MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 15TH MAY 2024 - DAY 83

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THE INQUIRY RESUMED AS FOLLOWS ON WEDNESDAY, 15TH MAY 2024

CHAIRPERSON: Right. Well, good morning everyone. Just before we start and bring the witness in, just a few words from me. Because of the nature of the evidence, and indeed the witness, and because I do understand that emotions may run high, can I just ask everybody in the public gallery, many of whom I suspect are here to support and perhaps thank Geraldine O'Hagan, just to ensure that throughout the evidence everybody in this room, and indeed in Room B, remains silent. This has to be a safe and welcoming space, obviously, for everybody, and expressions of either approval or disapproval from those attending don't assist. 10:04 10:04 10:04

So, could I also remind everybody to have their telephones off, or at least on silent. And we'll then get the witness in. I think, Mr. Doran, you're going to say a few words when we bring the witness in. 10:05

MR. DORAN: Yes, indeed, Chair.

CHAIRPERSON: Okay. Right.

(Short pause in proceedings) 10:06

THE WITNESS: Good morning.

CHAIRPERSON: Good morning, Ms. O'Hagan. So, I think, just before the witness is sworn, counsel to the

Inquiry is going to say a few words, largely to welcome you.

THE WITNESS: Thank you.

CHAIRPERSON: You know this room quite well, you've been here often. But I'll hand over briefly to Mr. Doran. 10:07

INTRODUCTION BY MR. DORAN

MR. DORAN: Yes, Chair and Panel. I just want to say a few words by way of introduction this morning before handing over to Mr. McEvoy. There are three witnesses listed in the schedule. First, Geraldine O'Hagan. And I am very pleased to see that Geraldine is with us in person this morning for the presentation of her evidence to the Inquiry. 10:07 10:07

The oral evidence of H260 is then scheduled to be heard at 11:30. And the day's evidence will close with the reading of two statements by Ms. Bergin. Those are the statements of H230 and H339. 10:07

Mr. McEvoy will be reading in Geraldine O'Hagan's statement in a moment, but I would like to say a few words on behalf of the Inquiry team before that is done. 10:08

As the Panel is aware, Ms. O'Hagan has acted as a family liaison social worker in the specific context of

the 2017 Safeguarding Investigation. In that role, she has provided support to families and individuals who have been affected by the issues at the centre of the investigation. The Panel and all Core Participants will have had sight of Ms. O'Hagan's statement and will 10:08
therefore be aware that she has very recently been diagnosed with a serious illness.

In the present circumstances, I think it's fair to say that she would have been very well entitled to 10:08
prioritise her own care and well-being over the provision of assistance to the Inquiry. To her great credit, however, she has provided a detailed statement to the Inquiry and has attended in person today to assist with the Inquiry's work. 10:09

This is not at all surprising. I can recall the very early engagement sessions that the Inquiry organised for the purpose of introducing families and others to the Inquiry's work. Ms. O'Hagan attended those 10:09
sessions and provided significant support to families in their early interactions with the Inquiry and its staff.

Moving on from those early events held by the Inquiry, 10:09
in her role as family liaison social worker, Ms. O'Hagan has provided ongoing support to a number of witnesses and families in their engagement with the Inquiry. On many occasions she attended the hearing

room in the course of the patient experience evidence, and sat alongside witnesses as they gave highly personal accounts of their experiences and the experiences of their family members at the hospital.

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One of the key objectives of an Inquiry is to ensure that the voices of those affected by the events under scrutiny are properly and fairly heard. Ms. O'Hagan has played a significant part in making that happen. And on behalf of the Inquiry team, and indeed on behalf 10:10
of those whom she has assisted, I would like to record our sincere gratitude for the contribution that she has made.

CHAIRPERSON: And I ought to say that I'm aware of others in the room who wanted to express orally similar 10:11
gratitude, including the Trust, but I have taken the view that the best person to do that is counsel to the Inquiry.

THE WITNESS: Thank you.

MR. DORAN: Thank you, Chair. And Mr. McEvoy will now 10:11
proceed with the reading of the statement.

CHAIRPERSON: Right. Thank you. Mr. McEvoy.

THE WITNESS: Thank you.

MS. GERALDINE O'HAGAN, HAVING BEEN SWORN, WAS EXAMINED 10:11
BY MR. McEVOY AS FOLLOWS:

MR. McEVOY: Well, good morning, Ms. O'Hagan.

A. Good morning.

1 Q. We've met once or twice before.
2 A. We have, indeed.
3 Q. Before you is a bundle with your statement in it, I
4 hope. You recognise that as being a statement that you
5 have prepared -- 10:12
6 A. I do, indeed.
7 Q. -- for the Inquiry. And do you wish to then adopt that
8 statement as your evidence to the Inquiry?
9 A. Yes, please.
10 Q. Okay. So, as Mr. Doran has indicated, I am now going 10:12
11 to read it into the Inquiry record. All right? And
12 it's statement dated 3rd May this year:
13
14 "I, Geraldine O'Hagan, make the following statement for
15 the purpose of the Muckamore Abbey Hospital Inquiry. 10:12
16
17 My connection with Muckamore Abbey Hospital is that I
18 am a Belfast Health and Social Care Trust (Belfast
19 Trust) family liaison social worker (FLSW) to the 2017
20 CCTV Adult Safeguarding Investigation in Muckamore. 10:12
21
22 I support families and individuals who have been
23 identified as victims of alleged abuse on review of
24 CCTV footage pertaining to the 2017 Operation Turnstone
25 police led investigation. There is a family liaison 10:13
26 protocol of April 2019 which speaks to my role as an
27 FLSW and sets out my roles and responsibilities.
28 Additional information is provided at Exhibit 4.
29

The relevant time period that I can speak about is from December 2017 to date."

There is then a section headed "Significant Note":

10:13

"Before I get into my statement, there is something significant that I must share to help the Panel understand where I am at with my statement at this point. I am very recently diagnosed with terminal illness. I have been told I have Stage 4 lung cancer, which has spread to my spine and bones. This news came out of the blue for me, as I had not long started my statement giving process when I found this out. Therefore, my diagnosis and subsequent prognosis, which is that I do not have long to live, means that my approach to this statement has been affected and it has, no doubt, shortened how comprehensively I wanted to share, but I will try my best.

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I am heartbroken that I will not be here to play my part in delivering a much needed service for these families until the end of their journey with the investigation. I hold these families in the highest regard and always try my best to be a voice for those who often do not have the communication and power to protect and speak up for themselves.

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I came into my FLSW post to speak up for the voiceless and to support the families on this difficult journey.

I hope I am here, and in the hearing room, when my statement is read in, but if I am not, please forgive me for not being with the families until the end of this journey with them. Additionally, and in that case, I give the Public Inquiry my full consent to take 10:15
and use my words to help the goals and aims of the Inquiry. I do not need anonymity either at this stage, because the fear of losing my job or of reprisals is no longer something that has a hold over me. I ask the Chair and I ask the Inquiry Panel to promise to try 10:15
their best in delivering on their promises to all of us and patients and families. I ask that you try your best to get to the bottom of things in Muckamore Abbey Hospital and to really help make things better in the future for people with learning disabilities and their 10:15
families.

To give a background of my health and social care experience, to include and my pre and post social care work qualification, in order to help the Panel 10:15
understand my longstanding experience in the learning disability field for both adults and children, my first relevant role was working as a health care assistant and as an advocate with Crossroad Care NI, supporting families who were impacted by stroke, multiple 10:16
sclerosis, and those caring for children, adolescents and adults with learning disabilities. I worked in this role from 1995 to February 2000 when, at that point, I qualified as a professional social worker and

graduated from the University of Ulster, obtaining a BSc Honours in social work.

I always wanted to be a social worker, as I myself experienced being in receipt of social services from a young age. I was placed in care as a young girl and because I have experience of institutional care myself as a service user, this informed my views of what good care and bad cares look like. I have always felt that my own difficult experiences in early life have helped me to be a better social worker, as I can truly empathise with people who feel hopeless and lost. Being a kind person and being an advocate for people in those circumstances really makes a difference to them, and I hope I have made a difference to the people I have worked with. I cannot emphasise enough how important it is that people who work in this profession really have the right value base, because workers have much more power over the people they care for. So, just as a worker with the right value base can make a positive difference to the lives of vulnerable people, a worker with the wrong values can really hurt vulnerable people. I hope I have been true to my professional values of fairness, unconditional positive regard for others, and social justice during my working life. If you do not know how to do the right thing, even if no one is watching, then you should not be in the caring profession.

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As part of my social work training, I attended a number of placements throughout my studies, to include elderly care within the South Eastern Health and Social Care Trust and supporting young vulnerable people under the care of the Belfast Trust. These experiences all helped and form the kind of social worker I am today. 10:18

Immediately after qualifying as a social worker, I secured a role with the Belfast Trust, working within Child Protection Services, based on the Shankill Road, Belfast. At that time, within the Belfast Trust, as was the case with other Trusts, children's protection services included looked after children who were subjected to care orders, as well as fostering and adoption services. I played a key role in supporting contact between looked after children and their biological parents. After three years, I moved to Knockbracken Healthcare Park, where I specialised in supporting vulnerable individuals who were exploited through prostitution and manipulation in the community. I also supported individuals experiencing domestic violence and homelessness. I then joined the social work team working in children's disability services in Knockbracken Healthcare Park in 2007. As part of my role, I assessed the individual needs of children and young people with learning disabilities and organised packages of care to be provided to them in collaboration with their families. This work gave me an insight into how essential early intervention, a 10:18 10:18 10:19 10:19

good multidisciplinary team and properly resourced resettlement and respite services are to providing care.

People with learning disabilities are more likely to end up in care or in hospital when there are not enough resources in the community to help them and their families keep them in the community. This is a fact. Working in children's disability also gave me an insight into the importance of families being at the forefront of any decision-making and planning, especially when that young person lacks capacity to manage this themselves. I learned that when families were excluded or poorly involved in decision-making from the outset, it had a devastatingly negative impact on the success of the care for the young person with disabilities. It was clear from all my combined experiences in health and social care to date that if you do not involve patients and families in their own care and decision-making, then nothing works properly, and families and their loved ones end up feeling totally hopeless and totally powerless. I am positive from a business point of view it also ends up costing more money. So, if for no other reason than that, Belfast Trust should pay heed to the cost of getting things wrong. This experience and insight helped me identify times when services were poor in terms of advocacy, respite, least restrictive approaches, and resettlement, and Muckamore Abbey reflected much of

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that too often.

In my social work role in children's disability services I advocated on behalf of individuals to ensure that their needs were met. I worked in this role for 12 years from 2007 to 2019, and I know what good advocacy and bad advocacy looks like, and I recognise when obstacles are put in the way of advocates to make their job harder and make it less likely, they will succeed on behalf of the service user they are supporting. 10:21 10:22

In and around 2019 I came across an expression of interest advertised by the Belfast Trust for a Band 7 Designated Adult Protection Officer (DAPO) and I saw from reading the job description that part of the role involved family liaison social work for families affected by the reported abuse in Muckamore Abbey Hospital. I also saw that a big part of the role meant working in partnership with other agencies, mainly the PSNI. I was interested in the role as I believed that with my experience, I could be a voice for young people with learning difficulties who did not have one, particularly those who are non verbal, and I had lots of experience by that point of working in good partnership with other agencies for the benefit of service users. I applied for the role by way of secondment from my position in children's disability services. I did not know anyone who worked in 10:22 10:22 10:22

Muckamore at the time of applying for the role.

I began my role as a DAPO in December 2019 with the 2017 Adult Safeguarding CCTV Investigation team. When I was initially appointed to the team, my core job was 10:23
to review referrals which captured CCTV footage of incidents of abuse. I learned that there were other social workers in the team that had family liaison roles, but at that initial point I was not allocated to this type of work. The team was based in McKinney 10:23
House in Musgrave Park Hospital. I attended an informal type of induction and CCTV training. The team also included H772, Band 7 social worker; H781, Band 7 social worker; H773, Band 7 senior nurse and MAPA expert. The team was led by H826, Band HB Senior 10:24
Service Manager; H828, Band A; H827, Band 8A; and H887, Band 8A, who was also my line manager. The management personnel in the team were all social workers.

I found the task of reviewing CCTV footage challenging. 10:24
I was looking at footage of vulnerable patients who were being poorly treated and abused by their ward staff. The big challenge for me was the speed at which I was asked to view the footage, as well as how I was being asked to view the footage and this was all coming 10:24
from the senior management. At the start of my work with the team, I was encouraged in my induction to take my time and become familiar with this type of work. However, the person who gave me the induction had very

different views from the senior management when it came to this and, once I got into the work, it was very different from the induction. Looking at CCTV to try and figure out harm to patients was not as straightforward as you might imagine, because you had to identify the staff, as well as what was going on for the patient before, during and after the incident, so you could not rush through it. The emphasis from the senior managers was speed and getting our weekly statistics to be as high as possible, and it did not matter if this was harmful to working out what happened to the patient. This left me feeling quite worried, because I did not want to fall behind in any work, but at the same time I wanted to do my work well and not miss anything. If you go too fast when reviewing CCTV cameras, you miss a lot of things, but no matter how often I tried to raise this with some of the other DAPOs and the senior managers, and talk about the duty towards these patients, I felt that some of the DAPOs and all of the management became more annoyed with me and against me for not falling into line with them on the statistics issue. I was conscious that I was new to the team and I watched how other staff who were there longer than me raised the issue of speed and the big risk that things were being missed, only to see them being shot down at team meetings and treated in a bad way by management. It was very unprofessional and I was disturbed that two of the DAPOs appeared to go along with this approach. When I asked them what they

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thought of the speed issue they would say things like "It does not matter if things are missed as the police have the footage too, they can pick it up." I found statements like that very far removed from proper social work and at times I even wondered what social workers like this were doing on such an important team. 10:27

So, for example, I was told by H887 that when I was viewing CCTV footage I was to review at least 8 cameras showing an incident occurring at different angles at one time. I was told that it was not acceptable to view in realtime and I had to at least be up to eight times the speed. It was impossible to safely watch cameras at this speed, and all at the same time, without missing lots of vital information. I knew this had to be wrong. I raised my concerns with H887, who told me that other team members were doing it and that she could see no reason why I could not view cameras like this. Her response made me feel undermined, particularly as I had expressed my concern that I would not pick up on things that may be important. I told H887 that I was struggling with managing eight or more cameras at a time and that I may be better in a family liaison role. I asked her to consider moving me into direct work with families instead. She initially seemed to be open to this suggestion. She asked me not to discuss it with anyone else in the team and she would talk to H826 about it. 10:27 10:27 10:27 10:28

Also, to make things a little more challenging for me, I have a diagnosis of dyslexia, which means that I require administrative support for me to transcribe my notes after reviewing the CCTV footage. The Belfast Trust was aware of my support requirements, and long before I joined the CCTV investigation team, the Trust appointed H255 to provide administrative support to me when I worked in Knockbracken Healthcare Park by way of reasonable adjustment. This support did not initially transfer with me when I moved to the 2017 CCTV review team, despite it having been made clear to the management at the point of application and interview that these were my needs and I already had reasonable adjustments in place. They said that was no problem at the time of my recruitment. However, once I got into the job role and the issue of speedy viewing came to the fore, I felt that I was resented for my dyslexia diagnosis and made to feel that I was not fit to do the job. I informed H887 that I needed support in my role. However, this was not forthcoming, and the way this manager started to treat me was not good. She said that I would not need admin support and there would be no role for H255. I pressed H887 if H255 could be brought in and provide administrative support as she was experienced in working with me and that always met with disapproval. In the end, I had to involve the support of Disability Action Workable Programme, Miriam Bacon, to advocate and press H887 to give me my reasonable adjustments. The Department of Communities

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Officer, Nuala McCourt, also supported this push to impress upon my social work managers to provide my reasonable adjustments. I have notes from this period and can provide the Inquiry if needed. Finally, after much advocacy, H255 was allowed to do ten hours per week with me, but it took until some time in and around the end of February 2020. When the team realised H255's value as an administrative assistant, her hours were increased to full-time administrative assistant for the team, with a dedicated time of ten hours to meet specifically with me each week to help with my administration needs. 10:30 10:30

After viewing footage, I drafted a chart and gave it to H887, who sent it to H826, who in turn sent viewing statistics to the executive team. I was also supposed to make referrals on any adult safeguarding matters that I picked up. At this time of me handling safeguarding referrals and viewing CCTV, I did not speak to the PSNI or have any kind of working relationship with them. This was not the way it would be done in the community, which would have involved me having contact with the PSNI. But in this particular team, communication with the PSNI was handled only by the senior managers that I mentioned. 10:31 10:31

I reviewed CCTV footage for three to four months and identified a pattern of when incidents seemed to occur, which I always noted in my incident records. For

example, where I identified certain staff were working a shift together on a ward, they formed a clique and, therefore, it was likely an incident would occur: I noticed that when a particular group of individuals were not working together, they behaved in a different manner. When they worked on separate wards, they treated patients well, but when they came together, they behaved badly. At the time of reviewing CCTV footage, I did not know if staff were related or had personal connections to each other. I was aware there was a human resources team elsewhere in McKinney House, but at that time I did not have much contact with them, if any at all, so I cannot really give an account of what they did for the investigation. It seemed that only senior management handled communication with the human resources team and I was not kept in the loop about how that was meant to work. 10:32 10:32 10:32

I cannot describe how horrific it was watching CCTV showing vulnerable people being treated so badly. I witnessed patients being physically abused. Footage often showed staff ignoring patients and I wondered if patients sometimes acted out because they were bored, with no meaningful activities to do. There is one incident that remains in my mind and bothers me. On this occasion, staff were holding a patient, P60, by his head on a table so that he could not move and free himself. He looked very frightened and the restraint by the staff looked to be way over the top, and by the 10:33 10:33

look on P60's poor face, from the heaviness staff seemed to be pressing down on him, it was causing P60 pain. I was aware that P60 wanted a cigarette and it seemed to be the trigger that had made staff respond to him in an unfriendly way. But they quickly moved on him, taking a hold of him on both sides and then pressing his head on the table with aggression, with his arms bent up behind his back. I remember some other patients in the background standing watching this. One of them was laughing and another one looked afraid. I remember calling over one of the other DAPOs, H781, to help me identify the staff involved to talk to her about the incident. She said to me that when she started, she had to put work in to identify staff herself and that I should be doing this on my own. In relation to how staff were treating P60, she just shrugged her shoulders and said "That happens all the time." She did not seem bothered by this and she did not help me identify the staff involved. I felt horrified at what was happening to this patient, as well as the unhelpful and uncaring response of the social worker. I do not think the Belfast Trust should be employing staff like this social worker, who do not seem to care about what happened to patients in Muckamore Abbey Hospital. 10:33 10:34 10:34 10:34 10:35

I experienced a lot of bullying from H781 and H772, who were very close friends when I worked with the CCTV review team. This bullying came in the form of being

unfriendly, unhelpful, and excluding me. I overheard H781 saying one day that I was not dyslexic, but instead I was lazy and I was using dyslexia not to work. I became aware that these things were being said about me to my manager, H887, and I believe this influenced her in how unfriendly she also became with me. This was very distressing for me and I wondered what kind of team this was. If DAPOs were not able to support a colleague who had a disability and learning need, then why were they involved in understanding the abuse of patients with learning disabilities? I found this attitude was also reflected in the behaviour of the senior managers in the team, who I knew were turning a blind eye to the bullying behaviour of these DAPOs, as the same DAPOs were producing good statistics. 10:35 10:35 10:36

I continued watching footage, which I found very upsetting and I was often tearful when watching it. I again shared my distress and concerns about reviewing the footage and viewing at speed with H887, who told me that she would try to secure a family liaison role for me as soon as possible, on the condition that I did not speak to anyone else in the team about this until she spoke with H826 first. A few days later I was speaking to H722 and told her that I found reviewing the CCTV difficult. In an effort to connect with my peer and try to have her be friendlier towards me, I told H772 that H887 said that she would try to find me an FLSW 10:36 10:36

role. I advised her that it was to be kept quiet until it was sorted out for me. However, H772 complained about this news to senior management, and the next thing, I was called in to H887's office, where she told me that the offer for me to work as an FLSW was no longer on the table as I shared our discussion with other team members. This was typical of how the team operated under that management, and I became more and more concerned that they did not have the patients' best interests at heart at all. 10:37

At this time FLSW2 was the main FLSW with whom I had some low level interaction when he required additional support, as there were a lot of families affected under Operation Turnstone. I was keen to move to a full-time FLSW role, so I was very upset when H887 told me the family liaison role was no longer an option for me, because I disobeyed her. After this, I was constantly called in to H887's office where she would criticise my style of recording of what I had seen on the CCTV footage. She made me feel like an idiot. This all seemed to have an even worse effect on how some of my colleagues treated me and the bullying I experienced intensified. H781 and H772 continued to isolate me from the team. I did not formally raise the issues I was experiencing at that time, as I did not feel that senior management would recognise it or support me. I did speak to my other peers, FLSW4, FLSW2 and H773, who supported me and gave me helpful advice. One day I was 10:37 10:38 10:38

going to buy fish and chips for lunch and offered to get some for the team. Everyone except FLSW4 refused. FLSW4 shared a fish and chip with me, and after this, H781 and H772 ignored her too. They often made comments about FLSW4 as well, particularly about her using highlighters or asking questions in meetings. They did not like anyone who was a conscientious worker.

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Some time in and around March 2020, I was told that senior management within the review team, to include H887, H828, H827 and also the senior service manager, H826, were moving back in to their former posts in adult safeguarding within the community. It seemed to be a time when it looked like the team would be disbanded completely and the future of the work was unknown. I was not given any reassurance or guidance as to what would happen to patients that had been viewed or their families. It all seemed to be up in the air.

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In April 2020, a new senior management team was brought in, led by H238, who was an adult safeguarding expert for the Belfast Trust. H805 and H254, who are both Band 8A social workers, formed the new management team. I previously worked with H238 in adult safeguarding during my time in Knockbracken Healthcare Park, and I was delighted to hear she was to be the new service manager. I had a good working relationship with H238

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and I knew she was a social worker with the right values and compassion and, at the end of the day, having the right values in this profession is more important than anything else, because if you have the wrong values, a person like that could cause a lot of damage to people and healthcare work. I told H238 about my concerns and difficulties when reviewing the CCTV footage and the whole ethos of the previous management in not caring about missing vital safeguarding concerns as long as viewing statistics were high. I also told H238 about the bullying I experienced and I was clear with her that social workers with terrible values should be dealt with properly, instead of just being ignored for an easy life for a manager, or moved sideways elsewhere in the Belfast Trust, which seems to be what the Trust always does with bad characters. I also talked to H238 about my relationships that I had started to build with some of the families I was working with, and I was delighted when H238 told me that as the families had been through so much that they deserved a Rolls Royce treatment. It was so refreshing to hear this new attitude from a senior manager and I felt much better about the work. She told me she appreciated me telling her how I found it difficult to manage and that I would be great in an FLSW role. I began working as an FLSW in earnest from April 2020. 10:41 10:41 10:41 10:41 10:42

H238 took to overseeing how the work with families was

managed and allocated and she sent me details of individuals and families that I was to work with. I had access to patient records through PARIS, double-check information about the patient or family and who else in the community was linked to them. My main role was to contact family members of patients to inform them that their loved ones came up on CCTV footage as being involved in an incident. As the PSNI were actively investigating, I provided a brief factual overview of what occurred to families and advised them that the Belfast Trust was also investigating the concerns. I told families that I was told by Belfast Trust managers that the abuse was being taken very seriously and to reassure the families that no stone would be left unturned. I always relayed that message to the families and at the same time gave them support as required. The PSNI also contacted the families and I was contacted by the police family liaison and/or the families when that happened. I provided families with my contact details and told them that they could contact me at any time. 10:42 10:43 10:43 10:43

Due to pandemic restrictions in 2020, I contacted families by telephone, or met with them on Zoom or Teams, being able to see people face to face, even via a computer screen, was better than nothing, and we just made it work. Some individuals who had experienced abuse were still patients in Muckamore, whilst others had been resettled in the community. Among the 10:43

families that I supported, some of their loved ones remained in Muckamore and were on Six Mile or Cranfield 1 Wards. I supported families by listening to their concerns and being there to help them process what they were told by us or the police in relation to the abuse allegations. There was a lot of anger and hurt in the families' responses and often disbelief that this had happened. There was a lot of guilt felt by families who worried they had let their loved one down by letting them go into Muckamore Abbey Hospital in the first place. Families blamed themselves for not seeing signs of abuse, or worse, telling me that they had worries and concerns, such as seeing bruising, but they felt not listened to when they reported their concerns to ward managers or to social workers. P5's mother is an example of one family who said she worried about the frequent bruising seen on her daughter's body. She was told that P5 must have either caused it to herself or it happened when she was resisting staff who had had to restrain her. I always say to families that the guilt is not theirs to feel. After all, they were trusting that Belfast Trust staff would be professional and look after their loved ones and not abuse them. Many of the families continue to really suffer from this, which I think is desperately sad.

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I supported families by promoting self-care and looking after their mental health after hearing about their loved ones being involved in an incident. I also

helped them access any benefits to which they were entitled or helped them access any services that would alleviate some of their problems. I linked families in with other services as appropriate and as time went on and they trusted me, I was asked to advocate for them on current issues with which they were struggling. My goal was always to meet with families and patients in person, as soon as possible, so I could get to know them to better support families. It took a long time for families to trust me, as they saw me as part of the Belfast Trust, which they no longer trusted. I have established good relationships with families and individuals who were abused, and this has made a huge difference in the level of support that is given to them. 10:46 10:46 10:46

Once the Covid-19 restrictions eased around 2021, I met with families and individuals affected by the abuse in Muckamore in their family home and this was much better. Throughout the investigations the PSNI also met with families to update them on progress. I supported families when they met with PSNI, who gave them information about their loved one being involved in an incident that was recorded on CCTV footage. I worked closely with the PSNI and I valued this partnership because it ultimately benefited the families. I was aware of the poor working relationship between the previous management team and the PSNI, because I saw it and also was aware of the talk about 10:46 10:47

it from within the team, but I never understood it. It never made sense why the previous social work managers had a problem with the PSNI. After all, it was a criminal investigation.

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Something I soon noticed about working with the families was that from their point of view, they did not really differentiate between historical and contemporaneous issues. For them, they were living every incident in the present and that then got mixed in with any other current issues, such as ongoing ward management of their loved ones, or resettlement issues, to just name two. From the families' perspective, they saw ongoing problems as an extension of the historical problems and saw it as ongoing evidence that the Belfast Trust was letting them and their loved ones down. It was never historical to the families. For them it was always current. I do not know how many times either myself or family liaison colleagues tried to explain this to Muckamore staff or other Belfast Trust community staff, but it was not always accepted. In Muckamore, too many staff, most especially the senior nursing staff, remained defensive of families or cold or dismissive. There were times I saw senior staff undermining families in meetings. I recall too many occasions where family were upset following a meeting with Muckamore staff, not just because of what was going on with their loved ones, but because of how they felt treated by some of the senior staff in

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Muckamore. It took a huge push to even get Muckamore staff to put their cameras on when meeting with families via Zoom or Teams. This happened not just during the pandemic, but afterwards too. Often I would be accompanying a family to a meeting and we would be staring at blanked out screens. It was such an unnecessary barrier.

I attended multidisciplinary or MDT meetings with and on behalf of families. I felt that my presence at MDT meetings was not often welcomed by staff in Muckamore. I was often questioned about why I was attending meetings, or what was my role, and I was asked was it appropriate for FLSW to be involved at all? I explained on many occasions that my role as FLSW is to advocate on behalf of families and support them with their issues at their request. I started being asked by Muckamore staff to set out an agenda with points that families wanted to discuss with the team in advance before I attended with them, but I noted repeatedly that there was seldom a minute taken of the meeting. After multiple times raising this as an issue, minutes were then taken, but not shared for weeks, and would need chased up by either me or the families themselves. Sometimes minutes were not shared at all. This felt to the families like another barrier or level of non-cooperation by Muckamore nurse management."

CHAIRPERSON: I'm just looking at the time. We are almost exactly halfway through the statement. Would a short break be of assistance to you?
THE WITNESS: Yes, that would be very helpful, thank you. 10:50
CHAIRPERSON: Okay, certainly. We'll try and make it ten minutes, but you let us know as soon as you're ready.
THE WITNESS: Thank you.
CHAIRPERSON: All right. Thank you. Ten minutes. 10:51

SHORT ADJOURNMENT

CHAIRPERSON: Thank you. Okay, are you ready to go on? 11:12
THE WITNESS: I am, indeed. Thank you.
MR. McEVOY: Chair, Panel, just before I proceed, it has been drawn to my attention that the version of the statement that was being shown on screen had some ciphering errors. 11:12
CHAIRPERSON: Well, I think there was one.
MR. McEVOY: There are two, and I can clarify those. At one juncture, I think around paragraph 18
CHAIRPERSON: 18?
MR. McEVOY: 722 appeared on screen and it ought to read H772. I am reading from a corrected version, which should now hopefully be up on screen. 11:12
CHAIRPERSON: It's not at the moment. Hold on. So it's paragraph 18 on the corrected version?

MR. McEVOY: Yes.
CHAIRPERSON: And what was the cipher that was used?
MR. McEVOY: 722 appeared on screen.
CHAIRPERSON: And it should be?
MR. McEVOY: 772. 11:13
CHAIRPERSON: I'm sorry. Thank you.
MR. McEVOY: Further, Chair, just for completeness, at 16, P54 appears in paragraph 16; it should read P60.
CHAIRPERSON: P60. P60 throughout?
MR. McEVOY: It should read P60 throughout. And I 11:13
think that's the version that I read in.
CHAIRPERSON: Yeah. Okay. That's fine. Thank you.
MR. McEVOY: Thank you. And, again, apologies to everyone.
CHAIRPERSON: Thank you. 11:13
MR. McEVOY: So, Ms. O'Hagan, we'll take it up then at paragraph 28:

"To give one example just to illustrate what I said
above, I recall I attended an MDT meeting about a 11:13
patient P18 who was on Six Mile. Dr. H50, consultant psychiatrist; H230, senior nurse manager; H231, ward manager, and representation from occupational therapy and others attended MDT meetings. I recall this
meeting seemed to be disjointed and not properly 11:14
Chaired. The main issue for his mum at this particular meeting was that P18's medication was unclear by name and dosage and she did not know what the treatment plan was. So, for example, P18's mother explained that she

would be handed boxes of tablets at the door when P18's father was picking P18 up, with no clear indication of what the medication was or what it was for. I recall on this occasion that Dr. H50 said he would follow up, but this did not happen and there was no adequate explanation as to why it did not happen. If I can get into my meeting minutes, I will find the meeting I am referring to, but in most meetings there was a running theme of parent concerns not being followed up. So I would ask the Inquiry to follow up on these minutes and with the families. When I tried to follow up on these concerns on behalf of the family, this would bring me into continual conflict with ward staff, who did not seem to understand my role, no matter how many times I explained it. This lack of partnership working was, in my opinion, a further barrier to me carrying out my role as FLSW to ensure positive outcomes for families. I think the most people I ever counted at an MDT meeting was at a P34 one in February 2023, where there were at least 24 professionals at it, yet only two cameras from Muckamore staff were switched on. It was very difficult to know who was actually at the meeting. When I asked for cameras to be turned on, H415, ward manager, explained that most staff did not have working cameras. That was the usual response. Either that or that the internet reception on-site was too poor to carry the camera. I recall P34's mother saying to me after the meeting that she felt overwhelmed, as they did not know who the people were and could not see them

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when talking. This comment by a family member was said many times following MDT meetings at Muckamore. Families tended to feel unheard, overwhelmed, and the progress was too slow. I raised this issue with my then line manager, H238, many times, and she in turn advised that she was raising it as an issue throughout her line, but it did not result in meaningful change.

When Covid-19 restrictions were relaxed, I arranged to meet with the affected patients' loved ones of the family I was appointed to support. I met them with their families to explain my role and that I am here to help their parents. I wanted to understand their needs so that I could advocate for them and their family more effectively. When I first started supporting families directly on Muckamore Abbey Hospital site itself back in 2021, the first thing I noticed was that it was a very institutionalised environment for people who were living there for a long time. Although many patients clearly viewed Muckamore as their home, it did not feel or look anything like a home. I felt from the beginning that the Muckamore staff were suspicious of me and what my role entailed. I found myself often and repeatedly explaining my role and that I was a Belfast Trust worker who was there to advocate and support families. I had it said to me on several occasions how could I be Belfast Trust and yet also challenge Muckamore staff about decisions or lack of decisions when it came to patients? I recall ward manager H415

asking me to explain this at several MDT meetings. It was strange to continually have to explain that being Trust staff does not mean I cannot ask questions of other Trust staff. I am asking questions so as to help the family understand or to help the family have their views taken on board in the care of their loved one. No matter how many times I explained this, I was met with further obstacles and barriers.

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When meeting with individuals on Six Mile or Cranfield 1 Wards, I did not go directly onto the patient area of the wards, but instead met them in a room within the reception area of the ward. My first impression of Muckamore was that it was clinical and a controlled environment. Obviously, it was a secure site, and most doors required staff passes to open or close, so patients' movements were controlled or managed in this way for the security of the patients and all hospital staff.

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Although I was not directly on the patient areas of the wards, I worried that the environment was not patient-centred. From my observations, staff on Six Mile and Cranfield 1 told patients what to do rather than ask them what they liked to do. To me, there seemed to be very little input from the perspective of the patient for day-to-day care. For example, P18 told me that he felt unsafe on Six Mile assessment ward and that he would lock himself in his bedroom to protect

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himself from other patients. I always reported these matters to ward staff and P18's family.

Another example of lack of patient centredness was P34's pod, which was in Cranfield 1 Ward. In my opinion, he was living in a secluded area with minimal home comforts and no interaction with his peers. He had a small, matchbox sized looking pane in his door, which was his only view of others on a day-to-day basis. This made me sad, because P34 was able to be managed on his own with the likes of H633 from day care, who would take him on trips around the grounds and bring him to the Cosy Corner, where he would purchase the snacks of his choice and enjoyed this one-to-one interaction. Having had almost 30 years of working with learning disability, I understand the importance of meaningful and therapeutic stimulation required to meet the needs of someone with a learning disability and, in my opinion, P34 had the ability to thrive, but did not have the opportunity to do so in Muckamore Abbey Hospital. 11:20 11:20 11:20

Patients were usually brought out to the reception area of each ward by a member of staff. Patients were usually happy to see me and their parents. Some staff were not able to speak English and I sometimes found it difficult to understand what they said. This made me wonder how much of a barrier this created for the patients with individual complex needs. I think there 11:21

should have been more consideration given to this staffing issue and the impact it was having on the patients. For example, when staff were a good fit with the patient, such as in the case of Staff Nurse H96 and patient P18, this worked well, and was evident in P18's presentation. When this was not in place, it was evident that P18 was unsettled, and he would often telephone me and tell me he was unhappy. On these occasions, I spent time with P18 on the phone trying to reassure him that the staff were there to help. 11:21 11:22

P18 is currently an inpatient on Six Mile Assessment Ward in Muckamore Abbey Hospital. However, for a part of 2017, P18 was a patient on Psychiatric Intensive Care Unit (PICU) and was therefore identified as an individual subjected to abuse on the 2017 CCTV Safeguarding Investigation. P18 has a severe learning disability and is extremely vulnerable. Although P18 resides in Six Mile, which is a forensic ward, he is not a patient with a forensic history, and residing in such a ward exposed P18 to unsafe and inappropriate language and behaviours from forensic patients. When I raised my concerns in relation to the forensic nature of the ward with H231 and asked why P18 was on Six Mile, H231 told me that the ward was assessed as the most suitable place for him, as if P18 were living in the community, he would be deemed forensic. When I asked H231 to help me understand what she meant, she highlighted an incident when P18 touched her 11:22 11:22 11:23

inappropriately, as evidence that, though he does not have a criminal record at this time, he would have if he was in the community.

P18 has had a difficult experience in Six Mile. He has been targeted by another patient, P54, who is a forensic patient, resulting in P18 being involved in, and seen in a lot of patient-on-patient bullying or harassment incidents. I am also FLSW for P54's family. Other patients affect P18's behaviour. P18 has been subject to threats, such as "I'm going to rape your mammy" from P54. P54 also kept P18 awake by banging on his door and attempting to get into his room. His mother, P18's mother, has told me that P18 rings her from his bedroom, distressed, when this happens. P54 is under one-to-one supervision care, which raises the question how he is able to behave in this way if he is supervised? P18's mother has raised her concerns with staff in Muckamore many times, with little to no resolve. Recently, P54 was moved out of Six Mile, but I do not believe P18 has recovered, as during my last contact with his parents, they expressed ongoing concerns about their son. I also do not know if the move has helped P54 either, based on the reports from P54's parents in regards to P54's continued mental and physical health deterioration. In my opinion, placing long-stay patients with forensic and non-forensic backgrounds together in the same locked wards is detrimental for both types of patients, but in

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particular to those patients with non-forensic backgrounds as it needlessly exposes them to sexually harmful and/or violent behaviours in a peer learning environment.

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There have been times when I met P18 when he presented as heavily medicated. P18 has limited speech, and the medication causes him to slur his words and he cannot give his usual standard of verbal feedback when I ask him questions. 11:25

On 17th October 2022, P18 was involved in a significant adverse incident on Six Mile Assessment. On the day of the incident, P18's mum and I were travelling to Muckamore to meet with the collective leadership team 11:26 that includes H234, who is a senior manager at Muckamore, and H522, who was the then co-director in Muckamore, to discuss concerns around P18's safety on the ward and potential for re-settling P18 so he could live in the community. P18's mother and I travelled 11:26 together to this meeting. On our way to Muckamore, P18's mother received a call from H895, who was a staff nurse on Six Mile Ward, who advised that an incident had arisen with P18 and the PSNI had attended. I told P18's mother to put her phone on loudspeaker. H895 11:26 said that P18 assaulted staff on the ward and was threatening. I explained to H895 that we would arrive at Muckamore shortly and that we would be able to call to the ward to check how P18 was. When we arrived at

Muckamore, agency staff brought P18 into a small room off the reception area. P18 was crying uncontrollably and hugged his mum. He repeatedly said that the PSNI hurt him and asked if I, as a social worker, was going to "sort it out". I could see that P18 had marks on his arms, wrists, and ankles, where the PSNI had restrained him using handcuffs. There was a burn mark to the left side of his face. I was not made aware until much later that P18 had had a hood also placed on his head for the duration of the incident. 11:27

As P18 was visibly distressed, I took his mum out of the room and asked her what she felt would help de-escalate distress for P18 at this time. P18's mother felt that taking P18 home to de-escalate the situation would help him settle. P18 goes home three times a week on Wednesday evenings, stays overnight on Fridays, and has dinner with his family on Sundays. It was agreed with the ward staff that P18's dad would collect him from Muckamore later that day. H895 agreed to prepare P18's things for him to go home. P18's mother and I met with H234 and H522 after the incident and raised concerns about what happened. P18's mother put her questions to both senior managers and said that she wanted to know how the PSNI attended in such big numbers and why the ward staff felt that they had no choice but to call them? P18's mother asked how P18 ended up so hurt in the incident and what exactly happened that morning? I remember that P18's mother 11:28 11:28 11:28

was assured by both senior managers and promised that they would get to the bottom of what happened without delay and get answers to all her questions too as soon as possible. Unfortunately, as I write this, these promises have not been followed through, and the family of P18 remain very distressed about this and even more untrusting of Muckamore management.

When a serious incident occurs to a patient, there are reporting and investigative mechanisms to be followed, and that is the way it works across the Belfast Trust. So when H234 assured the family that a serious adverse incident investigation was to be carried out, I reassured the family that they would soon have the answers to their questions and would be fully informed throughout the process. I sought advice from my own line management also in regards to the family's concerns that the ward staff did not protect P18, and as per our safeguarding policy, I made an adult safeguarding referral, as that is the proper response when there is concerns about staff actions with a patient. An Adult Safeguarding Investigation could have looked at the staff actions and determined if there was any accountability. A serious adverse incident looks at what is happening, and any learning. But not staff accountability. A Safeguarding Investigation can happen before or parallel with a Serious Adverse Incident Investigation so one does not impede the other. So, it was a surprise to me when it

was relayed to me by my line manager that the screening decision from the adult safeguarding lead in Muckamore at that point, H704, was that the safeguarding Muckamore team was going to hold back and wait for the serious adverse incident final report to be given, as well as a DAPO assessment to be given. H234 told me and the family of P18 that she carried out the initial investigation alongside H290, the ward manager. She met with the PSNI without informing P18's mother or me as FLSW. There were e-mail exchanges between H234 and FLSW4 where H234 is put on notice that an FLSW was to attend any meetings with the PSNI. I asked H234 for an update on behalf of the family, to which H234 refused to agree and later said she would update the family herself. However, after a few weeks, this had still not happened, and I requested minutes from the police meeting, as well as asked for the family to be updated with information. H234 eventually met with P18's family in the middle of November 2022 in the Boardroom at Muckamore. It was stressful for the family to attend this, but I kept reassuring them H234 was going to get them the information they needed. It was so disappointing, therefore, that even though she agreed to answer all the family's questions, she did not provide the answers to these questions at the meeting and said that the hospital management team were actually still investigating the incident. She said that once the serious adverse incident report was completed, she would share it with the family without

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delay. She also agreed to send them a copy of the minutes following her meeting with the PSNI, but to date she has not provided them either. P18's family also requested a copy of the CCTV footage showing the incident, P18's patient file and MAPA assessment under 11:33
a data protection request to the Belfast Trust, but as far as I know, at this point, doing my statement, these things have not been provided. The family just want to be helped to view the footage themselves at this point, not stills, not images, just the actual unredacted CCTV 11:33
footage of their son's care that morning. They have expressed so little faith in Muckamore management, to be honest and transparent, that they want to view the footage now themselves and see with their own eyes what happened. The family of P18 have suffered so much with 11:33
how this process has been handled and, in my view, that is wrong. This experience, so like other experiences I had with trying to advocate for families in Muckamore, and getting nowhere, made me feel very disempowered. I thought if I am meeting all these obstacles as a senior 11:34
social worker, how bad would it be if the family were dealing with this on their own? This has been pointed out to me by a number of families, that if I cannot get answers after they tried to get answers, then the Muckamore management system is severely broken. There 11:34
are important reports and e-mails related to this whole event and I hope the Inquiry can have them all given to them. I have exhibited some of the documents at Exhibit 1.

I have worked in the care sector for many years and never seen a case like this where an individual had been subjected to treatment that P18 had been by staff or PSNI. P18 is extremely vulnerable, and use of this restraint as a reaction to P18's behaviour is, to me, unacceptable. The fact that Muckamore did not follow up with proper information to reasonable questions just added insult to injury for the family, and my advocacy in this situation did not seem to matter. It is important to add that a very similar incident occurred to P18 in October 2021, and at that time I was advised by H231 that the incident was being followed up by safeguarding Muckamore social worker H251. P18's mother also told me that H251 reported to her that the matter was being investigated by the Police Ombudsman, as well as Muckamore Adult Safeguarding Team, but to date there is no record of either investigation having been completed. 11:34 11:35 11:35 11:35

I recall visiting P34. It was maybe mid 2022, and he was a patient on Cranfield 1, with his mother. And on arrival, we were met with H323, who is the ward manager. She told us that it was not advisable to visit P34 as he had been administered PRN medication and was in an agitated state. His mother said she wanted to see him and, therefore, H323 brought us onto the ward to meet P34, who was sitting in a pod at the side of the building. It was clear from her manner 11:36

with me and with P34's mother that H323 was unhappy with his visit taking place. P34 acted very appropriately during the visit and there was no sign of agitation. He told his mother and I that staff hurt him, which raised queries over adult safeguarding. I 11:36
agreed with P34's mother to report the concerns and have Muckamore safeguarding staff follow up on it. I later did that, though I do not know what the outcome was. To help settle P34, his mother and I reassured him that he was okay. We had a lovely visit aside from 11:37
that part of it. When leaving the ward, H323 asked me who I was and what my role was? When I told her I was FLSW, she said in what could only be described as a sarcastic voice, "Well, bully for you, bully for you, I'll let you out." H323 had a terrible attitude. I 11:37
thought if she spoke to me like this, then I wondered how she spoke to patients on the ward.

I took these interface issues to my FLSW colleagues, FLSW2 and FLSW4, and in turn also took them to our 11:37
service manager, H238, to explain the obstructions. H238 was always helpful and she promoted openness and transparency. I recall experiencing difficult relations with H300, who was a senior manager in Muckamore and part of the collective leadership team. 11:37
The only way I can describe his actions with me was intimidation. It got so bad that H238 advised me not to return his calls anymore and that she would return them on my behalf. I found H238 was protective of us,

and I was glad she was, because it was a difficult site to work on as an outsider. Things came to a head when H238 organised a meeting with the Muckamore collective leadership team in May or June 2022. At that meeting we explained all our issues in detail, and I remember 11:38
H428, the Senior Director in Muckamore at the time, e-mailed all staff on-site to tell them who we were, what we do with the families, and told staff to work with us. I would like to share a copy of that e-mail with the Inquiry and any other patient notes and 11:38
minutes that I can locate in time before I become too ill. I think there was some improvement for a while, but then some time after that H428 left Muckamore, and H238, who had done so much for FLSWs and families, retired. I noticed after they left Muckamore that 11:39
although direct hostility and unfriendliness from some senior nurse management towards family liaison in Muckamore eased up, it was replaced by senior nurse management, who complained about my tone, or manner, or how I went about things. Sometimes they did not use 11:39
the word "complaint", but they would lift the phone to my new service manager, H254, about me, and a complaint was what it amounted to. Complaints were put to my new service manager that my tone was unprofessional or inappropriate in some way, because I challenged 11:39
Muckamore staff in meetings. Every time these complaints came in about me, it would tie me and my line management up for weeks dealing with them, investigating them, and responding to them. Most of

the time the complaints were found to be unsubstantiated or heavily opinionated, with no substance behind them. And other times I agreed I would try to tone down my questions or e-mails and dilute my advocacy, in order to keep doing some level of work for the sake of the families. This did not matter, because it was exhausting dealing with these complaints, and I truly believe these were tactics used by senior nurse management on Muckamore site to obstruct the work of family liaison. I would often say to my line manager and service manager that "I feel I cannot do right for doing wrong." I did not always feel supported enough by my current line management, not in the same way that I did under H238. Things came to a head with these complaints in June 2023 when the outcome of it was that I was placed on informal capability, that is that my practice required increased supervision and I had to prove that my practice was beyond reproach. I accepted it, although it hurt my professional pride terribly. But I have faith in my practice and my values, so I went with it for the few months that it lasted. I wish the standards to ensure my professionalism were used on the Muckamore Abbey Hospital management themselves, because I have seen lots of unprofessional or unethical approaches by senior hospital management, most especially H230, H300 and finally, H234, but they seem to have better protection than I do.

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At the start of 2024, it transpired that when I returned from Christmas leave, H234 did not want me involved anymore in resettlement meetings. This coincided with other Bryson House advocates telling me (Stephanie Delaney and Donna Irvine), that they had also been advised by Muckamore senior management to no longer attend resettlement meetings as Muckamore preferred a particular advocate to attend these meetings in lieu of the allocated advocates. I was concerned about this as that particular advocate, Liz Moore, was seen by me and by other advocates as being too close to Muckamore senior management and, therefore, not a strong advocate for families. In terms of H234's complaint against me, she made a verbal complaint again about me, which made its way to H256, who is the Director of Social Work in the Belfast Trust, only on this occasion she made it via Gareth Farmer, her co-director counterpart in the Northern Trust. When I raised this with my service manager, H254, that I believed H234 was behind this complaint again, H254 initially denied that to be the case and told me the complaint was Gareth Farmer's solely and therefore it was independent from Muckamore. I did not believe this as it was contrary to my most recent positive experiences with Gareth Farmer and the Northern Trust resettlement team in relation to my Muckamore impacted clients. I advised H254 that I feared she was being misled and that this was another underhanded tactic being used by a Muckamore senior

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manager to disrupt my advocacy for families. I requested from H254 that I would like this to be investigated properly this time and have Gareth Farmer explain in writing what the nature of the complaint was about. H254 agreed to do this and, when things were; looked into, it transpired that I was right in my belief that the concerns thought to have come from Gareth Farmer actually came from and originated from H234. It also turned out that the complaints were completely unsubstantiated, and H256 e-mailed H234, and Gareth Farmer, co-director in the Northern Trust, that should they come back with a complaint again, they needed to substantiate it the next time and she was counting the matter as closed. I have a series of e-mails and notes related to this episode which I am happy to share with the Inquiry team (see Exhibit 5). This final episode almost broke my spirit as a professional and the stress was immense. The knock-on effect of this also was that I was told by my manager, H254, to pull back from P34's Northern Trust resettlement meetings. This caused terrible distress to the family of P34, who felt confused about the loss of their FLSW support, and it also confused me as a professional, as H254 was content for me to continue to support P54's family, who was also embarking on his resettlement journey. P54 was also a Northern Trust patient. I have exhibited documents within my possession relating to P54 at Exhibit 3.

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One of the families who I support are parents of P16. P16 was subject to abuse as a patient on Cranfield 1 when he was identified on 2017 CCTV recordings. P16 was to be resettled into the community in or around 2021. H408 was the senior manager who managed resettlement of patients at that time in Muckamore. P16 had previously been moved into the community, which he found difficult, so returned to Muckamore. Due to P16's needs, he required nursing care on a one-to-one basis. P16 moved to the mews as supported living accomodation with Cedar Foundation. P16's mother told me that she worried so much about P16 in the mews that she could not sleep. She told me that when she visited P16 in the unit, she found wipes with faeces on them sitting in his washing machine. Staff used P16's electricity and gas when he was not in the accomodation, which she paid for. She reported these issues to the mews and staff were dismissed. As a result of this negative experience, P16 had to go back to Muckamore. I attended MDT meetings with H408 and other members of P16's care team. I found that H408 seemed to prioritise moving patients out of Muckamore over moving them out in a prepared fashion and at their pace. This became a continuous issue that I tried to draw attention to and ensure that the patients' lived experience of the failed placement in the mews was not repeated."

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CHAIRPERSON: Just pause for one second.

MS. RICHARDSON: Chair, can we have a wee break please, just for five minutes, just the witness --
CHAIRPERSON: Yeah, of course. Okay.
MS. RICHARDSON: Maybe five minutes.
CHAIRPERSON: Okay. We may stay. I think actually it's probably better we stay in the room. Just getting everybody out and then back in, it turns out to be 15 minutes. 11:47

SHORT PAUSE IN PROCEEDINGS 11:47

MR. McEVOY: Chair, it just occurs to me, that the feed may still be running.
CHAIRPERSON: I was just thinking that as you stood up. Just so everybody notes, the feed is still running to Room B, so they will be able to pick up from microphones the things that are said in here. 11:49

SHORT PAUSE IN PROCEEDINGS

11:49

THE WITNESS: Apologies.
CHAIRPERSON: You do not have to apologise in the circumstances. Thank you. Okay.
MR. McEVOY:

11:53

"I explained to H408 that given the fact that P16 had been subject to incidents of abuse in Muckamore and had a bad experience in the mews, any further attempt to re-settle him should move at P16's pace. The MDT

eventually identified a location suitable for P16. This time a huge effort was put into advocacy for a better experience for P16. I recall that P16's mother later told me I had helped her speak out better in these types of meetings. She told me that my support on behalf of her and P16 gave her confidence to say what she wanted to say. P16 now lives in that location and is doing well, and I feel this person-centred approach actually made this success story possible. When professionals listen to families it always works out better. I have exhibited documents within my possession relating to P16 at Exhibit 2. 11:53 11:54

I feel at this point I am running out of time and energy to be able to write this statement. Today, I am in the Northern Ireland Hospice and I am very tired as I write this. I need the Inquiry to follow up on how long it took to get psychological supports for the families in place. When I first started doing family liaison social work in 2020, I was told by my FLSW colleagues that the executive team had promised psychological support services to the affected families, but by 2020 that had still not been delivered on. At that point I recall thinking Covid-19 had delayed it, but it did not explain what was delaying things in 2019 and 2018. From late 2020 onward, I continually raised an e-mail, and in person, the need for my team's senior management to chase up the outstanding psychological services for these affected 11:54 11:54

families. I know that H238, as well as H254 and H805 continually forwarded my e-mails up the line, but there was just no progress made. The other FLSWs and I increasingly found we were managing the heavy impact of the families on our own, and it was really tough, because many of the families were so broken by what had happened to their loved ones in the care of Muckamore. My line management kept coming back and saying that H404, lead psychologist in the Belfast Trust, was saying she was looking for psychologists to do the work but there just were not any available. In my quest to help address this deficit, I discussed a skilled psychologist substitute with my line manager, H238, and provided her details. This person, who I had worked closely with in the Belfast Trust Children's Disability Services was called Denice McCartan. I also checked in with Denice who confirmed she would be able to provide support. However, H404 turned this down. I have e-mails in relation to this if these can be found and given to the Inquiry. I do not recall an adequate explanation from H404. In my view, H404 was promoting Belfast Trust psychological service and yet there was no delivery of services. There was no follow through on the delivery of psychological services until the end of 2023 when our Director, H256, got involved in advocating for the families. It was further concerning for me to sit through a session provided by Sarah Templar, who is the liaison between Belfast Trust and the Public Inquiry, some time towards the end of 2023,

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and hear her explain what she called extensive psychological supports for families. This was not accurate, as there were significant delays in these services being provided, and at that time some families were still not in receipt of services. 11:57

I believe there are too many unnecessary obstacles for families in delivering services for people with learning disabilities within the system. In my experience, the main obstacles continue to be poor 11:57 communication, poor investment in community services, and an imbalance of power between those who deliver care and those in receipt of care.

I would like the Panel to use my statement in whatever 11:57 way they can for the betterment and service provision for adults with learning disabilities in the future. I am sorry that I have not had the time to pull this together in the way that I had wanted to. Please accept my apologies. I am trying to content myself 11:58 with the fact that in 2023 I worked hard over a number of months at my service manager's direction to ensure every one of my family and patient records were uploaded and made available to the Inquiry. I was reassured by my service manager that all of these 11:58 records were given to the Public Inquiry to help them understand the plight of families as well, as the families' concerns, as well as family liaison work. I hope the Inquiry found this information helpful and

have heard that at the heart of my work is the voice of the families."

So, Ms. O'Hagan, that completes your statement to the Inquiry. Is there anything else you'd like to add? 11:58

CHAIRPERSON: Are you ready to say your piece now?

THE WITNESS: Yeah. Probably again, sorry, if I could have five minutes?

CHAIRPERSON: Do you want five minutes?

THE WITNESS: Because there's a number of things that I would like to add in addition to what I've said. 11:59

CHAIRPERSON: Okay. Well, then we will rise, because I don't want you to be under pressure.

THE WITNESS: Yes.

CHAIRPERSON: Obviously, we'd like to continue as soon as possible, but you must have the time to think about what you want to say. So, we'll stop, and I'll just ask the Secretary of the Inquiry to let us know as soon as you are ready to go again. All right? 11:59

THE WITNESS: Thank you very much. 11:59

CHAIRPERSON: Okay. Thanks. We'll rise.

SHORT ADJOURNMENT

CHAIRPERSON: Thank you. Just give me a second. 12:20

Right. So tell me how you want to do this.

THE WITNESS: I would ask, if you don't mind, Chair, that I share some more information. Just having had consultation with families, I believe there are some

addendum information really that I would like the Panel to hear.

CHAIRPERSON: Sure.

THE WITNESS: Just to ensure that their voice is heard. And if you don't mind, my son's going to read it out, because I'm having difficulty, and then I'll close at the end, if that's okay with you? 12:25

CHAIRPERSON: That's absolutely fine. Thank you very much.

THE WITNESS: Thank you very much. 12:26

CHAIRPERSON: Okay, if you want to start. Can we have the son's name, do you mind?

MR. JOSH O'HAGAN: Josh.

CHAIRPERSON: Thank you.

MR. JOSH O'HAGAN: 12:26

"There needs to be an early intervention and assessment in children's services and understanding of individual needs and learning disabilities, importance of families being at the centre of decision-making to ensure 12:26 there's a clear assessment of individual needs and how best to meet them. Families have realised concerns of feeling excluded and often not heard when they want to provide crucial information on their loved ones. Families have also raised concerns about fundamental 12:26 health care needs not being met. For example, neglect of oral hygiene and the requirement to provide nutritional support. Delays in ASG referral have to be requested by family. ASG process not efficient, long,

dragged out process. Lack of family involvement in ASG process. Lack of family involvement in creation and updates of key documentation, i.e. care plans. Insufficient monitoring from the Trust once in community placement." 12:27

CHAIRPERSON: Do you want to add to any of that?
MS. O'HAGAN: I suppose just to say that at the heart of this Inquiry, I see the effort and the work that has gone into hearing the voices of the family, and from my 12:27
point of view, I went into this job because I believe in people with learning disabilities. I respect people with learning disabilities, and one of biggest things is I feel there needs to be trained staff dealing with people with learning disabilities. 12:27

Young people with learning disabilities and young adults with learning disabilities don't choose to go out to maim or hurt anybody, but we need to recognise their individual needs and why the behaviour is 12:28
presenting and being more tuned into the behaviour, there needs to be more training and awareness for people working with learning disabilities.

Certainly from my point of view, it has been nothing 12:28
but a pleasure to work with these families. It's been nothing but a pleasure to work with the families and, you know, the fact that they actually allowed me into their lives, having had -- been given the information

of what happened to their loved ones, and that I worked for a Trust that these other staff worked for, they were still able to welcome me into their homes and they put their faith and trust in me, and it has been nothing but an honour to work with the families. 12:29

I'm just sad that I won't see this to the end. But I do think... [Witness is upset]. Sorry. I have faith in the Inquiry that no stone will be unturned and I have to say that what I have viewed, I will take to my 12:29
grave, and I hope that never, ever, ever anybody should suffer like these people have suffered, and I wish the families the very, very, very best in their journey, and I hope they get justice, because that's what they deserve. 12:29

Thank you very much, Chair, and thanks again.

[Clapping]

12:30

CHAIRPERSON: I understand. I understand. But please take your seat. Thank you. If you don't mind, I'm going to call you Geraldine, because you and I have met now many times, and I think it started when I was wandering around Northern Ireland at various hotels and 12:30
engagement sessions and we met up frequently at those. And so you have been supporting families, and the Inquiry in fact, from the very early days. So, I do want to thank you on behalf of the Inquiry Panel for

doing so much to assist us to meet our Terms of Reference, in particular assisting families and patients to, as you've said it, have a voice, and to be able to come along here, as so many have, and give evidence, because that has helped them, but it's also helped us. 12:31

So, you can leave this room in the secure knowledge that not only have you done your very best, but you have succeeded in supporting and helping many, many people to have a voice. 12:31

MS. O'HAGAN: Thank you.

CHAIRPERSON: Thank you. We've got another witness who's going to come a bit later. We'll stop there. In relation to your exhibits, I ought to have said this, they are being worked on, they will all be redacted and produced in due course, I hope next week. Geraldine, thank you very much. 12:31

MS. O'HAGAN: Thank you, Chair.

CHAIRPERSON: I'm going to rise and we will sit again at half past one. Okay. Thank you. 12:31

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT

CHAIRPERSON: Okay. Ready for the witness? No restriction order application? 13:29

MR. McEVOY: No applications, Chair. The next witness is H260.

CHAIRPERSON: All right. Thank you. You're having a long day, Mr. McEvoy.

MR. McEVOY: It's the old dog and the long road, Chair. 13:29

H260, HAVING BEEN SWORN, WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

CHAIRPERSON: Can I just welcome you to the Inquiry. I think it's the first time we've met, the first time you've been here. Thank you also for your statement. And I'll hand you over to Mr. McEvoy, who I assume you've met briefly. 13:30

MR. McEVOY: Good afternoon, H260. So we have met. 13:30

A. Yes.

5 Q. As you know, my name is Mark McEvoy and I am one of the Inquiry counsel. H260, before you is a small file with a statement which is dated 8th April 2024. Do you recognise that as being a statement of 15 pages which you've made for the purposes of the Inquiry? 13:30

A. Yeah.

6 Q. And do you want to adopt that statement then as your evidence?

A. Yes.

7 Q. Okay. I have a number of questions arising from your statement, and the Panel may have questions as well as we go. Could I ask you to keep your voice up and try to speak as slowly as possible. 13:31

A. Okay.

8 Q. All right. We have a stenographer who's taking a note of the evidence as we go and it's very important we don't miss anything. Obviously we want to make sure that you have a full account of your evidence on the record as well. 13:31

A. Okay.

9 Q. All right. So, I'm going to sort of précis some paragraphs of your statement and then I'll alight on others with some questions, all right? And hopefully that will make sense as we go. But to begin with, you tell us that your connection with Muckamore is that you're a Staff Nurse, Band 5, and Deputy Ward Sister, Band 6 at Muckamore, between March 2013 and May 2023, employed by the Belfast Trust. 13:31

You go on then to tell us that the relevant time period you can speak about is from 2011, "when I completed a placement as part of my degree", you say, at Muckamore, until May 2023, when you left. 13:32

Then you go on to tell us about your qualifications. So you have a Bachelor of Science in Learning Disability from Queens, qualified as a learning

disability nurse in February 2013. During the course of your studies you did two placements at Muckamore; one was for six weeks in your second year at Cranfield Women's Ward in 2011, and then your final placement at the end of 2012/start of 2013 for 14 weeks in Greenan. 13:32
You tell us that you enjoyed those placements in Muckamore, as you had limited experience working in an inpatient learning disability service environment. And you then decided to take a position in Muckamore as you had enjoyed your two practice placements and felt it 13:32
was a good place to gain experience.

A. (Witness Nods).

10 Q. Then in 2013 you applied for a temporary staff nurse position in Muckamore through health and social care recruit for a position as a Band 5. You commenced work 13:33
in 2013. As your nursing registration formalities were not completed at commencement of employment, you worked as a Band 3 until your PIN, or your PIN was live on the NMC Register. You had no friends or family working in Muckamore when you began, but you tell us then you went 13:33
on to marry your now husband, H67, who was also a staff member at Muckamore from 2007.

You then go on to tell us about your recollections of your induction, and you describe that in some detail, 13:33
and all of the various training courses. You tell us that your first impression of Muckamore as a place to work was that it felt like there was a good team of staff with varying degrees of experience. You felt

that the team was -- supported each other and worked well together to provide care for service users.

Then you say that when you first qualified, you were supported through your preceptorship during your first six months as a staff nurse, facilitated by a more senior or experienced member of nursing staff, and following completion of this, you were able to fulfil the nurse in charge role. However, as there were a number of trained staff with more years experience, those opportunities were less at that time. 13:34 13:34

In paragraph 8 you then say that between 2013/2014 there were no permanent Band 5 jobs, and you started in Cranfield Women's Ward in a temporary position with your contract being reviewed and maintained until you became permanent following a further interview. 13:34

What was your understanding, just picking up on paragraph 8, of why there were no substantive Band 5 posts available when you qualified? 13:34

A. I think from my recollection it was that the hospital was planning for closure still at that stage, and there wasn't any permanent 5 posts available, and I'm not really sure for what reason, it was just that your contract was continued to be reviewed and then eventually there was -- we were informed that there was permanent positions being released and that you would have to reapply. 13:35

11 Q. Yeah.
A. From memory, I believe that they wanted to change the ratio of nursing staff, so they wanted it to be 60% registrants to 40% unregistered staff at that point, and I think that was maybe the reason why that it changed in the sense that there was permanent posts then released.
12 Q. Okay.
DR. MAXWELL: Can I ask what the ratio was before this decision to change it to 60% registered nurses? 13:35
A. I really don't know. I'm not sure.
DR. MAXWELL: So in your experience, when you were working in a temporary post, when you were on duty would there be equal numbers of registered nurses and care assistance or were there more care assistants than there were -- 13:36
A. I would say that there was probably equal numbers at that stage. Like I had said in my statement about being under my preceptorship, at that time there was quite a lot of substantive registered nurses, you know, and from my period of preceptorship I never had to take charge because there was always more senior staff available. So I would say that it was probably maybe 50/50, but I couldn't be sure. 13:36
DR. MAXWELL: So you were newly qualified at this stage? 13:36
A. Yeah.
DR. MAXWELL: What was your expectation of where you would be working, if everybody believed that the

hospital was going to close? Where did you think your career would happen if Muckamore closed?

A. I suppose, like I had said, I went there because I felt like I would gain experience. Muckamore wasn't close to home at that stage, so I never anticipated that I probably would have stayed working there for as long as what I did, and I was maybe just waiting for something else to come up. But I suppose the opportunity for progression arised and then I continued to work there. 13:37

DR. MAXWELL: So does this mean that there weren't many jobs in the community? Because you could have presumably applied for a job as a community registered nurse on qualification? 13:37

A. From my memory, I don't believe there was.

DR. MAXWELL: So they weren't recruiting community nurses or hospital nurses? 13:37

A. Yeah. Yeah.

DR. MAXWELL: Thank you.

CHAIRPERSON: And just this: When you talk about a temporary position, would that be a six month contract? 13:37

A. Yes, I think so.

CHAIRPERSON: Yes. Thank you.

13 Q. MR. McEVOY: Okay. Then in paragraph 9 you give us an idea of what your Band 5 role consisted of, and it was direct patient care, assisting with activities of daily living, medication management, daily notes, care planning, attendance at multidisciplinary team meetings, clinical meetings, delegation of tasks, coordinating the shift, and so on. Lots of different 13:38

duties and responsibilities. As a Band 5 staff nurse, you say you would have delegated tasks to other Band 5 staff nurses and Band 3 health care support workers, based on their competencies, knowledge and skills, and you also conducted Band 3 clinical supervisions, identifying any training needs, which you would have then passed to the Ward Sister or staff member.

In paragraph 10 then you tell us that as a Band 5 you were a named nurse for a group of patients. This means that you were responsible for the care planning updates and completing risk assessments for those particular patients. Did primary nursing or the named nurse remain in place throughout your time in Muckamore? 13:38

A. Yes. No, that was an established rule in all the wards, that you would have had -- all the patients were delegated to a registrant, who would have been in charge of their care in terms of their care plans, facilitating their one-to-ones, and really just being a point of contact for them during their period of admission. 13:39

14 Q. Okay.

DR. MAXWELL: Can I ask how that changed as the vacancies increased? So we've heard a lot about vacancies, and certainly after 2017 we've heard that it was predominantly agency nurses. How can you run primary nursing if you haven't got substantive staff who are there and know the patients? 13:39

A. It came with a great deal of difficulty, especially

post 2017, where there was -- the learning disability nurse was greatly depleted. So the number of patients that each staff member were allocated to care for maybe would have increased. As a Deputy Ward Sister I would have been allocated as a named nurse as well, just to share out the responsibilities to try and equalise the workload. And like I've said in my statement, you know, I'd found at times where as the Deputy Sister, like I was finding where I was updating care plans, because despite agency staff, who were established within the team, they were under what was called a block booking, were there for a significant period of time, you found it was very difficult to get them to engage in the care planning process and to take up that responsibility of ensuring the patients' care plans were up to date and that they were taking on that role.

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DR. MAXWELL: So would it be fair to say that it became more difficult to perform the role of named nurse well as the number of patients that you were responsible for increased?

13:41

A. Yeah, I suppose the workload increased in terms of, like, care planning and ensuring the risk assessments were completed. In terms of being able to engage with them on a one-to-one basis, you know, you found time in your day to be able to facilitate that, you know. Patients often, especially in the likes of Six Mile Ward, would have seeked you out and saying "Can I have a one-to-one?" So you were able to engage with them during that time, you know, you would fit it into your

13:41

day. But, yes, it was difficult.

DR. MAXWELL: And was it the named nurse's job to liaise with the families?

A. Yes, between the named nurse and, I suppose, as ward management, you know, your role would have been to engage with families as well. 13:41

DR. MAXWELL: So, when you started in 2013, how many patients would a named nurse expect to have on her caseload?

A. I suppose during my preceptorship it was maybe one or two. As time went on during my career in Muckamore, you know, you could have been up on three or four patients that would have been, you would have been named nurse for. 13:41

DR. MAXWELL: So the point at which you left, would anybody have had more than four patients on their caseload, as a named nurse? 13:42

A. I'm not sure. But it would be possible.

DR. MAXWELL: Okay. Thanks.

15 Q. MR. McEVOY: Okay. You then go on to tell us a little bit about care plans and how these were updated six monthly or as need changed, and then talk about a risk screening tool on a patient's admission, which would have then been the basis for the completion of a comprehensive risk assessment, dependant on the multidisciplinary team's agreement. 13:42 13:42

You talk about how, or describe how a comprehensive risk assessment had a chronology of events as part of

the risk assessment coordinated by the named nurse, but the overall responsibility for completion of that comprehensive risk assessment sat with multidisciplinary teams.

13:43

You then say that physical health monitoring was part of the Band 5 role, to include baseline clinical observations, which were obtained as well as the patient's weight, and you talk about other tools, including the Malnutrition Universal Screening Tool and Ulster Risk Assessment were completed, as well as antipsychotic monitoring for the patients requiring it. 13:43

You then go on to describe your experience and recollections of Cranfield Women, how it facilitated admissions from the community, and it was rare for admissions to be planned in advance, generally an emergency situation arising out of a crisis in the community which precipitated an admission and there was no admissions panel. You then talk about how you would have had engagement with the consultant making the admission as to whether the patient was coming in on a voluntary basis or otherwise under the mental health legislation and given an overview of the reason for admission by the consultant. 13:43 13:44

You talk about how voluntary patients generally were supported by a family member, support worker, or social worker. Detained patients were admitted with their

main carer. And then you tell us how upon admission, as a staff nurse you completed the admission form, gathering as much information as you could from the patient or their family member or their social worker. And then you tell us about how you took steps to ensure that you recorded relevant information, including a patient's activities of daily living and their care plan, such as physical health, eating, drinking, sleep, behaviour, mental health and social factors, and then where you identified gaps, you would have followed that up at the earliest opportunity with the next of kin or place of residents to complete the care plan. 13:44 13:44

Then as a named nurse you said that it was responsibility to complete the patient's care plan and complete referrals that were deemed necessary to meet the patient's care needs. Sorry. 13:44

DR. MAXWELL: Can I just ask a question about that? So, as the named nurse, what we've heard from some families is that there were unexplained injuries on their family member, and some expressed some concern about foot care and dental care. As the named nurse, how often would you physically examine the whole of a patient so you could see whether there was bruising or problems with their feet? 13:45 13:45

A. I suppose for patients who required assistance with personal care, it would have been something you maybe would have done on a daily basis. If you were showering them, you know, like you would have observed

for if there was any bruising, or if there was any concerns about their feet or their dental -- or their teeth, sorry. But obviously then there was more patients who were more capable who didn't require maybe assistance, and it would be following up with them if they required assistance from podiatry, if they required it, if they stated they needed it. Podiatry generally was on-site once a week on a Friday, and that would have been followed up and getting, booking them in to be seen on the ward, and it was quite accessible. Dental also was quite accessible on-site, up until more recent times when it really retracted and they were only available once a week. 13:46 13:46

But it was at times down to the patient, if they told you that, you know, they were experiencing dental pain or they required their feet to be attended to. But as the named nurse and if you were carrying out personal care and you seen it that it was a need, you would have been acting upon it. 13:46

DR. MAXWELL: So, I think for some of the patients, their personal care would have been by the care assistants. So could you just give me an idea of how often they would actually have the personal care delivered by a registered nurse rather than a care assistant? 13:47

A. I suppose that was maybe dependant shift by shift, do you know, how many registrants were on shift. So if there was more than two, you know, everybody else would

be delegated to complete like personal care tasks. I suppose from experience, whenever I worked in Cranfield Women and there was quite a lot of registrants, you know, you would have been assisting with patients and getting them up in the morning and supporting them with personal care. So, you know, even if you were delegated to complete medications, you know, that generally didn't start until most of the patients were up out of bed. So, you know, it could be on daily basis you were maybe at least helping with at least one patient to support them with personal care, if not more. 13:47 13:47

DR. MAXWELL: And if the care had been delegated to a care assistant?

A. Yeah. 13:47

DR. MAXWELL: Would you expect them to give you some feedback after they'd completed it?

A. Yes, generally you would have asked the care assistants like "Were they assisted to shower? Was there anything that you observed?" The care assistants were very knowledgeable in the sense of coming and reporting if there was anything they observed, you know, any changes to patient's skin condition, if there was any bruising observed, completing a body chart with consent from the patient, or if it was that they observed bruising and they a wanted a registrant to see it, you know, that you would be going back and looking at the area, seeing what was happening and then, you know, completing the body chart yourself and accurately recording it then on 13:48 13:48

the patient's notes. And like if you had cause for concern, then referring them to the doctor on-site or the SHO.

DR. MAXWELL: Because I don't think the care assistants could enter directly on to PARIS, can they, or can they? 13:48

A. I suppose in PARIS I can't remember what date it came into force, but prior to that everything was written documentation. So it would have been reported to you as the registrant and wrote into the notes. Some care assistants would have wrote into the notes and you would have countersigned it, you know, that they had -- what they had completed, what tasks they had completed. 13:49

DR. MAXWELL: But when you did move to PARIS, can the care assistants put something directly on to PARIS or did they -- 13:49

A. Some staff members did have access to it, but it was limited.

DR. MAXWELL: But not all?

A. But not all. 13:49

DR. MAXWELL: So it was the responsibility of the registered nurse to make sure that all relevant information had been recorded?

A. Yes.

DR. MAXWELL: Thank you. 13:49

CHAIRPERSON: And one from me as well. When you're made a patient's named nurse, would that happen on admission of the patient?

A. Yes. Yeah, generally on admission, if not the next

day, whenever, you know, ward management were on-site.
CHAIRPERSON: How long would you remain named nurse for a patient? If they were a long-stay patient, would you be their named nurse until you were moved on?
A. It just depended on how -- you know, the relationship with the patient. Sometimes there was an alternation, they alternated the patients around the team, you know, so that the patient had somebody different. But, you know, it could be maybe like a period of time. You know, I couldn't say what length. But there was times where the named nurses were rotated and that they were changed up amongst the staff team. 13:50 13:50
CHAIRPERSON: But there would be only one named nurse per patient?
A. There would be a named nurse and then at times there would be an associate, there would be an allocated associate nurse. 13:50
CHAIRPERSON: Right.
A. So if you were maybe off sick or on annual leave --
CHAIRPERSON: Yes. But when you go off duty -- what is it, an eight hour shift? 13:50
A. It depends. Some were 12-hour shifts.
CHAIRPERSON: And 12-hour shifts. All right. But say you have a 12-hour shift, then you're off duty, you are still of course the named nurse for that patient and you wouldn't hand over as named nurse, you wouldn't hand over the role of named nurse? 13:50
A. No.
CHAIRPERSON: No. You remain named nurse whatever's

happening on the shifts?

A. Yes.

CHAIRPERSON: Now, would you expect the parents, relatives, whatever it is who would visit the hospital, to know who the named nurse for each patient was? Do you know what the system was for that? Because we've had some - just to give it some context - we've had some relatives say "I didn't seem to have anyone I could contact, I didn't know who the named nurse was." 13:51

A. I suppose at a point of admission it was really a registrant would have completed the admission process and then you were allocated as the named nurse, and then it was within your role to sort of identify yourself to the families, you know, and make them aware that you were the patient's named nurse. 13:51

CHAIRPERSON: Okay.

A. I know it was something I would have done. I would have let them know, the families that were involved, that I was their --

CHAIRPERSON: And you would introduce yourself to them to? 13:51

A. Yeah

CHAIRPERSON: If you knew they were coming, obviously?

A. Yeah.

CHAIRPERSON: Okay. Thank you. 13:52

16 Q. MR. McEVOY: In paragraph 15 then you explain how, or describe how:

"If a patient experienced an episode of choking, a

referral was made to the Speech and Language Therapy Department. Patient was reviewed by medical staff, case notes updated, a Datix form completed and next of kin informed."

13:52

Pausing there. Would a patient at risk of choking need supervision outside of meal times?

A. I suppose it was dependant on -- like, I suppose if they were going out on like a trip to the Cosy Corner, they would have been supported by the staff, so there would have been a staff member with them. If they were eating -- generally if patients were eating it was usually in the dining area, which was supervised by staff. More so patients who were allocated maybe a level of observations during eating and drinking would have always been supervised by staff.

13:52

13:53

17 Q. Okay.

DR. MAXWELL: But just to be clear, if the reason for the supervision was a risk of choking...

A. Yes.

13:53

DR. MAXWELL: When they were not in a mealtime and other parts of the ward, they may not have been under direct supervision, because the risk was associated with eating?

A. Yes. Sorry, yes. So, I mean, if they were on general observations, aside from eating and drinking, you know, then there wouldn't always be a staff member with them, unless they were in the common areas.

13:53

DR. MAXWELL: So you could be on general observation

unless and until meal times when you had enhanced supervision?

A. Yes. Yes. Sorry.

DR. MAXWELL: Thank you.

18 Q. MR. McEVOY: Okay. So, moving on, I suppose, to paragraph 16. You describe how the approach to care planning was the same in every ward, they were completed in a person-centred approach. Every ward -- sorry: 13:53

"Each ward had its own multidisciplinary team. However, a lot of allied health professionals worked across all of the wards. The care plans for patients in Erne 2 Ward did not change much from week to week. In other wards, such as the Admission Wards, patient care plans would be reviewed and updated based on the patient's presentation until they presented in a more stable manner." 13:53 13:54

And then you talk about how Six Mile was different due to the patients having a forensic background and the different risk, etc., that they presented. 13:54

For those of us who aren't health care professionals, can you give us an idea of the structure of care plans and how, the extent to which they've changed over time; did they require different information? Like, say, for example, dental needs or something like that, how would they have been incorporated into a care plan? Or if 13:54

there's a better example, perhaps you can give us one.

A. So, like I've previously said, care plans would have previously been a written documentation that would have solely been on the ward, and solely really nursing staff would have been involved in that. So as time progressed and care plans went on to PARIS, they were accessible by all MDT professionals. So they were accessible, everybody could read them. 13:55

In terms of the likes of dental and things, how they were incorporated, you know, you would have been completing your assessment of, say, their ability to carry out their dental hygiene, was it something that they required assistance with, and then you would have been putting in a plan of care for it. 13:55

19 Q. Yes.

A. That would be that, you know, staff support them to carry out their dental care.

I suppose an example of how things evolved for speech and language, there was the development of, like, personal place mats and they were very much visible within -- they became visible in the ward. So instead of them just being within the physical care plan, they were maybe at the patient's dining area, that they were available for everybody on the team to read, you know, that if you were handing out a meal and it was that they required it to be cut up into small bite sized pieces and then required a drink, that it was visible, 13:55 13:56

it was there in the ward so everybody knew what their choking risk was.

20 Q. Okay.

DR. MAXWELL: Can I just expand on that? So, I'm interested in what had model of nursing was. So we've heard from some nurses who were working there before you qualified who talked about using the Roper, Logan, Tierney model, Activities of Daily Living. In my experiences, sometimes the records will change when the model of nursing assessment changes. So, what model, if any, was in use when you were there? 13:56

A. Yeah, so it was initially Roper, Logan, and Tierney, but then it kind of evolved into more like an adapted version of Roper, Logan, and Tierney, especially whenever it moved onto the PARIS system, things were broken down that wee bit more into physical health, eating and drinking, elimination, behaviour, social factors, everything. You know, it was expanded upon. There was a greater -- greater detail went into the care plan. 13:57

DR. MAXWELL: So you'd expect more information in the assessment as the years went on?

A. Yes. And in terms of the plans of care, they became more personalised. When it was a written care plan, the plans of care would have been like pre-typed and you would have been like ticking one ones, what the identified needs was and what the plan of care what you were actually going to do for them. So, like, for in terms of their physical health, maybe referring them to 13:57

the GP, you'd be ticking them and you'd be signing whilst --

CHAIRPERSON: Would you slow down a tiny bit.

THE WITNESS: Sorry, am I talking too fast?

CHAIRPERSON: All right. 13:57

THE WITNESS: Whenever it went on to PARIS, it was that you were writing, you were writing it person-centred to each individual patient.

DR. MAXWELL: So when it moved on to PARIS, you didn't have these prepopulated plans that you'd had when it 13:58 was written documents that you just crossed through and signed?

A. Yeah. So when it was PARIS, it was very much more person-centred and you were writing it based on your identified need for each individual patient. 13:58

DR. MAXWELL: Thank you.

21 Q. MR. McEVOY: Now, H260, at the bottom of page 5, which is the beginning of paragraph 17, you say that:

"Family involvement and engagement was always welcomed. 13:58 Some families were heavily involved in their relative's care and remained in regular contact."

Now, I'm sure it's probably not a surprise if I say to you that lots of the families who've come and give 13:58 evidence to the Inquiry about their experience of Muckamore would say something very different about their experience, and would say that they weren't always welcomed, and felt excluded from their

relative's care. When you say that, is there context you want to add? Are you saying that about your personal approach or are you saying that about the staff with whom you worked, who worked for you? Is there anything you want to add to explain what you mean by that statement? Because it stands in contrast to what the Inquiry heard during the course of the patient experience. 13:59

A. Okay. I suppose from context of that, you know, I found that there was some patients who were admitted to hospital had limited to no family contact, you know, they may have had known relatives, but they weren't involved in their care, you know, so it was MDT decisions, you know, regarding medication changes, movements to -- 13:59

22 Q. Slow down a wee bit just so we can get everything. You're okay. You're doing well, just slow down.

A. Like movements to placements, you know, it was all based on the MDT's assessment. Whilst when I say families were heavily involved, I mean that there was families who visited every week, you know, they wished to be attending their admission meetings, their progress meetings, discharge meetings, that they wanted their opinions to be listened to, and that their views on where their relative should live, you know, were taken into consideration. 14:00

23 Q. And were they?

A. For the patients that I looked after, yes. You know, there was a number of -- like I predominantly work with

female patients, so there was a lot of female patients that, you know, their relatives visited every week and they were very much involved in the discharge process, you know, and that was going to view placements, seeing if they were suitable, whether they were logistically within their geographical location, you know, was it close to home? You know, was it going to suit that they were going to be able to visit family easy?

24 Q. So during your time, for example, in that female ward, you don't have a personal experience of a family indicating to you that they felt that they weren't being welcomed or engaged with?

A. No. I mean any of the patients that I looked after, I feel like families were very much respected and, like, their wishes were taken into consideration. There was a number of patients who, in terms of their medication, family were listened to if family felt that they weren't happy with the antipsychotic medication that they were on or how they were presenting under certain medications. You know, like families' views were taken into consideration.

DR. MAXWELL: Can I just pick up on that? So you talked about when you moved to the PARIS care plan, this move to person-centred care, and I know there's been a big movement in nursing in Northern Ireland around person-centred care and the, I think it's called the Census Framework, isn't it? Were there any discussions in the nurses' meetings, and certainly when you got to be a deputy manager presumably there were

meetings between the ward managers, about how you were going to promote person-centred care, and the importance of involving family as part of that whole framework? I mean, if you don't remember, that's fine.

A. Honestly, I don't remember. 14:02

DR. MAXWELL: Okay.

CHAIRPERSON: And when families did come, where would they be able to see their relative?

A. So, all the units had, like, visitors' rooms that were available at the front of the unit. So, you know, 14:02 there was two visitors' rooms at the front of the Cranfield building that were generally used for visits; the hospital grounds, which were available for walks, there was park benches around the site; the Cosy Corner, and then relatives had the opportunity, if they 14:03 wished, to take their relative off-site if it had been agreed with MDT, or if they were presenting in a stable manner, to leave the hospital site

CHAIRPERSON: And could they see the ward?

A. From memory, in the early days the ward, if it was 14:03 unsettled, families weren't really taken on to the ward environment really for their own safety. So visits were generally facilitated off-site. But, you know, if family members wished to come into the ward, you know, in later times, they would have been facilitated to 14:03 come on with staff, you know, that the nurse in charge would have been made aware that the family member wished to come on to see their relative in their room.

CHAIRPERSON: And can you just give me a picture of the

ward itself? Because it's all very well talking about "the ward", but it would help me to have a mental image. Are we talking about pre-16 still Cranfield?

A. Yes, so --

CHAIRPERSON: How many beds? 14:03

A. So Cranfield Women was a 15-bedded unit. It was a large building that was split into three. So it was Cranfield Women, Cranfield Men, PICU. There was visitors rooms at the front of the unit and then a link corridor that would have taken you down into the actual 14:04 ward.

CHAIRPERSON: Yes. And so how many beds would we see if I were to walk into the ward, as it were, back in 2015?

A. So it wouldn't really be set up like in a generalised 14:04 hospital.

CHAIRPERSON: No, quite.

A. So you'd enter the ward and you'd have your general area, which would be the dining space, and then the nurses' station, and then there would be two corridors 14:04 off which had individual bedrooms. So each patient had their own individual bedroom with an en suite.

CHAIRPERSON: So, the issue of parents or relatives coming to visit, in a perfect world - and I appreciate it rarely is - a parent would, or should, be able to 14:04 see the room in which their loved one is living?

A. Yes.

CHAIRPERSON: That couldn't always happen?

A. It was probably dependant on how the ward was

presenting at that time

CHAIRPERSON: Okay.

A. But if family members wished to see their patient bedroom, where you could, you would facilitate it, yes.

CHAIRPERSON: Okay. Thank you. Sorry, Mr. McEvoy. 14:05

25 Q. MR. McEVOY: Turning over to page 6 then. In paragraphs 18 and 19 you describe how:

"Beginning in July 2016, senior management made the decision for Cranfield Women Ward and Killead Ward, 14:05 which is a ward with male patients, to swap, due to the patient profile, and requiring admission and capacity of female admission beds."

And you give us some statistics in terms of available 14:05 beds. You move then from Killead female admission as a staff nurse to Cranfield 1, for a couple of months at the end of 2016/start of 2017, before you commenced as a Band 6 Deputy Ward Sister on Erne 2. And then you move from Erne 2 in June 2017 to Donegore. You then 14:06 say that:

"Donegore and Killead Wards amalgamated and became known as Ardmore."

14:06

Now, what was the effect of all of the reconfiguration of those wards in that period on patients, particularly their behaviour?

A. From memory, it all sort of happened, like the move,

physical move, happened in one day of the swapping of the patients. There was a lot of planning went into it, and where patients, where their bedrooms would be allocated based on the patient profile and the logistics of the ward. 14:06

I don't specifically recall, but how totally impacted patients, there may have been a period of unsettled for some patients because it was a larger environment, you know, there was a lot more open space, a lot of 14:07
different, like, day rooms. For talk's sake in Cranfield there was one day room and maybe two small day spaces off that, you know, and generally all the patients would like to sit in the one space, whilst when we moved to Killead it was a large dining area 14:07
with small rooms off each area, which sort of the patients found that wee bit harder and we found that a lot of the patients preferred then just to sit in the dining space because they were all together again. So, you know, I'd say it did come with some difficulties 14:07
for the patients to re-settle into a new environment, and some patients went into what was called a "pod". So there was, at the end of the corridor there was a pod area. From memory, one female patient had gone into it. So, I suppose it was unsettling for them, you 14:07
know, a change of environment.

26 Q. It took place in one day, as you say, but you've said that there was a lot of planning that went into it.

A. Yeah.

27 Q. When the planning was being undertaken, was thought and anticipation given to the effect of the different kind of layout of the wards on patients and how they may react?

A. Yeah, I think so. You know, there was obviously patients who required the use of, like, disabled bedrooms and, you know, the patients were allocated where it was best suited for them and who they were going to be, their bedroom was going to be beside, you know, especially in terms of patient profile and who got on best together. 14:08 14:08

My personal experience was they felt that the patients would have, you know, they put the patients who got on best together in similar corridors and that they would make use more of all these separate day spaces, which wasn't really what happened; the patients, like they had done in Cranfield Women, preferred to all sit together. 14:08

28 Q. Yes. 14:09

A. And obviously that comes with logistics of, like, tension and things with some.

29 Q. Of course. Was there consultation, so to speak, with the patients, insofar as you were able to have it, about what was going to happen or -- 14:09

A. I can't remember. I really couldn't say.

DR. MAXWELL: Was there consultation with the nursing staff who knew the patients, since you were their named nurses?

A. I think so. I think it was discussed, you know, that this was going to happen

DR. MAXWELL: That's not a consultation if you were told it was going to happen.

A. Well, no. The view was that it was for the reason of the bedding capacity that it was taking place, that the female admission unit was so sought after in the sense of that we were always above capacity in terms of the amount of patients that were being admitted, that this was going to solve the issue of admissions, that there was going to be more beds to facilitate bringing in more women, and then they wouldn't have to be sleeping out in other units. 14:09 14:09

DR. MAXWELL: Was it associated with the closing of any wards? 14:10

A. The move?

DR. MAXWELL: Yes.

A. I don't believe so.

DR. MAXWELL: Okay.

30 Q. MR. McEVOY: Okay. In paragraph 20 you describe your duties and responsibilities that went with your role as a Band 6 in Muckamore, and you describe these as being both clinical and managerial. You were the nurse in charge of the shift, you completed care plans, Datix approval, adult safeguarding screening, and the health roster, and you prepared risk and governance templates on a weekly basis and attended the associated meetings. These were attended by ward representatives, other heads of disciplines and were Chaired by senior 14:10 14:10

management. You discussed at that those meetings anything recorded in Datix forms, complaints or compliments, and there was a focus on adult safeguarding, and you also attended multidisciplinary meetings, known as the purposeful inpatient admission, which were daily in Six Mile, and you describe who all was in attendance as those, including the consultant, ward senior house officer, social workers, and other health care professionals. 14:11

"Not everyone attended daily, but there was a weekly meeting which everyone did attend."

You say. You then go on to say a little bit further on down the paragraph, how you: 14:11

"...recorded staff over time sending out shifts to the nurse bank and adding agency to backfill deficits."

It was your responsibility to forward plan for the week ahead, ensuring staffing levels were balanced each day and to ensure deficits were being filled. 14:11

"As staff teams became reliant on agency staff, the completion of E-rostering..." 14:11

-- you say:

"...became very administration heavy and time consuming

due to the manual adding of agency staff shifts compared to how it would operate with a full substantive team."

You then say:

"On shifts where the ward would be short-staffed, focus was on meeting the patients' needs and ensuring a safe working environment. At times additional activities, appointments or day care attendance were cancelled due to short-staffing. Alternative activities would be offered on the ward."

When those cancellations happened, what sort of alternative activities would be offered?

A. I suppose it would be dependant on what actually they were due to go out to. You know, if patients were supposed to be going out for, maybe out for a meal, and there wasn't sufficient staffing to facilitate it, that you would maybe complete a cooking activity. Most of the wards had like a life skills room, so it was like offering an alternative to, you know, to facilitate that one-to-one time with your patient, an activity that they enjoy. For the likes of Six Mile room, they had a games room, you know, where you could go and play pool, take patients off side to have one-to-one engagement with them, in terms of activity, watching films. There was the opportunity to use -- sorry, Moyola, you know in the evenings, that you could go

over there to watch films, and there's a room that you could facilitate things like that.

31 Q. Yes.

A. So it was just offering alternatives so that the patient didn't feel like let down that they weren't getting that one-to-one experience with their named nurse or staff. 14:13

32 Q. Now, in paragraph 20 you've made reference then to shifts where the ward would be short staffed, and looking on down to -- and you continue then with a description of the obligations you were under and duties that went with your Band 6 role. But having made reference to short-staffing on the ward, you tell us in paragraph 22, about five or six lines down: 14:13

"As Deputy Ward Sister I ensured there was adequate staffing levels to meet the needs of the patient group." 14:13

I suppose for present purposes, if I can just ask you to look across at page 8 and the start of paragraph 23: 14:14

"I frequently had concerns around staffing and I raised this with the Band 8A who was on shift at the relevant time." 14:14

And you say then:

"From 2020 staffing was a constant challenge with the

increased reliance on agency staff to fill deficits."

So, I suppose there are a number of statements there which may not, to the reader, sort of initially sit well together. So you tell us that as Deputy Ward Sister you ensured there were adequate staffing levels to meet the needs of the group, but you have made reference to short-staffing, and you've also then of course made reference to having concerns, frequent concerns, about staffing and indeed raising it with the Band 8A. 14:14 14:14

So, can I give you the opportunity then just to explain what you mean by that? How did you ensure adequate staffing if there were issues about short-staffing? And, indeed, these are issues that lead you to expressing concern and raising them with your Band 8A. 14:15

A. Okay. I suppose in the context of me saying, you know, where appointments and things had to be cancelled, at times that could have been due to like maybe staff members phoning in sick, or changes in the roster at that period of time, you know, on a daily basis. 14:15

33 Q. Yeah.

A. So you'd be ensuring safe staffing by, you know, like your tasks as a Deputy Sister of completing a roster, and everything, things like that were put to the side and the focus solely was on patient care at that time. When I talk about the staffing challenges, you know, the reliance on agency was great, and you found that 14:15

when you were completing a roster you could maybe have everybody scheduled in, and the numbers were balanced in the sense that you had sufficient staffing levels for each day, but there were times where agency staff members would have maybe just rang and said 'I'm not going to be in this week'. So that would be one full week of one staff member who wouldn't be on shift. And I suppose that's where your concerns would rise, you know, 'how am I going to backfill these deficits?'

34 Q. And indeed you go a bit further actually in paragraph 23 and you say: 14:16

"Some agency staff lacked engagement with patients which put a greater pressure on to substantive staff." 14:16

A. Yeah.

35 Q. Can you just -- we know what you're driving at there, but if you want to explain a little bit more maybe from your practical experience about what that meant or what that looked like on the ward? 14:16

A. So, like on the ward you would have found that like agency staff would have maybe have just supervised the day space but wouldn't be looking at what's going on around them, and that, you know, to try and engage patients in a level of activity, and it was down to maybe just getting them to play a game of cards or to go for a walk. It was -- you were constantly having to delegate and saying 'Will you go and do?'. 14:17

36 Q. Yes.

A. Whilst in respect of substantive staff, they knew that was their job role and they just went and did it, you know.

37 Q. Yes.

A. You don't have to ask staff to go and do them things. 14:17

38 Q. Yes.

A. And that's where I found there was a greater pressure on substantive staff, and they felt it too, you know, where the patients were seeking out substantive staff members as opposed to maybe agency staff. 14:17

39 Q. With whom they were familiar?

A. Who were familiar to them, and know their needs, and know what supports them during times of crisis.

40 Q. Yes. Yes. I think Dr. Maxwell has a question.

DR. MAXWELL: This term "safe staffing" is sometimes 14:17 used to mean the number of bodies, but actually safe staffing is much more than the number of bodies, it's what they can do. How many of your agency nurses were actually trained as learning disability nurses?

A. Figures, I really wouldn't be able to, you know, give 14:18 specifics. But the majority of the team was mental health trained nurses as opposed to learning disability nurses.

DR. MAXWELL: So even with the best will in the world, they wouldn't have the skills to assess people with 14:18 learning disabilities in the same way that a registered nurse learning disabilities would?

A. Yeah.

DR. MAXWELL: So you might have filled the numbers, but

it wouldn't have been the same as if they had all been registered learning disability nurses?

A. Yeah. Yeah. You find that there was more -- depending on -- some staff members were more open to learning and learning how to best support the patient with the learning disability, whilst some nurses were very much that they were from a mental health background and their job role was supervision and monitoring their mental statement. As a learning disability nurse you're taking all factors into consideration, you know, especially social factors. And, for example, there was some patients who went home maybe two or three times a week, and on the days that they didn't go home, that is when you found that their behaviour was maybe a wee bit more unsettled, and that's when they needed staff to see the triggers and engage them in activity to make that day that wee bit easier. And you kind of found that them skills were lacking. 14:18 14:18 14:19 14:19

DR. MAXWELL: So we have heard a lot in the Inquiry about behaviour support plans and behavioural specialist nurses, and we've heard a lot about challenging or distressed behaviours. In your personal opinion, which I accept is your personal opinion, were these agency nurses adequately skilled to follow positive behaviour plans? Or would they have been able do it as well as somebody with a learning disability background? 14:19 14:19

A. I think it was dependant on the situation and the patient group. I found whenever I was in Six Mile Ward

there was a number of patients who had positive behaviour support plans, and the agency staff were very good at reading them and knowing how best to support that patient, you know. And we made them very -- they were very accessible on the ward, and that would have been part of the induction programme of, you know, getting them to read the positive behaviours support plan as to know how to best support that patient during a crisis. But, again, it was person specific, you know, some people were more open to learning the routine of the ward than others, and it could be a challenge. 14:20 14:20

DR. MAXWELL: Thank you.

MR. McEVOY: You then go on to tell us a little bit more about meal times, which I think you've talked about anyway in your oral evidence, and how those were managed, and then you also then give us the specific example of - and this is at paragraph 25 - a lady in Cranfield Women's Ward who had a prolonged admission, and you describe the Level 3 observations that were in place to ensure her safety. You describe your view on how the staff provided that patient with compassionate person-centred care, the care that was taken to help her with her -- maintain her appearance and so on, and she had a poor appetite, staff went shopping for her. So the steps that you describe show how there was a person-centred compassionate care provided to patients at Muckamore. 14:20 14:21

Then again in 26 you continue:

"From my experience of working at Muckamore, I felt the objective was the same in every ward; ensuring safe, effective patient care, with the ultimate goal of discharge to a community setting. I feel there was a caring compassionate culture provided to inpatients, with staff often going above and beyond their job role. Staff worked in stressful environments, often in understaffed and aggressive situations, and there was a teach approach to the care of patients, implementing care plans to meet patients' needs." 14:21 14:21

You then say:

"I never witnessed any poor care or abuse at Muckamore and I never witnessed any practice which I had concerns about. I never witnessed any staff-on-patient abuse." 14:22

I'll just pause there for a second. When the 2017 concerns came to light, what was your reaction? How did you feel about them? 14:22

A. It was very disheartening to know that maybe that was going on in another ward within the hospital site, you know, and the patients were not being treated in the same compassionate respectful manner that I would want my relative to be treated in. And I suppose you had a lot of questions, you know, about how long it had been going on for, you know, what had taken place? And I 14:22

suppose it's things that really haven't been answered, you know, nobody has been given the specific answers of to what level of abuse had been taking place, apart from, you know, maybe hearsay of what you've heard.

41 Q. Yeah. 14:23

A. You know.

42 Q. Okay. You do then recollect, however, witnessing patient-on-patient incidences and making appropriate safeguarding referrals, and you then describe an incident or a situation when you worked on Six Mile, 14:23 and there were occasions where patients made allegations regarding staff, and you talk about one patient, P54, who made allegations that he had witnessed staff having sex.

14:23

"A safeguarding referral was completed for this and then sent to the designated adult protection officer for investigation."

You note that: 14:23

"P54 presented with sexual ideation and this was exhibited in his behaviour towards others. When P54 made allegations against staff, a safeguarding referral would be completed." 14:23

You then tell us that:

"A protection plan would be put in place to safeguard

the patient and staff member. The protection plan would consist of no alone working with the patient. Staff members were not to work outside the areas of cameras and at times working solely on one side of the unit."

So, I suppose one perception of what you tell us there about the protection plan, and it may not be the right one, but one perception of what you tell us about the protection plan and the nature of it is that it's rather more focused on protecting the staff member as opposed to the patient. Would that be fair? 14:24

A. I suppose in one context, yes, it's in terms of protecting the staff member. And then in the other context it is in terms of the patients in that they wouldn't work on that side of the unit. So when I say that at times working solely on one side of the unit, that would have been until the investigation was completed. So in respect of the patient, that would be. So if that patient was on the assessment side of the unit, the staff member wouldn't work on that unit, so they wouldn't be directly working with that patient until the investigation was completed and then they would work on the treatment side of the unit. So I suppose when I say that, I am trying to give both sides -- 14:24 14:25 14:25

43 Q. I know, yeah.

A. But it mightn't come across that way.

44 Q. Yes, of course. No it's just, as I'm sure you can

appreciate, one looking at that might say 'well, look, this is trying to get the person making the allegation out of the way of the staff member and vice versa'.

A. Yes.

45 Q. Who is really the focus of protection, and if that's incorrect, then it's helpful for the Inquiry to know why that would be so. There's nothing you want to add to that, no? 14:25

A. Ehm, no, I suppose in terms of the patient, that you would be carrying out the safeguarding referral and you would be taking the allegation seriously, you know, and that you would be carrying out the appropriate process so that the patient's allegation is taken seriously and that you're responding to it in the appropriate manner. 14:25

46 Q. Okay. Thank you. I think we have talked about short-staffing and what you did to try and manage that and the concerns that you raised, and you're quite categorical that you didn't see any abuse or poor practice towards patients. But did you ever see an incident that gave you cause for concern, even in light of all that short-staffing and issues that you were confronted with? 14:26 14:26

A. No. No, like, in terms of any forms of abuse, I never witnessed anything that I had concerns about. And if I had, I would have been responding in the appropriate manner and raising the concern. 14:26

47 Q. Yes. Now, moving on to paragraph 28 --

CHAIRPERSON: I'm just thinking, the witness has been going about an hour. Are you okay to continue?

THE WITNESS: Yeah, I think I just want to keep going.
CHAIRPERSON: I thought you might. All right.
MR. McEVOY: We don't have very much further to go any way
THE WITNESS: I mean if you want to have a break, that's okay. 14:27
CHAIRPERSON: No, we don't need a break. But if you do need a break, please don't be shy about asking.
THE WITNESS: No, I'm okay. No problem. Thank you.
MR. McEVOY: Okay. We don't have very much further to cover anyway. 14:27
CHAIRPERSON: Okay.
48 Q. MR. McEVOY: Now, prior to the events, you say in paragraph 28, of 2017, you felt there was a good atmosphere on the wards where you worked, you never noticed a change in atmosphere depending on staff members on duty, or if senior management were on the ward. You do recall having been told by H77 that CCTV would be installed. You don't recall there being a formal consultation or meeting to discuss this with staff. 14:27

"We were informed that CCTV was being installed for the sole purpose of adult safeguarding due to the number of referrals being made." 14:27

So this is prior to the events coming to light. And in your recollection, you're very definite about it, you had no concerns in your experience, no exposure or

recollection of any staff-on-patient abuse or poor practice. And, therefore, when you were informed that CCTV was being installed for the sole purpose of adult safeguarding due to the number of referrals, you don't note in your statement any shock or surprise about that. Was there any? 14:28

A. About why it was being installed?

49 Q. Yeah. The reason. In other words, the uptake in the number of referrals, adult safeguarding referrals.

A. I think at that time the ward was quite unsettled and, you know, there was a number of patient-on-patient incidents. So whenever I say that, you know, the number of safeguarding referrals being made, I probably reference that meaning as in patient-on-patient incidents. 14:28

50 Q. So you would have anchored that in maybe it's more patient-on-patient --

A. As opposed to staff-on-patient, yes.

51 Q. Okay. And then going on over to page 10, still in the same paragraph, you go on say that you felt that after the CCTV was installed, and you were told about this, you say -- sorry, just before we leave that page -- you don't believe it had an impact on the conduct of staff members, but by Christmas 2018 there was a staffing crisis, morale on the wards was low. And then you discuss the impact of precautionary suspensions on staff who felt they would be next if they made a mistake or were perceived to do something wrong. For example, the use of physical intervention. 14:29 14:29

You then say that you:

"...felt under pressure as Deputy Ward Sister to support the staff on your team." 14:29

"CITREP", have I got that right?

"CITREP reports were being produced on a weekly basis by senior management which were available to all staff, 14:30 reporting on contemporaneous recordings on the wards. At times there were comments in these reports regarding staff body language and sometimes a response to the observation was requested. I recall appearing on a CITREP report on one occasion where the report said 14:30 that I entered Six Mile and I held the open palm of my hand out in front of a patient to gesture personal space. There was an inference that this is not the way I should have responded to the approach on the patient." 14:30

And then you go on to describe exactly why you did what you did and why you gestured as you did on the -- and why that should have been so. But were you invited to make any comments on the CITREP, on that CITREP, the 14:30 one that identified you?

A. Ehm, no.

52 Q. You had an explanation to provide --

A. It was -- yeah. So I was able to -- when you read the

report, it said that the Deputy Ward Sister entered the ward, and at that point I was the only Deputy Ward Sister.

53 Q. Yes.

A. It clearly stated the date and time, or period of time that this incident had taken place. 14:31

54 Q. Yes.

A. So I was able to identify myself that, you know, that this was me.

55 Q. Yes. Yes. 14:31

A. And then obviously I provide an explanation of why I've responded in that manner, to which, you know, from what I've said in my statement was that that patient had sexually assaulted members of staff the previous day, and I was maintaining my own personal safety in that context. 14:31

56 Q. Mm-hmm.

A. So, I wasn't, in terms of personally able to provide a response.

57 Q. Yes. 14:31

A. From recollection, the service manager was asked to provide a response because they were over the -- they had responsibility for that unit at that time, so I was able to say, 'Well, this is what happened'.

58 Q. So you were able to convey your -- 14:31

A. Well she was able to provide the response --

59 Q. -- reason?

A. -- as to why that had taken place.

60 Q. Yes.

A. I suppose what I'm trying to say there is that, you know, there was viewings happening of CCTV and things were maybe being perceived in a manner that they weren't...

61 Q. Yes. And the context wasn't always clear, is that the -- 14:32

A. The context wasn't always clear, yeah.

62 Q. Okay.

DR. MAXWELL: Can I ask you, you say the CITREP, and your statement is the first time we've heard about this. 14:32

A. Okay.

DR. MAXWELL: You were saying this was produced on a weekly basis? This was based on the CCTV viewing?

A. Yes. 14:32

DR. MAXWELL: So this was the contemporaneous. This was different from the six month stuff that was being looked at historically?

A. Yes.

DR. MAXWELL: Was this just a written report of what had been seen. 14:32

A. So it was a safety report that was produced on a weekly basis that kind of looked at the like governance of like maybe the number of incidents that had taken place on the hospital site in that week. It would have looked at how many patients were on-site from each Trust, was there any discharges taking place? And then a part of that report would have discussed some, whether it was how many adult safeguarding incidents 14:32

had maybe taken place during that week, and then the other part was that there was recordings, or written observations of contemporaneous viewing. So that was where they were viewing CCTV post the events of 2017 and looking at snippets of each day in each ward, and then it was recorded and it was available for staff to read.

DR. MAXWELL: So they were randomly taking samples of the CCTV, were they?

A. Yeah. 14:33

DR. MAXWELL: But nothing had triggered them to go and look at what you were doing at that time on that day?

A. No, it was just -- it was random samples of each ward. It could be like a day duty, night duty, anything.

DR. MAXWELL: So anything that was thought to be 'We need to know more about this', was put on the CITREP rather than somebody coming back and talking to you before it got on to the CITREP? 14:33

A. Well, it wasn't just like things that they wanted context to, it was also maybe recording like just general practice of good things that they observed, it was maybe like you would have read, you know, staff and patients sitting in the dining area engaging in activity, or where they had viewed the life skills room where the staff were maybe doing a cooking activity. 14:33 14:34 You know, it wasn't solely just things that they wanted context to, it was also monitoring group practice as well. But like I said, it was contemporaneous, and it was at random, you know, it was random times of the day

in each ward, and it would have been in a table format, and in what time period that it had taken place in.

DR. MAXWELL: So just this specific incident -- sorry, do have a drink.

A. Sorry. (Coughing). 14:34

DR. MAXWELL: So it got put on the CITREP before you had had a chance to explain it. Did CITREP say 'this is good, this is bad, this is what is going to happen', or was it just a description and it was just left there hanging? 14:34

A. It was there and then that it was provided on the report and then there would maybe have been an e-mail asking for a response to what they had observed, to which then the service manager, or the assistant service manager then provided - investigated and 14:35 provided the response to it.

DR. MAXWELL: And this CITREP was available to all staff? So all the health assistants --

A. Generally --

DR. MAXWELL: The porters. 14:35

A. That was whenever I worked in Six Mile, so we printed it out and left it available for staff to read. How it was used in other wards, I can't answer.

DR. MAXWELL: Okay. Okay. Thank you.

63 Q. MR. McEVOY: Now, H260, in paragraph 29 then you say 14:35 that you always felt supported during your different roles working in Muckamore ward level.

"My Band 7 ward managers were very supportive. Never

had any difficulty raising issues of concern."

Just thinking back to the issue of staffing that we talked about a few moments ago, and you said that you were able to raise them with your Band 7, you raised them with the Band 8A as well. On this evidence, no difficulty raising them with your Band 7, presumably something like staffing, the staffing issue? 14:35

A. Say that again, that question again?

64 Q. You wouldn't have had difficulties raising staffing issues with your Band 7? 14:36

A. No. And it was always a very good working relationship. You know, there was a general respect, you know, for each other's role.

65 Q. Yes. So able to raise it with Band 7, able to articulate and convey problems 'I don't have enough people'? 14:36

A. Yeah.

66 Q. 'I don't have enough people who can do what we need them to do'. Where do you think the problems lay then? Because you described how, you know, you didn't necessarily get answers when you raised concerns. When you raised them with your Band 7s, where do you think the problems lay? 14:36

A. In terms of staffing? 14:36

67 Q. Yeah.

A. I suppose it was how things were unfolding within the hospital.

68 Q. Yes.

A. You know, a lot of staff were being placed on precautionary suspension, so your substantive team were being depleted, you were being backfilled with agency staff. So, you know, your team was getting smaller and you were getting more new people that you were having to induct to learn the routines of the ward. So I suppose it's based at a more senior management level that, you know, there was no sort of acknowledgment to how are we going to try and build a new team with these new staff members that, like, some maybe only stayed a few weeks and then moved on, and you were backfilling in with another person. But I suppose the difficulty lay with, you know, how the events post-2017 were being managed, you know, and how the hospital in itself was being managed. 14:37

69 Q. Yes. Yes. And, indeed, that's exactly what you go on to say in this paragraph:

"After 2017, frequent change in the senior management team, varying degrees of experience within learning disability services." 14:37

You describe constant change in senior management, contributing to feelings of instability within the hospital. 14:38

"As a Band 5 staff nurse I had limited dealings with senior management and issues of concern were raised with ward level management. As a Band 6 Deputy Sister,

in the absence of the Ward Sister, I would attend the weekly ward managers meeting, facilitated by the Assistant Service Manager. Prior to 2017 the Assistant Service Managers - in other words the Band 8As - were located in the administration building, and then afterwards they relocated to their respective wards in 2018. This increased their visibility and accessibility for staff. Service managers, Band 8Bs, presence on the ward was variable."

14:38

Do you know -- I suppose the first question, do you know whose decision it was to make that move to send that level out to the wards from the administration, those levels?

A. No, I don't know whose decision it was. 14:38

70 Q. And I suppose you've described increased visibility and accessibility for staff. Any other effects? Or if I can put it this way: Was it positive, negative, more positive than negative, more negative than positive?

A. I suppose it was more positive, you know. They were more accessible to us as ward management, you know, to raise concerns of even just daily issues of, you know, maybe staffing levels or, you know, incidents on the ward that you had, that had maybe taken place overnight, you know, it was another person to speak to, you know, to see how you were going to manage things, you know, if there was, like, staffing deficits, or you wanted to discuss an incident with them, you know, and they were just more accessible to you. 14:39 14:39

71 Q. Yeah.
A. You know, they were available. There's one of the Band 8As that was over Six Mile, they would have came in on a daily basis at the start of their shift. I don't know if you want their name, but... 14:39
72 Q. Well, perhaps you can -- I'm not sure if you can see the name on the list --
A. They're not actually on that, where I haven't discussed them.
73 Q. Okay. By all means write it down and the secretary will give you a piece of paper to write it down on. 14:40
A. They would have came in on a daily basis and asked how things had been overnight, was there anything that they needed to know. So I think they were more knowledgeable about how things were working on the wards. 14:40
74 Q. Yes. Okay. And we'll come back -- the secretary will check to see if there's a number, but we'll come back and we'll proceed. You then say that prior to 2017 there was a lack of senior management or Board presence on the wards, and you tell us that they hadn't conducted visits previously and, indeed, you say prior to 2017 you'd never seen H730 or H296. 14:40
CHAIRPERSON: Sorry, those have both been ciphered, have they, as directors? 14:40
MR. McEVOY: They have.
CHAIRPERSON: I see.
MR. McEVOY: They have.

"But started doing so in 2017."

We can roll them back, Chair, if necessary?

CHAIRPERSON: Yes, don't worry.

75 Q. MR. McEVOY: But how was that perceived or viewed by yourself and the other staff on the wards? Like that Band, the person responsible for Six Mile who was at what Band? It was a Band -- I want to get this right. 14:41

A. 8A.

76 Q. An 8A. And that person is H426. 14:41

A. Okay.

77 Q. Okay. Thank you. Sorry, I was asking you how it was viewed then when you started to see people at director level on the wards by other staff, yourself and other staff. 14:41

A. I mean, where I've said I don't recall them -- like I've said that I didn't recall them prior to 2017. I think H296, I remember seeing them post-2017, but H730, I don't know them.

78 Q. Yeah. 14:42

A. But how they were perceived? You know, obviously they were walking around the wards and having a view of how things were working. But I suppose there was no real context to the reasons for doing so, you know? And it maybe made you anxious, you know, that there was things happening in the background that you weren't being made aware of, whilst if it had have been common practice, it wouldn't have been a cause for concern. 14:42

79 Q. Yes. Okay. You go on then just to talk about your

engagements with RQIA and their announced and unannounced inspections, and you give some discussion about restrictive practice and how those were examined, and you also talk about the management of actual and potential aggression or MAPA, that the Inquiry has heard a lot of evidence about. 14:42

But the final topic I just wanted to raise with you was the question of the administration of PRN medication, and you remind us in paragraph 33 that it was a decision of a registered nurse, based on the assessment of the patient's presentation, and if it was deemed necessary to alleviate their symptoms of agitation. 14:43

"The administration was recorded in the prescription Kardex and in the progress notes and nursing staff would record if the PRN medication had a desired effect." 14:43

During the course of your time, did you ever have to administer it, PRN? 14:43

A. Yes.

80 Q. Yes. And can you give us an idea of frequency? Was it something you were doing daily, weekly, monthly?

A. It depended on how each patient presented. You know, where patients were going through behavioural concerns or difficulties with their mental health, where you maybe had been administering it maybe on a daily basis. There were some patients who we worked with and they 14:43

were knowledgeable about their mental health and how they were feeling, and were able to express, you know, feelings of agitation or anxiety and would request PRN medication, and that would have been clearly documented that it was at the patient's request that it was administered. But, again, like I said in my statement, based on my assessment of the patient's presentation, that was getting to know them, you know? A lot of them patients have been there for a significant period of time and you were getting to know how they presented during periods of agitation, or where they're feeling that wee bit more anxious, and using your professional judgment, that PRN was administered to help alleviate those symptoms of agitation, often just to try and prevent the escalation and behaviour where they become unsettled, you know, and display dysregulated behaviour. But it was patient based. But you could have been administering it on a daily basis. It just depended on how each patient was presenting -- 14:44 14:44 14:44

81 Q. Patient to patient? 14:45

A. From patient to patient at each particular time.

82 Q. Yeah.

A. You know, if they were going through a period of settledness, you know, like their routines were regular, and their mental state was stable, and their behavioural stale was stable, that you maybe didn't need to administer a PRN. 14:45

83 Q. I think Dr. Maxwell has a question for you.

DR. MAXWELL: No.

MR. McEVOY: Oh, no, you haven't.
CHAIRPERSON: Well, then I do. Would it always be a nurse that had to authorise and administer - the PRN would be written up, we've heard about this.
A. Yeah.
CHAIRPERSON: But would it always be a registered nurse who would have to authorise the administration of the PRN?
A. Yes. So it would always be a registered nurse that would be making the decision to administer it.
CHAIRPERSON: And would it always be a registered nurse who actually administered it?
A. Yes.
CHAIRPERSON: Or could that be deputed to somebody?
A. No, it would have been the registered nurse
CHAIRPERSON: Always?
A. Yeah.
CHAIRPERSON: Okay. Thank you.
84 Q. MR. McEVOY: Okay. Just one final issue, H260, then, and it just relates to the question of resettlement, which is at paragraph 35, and you discuss it in a bit of detail. You talk about how it was ongoing from when you were a student, you were obviously -- and being a recommendation from the Equal Lives Report back in 2005. You talk about how you prepared a patient's discharge from the point of admission, the various meetings, pre-admission progress and pre-discharge meetings on Cranfield Women, to ensure that plans for discharge were made and were progressing.

"Some patients who were admitted for placement remained until they were ready for discharge. Sometimes then, obviously, these would have required adaptations or increased support to return home. Other patients were admitted during a crisis and therefore the placement was immediately terminated, often resulting in the patient being placed on the delayed discharge list. Patients who were deemed medically fit for discharge often remained in hospital due to the lack of community infrastructure. In order to assist, it was sometimes the role of the named nurse to visit potential placements to assess suitability." 14:47 14:47

And during your time in Erne 2 then: 14:47

"The objective of this ward was to re-settle patients as this ward was preparing to close. The ward facilitated In-reach to the community providers." 14:47

How did -- what was your experience of In-reach to community providers? Again, was it helpful, unhelpful, bit of both?

A. Oh, it was welcomed. You know, it was their opportunity to get to know the patients in their current environment, alongside staff who work with them quite well. 14:47

85 Q. Yes.

A. And it was sort of just to get to know their routine so

it could be relatively replicated whenever they moved to their community placement. And then where I've gone on to say that the ward also provided outreach. So, again, it was to make that transition from hospital to community that wee bit easier for the patient, to provide a level of support which was gradually reduced, to then with a view of it stopped and then a full discharge.

86 Q. Yeah.

A. So I feel that the community providers were very much welcomed on the wards to support successful discharge. 14:48

87 Q. You talk about how, as the Inquiry has heard in some detail:

"...the resettlement process can be difficult, especially for those patients with complex needs, often patients requiring bespoke packages which can take significant length of time due to potential building of the appropriate placement." 14:48

And then you give a description from your own experience of your care for a patient who had been an inpatient from a young age:

"They had in-reach from a community placement for approximately two years. When discussions were taking place to progress to overnight stays and trial leave it was deemed not appropriate for the patient's needs. A resettlement process had to then begin again for this 14:49

patient and the patient continues to remain in hospital awaiting resettlement."

So I think the Inquiry would just like to understand just exactly what happened there in that last few lines: 14:49

"The process had to start again, but overnight stays hadn't been trialled."

14:49

A. Okay. So when I say the resettlement process had to begin again, I mean that that placement was deemed not appropriate, so you were basically back to the beginning again. So you were looking again, seeking out a suitable placement. 14:49

88 Q. Okay.

A. So that -- the one that had been identified and they were trying to progress, it was deemed not suitable.

89 Q. Yes.

A. So I mean that was it, you were back to the beginning of -- 14:49

90 Q. Square one.

A. -- the start again, trying to find somewhere suitable for that patient. And, I suppose as nurses, that's extremely frustrating. 14:50

91 Q. Yes.

A. You know, that you'd get to a point where, 'Right, we're moving on to the next stage of resettlement', and then you're hit with 'It's not going to happen'. And

it's disappointing for that patient too, that, you know, where they think is going to be potentially their new home isn't going to take place.

92 Q. Yeah. Yeah.

A. And like I said, that patient is still an inpatient. It's frustrating. In terms of where I said the community infrastructure isn't available, we're still in that situation where it isn't available, and there is patients remaining in hospital, that there isn't the service available to support them, and it's very much bespoke packages that are required. 14:50 14:50

MR. McEVOY: Yeah. That's helpful. And I think that explains it. So, look, H260, those are my questions for you. I know that towards the end of your statement you've expressed some reservations about how you found the process up to this point. I hope that you have found the process today no less stressful than it needed to be and you've felt that the opportunity to come along and give evidence has been again more positive than a negative experience. So, thank you very much on the Inquiry team's behalf for coming along. 14:51 14:51

THE WITNESS: Thank you.

MR McEVOY: It may be that the Panel have some questions. 14:51

H260 WAS THEN QUESTIONED BY THE CHAIRPERSON AS FOLLOWS:

CHAIRPERSON: I just want to ask on that topic, I

understand you much would have preferred to make your own statement on your own, is that right, or to your own solicitors?

A. I suppose whenever I read back at what had been written on my behalf, it wasn't how I would have worded it, you know, and in the context of it wasn't a nurse writing what a nurse would write, you know, and it's with a view that a solicitor is writing about nurse's duties whilst a nurse couldn't write what a solicitor would write about, you know -- use solicitor terminology. 14:51

CHAIRPERSON: Yes. Okay.

A. And I felt that had I been given the opportunity to write the statement myself, it would have been done a lot quicker.

CHAIRPERSON: Was it ever explained to you why I'd made that direction that you had to go and make it to an independent firm? 14:52

A. No, but I did read your statement from last week, so it provided context to the situation.

CHAIRPERSON: Right. All right. I'm sorry, I'm genuinely sorry that you found the process difficult. I know you've got two young children. But there were reasons for that decision that I made. 14:52

A. No, no, and I accept that. You know, I wouldn't be argumentative of it. You know, I understand the reasons why. I just feel like it would have been a lot easier had -- whenever the statement was returned to me, that the questions were attached, and it would have made it an easier process for me to say, 'well, this is 14:52

what I need to change', whilst I was surmising it.
CHAIRPERSON: Yes. No, I understand. Are you content now that you have given your evidence in the way you would like to?
THE WITNESS: Yes. Yes. 14:52
CHAIRPERSON: Dr. Maxwell, do you have anything to ask?
DR. MAXWELL: No.
CHAIRPERSON: Can I thank you very much indeed, both for your statement and also for coming along to help the Panel this afternoon. You can now get back to your 14:52 two young children.
THE WITNESS: Thanks very much.
CHAIRPERSON: Thank you. We'll take a break. We are going to carry on, and I'm hoping that we can finish reading -- there are two more statements to go. We'll 14:53 see how far we get. We'll take a short break.
MR. McEVOY: Just on behalf of the Inquiry team, I also just want to thank the witness for waiting, because there was a little bit of a delay
CHAIRPERSON: Yes, because you were called this 14:53 morning. Okay. Thank you very much, indeed. Okay, we'll take a ten minute break and then try and deal with the last two statements.

SHORT ADJOURNMENT 14:53

CHAIRPERSON: One second. Just before you again, Ms. Bergin. Sorry. Part of my statement that I read out just a couple of days ago now, headed "The Chair's

Statement on Staff Criticism of Staff", there was a paragraph that I had written but it had been lopped off the page when I printed it, and I'm just going to read it now. It's the final paragraph of the whole piece. And as soon as I have read this out, we will then publish it on the website so that everybody can read it. But it was after my dealing with Restriction Order No. 4, and what I intended to say and had written is: 15:08

"As we move forward to hear from those in senior positions or management roles dealing with the operational side of MAH, I will be much less willing to impose restriction orders to allow witnesses to be ciphered or to give evidence anonymously. It is an important part of a Public Inquiry to allay public concern and part of that function is the public seeing and hearing senior people giving evidence and, where appropriate, being held to account. Further, the more senior the individual, the less practical it will be to try to protect their identity, even if such a course were otherwise appropriate." 15:08 15:09 15:09

And funny enough, we've just seen an example of that with the last witness. But we will move on from that, and that statement can now be published on the website. Ms. Bergin, where are we going? 15:09

MS. BERGIN: Good afternoon. We are starting, Chair and Panel, we are starting with H230. There are, as you have already indicated, two statements, and this is

the longer of the two. The statement reference is STM-227, and a restriction order was granted on 26th April in relation to this witness' evidence, to be referred to by their cipher.

CHAIRPERSON: Yes. Thank you. 15:10

STATEMENT OF H230 - REFERENCE STM-227 READ BY MS. BERGIN AS FOLLOWS:

MS. BERGIN: The statement is dated 10th April 2024, and states as follows: 15:10

I, H230, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. My connection with MAH is that I am a full-time Band A8 Assistant Service Manager at MAH. 15:10

The relevant time period I can speak about is between January 2020 and July 2023."

15:10

The witness then outlines their experience working in health care and becoming a mental health nurse, and their professional experience as a mental health nurse before they started working at Muckamore in January 2020 as a Band 8A ASM Assistant Service Manager. The witness outlines their previous experiences, including working on MAPA policies and adult safeguarding that they believed could be helpful to their role at Muckamore. 15:10

Picking up at paragraph 11:

"At MAH, I was responsible for Ardmore and Moyola day care services. Later that year, in 2020, I took over responsibility for the shift coordinating services for MAH in addition to work on the above named wards. This was similar to the mental health role as coordinator for acute services that I previously held whilst working for the Belfast Trust. However, at MAH this was a learning disability role. 15:11 15:11

In October 2021, the incumbent ASM was off work on sick leave and I took over responsibility for Six Mile Ward and Erne Ward as the ASM. I remained there until the Erne Ward was closed due to reductions in patient numbers and the building not being fit for purpose. Erne Ward officially closed in June 2022. Killead Ward opened during July 2022, and I took on the role of co-ASM of Killead Ward, along with H290, who was a retired nurse and was employed through an agency as an ASM. I remained in this post in Six Mile and Killead Wards as co-ASM until February 2023, when I sustained a head injury at work caused by a patient assault." 15:12 15:12

The witness goes on to state that they were off work due to that assault until May 2023, and returned to work in an administrative role in Knockbracken, where they were involved in Serious Adverse Incident

Investigations and internal investigations relating to patients with learning disabilities.

Picking up at paragraph 14:

15:13

"In July 2023, I returned to MAH to work in my previous role as an ASM in Moyola day care services, in addition to the role of ASM for shift co-ordination services. During January 2024, I was appointed to take responsibility over Cranfield 1 Inpatient Ward as ASM." 15:13

The witness then describes their previous experience in relation to working with people in learning disability settings, and also that they have a relative with Down Syndrome whom they care for. 15:13

Picking up at paragraph 16:

"When I joined MAH in January 2020, I completed Positive Behaviour Support (PBS) training as well as 15:14 undertaking several short safety intervention training courses to update my knowledge and ensure that I was properly educated in the latest mental health and learning disabilities training. In addition, I undertook training in the Management of Actual Or 15:14 Potential Aggression (MAPA)."

The witness then says that they would have known some MAH staff from attending joint conferences and training

events, but they had no family or friends at MAH at the time of their recruitment.

At paragraph 18:

15:14

"As an ASM, I was working with my previous colleague, H290, who supported me in my new role and who had worked her entire career at MAH, and H308, who was an acting Band 8A and who had also previously been my line manager before I joined MAH. I was working with two 15:15
very experienced nurses in addition to a new service manager, H300, who had a social work background and was very approachable and knowledgeable. When I began in this role in January 2020, MAH was trying to work through the chaos and challenge of multiple RQIA 15:15
notifications relating to senior management, in addition to multiple safeguarding notifications of patient finances. To compound the challenges, there was a high turnover of staff. When I joined MAH, there was low morale and a high level of sickness from staff. 15:15
Staff were going through a "bereavement" due to loss of colleagues, and also the patients struggled to deal with the high turnover of staff. I had to support the remaining staff through the impact of RQIA notifications, safeguarding notifications, and the 15:16
influx of agency staff. Staff were leaving due to stress, pressure of the Public Inquiry and working conditions, for example, the shortage in staff resource. The increase of agency staff placed more

strain and responsibility on the permanent staff.

My first impressions of MAH were that I felt it was very chaotic. This was due to high levels of staff turnover, either through suspension, sickness, leaving to another role, due to the stress of constant RQIA requests and requests from the ASG team. While the ASG team sought to implement and deliver requests in a professional fashion, and without disrupting the patients' well-being, the mental toll on staff was significant. Personally, the toll was significant due to the requirements for me to digest information from RQIA or ASG on a daily basis, which was a shift from what a normal ASM role would have required. 15:16 15:16

When I joined MAH, many staff were afraid to say that they worked at MAH. Staff were taking sick leave due to the stress and strain caused by RQIA and ASG notifications. A number of patients at that time had complex needs and required a high level of support and care. In the absence of the same nursing staff, the patients were becoming dysregulated, which compounded the chaos. The RQIA guidance and processes had to be followed to ensure adherence to the ASG system. The ASG system required a high volume of work with a fast turnover, which brought about many competing demands and significant administration. Safety plans had to be put in place and the ASG team had to be updated regularly to protect both patient and staff well-being. 15:17 15:17

There was a high level of agency staff who were not indigenous to Northern Ireland, and I had to support them, which was part of my role. Some of the agency staff did not have knowledge of changes in legislation or systems, so I took time to train the agency staff. Some agency staff had the requisite experience and some did not. When I worked with agency staff, some were not invited back, as they were not competent to perform the role. Some of the agency staff struggled with the Northern Irish dialect. Certain patients struggled to understand some of the staff from overseas. The language barrier was an issue for the verbal patients in particular, as local patients would have spoken with certain colloquialism, for example. 15:18

In terms of the culture, on my arrival there were a lot of changes to staff on the wards. However, the staff were open and warm to the patients and always tried to advocate for those patients in what are difficult circumstances. The safeguarding process was ever-changing and this was difficult for the staff to understand and to keep abreast of. The process included changes in how safeguarding information was recorded and how documentation was held, which required staff to learn new information gathering processes. 15:19

All staff were willing to learn and to change. The changing management made it more difficult as each new

senior leader had their own agenda and the focus often changed. As leadership structures changed, they had their own priorities. For example, how documentation was collated or recorded, and how families were to be communicated with, varied between different management, although I cannot recall specific managers. 15:19

I like to visit patients every morning and check to see that the ward staff are engaging with patients." 15:20

The witness then goes on to say that:

"It has taken around four years for some patients to build up trust with them, which reflects how important consistency of staff is for building trust with patients." 15:20

They then describe the difficulties experienced at Muckamore during Covid, including families being unable to see patients when they wanted to, and difficulties around staff having to wear masks with patients who relied on smiles, and that MAH published a paper by infection prevention control team. 15:20

The witness continues that: 15:20

"Staff tried to keep Covid concerns away from patients, and MAH was the only Belfast Trust scheme where all patients participated in day care activities on-site.

They continue to describe patient activities, including a Six Mile Monday film evening, ice hockey games, outings, and outings to Belfast Opera House, and also staff supporting patients for home visits. 15:21

The witness then describes staff anxiousness about their jobs, being unsure about what would happen at MAH, and the context of RQIA and ASG notifications and the Inquiry, and the witness says that: 15:21

"This affected staff morale, and the high turnover of staff also affected the atmosphere onwards at times."

The witness describes the different compositions of 15:21
different wards, including male or female, forensic wards requiring forensically trained staff, including consultant psychologists, but little physical nursing care, and also complex needs wards, where full nursing care, including bathing and eating support was 15:22
required.

Picking up at paragraph 29:

"Staff tried their best to deal with the resources 15:22
available. However, as time went on, MAH lost many senior and experienced nurses to other health and social care trusts across Northern Ireland. In some instances it was natural attrition and in other

instances the nursing staff found the atmosphere too much. The sheer impact of their role and stress caused so much turmoil that some staff decided to leave, even if they had worked there for a number of years, as they knew that they had to move to look after their own mental health. I do not have personal examples. 15:22

Some patients were treated differently simply due to different legislation. For the forensic patients we had to take a strong clinical approach, including making sure we kept to the patients' care plan (as agreed by the MDT) and ensuring that we undertook all relevant processes to deliver that care plan. Certain care plans may have had more restrictive processes in place due to each individual's requirements. The approach to patients really depended on their specific needs. All staff tried to treat patients with dignity and respect and advocated for those patients who could not advocate for themselves. If I identified any poor treatment of patients, I would have immediately addressed the issue. There are two incidents by way of example: 15:23 15:23 15:23

A. A first incident took place on Six Mile Ward in November 2020. I was asked to review an incident on CCTV in which the ASG team had raised concern regarding three staff members. There is a weekly quality review of the CCTV in which an independent individual reviews the footage. The independent review discovered the 15:23

incident and I was then asked to review, as a lead nurse, and subsequently developed an interim protection plan. This was a MAPA related issue, which is now known as safety intervention. The incident related to three staff members, Band 5 staff nurses, although I cannot remember their names. Following my review, I was not happy with how MAPA was used. In this instance I advised ASG accordingly, who then took it forward by starting their own independent investigation. Whilst waiting on the outcome, I felt it was better if the staff members were not working in a front-facing patient area and were removed from the site until there was an outcome determined. In the end, the outcome was additional training. The PSNI found there was no case to answer and I felt that I had escalated the process properly and appropriately. The three staff members were not invited back onto the wards following this incident. 15:24 15:24 15:25

B. The second incident happened during my nightly ward checks when I identified an agency nurse whose level of alertness was not appropriate as their eyes were closed. I removed them from the area immediately and placed them under the supervision of the nurse in charge and identified two new staff members to look after that patient. I notified the agency nurse's employer, who dealt with the issue immediately. I completed the relevant forms, for example, a performance pro forma, in order to raise concerns in 15:25 15:25

which I reflected their standard of practice so that it would be referred to the nurse bank. This triggered an independent investigation which came back to me. The outcome being that the staff had to complete a reflective piece regarding working on night duty. 15:25

In day care, we have worked very hard during the past six to eight months to re-establish support for the spiritual needs of the staff on-site. A weekly non-denominational service now takes place at MAH. MAH 15:26
has reached out to sporting clubs in the community and, as mentioned above, patients have been off-site on two occasions to see the Belfast Giants play ice hockey at the Odyssey Arena. One patient was out of MAH for the first time in two years. A number of in-house parties, 15:26
including end of summer, Halloween and Christmas, have taken place throughout the year, and the day hospital management team has engaged with various different groups and charities to attend MAH for recreational value." 15:26

The witness then says that the only poor care they have witnessed were the two incidents already referred to.

Picking up at paragraph 33: 15:26

"The atmosphere changed when different staff were on the ward. The change was due to less familiar staff being on duty, for example, agency staff. The change

of staff was unsettling for some patients, particularly those who were non verbal, as they had built up a rapport of social cues with the longer term members of staff. It follows that when less familiar staff came onto the ward, it may have had an impact on the atmosphere. This is not a lesser standard of care, but a point of familiarity between patients and staff. By a change in atmosphere, the patients became more restless and, as a result, the staff would have been required to undertake increased observation levels and increased one-to-one interactions. 15:27 15:27

My work allocation is dictated by my general job description and depends on whatever competing issues emerge on any given day. Ideal with issues by prioritising the most urgent to the least urgent and ensuring I follow my contract, the code of professional conduct, and all aspects of law. Most importantly, ensuring that patient's needs are met. 15:27

H300 is the service manager and my line manager at MAH and I came into post a few months before him in January 2020. He is a fair and honest line manager and is always objective and supportive to me. He would not ask me to do anything he would not do himself. He is approachable and has a sound knowledge of adult safeguarding. He has a lot of experience in working in learning disability and adult/child safeguarding, which was reassuring to me and is paramount to working at 15:28 15:28

MAH. He assists me in following processes through regular ASM meetings, as well as ad hoc meetings when required. He is currently working on a project in relation to resettlement.

15:28

I have always felt supported in my role. While there was no service manager before H300, there was a divisional nurse, H882, who would have overseen my work and practice. I have always felt that everyone was trying to provide the best care possible for the 15:29
patients. I always felt that every medical staff member delivered their role in a patient-centred fashion.

I was well supported by my line manager, H300. 15:29
However, if I needed to speak to the divisional nurse, H882, I could have spoken to her and asked any questions. I would have asked questions from time to time, but I cannot recall any specific questions. H882 was approachable and could advise me from a clinical 15:29
and process point of view if I needed to take forward any concerns. H301 was the co-director for MAH for a period of time and was also very approachable, as was her successor, H627. H300 was my main point of contact when I required support and I was very happy with his 15:30
support and management. For example, as referenced above."

And the witness continues to repeat the similar

comments that they've made about that witness above.

Turning to paragraph 38:

"There is an immense amount of pressure on all staff. However, everyone tried their best in relation to patient care, particularly in relation to the limited resources. We all attempted to make the best of a pressured environment. 15:30

The co-directors at MAH and senior management tried their best to support the staff. For example, they worked hard to bring in more resource, including staff. My understanding was that the management were trying to work on solutions and deal with problems arising from the investigations and the Public Inquiry. Those solutions consisted of reviewing, discharging and resettlement plans, which would have reduced patient numbers. I had a good experience working with the senior management. H627 is currently off on sick leave and H234 is now the co-director of MAH, who I understand is working hard to resolve any issues arising from the investigations and the Public Inquiry." 15:30 15:31 15:31

The witness then describes feeling comfortable to report or escalate any issues to managers, and refers back to the two previous incidents that they dealt with.

Continuing at paragraph 41:

"I have also escalated concerns regarding the professionalism of the ASG team. This was escalated to H300, my line manager. I was concerned regarding the treatment of staff who were under investigation by the adult safeguarding team and I was not sure how this should be managed. My complaint concerned whether the ASG team were properly following Belfast Trust policies, human resource procedures and employment law. This investigation remains open and is being dealt with by human resources in the Belfast Trust. For example, I felt that MAH was formulating internal protection plans that were generic and not individualised and not in keeping with the specific complaint raised at that time. The investigation is still ongoing, so I cannot comment on the outcome. 15:31 15:31 15:32 15:32

From my start date at MAH in January 2020, I am only aware of two admissions. Upon those patient admissions, I would have obtained all the information from the PARIS notes (i.e. the electronic notes (PARIS). I also would have obtained anecdotal information from the patients themselves, service providers, and any nurses who had dealt with those patients." 15:32

The witness goes on to say that they consider family

involvement and partnership as being vital and discuss the importance they place on discussing with families and addressing with families any concerns.

Picking up at paragraph 43: 15:33

"Upon a patient's admission, I was given access to the ASW (Approved Social Worker Report), a medical report from a general practitioner, and any briefing from the community contact in order to obtain information on a 15:33
patient's skills and abilities. I also received details of the acute need for the patient entering MAH. Otherwise, it was a matter of collecting the information retrospectively from the family or carers and other nursing staff. Similarly, in respect of each 15:33
patient's challenging behaviours prior to admission, I had access to the ASW report, general practitioner's medical report, and any community briefings. MAH conducted a post-admission review meeting, held by the multidisciplinary team at ward level, and then a plan 15:34
was put in place involving various physical and mental health needs of the patient, with a number of medical professionals in MAH. Assessing patients in the first few weeks post-admission is not my role. Instead, I am required to ensure that a care plan is put in place and 15:34
completed by the MDT. I ensure that any assessments are up to date and any queries from the relevant staff are addressed and answered. I do this by assisting in relation to equipment requirements or community

services required. For example, if a community team is not answering, I would reach out to the relevant team to ensure that the query is dealt with in a timely fashion.

15:34

In terms of developing a care plan for patients, as mentioned previously, my role was to ensure that these were completed by the MDT in a timely fashion. If this did not happen, I sought to ensure why they were not completed and then put processes in place. Overall, I tried to attend the MDT meetings to ensure the patient's journey towards discharge was adhered to in line with the recovery model of care. If any plans could not be completed, then I addressed the noncompliance as soon as possible, or sought access to other support, such as an occupational therapist."

15:35

15:35

The witness then outlines some further steps that they took in terms of sourcing equipment or arranging building works.

15:35

Picking up at paragraph 45:

"The patients have numerous types of treatment plans, including standard nursing, speech and language team, speech and language therapy, psychiatric care, nursing plans, occupational therapy plans, and positive behavioural support plans. Active risk assessments and fall risk assessments need to be individualised. If a

15:35

patient is diabetic or Lithium using, then there are standard practices to follow. As a registered nurse, I was able to administer medication and would have sought to understand the rationale behind the medication and the compliance requirements. I would consider any omissions of administrations in line with Belfast Trust policy. This is done in conjunction with the MDT. Every week the MDT records the frequency of PRN, when PRN is required, administrations of PRN per patient, and the reason for it, in an attempt to understand current trends and themes. The MDT must always understand why the PRN has increased or decreased to ensure the patient is receiving the adequate medication, for example, has a patient had an acute mental health episode. 15:36 15:36 15:36

A PBS plan is managed by the MDT, and if there are concerns raised by patients or families then they were addressed via the MDT. My role was to assist the MDT to try to ensure they were following all the relevant policies. As an example of therapies, I am aware of one patient who is currently receiving dialectical behavioural therapy (DBT). Some patients receive aromatherapy or reflexology. If patients are referred to cognitive behavioural authority (CBT) or DBT, they are referred to the psychologist specialising in this treatment and would receive the treatment by practitioners who were trained in this specialism. 15:37 15:37

Two main assessments were used at MAH in relation to patients who might pose a risk of violence. The first is a general or brief overview and the second is a Comprehensive Risk Assessment (CRA), which is to prevent specific risks and follows the patient's journey outside of MAH and throughout health care. For example, if the patient was from a forensic background, then they would have had reviews and applied the "Dundrum model". This would have been supported by the medical team and psychology team and would have been individually led due to the patient's needs. The comprehensive and brief risk assessments are both available on PARIS. 15:37 15:38

I was aware of each patient's choking risk on foot of regular reviews by the Speech and Language Therapist Team (SALT). In relation to self harming, there was a risk assessment taken on each patient, a policy supported by H223 in relation to head banging was developed at MAH. Self-harming is an intentional harm, whereas for a learning disability patient it can be a learned behaviour and a method of comfort for the patient. 15:38 15:38

I was aware of restrictive practices and the appropriate methods that we could use. There are Belfast Trust policies which helped me support and conduct any restrictive practices. The practices were recorded both on PARIS and a paper copy that would have 15:38

been completed and kept on the patient's hard copy file. The hard copy would have been uploaded electronically. For example, there was a seclusion policy for MAH, and a document to record the use of any seclusion, and was training available to all staff. I cannot remember any specific examples or dates of seclusion practices. 15:39

It depended on each patient's level of distress as to how patients were managed. Each patient has a specific care plan and behavioural plan which will guide staff when the patient is in a specific state. Particularly if the staff member is not familiar with them. If possible, the staff would try to engage on a level that the patient understood and provide de-escalation intervention verbally and with good eye contact. De-escalation must be pitched at a level the patient understands, using appropriate body language (including open gestures). Patients might be moved to a quiet room, their own room, go on a walk, move to wherever they felt safe, or engage in an activity which helped them relax. 15:39 15:40

If those de-escalation techniques were not successful, then there was use of safety intervention, such as low level holds or high level holds if the patient was becoming aggressive, for example. This model worked towards de-escalation at all times and the least restrictive options rather than prolonged action. 15:40

Staff could also use behavioural support staff to help with patient anxieties by resolution through therapeutic actions. Staff also had the availability of a patient's medication, which they could offer to the patient to reduce anxiety or stress as required. Giving medication as a de-escalation technique would be decided by senior staff in the MDT, that being the senior nursing staff or the nurse in charge. 15:40

In my view, restrictive practices were used extremely well. There is always room for improvement regarding record keeping in terms of the human impact on infrastructure, and this improvement could be met by better resource and IT equipment, or more detailed paper notes and notes on the electronic system. Perhaps if there was one system it would be easier and more streamlined. 15:41

Decisions around restraint and seclusion were made by the medical and nursing team at that time and at the moment of necessity, given the nature and requirements for use of restraint, the decision could have been taken by anyone on the team and they were all trained under the relevant processes. It could be a life saving intervention, such as a safeguarding move or safety intervention. I am not aware of many planned restraints. The very few would have been decided by the MDT. For example, intramuscular injection or 15:41 15:41

another medical intervention. To my knowledge, restrictive practices were always recorded on the hard copy patient's notes, PARIS, and Datix.

In terms of examples of restrictive practices, we have a number of locked wards at MAH, which is to keep both the patients and staff safe. All wards are locked with Six Mile Ward being more secure. All wards have airlocks and individual swipes and passes for access. 15:42

Some patients will have DOLS (deprivation of liberty). This is a system for assessment which helps to ensure restrictions are proportionate and necessary. For example, restriction on a patient's use of their finances. These limitations will be assessed and agreed by the MDT and fall under regular review by a consultant and social worker. The capacity of the patient can fluctuate and, as such, the DOLS is under constant review." 15:42

The witness then provides an example of seclusion of an extremely dysregulated patient who failed to de-escalate from Six Mile Ward, where MAH required support from the PSNI and staff were afraid of being hurt, and there was a risk of the patient being injured. The patient was placed into seclusion to de-escalate for one hour, and the witness goes on to say that: 15:43

"There are routine medical checks with strict timings for reviews during seclusion, based on the time spent in seclusion, and there is also constant supervision by nursing staff."

15:43

The witness then says that:

"CCTV was already in place when they began at Muckamore and they were told that this was to keep staff and patients safe."

15:44

Picking up at paragraph 59:

"Discharge and resettlement were key focuses at MAH. The majority of the patients were delayed discharges on my arrival, which means that those patients had not met their planned discharge date. After a period of time when the MDT declares a patient to be fit for discharge, that patient has 24-days before becoming a "delayed discharge". There was an importance placed on finding the correct community placements for patients. I was aware that a number of patients had failed resettlements prior to my arrival. The general theme was that the community teams did not totally understand their needs. The MAH patients required resilient staff to deal with complex needs and an appropriate infrastructure to deal with them. A lack of proper infrastructure in the community often caused a breakdown in relationships, with some patients

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returning to MAH. For example, some patients would go out on trial leave but would become distressed as the community carer did not follow the PBS plan and, as a result, some patients would return to MAH on the basis that the resettlement had failed. I do not have any specific examples. 15:45

I have been involved in the discharge and resettlement process for a number of patients. This process is driven by the MDT and resettlement officer who found a suitable community placement. MAH is a regional service and includes patients from outside of the Belfast Trust. As such, this made the resettlements more difficult as MAH was required to source community places outside of the Belfast Trust. As a consequence, MAH worked with multiple health and social care trusts across Northern Ireland and their respective community teams. Each Trust may not have been familiar with the MAH patients, thus making the resettlement process more difficult. 15:45 15:46

During my time at MAH, the MDT devised a new resettlement process including an "in-reach" and "out-reach" model which wrapped around the patient to increase the success rate of the resettlement. This involved the community teams coming into MAH to learn and interact with the patient prior to them living in their community home. The MAH staff joined the patients in their community home and, after a period of 15:46

time, once the patient was settled, the staff withdraw. In some cases MAH staff would have stayed for four weeks, and in other cases the MAH staff stayed for four days, it just depended on the patient's needs. This model has been very successful to date. This process allowed the community to understand the patients in much more depth, which has been of real benefit to the patients. I felt that I had the correct training for this process. 15:46

MAH helped support seven female patients to be resettled from Ardmore Unit into community settings. This was part of a resettlement model to ensure that the providers would come into MAH to meet the patients before they were moved into the community. This was a very successful resettlement process. 15:47

Staffing is reviewed and monitored on a shift by shift basis by the nurse in charge. I attended the ward on a daily basis to have physical oversight. Each day at eight o'clock in the morning a safety huddle via Skype (which is the internal call system) took place to look at the immediate staffing across the service and to facilitate safe staffing. I helped build the shift co-ordination service to allow a senior level of cover which is clinically based to help and support staffing outside of the nine to five hours. 15:47 15:48

To ensure there was sufficient compliance, MAH

conducted two audits per month to review patients' property and finances. The reviews were recorded on an audit sheet by the ASM conducting the audit. I ensured that all relevant staff completed the E-learning specific to MAH to ensure those staff clearly understood their roles and policies. All staff were required to review the training matrix to meet their training needs. Audits were conducted on all wards. Any issues identifying would have been escalated to the finance officer." 15:48

-- who the witness names. The witness then further describes being involved in resettlement meetings and assisting to resolve issues.

Picking up at paragraph 66:

"Due to our close relationship with patients' families, MAH received concerns and complaints from time to time. For example, if a patient did not get to attend a planned visit to a family home, if a family took issue with the non-visit, then the family was encouraged to follow the complaints process. Depending on the nature of the complaint, each issue was dealt with individually. Families were encouraged and supported to follow the complaints process. If the complaint was of an adult safeguarding nature, the staff would have followed the adult safeguarding process. We had the support of human resources and senior management in

dealing with any concern or complaint. Local review and SAI methodology helped support families when complaints were made. The staff always endeavoured to respond within the timeframes required to deal with the complaints or queries. 15:49

In terms of supervising unregistered staff, the relevant ward manager recorded monthly returns on supervision and ensured that there was supervision regarding unregistered staff and asked supervisors when 15:50 and where they completed that supervision. This is a face-to-face meeting and an opportunity for the supervisor and supervisee to improve any practice by introducing learning outcomes. I conducted a regular review of ward audits. For example, I would review 15:50 fluid balance charts, fifteen minute charts, and PARIS.

When staff were assaulted by patients, I always ensured that they received urgent medical attention, were removed from that area, and advised them of their right 15:50 to make a complaint to the PSNI. Similarly, I provided all of the relevant details and options available in respect of escalating within the Belfast Trust if that staff member felt they required Belfast Trust support. I would have facilitated transferring the staff member 15:51 to the Emergency Department, if required, and kept in regular contact if they were off duty, including keeping notes, collecting statement, if necessary, complying with the PSNI, and any ancillary legal

requests. I do not have any specific examples.

I reviewed restraint and seclusion incidents for the level of de-escalation employed immediately prior to the incident and considered learning outcomes which, in 15:51
turn, could be used to address any training or process concerns, ensuring that I stuck to the "no blame" methodology. This is when one focuses on learning and not finger pointing to those who may have done wrong. If I identified anything I was not happy with, I would 15:51
have escalated to the ASG process, and if it was extremely serious, then I escalated to the PSNI. There is a process of escalation within the Belfast Trust in which one can contact the PSNI when required. I cannot recall any specific incident, although I have made 15:52
calls to PSNI in the past. I always followed Belfast Trust policies and kept families aware throughout.

I conducted regular skills audits of ward based staff by reviewing their mandatory training, encouraging 15:52
staff to take up schemes in the Belfast Trust and Clinical Education Centres (CEC). I also encouraged unregistered staff to take on training that would open up opportunities for further clinical training and career development. I would have met with staff who 15:52
were not complying with their training and sought to understand the reasons for the noncompliance and how to resolve that noncompliance. I cannot remember any specific examples, however, I would have ensured that

staff who had returned from long-term absence had completed all the mandatory training when returning to MAH.

Reviews of case mix and skills required on each ward was conducted by the leadership team in totality, that is a Band 8A lead nurse and ward charge nurse. They looked at the mix monthly, on average, to consider and address the skill-set at that point in time. This was not my responsibility. The frequency of staff incidents were reviewed through the governance process and a systematic review. Weekly governance meetings and monthly service review meetings were led by one of the senior leadership team. MAH conducted data analysis to better understand the incidents which took place. Our business manager, Band 7..." 15:53 15:53 15:53

-- which the witness names:

"...would have provided graphs to better understand the correlations and each area would have held a clinical review group meeting (which included the MDT) pertinent to their group area. 15:53

I received good support from corporate nursing, for example the divisional nurse, and when I made contact they always responded. This was overseen by the Director of Nursing for the Belfast Trust..." 15:54

-- who the witness names:

"In terms of frequency, I would have been in touch at least once a month with corporate nursing. We have nurses on historical review safety plans, and through this, we liaised with corporate nursing. This team related to historical complaints and nurses who were under investigation and, so, there is a safety plan in place to conduct safe practice and learn from issues of concern. I was required to complete progress reports, which I provided to the nursing team to ensure that everyone understood and reflected on the complaints that were raised. 15:54 15:54

I received good support from H300. Otherwise, there were four separate levels of leadership, and the level of support varied depending on the availability of leaders. A senior nurse who I currently report to, H702, is very helpful, and any time I ask for help from the divisional nurse or the co-director I always felt that I received the assistance I required. The assistance required varied from policy advice, HR advice, to clinical advice. 15:55 15:55

In terms of human resources support, I only received that support if I reached out to human resources. I do not have any specific examples. I do not believe there was adequate support for staff who were on safeguarding processes, as there was little or no contact from the 15:55

ASG team. I felt there should have been a designated staff member appointed on a local basis, particularly as human resources is not my role and I am not an expert in human resources. It would have been advantageous to have someone on-site. When dealing with every day situations, I was able to get a human resources representative, but in relation to the safeguarding issues, I felt there could have been more support within MAH. 15:56

I would not have had contact with senior directors but instead would have followed the line management processes, and any discussions would have flowed through my manager." 15:56

The witness describes information sharing as being transparent, and they themselves playing a significant role in merging the Erne Ward into the Donegore and Killead Wards, which they say was:

"...well planned and carried out in conjunction with families and that the leadership team provided good support during this." 15:56

Picking up overleaf, paragraph 78: 15:57

"For me, it is sad regarding MAH's planned closure and leaves a lot of staff and patients with heavy hearts. The investigations take away from a lot of good that

has been done over the years and leaves a black mark on health care in Northern Ireland."

And the witness goes on to sign the declaration of truth. 15:57

CHAIRPERSON: Right. Thank you. That's taken over an hour, I think, to read. The next statement, if you can précis it, is quite a lot shorter, isn't it?

MS. BERGIN: It is.

CHAIRPERSON: Would you like a five-minute break? 15:57

MS. BERGIN: I'm okay to keep going if everyone else is, but I am entirely in your hands, Chair.

CHAIRPERSON: If you're sure? Okay, let's crack on.

MS. BERGIN: Yes. No, I am. Yes, thank you.

CHAIRPERSON: Okay. 15:58

MS. BERGIN: The next statement to be read is that of the witness H339. The statement reference is STM-216. The statement is dated 27th March 2024 and, as before, Chair, a restriction order was granted on 26th April requiring this witness to be referred to publicly by 15:58 their cipher.

STATEMENT OF H339 - REFERENCE STM-216 WAS READ BY MS. BERGIN AS FOLLOWS: 15:58

MS. BERGIN:

"I, Dr. H339, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

My connection with MAH is that I was a medical doctor completing further specialised training in psychiatry as a core trainee and then returning as part of my higher training in psychiatry of intellectual disability. 15:58

The relevant time periods that I can speak about are between August 2015 to February 2016 and August 2017 to February 2018." 15:59

The witness then outlines their psychiatry training, which included two jobs at MAH, and the first was as a core trainee between 2015 to 2016. During the witness' higher training in psychiatry, they go on -- in psychiatry of intellectual disability, they had their second job at MAH between August 2017 and February 2018, and then qualified as a consultant psychiatrist in intellectual disability and worked in another hospital where they currently still work. 15:59 15:59

In their first placement, they worked on Six Mile, Erne Ward and Moylena Wards, four days per week, and the witness describes their induction as including safeguarding and reporting of concerns at MAH. 15:59

Picking up at paragraph 8:

"The Six Mile Unit specialised in forensic care, with

male patients only. Six Mile was divided into assessment and treatment sections. I worked under the supervision of Dr. H50, consultant psychiatrist. There were a smaller number of patients on the assessment section which facilitated more in-depth assessment of 16:00
their needs and development of a comprehensive therapeutic programme. There were more patients in the treatment section. These patients would have been participating in their own treatment plan with a strong emphasis on psychosocial approaches and some patients 16:00
would have been prescribed medical treatments, including anti-depressants or anti-psychotics, depending on the nature of their underlying mental illness. Patients on Six Mile were generally very active, spending a lot of time out of the ward at day 16:00
opportunities.

Earn and Moyola supported long-term patients with complex needs and severe intellectual disability. I work with Dr. H30, consultant psychiatrist. Patients 16:01
were in the process of moving to new homes in the community which supported their needs. Staff engaged patients in activities on the ward, such as arts and crafts, and activities in an outside space near the ward that was adapted to meet the patient's need. I 16:01
recall a garden outside Erne which formed part of a horticultural project involving staff and residents.

I accompanied the consultants when they met with

patients to evaluate their mental state. They spoke with patients and asked questions. They also spoke to ward staff to gain collateral information regarding any recent issues or concerns to inform assessments and treatment of the patient's presentation. Positive behaviour support was routinely implemented as part of patient care." 16:01

The witness then says that: 16:02

"In respect of dialectic behaviour therapy (DBT), and equip therapy, a consultant psychologist was part of the multidisciplinary team at the Six Mile Unit. However, I do not recall their name. I recall dialectal behavioural therapy being offered to patients at MAH." 16:02

The witness then goes on to state that they are not familiar with the term "equip therapy", but recalls that some of the psychological interventions delivered by the psychologist in the Six Mile Unit would have incorporated work on emotional regulation and problem solving: 16:02

Paragraph 11: 16:02

"I attended weekly ward round meetings on Six Mile Unit, a multidisciplinary team (MDT) with the consultant nurses, allied health professionals and

social workers, who met to discuss each patient on the ward. The MDT discussed patient treatment plans to identify what worked well and what could be changed to support patients further. Medications prescribed to patients were reviewed at least once weekly. The psychiatrists considered the patient's overall presentation, with particular focus on mental health. Psychiatrists reviewed patients' weekly report as provided by ward staff and any assessments carried out by other allied health professionals. Psychiatrists worked with the multidisciplinary team and supported the development of positive behavioural support plans that focused on reinforcing positive behaviour inpatients. There was a positive risk taking approach in place, which is that the MDT carefully considered the risks and developed management approaches with the hope of achieving better outcomes. For example, I recall a patient who was assessed at high risk of absconding and placing himself at high risk of serious physical harm. The MDT worked together to put a plan in place with the appropriate risk assessment reintegrating this man into the community, beginning with small outings on the hospital site, building up to longer outings in public places. I cannot recall his name. 16:03 16:03 16:03 16:04

From my recollection, the multidisciplinary ward rounds in Erne and Moylena would have been similar in style. To the best of my recollection, I was unable to attend

many of these ward rounds. This was due to my working timetable and training obligations.

Most patients on Six Mile, Erne and Moylena were longer term patients. From my recollection there was not a high turnover of patients, and there were limited new additions. Some patients admitted to Six Mile were Court directed. I was asked regarding specific examples of admission and I recall one patient being admitted to Six Mile. I do not recall his name. The patient was admitted towards the end of the working day. In the first few hours following admission the patient was seen by a duty doctor of the day. A history was taken, a physical and mental state examination carried out, and a medical prescription card, otherwise known as a drug Kardex, was completed, detailing any existing medications. A brief risk screening tool was completed. During the next working day, the Six Mile consultant assessed the patient and examined his mental state. After examining the patient and seeking collateral information from various sources, including the community team, Courts Service and family, recommendations were made on how to support the patient. This would then have been incorporated into their care plan. Information from the patient's family and those who knew them best would have been gathered to inform the assessment. On admission, a brief risk screening tool would have been completed for all patients. As further information became available,

16:04 16:04 16:05 16:05 16:05

this would have informed a more comprehensive risk assessment and management tool developed by the MDT.

As a doctor in training, I was required to complete assessments to meet training requirements. This included tasks such as interviewing patients. This was carried out under the supervision of a senior registrar or the consultant on the ward. I met with patients in a private room or area within the ward that was conducive to conducting an interview and medical examination. I spoke to patients about their mental health and considered their communication profile carefully, using it to help with tailoring the history and examination. For example, a patient's communication profile may have detailed that a particular patient could be supported to understand verbal communication through the use of simple words and language used in short sentences. I would have been able to adopt these supportive approaches when communicating with the patient. Some patients with non-verbal communication may have used a picture chart with symbols to express how they were feeling. When I assessed a patient and made recommendations regarding their care, I discussed this with the consultant in charge of their care, the supervisor would have given me feedback. This would have been formed part of my portfolio of progression in my training. 16:06 16:06 16:06 16:07

To develop my knowledge and understanding of treating

patients with intellectual disabilities, the consultants would have discussed how to assess patients and their treatment plans with me. I felt that my own impressions and recommendations were valued by the multidisciplinary team. Care and treatment plans were 16:07
patient-centred, decisions to implement changes to treatment plans were discussed at ward rounds and were made by the MDT. If, on review of the care plan and weekly reports from staff, a psychiatrist recommended a change to a patient's treatment plan, it was discussed 16:07
with the patient and/or relatives and carers and the multidisciplinary team before they were implemented. I recall meeting families with the consultants wherein they would talk through the proposed changes. Some patients had advocates who attended meetings with the 16:08
patients or on their behalf. I was asked specifically on my knowledge of the advocacy role and their training, however I do not recall this in detail. My memory is that the advocacy role was highly respected by the multidisciplinary team. Families and carers 16:08
were updated on the patient's presentation and changes to the care plan by ward staff following the weekly ward rounds. If family and carers had any queries they could speak to ward staff when visiting the patient or telephone at any stage." 16:08

The witness then says due to the passage of time they cannot recall specific examples, and they say that they are:

"...likely to have spoken to families directly about patient care to discuss medical treatment that was approved by the supervising consultant. Any discussions were documented on patient records. 16:08

Staff in MAH took a holistic approach when reviewing and amending patient care plans. This ranged from ensuring patients received therapeutic treatments according to their needs, some of which may have been 16:09 medication. Medication was not the primary approach taken by the MDT. Psychiatrists in MAH would have managed the psychotropic medication prescribed to each patient. There was an emphasis on holistic patient care and recommendations reflected patient care as a 16:09 whole. This included psychological and social therapeutic options, including nutrition, exercise, and social outings. I recall allied health professionals, such as dieticians, musicians, and an art therapist, who contributed to patient care. I cannot be sure but 16:09 I think there may have been a drama group in MAH at this time. I remember seeing physiotherapists and podiatrists on the ward. Staff on both Six Mile, Moylena, and Erne, implemented recommendations within patient care plans. There were many times when staff 16:10 went above and beyond to care for patients. I recall there were times when the wards were short-staffed, and staff who were due to finish their shift stayed with the patient for as long as needed. Staff would have

facilitated outings with patients and would have helped them celebrate special occasions, for example, their birthday. Another example was the garden project at Erne Ward where staff worked together to develop the space for patients. 16:10

As a trained medical doctor, I had skills in the assessment and treatment of physical illness. I was able to assess patients' physical health according to my level of competence in this area, alongside their 16:10
mental health. Where I identified a potential physical health need, I referred the patient to the appropriate health professional. For example, where a patient had chest problems, I referred them to a respiratory physician. In addition, patients in MAH had direct 16:11
access to a general practitioner who had expert skills in managing health needs from a primary care perspective, for example, hypertension. The GP was available for a set number of hours every evening and over the weekend. 16:11

The consultants were based in MAH and visits to patients on each ward were routine. Consultants were on the wards multiple times a week. This gave patients and staff on the ward an opportunity to speak to the 16:11
consultant if they had any concerns about a patient's mental health. I was asked regarding examples and to my recollection concerns may have included a patient presenting differently to his or her baseline, or if a

patient became more aggressive, or if staff were worried about impact of medication, or if they had general concerns about the patient. If staff on the ward were concerned outside of the consultant's visit, they could contact the general doctor on-call by a "bleep" system that would alert the duty doctor who would contact the relevant ward. This system of contact was available to all staff on wards, however would generally have been discussed with the senior member of nursing staff on the ward before referral on to the medical team. In addition, my recollection was that if the consultant was best placed to deal with the matter, staff may have contacted the consultant directly by telephone call to their secretary or by e-mail. 16:12

Medical staff contributed to treatment plans focused on patient recovery. This included prescribing medication to treat their symptoms of underlying mental illness, if this was relevant. Psychiatrists were able to refer patients for psychological therapy to the relevant psychologist. I am unable to provide a specific case example of such a referral due to the passage of time." 16:12

The witness then says that: 16:12

"In relation to pro re nata PRN medication, otherwise referred to by "as required medication", this was prescribed to patients after careful assessment by a

doctor. This would have normally been considered by the patient's own medical team, including their consultant psychiatrist. PRN medications to relieve anxiety, or agitation, or aggression, was part of a comprehensive therapeutic programme aiming to treat the underlying mental health condition." 16:13

The witness then goes on to say that due to the passage of time they don't recall specific examples, but they likely would have been involved in the writing of such medications on a patient's medicine Kardex. 16:13

"PRN was used as a last resort when all other verbal and non-verbal de-escalation techniques were infective. PRN medicines used for acutely disturbed or violent behaviours were used in line with recognised guidelines set by the Belfast Trust and prescribed according to the British National Formulary. I no longer have access to the specific Belfast Trust Guidelines used at the particular time when I worked in MAH. PRN medication would have been reviewed regularly according to the patient's needs. This may have been reviewed daily, if needed, or at a minimum once weekly during the multidisciplinary ward round. Patients would have been monitored for side effects of the medication by nursing and medical staff on the ward. Occasionally PRN medication may have been prescribed by an on-call doctor outside of the normal working hours. This would have been after a thorough consideration of the case 16:13 16:14 16:14

and discussion with the most senior member of the staff on the ward at the time. This emergency prescription would then have been considered by the patient's own medical team at the first available opportunity and continued, if necessary. 16:14

As a qualified medical doctor undertaking further training in psychiatry, I could prescribe medication as indicated by the patient's needs. However, I would have discussed longer term treatment options with the 16:15 patient's consultant. I would have prescribed medications having reviewed the patient's medical records, including allergy status, to ensure medication prescribed was suitable. Any medication I prescribed was done in accordance with the British National 16:15 Formulary Guidance and recognised guidance at national or local level, (e.g., NICE guidelines) or local Belfast Trust Guidelines. I would have organised monitoring of the patient's physical health, including observing for side effects of medication or organising 16:15 blood tests according to the specific monitoring requirements of specific medications.

I had access to patient medication prescription Kardexes, which provided a record of the patient's 16:15 medication. Every effort was made to discuss changes to psychotropic medications with the patient, according to their understanding, and their family, providing family were contactable and the patient had consented

to contacting family. Medication was prescribed in accordance with the British National Formulary and Clinical Guidance published by NICE.

I was asked by the Inquiry what my views were regarding feedback from families that patients often appeared sedated. I cannot recall specific cases. However, some me medications prescribed to relieve anxiety and distress may have caused the patient's level of awareness to be reduced. This would be a recognised side effect of many medications, as published in the medications summary literature and other publications, including the British National Formulary. Patients were regularly monitored for side effects from medication, including sedation. Action was taken if the patient was found to be sedated. This may have included a change to the prescription of medication. The side effects of medications were carefully considered alongside the intended benefits before medication was prescribed and when the ongoing prescription was reviewed by the patient's medical team.

I recall assessing patients who were medically unwell when all options to safely assess and treat patients on the MAH hospital site were exhausted. I referred patients to the local Emergency Department, which I believe was Antrim Area Hospital, for further treatment. I do not recall specific examples. If the

medical staff at MAH required advice from the general acute hospital based specialties, they would contact the relevant hospital specialty for advice. For example, in the treatment of epilepsy, MAH doctors could contact neurology consultant from the relevant neurology service to whom the patient was known. 16:17

I attended management of actual or potential aggression MAPA training in MAH and in Knockbracken Healthcare Park. This is compulsory training which I attended annually. In this training there was a particular emphasis on early de-escalation to avoid crisis and escalation to where the patient presents with aggressive behaviour. If in the event of physical aggression, physical intervention or restraint was always considered a last resort. For doctors the specific focus of training was safe disengagement from patients when personal safety was compromised. I was not trained in physical restraint and never was involved in dis-intervention with patients. From memory, I believe that physical intervention was not routine practice on the wards where I worked. I cannot recall seeing hands-on restraint being used by staff on patients on the wards where I worked. Patients may have had restraint as part of their plans, but I cannot remember the details. 16:18 16:18 16:19

During my second placement at MAH, I participated in formal behaviour training provided by an external

agency regarding positive behaviour supports."

And the witness describes this course as being attended by staff from various disciplines:

16:19

"I assisted the multidisciplinary team in preparing treatment plans for patients moving from Moylena to the community. The MDT invited the patients' family to discuss progress regularly. I cannot recall the specific frequency of this invitation. I visited 16:19
several facilities that were planned for patients to move to as part of the overall process of selecting the living environment that would best meet the patient's needs. Medical staff monitored the patient's mental health during this process. Staff on each ward adopted 16:19
patient centred practice by supporting patients to develop their skills and abilities, to assist in recovery from mental illness, and to maximise their potential in the context of their intellectual disability so that they could move into the community." 16:20

The witness then says that they do not recall observing formal capacity assessments and other members of the MDT would have been involved, including psychologists.

16:20

"I felt supported by staff on Six Mile, Erne and Moylena during my placement. Dr. H50 and Dr. H30 were available when I needed to speak to them. The charge nurse on Six Mile, who I think was called H69, and the

charge nurse on Moylena, H214, were both approachable. I cannot recall the name of senior staff on Erne but I recall that they were also approachable and accessible.

I completed my first placement in MAH in February 2016. 16:20
I returned to MAH in August 2017 to undertake a second placement as a higher trainee doctor. I worked on PICU psychiatric intensive care unit two days a week, with the remainder of the week spent working in brain injury services within the Belfast Trust. Dr. H30 was my 16:21
clinical supervisor.

PICU was accommodated in a spacious and modern building. There may have been five or six patients on the ward. The ward was spacious with a large outside 16:21
area which patients could use. Patients on PICU were admitted with high complexity and high levels of risk for a period of assessment and treatment of mental illness. Some patients were delayed moving on from the PICU ward due to complexity and difficulty finding an 16:21
appropriate environment that could continue to meet their needs. I had access to patient records on the electronic PARIS system. The PICU MDT worked together to support the patient being moved to a lesser restrictive setting. 16:21

Safety briefings were given by the nurse in charge at the start of each shift on PICU, and all staff were invited to attend, including nurses, allied health

professionals, and domestic staff. I believe that MAH was one of the first hospitals to implement safety briefings into its operational practices and incorporate the briefings across the entire hospital site." 16:22

In relation to practices or cultures at MAH that the witness might have sought to change, they state:

"As I worked in MAH for a limited period as a junior doctor commencing my specialist training, my focus related primarily to the clinical care of patients and gaining experience in this area. During my second job at MAH in 2017, I became aware of allegations of abuse on the ward, and this was being formally investigated. I did not come across any matters which caused me concern. 16:22 16:22

I was aware that there was a seclusion room on PICU that was used where patients presented as high risk to themselves and/or others and lesser restrictive options had been ineffective. I cannot recall the exact procedures regarding use of seclusion, but any patient who was secluded had a number of reviews by both nursing and medical staff at prescribed intervals. Seclusion was intended to be used only for the minimum time period. I worked as an on-call doctor during my training, which meant that I was not always based on the MAH site. There were times when I may have been 15 16:22 16:23

or 20 miles away in another hospital when I received a telephone call from staff in MAH regarding a patient who was secluded. As necessary, I would attend MAH to assess the patient in the most practical time. After seclusion, a physical and mental health examination would have been completed by medical staff. When completing this task, I also reviewed the patient's notes and discussed reasons that may have caused the incident to occur with staff. I did not witness any inappropriate use of seclusion. 16:23 16:24

I did not witness any safeguarding concerns on any wards during my two periods of training at MAH."

And the witness again describes those dates. 16:24

"I did not see any poor care. If I had, I would have raised my concerns with the charge nurse or consultant on the ward. I recall seeing posters in communal staff areas that provided details of staff with designated safeguarding roles and points of contact. There was no time during my training working at MAH when I did not feel that I could raise concerns. 16:24

Incidents were recorded on Datix forms and these were reviewed by the MDT on ward rounds. The MDT reviewed the information provided to look for potential causes and to assess if additional support could be offered to reduce the likelihood of a further incident. Regarding 16:24

reporting of vulnerable adult concerns, specific recordings forms were in place. A specific adult safeguarding team was available. The MDT would have been made aware of the concern and worked with the specialist safeguarding team as request in terms of the investigation and development of a management plan to promote the patient safety. I cannot recall specific cases. I recall attending safeguarding training during my time in MAH. This involved basic training on recognising forms of abuse and how to raise my concerns. 16:25 16:25

I was aware family members worked within in the hospital grounds. For example, one couple where a husband worked on a ward and his wife worked on a different ward. I cannot recall their names. I am not aware of family members who worked in substantive roles on the same ward together. 16:25

I do not recall being involved in dealing with complaints from patients' relatives. 16:25

I became aware of allegations of abuse by staff towards patients in and around the later months of 2017. I cannot recall the specific date. As stated, my time was divided between brain injury services and MAH, so my knowledge was limited. I believe my supervising consultant may have made me aware that concerns around safeguarding in PICU had been raised. I was aware that 16:26

CCTV footage was being reviewed and some staff had been suspended.

I have worked specifically in learning disabilities for over eight years." 16:26

In relation to how the management of intellectual disability patients has changed over time, the witness says: 16:26

"As I have completed my training, my role within the specialty has change. Over the years I have worked with psychiatrists and other professionals who prioritised patient care and supported patients living in their own homes within local communities. 16:26
Professionals seeking this goal have often been hindered in their work by lack of resources at many different levels, ranging from financial constraints within the sector to societal attitudes about where and how people with intellectual disability should live and 16:27
be cared for. As the years have progressed, I do believe there have been positive changes. I believe that as a whole the wider healthcare system and society is recognising the needs of people with intellectual disabilities more fully and this is facilitating the 16:27
ongoing work of inclusion and empowerment of people with intellectual disability.

My overall experience in MAH was positive. I did not

witness any treatment provided by staff to patients that caused me concern. I was surprised and appalled by the allegations that patients had come to harm under the care of the hospital."

16:27

And the witness then signs the declaration of truth.

CHAIRPERSON: Ms. Bergin, thank you very much indeed for that quite long haul. Thank you to both of those witnesses, of course, for making their statements.

16:27

We will next be sitting on Tuesday, 28th May. In the meantime, CPs will be receiving various modules, including modules -- the evidence for Organisational Modules, at least 1 to 3, as well as Evidence Module 6, which is the Ennis bundle and the related statements. 16:28 So, I can assure you, you will have lots to read.

In the meantime, can I thank everybody very much indeed.

MS. RICHARDSON: Whenever we go to the Organisational 16:28 Modules, the next one, they will be on our website.

CHAIRPERSON: Oh, yes, I'm sorry. Thank you. As ever, I'm reminded by the Secretary to the Inquiry, we will be publishing as well all the material, when we can, on the website on the modules. And when we start the 16:28 Organisational Module evidence, we will be returning once again, after quite a long break, to a live feed, so that members of the public are able to watch that as they wish.

All right. Thank you. Right. Thank you everybody and we'll see you back here in a week and a half.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 28TH MAY 2024 16:29