MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 3RD JUNE 2024 - DAY 86

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

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86

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THE INQUIRY RESUMED ON MONDAY, 3RD JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Yes, is there any application in relation to this? 09:56

MR. McEVOY: There is no need for an application, Chair. I think there was an application, but the basis for it has been resolved, so I think we can proceed.

CHAIRPERSON: And we can deal with the paragraphs in a suitable way? 09:56

MR. McEVOY: In a suitable way.

CHAIRPERSON: Which the -- I think it was the PSNI have some concerns. All right. Can we get the witness in? Thank you. 09:57

H324, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

CHAIRPERSON: Good morning.

A. Morning. 09:57

CHAIRPERSON: We've met briefly outside. Can I just thank you very much for coming to assist the Inquiry. If you want a break at any stage you know just to let me know, and I'll hand you over to Mr. McEvoy.

A. Okay. Thank you. 09:58

MR. McEVOY: Okay. Well, good morning.

A. Morning.

1 Q. And for today's purposes you're known as H324. So good morning H324. Before you is a little folder with your

Inquiry statement dated 22nd May 2024.

A. Mhm-mhm.

2 Q. And I have some questions arising for you from that statement?

A. Okay. 09:58

3 Q. In the statement you tell us that you worked as a Band 5 Staff Nurse at Muckamore and you started there indeed at Muckamore in February 2008 as a student nurse?

A. Yeah.

4 Q. And your time as a Band 5 then began in January '13 until August '15, and then at Section 3 you tell us that you're a Band 7 nurse currently within the Belfast Trust? 09:58

A. Yeah.

5 Q. Are you -- what area are you working in now? 09:58

A. I am working in the community.

6 Q. Okay.

CHAIRPERSON: Mr. McEvoy, just for process, do you want to ask her to confirm that her statement...

MR. McEVOY: Yes, you're content. 09:59

A. Yeah. Yeah.

MR. McEVOY: Content to adopt your statement.

CHAIRPERSON: Thank you.

MR. McEVOY: And you are in the community, and in band -- I beg your pardon, in paragraph 3 you tell us that you qualified from Queen's in 2011 as a registered learning disability nurse. 09:59

A. Yeah. Yeah.

7 Q. And are you still working within learning disability

now?

A. Yes, I am, yeah. In Community Learning Disability Services.

8 Q. Okay. In terms of what you tell us at paragraph 4 then, when you went on to take up a post as a Staff Nurse in Muckamore in January '13, you tell us that you were supposed to be starting in Donegore, but then you were asked by H77 to go and work on Greenan? 09:59

A. Yeah.

9 Q. Which you describe as a nursing care ward with around 28 patients, with the majority being wheelchair users, and "I spent some time on this ward as a student", you were happy to accept and stated you'd be happy to work there. And you say you loved the ward? 09:59

A. Mhm-mhm. 10:00

10 Q. And the Sister in charge in Greenan when you were a student nurse was H154, and she was still there then when you went back in 2013. When you took up the role in January 2013, you say it was a temporary post on a rolling contract for about three months in duration? 10:00

A. Yeah.

11 Q. And you tell us then the hospital was supposed to be closing?

A. Mhm-mhm.

12 Q. Can you tell us how did you know that at this point in time? 10:00

A. Well I suppose it was in keeping with the government guidelines that the long stay hospitals for people with learning disabilities were going to be closing and a

lot of them had been identified for resettling. It was just a matter of getting resettlement placements. So that was -- for a long period they weren't employing people as permanent Staff Nurses, and during that period I think they were redeploying Band 3s into the community because they had too many staff at that time. 10:00

13 Q. Okay.

CHAIRPERSON: You are a really fast talker.

A. Sorry. That's me trying not to talk fast! Sorry.

CHAIRPERSON: So between you and Mr. McEvoy, if I could ask you just to take a breath occasionally. All right. 10:01

A. Yes. Sorry.

MR. McEVOY: All right. Take your time.

DR. MAXWELL: Can I just ask you about that? You said that Band 3s were being re deployed to work in the community. 10:01

A. Yeah, yeah, yeah.

DR. MAXWELL: So at that time would it have been your perception that the hospital was over-staffed?

A. Well working on the ward I wouldn't have felt that it was over staffed, but they had said -- I think what the vision just had been, our understanding would have been that they had wanted a higher percentage of Band 5s due to the client group that was going to be likely in the core hospital. So working on the ward I didn't think it was over staffed, but they had felt that they were over staffed in Band 3s -- so maybe about -- I don't know a dozen, half a dozen people were sort of redeployed to community settings, either in residential 10:01 10:01

homes, supported living, or some of the day care places. And I know too a couple of them went then to like a community behaviour team from Muckamore.

DR. MAXWELL: So I understand the vision, but of course there's a lot can happen between a vision and reality. So the vision was we're closing it, we'll move everybody out, but your experience was that actually there weren't enough staff for the patients who were left. Is that correct? 10:02

A. Yeah. Yeah. I think -- from memory I think people had been given an option, because of the vision, had been given an option to apply for redeployment because they had wanted the core hospital of like the admissions ward or the longer stay, or the forensic ward, they had wanted those to be mostly staffed by Band 5 Staff Nurses due to the clients that were going to be in it. So I think that might have been what their idea was, but the reality was we were very short staffed. 10:02

DR. MAXWELL: You also say, I think, that they weren't offering substantive posts to Band 5. 10:03

A. No. No.

DR. MAXWELL: So if the vision was 'We'll have less threes and more fives', but they weren't actually recruiting substantive Band 5s, that seems a little odd. 10:03

A. Well it was very odd, and we used to wait to get our contracts. It would have been maybe like the week before the contract was running out that would have been the first time you got any sort of correspondence

that you were going to be given another three months. So it was kind of...

DR. MAXWELL: Can I ask, as somebody just qualifying and you're thinking you've got your whole career ahead of you, would going to somewhere on a temporary contract that you thought was imminently closing be seen as a good career move? 10:03

A. Well I had initially, when I first qualified, had worked down in Newry, and so that was about an hour, well about 45 to an hour's away, depending on the traffic and how I was driving, to get there. And then I took a post in Coleraine, which was an hour the other way from my house. So when the opportunity just came up to work in Muckamore, it was 15 minutes away from my house, and I probably wasn't thinking long-term career, I was just thinking short-term that it was more convenient rather than spending an hour driving too and from work working in the nursing home. Going to Newry we'd have been doing like five nights in a row because of the way the duty fell, the week starting and the week ending, which was very tough. I did it for 13 months and then got worked up in Coleraine, and my brother-in-law was a mechanic and told me off for the abuse to the car, and I was tired, so I needed to work somewhere closer to home just. 10:03 10:04 10:04

DR. MAXWELL: So your choice to go to Muckamore wasn't a career choice, it was a pragmatic choice?

A. Well I suppose it was a career choice as well. I was working for the agency in the community in Coleraine,

so I suppose it was a wee bit more stability and it was just something at that time that I felt was the right thing to me do for me.

DR. MAXWELL: I will stop in a minute, but you were working for the agency, is that because they weren't recruiting community RNLDs either? 10:05

A. That was due to -- they were really short staffed and they needed somebody in quickly and I got it through the agency.

DR. MAXWELL: But were community RNLD posts available? 10:05

A. This was a Band 5 one, so I'm not sure whether or not in the Belfast Trust they were available at the time. I just had seen that this was a Band 5 in the Northern Trust was available and I applied for it just.

DR. MAXWELL: Thank you. 10:05

A. I just took the opportunity.

DR. MAXWELL: Thank you.

14 Q. MR. McEVOY: You were able to apply for a permanent post then in 2014.

A. Mhm-mhm. 10:05

15 Q. And you had to re-apply and then interview for it?

A. Yeah.

16 Q. And then that post, your understanding was that it was going to be in Cranfield Men?

A. Mhm-mhm. 10:06

17 Q. But in fact then in around October or November of that year you were told then that you were being moved to Moylena as Greenan was due to close?

A. Mhm-mhm.

18 Q. And you can't recall who informed you of that move. You expressed your view and your understanding that you were supposed to be commencing your permanent post in Cranfield and your line managers told you that they didn't want to lose you, your experience working in resettlement, and you were moved then to Moylena. You say:

"If Greenan was still open today I would probably still be there, as I really loved it. The only reason I left Muckamore at all..." 10:06

- would that be fair to say?

"...was because of an opportunity to get a Band 6 post in the community." 10:06

A. Yeah.

19 Q. Then you tell us you didn't have any family or friends working in Muckamore when you started. You then describe your induction as a Band 5. You're very familiar with the hospital. You remember H154 going through the policies with you and the mandatory training that you did? 10:07

A. Mhm-mhm.

20 Q. Again you emphasise how much you enjoyed working on Greenan, describing it as a nursing care ward for long stay patients, many of whom had been in the hospital for many years and were mostly older. Most patients were profoundly disabled with a history of psychotic 10:07

disorders, a tough job physically, which you enjoyed. Patients were wheelchair users and required the use of a hoist for transfers. Although you recall a key pad on the door, it was an open ward, and the key pad you think was installed, or you recollect was installed, as a patient from another ward had entered the ward and had attacked a profoundly disabled patient, leaving that person with scars. But staff and families had the code and came in and out as they pleased? 10:07

A. Yeah. 10:08

21 Q. Okay. You then go on and tell us about Ennis Ward, which you worked on as a student, describing it as a locked ward, a women's ward, which you recall had a lot of slapping and grabbing in this ward from the patients. The women on that ward being moved to the community. And there were a lot of In-Reach staff from the community coming to the ward to meet with the patients. Cranfield Women's Ward was another ward you were placed in as a student, it was an admissions ward, and you describe that as being an eye opener. 10:08

A. Mhm-mhm.

22 Q. When you there the ward wasn't long open. The hospital was trying to move from an old institutionalised style operation, you say, and the ward was all one open space. Cranfield Men's and Cranfield Women's Wards were beside each other and both wards were open, which meant that the men and women patients could see each other. It could be, you say, a hectic environment to be in, and potential mixing of the patients caused a 10:08

lot of tension. If there was ever an incident when staff were occupied, patients would take advantage of the staff being distracted. And then you describe some of the techniques for breakaway when you were at Queen's on placement. 10:09

You weren't MAPA trained as a student, but you now know that for the Cranfield wards breakaway techniques were not sufficient, and you remember that being raised with Queen's and being told that you shouldn't be present if an incident was occurring. This would have been difficult as a student as staff would have been trying to manage or diffuse a situation, maintain patient safety, staff, and also students. But you certainly learned de-escalation skills from your experience there. During your time in Cranfield Women's you recall there were a lot of incidents, but none which you can recall specifically. You then describe going to F3 after Cranfield Women's, that being a male long stay ward. A lovely ward to work on, you say, which had a big dormitory where the patients slept. 10:09 10:09 10:10

"The ward had been sectioned off using furniture to create smaller private areas."

10:10

This, you felt, was the best they could do with the resources available at the time. The patients were happy, but you do recall there were a lot of incidents on the ward also. There was one incident you recall as

a student where a Staff Nurse had her two front teeth knocked out by a patient. As a Staff Nurse working in Muckamore you say that would you rather have worked on the male wards than the female wards. Is there a reason why you say that? Was it a personal preference or was it --

A. Yeah, I suppose it was personal preference, but on the female wards the female patients at times would have been a lot nastier, and probably a lot more vicious. And with the males, from experience with the male patients, if there was an issue on the day it was dealt with on the day, or like it was there and done and dusted on the day, whereas the females would have like recalled something like six weeks before that you might not have even remembered or might not have been on duty. So they were probably that wee bit nastier to work with. And they would have been a bit more vicious that they would have been scratching at you, like scratching and grabbing at you more than what the male patients would have.

23 Q. Okay. You then tell us that when you were asked to move from Greenan to M4 as a Staff Nurse, you weren't happy, because as you've mentioned you loved Greenan. And when you arrived to work in M4 it was chaotic and very short staffed.

A. Mhm-mhm.

24 Q. Management at the time were H355 and H426. One was a Band 6 and the other Band 7. You can't remember which way about. Before moving on, during the period of

2013/2014 when you were new in post, can you tell us something about how the closure of wards and the movement of patients affected them?

A. Affected the patients?

Q. Patients. Yeah. 10:12

A. Yeah, it was a having a negative impact on a lot of the patients and their families, particularly in Greenan. Like a lot of those ladies had been in the hospital for the guts of 30/40 -- I think there was one was there even for 50 years -- and the families were really 10:12 really upset. They understood, like we would have explained to them that it wasn't us, do you know, because like a lot of, like we would have had people like -- I remember a particular family like they were "Why are you doing this?", and we were like -- it's not 10:12 we're doing it, but we're having to facilitate it because it is in line with the government guidelines that people shouldn't be in long stay hospitals. I felt that it was impacting on patients because they were being moved from -- sorry. They were being moved 10:12 from a place where they had been for a very long time, familiar with other patients and familiar with staff. That aside we were aware like what resettlement was and there was no real need for people to be in the hospital that length of time, but just given they had been there 10:13 for so long and familiar surroundings, it was tough. Like it was really, really tough, and we would have seen some of the patients physically deteriorating, do you know. Like you were talking about people who

didn't have capacity, and they probably were wondering 'why am I being moved?', do you know.

CHAIRPERSON: Can I just ask you, let's assume that those moves were absolutely necessary, just take that --

A. Necessary?

CHAIRPERSON: Necessary. Take that as a sort of assumption.

A. Yeah.

CHAIRPERSON: How was the preparation for those moves done? How long did you have? 10:13

A. We would have had weeks and weeks. It probably depended on the placement or depended on their staff. In Greenan, in particular, we would have had a lot of In-Reach staff. So one particular place we had six ladies were going to one nursing home and they nearly became part of the ward staff, they were there that often, and then when the ladies eventually did move the six of them together we then staffed, we like -- like a Staff Nurse and a Nursing Assistant would have went down to the nursing home and sort of been present to facilitate the resettlement, but sort of to allow the staff to work on it, but we were there as the people that knew the patients the best. 10:13 10:14

PROFESSOR MURPHY: So that was an example of resettlement well handled, but did you see examples where it didn't go that well? 10:14

A. Well, a personal opinion? I suppose I can think of one or two that they were moved and they physically

deteriorated. Probably -- it might be just our feelings, but we know like the people sort of -- well there was one particular lady I can think of that when she moved to the nursing home she had always had a great appetite when she was on the ward, and when she moved to the nursing home she didn't, her appetite deteriorated, and just her physical appearance -- she did lose weight and she just didn't seem herself. So we had sort of talked to the, the nursing home contacted us then like 'You told us she has a great appetite, do you know, this is not what's being shown here'. So some of the staff were sort of deployed down to the nursing home at different times to sort of familiarise the staff or familiarise her with the area so that we sort of -- and a different -- I remember I was one of the people going down to sort of feed her and sort of participate in her care to try and make it more pleasant experience for her. She would have been profoundly disabled and non-verbal, but quite clearly that the move did have an impact on her life. 10:15 10:15 10:15 10:15

PROFESSOR MURPHY: Thank you.

26 Q. MR. McEVOY: Okay. Then you tell us then at paragraph 13 at the top of page 5, before you were moved as a Staff Nurse from Greenan to M4 you had been off for personal reasons for six to eight weeks, and then you went back for a week before going over to M4. While on M4 then, sorry, you describe a patient who had tried to sexually assault the staff on many occasions. You recall an incident in December '14 where that patient 10:16

punched you in the lower abdomen womb area, causing you injury, and you were off for a number of weeks afterwards. During that time when you were off, H377 contacted you and asked if you would come back to Cranfield Men's Ward, as you were originally supposed to, that was your original understanding, because the Christmas off duty was short. When you came back in January '15, Greenan was closed and you were still on M4.

A. Mhm-mhm. 10:16

27 Q. Greenan had closed and H154, who you seemed to have got on well with, would that be fair to say?

A. Yes.

28 Q. Was then moved to M4 and was the Sister in charge. During your time in M4 you staffed for a period the Oldstone Bungalows, which was a resettlement section across the road from the main Muckamore site. 10:17

"I cannot recall how long we did this for."

10:17

You were the only Staff Nurse there for three patients. Two of them had a forensic history and one was still the subject of a hospital order, and you had no, you say, no -- you had never worked with patients of that kind and had no training to do so. How did you feel about that? 10:17

A. It was just part of your job. I suppose before we went over when we were staffing then the Oldstone, we were given a run down, you know, like an introduction to the

patients, we had access to their nursing file. We were aware of what the past of the patients were.

29 Q. Yes.

A. And I suppose sort of what -- you were given sort of advice or sort of like -- I can't think of the word, sorry. Like an introduction to the patient and sort of explained sort of who and what, just absolutely everything, and about the history. I didn't feel -- and just from reading that I suppose I didn't really feel, you know, as a registered Staff Nurse, so long as I had had the information on the patient I don't feel that I would have necessarily needed specific training for those particular patients. We weren't doing any -- they were identified as being resettled or discharged. So I suppose there wasn't anything -- there was no specific or proactive work being done with the forensic side of things, so I wouldn't have needed to have specialist. 10:18 10:18 10:18

30 Q. Yes. Yes.

A. Just reading that and just I don't think I would have needed... 10:18

31 Q. That's fine.

A. I suppose it was just part of your job that you had to do, and it was grand. We had a phone and you would have rang over if you needed anybody. You would have rang the ward. I'd have rang the Charge Nurse of the Forensic Ward. I don't see a cipher. 10:18

32 Q. Yes.

A. If you needed anything. Because sometimes other

patients from the other ward would have come over and I would have rang over just to make sure that like they were all right to mix, because I didn't know the full history of absolutely every single patient that wasn't on that ward, or the nursing office you would have rang if you had needed support. But generally it was fine, it was just part of your work.

33 Q. Okay. On M4 then, in paragraph 14, you tell us that all the male patients were able-bodied or predominantly able-bodied. Some of them required constant supervision, different levels of supervision, recorded as Level 2, which was supervision every 15 minutes. Level 3 was within eye contact at all times, and then Level 4, which was when a patient had to be within arm's length at all times. The ward was short staffed and you were left with one-to-one supervision of a patient while taking charge of the ward. That's the same patient that injured you? 10:19 10:19 10:19

A. Mhm-mhm.

34 Q. And you highlighted this to your line managers H823 and H377. They kept saying they were aware and they would do something about it, but nothing ever happened. How did you feel about your personal safety during this time? I mean you've described one injury in the previous paragraph? 10:20 10:20

A. Yeah. I don't know. I don't know. I suppose at that time I felt that my concerns were not being taken seriously, and I suppose that I had expressed -- like so I had expressed to the management that are mentioned

there my concerns, even when I first came over there, before anything had happened, my concerns of taking a Level 3 one-to-one and being in charge of the ward, because there was other things you needed to be doing if you were taking charge of the ward and you couldn't give a Level 3 supervision. 10:20

35 Q. Yes.

A. So I had highlighted that before anything had actually even happened. So personally my safety was compromised and I felt sort of at risk, and then when I was injured it sort of -- I was right to be feeling I was at risk. 10:21

36 Q. And you've described your moves around the various wards and what was going on in the various wards during this time. Were there particular wards that were more short staffed than others? 10:21

A. I'm not sure. I suppose when you were in the ward you were only concerned with your own ward, but from experience with M4 in Greenan, if we were ringing over to get -- we would have rang over to the nursing office to get the nursing officer. 10:21

37 Q. Yeah.

A. And I would have always proposed if they could give me staff 7:25 to 9:00 o'clock so we could get the people up and get their breakfast and get their medicine and then get them off to day care, that generally the other, like the more able wards in the core, is what they deemed the core, a lot of those patients sort of lay on to after 10:00 maybe. So that was how I always sort of proposed if we got staff. But I never -- 10:21

38 Q. Sorry, I didn't catch the hours there. What was the busy time?

A. 7:25 to 9:00.

39 Q. Yes.

A. So that would have been our really, really busy time. So I would have rang -- like they used to laugh, I used to ring and say 'Listen, if you give me somebody 7:25 to 9:00 o'clock that will make all the difference here. We can get these ones up, washed, dressed, get them their breakfast', and a lot of them were going to the day care on site. 10:22 10:22

40 Q. Yes.

A. So if we could get that 7:25 to 9:00, particularly in Greenan, like that made all the difference. I suppose from my experience our ward was always short, and I suppose on different occasions I was sent out on relief, so I would imagine maybe that all the wards were of a similar... 10:22

41 Q. When you say "sent out on relief", can you just explain what that means? 10:22

A. Yeah. So again when I rang the nursing officer they would take somebody else from another ward to staff another ward, so that would be deemed relief. So we would have had a relief book that everybody's name and where they went, so there was a record of it so that it was fair. So if my name hadn't been there in the last 10 goes, it would have been my go. You'd have had to just do it methodically like that. 10:22

42 Q. Yes.

A. So you could have been sent to any...

43 Q. So you would have had to go somewhere else?

A. Yeah, yeah, yeah.

DR. MAXWELL: Can I ask about the shift patterns?

A. Yeah. 10:23

DR. MAXWELL: It's common in other areas of nursing to have shifts that reflect the patient needs. So, to have people who work after is because, as you say, getting people up in the morning and breakfasting, that takes quite a lot of person power. Dementia wards 10:23 often have this concept of sun downing, that people's behaviour seems to deteriorate in the evenings so they'll have twilight shifts.

A. Yeah.

DR. MAXWELL: Was there ever any consideration given to 10:23 having these different types of shifts on different wards to meet different patient's needs?

A. There would have been twilight shifts across the hospital.

DR. MAXWELL: There were twilight shifts? 10:23

A. There would have been a 6:00 to 11:00. So you would have had a.m. was 7:25 to 1:00 o'clock, and the p.m. was 12:45 to 8:30. But there would have been -- we would have -- the 6:00 to 11:00 workers, and they would have worked 6:00 to 11:00, and then, what was that, 10:24 then you could have done a long day or the night duty. But there was -- we would have had twilights.

DR. MAXWELL: Okay. But you didn't have a morning shift?

A. No, just the 7:25 to 1:00. There was never...

DR. MAXWELL: And when you say that the ward was short staffed, was it short for the whole shift or just round these particularly intense periods? So after 11:00 or 12:00 until about 6:00, was the ward adequately staffed? 10:24

A. On days, yes, it would have been, because there would have been maybe more people -- like we would have had people that didn't work mornings, or people that didn't work after 6:00am, it just really depended. It depended on staff leave, staff sickness, you know. It wasn't like chronically short every single day on every single shift. We could have obviously done with more staff on each shift on each day. But, yeah. I suppose we got it done, do you know, is the thing, and I suppose from that point of view it was adequately staffed, but it would have really depended. It wasn't any particular -- you know, it wouldn't have been like 'Oh, my goodness, we're always short in the morning times', you know, it was... 10:24 10:25 10:25

DR. MAXWELL: But if you're very taken up with trying to get everybody's personal hygiene done, get them dressed, have breakfast, how much time does that leave for the positive behaviour programmes, for the activities for things? 10:25

A. Not a lot.

DR. MAXWELL: So there was work left undone, to use the current phrase?

A. Yeah. Yeah. We would have done -- we would have been

trying to allocate staff on the allocation sheet to try to make sure -- because that would have been something that would have been brought up by the RQIA, that like ward based activities or things weren't being carried out, so there was a big drive at a time on the allocation sheets, like I would have -- myself or anybody would have been personally allocated to ensure that activities were carried out. So like after 9:00 o'clock, or after everybody has had their -- got up washed and dressed and out to day care, and after sort of like the staff breaks in the morning, there would have been, somebody would have been allocated to that, no matter what happened they would have had to do that. But it might have meant that as nurse in charge you were maybe going putting laundry away to allow some other member of staff to do those tasks. 10:25 10:26 10:26

DR. MAXWELL: It doesn't seem like a good use of resources?

A. We did what we had to do, do you know. It was just kind of -- yeah. 10:26

DR. MAXWELL: So as far as you know, when people were determining how many staff you need, were they just looking at people's physical needs or were they looking at all these other things that you do as part of providing care? 10:26

A. I would imagine that it was their physical needs. There was never any formal discussion that I would have been involved in with that, but knowing what we got and what we had, I would imagine there's the physical

needs, meet their physical needs first.

DR. MAXWELL: Okay. Thank you.

44 Q. MR. McEVOY: Now at paragraph 15 in the bottom of page 5, you say that in line 4 that you would describe the culture on M4 as "okay": 10:27

"People just got on with what they had to do. Like any ward, some people were happy, some were not, and some just liked to moan. There were a lot of older men working on M4. It was a high incident ward. Patients 10:27 would attack staff quite a lot of the time, often involving biting and punching. The male staff on the ward would have ensured the safety of patients on female staff so it was almost like an added stress for the men if mostly women were on shift. It was a tense 10:27 ward to work on as it had so much potential for serious incidents."

You remember on a number of occasions telling the nursing officer you were not taking the keys to take 10:28 charge of the ward as it felt so short staffed it was dangerous. You would have received staff fortunately, but this would have been at the expense of another ward. So in fairly marked contrast to your memories of Greenan which are good, you describe Moylena as okay, 10:28 but also as tense.

A. Mhm-mhm.

45 Q. How could it have been improved, thinking back to it?

A. That's a hard -- I'm not sure -- I suppose like

anywhere if we had of had enough staff to carry out activities with the patients. So my later time in Moylena we then got access to the hospital bus and we were able to take people out, and it was, you know, there was a noticeable difference that people weren't under as much pressure, patients and staff included in that. So I suppose probably if we had of had more staff. When I first went over the staff that were there, I don't know, I don't know if they were inexperienced or not running a ward, and that potentially led to a lot of chaos, because they might not have -- well they didn't have the experience of running the ward, and when I first went over a lot of the Staff Nurses were sort of preoccupied by sort of hanging out in the nursing, in the office of the ward which we wouldn't have done in Greenan, so I was a bit baffled about that. 10:28 10:29 10:29

46 Q. Can you tell us more about that?

A. Yeah.

47 Q. When you say "hanging out in the office", what does that mean? 10:29

A. You would have found like a concentrated number of staff in it. When I first went over I -- there would have been like a concentrated, there would have been about three or four Staff Nurses in the office. The office wouldn't have been much bigger than this desk. 10:29

48 Q. Yes.

A. And I remember that being a bit of an issue because it would have always been a discussion who was qualified

the longest would have taken charge, and I remember this one day I was walking past, I had a patient and I was walking past, and they found out that I had been qualified longer, so then they were like up in arms that I should have been taking charge and they were kind of like huffing that I should have been taking charge, but I had said I was -- that was my first day on the ward, I wasn't taking charge of the ward, didn't know the patients, couldn't possibly administer medication to people that I didn't know, and I wasn't doing it. So there was a bit of a discussion, because I had said then to the Charge, or the Deputy Charge at the time, going 'like that's crazy that they're all sitting about in the office', do you know. I was on a Level 3 of a patient that I didn't really know, getting slapped, and bit, and punched, and they were all just sort of sitting there. 10:30 10:30 10:30

DR. MAXWELL: What were they doing?

A. I don't know.

DR. MAXWELL: So there is quite a lot of administration. We've heard from other witnesses that there were no administrative support. A lot of wards would have a ward clerk. 10:30

A. We would have had a ward clerk. There was two girls that did it, but they wouldn't have been every day, but they would have been -- they would have come over or they would have come over and collected the work that needed done and would have went over to the admin building, because M4's office wasn't that big, so they 10:31

wouldn't have had -- but we would have had a ward clerk in Greenan then, they were part-time because they were shared with other wards, but they were -- we had -- they weren't called "ward clerks", but they were, do you know. I can't think of what they were called, but they were...

DR. MAXWELL: Okay. Okay. So if I had been there and I had asked these people who were hanging about in the office, what would they have said they were doing?

A. I couldn't possibly say. I do recall -- 10:31

DR. MAXWELL: You didn't justify it? You didn't ever challenge them?

A. No, as said -- well, I did. I says "I don't know what you are sitting in there for?", and then they all muttered something, and I thought on my first day I didn't really sort of want to fall out with everybody, but I do recall being in M4 that in the evening time I had got all the nursing notes done, incident forms, and the handover done, and come back around the ward to see if everything was all right, because M4 was locked, but where the office was was on the corridor and then there was a corridor and then a locked door and then different doors to different day rooms, so you were very far removed, so I would have went around to make sure everything was alright, you were in charge of the ward and you needed to see the people, and I would have walked around, and I remember one of the nursing assistants saying to me, it was like "What are you doing? Have you not loads of paperwork to do?", and I

was like "No, it's done." But I think there was potential that they were maybe taking advantage of sitting in the office maybe. I don't know. But, yes, we did have a lot of like, you know, we would have had load of incidents forms, we would have had to do all the ward report, and we would have had to do, would have had do, but you got them done.

CHAIRPERSON: Can I just take you back to the beginning of your answer some time ago now about when you got access to the bus? 10:32

A. Yeah.

CHAIRPERSON: And you said that the behaviour of the patients changed quite noticeably, and it may be obvious, but was that your experience that when you had something to do with the patients, such as taking them out on the hospital bus, that would possibly reduce the aggression and the difficulties? 10:33

A. Well on that particular ward there was. I felt that, you know, they were a bit happier they knew they had something to look forward to, they were getting out, you know, it might have been only going and getting ice-cream or going -- we would have went maybe to Antrim Gardens and would have went for a walk around there and got a cup of tea and a bit of shortbread, you know, but if I -- just if anybody had something to look forward to it was maybe a wee bit more pleasant for them. I remember trying to do arts and crafts on that ward, but it didn't go down too well, so there was other things tried, but the bus seemed to be the best 10:33 10:33

thing.

CHAIRPERSON: And the same patients who might be aggressive and difficult, for want of a better word, on the ward, when you took them out on a bus, or you gave them something to do, would that aggression diminish or disappear? 10:34

A. It probably depended. I can think of a couple of occasions there would have been -- a couple of the patients that you would have took out on the bus by themselves, you know, or there would have been ones that you could take a couple out, but there would have been one that we would have come back early because there was potential of causing harm. 10:34

CHAIRPERSON: So it wasn't always entirely successful?

A. No, no, it wasn't. Like, you know, you could say like a good lot of the time it was, but like there was a number of occasions having to come back to the ward early because somebody just wasn't enjoying it, or maybe, do you know, whatever was happening, so they would have had to come back to the ward earlier. 10:34

CHAIRPERSON: Yes. Thank you.

49 Q. MR. McEVOY: You gave the example of arts and crafts and it not going down well. Who did it not go down well with?

A. Oh, some of the patients. He toppled the table. So we -- just it was something to try, because he didn't want to go out on the bus and he didn't want to go walking, and it was on the run up to Christmas, so I was like "Sure we'll make Christmas trees", and he toppled the 10:34

table.

50 Q. Right. What did you have in Moylena? Did you have access to behavioural support?

A. Well, there would have been the behaviour team.

51 Q. Yeah. 10:35

A. So I suppose as learning disability nurses we were expected to have a certain level of experience or knowledge to work with the patients that are displaying those.

52 Q. Yep. 10:35

A. So I think it was more down to whatever threshold was hitting to get the behaviour specialists in.

53 Q. Yes.

A. I don't really recall them being on M4.

54 Q. Does that mean that the threshold wouldn't have been reached? 10:35

A. Yeah. Yeah, yeah. That they might not necessarily have been hitting the threshold. Yeah.

55 Q. Okay. You then say that in Greenan Ward the rate of incidents occurring -- I'm at paragraph 16, thank you: 10:35

"...was so low that I cannot recall any incidents happening during my time there. There was a patient who had psychotic tendencies and he was detained under the Mental Health Order. She would talk about staff 10:36 member's personal lives and make comments, but that was about the worst of what would have happened on Greenan. Other patients on Greenan were voluntary and not subject to the order and were awaiting suitable

community placements."

Then you say:

"As an example of good care towards a patient in Greenan, I recall a female patient who was fed in a chair in the day space and required assistance for feeding." 10:36

You were her named nurse: 10:36

"The patient would not move all day from this chair except to go to bed and to toilet. She would go to day care but not always want to say. Over a long period of time, possibly matter of weeks..." 10:36

- yourself and other staff managed to get her to the dinner table and eventually she was able to feed herself.

10:36

"This involved all staff ensuring no other patient or crockery was on the table, as on many occasions she would have pulled the tablecloth off or knocked things off the table. It took time and patience to work with her and encourage her to be comfortable at the table and eventually feed herself. After some further time she was even able to walk up and down the ward and communicate to ask for things. It was not very often, so when she asked for things we ensured she got them, 10:37

no matter what she requested, and this was done to encourage her to speak and express her wishes. It was very helpful when she was resettled into the community."

10:37

You then describe how this patient would wear polyester onesies, or even a T-shirt which had to be stitched to her trousers, as she would strip off several times a day, and as a ward you were trying to move away from this, so as her named nurse you purchased a variety of clothes you felt would have met her sensory needs, and you brought clothes that could be layered, but not too heavy, and:

10:37

"The stripping incidents were not totally eradicated but were reduced, and H154 was happy with that and supported it, as it was very person-centred."

10:37

And you eventually got the patient to wear socks and shoes to day care.

10:37

So that good care example shows an improvement in eating, walking, communicating, and less of the stripping behaviour. Was that based on your own work and your own observation, or had you input and assistance from other professionals?

10:38

A. No, that was just cause I was her named nurse and she would have been sitting in what would have been called like a tub chair, it was big sort of like half moon

chair, and she would have been siting with her wee knees up to her chin nearly, so I just thought I'm not feeding anybody like that, you know.

56 Q. Yes.

A. So it was kind of like at a ward level we said, 'Well, no, actually we're going' -- and that's kind of what -- there wasn't really any input from other professionals for that, that was just something that we were doing at ward level. 10:38

57 Q. So that's the feeding. What about the other aspects that you have described, the walking and the speaking and all of those things? 10:38

A. Well, with the walking just it was basic a nursing things, she should have been doing a wee bit of exercise or a wee bit of movement. Her wee joints would have been really stiff from sitting. So we would have got her like -- she sort of -- she would have took you by the hand and she would have walked wee bits and would have got better over a period of time. But I suppose she did have a wheelchair for transporting. 10:38 10:39

58 Q. Yeah.

A. So -- but there was no input, and I suppose I didn't feel there would have been any need for any other professional input for those sorts of things. Like as registered nurses we would have been more than capable of doing that. 10:39

59 Q. Okay. And in terms of the clothing, if I can call it the all-in-one clothing, or the onesies, had that been common? I know you had your student placements there,

but do you know pre-2013, was that something --

A. I suppose it probably would have been common at a time. As the years went on as a student and as a Staff Nurse, it was something that there were -- like the majority of them moved away, but this particular lady she wouldn't tolerate anything else, she was so used, you know. 10:39

60 Q. Yes.

A. It probably would have been more common as a student to see the polyester jammies, not everybody was in the all-in-ones. The all-in-one would have been more to prevent somebody from picking at their pad, and potentially if somebody had PICA or anything. 10:39

61 Q. Yes. Yes.

A. But not everybody would have been in an all-in-one, but they would have, likely when I was a student, would have all had the polyester jammies. 10:40

62 Q. And you've described what you did in terms of going to get -- purchasing a variety of alternatives?

A. Yeah. 10:40

63 Q. Can you tell us a wee bit more about that and how you went about that process?

A. Yeah. So as a named nurse we would have had the responsibility of purchasing the patient's belongings, their clothes or whatever. So I went -- I think I went to Marks & Spencers and got like the elasticated waisted trousers, that they were still -- they looked like trousers. They were like -- I got all different ones. But got those. Got like jeggings. They looked 10:40

like jeans, but they were soft and stretchy. And it was kind of like an exposure type thing, we kind of put them on her in the morning and she got used to them, and then to the point that she tolerated them. But I would have been buying stuff that was sort of like more modern, but like trendy, but age appropriate for her in particular. She was very small, so it was difficult to get some of the clothes. But you would have got stuff -- we would have sent it over to laundry and would have got it mended if we needed things shortened or whatever. 10:41 10:41

64 Q. Yes. Yes.

A. So I just, I just purchased things that I thought were sort of -- that she might like. And once we got sort of established that she liked the black trousers and like the jegging type ones, we then went -- well I went and got sort of more similar type of the clothing. 10:41

65 Q. Softer material?

A. Yeah, yeah, yeah. But still like, not like joggers or anything. 10:41

66 Q. Yes.

A. But still sort of to be sort of respectful?

67 Q. Did you think that the material in the onesie, the polyester material, that the patient disliked?

A. No, I think she did like it. I think she liked it. And that's why then we -- when I got -- actually then around that time I think the fancy onesies for jammies came out. 10:41

68 Q. Right.

A. So we were able to get like fleecy ones and nicer ones.

69 Q. Yes. Yes.

A. We didn't try her with pyjamas because it was kind of night-time, she would have really like pulled the pad apart and would have been eating it. I suppose if I had of been there longer, or she, you know, she could have moved out to the community and have maybe moved on to pyjamas, but as sort of time went on, we didn't have the time. 10:42

70 Q. Yes. 10:42

A. We were sort of concentrating on the clothes and the socks and shoes.

71 Q. Okay. I think you possibly have answered this question already, but those decisions that you took on behalf of -- in care of this patient, were those based solely on your own initiative or was there input from any other professionals? 10:42

A. Well I suppose the responsibility of the named nurse is ensuring that your patient, the patient that is allocated to you has enough clothes, has enough of their personal items. So I suppose it was kind of like, it was my responsibility as a named nurse to ensure that she had appropriate clothing, and with the view of her going out into the community, into the nursing home, that it would have been more appropriate that she was wearing nicer clothes and getting used to it. 10:42 10:43

CHAIRPERSON: Can I just ask how many patients you have been named nurse for?

A. Five to six maybe. That was on our ward. That would have been sort of standard.

72 Q. MR. McEVOY: Okay. I want to move on now and ask you about paragraphs 18 and 19 of your statement. All right. Now this is -- these paragraphs concern an incident of, the only one incident of poor care that you witnessed on Greenan, and just to orientate us in time, I think you say earlier on in your statement you were in Greenan from early 2013 to late 2014, would that be right? 10:43

A. Yeah. Yeah.

73 Q. So some time in that period. Okay. You have identified, and I think he has a cipher of P227 as a male patient, and we just know it is just his first name that you've given. 10:44

A. Okay.

74 Q. Now, I don't want you to tell us his full name if you know it. Okay? I don't want to you tell us, but just simply "yes" or "no", do you remember his surname?

A. Oh, yes. Yes. 10:44

75 Q. You do. Okay. Could you write it down for us, do you think?

A. Yes.

76 Q. The secretary will give you a piece of paper.

CHAIRPERSON: I think the Panel would like to see it as well, please. 10:44

INQUIRY SECRETARY: Two seconds and I'll just get the --

CHAIRPERSON: Okay. Just to explain. There are

reasons why the identification of this patient could be sensitive, so we're just going to leave it at the cipher at the moment.

MR. McEVOY: What we can indicate, and you don't need to worry about this, but I think what we can indicate for the record is that that person has also another cipher which is known to the Inquiry. We can say that.

CHAIRPERSON: Yes.

77 Q. MR. McEVOY: Now, this person, male patient, required two-to-one supervision as he had mobility issues which prevented him from being able to support himself, and you say that the two-to-one supervision was carried out by we'll say two staff members who weren't nurses. I think we can possibly say that? 10:45 10:46

A. Mhm-mhm. 10:46

78 Q. And/or by Band 5 Staff Nurses, and on this particular occasion then that you describe, you were carrying out a walk around on the ward with another member of staff, when you were passing that male patient, and then two members of staff, not nurses, who you have identified, and you saw one of them squirt water into the face of that patient and onto his body, and he was visibly soaking, and there was no reason for that staff member to have done it. You challenged the two staff members, not nurses, on this, and they said it was only a joke and suggested that they could tell others that he had wet himself, and yourself and your colleague took the patient and got him cleaned up and "once we got that patient cleaned up" you rang the night charge who 10:46 10:47

advised you to ring the senior manager who was on-call, and that was H77, and you did that and you told H77 -- I beg your pardon -- about the incident, and both H77 and H507, the Service Manager, met with you the following morning and the incident was reported to the police and they took a statement?

A. Mhm-mhm.

79 Q. Okay. When you moved from Greenan to M4, one of those staff members who you have described, not nurses, had a family member who was banked on M4, and you say it was not comfortable for you initially working in the ward with all the chatter about you work making a report when you worked in Greenan, as that member of staff had been suspended as a result of your report of the incident with the male patient. You recall a male nursing --

CHAIRPERSON: I'm so sorry to interrupt, but before you go on there's just a couple of questions while it is still fresh in our mind that I want to ask about the incident, without obviously naming anybody, but you say you were effectively walking past?

A. Yeah.

CHAIRPERSON: Would it have been obvious to the care assistants involved that you were walking past?

A. Maybe not. I couldn't say, but I don't think so. I don't know.

CHAIRPERSON: Right. Okay. But at the time you did challenge them?

A. Yeah.

CHAIRPERSON: And they didn't seem to see very much wrong with what they had done?

A. No, they thought it was funny.

CHAIRPERSON: Yes. Okay. Thank you. Sorry, Mr. McEvoy, but I didn't want to lose that moment. 10:49

DR. MAXWELL: Can I just follow up then? So we have heard of occasions where people thought what they were doing was acceptable, was banter, and clearly it wasn't. In response to this incident, was there ever any sort of reflection with the ward team from the Ward 10:49 Manager or senior nurses, without going into details of who was involved, to say 'Just to be clear, this sort of behaviour is always unacceptable'?

A. No, I think knowing the patient that it was, you know, I take what you're saying about the banter, but there 10:50 would have been maybe more able patients. But he -- I don't -- there wasn't ever anything. I don't think there was ever any question that.

DR. MAXWELL: And not in relation to him.

A. Oh, in general? 10:50

DR. MAXWELL: So it points to the idea that actually some of the health care assistants at least thought this sort of behaviour was acceptable, I don't know how many, it might have just been these two, maybe more. In response to that, not managing those people, was 10:50 there ever anything from the Ward Sister or the Senior Nurse to say 'This isn't acceptable. It's come to our attention that some people think this is acceptable. We're laying down a marker now, this is always

unacceptable'.

A. I don't recall.

DR. MAXWELL: You weren't aware of that of anything like that?

A. I don't think so. No. 10:50

CHAIRPERSON: You're going to come on, I think, to the proceedings that took place afterwards, but so far as a general declaration, as it were, to the staff on the ward, you don't remember anything being done?

A. No. 10:51

CHAIRPERSON: Mr. McEvoy.

MR. McEVOY: Those members of staff, not nurses, working at a lower level, I think we can be clear about that, not in the nursing profession I think we've indicated, as a Band 5 nurse and someone working as a 10:51 named nurse indeed on the ward, was it, was it easy to challenge the practice? This topic may have already been covered. Was it easy to challenge the practice of those type of staff? Did you feel it was easy to challenge the behaviour of those type of staff? 10:51

A. It wasn't easy, but I had to do it, do you know. I couldn't possibly have not. It was, I suppose it was difficult, but there was no way you could -- not in a million years would I have walked past that and not challenged it. 10:51

DR. MAXWELL: Can I just ask you a little bit about that, because we know in other settings, often the health care assistants or Nursing Assistants, or whatever we're calling the Band 3s, have been there a

long time, longer than the Staff Nurses. How did they see Band 5s? Did they see you as senior to them or did they just think you were transient people?

A. I suppose it depended. There would have been ones have been like 'Oh, I've been here for 20 years', you know, and there would have been ones -- there would have been Band 3 you'd have put your live in their hands that you would have known that they be really, really good and really good members of staff. There would have been ones going, do you know, 'You're only newly qualified, what would you know?'. But at the end of the day I had a professional registration to uphold. 10:52 10:52

DR. MAXWELL: Absolutely.

A. And when I had worked -- my first job when I qualified, I did have a bit of a difficult time and I just thought, do you know, I am not prepared to lose my nursing registration, you know, and I think that's -- you know, I didn't really care what anybody -- to an extent I obviously was emotional, I felt, but at the end of the day I would have had to stand over my NMC registration, and as difficult as it was -- 10:52 10:53

DR. MAXWELL: But it was difficult to do.

A. Oh, it was. Aye. Yeah. But, do you know, it was something that needed done, but it wasn't easy, no.

80 Q. MR. McEVOY: And just on that very point. You describe how you recall a male nursing assistant, you don't recall his name, saying to you that he heard you were a tout, but that you didn't seem that bad. Was that sort of behaviour and those sort of words, was that common 10:53

in Muckamore?

A. No, that was kind of the first time that I would have sort of ever experienced that. You know, going from Greenan, like it was lovely, and going to that, that was the first time, and thankfully the only time I ever 10:53
experienced that. I suppose, I don't know what other people experienced, but that was -- like I don't know if that was the norm or like -- that was my difficulty when I first went to M4, and I would imagine maybe some
of the chatter in the office when they were hanging 10:54
about was that I was one of them, you know, the one that was telling tales or carrying stories, so it was, it was difficult. But that was -- like, do you know, I was doing the right thing, so I didn't really care what
he had to say, but that was the only time I had ever 10:54
experienced that.

81 Q. Had you heard of others having a similar experience, others who may have spoken out?

A. I didn't know of any other people that had reported anything. 10:54

CHAIRPERSON: But there was an individual who said that to you.

A. Mhm-mhm.

CHAIRPERSON: But were you aware of others by the way they treated you. 10:54

A. Yeah. Oh, yeah.

CHAIRPERSON: A similar view.

A. No. Yeah. My first day in M4 was a long day on a Sunday, and it was the worst long day I could have ever

have put in.

CHAIRPERSON: Because there was...

A. Yeah, like, you know, I was excluded. Like I went looking for somebody. I was on Level 3 for hours and hours, and I went looking for somebody to say 'Is somebody going to take him so that I can go to toilet?', or 'Is there no lunch breaks?', you know, 'Do you not do tea breaks here?', and sort of making them have to take -- give me a break. Yeah. No, it was... 10:55

CHAIRPERSON: And what happened about that? 10:55

A. Oh, no, they had to give me a break. They had to.

CHAIRPERSON: Right.

A. So they took this particular patient, and then in the p.m. I says I wasn't taking him because I didn't know him well enough, and I felt that I was irritating him more, and therefore I was then getting -- like he had these things and he was whipping me with them and he was hitting me, and I just thought somebody knows him better that's not going to be irritating him, so I said in the afternoon very strongly that I wasn't taking him. 10:55

CHAIRPERSON: But there was -- it sounds as if the issue was not around that patient specifically, but around offering you support.

A. Yeah. No. Yeah, it was a very difficult 13-hour shift. 10:56

DR. MAXWELL: And was that hostility from registered nurses as well as health care assistants?

A. Everybody on the ward.

DR. MAXWELL: So registered nurses as well. They knew that you had -- well...

A. Well I perceived that I was being -- like if somebody new had of come to my ward I wouldn't have been treating them the way I was treated. So I just felt that it was -- and then off that comment of being a tout, is what I felt then that was what the chatter was, because I was aware that there was a lot of talking around the hospital. Everything goes, do you know, everything was being told. 10:56

PROFESSOR MURPHY: So it must have been very difficult going back the next day. How did you win them round?

A. I didn't win them round. I just went and did my work. I just went and did my work and, do you know, as I said before I have a registration, I am a registered nurse, I had a job to do, and that was their problem, and I didn't feel that I needed or could have challenged absolutely everybody, because then I probably would have been perceived to be the problematic one. But I think as time went on and I was on the ward and just getting on with my work, I think then people just seen who I was, and that I wasn't so much of an issue. And then the other person's relative stopped banking on the ward, which alleviated a lot of pressure, a lot of like whispers, sort of, whatever it would be called sort of, like that kind of eradicated that, and then people just -- we had too much work to be doing, to be honest, well I felt, to be caring what they thought, you know. So I think in time that they kind of just got over it and

moved on, because it wasn't...

CHAIRPERSON: Are you going to move on to the proceedings that followed?

MR. McEVOY: Yes, I am, Chair.

CHAIRPERSON: How long is that going to take us? I'm just thinking about the witness. 10:57

MR. McEVOY: Yes, I think it might be a good moment. I have one question just before we leave and then we can possibly look at a break.

CHAIRPERSON: Yes. Okay. 10:58

MR. McEVOY: You had described, earlier in your evidence you had described the contrast, and taking you to the contrast between your Greenan experience and your Moylena experience. You describe it as "okay", you describe it as "tense", and I took you through all of the reasons why you described that in terms of staffing levels and responsibilities. Would it be fair to say that the fact that you had made this report was also possibly a factor and why you found it tense in Moylena? 10:58 10:58

A. Oh, yeah, 100%, yeah.

MR. McEVOY: Okay. We could possibly take a pause there, Chair?

CHAIRPERSON: We normally take a break. You've been going about an hour. 10:58

A. Okay.

CHAIRPERSON: It might feel longer, it might feel shorter to you, I don't know. But we'll take a 10/15 minute break.

A. Okay.

CHAIRPERSON: I think somebody will get you a cup of tea and we'll see you back -- don't discuss your evidence with anybody and we'll see you back in 15 minutes. 10:58

A. Thank you.

CHAIRPERSON: Thank you very much everybody.

SHORT ADJOURNMENT

10:58

THE HEARING RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you. Yes.

MR. McEVOY: Chair, Panel members, just before we proceed, you will recollect that in the previous 11:20 session in the earlier part of the session, I asked the witness whether she could give the surname of P227, and for the benefit of the Core Participants and anyone who may be following proceedings, the Inquiry team will follow up with that identification and further 11:20 communication about it may follow as necessary.

CHAIRPERSON: Yeah. I mean I think it's obviously important for CPs particularly to know...

MR. McEVOY: Absolutely.

CHAIRPERSON: If at all possible to be told who that 11:20 is.

MR. McEVOY: Exactly.

CHAIRPERSON: Okay.

82 Q. MR. McEVOY: So H324, we were just about to come on to

the aftermath of your report of that incident that we looked at, and as far as you're aware then you recollect that one of the staff members was suspended and you then had to go and attend a hearing.

A. Yeah. 11:21

83 Q. In relation to the investigation. Turning overleaf now to page 8. And you recall this about the hearing then:

"There was a Band 8B from the community and H758 present to Chair the hearing. From memory there were 11:21 two others with him on the Panel..."

- but you don't remember their names. Also in attendance was H77, yourself, staff member, and their union rep. You weren't given any information prior to 11:21 the hearing about its structure, and you say it was awful, and you weren't expecting that staff member, who was the subject of it, to be there in such close vicinity to you. You remember that you sat beside one another and you remember that staff member saying that 11:22 what they had done to the patient was a joke. They denied it was intentional. And you recollect then H758 asking you questions. You don't know why you were all in the same place together, but you know now that from a safeguarding point of view that's not how it should 11:22 have been done.

Perhaps the answer to this question is somewhat self-explanatory, but what was it about the hearing

that was awful? What in particular?

A. Going into the room, seeing the person, and then being sat beside the person. Their union rep was quite aggressive and, to be honest, I was quite blind-sided. H77 had sort of said that I would be going in and sort of chatting or discussing with the Panel, like with the safeguarding panel, and he himself wasn't aware that that was going to be the setup. 11:22

84 Q. Yeah.

A. So I was quite blind-sided. Something that was really really stressful and difficult to manage and then being sat down beside her was... 11:23

CHAIRPERSON: So can I ask you a bit more around it? Did you have to write anything down or make a report before the hearing? 11:23

A. Not that I recall. I remember I had to do a statement. So I had to do a statement for the Trust.

CHAIRPERSON: Right. Okay. Yeah.

A. But I don't recall at that time doing any writing, but I think... 11:23

DR. MAXWELL: Did you fill in an incident form?

A. Oh, yeah. Yeah.

DR. MAXWELL: You did.

A. Yeah, yeah. So the evening that that happened there was an incident form filled out, and that was all documented in the daily notes, that was we were doing paper notes then, so that would have been documented with the number of the incident form, whatever the -- we would give -- 11:23

DR. MAXWELL: Did you write in the patient's notes?

A. Yes.

DR. MAXWELL: You did.

A. Yeah.

DR. MAXWELL: Okay. 11:23

CHAIRPERSON: And were you asked to say anything? Did you have to speak at the hearing?

A. I can't really remember. I think I had to sort of say what had happened or my, do you know, I think that's -- I can't really remember, but I think it was more kind 11:24 of just sort of going over what had previously been said in the statement.

CHAIRPERSON: And did you have any support from anyone at the hearing.

A. Well, H77 was very supportive at that time, but I 11:24 suppose I kind of was a bit green, for the want of a better word, then I didn't really know what to expect, so I kind of just went in, took H77 at the word of like 'this is going to be fine, this is standard, don't be worrying about it', so I didn't feel that I like 11:24 probably -- I don't know, but I don't think I needed anybody.

CHAIRPERSON: And just finally, where did the hearing take place?

A. In the admin building in the hospital grounds. 11:24

CHAIRPERSON: Within Muckamore?

A. Mhm-mhm. Yeah.

CHAIRPERSON: Okay. Sorry to interrupt. Thank you.

85 Q. MR. McEVOY: Just picking up with the Chair's question.

You say in your statement that H758, who was I think the Chair, asked you questions at the hearing.

A. Mhm-mhm.

86 Q. What were the -- can you remember anything about the tone of the questions, the way they were asked? 11:25

A. No, I think -- from memory I think like there wasn't anything, it was just sort of more 'can you explain, or can you tell me?', I think it was more that sort of, 'you've said here, what about', you know, just sort of explaining over the statement, from memory I think 11:25 that's what it was.

87 Q. And you told us a moment or two ago that the staff member's union rep was aggressive?

A. Yeah.

88 Q. How were they aggressive? 11:25

A. Just in their mannerisms, like how they were speaking, you know, quite curt like sort of to me, or like proposing that it was a joke and that I was overreacting, you know, things -- like that was the sort of gist. 11:25

89 Q. Was that through the Chair as opposed to directly to you?

A. Well I was sitting here and those two were sitting there. (Demonstrating). So I kind of felt it might have just been directly at me. It wasn't like 'Chair, 11:26 can I say?'. It wasn't that sort of formal.

90 Q. Right.

CHAIRPERSON: Just for the transcript you're saying you're sitting next to each other.

A. Yeah. Yeah.

CHAIRPERSON: Yes.

MR. McEVOY: I know you they were in close vicinity, but I suppose the Inquiry Secretary --

A. If you didn't know -- like I would have been closer to them than what Jaclyn is to me now. 11:26

91 Q. Okay.

CHAIRPERSON: So within a foot or two?

A. Yeah.

MR. McEVOY: You say then that staff member was able to return to work. You don't know what ward that staff member went back to work on... 11:26

A. Mhm-mhm.

92 Q. Or whether any restrictions were put in place for that staff member, but you had an idea that they weren't allowed to work with that patient again? 11:26

A. Yeah.

93 Q. The other staff member was not suspended, but was moved wards, and you're not sure to where. After the hearing then you recall that H77 got you a cup of tea and he did that as you were so distressed during the meeting and it was a much appreciated support. You say: 11:26

"The whole incident would have made me never want to report anyone or anything again. Notwithstanding this feeling I would have reported incidents had I needed to, but thankfully I did not have to." 11:27

So in other words, although it was awful, it didn't put

you off your obligation?

A. No. As I said earlier I have a registration of the NMC to uphold.

94 Q. Yes.

A. So no matter how difficult something is, you have to do it. 11:27

95 Q. Yes. You go on and you say:

"If I had been a newly qualified nurse I'm not sure how I would have handled this situation." 11:27

A. Mmm.

96 Q. Can you tell us more about what you mean by that?

A. Yeah. I suppose when I first qualified I worked in a nursing home for a 13 months, had a bit of a difficult time, so probably built a bit of resilience and a bit of managing or dealing with long members of staff. There was a particular -- I'm thinking of one in particular that I did have an issue with a member of staff that had been there for a very long time. So for the want of a better word, I probably got a bit of a thicker skin to manage these sorts of things. And then when I worked in the community, before I came to Muckamore, I just had had good experience and had good, good examples. Like I worked with good nurses, you know, so I suppose from then I kind of gathered strength from that, that I had to do the right thing, you know. But as a newly qualified Staff Nurse I would have done it, but I'm sure that I probably would have 11:27 11:27 11:28

ended off needing going off work sick with the stress of it sort of thing, you know. But I suppose as time went on I had been -- I think I was qualified maybe two and a half years at this point, I had sort of built enough resolve. 11:28

97 Q. Yes. And thinking back to the point you made, I know it's a bit further back up in the same paragraph, but thinking back to the point about safeguarding?

A. Mhm-mhm.

98 Q. How do you think that the meeting, thinking back on it, should have or could have been better handled? 11:28

A. Well from my experience now of working, when I worked in the community we would have been investigating officers with the adult safeguarding.

99 Q. Yes. 11:29

A. And I have been involved in interviewing staff that have had an allegation made against them, and it would never occur to me to put the staff that made the allegation in with the alleged perpetrators. So from experience now, I don't think -- well that wouldn't be done, but I don't know. 11:29

DR. MAXWELL: Can I just clarify? This was a disciplinary hearing, not a safeguarding investigation?

A. From my understanding, my memory, I think it was safeguarding, because that H758 was the DAPO at the time. 11:29

DR. MAXWELL: So there wasn't a disciplinary hearing that you were involved with?

A. Not that I was involved with.

DR. MAXWELL: And you think this was?

A. Safeguarding.

DR. MAXWELL: A safeguarding. And did the safeguarding meetings have hearings normally?

A. I'm not sure. This is the only time that I've ever been. 11:29

DR. MAXWELL: Okay.

A. Unless it was rolled -- like unless it was a safeguarding and a disciplinary into one, but I don't think... 11:30

DR. MAXWELL: It seems unlikely because they're two very different processes.

A. Yeah, but H758 was -- he wasn't the DAPO at the time, but...

DR. MAXWELL: Well, we can check. 11:30

A. Yeah. Okay.

DR. MAXWELL: We can check what the meeting was.

100 Q. MR. McEVOY: Yes. And I suppose just to clarify, you've used the phrase throughout "hearing" as opposed to "meeting". 11:30

A. Yeah. Well that's -- yeah.

101 Q. Okay. You have described then in your statement about your recollection from your training at Queen's. At no point in your training at university had we covered or been prepared for conflict within the work place. 11:30

A. Mhm-mhm.

102 Q. Did you get any -- had you any education, nursing education, about safeguarding and whistle-blowing?

A. Well we would have had to attend the mandatory training

for safeguarding, that would have been part of our mandatory training and part of the induction. When you started you had to get all your mandatory training up to date.

103 Q. Was that at Queen's as an undergrad? 11:31

A. No, no, as a Staff Nurse.

104 Q. As a Staff Nurse. Thinking back though to your undergrad training?

A. I'm sure. I couldn't say for definite, but I'm sure we did touch on safeguarding. But, honestly, it's that 11:31 long ago I couldn't say.

105 Q. And you go on and you say:

"I think after this incident I attended Belfast Trust training which probably would not have covered the 11:31 stress endured being a whistle-blower."

What was that training?

A. I think it was -- to be honest it was that long ago I can't really remember, but I think it was more sort of 11:31 your role and responsibility as a member of staff and having to whistle-blow. It wasn't sort of like the emotional support that you would have, do you know, it was probably not, you know, I think from memory it was more sort of like the whistle-blowing policy and you 11:31 had a duty to whistle-blow sort of thing, and kind of I think -- I don't remember really what else.

106 Q. Yes. Thinking back now to that experience, and I think you've described, you've used the phrase

"whistle-blowers" there and training and understanding of whistle-blowing and what it means. Given your experience, are there any steps that you would sort of propose or put forward to make the process more -- something that's simpler to understand as a staff member, and a current staff member the Trust?

A. I don't know. I don't know if I could think of something off the top of my head. I think just...

107 Q. In terms of the stress, for example, that you encountered? 11:32

A. Take some time off! I don't know. I suppose I was kind of lucky in the fact that I did have good emotional support. H188 would have been very supportive.

108 Q. Yes. 11:32

A. And H77 would have been very supportive. A couple of occasions following that I got phone calls to the ward saying "Come over here a wee minute", and it would have been just to take me off the ward to sort of go over, just as moral support. 11:33

109 Q. Yeah.

A. And I remember H188 leaving a bar of chocolate on the table as a way of sort of like 'this will be all right', sort of thing.

110 Q. Yes. 11:33

A. But I'm not sure what, as a current staff, I don't really know how you would ever anticipate that level of stress, you know. I don't know, you know, like if I was to do that next week, I'm not sure I would feel the

same stress, or the following week I would feel more stress.

111 Q. Yes.

A. I'm not sure how you could ever be fully prepared or anticipate the level of stress and sort of like the consequences. 11:33

112 Q. Could training and awareness raising about whistle-blowing and the policy, the Trust's whistle-blowing policy, address those sorts of things? Could it address the stress that you might feel? 11:33

A. I don't think so. I think I would -- I don't know. I don't think so. I think like it would be very generic sort of 'Whistle-Blowing, this is the policy', you know. Whereas like I might be more emotional today than I would be next week, or somebody else might go 'Well, actually, that's my job, I have do that', do you know. People might be more matter of fact about it. I'm not sure. You know, one size wouldn't fit all. So I'm not sure how you could do that, you know? You can give the basis and sort of the policy, but I'm not sure how you would encompass people's emotional. I'm not sure how. 11:34 11:34

113 Q. Yes.

PROFESSOR MURPHY: Might it have helped though if somebody had spoken to you about what to expect from the hearing? 11:34

A. Pardon?

PROFESSOR MURPHY: Might it have helped if somebody had spoken to you about what to expect from the hearing?

A. Yes.
PROFESSOR MURPHY: Because it sounds like you didn't have any preparation for it.
A. H77 had said, 'Well, we're going in here H758 will just be asking you a couple of questions. It'll be basically on your statement. Like it'll be fine. It's just sort of more of a straightforward thing here, don't be worrying about it', so at that level I kind of thought 'well, this is just something straightforward.' Had I of known that the other people were going to be in the room it would have been slightly different and possibly needed more preparation or support around that. But H77 stated at the time that he was as shocked to see the people as I was. 11:34 11:34
CHAIRPERSON: There seemed to be two sides to this, that if you were less resilient might have put you off reporting anything again. One was the immediate reaction. 11:35
A. Yeah.
CHAIRPERSON: After you had called this out, from other members of staff, almost, you say all other members of staff on the ward. And the second was the way that you were treated, or the surprise that you got at the way that the hearing, whatever the hearing was, was conducted. 11:35 11:35
A. Mhm-mhm.
CHAIRPERSON: Is that fair?
A. Sorry, what was?
CHAIRPERSON: So there's the two aspects that have so

troubled you.

A. Oh, yeah, addressing it and then -- yeah, yeah, sorry, yeah.

CHAIRPERSON: Yeah. And you said well, you know, you're quite resilient now and because you're registered you would certainly report something again. 11:36

A. Mhm-mhm.

CHAIRPERSON: But it may follow from that, that a less resilient person, whether registered or not, might be put off. 11:36

A. I could see why people would be put off. I would be disappointed though if they weren't, you know, when you're working in learning disability you're advocating for the vulnerable people, do you know, that you're working with, and I'd be really disappointed if people didn't. And I suppose having the nursing registration, you have do it, whether it's a nice experience or a terrible experience. I could see why people would be put off, but I don't see why they would be working in that field if they wouldn't be advocating for their patient to the best of their ability. 11:36

CHAIRPERSON: But you did say that it was both unregistered and registered people who reacted badly towards you, or poorly towards you.

A. Mhm-mhm. 11:37

CHAIRPERSON: When you returned to the ward.

A. Yeah.

CHAIRPERSON: Can I just ask this about whistle-blowing? Was there anybody that you were

given, as it were, to go and speak to if you did have any safeguarding concerns?

A. The H188 was the safeguarding officer for our particular ward.

CHAIRPERSON: So that's who you would automatically. 11:37

A. Yeah. Yeah. And then you would have phoned and then says that you're putting -- if there was an issue -- I can't remember what the form was, but it would be an APP1 now. I can't remember what it was called then. But you would be phoning and discussing it to make sure 11:37 if it is an appropriate referral to put it in. But like H188 would have been very, he would have been a good point of contact.

CHAIRPERSON: Okay. Thank you.

114 Q. MR. McEVOY: Just before we leave this point and I 11:37 think it already has been touched on, but you say that you were lucky to have H188 and H77 as people to give you moral support, as you described it. And I suppose in other circumstances you might not have been so lucky to have had those people as your managers to speak to. 11:38

A. H77 wasn't my manager.

115 Q. Of course.

A. It was just I needed support and I was ringing him, do you know.

116 Q. Indeed. You were fortunate just to have access to 11:38 those people?

A. Yeah. Yeah.

117 Q. If you hadn't been so fortunate might it have changed your view about the experience?

A. Well, it probably would have been much more negative view on it.

118 Q. Okay. Leaving that issue for now then, you go back to talk about the atmosphere on the wards. You say it was generally good but always depended on people. I'm at paragraph 20 now at the bottom of page 8: 11:38

"Some staff would be worriers."

Would you describe yourself as a worrier? 11:38

A. Not really.

119 Q. Okay. What would they be worrying about?

A. Well I think when I was making that comment I was thinking of a couple of people would have been worrying about like fussing, making sure that the breaks were 11:39 allocated before, you know. Whereas I would have been very much about 'Well, let's get everything sorted and then we'll look at the breaks or look at the staffing situation', whereas there was a couple of older ladies that I would have worked with would have been running 11:39 around with the allocation sheets going 'Oh, everybody' -- and like everybody did get their breaks, they might not have just been like 10:00 o'clock, 10:30, they might have been getting it at 11:00 or just slightly after, and like people might have been panicking, just 11:39 because the wards could be tense just.

120 Q. Just on the allocation sheets, since you mentioned it, and I was going to come to it.

A. Okay.

121 Q. What is the allocation sheet?
A. Allocation sheet would have been, so for talk's sake, it would have been done on daily basis and the allocation sheet was to allocate tasks to staff. So that would have included the nurse in charge, the back-up nurse, and the people that were going to be allocated to the groups. So the patients would have been grouped into Group 1, 2, 3, and 4, for talk's sake, and then the levels, which would have been people that would have required the one-to-one Level 3, so that would have been all. So you could have went in and looked and it would have been in the office. So at the start of the shift... 11:39 11:40
122 Q. Just slow down just a wee bit.
A. Oh, sorry. 11:40
123 Q. You're okay.
A. So at the start of the shift people would have come in and looked at the sheet, and then they would have known where they were allocated. So I would have looked at that and says 'Right, well I'm allocated to so and so', or whatever group, 7:25 to 9:00 o'clock, knowing that they were going to the day care, or a Level 3, 7:25 to 13:00 hours, or you could have been the nurse in charge and then you would have known then that you were taking charge of the wards, you were doing the medicines, you had to phone over to the nursing office if you needed staff, you had to contact the doctor, you looked in the diary, you know. But that would have been all allocated so that at any one time anybody could have 11:40 11:40

just looked at that and said 'Right, well I'm looking for so and so. They are on Group 2, so they should be down where Group 2 are', or they're allocated to Level 3 so and so, they will be down in that room. So it was... 11:40

124 Q. And were allocation sheets hospital wide?

A. Yeah, like all the wards would have had them, yeah.

125 Q. Okay.

DR. MAXWELL: Can you explain what a back-up nurse is? You just said -- 11:41

A. I suppose we would have been very lucky to have back-up nurse.

DR. MAXWELL: But I don't know what it means.

A. Yeah. No, a back-up -- it was just literally a second registered nurse that was on the shift. 11:41

DR. MAXWELL: So there sometimes only be two registered nurses on duty?

A. Mhm-mhm.

DR. MAXWELL: And from what you're saying sometimes only one. 11:41

A. Yeah. Yeah. So in Greenan we would have had two medicine trollies, and one of the times it took I think about three and a half hours to do the medicine round, so then we split it into two medicine -- like split it properly into two medicine trollies so that the nurse 11:41 in charge would have done one and the back-up nurse would have done it.

DR. MAXWELL: But it would have been -- it wouldn't have been unusual only to have one registered nurse on

the shift?

A. It didn't happen very often, but it had happened, yeah.

DR. MAXWELL: But you told us earlier that there were groups of registered nurses sitting in the office.

A. Well, that was M4. Sorry, I'm speaking about -- I'm just sort of referencing Greenan. 11:42

DR. MAXWELL: So in Greenan there was a lower number of registered nurses because this was a ward for people who were stable and waiting for community placements?

A. Ehm, yes, and I suppose -- I think as well not a lot of people wanted to work in Greenan because it was deemed to be a heavy ward, you know, there was a lot of -- 11:42

DR. MAXWELL: Physically heavy.

A. Physically heavy, yeah. And I think, you know, at the start of the statement when I was offered to go there rather than Donegore, they were shocked that I had said I would rather go there and stay there if I could, just because I had experience of there. 11:42

DR. MAXWELL: So it was harder to recruit to Greenan than it was to M4? 11:42

A. I think so. Well, just I think if people had of been given the option they would have rathered not worked in Greenan.

DR. MAXWELL: Thank you.

126 Q. MR. McEVOY: In 23 you say that you always felt supported in your role at Muckamore. H154 was very supportive, you say. 11:42

A. Mhm-mhm.

127 Q. And you give an example. When you were getting married

she made sure you were made exempt from relief duty.

A. Mhm-mhm.

128 Q. Where staff members would have to go to other wards which were short staffed, and you explain that the reason why she made sure you were exempt was so that you didn't get injured before your wedding. 11:43

A. Yeah.

129 Q. On the run up to your wedding there were significant injuries to many staff in the ICU, including serious facial injuries. 11:43

A. Mhm-mhm.

130 Q. Can you give -- thinking back, can you give a reason why there might have been so many injuries to staff in that period? And I suppose there's a second part to that same question. 11:43

A. Okay.

131 Q. The fact that so many assaults were happening, did that affect staff behaviour towards patients, staff interactions with patients?

A. The particular patient that was causing these injuries had been moved. I'm not sure what I can say. Can I just... 11:43

132 Q. Well, don't name the patient, but I think you can --

A. No. So he had been -- this patient had been moved from the children's services up. I think now slightly, I think from memory slightly before his 18th birthday, because he was so challenging. Subsequently has I think gone to be nursed in England, which has -- he required like a higher security, sort of like a high 11:44

secure.

DR. MAXWELL: So it was known before he came to MAH that this patient had particular difficulties and challenges. Did the Trust ensure that there were additional staff? 11:44

A. To be honest, I don't know. It wasn't my ward. But I know, because I know people, that staff would have been sent from the children's up with him because they were familiar with him.

DR. MAXWELL: Okay. But that may not have meant there were enough staff. They were moving him because they couldn't manage him there? 11:44

A. Yes, I think he had caused a serious injury to another child.

DR. MAXWELL: Yes. No, my question is not about his behaviours, it's about the response of management to that. Did they recognise this was a high risk patient and, therefore, needed maybe a different skill set, or more staff, or both. 11:45

A. No, I think it was maybe a week before his 18th birthday, and I think naturally they felt that he was going to be nursed in ICU. 11:45

DR. MAXWELL: I understand that. But when he got to Muckamore was there a recognition that he was a higher risk patient than some others, and probably needed more and different staff support? 11:45

A. I don't know. I wouldn't have -- I was only ever in ICU as a relief staff.

DR. MAXWELL: So you weren't working in ITU, but

nevertheless it was decided that because of your wedding you should avoid injuries, particularly facial injuries. Does this mean that there were patients on your ward who were injuring staff?

A. Well on Greenan, the ward I worked in, people would have been getting their thumbs -- there was a couple of thumbs broken, but that would have been like sort of the most extreme injury. 11:45

DR. MAXWELL: So why was there a need to make sure you weren't injured before your wedding? 11:46

A. Because the -- I think on the couple of weeks before my wedding there was a female member of staff had her nose broke, another had her cheek bone --

DR. MAXWELL: On your ward?

A. No, no, no, in ICU. So it was to prevent me from going to any other ward. So I wasn't being sent out on relief because the injuries were so significant. 11:46

DR. MAXWELL: Okay. Thank you.

133 Q. MR. McEVOY: Okay. You then go on, well you confirm then that at paragraph 25 you weren't involved with the admission of patients to the hospital. The wards you worked on had long-term patients. 11:46

Then in 26 you say that you don't recall ever having had any issues with family members visiting the wards. Greenan was an open door ward and families could come and visit when they wanted because they would have the code. M4 was locked, but families would just ring the bell and they would be shown to the visitors room. 11:46

"It would not have been appropriate in some of the wards for family visitors to go in to the main day areas as it would potentially have been a risk to them."

That's Moylena you're talking about there?

A. Yeah. Yeah.

134 Q. Yeah:

"Sometimes family would ring ahead to let us know they were calling up and if they were taking the patient out or not."

There were minor issues around clothing, you say, but never anything serious. What type of minor issues do you mean?

A. Like stuff would have went over to the laundry and then maybe would have taken a couple of weeks to come back, or it would have been sent to another ward, so then it sort of would have went round the hospital by the time it came back. It was mostly if you had knowledge of the hospital you would have known what ward to send the clothes back to. Or socks were always a difficult!

135 Q. Yes. We've had evidence in the Inquiry from relatives.

A. Yeah.

136 Q. Who described the stress about clothing items going walkabout within the hospital, and things going missing, and spending money, quite a lot of money in

some instances, buying nice items of clothing for their family members and then those things going missing. Do you recall family members being distressed about that?

A. Not in my wards.

137 Q. Yes. 11:48

A. So as I was saying earlier on about being the named nurse, we would have had to have an inventory of all the items of clothing that each patient had and that would have been like randomly checked.

138 Q. Yes. 11:48

A. So like the Ward Manager, or she could have sent you to go and check to make sure that so and so, all the items are there, and like we would have kept an inventory on the ward of the people's belongings. Not sure why that might not have been the case on other wards. 11:48

139 Q. Yeah.

A. But we didn't really have anything other than like socks going missing, or maybe not the pairs. Like that was -- do you know, we didn't have anything.

140 Q. Yeah. 11:48

PROFESSOR MURPHY: Was there still a centralised laundry?

A. So for the rest of the hospital -- we would have used the centralised laundry, but the like of Cranfield, Cranfield would have had a like a laundry service on site. So from memory -- 11:49

PROFESSOR MURPHY: Because it was a newly built ward?

A. Yeah. Yeah, yeah, yeah. And I suppose that was with the view that all the other buildings were going to be

obsolete and then they were going to be self-sufficient and have their own laundry. But we, in Greenan and M4 would have used the centralised. So it would have been taken away. You would have left the bags out in the, we had like a big shed out the side of the ward, and we would have left the bags there and they would have been collected and then the laundry would have been delivered back to the ward. 11:49

PROFESSOR MURPHY: So your laundry was in a bag labelled with the name of the ward? 11:49

A. Yeah.

PROFESSOR MURPHY: Was it so that that was the only way they could prevent --

A. Well, in the long stay wards all the patients had their item of clothing personalised with their names. So say for talk's sake I bought 10 new items for a patient, I would have got the marking book, we had a marking book, and would have written 'pink jumper, blue jumper', blah-blah-blah, for whoever, and then sent that over for marking. So like the industrial labels, you know, they would have been hard washing, you know, they wouldn't have come off. And that's how -- like so that would have went in the bag for Greenan, and then when they came back, all the stuff, and that would have been a ward duty then to sort out the clothes and then put them all in people's wardrobes or drawers. 11:49 11:50 11:50

CHAIRPERSON: So there was a system on some wards for tagging the clothes?

A. Yes.

CHAIRPERSON: Physically putting a tag on each article of clothing?

A. Yes. So we would have sent it out to the laundry with the marking book, and that was -- so the purpose of the marking book was to get the labels put on it. However, I know that the feeling was that was very institutionalised, and I know -- it's very institutionalised. However, that eradicates the risk of losing clothes, you know. It's a kind of Catch 22. But I know like in the newer wards, I remember being on relief in Cranfield Men and a particular male patient, a family member was going do his laundry, and he had soiled himself, and I ended up having to put on like Bermuda like swimming shorts on him, because that was the only items of clean clothing that he had. It was -- I had to go back to the staff and went "I'm really sorry, but that's all that he has in his drawers", so they had said that they were going to contact the family to say that he needs -- I think the family, or the mummy or somebody would have come up and visited him a couple of times a week, would have taken the clothes home. But I think on the newer wards they were trying to move away from that.

11:50 11:50 11:51 11:51 11:51

CHAIRPERSON: Right. So on some wards there was tagging?

A. Yeah.

CHAIRPERSON: On others there wasn't. Did it depend on whether the clothing was going to go to the central laundry or not?

A. I don't think so. I think -- now, I'm not sure, I might just be making -- I'm not sure if this is accurate or not, but I think the idea was that the like of Cranfield -- so initially Cranfield Women's, Cranfield Men, and ICU, that was the three wards, there was a lot less patients, and because they were sort of newly or newer admitted they wouldn't have had the level of clothes that the other ones in the other wards would have had, so I think the method behind it would have been, or the thought behind it, sorry, would have been that 'Well, there's six patients there, six patients,there, six patients there', I as a staff member this ward knows each others -- 11:51 11:52

CHAIRPERSON: And you've got an inventory.

A. Yeah. And I think that might have been what they were gearing for. But we were a lot stricter with the inventory in that, you know, I suppose we were maybe old style sort of still doing the institutionalised stuff, but it worked because we had so many clothes. 11:52

CHAIRPERSON: Thank you. 11:52

141 Q. MR. McEVOY: Okay. At the top of page 11 then at paragraph 27, you talk about how, when you went to a new ward, you were given a verbal run down on the patients and their individual skills and the medical file of each patient was made available to staff members. Care plans were recorded in the nursing notes. When you first started in Muckamore you were given time to read each patient's nursing notes. Did that change? 11:52

A. No, I think I was asked just were you, and I says 'yes, I was'.

142 Q. Okay.

A. But like I know if I was doing an induction to somebody, or even somebody was over on relief, that's where like the verbal run down would come from. But if it was a new staff member, you would be sat down and go through it very like thoroughly of each patient. 11:53

143 Q. Okay. Before the PARIS system was introduced these notes were all handwritten, and included in each patient's nursing file were the assessment, activity and care plans, and that was known as the Kalamazoo. Am I saying that correctly? 11:53

A. Yeah.

144 Q. 11:53

"The Kalamazoo consisted of paper notes of approximately 10 to 15 sheets of paper for each patient and that was an easy way to get caught up with all the recent information. Each patient also had a medical file and these were used for the MDT meetings. The files were kept in two cabinets in the office. The doctor would have been aware of any significant changes to a patient's care plan and would have recorded dates in the doctor's diaries if, for example, anything was to be reviewed, such as a patient meeting, a Kardex rewritten or a prescription of medication by the out-of-hours GP, and would also have included any changes in speech and language guidance or occupational therapy assessment." 11:53 11:54

A. Mhm-mhm.

145 Q. Is it -- would the Inquiry be correct in understanding that MDT notes were separate from nursing notes?

A. Yes and no. I suppose any of the assessments, so the like of OT coming onto the ward, they would have had their own folder, but -- like if they of had an assessment, like a copy that of assessment would be carried in the nursing file, and then there would have been like notes I would have written saying "so and so occupational therapist came and visited. See updated assessment", or whatever. 11:54 11:54

146 Q. So the nursing notes would have directed you to the MDT notes?

A. Yeah, yeah, to the new updated. Speech and language could have been updated. But mostly people, anybody writing in the medical notes would have been the doctor, would have been writing in their own. 11:55

147 Q. And would you expect then that you would have been able to see that, see MDT input, regardless of whether there were staffing issues or anything else that might have been getting in the way? 11:55

A. Yeah. Well, we would have contacted -- if you needed somebody, you know, for talk's sake, if we had somebody and an example of you thought they maybe were holding food in their mouth or they weren't eating. 11:55

148 Q. Yes.

A. Like we would have immediately contacted the speech and language, you know, and they would have been over for the next meal time. You know you could have phoned

them at 9:00 o'clock and said -- or you could have phoned them and said 'night duty staff last night felt that she seemed to be not eating well or struggling with the large', you know, or whatever it could have been, and we would have contacted speech and language, and we would have had a good lot of input from the occupational therapists, because at that time they were moving to more like personalised, like really sort of higher tech, higher spec chairs for the people, that they could. So we would have had people would have had wheelchairs and like soft seats to sit in, but that was kind of around the time that there was -- I don't know, from the OT point of view like it was a new, finding that these chairs could be actually sat in all day and it was a wheelchair. So we would have had a good bit of input from the OT, but they would have been on the ward quite often. But anybody, if you had of needed them, you would have phoned them and says 'you need to come for so and so', or whatever. Like there would have, there would have been a lot of input. 11:55 11:56 11:56 11:56

PROFESSOR MURPHY: But the fact remains, from what you're saying, that there were nursing notes, there were medical notes that the doctors wrote in, there were SALT notes, there were OT notes, there were psychology notes, and maybe even behavioural notes, all separate. 11:56

A. Yeah. Yeah. But on the ward what would have been kept would have been the nursing folder. So the nursing file for the person and the medical notes. So the like

of psychology would have kept their folder. We would have had a copy of it included in the nursing notes, but they would have had, like on their, in their own office or whatever their filing system was, they would have had their own notes. And the like of OT, they would have had their own folder for the person and kept wherever they were.

PROFESSOR MURPHY: And is that still the case?

A. In the hospital?

PROFESSOR MURPHY: Yes. 11:57

A. I'm not sure. I don't know. I suppose that was the benefit then of PARIS coming in that everything was centralised, that everybody then could see -- but I suppose that was old-fashioned, that everybody had their own thing, and that was the purpose of PARIS. 11:57 But I would imagine -- well, I know from community that it is all sort of centralised on PARIS and I can go and look, I can do a referral to OT and then I can go and see that the OT has been out and what they've done and what they've recommended. So it is all centralised 11:57 now.

PROFESSOR MURPHY: Thank you.

CHAIRPERSON: When did PARIS come in? I know we've been told this, but I can't remember.

A. Maybe 2014 or 2015. 11:57

CHAIRPERSON: Right. Around then. Okay.

149 Q. MR. McEVOY: Okay. Then you go on to talk about your experiences with the patient sort of on a general level. The more you got to know a patient the more you

understood about them, behaviours, changes in mood. Some patients would decline around the anniversary of the death of a loved one. One patient you recall who would get excited on a Friday as their mum would come and visit on Saturday. Others might present as having symptoms of dementia, but it might have been a symptom of something else, for example, UTI. In Greenan, and I think you told us about this: 11:58

"In Greenan the ward patients did not tend to have challenging behaviours, but there were occasions when staff on Greenan had their thumbs broken by a particular patient. M4 Moylena was slightly more challenging." 11:58

You were trained in MAPA as a Band 5 nurse.

"On M4 you didn't use MAPA, but it was required on the ward." 11:58

In other words, used by others and not you.

A. Mhm-mhm.

150 Q. "In Greenan the PRN medication that would have been administered would mostly have been paracetamol and either a 1g or half a milligram of Lorazepam. This was one patient in particular and would have requested this herself if she felt she needed it." 11:58

Was that the case with most PRNs, that patients, and I'm thinking about Greenan here...

A. No. So in Greenan a lot of them wouldn't have had -- see like that Lorazepam, from memory it's -- I'm just thinking of one person in particular, and she says like 'Will you give me a wee point 5 there'. 11:59

151 Q. Right.

A. Because she was feeling a wee bit stressed.

152 Q. Yeah.

A. And she would have requested it, and you know she wouldn't have -- 11:59

153 Q. She knew?

A. Yeah, she knew. She would have been the one that was breaking the thumbs.

154 Q. Right. 11:59

A. So she would have come back and been very remorseful and says 'Oh, like if you give me that I'll be all right now', sort of thing.

155 Q. Yes.

A. But she would have been the only person, other than somebody, like anybody else it was Paracetamol, do you know, and you would have done that, do you know, if you felt they were displaying that they may well have had a headache or a temperature or anything. It was just about knowing the patient. But she would have been the only person that would have verbally asked for anything. 11:59 12:00

156 Q. But PRN was more of a feature then on Moylena?

A. M4, yeah.

157 Q. Yeah.
A. Yeah. Yeah.
158 Q. Higher doses were given, but you can't recall more specific details?
A. No, I can't. I just remember just looking at it, going 12:00
'this is very different', it was very different clientele.
159 Q. Right. Yeah. Okay. I'm just at the top of page 12 now:
12:00
"As Staff Nurses we would have been there to review the use of medication and discussed it with doctors about reducing it if the patients didn't need it. When PRN was prescribed to the patients it was always a clinical decision led by the doctors following discussion with 12:00
MDT. If a patient required PRN it would have been recorded on the patient's Kardex by the relevant Staff Nurse and talked through at the handover at the end of the shift as well. We would have monitored the behaviours of patients as they happened and then would 12:00
monitor and record why they happened, if we knew the reason. For example, if there were any contributing factors such as the noise level on the ward that might have caused the patient to request the medication."
12:01
Was that the practice? In other words, was that done all the time? It was something that was done -- in other words you would have sought to put a reason down?
A. Yeah. Well I suppose for anything behaviour wise, you

know.

160 Q. Yeah.

A. Like you were always sort of thinking, like we would talk about the ABC, what's the antecedent, you know, there was always a cause. 12:01

161 Q. Yes.

A. So it wasn't just somebody decided to do whatever, you know, we would always look and see 'Right. Well actually it was because so and so and so and so was there.' 12:01

162 Q. Yes.

A. Or if the OT had been in, you know, and they had been irritated by a high like sort of footfall on the ward.

163 Q. Yes. So you would expect to see a reason for the PRN. There was never -- you don't recall ever seeing gaps? 12:01 In other words, no reasons.

A. From experience, no. No, it would have been -- you would have had to explain why you were...

164 Q. Okay. Thank you. Then at paragraph 30 you talk about the nursing assessments carried out annually or when 12:01 required in both Greenan and Moylena. If there was a physical deterioration and it was clear, that would cause an assessment. You talked earlier on in your evidence about noticing physical deterioration, especially maybe when resettlement came on to the 12:02 equation.

A. Yeah.

165 Q. Would an assessment have been done at that stage? Would there have been a need for a reassessment if you

had noticed --

A. Oh, if there was any change whatsoever. So the assessments would have been -- the reassessment would have been done yearly, but if there was any sort of change whatsoever, that would have triggered reassessment. 12:02

166 Q. Okay. And then a little bit on down in paragraph 30 you talk about audits on Greenan and Moylena carried out by the ward managers. Can you tell us just what the audits involved, in broad terms? 12:02

A. I suppose from memory, I remember in Greenan there being an audit to make sure that the care plans were up to date. I remember there being a financial audit to make sure, like because you were dealing with quite a lot of money. 12:02

167 Q. Yes.

A. So we were making sure that -- we would have had -- we had folders for everything, but we would have had a folder for like the paper, but there were like you know the carbon copy, there would have been three. One went to the cash office, one went I think on the file, and one went -- I can't remember actually on our thing, but we would have had the pink form, I think, and would have stapled the receipts for the purchases. So I would have requested £200 for clothes and then I would have had to make sure then that the receipt tallied up. So like there would have been a lot of financial audits. I remember being on the ward when pharmacy were doing an audit to make sure, you know, we had 12:03 12:03

Oramorph on the ward. So that sort of...

168 Q. That's a strong --

A. Yeah, it's liquid morphine.

169 Q. Yes.

A. So it was for oral morphine, sorry. Or for a PEG, sorry. But like we would have had medication audits as well. I can't remember how often, but the head pharmacist would have come out and he would have looked at the controlled drugs book, and that would have incorporated then looking to see where the controlled drug key was kept, you know. So one of the times then we didn't have controlled drugs on the ward, so then our controlled drug key would have had to be kept in the nursing office, because it wasn't appropriate for it to be kept on the ward, which we all learned when the pharmacist came out! But other than that, if there was controlled drugs, the nurse in charge had to have the controlled drug key. 12:03 12:03 12:04 12:04

DR. MAXWELL: Can I ask about the care plan audits? So was that using a particular audit tool? Was there a written document?

A. Well, I'm not sure what she would have been doing, but from memory then it would have been mentioned in the notes, from memory, like "care plan reviewed today" and whatever discontinued, you know, on the nursing notes. But in the care plan itself it would have been making sure things -- some of the stuff you would have seen in the care plans would have been maybe from like years before like and somebody has physically deteriorated, 12:04

that they wouldn't be -- that wouldn't be a risk anymore, so it wouldn't have necessarily needed to be in --

DR. MAXWELL: So this was a review of an individual patient's record? 12:05

A. Yeah, yeah, yeah.

DR. MAXWELL: Rather than an audit of all the records on the ward at a point in time, to make sure that they got all the entries, all the risk assessments done?

A. No, I think it was sort of more like -- 12:05

DR. MAXWELL: As a review.

A. Yeah, more of a review, when she would have been auditing to make sure that they were up-to-date.

170 Q. MR. McEVOY: Okay. At 31 then: 12:05

"For both Greenan and M4 treatment plans were not used as the patients were long stay patients and were not receiving treatment."

I suppose, the person out on the street, or a member of 12:05 the public following the Inquiry might say 'Well, if they were long stay patients and weren't receiving treatment, why were they in hospital?'. Can you help us with that?

A. Yeah. Well that's why then with government papers of 12:05 the resettlement and the closure of the long stay hospitals, I suppose in the 50s and 60s a lot of these people would have been admitted to Muckamore over the years, with the downsizing and the sort of introduction

of more community placements. I think it was to do with funding why there was a lot of people held up not getting out to the community earlier.

171 Q. Yes.

A. I suppose they were being looked after and receiving nursing care, but that could have been met in a nursing home. 12:06

172 Q. Yeah.

A. But it was just at that -- well when they were admitted, that was the sort of standard procedure, that people would have been admitted to long stay hospital if their family couldn't provide the care that the person required, or sometimes people just were sort of advised to bring their loved one to a long stay hospital where they would have been getting at a time treatment, or what was deemed to be treatment in the care place. 12:06 12:06

DR. MAXWELL: Can I ask what's the difference between a treatment plan and a care plan?

A. Yeah. They asked about like with the new -- I think it was in relation to like the newer... 12:06

DR. MAXWELL: The what, sorry?

A. The newer people that had been admitted, or they're supposed to be -- from what I know was they were like under a treatment plan of like 'Right. Well you're here for six weeks' assessment', and then if they were going to review that, like that sort of treatment plan. 12:07

DR. MAXWELL: So is a treatment plan a separate document from a care plan?

A. Not that I know of. I don't think so. I think that's just been worded not...

DR. MAXWELL: I'm struggling to understand.

CHAIRPERSON: So was there a question of timing? Did a care plan become a treatment plan. 12:07

A. No, they asked me were they under any treatment plans? I think it has just been a misunderstanding with whoever --

DR. MAXWELL: Oh, the Inquiry asked?

A. Yeah, yeah, they asked me, and I said that -- 12:07

DR. MAXWELL: So we need to --

A. -- they weren't under any treatment plan.

DR. MAXWELL: -- wonder what we thought it meant.

A. I felt what they meant was like the newer wards or the newer admitted people were there for -- they obviously 12:07 weren't going to be there for 40 years. So what I think that they were meaning was like, so for somebody being admitted they're likely going to say 'Right, you're going to be assessed for six weeks and receive treatment for six weeks', and that's part of their 12:07 treatment plan.

DR. MAXWELL: So everybody had a care plan?

A. Yeah.

DR. MAXWELL: Regardless of whether they were actively on some programme or not? 12:08

A. Yeah. Yeah.

DR. MAXWELL: And the decision about what sort of interventions they would receive would be discussed at the MDT meeting?

A. Yeah, I suppose. Yeah. I suppose with the longer stay patients, the ones that I worked with, it was well-established that they were just there to be nursed.

DR. MAXWELL: But was there an MDT meeting -- 12:08

A. Yeah, we would have them.

DR. MAXWELL: -- for the longer stay patients.

A. Yeah, we would have had them.

DR. MAXWELL: So had their condition changed and they might have benefitted from, for example, DBT, that 12:08 could have been discussed at the MDT and it could have been implemented?

A. Well I suppose they could have been. But at that time DBT wasn't being offered to the like of the patients. Initially, I think from memory, it was being offered to 12:08 the forensic patients when I worked in Muckamore, and I'm not sure that they would have deemed the cognitive levels of the patients that I worked with on that ward, that they would have either benefitted or been able to fully participate in it. But, no, there definitely was 12:09 -- there was the MDT meetings, and there was discussions, and a lot of the MDTs were held with the community like care manager to be included, so that we were continually trying to plan.

DR. MAXWELL: So all patients had a care plan, but most 12:09 of the patients on Greenan and M4 were not receiving what you would consider to be an active treatment for their condition?

A. No, they were just being nursed and looked after in the

hospital.

DR. MAXWELL: Okay. Thank you.

173 Q. MR. McEVOY: Towards the end of -- the final sentence, in fact, at paragraph 31, bottom of page 12, you talk about how there were certain therapies used, DBT and CBT and so on, and in this final sentence you say that: 12:09

"In M4 and Greenan the patients on those wards were not undergoing any form of treatment or taking part in therapies, other than music therapy or the aromatherapist on sight." 12:09

Is that -- there's no therapeutic input of any description then?

A. I suppose that probably reads, you know, quite negatively, but I think what they were asking was like the like of people maybe on the Forensic Ward that would be undergoing a treatment plan to sort of lessen the likelihood of them re-offending. 12:10

174 Q. Yes. 12:10

A. Or somebody who has been admitted, that, 'Right. Well we're going to provide care, assessment here, adjust medication in the hope that when you are discharged that you can live in the community and don't require readmission', and I suppose that looks negatively that nothing was being offered to these people. But, you know, they were -- do you know, they were there. 12:10

175 Q. Yes.

A. They had been there for 40/50 years. They were being

looked after, they were being nursed, they were attending their day care, you know. If we felt that, you know, we would have had music people coming in weekly, and we would have had -- like they would have had the music therapists coming in weekly, and they would have had people, like we would have paid -- like the ward would have paid for like bands, like people to come in.

176 Q. Yes.

A. And there was the aromatherapist. But I think that just probably looks badly that they're not receiving, but they are, they're being really well looked after. 12:10

177 Q. Yeah. It's just that when you read that sentence and then the sentence at the top of the next page, page 13, the very next sentence says: 12:11

"These patients would have been involved in extreme incidents."

A. Yeah. 12:11

178 Q. And I suppose when you read that --

A. That was actually in reference -- I had picked up on that the other day. That's actually in reference to the -- in the paragraph about the Oldstone Bungalows.

179 Q. Right. 12:11

A. So they -- I'm not sure the flow of that.

180 Q. Okay.

A. But that was do with patients that were in Oldstone that were forensic. So that's what that's actually in

relation to, because I looked at that --

181 Q. So the sentence is out of sequence then?

A. Yeah, that is. Yeah. Because when I seen that, I was like "oh". No.

182 Q. Because when one reads those two together -- 12:11

A. Yeah. No, no, that's -- because that's in relation to the Oldstone Bungalow patients that were of a forensic nature. So that's I think...

CHAIRPERSON: So "these patients" doesn't actually refer to paragraph 31? 12:11

A. No. No, no. It refers --

MR. McEVOY: It refers to the earlier reference about the Oldstone Bungalows.

A. Yes.

183 Q. When you went -- and that's when you went over, I think 12:12 in your evidence, you went over and you were looking after patients on your own, and we talked about that?

A. Yeah. I can't actually see what paragraph it's in.

184 Q. Paragraph 13.

A. 13. Yeah. Oh, sorry. Yeah. 12:12

185 Q. Towards the end that of paragraph --

A. So that's actually in relation to that there, with the forensic patients.

186 Q. Okay.

A. Because that was -- because I remember that when I was 12:12 reading that I was asked about how those people ended up being in the hospital, and I had said that they were of an extreme forensic nature.

187 Q. So 32 should follow?

A. 13.

188 Q. 13?

A. Yeah.

189 Q. The whole of that paragraph?

A. Mhm-mhm. 12:12

CHAIRPERSON: Thank you.

MR. McEVOY: Okay. So we can take up maybe then at 33:

"The patients I worked with in Greenan and M4 would sometimes self-harm." 12:13

A. Mhm-mhm.

190 Q. And you describe one of the patients that you work with who had caused paralysis to her lower body and would pick her skin on the legs which would require them to 12:13 be dressed. Never got the chance to heal. You'd have had to ensure nails were cleaned a few times daily. Some patients were autistic and had ritualistic behaviours. You remember getting hit several times in the face, and head, and shoulders, while doing the 12:13 medication round because a patient didn't get his desired yoghurt. You locked the trolley and brought him to yoghurts to show him the flavours for him to chose one. Was that a typical behaviour?

A. Yeah, that like - yeah. 12:13

191 Q. On those wards?

A. Yeah. Yeah.

192 Q.

"If the ward became very noisy some patients at times

couldn't manage this. One of the key things was to keep certain patients separate on the wards and this would have been recorded on each care plan. For example, the care plan would indicate if a patient did not get on well with another patient or if a patient preferred a quieter day room. I recall there was a patient who would defecate on the floor and smear it due to a sensory need."

Then you say: 12:13 12:14

"The ward staff started to give the patient cream and allowed her to smear the cream on the floor as she liked the feeling and sensation of it and reduced the instances then of the defecating behaviour." 12:14

A. Mhm-mhm.

193 Q. In terms of what you tell us about keeping some patients apart, and the impact of noise on the number of incidents that happened, was there a discussion among ward staff about the possibility of reducing the patient numbers on the ward, like having smaller groups of patients? 12:14

A. That would have probably required them to be resettled or discharged. 12:14

194 Q. Yeah.

A. I think at the time it was the best that we could do. You know historically they would have known that so and so didn't get on with the other one, and like they

wouldn't -- or there may have been incidents in the past and staff would have ensured that they were in different day spaces. But I suppose ideally, yes, reduce. But there was nowhere to move them to.

PROFESSOR MURPHY: But given that wards were closing. 12:15

A. Pardon?

PROFESSOR MURPHY: Given that wards were closing. Surely one of the decisions that could have been made was to have smaller groups of patients?

A. Yeah. Yeah. 12:15

PROFESSOR MURPHY: It didn't necessarily mean they had to be out in the community, although obviously that was the long-term aim. But short-term could not the wards that had been emptied have been used for reducing patient numbers? 12:15

A. There was a lot of empty buildings. Yeah. I think that would probably come down to the staffing then, that if they were to create another ward, or reopen another ward, that they would have to staff it, and I would imagine that that wasn't really in the greater 12:15 plan.

PROFESSOR MURPHY: Do you think that was a financial decision really?

A. I think it was a person issue. They wouldn't have had -- I don't think that they would have had the staff or 12:15 the people to staff it safely. It was probably resources. It was probably a number of factors. I probably think that they probably didn't want to be seeming to be opening another ward, or reopening

another ward, because that would have had a negative look on the hospital, that you were supposed to be downsizing and resettling people, but here we are reopening a previously closed down ward. It would have been deemed that, you know -- we had a lot of negative press that youse were trying to keep people there or youse were against resettling, and I suppose if they were to reopen another ward, I think it would have looked bad. And on top of that I think that resources, financially, and staff, I think there was -- I think it was slightly more complicated than just going 'Right. We'll remove four people from there and put them into another ward', I think that that could well have been considered at a higher level, but I think that they wouldn't have been up for that because I don't think it would have fitted in to what they were trying to do on the downsizing and reducing the number. And I suppose I think like a lot of the wards sort of closed because patients were moving out and they needed to move the staff. 12:16 12:16 12:16 12:17

PROFESSOR MURPHY: Okay. Thank you.

195 Q. MR. McEVOY: At 35, you touch on something we've already talked about, which is meal times, and these were carried out in two sittings.

A. Mhm-mhm. 12:17

196 Q. The first was for the patients who didn't need much help. The second was for patients who required assistance. A level of supervision might have arisen where there was a risk of choking, and staff, all

staff, you say, would have been aware of those risks.

"Staff breaks were staggered to make sure there was enough supervision at meal times. There was one patient who would have swallowed anything, meaning that staff would have had to feed him. Most of the patients would have had speech and language recommendations at meal times, for example chopped food, mashed diets." 12:17

And of course you explain the risks posed by choking in learning disability, and speech and language would recommend different guidance as per the patient's needs and risks. 12:17

I mean throughout our discussion this morning I've asked you on a number of occasions about access to other professionals. I'm thinking in particular about speech and language therapists. Was there regular access to them? 12:18

A. I know in Greenan we did, because it was kind of ever changing, you know, just with the population that we had on the ward. And I suppose I remember good input in M4 as well. But we would have had access to them. 12:18

197 Q. Yes.

A. And it would have been regular enough contact. 12:18

198 Q. Okay. Right. In 36 then again you talk about Greenan, and you describe again, as you have already, about how it was -- you describe how it was an open ward with a lock on the outside to prevent other patients coming

in. There was no seclusion on Greenan or M4. You describe one of the restrictive practices being to lock wardrobe doors to stop patients taking other patient's clothes and belongings. You say there was only one specific time that you recall having to use restraint in Greenan. This was in relation to a female patient who had come over from Cranfield.

A. Mhm-mhm.

199 Q. "She had lost some of her toes due to reported self-injurious behaviour before admission to MAH. When it came to change the bandages on her feet she would not let us and we had to hold her to change the bandages." 12:19

12:19

You say obviously you were trained in MAPA, as you told us previously. You only ever had to use it for this patient. You recall that.

"...the decision was discussed with the doctor at ward rounds. The more you tried to change the bandages without using a form of restraint the more distressed she became." 12:19

And this was all documented in detail. 12:19

"The incident was recorded in an incident report and a body chart and it was reviewed by H209 and the behaviour team. The review determined that the

restraint was justified as it had been previously discussed and approved..."

And you believed the behaviour team looked at this incident and supported staff if there were any other available options. 12:20

I mean thinking back on it, do you think that in the review process there was recognition that this might have been, the process of wound dressing and changing might have been very painful for her, it wasn't just a matter of her being challenging? 12:20

A. Yeah. No, absolutely. If you had of -- like what was under the bandages, I'm sure that she was in pain. However, I suppose we had been informed by the previous care where she was before she came, like what you find in learning disability as well is that a lot of people in learning disability have a high pain threshold, so she probably was able to sustain more pain than you or I, but there was absolutely no issues to say that she was likely in pain. She didn't want to be bothered either. I suppose, and what we had considered as well is that she had just been admitted to Cranfield Women and then taken from there, where she had just been landed in, and I think maybe a day or two later brought down to us, you know, in Greenan. So like all of that was considered that this is so new, you know. So we just -- everything had to be considered that she was -- I think she had maybe been in a nursing home 12:20 12:20 12:21

beforehand, so from a nursing home that she was familiar with, being taken from there, being admitted to the Cranfield Women's Ward, and then being brought down to us. So that was all considered that, you know, this is really distressing anyway without pain, you know, even before we got to the pain she would have been really distressed, because she was in an area that she didn't know with staff that she didn't know, totally unfamiliar surroundings, and then bringing in the distress of having to unravel the bandages. But while trying to do the dressings she would have continued to be banging her feet and her heels, and I am not sure -- like I didn't... 12:21 12:21

200 Q. Does that mean she was at risk of causing herself further injury? 12:22

A. Further harm, yeah, yeah. And I suppose I didn't work with her that long to really know like was it sensory seeking behaviours what they would talk about, as if she was getting something from it, or that there was something -- I think from memory I had heard later on that she was actually physically unwell, and I think when she would have been in Greenan we -- I remember bringing her -- I remember being in Antrim Hospital. 12:22

201 Q. Yes.

A. But I can't really -- that was around the time I think before -- around the time I had kind of went off work, I think. So my memory isn't that good of it. But as well is I don't have a great knowledge of her, but I think there was something physically the matter with 12:22

her, and I think quite quickly when she had been in our ward they were like she wasn't physically well.

202 Q. Yes.

A. And that was potentially why she was so self-injurious is because she was feeling something elsewhere, you know. 12:22

203 Q. Yes.

A. And that's kind of what we talked about earlier that, you know, if somebody is doing something, they're not necessarily just displaying this behaviour, it's as a form of communication to say 'well, actually, I can't explain to you why I'm feeling lousy here.' 12:22

204 Q. There's something else wrong.

A. Yeah. And that's kind of, you know, that's kind of what we had thought about. But I think she I think likely was physically unwell. 12:23

205 Q. Okay. Okay. Look, turning over to paragraph 40, just for summary sake you talk about ICU and you talk about how -- just before we turn to that paragraph, you talk about ICU. You don't talk about it in detail. You say that during your time at Muckamore there was no CCTV. 12:23

A. Yep.

206 Q. And while on Greenan and M4 you weren't involved in discharge because they were long stay wards. But in paragraph 40 you were heavily involved in resettlement. 12:23

A. Yeah.

207 Q. You were the named nurse for six to eight patients at any one time and you were expected to go to meetings about them?

A. Mhm-mhm.

208 Q. You describe a group of ladies being resettled to a nursing home placement in Armagh. You worked closely alongside the staff from the nursing home to ensure everything went smoothly. For six to eight weeks staff from the nursing home came to Muckamore to get to know the ladies and their care plans. The nursing home would have had their own care plans, but we would have made sure everything was included. There was a nursing assessment used based on the Roper Logan and Tierney model of nursing. Can you tell us a wee bit about what that is? 12:23 12:24 12:24

A. Yeah, that is a model of the nursing -- how we would devise their care plans, and that incorporates all of their daily, their daily activity living.

209 Q. Yes.

A. I can't speak!

210 Q. I think you go on then in fairness -- in fairness you go on in the next sentence to say --

A. Oh, does it say that? Okay. Yeah. Daily living activities. 12:24

211 Q. Yeah:

"We used to capture all daily living activities."

CHAIRPERSON: We've got to get it transcribed.

MR. McEVOY: Yes. So you say:

"It is used to capture all daily living activities and

when we were resettling patients from either Greenan or M4 the families did not usually get involved."

A. Yes.

212 Q. Did that model -- 12:24

A. No, no, that's just quite a common model that's used within nursing care. And just regarding the families, a high percentage of them, you know, we're talking about an older population, and maybe 20 or 30 years prior to that the mummies and daddies would have 12:25 visited, but as time went on they maybe have passed away and siblings didn't necessarily take as much to do, you know.

213 Q. Yes.

A. I can recall like one or two of them like would have 12:25 said 'Youse know her better. I'm happy if youse are' -- you know that way. But we wouldn't have had like a big -- there would have been maybe one or two patients would have had regular visits from their families, but I suppose just the longer stay, they were older and 12:25 maybe didn't have like close relatives.

214 Q. I think you're talking there about the instance of a patient whose sisters lived abroad and you were trying to resettle her.

A. Aye, that's -- yeah. Yeah. 12:25

215 Q. The sisters were very upset because they did not want their sister to leave as they viewed Muckamore as her home. Can you tell us how that was resolved, that situation?

A. Well I suppose like nobody really had a choice in the matter. It was a government driven policy that people were being moved out. In a less harsh way I sort of discussed that with the sisters, going like, you know, if I had my way she could stay here, you know, that's fine, but ultimately like that's not what's happening. The drive here is to get people resettled and out into the community. She doesn't need to be in hospital. She's not requiring any specific, you know, she was going to a learning disability nursing home with learning disability nurses. She didn't necessarily need to be in a long stay hospital. Just a lot of sort of emotional support given to like families about that, you know. And that particular one, there was a group of the patients that had been on the ward together for a very long time, and that was kind of what I had sort of said to her like, you know, the other options are if she doesn't go on this one we don't know where she is going to go because there has been no further nursing placement identified. So I kind of had sort of felt that it was the lesser of two evils that she was going to be going to a nursing home with patients that she knew, you know. 12:26 12:26 12:26 12:26

216 Q. Yes. Yes.

A. And like, do you know, she actually died a couple of months after being out, and the sister, like what I took from the sister, she was so upset and we got the blame of it, you know. And I suppose like she was just heartbroken, you know. She had just, I don't know, she 12:27

was very, very upset, but very cross at us in the aftermath of that. But I suppose it's just, it was just one of those things that was the nature of the long stay hospital, it wasn't going to be open forever and she didn't need, you know, she didn't need to be there. We would have liked to have kept her there, but she didn't need to be there. 12:27

217 Q. Of course. Of course. You tell us then that there's a matrix used by care managers to identify patients suitable for each placement. You weren't aware of it while you were at Muckamore, but you became aware of it working in the community? 12:27

A. Yeah.

218 Q. All the patients on Greenan and M4 were identified as being suitable. Why would you not have been aware of that matrix while at Muckamore? 12:28

A. Because that wouldn't -- as a Staff Nurse that I wouldn't have been, you know, the level that I would have been involved with is going and giving information about the patient that I knew, or my named patients. That matrix was they would have been, the care managers would have been two grades above you as a Staff Nurse. So that was kind of their like managerial sort of side of things, but I wouldn't have had knowledge of -- like the matrix is kind of looking to see, 'Right, well who lives there currently?', and what, you know, for talk's sake I could say somebody absolutely does not like loud music, and then they have the matrix, you know. I suppose it wasn't really my business either because 12:28 12:28

they would have had information of other service users that I wouldn't have needed to have knowledge of, you know. So I suppose from that point of view. But it was only just working in the community, and knowing care management, and knowing... 12:28

219 Q. Yes.

A. That's how I knew that's actually how they decide. Because the question was, the Inquiry question was like how were people identified? And it was kind of like 'Well, these six ladies know each other and there are six beds', it was a new place opening and there was six bed. Whereas like if somebody that had like real sensitivity to loud noise and they were going somewhere that your man up the stairs played drums, you know, they would have had that matrix to go 'that's a non-runner', you know. 12:29 12:29

220 Q. Yes.

A. So they would have had more sensitive information about other people that I wouldn't have necessarily needed.

221 Q. More relevant to the task that they had to do? 12:29

A. Yeah. It wasn't for me to know really.

222 Q. Yeah. Okay. Then in 41, and this is really just finally from me, but:

"I never had any formal training on resettling patients but I did not think I needed to be able to advocate for patients." 12:29

Is there anything you want to add to that? In other

words what you're essentially saying there, if we understand that correctly, is that resettlement is something that comes with the job essentially?

A. Yeah. And I suppose like the resettlement policy, do you know, it was, do you know, it wasn't anything -- it was just one of those things. It was a fact of life that these people were being moved out into the community and, you know, I think the question was like, you know, did I feel that I needed training? I didn't feel I needed training on a process that was going to potentially enable somebody to have a better life not living in a long stay hospital. And I suppose like I remember raising concerns about somebody that had been identified for another nursing home and raising concerns, and that was taken onboard, you know. I don't know how I would elaborate on that. 12:29 12:30 12:30

223 Q. Yeah. I suppose maybe just -- I know I told you that was my final question, but there's one that occurs to me. At the very start I asked you about your current post and you're in the community now and you're still working in the learning disability field. 12:30

A. Yeah.

224 Q. The Inquiry has seen and heard from you at quite some length this morning, but what are the attributes that you describe, you know, in your last paragraph there in terms of your nursing skills in Muckamore, what are the attributes you think are essential for a learning disability nurse going into the future? 12:30

A. Ehm, I suppose -- that's a really difficult question.

225 Q. Have a go. It's your opportunity to shine!
A. Yeah. No, I think though like you have to have a positive attitude, you know.
226 Q. Yes.
A. We joke about looking I think as a swan, being really calm on the exterior and your legs going a mile a dozen, you know. You need to be that sort of calm, but sure of yourself as well. 12:31
227 Q. Yes.
A. And you need to make sure -- like when I first moved into the community I was like I actually really like this because, you know what, you had to prove yourself to the person because you were going into their home. You know when I was in the hospital or a nursing home, you know, you were working there, but like when I've started afresh in the community you have to sort of build that relationship, make it therapeutic, and make it as positive and provide as much care and support to the people that you're working with. 12:31 12:31
I think overall like the skills that I learned in Muckamore like, do you know, like when I worked in the community the social workers used to come in and they would have been like 'Oh, my goodness, did you see such a thing?', and there would have been a big, big panic, and I was like, 'Like that's fine, don't worry about it', you know. And like a lot of them would comment going, you know, 'Oh, it's well seeing you come out of Muckamore. Youse are much more calm', you know. And 12:32

they would have made jokes about it. But I think like having a calm exterior, being caring, and kind and professional, and doing your best, you know, you're working with really, really vulnerable people, and particularly out in the community you're working with 12:32
people -- and in the hospital as well -- you're working with people with a lot of complex issues, you know. People might think that they're doing this because of this, but it's actually to do with something that happened at a very young age that's not being 12:32
considered and somebody would just put a negative thing going 'Oh, he's displaying' -- we had somebody, and the staff in a unit were like 'he's displaying this challenging behaviour. He's so difficult. He's so difficult', and I was like he actually has an 12:32
attachment issue, and that's where a lot of these, you know, and it is sort of -- a lot of it is educating as well and you're sort of educating other staff members, you know, of how to approach and how to look at it in a wider picture rather than just zoning in. 12:33

As I said before about the behaviour stuff, you're kind of looking 'Well, why?', you know, 'Why are they doing that? Why is somebody repeatedly head-butting the wall?', you'd be looking to see what actually is the 12:33
cause of that. And I think that's important and I'm very mindful when we have newly qualified Staff Nurses, you know, like reassuring them a lot. Like we have found ones that have come working with us recently, or

in the last number of years, are very nervous, and I think like there's such a negative spin on learning disability staff and learning disability nurses that they're very nervous and concerned to be in the field of nursing that we're in, and I suppose it's just trying to remember. 12:33

We did a thing there a while ago like "Remember Your Why" is like remember why you went into nursing is because you want to do the best for the people that you're working with. 12:33

228 Q. Yes.

A. And particularly if they have a learning disability or anything, any additional needs that makes them that bit more vulnerable, that you have to do your best. 12:33

229 Q. H324, those are my questions. Thank you very much.

A. Okay. Thank you.

MR. McEVOY: But maybe the Panel have some more.

CHAIRPERSON: I think we've asked the questions as we've gone along. So there's nothing more to ask you. 12:34

I just want to thank you on behalf of the Panel, because certainly my view is you have been very balanced in your evidence. You have been very frank. You've told us exactly as you found things to be, and you are sort of the witness we need. So can I thank you very much for giving up so much time to come and assist the Inquiry, and you can now go with the Secretary to the Inquiry. 12:34

A. Thank you.

CHAIRPERSON: Mr. McEvoy I think that's you done for the day, isn't it?

MR. McEVOY: That's my stint over. Thank you, Chair.

CHAIRPERSON: Ms. Bergin, you're reading this afternoon. 12:34

MS. BERGIN: Yes. I'm in your hands. We can make a start now or I'm happy to start at whenever your wish.

CHAIRPERSON: What we'll do is we'll take a break now because we've been sitting for quite a long time, but we might try and start a bit earlier. So if we start at 1:50. Okay. Thank you very much. 12:35

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

MS. BERGIN: Good afternoon.
CHAIRPERSON: Hold on. Okay. Ms. Bergin, we've got some statements to read. 13:46
MS. BERGIN: Yes. There are three statements to be read this afternoon, Chair and Panel. Two statements from Oliver Shanks and a statement from H303.

13:46

The first statement of Oliver Shanks is dated 28th June 2022. The reference is STM-031 and states as follows.
CHAIRPERSON: Okay. Hold on. Hold on. Sorry. Are you reading the whole thing into the record or are you going to precis it? 13:47
MS. BERGIN: So I'm going to precis certain parts of the statements where appropriate.
CHAIRPERSON: Yeah. Okay. Right. Sorry.

STATEMENTS OF OLIVER SHANKS REFERENCE STM-031 AND STM244 READ BY MS. BERGIN 13:47

MS. BERGIN:

"I, Oliver Shanks, MRCP, FRCP Psych, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement. 13:47

My connection with MAH is that I was a consultant psychiatrist at MAH. The relevant time period that I can speak about is from 1982 and January 2001.

I joined MAH in 1982. This was my first consultant post. I was a member of the consultant medical staff at MAH. I was proud of the service delivered and worked hard with others to maintain it. I have no knowledge of MAH in the time after 2001. I am devastated to hear the extent to which the well planned resettlement programme and continuing care of the patients in MAH fell apart. I am especially distressed to hear about the lack of respect and understanding suffered by the patients. 13:47 13:48

I note the Terms of Reference of the MAH Inquiry include making recommendations regarding the training of staff, the management and governance of such facilities. Whilst it is important for the Inquiry to examine what was done wrong, it is also important to examine what was not done that would have made things right. I am aware of the considerable expertise of members of the Panel, but I wish to describe below examples of what MAH at one time aspired to and in many cases achieved. 13:48 13:48

I submit that training should emphasise that interaction with patients must be respectful and age appropriate. The importance of age appropriate

interaction cannot be over-emphasised. People with a learning disability are not overgrown children, as the archaic use of the term "mental age" might suggest. They are people who happen to have a learning disability. Specialist nurse training should have 13:49
multidisciplinary components, as should training of all disciplines. After training there should be continuous professional development. Social workers can explain the importance of family and community facility involvement. Speech and language therapists can 13:49
demonstrate and teach not only the simplified sign language Makaton, but also the extent to which successful non-verbal communication can be achieved. Psychologists can explain how difficult behaviour is a potent form of communication. Psychiatrists can 13:49
explain the variety of syndromes, the manifestations of epilepsy and mental illness. Dieticians can explain not only the importance of sensible foods but also the emerging importance in certain conditions of specialist diets. Several other therapeutic disciplines have 13:50
important contributions to make to the initial and in-service training.

An important part of the training involves reviewing and conducting research. Research is a potent stimulus 13:50
for critical observation. It can involve both senior and junior staff and it requires outside scrutiny. Managers should supervise staff regularly in a supportive manner, not only assessing performance but

also eliciting concerns and anxieties.

Governance should include the physical presence on a regular basis of senior staff.

13:50

I eventually left MAH in January 2001 when I retired from medical practice."

The second statement of Oliver Shanks is dated 2nd May 2024, and the statement reference is STM-244, and 13:50
Dr. Shanks states at the beginning of his statement that he was a psychiatrist at MAH from 1982 until his retirement in 2001. Following graduation from Queen's University, Belfast, in 1974, he became a member of the Royal College of Physicians in 1978, and the Royal 13:51
College of Psychiatrists in around 1979. He worked as a child psychiatrist and then joined MAH in 1980 as a registrar.

There were three consultant psychiatrists at MAH at 13:51
that time. Dr. Scally, whom he shadowed; Dr. Moffett, and Dr. Calvert. There were also Dr. H566 and Dr. H41 who were appointed consultants in 1986.

There was normally one junior doctor attached to each 13:51
consultant. Dr. Shanks became a Senior Registrar in 1981 and was appointed as a consultant in 1982. He states that he went into learning disability specifically because:

"...there was no expectation for a complete cure, but rather a desire for a better long-term outcome for the patient..."

13:52

- and he wanted to be part of the instigation of change in societal attitudes to learning disability which were occurring at that time.

Picking up at paragraph 6, Dr. Shanks continues: 13:52

"Within MAH I was based in the administration building. I was on site at MAH every day. I would either do a morning or an afternoon session. As well as being in MAH I had a clinic within the Belfast Trust at 17 13:52 Wellington Park, Belfast. If I was not in MAH in the morning or the afternoon, I would be in the clinic.

I successfully applied to become a consultant psychiatrist in MAH in 1982. My office was based in 13:53 the administration building but I would treat patients from particular wards. I was initially assigned to treat patients on the Conicar and Clonshee Wards as these wards were children's wards, and the hospital wards, Rathmore and Rathmullan, because of my 13:53 qualification in physical medicine. I then began to treat patients on a long stay adult ward, a male admissions ward, Movilla, and a Forensic Ward, Mallow.

During my training to become a psychiatrist at postgraduate level, part of the course was learning disability specific. This was completed in MAH and St. Georges Hospital, London, with Professor Bicknell and Dr. (lately Professor) Sheila Hollins. The training which I undertook in working towards my membership of the Royal College of Psychiatry contained specific sections on children's learning disability, old age and general psychiatry. I did also complete other forms of learning disability training, specifically during my first post as a registrar when I worked in Purdysburn Hospital." 13:53 13:54

And Dr. Shanks states that he would have got an afternoon off to visit MAH for this training. 13:54

"I recall that I visited MAH before I commenced working at the hospital. I recall that it was a good facility and I remember being impressed. I liked the people I was working with and I liked the patients. I recall that Dr. Scally had a very good reputation when I went to work in MAH in 1982. Back then, in the 1980s, the hospital was very modern, there was a swimming pool on site and a day care centre. I recall that the cafe was introduced at a later date, supported by the parents and friends, but I cannot recall when. 13:54 13:54

During my time in MAH I would see patients every day, sometimes this would be in an office located in the

administration building or in a consultation room on the ward they were in. Every day in MAH was different. I would see patients depending on the needs of the individual patient. There were ward rounds carried out every week for which I would have been present and I would also informally bump into patients and have a chat with them. If during the ward rounds something cropped up, I would have met with the patient. Other times, I would have met with the patient at a planned appointment. I worked in MAH between the hours of 9:00am to around 6:00pm, but occasionally I would have visited the hospital at night to make sure everything was okay." 13:55 13:55

Dr. Shanks then recalls an example of a mother of a profoundly disabled child patient who was in tears, having been told that the disability had been caused by the mother's failure to live up to her religious beliefs. 13:55

Dr. Shanks continues:

"I recall that patients always had more than just medication on their treatment plans. Medication was just part of a wider plan. The medication element of the treatment plan came from the medical team. I would have contributed to this as a psychiatrist. Social workers, along with families and the patients themselves, would have contributed to the treatment 13:56

plan. The plans were structured to be multidisciplinary. I recall there was a pharmacist on site at MAH, but I do not recall that they ever had a direct input to the treatment plans. I believe they were involved in the formulation of the medication and were available for advice. When I was a registrar, I had an input towards the treatment plan of the patients. If something was more complex that I felt I could not do myself as a registrar, I would have discussed this with the consultant. On occasion, when I was a consultant, I obtained a second opinion on a patient if there was a condition which was particularly difficult to treat. 13:56 13:56

The primary treatment options were different for every patient and these would depend on what the individual needed treatment for. For example, if a patient suffered from epilepsy I would prescribe medication. However, if a patient had behavioural issues I would direct they were treated with behavioural methods. On occasion, I would prescribe medication in addition to the behavioural methods. 13:57 13:57

Again, in relation to the use of primary therapeutic interventions, these would have depended on the individual patient. I recall the interventions that were used would be psychotherapy, talking therapy, medication, social interaction and behavioural therapy. Therapeutic intervention itself is also a form of 13:57

treatment. It was my role as a consultant to ensure they were used appropriately and I would have relied on my professional training and experience to assess this. I recall the introduction of group therapy, but this took a while to establish. Psychotherapy was gradually introduced during my time in MAH and I was part of the piloting for this. The application of psychotherapy was gradual. 13:58

I recall that in my initial years there was an issue with overcrowding in MAH. I recall that some patients would sleep out. Patients on a ward would spend the day in their ward and then would be moved to a different ward to sleep as there was not enough room for them as there were new admissions. The newly admitted patients would stay on the same ward day and night and the patient who was maybe ready for resettlement would have been moved to sleep out on another ward. 13:58

During my time in MAH the general relationship between staff and families was good and developed further. The general attitude towards learning disability changed. People with a learning disability used to be referred to as "mentally handicapped" and the change of this phrase reflected a wider societal change. There was a change with the introduction of special education too. I felt these were positive changes which reflected improvement in the treatment of learning disabilities. 13:58

I recall when I worked on the Conicar Ward, which was a children's ward, most patients were in their late teenage years. Some of the staff members tended to hug the patients when greeting them. I insisted on shaking 13:59
their hands when I greeted them as it was more appropriate with young adults. I understand that this was more the societal attitude at the time, i.e. to treat the patients like they were all children. I felt that this culture changed during my time in MAH for the 13:59
better.

After a patient was admitted to MAH, as a consultant I would have been involved in developing the care plan. The process began at ward level. There were several 13:59
disciplines involved in the adaptation of the new care plan during the patient's period of care, such as medical, social workers and nursing.

During my time in MAH there was always a nursing 14:00
hierarchy. There would be experienced senior nursing officers who would be in charge of multiple wards, then charge nurses in charge of a ward, and staff nurses. This appears to have changed since I left MAH. I think this hierarchy worked well. We all worked well 14:00
together. We would on occasions have robust discussions but they were constructive.

As a consultant I would have attended weekly ward

rounds as part of the multidisciplinary team. These meetings were conducted in a consultation room and involved discussing each patient on the ward in turn. Present would have been myself, a social worker, a day care worker and I recall at one stage there was a dietician involved. I was in attendance as part of the medical discipline. I recall that on occasions a psychologist would be present. They are not medical doctors but they might have a PhD. 14:00

I recall that once a month an orthopaedic surgeon would have visited the site, his name was Mr. James, as occasionally orthopaedic intervention was necessary. The medical representation at the MDT meetings would involve the consultant psychiatrist and the junior doctor who was attached to that consultant. 14:01

I recall that patients would sometimes attend the MDT meetings but they would not stay for the entirety of the meeting. Patient advocates were only being introduced at MAH when I left in 2001, so I did not experience them. 14:01

I had a good relationship with the on-site management team at MAH. I felt supported. The most senior manager on site at the time I started was Bill Canning. Later there was Norma Heatherington and Miriam Somerville. My interactions with the management on site were not frequent. They would involve casual 14:01

meetings which would have taken place in the administration building but they were not formal meetings.

The Datix system was introduced at MAH after I retired in 2001. During my time in MAH there would have been a system in place for recording serious incidents, however, I was not involved in compiling the reports. Before Datix I believe these would have been recorded on paper and, if an incident had taken place, I would have seen the report for the purpose of me being kept informed. I cannot recall a particular time I would have seen these documents, nor can I recall how frequently I would have reviewed these documents. I would have received the documents from the nursing staff rather than have requested to see them. 14:02 14:02 14:02

I recall at MAH there were a number of external specialists available for consultation in complicated matters. Around 30% of people with a learning disability suffer from epilepsy. This was the same for the patients in MAH. Most of the time the epilepsy was easy to control with medication. However, a neurologist's opinion was sometimes needed. If I did not think I could manage a case of complex epilepsy on my own I would have sought help from another consultant. I might also seek a second opinion in a case of treatment resistant psychosis. This would not have been frequent. There were no criteria as to when 14:03 14:03

a patient would be referred for a second opinion from a consultant or hospital. It was case specific to each patient. I would have made a referral if I thought I needed advice or could not manage the patient myself.

14:03

I recall that I would have been made aware when seclusion, physical intervention or sedation was used on a patient. I would have been made aware by the nursing staff on the ward, I would have been told when the incident had occurred at the ward round or at the weekly MDT meeting. The incident would have been on the agenda for the MDT meeting. I recall that PRN medication was used when required, but it was not encouraged for behavioural problems. My role as a consultant was to ensure that these methods were used appropriately. If they were being used inappropriately I would have relayed this back to the staff in question. The issue was usually that the methods had not been used. For example, a situation that required the use of PRN medication and it was not used."

14:04 14:04 14:04

Dr. Shanks doesn't recall any specific incidents seclusion was an alternative to PRN medication and he states that it generally wasn't used.

14:04

"The term "safeguarding" was introduced after my time in MAH but there must have been an equivalent when I was there. I would not have been involved directly but I would have contributed if required. Usually the

issue would have been initiated elsewhere by the social worker or a member of MAH staff of another discipline. If there was a general discussion around the safeguarding of a patient I would have contributed.

14:05

As far as I can recall the positive behaviour support plan for patients would have been part of the general treatment plan. Cognitive Behaviour Therapy (CBT), was only just being introduced in MAH around the time I left. I recall that CBT would have been psychology led but that medical staff would have been involved in this. I recall that there was training for this and I attended one or two training sessions before I left.

14:05

I cannot recall that during my time there were any specific polypharmacy reviews, however medication of patients would have been reviewed at the weekly MDT meetings.

14:05

During my time in MAH, learning disability was still going through societal change. I left MAH in 2001 and learning disability was part of the general societal change at that time. A few families were reluctant for their member with learning disability to be discharged from MAH. Now, as I understand it, society is beginning to see people with a learning disability as adults and not as perpetual children.

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During my time in MAH I would have always welcomed and

encouraged family's input in regards to the patients and their treatment. My contact with families would have varied as some families were more involved than others. My contact would usually have been with families that wanted to be involved. Occasionally I would have pushed for more involvement from families, but they did not want to be involved. I recall that there were some families that were involved to an extent that proved extremely difficult. 14:06

If a family wanted to be involved with a patient I would have discussed issues and medication with them, preferably face to face. This would have been my preference but some families found it more convenient by telephone. If this was the case I would have made a note of this in the notes. At this time all notes were paper notes. After I had discussed anything with the family I would have recorded this myself. Consultants did use secretaries, but this was more for sending out letters and arranging appointments. 14:07

If a family member had raised a concern with me about a patient I would have referred this to the ward staff. I cannot recall any specific incidents where a family member made a complaint to me. However, if a complaint was made about a particular member of staff, I might have met with the nursing staff and the family member together, if it was appropriate. 14:07

In relation to overmedication, it was my role to ensure that this would not happen in the first place. I cannot recall during my time that any family member made a complaint about their relative who was a patient in MAH being overmedicated. This is not to say that it did not happen, I just cannot recall any specific incident. I do recall that at times there was difficulty in controlling specific conditions. 14:07

I recall that from the outset I had a good working relationship with the nursing staff and I worked in good partnership with the Ward Managers. I recall that the attitude and conduct of the staff reflected the nature of the patient. Each ward had a different culture as each ward dealt with various different abilities. For example, the Rathmullan and Rathmore Wards were more hospital wards where the patients were bedbound. I worked in both of these wards. I also worked on the Forensic Ward where I shared responsibility for this ward with Dr. Maginnity. We worked alongside the senior nurse, Sister Devlin. I recall the three of us worked well together. This ward was more progressive than the other wards as patients were more able. This made it easier to introduce talking therapies on the ward and social activities. I recall that working on the Forensic Ward posed more difficult at times. The problems the patients presented were different. You were put into a situation that had given rise to what social constraint 14:08 14:08 14:08 14:09

they were under. For example, where the patient was acting inappropriately we tried to help them cope.

I recall that there were nursing officers who were in charge of one or more wards at a time. My relationship with staff members and the nursing officers was good. 14:09

As a member of staff in MAH I underwent training in restrictive practices. I do not recall ever having to be involved in any restrictive practices. I believe that the term "restrictive practice" was introduced after my time in MAH. As far as I can recall the use of seclusion and administering medication was the responsibility of the nursing staff. However, the medical team, consultants, would have prescribed the medication. If I was present on a ward when seclusion or medication was being administered I would have expressed an opinion, but that was the extent of my input. I recall on one occasion a male patient was presenting as self-abusive. I was present for this incident while he was being restrained. He had required treatment at a secure hospital in Scotland. I recall his name was P215. I was involved in the decision-making process regarding this incident. I prescribed new medication to him and he was eventually successfully resettled into a community placement. 14:09 14:09 14:10 14:10

I recall one occasion when a member of nursing staff had an opinion that was critical of my work. His

opinion was that I had discharged a patient too early. The member of nursing staff in this instance was right and I could have done better. Thankfully the situation worked out well in the end for the patient.

14:10

I recall one tragic incident occurred during my early days in MAH where the bath water was too hot and a young patient got burnt as a result. The nurse was disciplined. I remember I went to speak to her and I was perceived by her nursing manager to be over-supportive. The nurse in charge felt that I was more supportive than I should have been towards the nurse, this was business between the nurses and I would just leave them to it.

14:11

14:11

I recall that I wanted to introduce more parental involvement. There were associate specialists in the hospital, they were elderly doctors or doctors who were not in training posts. They were there to provide general medical care. I recall that when I wanted to introduce the more parental involvement I received resistance from them. This slowed down the introduction of more parental involvement with the patients, but I did not raise any concerns at this time as the team were slowly phasing out and, although it slowed down the process, things were still moving forward. These general medical doctors were present during my early days in MAH and I recall that they eventually retired. Once they were phased out it was

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the responsibility of the consultants and trainees to provide general medical care.

The allegations of extensive abuse occurred long after I had left MAH. I recall that there were occasionally allegations of abuse during my time, but these were infrequent and were managed appropriately. I do not recall any specific incidents of this type however. 14:12

During my time in MAH, I was involved in dealing with complaints from patients relatives. I recall there was one specific incident, I cannot recall when, with a patient, I cannot recall the name, who had a bite mark on them which was noticed by the parents. I remember being a party to the investigation of this injury. I recall that we got an opinion from a dental specialist to see if we could identify who did this. Unfortunately, there was no resolution to this investigation. I recall that as a consultant, parents would approach me to make complaints. I do not recall any specific incidents, however, I recall that parents were always satisfied that everything that could have been done was and the relationship carried on successfully between that staff member and the parents. 14:12 14:12

14:13

I understand that both talking therapy and psychotherapy did evolve after my time in MAH. I also understand that parental involvement with patients developed considerably towards the end of my time at

MAH and after. During my time in MAH I helped develop patients discharged to the community. I contributed to this by being part of a project that ran in Carrickfergus. I recall that two nursing staff members from the Conicar Ward..." 14:13

– who Dr. Shanks names:

"...set up a successful nursing home in Ballyclare and a number of patients from MAH went there and were 14:13 supported. They set up the nursing home to encourage and support patients being discharged from the hospital. During my time in MAH a consultant ultimately had to be involved in the discharge of patients. 14:14

There is a distinct difference between discharge and resettlement. To me, resettlement was when someone came in for treatment, was treated, got better, stayed for some time and then left MAH to a setting different 14:14 from the one from which they were admitted. Discharge was more that the patient would return to the setting they had come from. In my role as consultant I was more involved from a hospital point of view rather than the community. I do recall on occasions I would have 14:14 followed up with some patients who had been resettled to the community.

My time at MAH was hard work but it was something

different every day and I enjoyed that."

The final statement to be read is from H303. Chair, a Restriction Order, No. 74, was granted by you on 28th of April in respect of this witness that they be referred to by their cipher rather than by name.

CHAIRPERSON: But that's it?

MS. BERGIN: Yes, that's the extent of the Restriction Order, Chair. And the reference is STM-211.

CHAIRPERSON: I mean just to make it clear, the reason that those restriction, or that type of Restriction Order is necessary, is that although somebody may have been given a cipher in the past from a precautionary point of view, when they actually come to give evidence they need to apply for a Restriction Order.

MS. BERGIN: Thank you, Chair.

STATEMENT OF H303 REFERNCE STM-211 READ BY MS. BERGIN

MS. BERGIN: The statement is dated 19th April 2024, and states:

"I, H303, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

There are no documents produced with my statement.

My connection with MAH is that I was employed as an occupational therapist at various grades as set out below from 2017 to 2023. The relevant time period that

I can speak about MAH is approximately between October 2017 when I commenced my employment at MAH and December 2023."

The witness then outlines that they qualified as an occupational therapist in July 2016 and they are registered under the Health and Care Professionals Council and the British Association of Occupational Therapists. 14:16

Prior to their employment at MAH they had experience of working in an educational and residential college for service users with learning disabilities. 14:16

The witness began working in MAH in October 2017 and worked as a Band 5 agency occupational therapist for 18 months. They had an on-site induction with a Band 6 occupational therapist, which included introduction to the assessments used in MAH and the wider Occupational Therapy Team who were based within the community learning disability team. Their first impressions were that MAH was well equipped and inviting. 14:16 14:17

Picking up at paragraph 8: 14:17

"As part of the Band 5 occupational therapy role, I completed the majority of my visits on Cranfield 2 Ward. However, I was expected to cover all wards as and when requests came through to the Occupational

Therapy Department.

My role included assessing personal and domestic activities of daily living and assessing if the use of aids or equipment could be beneficial in improving a client's independent function. For instance, if someone struggles to mobilise short and long distances, the use of a wheelchair may be beneficial. It would be the role of the Occupational Therapy Department to assess and follow the regional agreed pathway to procure an appropriately assessed wheelchair. Or, for example, if one of our clients struggled to maintain a standing position for the period of a shower, the use of a shower chair may be beneficial and again would be the responsibility of the Occupational Therapy Department to assess. 14:17 14:17 14:18

When attending the ward environment, I spoke with the nurse in charge or a member of the ward team to glean any relevant information required. For instance, if going to complete an assessment and the client had been awake for a large proportion of the night shift, then it perhaps was not the time to get a fair representation of function. We rely on our nursing family colleagues to share accurate information. 14:18 14:18

When completing assessments within the ward environment in regards to personal activities of daily living, for instance showering, these were generally completed

alongside the health care support worker as they generally completed these activities on a daily basis and knew the client's routines and more importantly triggers that may be associated with activities. Following the assessment, on occasion we would suggest alternatives in relation to pieces of equipment. For instance, the use of a jug when completing hair rinsing tasks. The Healthcare Support Worker would be able to advise on whether the piece of equipment had been trialed in the past and their impression of the alternative equipment. With the nursing staff we collaborated to consider if it would be of benefit to trial the aid or piece of equipment. We relied on our nursing family, registered nurses and health care support workers, to follow through with recommendations we made and encourage service users to utilise the aid or equipment. On occasion the client and staff member on follow-up may have advised that the aid was not beneficial. For example, the introduction of a pumped bottle for shower gel or shampoo may not have increased function or dexterity and may not have improved the independence within the activity." 14:19 14:19 14:19 14:19

The witness then describes their role in running various groups at MAH which were well received by wards, often facilitated alongside different disciplines, and gives the example of a six week Money Matters Group with psychology colleagues which tried to increase patients' awareness of money. 14:20

Picking up at paragraph 13:

"When considering participants for our groups we discussed the individuals with the nurses within the ward environment. For instance, the client's named nurse, Deputy Ward Manager or Ward Manager. The information was always beneficial and we were able to discuss risks and vulnerabilities, as well as whether there were any safeguarding issues between peers that we needed to be aware of. We completed risk assessments to reflect the risks and documented how we felt it would be appropriate to mitigate the risks. If including patients from more than one ward, we brought it to the multidisciplinary team meeting to get the opinion from the wider team." 14:20 14:20 14:21

The witness then states that the Occupational Therapy developed groups to benefit clients at MAH. A breakfast club "Watch me grow" was developed to increase awareness of horticultural and cooking where patients planted seed and then grew and cooked vegetables. The witness states that: 14:21

"Creating roles and responsibilities is a key area of an occupational therapist in encouraging clients to increase and maintain function and that some of the group had continued to take responsibility outside of weekly sessions." 14:21

The witness states that they applied and in March 2019 were appointed as a Band 6 Specialist Occupational Therapist. Around February 2022 they took up a Band 7 Team Lead Occupational Therapist maternity cover post.

At paragraph 17:

"During my employment within MAH as an occupational therapist, an occupational therapy technical instructor (OTTI) Band 4 was in post. It was their responsibility to assist the occupational therapists in assessing personal and domestic activity skills, as and when intervention plans were created and the OTT, under the occupational therapist direction, assisted in working through the intervention plans. For instance, if the goal was to improve an individual's cooking skills, the OTTI was able to complete a session on a regular basis, working through different cookery skills, with the aim that the client would become proficient in tasks to gain independence in cookery tasks even for one meal a day (a sandwich for lunch or putting together their breakfast). Our OTTI returned to the office following sessions and completed a handover of the session. The OTTI understood the importance of advising the nursing staff and Occupational Therapy Team if any issues arose within the session.

Following all contacts (direct or indirect) with

clients, notes were completed to reflect the session. These were entered within PARIS in the relevant area and were visible within the PARIS system.

The occupational therapy role also consists of assessing environments specifically for clients needs. This involves assessing function in relation to personal activities of daily living, including toileting, showering, transfers, mobility, and taking into consideration aids and equipment that may be required to support function. The assessment of each of these areas would influence environmental recommendations. 14:23

The Occupational Therapy Team was part of the wider multidisciplinary team which included physiotherapy, speech and language therapy and dietician, who all contributed in the weekly meetings. For a period of time this changed to a Purposeful In-Patient Admission, (PIPA), which was a daily meeting completed on the ward. Given the number of occupational therapy staff members and the number of wards, it was not feasible to complete this on a daily basis, therefore, we attended each ward on a particular day with other professionals attending the others and, if needed, information could be shared following the meeting. These slowly reduced in frequency to become bi-weekly and then subsequently a weekly meeting again. Representation from occupational therapy services generally remained at 14:23 14:24 14:24

once weekly with specific patient meetings sitting outside of the ward multidisciplinary team and attendance at these was as and when relevant to occupational therapy discussion.

14:24

Within the Occupational Therapy Team, if any concerns needed to be raised we brought them through on the day to the Ward Manager and they were discussed and reflected in safety briefs. For instance, if it had been recommended that a client use a non-slip mat for 14:25
increased independence during feeding activity and it had not been seen by the Occupational Therapy Team being utilised when on the ward, then this would have been raised with the Ward Manager to ensure that all staff understood the function of the non-slip mat. 14:25

Occupational therapy processes include the completion of an information gathering exercise, an assessment, compilation of a list of aims and objectives. If possible, in conjunction with the client, and 14:25
evaluation following the intervention. If the client is being considered for a community placement we would often complete an occupational therapy report which would encompass background information, functional abilities, engagement in activities, sensory 14:25
assessment, if required, and environmental assessment.

We, as the occupational therapy profession, did not feed into the nursing care plan, and that was the

responsibility of the nursing team to complete their own care plan. We assisted in the development of Positive Behaviour Support plans with generally the Positive Behaviour Therapist completing the support plan with us adding information in relation to function, and consideration of some of the sensory activities that the client may find beneficial. An example of a restrictive practice that I was involved in was the implementation of a pinpoint belt cover of an individual's wheelchair. The client lacked safety awareness and had the dexterity to open belt covers and didn't understand the risk coming out of the wheelchair may have placed on her if on the footpath. The use of the pinpoint belt was agreed within the wider multi-disciplinary team alongside family input. Alternatives were trialed prior to the pinpoint belt cover given the restrictive nature, however, due to the dexterity of the client none were effective in maintaining safety. This continued to be reviewed and it was documented that the pinpoint belt would be used for the least amount of time. 14:26 14:26 14:26 14:27

Our team's working hours are Monday through Friday, 8:00am to 4:00pm. There were occasions that we did attend earlier or stay later, for example, a client may have engaged in their personal hygiene morning routine prior to 8:00am. There may also have been urgent requests on a Friday afternoon whereby we would have ensured there was a contingency plan for over the 14:27

weekend timeframe and the review would have been completed on Monday morning on the clinician's return. For example, one Friday afternoon we had been made aware that a client's mobility had deteriorated to the point where a wheelchair would be beneficial for mobility. Occupational therapy did not maintain a stock of wheelchairs but we knew of a few wheelchairs around the site that were non-client specific and obtained one of them for the client. The client's mobility was reviewed alongside physiotherapy colleagues on the following Monday morning. 14:27 14:28

In terms of engaging with families, this was dependent on each family. Given our general working hours we did not always see families. However, if we needed to make contact I understood where to locate the contact details or could have passed information through the nursing team who had more regular contact with family members. 14:28

It is our own responsibility to maintain our continuing professional development. The Belfast Trust facilitated us with the opportunity to maintain corporate and professional specific training events. As previously mentioned, as an occupational therapist we have the professional responsibility in maintaining our professional registration and we re-register every two years through the HCPC, having to confirm that we have maintained our professional code of conduct and 14:28

continued with our own CPD. Upon starting my employment with the Belfast Trust I was invited to complete the corporate induction in Belfast City Hospital.

14:29

Within the Occupational Therapy Team we completed supervision within a timely manner. This included a variety of types including; one-to-one formal supervision, peer supervision within our wider Occupational Therapy Team, and informal supervision within the office.

14:29

When I started in MAH as an agency Band 5 occupational therapist, the CCTV cameras were functioning. There were cameras within our office environment and signs at the front door of the building to advise they were installed and functioning. I am aware that within the ward environment CCTV covered the communal areas and were not installed within the bedroom, en suite and bathroom environments, given the personal nature of these rooms.

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Our Occupational Therapy Team was managed by the Assistant Service Manager for Learning Disability Occupational Therapy Services. The ASM did not geographically sit within MAH but there was always a way to get in contact if there were any urgent questions. The ASM did make contact with MAH on a regular basis and it was an invaluable source of

14:30

support.

The Occupation Therapy Team has an office within the Moyola day services building."

14:30

And the witness describes how they were unable to see anything on site from that office.

"During my time within the in-patient Occupational Therapy Team I would say it has been a tight knit team that has worked closely with one another, utilising each other for our strengths within our daily work. We bounced ideas between each other and often came up with creative solutions.

14:30

When changes were made within the hospital profile, Occupational Therapy were not generally included within the discussion. I recall on an occasion occupational therapy were asked to assess a change in ward environment for a number of clients and advised of any adaptations would be required at the end of the week before the schedule moved. Thankfully at that point there were no adaptations were required. We generally heard of on-site developments in the likes of multidisciplinary team meetings.

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14:31

During my employment there were a number of senior management changes. This generally brought a different style of communication with the staff team as a whole.

I remember there were meetings for all staff members to attend and they would inform staff of ongoing issues and developments and, as referenced above, at other times some decisions would filter down through the multidisciplinary team meetings." 14:31

And the witness then states that to progress their career they moved to work within the Trust Community Learning Disability Team and they do not provide any input to MAH, and that they thoroughly enjoyed their 14:32 employment within MAH, and then provides the usual declarations in relation to their statement.

So Chair and Panel, that concludes the reading of the three statements for this afternoon. 14:32

CHAIRPERSON: That's fine. Thank you. I think tomorrow we've got one longish witness. But nothing to be read tomorrow? We might. Well, okay. But we can start at 10:00 tomorrow. Yep. Okay. Thank you very much. Okay everybody, we'll start at 10:00 o'clock 14:32 tomorrow morning. Thank you for your attendance today.

THE INQUIRY ADJOURNED UNTIL TUESDAY, 4TH JUNE 2024, AT 10:00 A.M.