must have been as an SHO, but it was 20 years
15 ago and I can't remember. 14:55
16 DR. MAXWELL: You can't really remember. Okay. Thank
17 you.
18 A. I'm sure I probably was, yes, but...
19 DR. MAXWELL: Okay.
20 246 Q. MS. BERGIN: At paragraphs 37 and 43 you have said that 14:55
21 you didn't have any safeguarding concerns, but you knew
22 how to and to whom to report any concerns that you had.
23 A. Mhm-mhm. I knew at the time. I can't remember now.
24 247 Q. Yes. Well, I wanted to ask you, you've said that you
25 can't recall if, during your induction, and I 14:55
26 appreciate it was some time ago, whether you undertook
27 safeguarding treatment. But throughout the course of
28 your time at Muckamore, between 2000 and 2008
29 substantively, can you recall doing any additional

1 safeguarding training in terms of the procedures to be
2 followed and what to look out for?
3 A. Yes, I can particularly remember some safeguarding
4 training with regards to children, but we would have
5 had it for adults as well, but I don't really remember 14:56
6 the details of it now.
7 248 Q. And can you recall if patients, and, again, no
8 particular names are to be mentioned, but can you
9 recall any patients, or relatives, or staff, ever
10 bringing any concerns to you as a consultant? 14:56
11 A. No, not to me. No.
12 249 Q. And what then was your reaction to the revelations of
13 abuse at Muckamore?
14 A. I found it very upsetting and quite shocking. That's
15 all I have to say about it really. It is very 14:56
16 distressing.
17 250 Q. Just picking up on that, did it cause you to reflect at
18 all on anything that you had observed during your time
19 at Muckamore?
20 A. No, it just -- I suppose it caused a lot of us to 14:56
21 reflect on what we thought we were providing as a
22 service, and we thought we were providing a service for
23 people, very vulnerable people who really needed it,
24 and it was just very distressing to find out what had
25 been going on. 14:57
26 251 Q. If I can ask you, continuing I suppose on the same line
27 in terms of -- well I suppose in the context of abuse,
28 but also in terms of inspections, were you involved in
29 relation to any RQIA inspections during your time at

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1 Muckamore?
2 A. No. No.
3 252 Q. And I don't mean that RQIA specifically were looking at
4 your department even, or you, but just generally did
5 you have an awareness -- 14:57
6 A. Oh, I would have had an awareness. Yeah, I would have
7 had an awareness that inspections were going on, but it
8 wouldn't have involved me.
9 253 Q. You weren't involved. Okay. And what about your
10 engagement then either as a registrar, or more 14:57
11 particularly I'm thinking about your role as a
12 consultant, what engagement, if any, did you have with
13 senior management or Trust Board members? Did you have
14 any?
15 A. I would have had some engagement. But there would have 14:58
16 been other consultants that were more involved in the
17 management end of things. And because my work from
18 2008 was all, all my clinical work was in the Northern
19 Trust, I tended to have engagement with Northern Trust
20 managers. 14:58
21 254 Q. And during your time then actually on the wards in
22 Muckamore, do you recall, for example, you know any
23 walk-arounds by any of the Trust Board or management,
24 in terms of inspecting or walking through the wards?
25 Is that something you can recall? 14:58
26 A. I think occasionally there were walk-arounds, yeah.
27 But, again, I wouldn't have been involved, or I would
28 have -- you know more latterly I wasn't -- you know,
29 since 2008 I wasn't there really.

1 255 Q. If I could move then to, and we're almost finished, to
2 resettlement and discharge of patients, and you've
3 referred, and I'm not necessarily going to go through
4 all of this, but at paragraphs 7, 38, 40 and 42, you
5 refer to, I suppose, the times whenever you were 14:59
6 involved in resettlement, or patients who were
7 preparing for resettlement, and you've already said in
8 fact in your evidence today that there was an eagerness
9 to discharge people as soon as treatment was finished,
10 but that resources weren't always available in the 14:59
11 community to do so. You've said in your statement that
12 resettlement is a long process and can take up to two
13 years. In your experience, what factors caused that to
14 be the case in terms of that length of time?
15 A. I suppose a number of factors. I suppose one of the 14:59
16 factors is the patient themselves, because you have to
17 try and find a placement that suits the patient and is
18 able to accommodate the patient, and then on the other
19 side of that, it's for the community to have the
20 resources to be able to put that package together. 15:00
21 256 Q. And how common was it in your experience for patients
22 to be ready to be discharged or for resettlement, but
23 to be unable to do so because of that lack resources,
24 how frequent was that or how common was that?
25 A. Well, there were sort of two categories. There were 15:00
26 the people who were delayed discharge and then there
27 were people who were on the resettlement list. When I
28 was working on the resettlement ward as consultant, it
29 was at the very end of that process, everybody in that

1 ward had been deemed to be resettled. Sorry, what was
2 the question? Sorry.
3 257 Q. Just how frequently that would have occurred that you
4 would have patients who there had been a delayed
5 discharge, or they were ready to be resettled but they 15:01
6 weren't able to be yet because of resources or...
7 A. Yeah, it was quite frequent. Yes, it was quite
8 frequent.
9 258 Q. And can you say anything about the impact that that
10 delay had on patients who were then remaining in 15:01
11 Muckamore?
12 A. Yeah, yeah. For some patients that they would have
13 been maybe ready for discharge, and from a mental state
14 point of view quite healthy, but if there was quite a
15 delay sometimes they could become unwell again. 15:01
16 259 Q. Okay. And one of the things you refer to in your
17 statement is that when patients were discharged,
18 sometimes on a trial basis, or resettled rather on a
19 trial basis, their bed in Muckamore would have remained
20 open for a period to see how the trial went, and 15:01
21 sometimes they would have returned, and when they did,
22 you've I think said in your statement that then you
23 would revisit the care plan and see if there was any
24 fine tuning needed before attempting the trial again.
25 Again, how frequently would that have occurred that 15:02
26 patients would have had to come back during the trial
27 period?
28 A. Well, my experience was just on that one ward for about
29 six or seven months. It was maybe one or two patients.

1 But that was at the very end of the resettlement
2 process for that ward, it was the last number of
3 patients being resettled from that ward. But maybe one
4 or two or three patients maybe.
5 260 Q. In terms of staffing levels. At paragraph 45 you 15:02
6 mention low staffing levels. When did you become aware
7 that that was an issue?
8 A. I can't recall.
9 261 Q. Well, when you refer to low staffing levels are you
10 referring to one type of staff, for example, nurses or 15:03
11 care assistants, or is it general?
12 A. It would be generally, you know.
13 262 Q. General?
14 A. But it's the sort of the way it is across the NHS
15 really. 15:03
16 263 Q. And are you able to tell the Panel anything about how
17 that affected, if it did, the care and treatment that
18 was provided to patients then with your staff? Did you
19 see an impact?
20 A. I didn't directly see an impact. I suppose, as we 15:03
21 referred to earlier on, if there wasn't enough, say,
22 for example, psychology input, it might have meant that
23 there were waiting lists, or people maybe weren't able
24 to access the therapeutic work that they needed. So
25 there would have been instances like that. 15:03
26 MS. BERGIN: I have no further questions, unless the
27 Panel do?
28
29

1 H73 WAS QUESTIONED BY THE CHAIRPERSON AS FOLLOWS:
2
3 CHAIRPERSON: Just on that, the period that you're
4 talking about, of course, in relation to low staffing
5 levels, is pre-2008? 15:04
6 A. Mhm-mhm.
7 CHAIRPERSON: So it was a problem even then.
8 A. Yeah. Yeah.
9 CHAIRPERSON: Yes. Can I thank you. We've asked you
10 to stretch your memory back quite a long way, and we're 15:04
11 aware of that, and you have helped us pre-2008. As
12 you'll appreciate, our Terms of Reference go back to
13 1999.
14 A. That's right, yes.
15 CHAIRPERSON: So it's important that we get a span of 15:04
16 evidence covering the whole period. So can I thank you
17 very much for coming along to assist the Inquiry.
18 Thank you.
19 A. Thank you.
20 15:04
21 THE WITNESS THEN WITHDREW
22
23 CHAIRPERSON: Tomorrow, Ms. O'Hagan is going to be
24 coming to give evidence. She's going to be supported,
25 she's going to be brought by hospice staff and 15:05
26 supported by hospice staff. Can I say this, it is not
27 proposed to examine her in any length, for obvious
28 reasons. She is going to be given the opportunity of
29 saying anything in addition to her statement that she

1 wishes to, and I'm not going to encourage lengthy
2 questions being submitted to counsel for the Inquiry,
3 for I hope obvious reasons. So, we will start with her
4 at 10:00 o'clock and then carry on with the schedule.
5 I apologise again for the late service of her 15:05
6 statement, but everybody will understand why we're
7 doing it in the way that we are. Thank you very much.
8 See you tomorrow at 10:00.
9
10 THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 15TH MAY 2024 AT 15:05
11 10:00AM
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